	Definition
(Continued from previous page)	
Owner or manager (of a sex business)	Individuals who own or run sex businesses. The extent of control a brothel owner or manager has over sex workers' working and/or living conditions varies depending on context. If an owner or manager recruits or harbours a sex worker through coercion for the purposes of exploitation, they are defined as a "trafficker" under international law.
Peer outreach/ peer education	Peer education is an approach to health promotion in which community members are supported to promote health-enhancing change among other members of that community. Rather than health professionals educating members of the public, the idea behind peer education, often using peer outreach to reach them, is that ordinary lay people are in the best position to encourage healthy behaviour to each other.
Sex industry	This term has been used in preference to "prostitution" to describe the phenomenon of commercial sex.
Sex work	Sex work is the sale/exchange of consensual adult sexual services. The term is non-judgmental and enables HIV responses to sex work to be addressed through a labour rights framework in addition to a human rights framework. The term is used in preference to commercial sex work and prostitution.
Structural determinants of HIV	Factors in broader society, such as social inequalities, laws, economic systems, and infrastructure, that impact on vulnerability to HIV infection.
Transgender	Transgender is an umbrella term used to describe people whose gender identity (or sense of themselves as male or female) or gender expression differs from that usually associated with their birth gender. Many transgender people live part-time or full-time as members of the other gender. Broadly speaking, anyone whose identity, appearance, or behaviour falls outside of conventional gender norms can be described as transgender. However, not everyone whose appearance or behaviour is gender-atypical will identify as a transgender person.

Table: **Glossary of terms used in Series on HIV and sex workers**

to reduce the environment of risk faced by women, men, and transgender people worldwide.

Finally, the reality most people wish to ignore—that much of our challenge in addressing sex work and sex workers is the need to understand human sexual desires and needs, including our own. We might prefer to think that sex and money were unrelated, that sex was somehow immune from the transactions so common elsewhere in our lives. But why should this exception be so? And why should we condemn and criminalise the exchange of money for sex, especially if the severely adverse conditions we create for such exchange hurt women and men and often fatally so? The persistence and ubiquity of sex work suggests only that sex, and the human desire for sex, is a normal part of human societies. Sex work is part of the human story. Accepting and embracing sex work—supporting those engaged in sex work to protect their health and bodily integrity and autonomy—should be our humane, as well as our pragmatic, approach to the reality of our human lives. And to our common efforts to defeat AIDS.

Pamela Das, Richard Horton
The Lancet, London NW1 7BY, UK

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Dispelling myths about sex workers and HIV

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Sex work might or might not be the oldest profession, but it has existed for millennia across all continents and cultures. Nevertheless, myths about sex work and sex workers persist (panel). These myths can denigrate, devalue, and marginalise sex workers. Some widely held and unsupported views hinder HIV responses, driving sex workers away from already scarce HIV prevention and treatment services. Here, we aim to dispel the most harmful of these myths with evidence-based literature.

The first myth is that all sex workers are women. Although most of the world's sex workers are women, sex workers can be male or transgender people.[1–3] As

for women, a wide range of typologies and working environments for male sex workers exist, who can be homosexual, bisexual, or heterosexual. Transgender sex workers have heightened HIV risk and vulnerability, and often require different services from other sex workers.[3,4] The second myth is that all sex workers are single. Many sex workers report intimate, stable, non-paying partnerships worldwide, and many are married.[5] Women, men, and transgender people who sell sex do so for many reasons, including to support their intimate partners, children, and broader network of family and friends.

The third myth is that most sex workers do not want children and try to avoid pregnancy. In a study of street-based female sex workers in Moscow, Russia, more than 80% were mothers, of whom more than 95% reported selling sex to support their children.[6] In Burkina Faso, Togo, and Swaziland, more than half of sex workers were reported to have at least one child.[7] In Iringa, Tanzania, the status of being a mother was especially important to sex workers because they lacked the status of being a wife.[8] A danger of the so-called low fertility myth is the denial of prevention of mother-to-child transmission services for HIV-positive pregnant sex workers—often on the grounds that unmarried or undeserving women should not receive them.

