The health status and health inequities of women, including transgender women, who sell sexual services in Australia

A review of the literature

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Women's Health West acknowledge the traditional custodians of the land on which we work, the people of the Kulin Nation, and we pay our respects to Elders and community members past and present. We express solidarity with the ongoing struggle for land rights, self-determination, sovereignty and the recognition of past injustices. We express our hope for reconciliation and justice.

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Background

Women's Health West provides specialist family violence services to women and their children, and deliver prevention programs that promote equity and justice for women and girls in Melbourne's west. For over two decades, our health promotion unit has worked to generate the social and cultural change needed to achieve optimal sexual and reproductive health for women and girls across our region. We also lead 'Action for Equity: A sexual and reproductive health plan for Melbourne's west 2013-2017', which is a regional partnership and plan comprising of fifteen organisations that work to redress the social determinants of sexual and reproductive health, in order to achieve health equity.

In Victoria, the commercial sex industry has been decriminalised for two decades, while street-based sex-work remains criminalised. The expanding unregulated sex industry in Footscray and Melbourne's western suburbs has received increasing attention. Research by White and Rowe (2011) showed that the majority of Footscray sex workers entered the industry to meet the costs of drug dependency and that limited access to education, employment, social support networks, mental health care, homelessness and visa conditions impede women's autonomy and ability to leave the industry. Women's Health West commissioned Deakin University to undertake a review of the literature of the health inequities of women, including transgender women, who sell sexual services to inform evidence-based health promotion practice and service responses in Melbourne's west and Victoria.

Introduction

This literature review explores the health status and health inequities of women, including transgender women, who sell sexual services in Australia. First, the review briefly sets out the legal and policy context regarding sex work in Australia. Second, the methods used to conduct the review are detailed. Third, the findings are presented that focus on the sexual and reproductive health of sex workers and explore the socioeconomic, political and cultural context, daily living conditions, and individual health-related factors, as per the 'Fair foundations: The VicHealth Framework for health equity' (VicHealth, 2015). The review is framed by the World Health Organisation's (WHO) conceptualisation of sexual and reproductive health. The WHO defines sexual health as:

> ...a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (WHO 2006 updated, 2010: 5)

A necessary component for understanding and operationalising sexual health is sexuality, which is defined as encompassing:

> sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships... Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors (WHO 2006 updated, 2010: 5).

Similar to the definition of sexual health, reproductive health is defined by the WHO as:

> ...a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO 2006 updated, 2010: 4).

The legal and policy context of sex work in Australia

Australia's laws regarding sex work and the sex work industry vary across states and territories (Appendix A) that includes the legal status of sex work as illegal, unregulated or criminalised, or as legal and regulated, or decriminalised. Criminalisation refers to legislative frameworks that designate sex work as a crime (Global Network for Sex Work Projects (NSWP), 2014). In all states and territories except New South Wales, street-based sex work is criminalised. Decriminalisation is the 'absence of the criminal laws that prohibit sex work itself or associated activities like brothel keeping,' as well as the absence of laws that prohibit procuring a sex worker, or the absence of indirect laws, such as public nuisance or obscenity (NSWP 2014: 3). Decriminalisation is associated with better health outcomes for sex workers (Harcourt et al., 2010). In Australia, New South Wales is the only state or territory to not only have decriminalised sex work, but to also have legalised it, thus enabling the state to regulate the industry.

