

# Research

for  
Sex  
Work

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*Research for Sex Work wants to provide a platform for the exchange of ideas and experiences with regards to AIDS prevention research and sex work. A lot of the research done in the field of sex work is done from the perspective of public health officials, policy makers or academic researchers. It is often criticised by sex workers themselves because they do not recognise their own realities and interests in the research questions and results. This results in recommendations that are hard to implement and these tend to complicate the relations between sex workers and the research community. What is needed is a strategic alliance between researchers who have chosen to utilise their research skills to produce information on sex work from the perspective of the sex workers, and organisations representing sex workers' needs. The newsletter Research for Sex Work is one of the tools to come to such alliances and a medium for advocacy for research that leads to actions that make a difference.*

## Violence, repression and other health threats

### *Sex workers at risk*

The interest of researchers, public health experts and policy makers in sex work, which was propelled by the HIV/AIDS pandemic, seems to me a mixed blessing. On the one hand there is more information available, there is more funding for sex workers' programmes and there seems to be the beginning of a better understanding among people in all levels of society about sex work. However, we are facing a rather one-sided interest. Many health experts with a limited hygienic focus, are solely interested in what role sex workers play in the dissemination of HIV and what kind of effective interventions can be developed to slow down the spread of the virus. They expect to keep their world clean from microbes invading it and are not very much interested in the men and women who do sex work.

This one-sided attention resulted in the presentation of a dominant public health framework on risk and risk taking before important aspects of sex work could be well conceptualised and analysed in a way that better fitted sex workers' daily realities. In the discussions of health and AIDS experts, the idea of risk has been limited to the risk of infection, ignoring the context of sex workers' realities and the conditions in which they do their work. Whereas these realities and conditions create a different understanding of what sex workers themselves experience as risk.

#### **Repressive laws**

To get infected with HIV is just one of the many risks sex workers are facing. They are often surviving in unsafe and economical unstable surroundings. This brings along a wide range of different risks. This again is connected to a more or less calculated estimation of which risks to take and which not. In the first place, most sex workers are dealing with repressive laws that undermine potential individual and group strategies to minimise risks.

In the few countries where there are no laws that criminalise sex workers, it is not so much better, because we see that migrant status (and sex workers often belong to the communities of illegal migrants) turns them into law offenders. The result of this is a non-co-operative legal system. Rapists of sex workers are rarely convicted for instance. Within that context sex workers are disempowered, whereas other stakeholders are protected when they are violent towards them.



What comes through in most of the articles in this publication is the role of the police as the most threatening stakeholder. Arrests, sweeping of streets, ticketing, bribes and harassment are common practices, while on the other hand sex workers have little to expect from the police in case of violence against them. They neglect or trivialise rape or violence experienced by sex workers. In addition to police personnel, there is violence by pimps and brothel managers at whose mercy many sex workers are often working. Clients are another possible threat. As we see in some of the contributions to *Research for Sex Work*, sex workers experience high rates of rape, beatings, even murder, by their clients. Very disempowering is the fact that there is so little support for them that they will often accept the violence or see it as part of the risks that are involved in sex work.

**No priority at all**

Some other factors contribute to the vulnerability of sex workers. In many cultures women are subordinate to men, which hinders them in complaining about violence and taking action. Migrant sex workers are in an even more difficult position. Some sex workers use drugs and/or alcohol during their work, which creates again another context for thinking about violence and risk taking. As most sex workers make a clear distinction between their profes-

sional lives and their private lives, they may not try to deal with the risks in their private relationships in the same way as they do in their professional lives. However, they are often not less at risk.

Looking at the full landscape of risks and risk taking, it is obvious that health risks are only part of it and more often than not no priority at all. As long as sex workers live in an insecure economic and social position, they cannot afford the luxury to pay special attention to some of the health risks they are facing, isolate these specific risks and pay extra attention to them. The continuous threat of violence, repression and intimidation leads sex workers to making different assessments of the risks they are taking. They are forced to take more risks and why would they bother about health risks in the first place?

**Human rights**

Programmes that deal with making sex workers' lives less dangerous will have to develop interventions at different levels. Hypocritical policies of allowing outreach workers distributing condoms, while simultaneously permitting police officers to intimidate sex workers (and even arrest them because they carry condoms) should disappear quickly. It may be useful to invest more in educating policy makers and police staff on the realities of men and women that for whatever reason are doing sex work. Legal support systems have to be developed for sex workers who are dealing with rape and beatings. All governments have ratified the UN declarations on human rights. Human rights organisations should become more active in coming up for the human rights of sex workers. At the community level, interventions in which sex workers support each other in early warning systems against violence, such as 'the bad date list', can be developed and stimulated.

Only when a holistic approach in understanding violence, risks and risk taking is developed and used in sex workers' programmes, will it make sense to also deal with health risks and the risk of HIV infection.

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# Contextual risk versus risk behaviour

## The impact of the legal, social and economic context of sex work on individual risk taking

Priscilla Alexander

A major goal of HIV/AIDS prevention projects is to convince and/or enable a critical mass of individuals to modify their sexual and drug use behaviour enough to reduce the rate of transmission of HIV from one person to another. Projects have tended to focus on specific populations, such as sex workers, injecting drug users, and men who have sex with men (whatever their sexual identity). In parallel with this work, there is an extensive discussion of something called a 'gender analysis', the gist of which appears to be that women are relatively powerless with respect to men, whether the subject is rates of pay, choice of work, or the decision of whether or not to use a condom.<sup>1</sup> Another discussion looks at the effects of poverty and inequality on health, and in particular on the vulnerability of impoverished individuals to a variety of health problems, including both violence and infectious diseases.<sup>2</sup> In this article, I want to discuss the distinction between 'risk', or the 'context of risk', and 'risk behaviours' or 'actions of risk', particularly as it relates to this group with whom we work, sex workers.

### The decision to do sex work

The decision to engage in some form of sex work is driven by economics. This is true whether the trigger is desperate poverty in remote rural communities in sub-Saharan Africa or South East Asia, or the need to supplement a meagre welfare check in the United States, find quick ways to earn the price of the next fix of a drug, or high-paying part-time work to pay for an education. The decision is more or less a 'free' or active 'choice' depending on the degree of desperation. However, we cannot ignore the effect of a context imposed from outside, within which the decision is made.

In an impoverished rural community, particularly one affected by drought, destruction of forestland, and/or drastic fluctuations in market conditions, the decision to turn to sex work is often enmeshed in the decision to migrate, to the city or to another country. It takes enormous courage to leave the familiar, to go somewhere strange, for a job you don't know much about, or perhaps no job, but only the idea that you can find one that pays enough to

support yourself, and also to send money home to your family. That is a 'risk taking' activity, that monumental move from one world to another, although the conditions that trigger the move may represent an imposition of risk, not a taking of it. However the migration is accomplished, conditions in the receiving country have a lot to do with subsequent decisions, and subsequent risks.