Fourth, all sex workers are imagined to be trafficked or coerced. Most sex workers are not trafficked. Human trafficking is specifically defined under international law. Many, but not all, Member States of the UN have ratified the convention.[9] According to the Palermo Protocol,[10] three conditions must exist for a person to be regarded as trafficked: act by a third party (ie, recruitment), means (ie, through force or deception), and purpose (ie, for forced labour). In the case of minors, only the first and third conditions need to be met. Most human trafficking is for labour exploitation.[11] Of an estimated worldwide total of 21 million trafficked people, roughly 4·5 million (22%) are victims of forced sexual exploitation, compared with 68% for labour exploitation.[12,13] The authors of a study in Cambodia reported that only 3·8% of sex workers were trafficked.[14]

The fifth myth is that sex workers do not and will not use condoms with clients. Sex—whether paid for or not—does not cause HIV infection. Penetrative sex is an HIV infection risk for sex workers and their clients when condoms are not used. However, in many settings, poor availability of condoms and water-based lubricants, police harassment and arrest of sex workers for carrying condoms, the use of condoms as evidence of sex work, and clients' absence of knowledge about condoms and preference for sex without condoms are barriers to consistent condom use.[15] When sex workers are taught how to use condoms and negotiate condom use with clients, they can consistently use them and experience significant reductions in HIV incidence. For example, 30 min, single-session behavioural interventions promoting condom use negotiation skills among female sex workers in Mexico successfully reduced HIV and sexually transmitted infection incidence by more than half.[16,17]

Sixth, sex work is illegal and therefore programmes cannot possibly be implemented. Sex work is legal or regulated in some regions; in others, it is criminalised. In some regions, the exchange of sex for money is legal, but surrounding activities, such as solicitation in public, are illegal. In most jurisdictions where sex work is criminalised, sex workers are subject to penalty; in others (eg, Sweden), the client is. Illegality of sex work creates barriers to sex workers seeking HIV prevention and care due to fear of authorities and concerns about confidentiality.[18] Services specifically designed for and with sex workers can overcome some of these concerns. Several successful interventions with strengthened community-led support and cohesive social environments are associated with sex workers' willingness to engage in HIV prevention and care.[19] Sex worker HIV prevention interventions can be successfully taken to scale, despite unfavourable laws and regulations.[20,21]

The seventh myth is that sex work is not work. By definition, sex work requires consent. Sexual exploitation, sexual violence, and human trafficking include coercion, deceit, absence of consent, and loss of agency. Sex work is a contractual arrangement in

***Panel:* Eight myths about sex workers and HIV**

- All sex workers are women
- All sex workers are single
- Most sex workers do not want children and try to avoid pregnancy
- All sex workers are trafficked or coerced
- Sex workers do not and will not use condoms with clients
- Sex work is illegal and therefore programmes cannot possibly be implemented
- Sex work is not work
- Laws against selling sex, buying sex, or owning a brothel prevent trafficking and reduce sex work


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which sexual services are negotiated through economic exchange. Under the International Labour Office's new international labour standard,[22] sex workers have the same entitlements as all other informal workers. In Brazil, sex workers can register their occupation and have the same rights as other workers (eg, pensions).

The final myth is that laws against selling sex, buying sex, or owning a brothel prevent trafficking and reduce sex work. No evidence suggests that criminalisation of sex work (such as Sweden's approach that criminalises the buying of and profiting from sex, and the renting of housing to sex workers) reduces sex work. Rather, criminalisation of clients may be an important factor in displacing sex workers to less visible areas or venues.[23-25] If criminalisation reduced sex work or its demand, an increase in sex work following their removal might be expected. However, the number of sex workers in New Zealand did not increase after decriminalisation of sex work in 2003.[26]

Moreover, no evidence suggests that criminalisation of sex work reduces trafficking for sexual exploitation. The claim by some politicians that Sweden's approach reduces trafficking is unsubstantiated.[25] In fact, two evaluations reported that Sweden's laws were a barrier to the prosecution of trafficking because clients who had previously assisted victims by alerting authorities now feared self-incrimination.[23,27] Half of sex workers in a Swedish study said that getting help was more difficult after criminalisation.[28] Antitrafficking advocates contend that criminalisation "drives the sex industry even more underground, which results in… significantly lower chances of identifying individuals who have been trafficked."[29]

An evidence-based approach to the literature calls for these myths to be dispelled, which is the first step towards a world where all sex workers—female, male, and transgender—can live without fear, harassment, arrest, stigma, and violence. In doing so, all sex workers could live with dignity and respect, and openly seek HIV prevention and treatment. Whether or not countries achieve an AIDS-free generation will depend to a large extent on their decision to embrace a rights-based approach to HIV prevention and treatment, which includes the recognition that sex workers' rights are human rights.