There are various forms of sex work in Australia and their legal status affects the occupational safety of sex workers (Table 1). Sex workers in the Australian Capital Territory, Queensland and Victoria are subject to varying legislation that relates to what is widely regarded as mandatory testing of STIs, which includes testing for Human Immunodeficiency Virus (HIV) (Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), 2017). In the Australian Capital Territory, Queensland, and Victoria operators of brothels must not permit a sex worker to provide services if they are infected with an STI, including HIV. In the Australian Capital Territory, owners or operators of a brothel or escort agency must take 'reasonable steps', which is undefined but understood as ensuring workers have 'regular' testing, yet what constitutes 'regular' is not specified (ACT Parliamentary Counsel 1992, s. 9). In Queensland, brothel managers are exempt from liability if they prove that based on 'reasonable grounds' the worker has had regular medical examinations that is defined as occurring every three months (Queensland Parliamentary Counsel 1999, s. 3). Similarly in Victoria, managers of brothels and escort agencies must take 'reasonable steps' to ensure workers do not have an STI or HIV, established through three-monthly blood tests and swab tests (Parliament of Victoria 1994 s. 19). Private sex workers must also adhere to the same testing regime and are not permitted to provide sexual services if they have an STI or HIV (Parliament of Victoria, 1994). The testing regime in Victoria was changed from monthly to three-monthly in October 2012. However, sex workers who practice illegally are not bound by mandatory STI and HIV testing, and testing is not able to be enforced or monitored, so a gap and inequity in policy and legislation remains. Overall, testing requirements have been associated with stigma and discrimination and impact upon the legality of working as a sex worker (Jeffreys, 2012).

Table 1: Variations in forms of sex work

Work type	Description
Street-based sex work	Solicitation for sexual services in a public or semi-public location. Servicing of clients in public locations, vehicles or 'short-stay' premises.
Brothels	Premises explicitly used for the provision of sexual services by two or more sex workers.
Parlours	Premises primarily used for massage or other non-sexual services, with sexual services also offered.
Escort work	Provision of sexual services at a client's home or hotel.
Private work	Provision of sexual services at a private location, such as a sex worker's home.

Method

The following section describes the methods used to search and review the literature. The findings from the systematic search of the literature are presented with each section considering the socioeconomic, political and cultural context, daily living conditions, and individual health-related factors as per 'Fair foundations: The VicHealth Framework for health equity' (VicHealth, 2015).

A systematic search of the literature was conducted through multiple platforms (EBSCOhost, Embase, Cochrane, and Informit). The concepts of health status, health inequities, determinants of health, health promotion, resources, programs, policy, regulated and unregulated sex industries, and sexual and reproductive health were searched. The inclusion criteria was Australian research published in English between 2010 and 2017 that focused on the health status or health inequities of women or transgender women who sell sexual services, and sexual and reproductive health. The exclusion criteria was research that focused on sex trafficking, on the legality of sex work or the sex worker industry, and non-empirical evidence, such as commentaries.

The search strategy was conducted in phases as described below.

1. Each concept was searched individually, resulting in 45,355,139 journal articles.
2. Each concept was searched in combination with a secondary search term, such as 'health status' and 'social determinants of health,' resulting in 19,733,959 journal articles.
3. The concepts 'health status' or 'health inequities' were searched with 'sex workers' and 'women and trans women,' resulting in 3,832,023 journal articles.
4. The concepts 'health status,' 'health inequities,' 'sex workers' and 'women and trans women' were searched with 'regulated or unregulated sex industries' or 'occupational health and safety' or 'legislation,' resulting in 1,157,539 journal articles.
5. The concepts 'health status,' 'health inequities,' 'sex workers' and 'women and trans women,' 'regulated or unregulated sex industries,' 'occupational health and safety,' 'legislation' were searched with 'sexual health' or 'reproductive health,' resulting in 539,071 journal articles.
6. The concepts 'health status' or 'health inequities,' 'sex workers' and 'women and trans women,' 'sexual health' or 'reproductive health' were searched with 'sex workers' or 'regulated or unregulated sex industries' or 'occupational health and safety' or 'legislation,' resulting in 836 journal articles.
7. Manual removal of 288 duplicates was performed, resulting in 548 journal articles.

Title and abstract analysis of these 548 articles was undertaken. Those that did not meet the inclusion criteria (n=496) were excluded. The full text of the remaining 52 articles was retrieved.

In addition, specific relevant websites and Google advanced searches were conducted. Grey literature was searched using Google advanced site: gov.au and site: org. The concepts 'health status,' 'health inequities,' 'sex workers,' 'women' and 'trans women,' 'regulated or unregulated sex industries,' 'occupational health and safety,' and 'legislation' were searched with 'sexual health' or 'reproductive health.' A total of six website results were found for .edu, 11 websites for .org, and 13 websites through gov.au. From these websites, 18 documents were retrieved.