### Context of risk

What is the context of the sex work that some migrants choose, or drift into, or are convinced or coerced to agree to? In virtually every country, some or all aspects of prostitution are illegal. Even the variations on sex work that are not exactly prostitution (e.g., pornography), and so may not exactly be against the law, are rarely subject to any kinds of workplace regulation, while a toy, shoe, or garment factory, or a restaurant or hotel might be. The decision to work in the sex sector may be conscious, an action, a knowing facing of risks (of the unknown, of one's ability to cope), but the context in which that work will be done is defined by the society and the state apparatus that surround it. Societal approval or disapproval affects how individual workers look at and name the actions they are taking (and the way they respond to requests for action from others). If sex work is highly stigmatised, these individuals may not consider what they do with men to date them, or offer them money, as 'work', with all the meanings of that word. To the extent that the state apparatus ignores, or defines as illegal this 'work', an individual has little room to exert control over the sex 'work' activities.

For example, in the United States, police in virtually every jurisdiction often confiscate condoms during so-called 'sweeps' of sex work districts, sometimes merely taking the condoms and throwing them away, sometimes puncturing holes in them and giving them back, sometimes using the possession of condoms as evidence of intent to commit prostitution. In Germany and Kenya, sex workers have told me that if a *client* wants to charge them with an offence that could be considered a violation of the 'sex work contract', judges will co-operate, but if the *sex worker* wants to charge a client with a similar violation, the judges refuse to honour the 'immoral' contract.

Sometimes the violation might consist of a disagreement over condom use, with a client thinking he didn't get what he wanted if the worker insisted on a condom (his sense of being violated), and therefore refusing to pay,

### Between global dangers and personal risks

The sex business is on the one hand increasingly portrayed as a phenomenon subject to globalisation (migration, trafficking) while on the other hand a lot of attention is paid to interpersonal relationships and individual risk behaviour (condom use, condom negotiation). In the theoretical paper 'Global threats, local options, personal risk: dimensions of migrant sex work in Europe', Sandra Wallman of the Department of Anthropology of the University College London advocates for more attention to the context of sex work, which she calls the meso level of analysis on risk. This middle or local level influences the risk taking behaviour of sex workers, as risk taking is usually not an entirely personal choice.

Wallman distinguishes risks from dangers, the latter being unmanageable threats. "Danger becomes risk, when people assess/calculate/decide their particular relation to it: Do I believe that this could happen... that it could happen to me... that I could avoid it happening?" , a continuous process of weighing-up. In order to be able to control global out-of-personal-control events, the local level can play an important role, according to Wallman. The meso level enters here in the form of Local Filters, such as NGOs and CBOs. By giving the example of one of the TAMPEP centres in Turin (Italy), she states, "These 'filters' structure the options available to migrants, and frame the context in which decisions about risk are actually made." Two findings are underlined in this paper: that a sense of control over threat is prerequisite to dealing with risk; and that it is on the ground, in local context, that control must be and can be negotiated.

S. Wallman, *Global threats, local options, personal risk: dimensions of migrant sex work in Europe*. In: *Health, Risk & Society*, Vol. 3, No. 1, 2001, pp. 75-87.

while the worker felt violated when the client refused to pay, or broke the condom. Even when the violation is major, such as rape or murder, redress is often denied. Many police and even some health care providers believe that a prostitute, by definition, cannot be raped. Some police have used the term 'NHI',

***Even when the violation is major, such as rape or murder, redress is often denied***

meaning 'No Humans Involved', when prostitutes have been murdered, an attitude that has sometimes delayed effective investigative responses until many sex workers have been killed. Too many incidents like that, with no redress, and the worker's ability and will to insist on a condom might collapse. The lack of redress creates a context of risk that is hard for any individual to overcome.

**Mandatory condom use**

In Nevada, the only state in the United States that allows any form of legal prostitution,<sup>3</sup> condom use used to be up to the individual sex worker and client to negotiate, until AIDS. Because of AIDS, the Nevada Department of Health convinced the state legislature to man-

date condom use in these legal brothels, perhaps the first law in centuries that sex workers have liked. Immediately, the context of risk changed in the legal brothels, and STIs disappeared overnight as an occupational hazard. But when countries tolerate or legalise brothels, while insisting that sex workers be licensed or registered and tested, instead of mandating condom use (universal precautions), clients use the testing as a justification for refusing to use condoms. Thus, the action of the state creates a condition of risk. Of course, when all forms and sites of sex work remain illegal, with the ever-present risk of police raids, the context of risk is monumental.

For HIV/AIDS prevention to succeed, the conditions of risk have to change. The context – legal, social, economic – of sex work has to change, with repeal of criminal laws, access to visas and work permits, freedom of movement and association, and occupational safety and health regulations, to reduce the imposition of risk from above. Until then, it will be heroic, strong individuals that can insist on safe behaviours, leaving those who are less heroic, those who are more timid and afraid, to suffer the consequences of the context of risk.

**Notes**

1. See, for example, the Report of the Secretary-General, Special Session of the General Assembly on HIV/AIDS, Agenda item 179, UNAIDS, 2001. Documents related to the UNGASS meeting in June 2001 can be found at [www.unaids.org](http://www.unaids.org).



2. H. Epstein, Time of Indifference. In: *New York Review of Books*, April 12, 2001, pp. 33-38. This article can be obtained online at [www.nybooks.com/nyrev/archives.html](http://www.nybooks.com/nyrev/archives.html).

3. Counties with less than 400,000 population in that state have the legal option to permit, and regulate and tax, brothels. All other forms of prostitution are illegal.

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# Different mindsets, different risks

## Looking at risk factors identified by Vietnamese sex workers in Cambodia

*Mony Tep, Salan Ek and Marjolein Maas*

***Between November 2000 and March 2001, staff of CARAM Cambodia and Marjolein Maas, a psychology student from the Vrije Universiteit, the Netherlands, carried out a qualitative research with Vietnamese women working in massage parlours in Cambodia.<sup>1</sup> By talking with these women a lot, they unveiled the risk factors they perceive to be important. Not surprisingly, HIV is only one of their concerns.***

*"I've made the decision to work as a massage girl to support my children; I'm very poor."  
"If you want to help me you should lend me some money so I am able to pay off my debts, this I call help because all I need is money."  
"I don't speak the language well and I don't know many people because I work long hours."  
"That owner was very difficult. [...] She said we were bad women, she looked down upon us."  
"If clients are drunk they force us, they aren't good to us."  
"The maid scratched my face because I became angry with her when she made a cynical remark... again."*

Those are remarks made by Vietnamese women working as massage girls in Phnom Penh, Cambodia, during one of five focus group discussions held at the CARAM office. The women work in massage parlours which people, mainly men, visit to get a massage, a haircut, a shave, or to have their face and ears cleaned. In addition, these places have become more and more known as places where sex services were provided, during or after working hours. This seems to be a hotbed of risks with regard to the spread of STIs and HIV and thus a hotbed of risks for the women themselves. It is time to act and inform the women about the serious risks they encounter. But what exactly are those risks?

### More vulnerable

CARAM Cambodia (Co-ordination of Action Research on AIDS and Mobility) works with migrants, among others with Vietnamese sex workers. Being a migrant makes a person more vulnerable to STI and HIV infection because that person has less access to information, support systems and essential services, often simply because a migrant does not speak the local language (well). Being a Vietnamese migrant in Cambodia can increase their vulnerability because of the strong anti-Vietnamese feelings in Cambodia. But when talking to the women there seem to be more factors that cause risks to their health and wellbeing.