Steffanie A Strathdee, Anna-Louise Crago, Jenny Butler, Linda-Gail Bekker, Chris Beyrer

Department of Medicine, University of California San Diego, La Jolla, CA 92093, USA (SAS); Anthropology, University of Toronto, Toronto, ON, Canada (A-LC); United Nations Population Fund, NY, USA (JB); Desmond Tutu HIV Research Centre, University of Cape Town, Cape Town, South Africa (L-GB); and Center for Public Health and Human Rights, Johns Hopkins University, Baltimore, MD, USA (CB)
sstrathdee@ucsd.edu

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Ebola: worldwide dissemination risk and response priorities

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The scale of the current outbreak of Ebola virus disease in west Africa is staggering. Thousands of infections and deaths have been reported in recent months, and unless major changes occur in the situation, incidence of Ebola virus disease has been projected to continue to grow and cumulative incidence to exceed 20 000 by November.[1] A humanitarian crisis that stretches far beyond the impact of Ebola virus infections is unfolding in Africa, devastating the health systems and economies in affected countries.[2] In the present outbreak, most infections remain confined to west Africa, although four cases have been detected outside this region: three cases diagnosed in Dallas, USA (of which one infection was contracted in Liberia and two were associated with nosocomial transmission from the first case), and one case in Madrid, Spain, associated with nosocomial transmission (figure).

In *The Lancet*, Isaac Bogoch and colleagues[3] report on the potential for international dissemination of Ebola virus disease. Their assessment of risk for different countries is an advance over previous work,[4] which analysed flight networks and connectivity, but did not account for passenger flows and final destinations. Because of the assumptions of uniform risk across the population and constant prevalence of infection (whereas, in fact, risk within the population is not likely to be uniform and incidence is doubling every 15–30 days),[1]

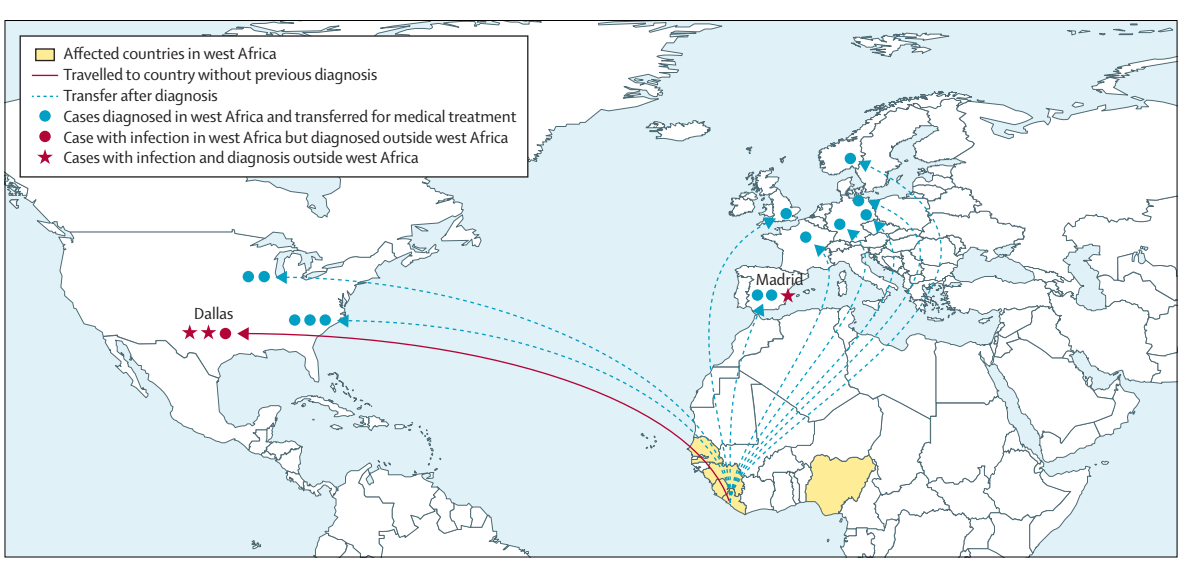

Figure: **Geographic location of reported cases of Ebola virus disease as of Oct 16, 2014**
Among all reported cases in the 2014 outbreak to date, most infections have been contracted in three countries in west Africa: Guinea, Liberia, and Sierra Leone.