The 52 journal articles and 18 documents underwent full review in relation to the inclusion and exclusion criteria. As a result, 48 articles and documents were excluded, resulting in 22 articles and documents that were included in the final review.

Socioeconomic, political and cultural context

Evidence of the sexual and reproductive health status and inequities experienced by sex workers was identified and related to macro-level socioeconomic, political and cultural contexts that impact upon social stratification and peoples' daily living conditions. The analysis identified two themes that are policy and legal status, and stigma, discrimination, and violence.

Policy and legal status

Policies that effect sex workers vary between states. These policies and legislation regard the determination of legal and illegal activities that include variations in the types of legal sex work, the operations and licensing of venues, and the resources and funding provided to services for sex workers. The status of different types of sex work as legal or illegal has implications for the health and wellbeing of sex workers. Vulnerability is increased among those working in sex work that is not legal, compared to those in legal practice (Berg et al., 2011). Those working in criminalised types of sex work were more likely to report negative outcomes related to sex work, pervasive to all areas of their lives, such as homelessness, poorer mental health, substance use and the experience of stigma and discrimination (White and Rowe, 2011). Further to this, research demonstrates homelessness, addiction, exploitation, and violence are negative outcomes of sex work. They are also factors that keep women in the sex work industry, and as such, act as determinants of engagement in sex work, as discussed under 'daily living conditions.'

Government-funded health promotion services for brothel-based sex workers exist in Perth, Melbourne and Sydney, despite variations in laws (Harcourt et al., 2010). Each city was found to have a large sex worker industry, however, health promotion for sex workers in Sydney was rated more positively compared to the other cities. Harcourt and colleagues (2010) found this was due to a range of factors that include the decriminalised and unlicensed sex industry in Sydney that facilitates outreach workers being able to reach brothel-based sex workers, larger financial backing for the community-based service, the provision of evening services, and outreach staff with Asian-language skills (Chinese, Thai and Karen). It is unclear however, if these staff were from the same cultural background. To this end, Harcourt and colleagues (2010) suggest New South Wales decriminalisation of sex work is a best practice approach to improve the health of sex workers. Further, Bates (2014) suggests this approach facilitates the prevention of STIs that include HIV, and enhances the rights of women who work in the sex industry.

Stigma, discrimination, and violence

Stigma, discrimination, and violence are widely experienced by sex workers in Australia (Harris et al. 2011; Begum et al., 2013). These experiences have a range of negative impacts upon self-identity (that include engaging in concealment and domain separation[1]), poor mental health, poor health service utilisation and safety, and unwillingness to report physical or sexual assault to the police.

Sex workers across several studies reported stigma and discrimination from various sources. For instance, a study by Harris and colleagues (2011) engaged nine female sex workers in interviews (three employed in massage parlours, four in street-based sex work, and two in a bondage and discipline (B&D) dungeon) in New South Wales. Participants reported experiencing stigma from family, friends and the wider community. They also reported experiences of public stigma that sometimes involved physical violence. The women perceived the police as sharing the public's prejudice or believed they would be ignored, and therefore did not often report physical violence or rape. A survey of one hundred street-based workers (that include 86 women and seven women identifying as transgender) in Melbourne found all sex workers described experiences of 'discrimination, marginalisation and social exclusion (that include an absence of supportive networks)' as a result of their street-based work (White and Rowe 2011: 44).

Negative health outcomes associated with experiences of stigma and discrimination were reported by some sex workers. All the women involved in Harris and colleagues (2011: 391) study reported experiencing poor mental health, such as stress and anxiety. This was attributed to the 'confrontational nature of the work' and the stigma the women faced from family, friends and the wider community. Participants utilised concealment and domain separation, and the use of legal and illegal substances as coping mechanisms.