The massage girls mention that not having any knowledge about STIs and HIV/AIDS puts them at risk, that they would like to know more about these diseases and that organisations should take care that they get the right information. They like it when an organisation shows some interest in them, in their lives and their wellbeing, that it provides them with information and that they have a safe place to go to when they have problems. But at the

## ***Being a migrant makes a person more vulnerable to STI and HIV infection***

same time a lot of these women do have some knowledge about HIV/AIDS. Their clients, massage parlour owners, or colleagues have taught them, and now they do use condoms but not consistently. *"A client told me how to use condoms. In the beginning, when I came here, I didn't know how to use them, but when I saw him wear it, I acted after him."*

Condoms are associated with sex work and are therefore only used when the women identify themselves as sex workers. They will not use them in their personal relationships, even if those relationships change frequently.

### Depression

Another risk factor is the state of mind of the massage girls and their own attitudes towards their own situation. A lot of the women said that they are depressed: *"We think about the present. We try to forget the past. [...] If we think, have depressing thoughts, we only get more depressed"*. They are separated from their relatives and children, they have a big family to support, they are divorced or widows, their family brought them to do this kind

CARAM Cambodia is part of the international network CARAM (Coordination of Action Research on AIDS and Mobility). It was founded in 1997 as a response to the lack of information on migrants in Asia and the conditions that put them at risk of HIV infection. Currently, there are National Focal Points in several countries in South and South East Asia, Cambodia being one of them. The organisations united in the CARAM network try to increase the body of knowledge on the issue of HIV and mobility, develop appropriate HIV prevention interventions with/for migrants and stand up against violations of the rights of migrants which compromise their health and wellbeing. As a network, CARAM acts both at national and international levels. The main target groups of CARAM Cambodia are Cambodian domestic workers leaving for Malaysia (prospective migrants) and Vietnamese sex workers in Cambodia.

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of work, they did not earn enough money in a former job, they used to do sex work before in a massage parlour or a brothel, or they have to pay off their own debts or those of family members.

They dislike doing sex work and feel the stigma attached to the job. They are 'that kind of girls' and do not want to be, but they do not earn enough money to start their own business or to quit working as a massage girl: *"Nobody wants to work like this, but we don't have money"*. They would like to change their own life circumstances but, at the same time, feel powerless to do so. Consequently, they can become depressed. Some start gambling or drinking and are reluctant to talk about their problems. They start to care less about

themselves and become obsessed with making money, which can make them forget to protect themselves properly.

### Physical and mental abuse

Taken together, these factors cause feelings of low social status, which can be intensified by physical and mental abuse and intimidation the women face from relatives, husbands, massage parlour owners, former employers, other people in their social environment or clients. *"About the shop-owner... if she heard we opposed the wishes of the clients she scolded us, sometimes she hit us. There were two or three girls who had head injuries. When we saw that we became very afraid too."* The women are shy to talk about this but encourage each other to do so: *"Why don't you tell us the truth to prevent other girls being misled too. [...] You should tell others the truth, don't keep silent"*. These women would like to learn from each other's experiences and would like to prevent other women from having the same experiences they had and still have.

When talking with the massage girls a diversity of problems and risk factors come up, which vary from feeling homesick to being hit by the parlour owner if the women refuse to have sex with a client. If the massage parlour workers are asked what they would like an organisation to do, the answers are as diverse as the problems that come up during a discussion.

### Daily threats

What becomes clear is that risks perceived by the massage girls do not, by definition, equal health risks like becoming infected with STIs or



# Some conditions influencing HIV/AIDS prevention and health promotion in Hong Kong

Pik-yuk Shara Ho

***From her experience with outreach work with (migrant) female sex workers in Hong Kong, China, Pik-yuk Shara Ho of the NGO Action for REACH OUT describes the changes that have taken place in the sex work population in the last few years. The factors that increase migrant sex workers' vulnerability to HIV/AIDS are then summarised, as well as current practices and regulations of the health care and legal systems which influence their access to health care and to HIV prevention programmes.***

As quoted from the South China Morning Post, there were 200,000 sex workers in Hong Kong in 1993.<sup>1</sup> Five years later, the Asian financial crisis in 1998 brought about poorer economic conditions and higher unemployment rates in South East Asia. One of its consequences was the huge influx of people carrying tourist visa who joined the sex industry in Hong Kong.<sup>2</sup> Many of these migrant sex workers come from Mainland China, Thailand, the Philippines or other countries in South East Asia. They are not a homogenous group because they come from a range of different ethnic, racial and religious backgrounds. According to official information, total numbers of migrant sex workers arrested were 2,965 in the year 2000, and 1,011 from January to March 2001.<sup>3</sup> In fact, estimating the number of migrant sex workers remains a problem. The sudden change in the composition of the sex work community in Hong Kong poses an enormous challenge to existing HIV/AIDS prevention and health promotion programmes for sex workers in the city. A number of complex factors – related to the characteristics of migrants, the attitude of health care providers and the legal situation of sex workers – influence the effectiveness of HIV prevention among migrant sex workers.

Given that HIV may be sexually transmitted, sex workers in Hong Kong are at great risk of

contracting HIV because they have multiple sexual partners and especially because they do not use condoms consistently. Research in Hong Kong showed that about 54% of female sex workers always used condoms at work, and only 8% always used condoms with their steady partners.<sup>4</sup> Other research indicated that 45% of sex workers were infected with some form of STIs.<sup>5</sup> According to these records almost half of the sex workers interviewed seldom use condoms.

An entertainment contract or tourist visa may be considered illegal if the presence of condoms is taken to proof sex work activity is taking place, leading to migrant sex workers experiencing even greater difficulty in practising safer sex.

## **Migrant female sex workers' extra vulnerability to HIV**

*Action for REACH OUT* (Rights of Entertainers in Asia to Combat Human Oppression and Unjust Treatment) is an NGO in Hong Kong which provides services to women in the sex industry in Hong Kong, including those coming from other countries. These services include outreach, referral, a hotline and a drop-in centre. The organisation is also conducting research on the needs and situation of women working in the sex industry and maintains a resource centre containing books, papers and articles. *Action for REACH OUT's* review of the health of female migrant sex workers identified five factors that make migrant sex workers in Hong Kong more vulnerable to HIV/AIDS than other sex workers, as these factors influence the effectiveness of existing HIV/AIDS prevention and health promotion programmes.

These factors are:

- 1 the stress of sex worker migration and settlement, particularly for those women who have experienced violence or trauma,
- 2 the loss of status and economic disadvantages experienced (for example, selling sex for money to support their family or selling sex for maintaining drug use) by many sex workers on arrival in Hong Kong,
- 3 religious background since many sex workers come from the Philippines and most of

HIV. Those health risks form only a small part of the whole variety of daily threats. Sometimes the cause is simple: the women do not know about STIs and HIV/AIDS, but the main cause is that there are other worries and risk factors to be considered. Being healthy is important to them, but being happy seems to be more important. Knowing how to prevent STIs and HIV/AIDS is important, but knowing how to deal with the difficulties of daily life, like not having enough money, being insulted, and having to deal with physical and mental abuse, seems to be more important.