Some sub-populations of female sex workers have been found to be at a heightened risk of experiencing stigma and discrimination. For example, female sex workers living with HIV have report experiencing compounding discrimination and stigma that stems from mandatory disclosure laws in some states, as well as public perceptions and negative media representations (Jeffreys et al., 2010). There is an absence of current literature about experiences of stigma and discrimination among other subgroups of female sex workers in Australia, such as sex workers from non-English speaking backgrounds and trans women, to inform knowledge and practice.

Violence and safety is a major theme emerging from the literature. Sex workers reported experiences of violence, physical and sexual assault that include rape, theft and harassment across all types of sex work, irrespective of the legal status of their work. Clients under the influence of alcohol or drugs were reported by parlour workers in New South Wales to be most threatening due to a perceived lack of respect for sex workers (Harris et al., 2011). Hubbard and Prior (2013) found while female sex workers who worked privately in Sydney expressed safety concerns, overall, private sex work was identified as the healthiest sex worker environment in the industry. This was related to female sex workers reporting high levels of self-confidence, safety, and job satisfaction, as a result of control over the environment and the terms under which clients enter the premises (Hubbard and Prior, 2013: 154). However, Harris and colleagues (2011) found female sex workers working in a B&D dungeon reported feeling safer and described safer encounters with clients, than those working in brothel or in street-based work, due to their higher level of autonomy over their working environment and practices. Similarly, safety incident reports, voluntarily lodged with the Sex Workers Outreach Project (SWOP) in Sydney from 2000 to 2008 suggest street-based sex work to be the least safe. In line with this finding, female street-based workers in New South Wales were more likely than parlour and B&D workers to report client violence in the form of rape or physical violence that includes bashings (Harris et al., 2011). In Queensland, female street-based sex workers were more likely than brothel or private workers to experience physical violence from a client, such as assault or rape (Seib et al., 2010). White and Rowe (2011) found female street-based sex workers reported experiences of violence as both a factor leading to street-based work and a factor keeping them in street-based work. Female migrant sex workers of Chinese-language background, in Adelaide, Melbourne and Sydney, reported significantly more experiences of sexual assault at work than migrant English-language sex workers and other sex workers in Australia (Jeffreys and Perkins, 2011). However, it was not explicit whether these experiences occurred in Australia or China, with 31 per cent working as sex workers in China.

[1] Domain separation refers to keeping work-life experiences and other life experiences separate; a clear boundary between the two areas of life (Harris et al. 2011).

Daily living conditions

The daily living conditions of sex workers are influenced by factors that relate to three broad themes. These include work and employment that relate to the lifestyle determinants of entering sex work, job satisfaction, social connectedness, and workplace sexual safety and risk management. Interpersonal relationships and housing conditions are also identified in the literature as determinants of daily living conditions.

Work and employment

Lifestyle determinants of entering sex work

A range of lifestyle determinants influence women's entry into sex work. These include financial factors, the flexibility of the employment, job satisfaction, and drug dependence. Two studies in Melbourne found financial gain was the primary determinant of women entering into sex work, while secondary determinants were the flexibility of the work hours and attainment of a specific financial goal (Bilardi et al., 2011; Bellhouse et al., 2015). Similarly, Seib and colleagues (2012) conducted a survey with 247 female sex workers in Queensland and found those working privately or in a brothel were more likely to report financial incentives and job flexibility as factors that influence entry into sex work. However, those working illegally were more likely to report drug dependence as the major factor leading to their engagement with sex work (Seib et al., 2012). This was also found by White and Rowe (2011), with drug dependency reported by many female sex workers as a major factor leading to their street-based work. Furthermore, for street-based workers in Melbourne, violence, exploitation and addiction were described as both the factors leading to street-based work and the factors keeping them in street-based work (White and Rowe, 2011). Street-based workers also perceived working in a parlour or brothel to be safer or subjectively better than working on the street, however, the income from street-based work was perceived as being more important (Harris et al., 2011).

Job satisfaction

Job satisfaction was related either positively or negatively to a range of factors including financial security, job security, emotional exhaustion, and drug dependence. Research in Queensland found job satisfaction was significantly related to the reasons for initial engagement in sex work, with those entering sex work on the basis of high earning potential and flexible hours reporting high job satisfaction (Seib et al., 2012). Research that compared the level of job satisfaction and standard of living of those working in Victorian licensed brothels to Australian women found overall job satisfaction was lower than that of the Queensland study, with one quarter of the sex workers reporting satisfaction, compared to 57.5 per cent of those working in Queensland (Bilardi et al., 2011). Compared to Australian women employed in other fields, however, sex workers were more satisfied with their work. Sex workers were least satisfied with their job security and the work itself, but most were satisfied with the flexibility, hours, and pay.

Some research has explored factors associated with low job satisfaction. Several studies identified drug-dependence as associated with reported low job satisfaction among female sex workers (Seib et al., 2012; Cregan et al., 2013). Seib and colleagues (2012) reported this was the case for those who entered sex work due to drug dependency. However, Cregan and colleagues (2013) found for those working in illegal street-based sex work in Melbourne to support their drug-dependence, this was associated with high levels of emotional exhaustion from their work and low job satisfaction. However, they found this relationship was age-dependent, as older female street-based sex workers experienced drug dependence and emotional exhaustion associated with feeling trapped, but this was not associated with job satisfaction in itself. This study conducted interviews with approximately 25 per cent of the total street-based worker population in the Melbourne area to investigate the factors that contribute to emotional exhaustion and job satisfaction. The majority of the participants were female (80 per cent), and drug users, with a small proportion of the participant's identifying as transgender (5 per cent).

Social connectedness

Social connectedness in the workplace was found to have differing influences on sex workers' perception of risks. This was found to be related to the type of work the sex worker was engaged in, but not its legal status. In New South Wales, female parlour workers reported their co-workers as supportive and a positive presence that mitigate the risks of client behaviour. Conversely, street-based workers perceived other workers as being unreliable or deceitful (Harris et al., 2011). Street-based workers reported having the least amount of solidarity with their co-workers, with distrust regarding 'advice on going rates' and 'undercutting prices' being perceived as highly risky (Harris et al., 2011: 392). Berg and colleagues (2011) suggest isolation within the workplace, either street-based or other, increases sex workers' vulnerability.

Workplace sexual safety and risk management

Sex workers often reported risks to their sexual health. This included the risk of contracting STIs, (Bilardi et al., 2016; Harris, Nilan & Kirby, 2011) despite sex workers reporting being well informed about the prevention of STIs and undergoing regular sexual health check-ups. Risks associated with drug use by workers and clients in an occupational setting, and using contaminated needles for injecting intravenous drugs was also reported (Harris et al., 2011). Female parlour workers in Melbourne were concerned about injecting drug use and condom use practices among their colleagues, and reported anxiety related to shared showers and shared clients.

Risks associated with clients' knowledge, attitudes and practices regarding safe sex and sexual health were also identified. Street-based sex workers in Melbourne reported clients frequently request unprotected sex (oral, vaginal or anal) (White and Rowe, 2011). In this study, 41 per cent of participants who were sex workers reported not using a condom when performing a sexual service, which was associated with drug dependency, where increasing desperation increased risk taking behaviour. In Queensland, street-based sex workers were also more likely than brothel or private workers to have been asked for sex without a condom (Seib et al., 2010). Hubbard and Prior (2013) found while private sex work is relatively safe in comparison to other types of sex work, private workers often experienced clients 'pushing' for sex without condoms.

Interpersonal relationships

Romantic relationships and social support are central to positive outcomes for women's sexual and reproductive health. Bilardi and colleagues (2011) found for women working in licensed brothels in Victoria, their personal experiences of romantic relationships were reported as negative, with 75 per cent reporting relationships too difficult and 80 per cent describing the work as interfering with their relationships. These experiences were due to jealousy of their partner, guilt, and mistrust regarding condom use. Concealment and domain separation affected the women's relationships, with over half reporting difficulties separating their work life as a sex worker in non-street based sex work from their personal lives (Bellhouse et al., 2015).