The massage girls expressed a clear wish to be informed about health risks: *"This place [CARAM] should treat both men and women because the diseases are very dangerous to those who don't know about them"*. Nevertheless, they talk more about getting help in finding a new job or finding out where certain places like clinics are in town, going back to their home country, being able to earn more money, and last but not least, being happy and making friends. *"Money is the first thing, but next, one must be friendly to and love each other so we can live in this society together. Everybody needs kindness."*

The purpose of this qualitative research by CARAM Cambodia was to get a clearer view on in which way community-based interventions could best be carried out. By conducting focus group discussions and social mappings we have tried to get insight in the community the massage girls live in and what their experienced problems are.

## **Note**

1. At the moment of writing, the report of the research with massage parlour women is still under construction. For further information please contact Marjolein Maas.

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them are Catholic; they would thus refuse to use condoms,

- 4 the lower standard of education among migrant sex workers, with a consequent lack of awareness, knowledge or resources,
- 5 the language barrier and the young age of migrant female sex workers.

### Social and health care services

General health services in Hong Kong do not fully meet the needs of sex workers. Only Social Hygiene Clinics in Hong Kong provide



health services to the general public with free access to treatment of venereal diseases and dermatitis. Action for REACH OUT has identified four main obstacles to health care for sex workers. These are:

- 1 Many female sex workers have had bad experiences and distrust the official institutions. Therefore, some migrant sex workers fear that medical practitioners in Social Hygiene Clinics will inform other official agencies (for example, the Immigration Department or the police) about their work.
- 2 The health system is not appropriate for sex workers. Staff in clinics are often reported as having a negative attitude towards sex workers. As a result, sex workers may reject health services or may not be willing to disclose their occupation to the health care workers. On the other hand, health care workers often do not understand or do not know the specific problems sex workers face.
- 3 Other health system constraints include unsuitable opening hours. Clinics are usually closed during the time sex workers would prefer to use their services.
- 4 Some migrant sex workers do not qualify for

all social support services in Hong Kong (for example, public sector housing, childcare services). Only non-governmental organisations in Hong Kong provide social support for sex workers.

### Legal situation

Laws and policies influence sex workers practice of safer sex and restrict their control over their working environment. In Hong Kong, sex work in itself is not illegal but soliciting for an 'immoral purpose' is illegal, as well as doing sex work on a tourist visa. Action for REACH OUT has found two main problems for promoting condom use under Hong Kong policy restrictions. These problems are:

- 1 Migrant sex workers go underground because of the strict laws and policies in Hong Kong. As a result, access to health care will be hindered or their health status will be ignored. Under these regulations, HIV/AIDS prevention programmes and health promotion programmes are not widely advocated and are approached with distrust. Therefore, they cannot openly discuss safer sex.
- 2 Publicly attracting the customer's attention is illegal. This regulation may lead to reduced negotiation time for using a condom. This environment may create unsafe working conditions and actually promotes unsafe working practices.

### Comprehensive services

Action for REACH OUT has eight years experience of a non-judgemental attitude to sex workers. We offer a series of educational sessions for sex workers and allow them to gain

official skills when they join our programmes. Action for REACH OUT is also well known for advocacy of sex workers' rights.

It is one of the few non-governmental organisations and charitable institutions in Hong Kong that offer comprehensive services to sex workers. Being a small organisation with very limited government support, the services we offer focus on the sex workers' needs to reduce illness and protect their health.

### Notes

1. 2000 Housewives in sex industry. In: *South China Morning Post*, 3 May 1993, Hong Kong.
2. *Oriental Daily*, 21 March 2001, Hong Kong.
3. *Oriental Daily*, 12 April 2001, Hong Kong.
4. D.K.S. Chan, A. Gray, A. Ip & B. Lee, *Condom use among female sex workers*. Chinese University, Hong Kong, 1999.
5. R.W.S. Foy, *Factors associated with condom use and sexually transmitted diseases/Human Immunodeficiency Virus infection in female sex workers in Hong Kong*. Hong Kong, 1996.

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### Activities Action for REACH OUT

- 1 *Skills. We encourage sex workers to play an active role in a peer education programme. This programme not only provides a series of training courses in promoting health but it also increases sex workers' health awareness.*
- 2 *Multilingual outreach workers. Outreach workers speak Cantonese, English, Hakka (a Southern Chinese dialect), Mandarin and Tagalog (spoken on the Philippines) with migrant sex workers. This is necessary to create trust and to provide supportive services (for example, accompanying women to health screening).*
- 3 *Active role in health promotion. A health promoter is responsible for public health education in night-clubs and on the streets. It is important to have continuous STI and HIV/AIDS education programmes and health promotion activities for sex workers.*
- 4 *Accurate health promotion materials. Cartoons or attractive pictures draws sex workers' attention. The harm reduction programme is designed specifically to fit their needs and fit their conditions. In addition, translated materials (for example in Thai, Chinese and English) are available for sex workers.*
- 5 *Build up community networking. We have a good relationship with other organisations and local doctors thus allowing us to share materials and create professional networking within Hong Kong in order to provide suitable services to sex workers.*



# Health impacts of prostitution

## Experience of Bangladesh Women's Health Coalition

Julia Ahmed

***Bangladesh Women's Health Coalition (BWHC) has been working in the field of reproductive health since 1980. Currently the organisation runs 18 reproductive health centres, covering around 300,000 people both in urban and remote rural locations. In 1994, BWHC started a brothel-based health project in Tan Bazar brothel – the largest brothel of Bangladesh – until the government crackdown in 1999.***

Tan Bazar brothel was situated in the central part of Narayangong, a town beside a large river with a long trading history situated to the south of Dhaka. The brothel had been in existence in this town for many years, and was originally associated with the jute trade, which flourished here during the British period. The number of sex workers in Tan Bazar brothel was not static, ranging from 2,500 to 5,000. They originated from different parts of Bangladesh. Their ages ranged from 13 to 45 and their income varied from 5 to 1000 Taka per sexual contact (1 US\$ = 55 Taka).

In order to conceptualise the problem, BWHC conducted a KAP survey among sex workers residing in Tan Bazar brothel. Although initially we targeted this project for the prevention and control of STIs and HIV/AIDS, during the pre-project activities, specific questions surfaced regarding STI/AIDS prevention work with sex workers. For example, we learned that health-related quality of life of sex workers, including the likely gap between their existing needs for access to quality health services, was quite independent of any vulnerability to STIs and HIV/AIDS. Health seemed to be defined as important in its own right. Thus, this project, called 'BWHC's Special Reproductive & Sexual Health Project', took as its basic premise the intrinsic value of health-related quality of life of sex workers. The goal emerging was to improve the health status of sex workers and their children residing in Tan Bazar brothel. And the strategic objective was to devise a comprehensive health package with special address to STI/HIV/AIDS.