In contrast, a smaller proportion of the women reported positive outcomes that include feeling understood, having a 'deeper intimacy' with their partners, and positive mental health that increases their self-esteem and confidence (Bellhouse et al., 2015). For some brothel-based sex workers, disclosure of their job to families was significantly positively correlated to job satisfaction (Seib et al., 2012).

Housing conditions

Multiple factors were found to impact upon the social determinants of health for sex workers. Homelessness was experienced by 60 of the 100 street-based workers surveyed in Melbourne (White and Rowe, 2011). Additionally, early childhood experiences of 'poverty, neglect, marked disadvantage, low education levels and abuse', were commonly identified, with many experiencing contact with child protection services (White and Rowe, 2011: 43). These experiences were linked to the determinants of subsequent homelessness and sex work, and were reported to have a negative impact upon the participant's current wellbeing. To this end, the compounding experiences of poverty and drug dependency were found to increase the risk taking of participants for financial gain that results in exposure to sexual and physical violence.

Health-related knowledge, attitudes and behaviours

The sexual health status of sex workers in Australia is linked to the individual's age, work type, locality, and criminalisation of the type of sex work they engage in. Themes of STIs and HIV, condom use, and mental health emerged from the literature.

STIs and HIV

Overall, female sex workers in Australia have low rates of STIs and HIV, compared to Australians in other industries. Rates reported among female sex workers include sex workers who engage in injecting drug use (IDU) (El-Hayek, 2011). For those working in brothels, rates of HIV and STIs are at a historic low (Donovan et al., 2010). Rates of chlamydia infection are lower among the sex worker population compared to the general population of Australia. Additionally, the rates of pharyngeal gonorrhea and genital gonorrhea in female sex workers are low (Read et al., 2011).

Rates of STIs are generally low in the sex worker population, however, particular subgroups experience higher risk factors for STIs and HIV. These include street-based workers, transgender workers, culturally and linguistically diverse (CALD) workers, and workers living with HIV (Berg et al., 2011). A multi-method analysis in Sydney revealed transgender sex workers to be at an increased risk of HIV and STIs, yet this population was underserved by sexual health services when compared to other sex workers (Berg et al., 2011). However, Bellhouse and colleagues (2016) point out that some current research does not differentiate between transgender women, transvestites or transsexuals, instead using the term transgender to encompass all identities. Thus, data pertaining to this group should be interpreted with caution.

Sex workers from CALD backgrounds in Illawarra were more likely to be at risk of HIV and STIs, and less likely to regularly access sexual health services compared to sex workers in Sydney (Berg et al., 2011). Martin and colleagues (2015b) found significant differences between Chinese and Thai sex workers in Sydney, with Chinese sex workers having higher sexual health literacy, were less likely to douche, and more aware of STI symptoms on their clients. Female migrant workers across Adelaide, Melbourne and Sydney were found to have the same rates of condom use, STI checks, and access to sexual health services regardless of whether they had a Chinese-language or English-speaking background (Jeffreys and Perkins, 2011). The migrant sex workers also expressed strong sexual health literacy. For street-based workers in Melbourne, the transmission of HIV and other STIs was also increased if participant's experienced 'homelessness, poverty and drug dependence' (White and Rowe, 2011: 44).

The frequency of mandatory testing regimes has been found to have little impact on the rates of STIs and HIV for female sex workers in Melbourne. Chow and colleagues (2014) collected data from a sexual health clinic in Melbourne, finding no significant changes to STI rates for female sex workers tested monthly compared to three-monthly. Other non-sex worker clients were two to four times more likely to be diagnosed with an STI than a sex worker. The three-monthly testing regime increased the clinic's overall capacity, the screening of higher risk clients, and was financially beneficial.

Condom use

Condom use is generally reported to be high among female sex worker communities. In Melbourne, research with sex workers about their romantic relationships found 96 per cent of the study population reported always using a condom with clients compared to lower use with regular partners (27 per cent), and casual partners (60 per cent) (Bellhouse et al., 2015). A cross-sectional study of 1,540 female sex workers who offered oral sex at work found 24 per cent reported inconsistent condom use (Read et al., 2011). Women working in a parlour with no council approval were more likely to report inconsistent condom use for oral sex (Read et al., 2011). Those reporting inconsistent condom use for oral sex, were also more likely to report inconsistent condom use for vaginal sex, report no vaginal sex, and/or be a new client at the parlour. Condom use was less commonly reported among Mandarin and Cantonese speaking sex workers (Read et al., 2011). A longitudinal study of CALD sex workers in Sydney found consistent condom use to be increasing, with a 49 per cent increase in consistent condom use for vaginal sex between 1993 and 2014 overall (Martin et al., 2015a). However, the rate was found to decrease by 9 per cent over the period from 2003 and 2014. This trend was similar for oral sex. For female migrant sex workers, across Adelaide, Melbourne and Sydney, condom use was reported to be high with over 90 per cent routinely using condoms (Jeffreys and Perkins, 2011).

Mental health

Poor mental health outcomes among sex workers is reported in several studies. These outcomes were related to the stress and risk involved in working in the sex industry, alcohol and other drugs, and job satisfaction. Women working in New South Wales reported experiencing negative mental health in relation to their employment, which was associated with the stressful and risky nature of the work (Harris et al., 2011). This was also associated with the stigma and discrimination sex workers experience (Harris et al., 2011; Begum et al., 2013). Women report using alcohol and other drugs as a coping mechanism. Drug and alcohol use, by both the women and their clients, was reported by all women in Harris and colleagues (2011) research to be a significant factor contributing to higher risks of violence and other health problems. As discussed in 'daily living conditions', older street-based workers in Melbourne were more likely to report drug-dependence, low job satisfaction, and high emotional exhaustion. Moreover, older drug-dependent street-based workers were more likely to report feeling 'trapped in their occupation', to be least effective in 'acting the part', 'attracting clients' and earning money, while being 'most fearful of finding other work'. This was linked to their ability to obtain drugs (Cregan et al., 2013: 853-7). In contrast, Seib and colleagues (2010) found positive mental health was associated with job satisfaction for sex workers in Queensland. Street-based sex workers were less likely to report job satisfaction (48 per cent) and more likely to report negative mental health, compared to those in private sex work (64 per cent) or those working in brothels (60 per cent). Private sex workers in Sydney report more positive outcomes, such as control and freedom, high self-esteem, financial freedom, flexible work and autonomy, in comparison to those working in a 'large commercial sex industry premises' (Hubbard and Prior, 2013: 150).

Conclusions and recommendations

Sexual and reproductive health inequities experienced by sex workers within all types of sex work and Australian states and territories impact upon the poor health and wellbeing of sex workers. The review of the literature highlights the impacts of sexual and reproductive health status and inequities experienced by sex workers, at all levels, evidenced by policy, legal status, and stigma, discrimination and violence. Influential factors that affect the daily living conditions of sex workers were largely connected to employment and include risk of violence, risk to sexual health, difficulties with interpersonal relationships, and housing. Further, risks involving STIs and HIV, inconsistent condom use, and poor mental health outcomes were found to impact upon individual health-related behaviours. However, these are not discrete and cut across the levels of the framework, factors within each level, and in some instances interacting with other factors, resulting in more acute disadvantage and marginalisation. The review highlights the sexual and reproductive health inequities experienced by sex workers, particularly those in street-based sex work, which are compounded by social position, gender, culture and ethnicity, legal status, and location.