### **Brothel-based health care**

A clinic adjacent to the brothel had been set up with coverage of broader health needs of sex workers, which included counselling, contraceptives care, condom promotion, prevention and treatment of STI/HIV, abortion, pregnancy-related care including antenatal & postnatal check-ups, infertility care, gynaecological care and common ailment management. Apart from this, child health care, including EPI (Expanded Programme of Immunisation) and a vitamin-A distribution programme, was also functioning.

From the survey we found that sex workers' limited access to information inhibited them from articulating their needs and asserting their basic health requirements and thus they could not participate fully in identifying and resolving their health-related problems.<sup>1</sup> Hence, this brothel-based project was operating with a combined clinic- and community-based approach. Targeted information was provided both by

clinic staff and community-based staff. Selected sex workers had been trained to work as peer educators to make known services using positive peer pressure. Also, they often acted as the important link in referral to the available services. Through the peer education programme this project was trying to transmit and reinforce targeted messages among sex workers focusing on improving their sexual health.

### **Health consequences of prostitution**

From the Tan Bazar project the harms of prostitution became graphically evident in its consequences to health. The clinic-based service revealed that acute and chronic pelvic pain, pathological vaginal discharge, genital ulcers, skin disease, generalised weakness and pain during urinating, were alarmingly high among women here. Neonatal death after delivery was also prevalent and this was associated with their work taking precedence over their baby. Amenorrhea (cessation of menstruation) and infertility were also common, as well as craving for motherhood.

The other area of attention was injuries from violence that this group of women often encountered, which were much more diverse, frequent and acute than experienced by other women. Black eyes, bruises and burns were very common. Another major problem of this community was their harmful health behaviour from smoking, alcohol use, addiction, which endangered their further welfare by increasing vulnerability to other health problems.

While it was necessary to recognise the impact on physical health, the mounting pressure stemming from various areas including the forced prostitution on their mental health needs no emphasis. Very often the women visited the clinic with chronic anxiety, depression, eating disorders, post traumatic stress disorder and sometimes even sexual dysfunction. Together, these resulted in physical, mental and moral collapse and as a consequence they did not want to go back to the work or were unable to return to a 'normal' way of life.

These health problems further compounded as sex workers found difficulties to reach friendly services where they could discuss questions related to their actual problem without being worried that confidentiality would not be respected. As a result, their reliance on quacks for health matters further increased their vulnerability where health was concerned in many ways.

*On 24 July 1999 the sex workers of Tan Bazar brothel were evicted in a pre-dawn raid by police under the name of social rehabilitation. Several hundred sex workers were removed to government-run vagrant homes. During this forceful eviction process the sex workers were beaten badly as they did not want to go to the vagrant house. In this house, the authorities could not keep them for a long time as they became very violent in this new environment. Following the eviction of Tan Bazar brothel, a sex worker forum named Shonghoti emerged and they fought a legal fight, which continued for quite some time. Ultimately the verdict came in favor of the sex workers. But despite the court rule and due to unknown reasons, till date the brothel is still closed.*

# Filial piety and Vietnamese sex workers in Svay Pak, Cambodia

Bettina Schunter

*“Having an elder daughter is better than having deep paddy fields and female buffaloes”* Vietnamese proverb

## High-risk group labelling

Apart from the scale of unprotected sex and hence potential exposure to STI/HIV, research shows that having an untreated STI greatly increases an individual's risk of getting or passing on HIV to the partner. Fortunately, most STIs can be cured with antibiotics. On the other hand, to date, HIV/AIDS still has no cure and this pandemic is different from other previous pandemics as it is not a mere bio-medical but also a development problem, which has an impact upon every aspect of human life. Unfortunately, the understanding of this pandemic has its roots in the discriminatory belief that the virus is only a problem of high-risk groups including sex workers. In reality, the glaring truth is that the virus does not discriminate between people. But the wrong assumptions which come from high-risk group labelling has left the sex workers with the added psychological stress of the inevitability of catching the virus.

Finally, I would like to point out a few things regarding the general approach to sex workers as a high-risk group. Very often when we think about any intervention programme with sex workers we put a lot of stress on the control and prevention of HIV/AIDS. But what they really need first and foremost is access to quality health care with sensitive counselling and referral to the support system. Too often, this group lacks these facilities, rendering them up to a life full of danger. Additionally, we very easily label them as bad people. Until this categorisation is done away with, any intervention we design for them will have little impact.

## Note

1. The survey findings were presented during the 6th Annual Scientific Conference of the ICDDR,B Centre for Health and Population Research and were published in its conference report.

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*Médecins sans Frontières (MSF)* has been working in the area of Svay Pak since 1995. Svay Pak is a predominantly Vietnamese fishing village with a concentration of Vietnamese sex workers, situated 11 kilometres north of the Cambodian capital Phnom Penh. MSF's involvement in Svay Pak started with an STI clinic and a condom promotion programme. Since the beginning of 2000, the project has focused on the well-being of the sex workers, introducing non-medical activities in *The Lotus Club (Cau Lac Bo Bong Sen)*, a drop-in centre on the first floor of the clinic.

The shift to activities that improve the well-being of sex workers was seen to be a necessary preliminary step in getting the women to explore taking more responsibility in their own

*The women feel they have to be there to support their families*

lives and thus in their health. In collaboration with the Population Council's Horizons project we are conducting Participatory Learning in Action (PLA) activities as part of a two-year operational research project. This research project focuses on community building and mobilisation amongst the primarily debt-bonded, brothel-based, sex workers in Svay Pak. As decision-making skills and life-skills are necessary for an investment in one's 'self', so too is an enabled community necessary for supporting those changes in individuals. The Lotus Club also offers English classes, karaoke, counselling and health workshops, and will soon start Vietnamese literacy classes as only around 65% of the women are literate, and literacy is empowering.

## Making money

The act of building an identity of community and self amongst the sex workers is difficult and takes a long time. MSF faces challenges, as the sex workers come from Vietnam with

the idea that they will only stay for a limited period of time and eventually return to Vietnam. Their energies, therefore, are put primarily into making money and repaying their debts as soon as possible so that they may return. Financial burdens, however, rise along the way and many end up staying a prolonged period of time. The most common financial burden is the family either borrowing money directly from the brothel manager or the woman sending money back to the family. Filial obligation or piety (the sense of duty towards one's parents), which is central to Confucian thought, is the compass by which these women direct their actions.

It is from the viewpoint of gender, as it is constructed by filial obligation, that I wish to raise questions about the work that MSF is trying to do with sex workers in Svay Pak. Is it possible to do empowerment work, life-skills building work, and community building work if we do not address the cultural construct of filial obligation? Is there a better way to ensure the women's sexual health and safety? How is self-perception of risk altered by filial piety?

## There's no place like home

Sex work is competitive. Attending the PLA sessions often means losing clients to women who stay in the brothel. As a result, women may not want to attend PLA sessions anymore. The notion of community then shifts from a combined effort to better circumstances to one with the sole shared interest of making money and supporting their families. During the Horizons session of the PLA project called 'Risks and Benefits', one of the risks identified was the loss of money while the women came to The Lotus Club to participate in PLA activities.