This review highlights a number of limitations. First, the majority of research has been conducted in New South Wales and Victoria. A factor that might contribute to this is the differing levels of criminalisation across Australia (Appendix A). Second, inconsistent definitions and terminology of groups (e.g. transgender) and the potential for inconsistent definitions of forms of sex work, for example, the mis-application of forms of sex industries, such as parlours and brothels. Third, little attention has been given to less visible and stigmatised populations, particularly when compounded by other stigmatising factors such as HIV, or illegal behaviours such as illicit drug use. Fourth, there is a gap in research regarding online-platforms for private sex-work. Finally, much of the research was non-specific with regards to gender (cisgender or trans) or sexuality of the female sex workers. More research that is specific to, and explicit about, the gender and sexuality diversities of female sex workers is needed. Further research about culturally and linguistically diverse female sex workers would be highly valuable to understand the diverse and varied experiences of Australian sex workers.

It is recommended:

- Further research regarding inequities and the effect on sexual and reproductive health, particularly for underserved groups, is undertaken to respond to the limited evidence-base on equity in access, support, and health services (Berg et al., 2011).
- Undertake research to explore the experiences and health inequities of sex workers operating via online platforms as well as research to consider the diverse experiences of difference population groups of sex workers, such as older and younger workers, CALD workers and transgender women to inform appropriate health promotion initiatives and services.
- Advocacy to ensure the different state and territory laws are in alignment in regards to the status of sex work. In particular, it is recommended a national policy approach and legal framework is prioritised. This would enable a more coordinated strategic approach to primary prevention and service delivery, such as under the National STI Strategy, or National Women's Health Policy. Decriminalisation is recommended to increase the realisation of rights, enhance police protection, and decrease the exclusion and stigmatisation of sex workers (Berg et al., 2011; Cregan et al., 2013).
- Health promotion interventions and health care service providers need to consider the legal context of sex work and the sex industry in the provision of services to effectively respond to the health needs of sex workers. Provision of Asian-language speaking staff, culturally appropriate programs, outreach services that include drug and alcohol services, and evening services are needed to increase engagement (Harcourt et al., 2010; Martin et al., 2015a; b).
- Health promotion services need to approach street-based work from a health and wellbeing perspective that works to redress the determinants of sex work that lead to women's compounding experiences of the law, drug dependency, homelessness, violence, and social isolation. Safe houses and community-based initiatives for sex worker communities are also recommended (Seib et al., 2012; Cregan et al., 2013).
- Research and primary prevention initiatives that explore and work with men and masculinities to enhance sex workers respect, safety, and control of their work environment must be prioritised. Primary prevention initiatives that decrease stigma, discrimination and violence against sex workers are urgently needed (Harris et al., 2011; Hubbard and Prior, 2013).

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Appendix A

Legal status of sex-work by Australian State

State	Decriminalised	Criminalised
Australia-wide		• Migrant sex-work • Trafficking in persons for the purposes of sexual servitude
Australian Capital Territory	• Brothels • Private sex-work (sole operator brothels or escorts)	• Street-based sex-work • Procure or hire a person under the age of 18 for the purpose of sex work • Penetrative sex without a condom, for both the worker and the client
New South Wales	• Largely regulated through a decriminalised model • Street-based sex-work • Brothels are regulated by local councils	
Northern Territory	• Private sex-work (alone) • Escort agencies with an operator's license	• Brothels • Street-based sex-work and soliciting • Allowing a person under the age of 18 to work in the sex industry
Queensland	• Private sex-work (alone) • Brothels (with a license)	• Brothels (unlicensed) • Parlours • Street-based sex-work • Two, or more, sex workers sharing one premises • Out-calls provided by a licensed brothels
South Australia		• Sex-work (being on a premises frequented by prostitutes or receiving payment for sexual services)
Tasmania	• Private sex-work (alone)	• Brothels • Street-based sex-work • Knowingly be a client of a sex worker working in a commercial sexual services business • Be a client of a person under the age of 18 who is working as a sex worker • A sex worker or a client to not use a prophylactic (condom, dam etc.) during sexual intercourse or to misuse, damage or interfere with the use of a prophylactic.
Victoria	• Licensed brothels • Private sex-work • Private Escorts • Escort agencies	• Street-based sex-work
Western Australia	• Some private sex-work • Escort agencies	• Brothels • Street-based sex-work • A person under the age of 18 working as a sex worker