In March 2000, anthropologist Anastasia Hudgins interviewed thirteen sex workers about their lives in both Svay Pak and Vietnam, and about AIDS.<sup>1</sup> All women interviewed said they came from the Mekong Delta area, from very poor families, and that they were in Svay Pak to support their loved ones. And all of them said that they wished to go back to Vietnam, which they referred to as 'home'.



### Family involvement

Three of the sex workers Ms Hudgins interviewed were brought by their mothers. To the best of MSF's knowledge, most of the sex workers working in Svay Pak were brought by family members. The women are brought to brothels where the brothel managers and community speak Vietnamese, celebrate Vietnamese cultural events, and for the most part, are not violent towards them. This fairly secure environment, and the approval and desire of the parents who send their young daughters to work there, raises the issue to what extent filial obligation engenders perception of risk.

Of course, one may assume that in a secure environment other immediate risks such as rape or violence may be reduced. Women may have more of an opportunity to reflect on HIV and risks of unsafe sex. However, we know that men force the women in Svay Pak to have sex without a condom sometimes, particularly the military police whom the brothel managers are unwilling to antagonise. In a survey carried out by Horizons in 2000, 30.4% of sex workers said a client had forced them to have sex against their will.<sup>2</sup> Men who force sex may be less willing to stop and put on a condom. The underlying issue is that the women feel they have to be there to support their families, that their families want them to be there (this feeling is either real or perceived) and so they accept different levels of risk.

### Coping with culture

Risk perception evolves from a prioritising of elements of a particular situation. If the sex worker's prescribed role in the family structure, as a woman, is to ensure the family is taken care of, she may prioritise additional monetary compensation for unprotected sex, above the risk of transmitted infections, even though she will become a burden on, and a shame to, her family if she returns to her village sick with HIV/AIDS. Some women will also agree not to use a condom as an incentive to attract clients if they have had problems attracting clients in the past.

One way or the other, sex workers' risky behaviour puts their role in the family at risk if they jeopardise their capacity to make money for the family. So, should MSF reinforce this factor, thereby further embedding the women

***"Will we be able to build a more enabling environment for them than provided by their families?"***

in their role, or should we continue as we are, trying to help the women to ultimately take decisions for themselves? Will we be able to build a more enabling environment for them than provided by their families? If the women continue to support their families, aren't they then 'empowered' in their own cultural context? To fully address and negotiate the social construct of family would take much more time and many more resources than either MSF or the women have. MSF can

respond to these social constructs and norms through encouraging more individually empowering activities, such as making and saving money, or helping the women to write letters home – to move towards confronting issues, if that is what they wish.

To try to persuade the women that protecting themselves is a means to ensure future family activity and filial responsibility is possibly the best method we have to ensure their health safety. Protecting themselves is also protecting their future husbands and children. After all, our aim is not to destroy the social fabric of the family, but to help the women become more aware of how the threads are woven.

### Notes

1. Hudgins, Anastasia, key informant video interviews, Svay Pak, March 2000.
2. The Horizons Project, Population Council, Survey, Svay Pak Round 1 data, October/November, 2000.

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## Promoting HIV testing among Guam sex workers: Problems in Paradise

Randall Workman, Thomas Pinhey and Ana Hill

The Pacific Island of Guam is about 7 miles wide and 30 miles long. Travel is easy to and from the Philippines, Japan, Hong Kong, Korea, and Australia, but it is 6,000 miles to its administrating power, the United States. As one of Asia's holiday paradise destinations,

tourism is the private sector economy, while public government and the military remain the major employers. In 1996 we conducted a needs assessment study for Guam's *HIV/AIDS Prevention Community Planning Group (CPG)*. The CPG is an

advisory body to the island's STD/AIDS Prevention Programme at the Department of Public Health, and is required as part of their US federal funding. The group is useful for co-ordinated island-wide efforts because it involves persons from known risk categories, such as the gay/lesbian community, drug users, persons living with AIDS (PLWAs), and agency networks (e.g., community NGOs, prisons, drug abuse programmes, hospitals, and youth detention centres). Interestingly, Guam's CPG network has never designated the 'sex worker' as a targeted risk population. Sex workers have always been considered, but within the con-



text of other high-risk categories, such as men having sex with men (MSM) or intravenous drug users (IDUs). This differs from the approach by many Asian countries, which single out sex workers as the primary target population for intervention.

Consequently, the original study was not designed for specific analyses of sex workers. While there are identifiable benefits for sex workers through non-labelling and not separating them for special public policy attention, Guam's CPG may have neglected some areas of need which should be addressed. In recent years there is a growing research literature addressing these needs, but very few studies of Pacific Islander sex workers in their home communities.

### Targeted high-risk groups

The 1996 study employed several methodologies, including case studies of PLWAs, focus groups, and a survey among people defined as being at risk for HIV. Community programmes provided interviewers who identified themselves as being in one of the high-risk categories. A total of 120 questionnaires were collected from targeted high-risk groups: (a) men who have sex with men; (b) intravenous drug users; (c) women at risk (e.g., spouses/partners of high-risk men), and (d) 'institutional access' persons (i.e. STI clinic clients, prison inmates, military). Even so we asked if the person 'ever accepted money in exchange for sex?' and later, 'accepted money for sex in the past year?' This identified one-third of the people (37) interviewed as recent or former 'sex workers'. About half of the MSM group indicated doing 'sex work', one-third of the IDUs and just over half of the women at risk gave positive responses, but only 14% of contacts at institutional sites admitted they had engaged in sex work. The sex workers identified were predominately indigenous Pacific Islanders (78%) or Filipino/Asians (8%).

### Risk perception and behaviour change

In the original report, we assessed who was more likely to perceive themselves to be at risk of HIV infection. There were reasons for this. Why and how a person admits (rather than denies) he or she is at risk and then actually takes action is a complex process. Effective prevention programmes should understand how individuals interpret information about the transmission of HIV, how they make sense of their sexual activity, and the possible disease outcomes that can result. Among the groups under study, we found that risk was generally determined less by one's own behaviour and more by the perception of a partner (or partners) being the source of risk.

Re-examining the data by 'sex worker' status, it was not surprising that sex workers fit this pattern. Sex workers identified themselves as being at risk more than other at-risk persons. Both groups (sex workers and 'recreational' high-risk persons) had made some changes in their sex activities since learning of HIV/AIDS. Both said they were more selective of partners, and both had begun to refrain from certain sex acts. There was no difference in personally knowing a PLWA, and about half of both groups had taken a risk the previous month. But in contrast to 'recreational' high-risk persons, the sex worker group was less likely to have made changes in avoiding sex with anonymous partners, and in the use of condoms.

We were confronted with an issue of motivation in a sex worker's decision to get tested. Although they were just as likely to 'know where to get an HIV test', and despite a greater perception of being at-risk, the sex worker group was significantly less likely to say they had had an HIV test (40% compared to 78% of other high-risk persons).

### Immigrants

Guam's local female sex work areas are concentrated in particular apartment and low-cost hotel areas of the central, more urban villages, but female sex workers are also active in the same tourism and commercial entertainment areas where local male sex workers are active. Male sex workers are known to operate in beach parks, parking lots, and their favoured clubs, whereas the female workers do not. Another important difference between these two sectors of Guam's sex industry is that the female sex worker population is not just local but composed of a large number of immigrants from Asia, who predominate as bar hostesses and massage parlour workers. Asians also predominate in the management

and ownership of most of the karaoke bars, strip clubs, and roadside massage parlours. The key informant sex workers and HIV/AIDS outreach workers interviewed in 2001 responded that they would expect very similar findings if we repeated the survey, even though since this study a condom distribution programme has been started through Guam's *Coral Life Foundation (CLF)*, a community-based, non-government AIDS organisation.

### Selective use of condoms

CLF operates an alternative testing site as a way to motivate people at high-risk to get tested and to increase testing. Peer counsellors and volunteers in their outreach programme go to high-risk sites to provide education, counselling, and condom distribution. According to one of the sex worker volunteers, condoms are being used more frequently than in the past, but not by everyone with anyone. Our female sex worker informants admitted that condoms are used selectively, depending on who the client is, what he wants, and how much money he offers. Guam's MSM sex workers reportedly also employ a selective process in condom use by scrutinising partners and being selective of those they sense as suspicious. These unreliable forms of 'risk reduction' make condom use optional – not assumed, but negotiated. This selection process is most often based on stereotype labelling within the community: what's their ethnicity, are they well-to-do, are they residents or tourists, can they pay cash?

*Among our female sex worker informants, Ivy has worked as a bartender and an exotic dancer, and Lelani has worked for massage parlours and a 'girl escort' service. As sex workers they have regular clientele, ranging from schoolteachers, to businessmen and police, but there are also military, tourist, and construction worker clients. Both are very conscious of the importance of condom use. Lelani really endorses the female condoms Public Health is distributing. Even so, and similar to the male sex worker informants, there are economics and an imbalance of 'power' between client and sex worker limiting regular use and increasing the fact that they take risks. The free distributions are not always available, and so factors like transportation to Public Health, and client demands remain the determinants of use. They also confirmed that when working in massage parlours, the 'mama-sans' charge the workers for all costs, reducing their income.*



Sex workers on the Guam beach Photo: Ana Hill

### Obstacles to testing

Our informants at CLF felt that testing for HIV among gay men has increased, but not among their male sex worker clients. The outreach workers sense this resistance stems not from an ignorance of risk, but more from over-confidence in feeling that they know how to be safe by refraining from certain acts, using condoms as needed, and carefully selecting customers. They come into the CLF centre for free packets, but choose not to be tested: the frequent comment is *"I'm not there yet"*.

For female sex workers, in contrast, personal relationships and economics are the forces affecting the frequency of HIV testing. We asked Lelani why she got tested while so many other sex workers did not. *"It's your partner's fear of who you've been with and their asking that puts on the pressure. That's why I do it, but many girls don't have that help for getting tested."*

Moreover, before 1998, the battery of tests needed for a health certificate to work the

massage parlours were conducted at Public Health for free. Since then the Japanese recession and collapse of the island economy has led the government to change policy. Public

## ***Risk was generally determined less by one's own behaviour and more by the perception of a partner being the source of risk***

Health still does an HIV and syphilis test at no cost, but each applicant must go to a private physician for the additional battery of tests (oral, anal, and vaginal) required to get a certificate. Our informants and Public Health indicate these tests can cost up to US\$ 300, and the health certificate has to be renewed quarterly! For many of the non-English speaking Asian workers, the massage parlour owners loan the costs, which have to be paid back (along with costs of condoms and other expenses). Our informants, all independents, indicate that most of the Pacific Island and non-Asian girls now work the massage parlours 'part-time', which is to say they work without a certificate. The costs of time, trans-

portation, and 'being processed', just don't make the free HIV test worth the effort.

Sex workers may be an at-risk population with circumstances and motivations that differ from other high-risk persons. This study shed light on how a person perceives being at risk. Views of one's sex partner(s) as the source of risk, rather than one's own behaviour, appear to affect how people make sense of their sexual activity and decide on protective measures. For sex workers, due to their occupation, these processes induce them to self-identify as being at risk, while other high-risk persons may find denial easier to maintain. However, conditions of their occupation negate sex workers from making those changes most often made by other high-risk persons (fewer partners, monogamy, and consistent condom use). How this relates to getting tested for HIV, and factors that reduce testing differ between male and female sex workers, with economics and access being stronger factors among the female sex workers.

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### COUNTRY EXAMPLE: SOUTH AFRICA

According to a study in eastern KwaZulu-Natal province 34% of long-distance truck drivers in South Africa reported that they always stopped for sex during journeys and 56% tested positive for HIV. At one truck stop, 95% of surveyed drivers were HIV-positive. Furthermore, 29% never used condoms with prostitutes. Of the 320 drivers interviewed, 70% had wives or girlfriends, and few had ever used a condom with these regular partners.

These were the results of a remarkable research by the South African Medical Research Council carried out by sex workers, who studied the habits of drivers in 1999 and 2000. Instead of marginalising sex workers, this project showed that they can be trained to promote HIV awareness and join the research community in the fight against HIV.

Medical Research Council researchers recruited ten prostitutes at five truck stops to gather data from their clients. The women were trained to obtain the truckers' informed consent to participate in the study, to complete questionnaires and to obtain a saliva sample for HIV testing.

According to Gita Ramjee, one of the researchers, the women were very enthusiastic about the project: "For them it was something empowering, the ability to become a researcher". The researchers decided to use the women in part because it was unsure how accessible the drivers would be to 'outside' researchers.

The Medical Research Council calls for the urgent establishment of mobile clinics along trucking routes, and more co-operation between the government and the trucking industry on AIDS awareness and condom distribution to truckers and prostitutes.

*'Prostitutes study truck drivers in South Africa, find high HIV rate'. Agence France Presse, 2 May 2001.*

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# Report from the USA: Do prohibitory laws promote risk?

Melissa Ditmore

As an outreach volunteer for FROST'D, I witnessed police harassment and interference in Brooklyn, New York City, with operations of a federally funded organisation that distributes condoms and needles and does blood testing for sexually transmitted infections. Most of the people who use these services are sex workers. This interference included ticketing women who came to the outreach van and performing 'sweeps' (arrests of all women on the street under suspicion of 'intent to commit prostitution') on evenings when it was known that the outreach van would be in the area.

These activities prevent women from visiting the services of the outreach organisation out of fear of arrest. In this way, the police repression of prostitution not only worsens the difficult situation of street prostitutes but may actually increase the spread of disease. Law enforcement practice against street prostitution, especially as it effects health outreach, may itself be a proponent of transmission of HIV.

## Under-reporting of crimes

Other examples of intimidating police behaviour that I witnessed or were described to me by FROST'D personnel include police parking their vehicles behind the mobile outreach unit, preventing prostitutes from accessing the care and services provided by FROST'D for fear of arrest, disregarding needle exchange membership cards (which allow a person to carry syringes and needles legally – they are usually illegal in the USA) and arresting or ticketing those women who do take advantage of the services provided by FROST'D after they have left the mobile unit.

Equally worrying is the fear of police officers and arrest that leads known prostitutes not to report crimes committed against them, including violent crimes such as assault and battery. FROST'D does not always ask if police harassment is happening, even as outreach workers and volunteers witness it. Some clients discuss it informally and voluntarily, but no systematic inquiry has been made. Therefore, reports are considered anecdotal or deemed to reflect an episodic trend. Without more regular inquiry it will be difficult to determine the degree to

which police interference affects outreach.

Researcher Priscilla Alexander of FROST'D and the *North American Task Force on Prostitution* theorises that greater probability of arrest and a feeling of a loss of control promotes drug use.<sup>1</sup> This is echoed by one FROST'D client's tale told to a volunteer.

*'Raisa' described having her needle exchange card destroyed by the police, who then charged her with needle possession, as a definite indicator of intent to purchase and use drugs, and, being in a known prostitution area, she was charged with intent to commit prostitution.*

*After this incident, she was known to the police, who proceeded to harass her on future occasions. This included harassing her in front of her home, which disclosed her occupation to her neighbours, although the police were unable to charge her at the time of this incident.*

*A third time, she was approached while purchasing food in a shop, and this time she spoke to the officers. Her assertion to them was that if they were genuinely concerned with preventing crime, they would help her away from illegal activities instead of repeatedly harassing her. She went on to describe that their harassment encourages her heroin consumption as a coping mechanism.*

This is the story of one person but her story is not unique and has been, unfortunately, echoed by a large number of street prostitutes in the USA.

## A better example

While it is impossible to measure the effects of harassment and arrest of prostitutes without systematic data, it is possible to compare projects operating under different legal systems. In France, where prostitution in itself is not

## One of the obstacles to outreach experienced is gaining enough trust to get over the fear of law enforcement

prohibited by law (however, other activities related to prostitution are illegal) some prostitutes work right outside the police department. This absence of worry about arrest and harassment allows *Cabiria*, an outreach project in Lyons, to focus on health, including condom and lubrication distribution as well as recommending sympathetic doctors to clients. *Cabiria* staff also includes therapists and lawyers.

This is not to say that prostitutes and outreach workers in France and other places where prostitution is not a criminal act have no police worries, but their worries are far less in com-

### FROST'D

*FROST'D (From Our Streets with Dignity) was founded in 1986 to study the risks for HIV infection among female, street-based sex workers. In 1989, it received a grant to do HIV counselling and testing. Since then, it has grown to include a range of programmes designed to help sex workers, substance users, the homeless, and their partners survive on the street, think about the future, and make the transition to the ordinary world, when they are ready. FROST'D works on the basis of harm reduction, which means reducing risks associated with sex work and drug use.*

*FROST'D operates four mobile outreach programmes for female, male, and transgender sex workers, substance users, the homeless, and their sexual and drug using partners, in low-income neighbourhoods in New York City. Mobile services include HIV counselling and testing, case management and referrals, a syringe exchange, and health care. In addition, two transitional housing projects for homeless people living with AIDS are operated.*

#### FROST'D

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parison to their American counterparts.<sup>2</sup> This effectively eliminates one of the obstacles to outreach experienced where sex work is illegal, which is gaining enough trust to get over the fear of law enforcement. This is of course a small step in establishing rapport but without this first step no encounter is possible.

Incidents like the destruction of the needle exchange card demonstrate illegal activity perpetrated by law enforcement officers. This is a separate issue apart from the law itself, and

even with the prohibitive laws in place, there is no excuse for the actions described above. These unnecessary and unlawful activities do not promote the enforcement of laws prohibiting either drug use or prostitution. Laws against prostitution and drug use could be enforced without harassment and intimidation and without interfering in health outreach activities. There is no justification for law enforcement to promote unsafe activities and unnecessary risk. In committing such acts, law enforcement effectively promotes the trans-

mission of HIV, which is truly criminal. The fact that such actions occur require an evaluation of police response to prostitution, with cooperative efforts to eliminate activities that may in fact promote risk.

#### Notes

1. Personal correspondence, March 2001.
2. See also the article on Cabiria by Françoise Guillemaut in this issue.

#### About the author

Melissa Ditmore is a member of the Network of Sex Work Projects (NSWP). The Network of Sex Work Projects is an umbrella group with members on six continents.

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#### COUNTRY EXAMPLE: TAIWAN

In September 1997, licensed prostitution was overnight abolished and the licenses of 128 women were withdrawn by the city of Taipei (Taiwan). After a two-year period of struggle by *TALP* (*Taiwan Association of Licensed Prostitutes*) and *COSWAS* (*Collective of Sex Workers and Supporters*), the brothels of Taipei's licensed prostitutes were finally allowed to open again in March 1999. However, not for long. The city council had granted the remaining handful of licensed prostitutes a two-year grace period to take up work outside the sex industry.

In March 2001, the grace period expired and legal prostitution came to an end. However, there are still thousands of illegal prostitutes (an estimated 100,000 women) working out of massage parlours, barber shops and teahouses. Taipei City police has vowed to relentlessly crack down on the illegal sex industry. Police officials said in March that any establishment found to serve as a front for prostitution will have its water and electricity supply cut off, while owners of such property will be fined and face criminal charges.

Needles to say, this will push the sex workers more underground, which makes them subject to unsafe sex practices out off fear that their clients might disclose their activities to the police.

#### NEW E-MAIL LIST IN ROMANCE LANGUAGES

In 1998, the Sex-Work e-mail list started for English-speaking people ([www.hivnet.ch:8000/topics/sex-work](http://www.hivnet.ch:8000/topics/sex-work)), with around 300 postings in the first three years of its existence. In the beginning of 2001, a new e-mail forum for discussion in Romance languages (Spanish, Portuguese, Italian, French) was launched, titled 'Industria del Sexo'. Following is the announcement in Spanish.

Para personas con trabajos relacionados al campo de la 'Industria del Sexo', hay un nuevo foro para hablar en idiomas romances. Aquí se puede abordar temas económicos, sexuales, políticos, sanitarios, sociales, globalizados, jodidos y divertidos, pero no discutir la cuestión de si la prostitución 'está bien' o no. No abordamos ideologías, y las trabajadoras sexuales no son el único sujeto que nos interesa; al contrario, queremos hablar de todos los sujetos involucrados, desde taxistas hasta empleados de ONGs, médicos, clientes, dueños de negocios, académicos y policía. Esperamos fomentar la comunicación entre personas que trabajan con trabajadoras del sexo de cualquier etnia, clase, edad, nivel económico y género. Compartimos información, informes y contactos. Solicita la suscripción a la lista con una breve descripción de tu interés escribiendo a la moderadora, Laura Agustín: [agustin\\_laura@hotmail.com](mailto:agustin_laura@hotmail.com).

# Prostitution and repression in France

## *The point of view of Cabiria*

Françoise Guillemaut

***When one mentions the question of violence in the field of prostitution, one immediately thinks of aggression on the street or theories of violence inflicted on women, prostitution being considered the main violence, and sex workers as victims, even slaves. Cabiria, a French community health NGO working with sex workers in Lyons, proposes to explore another aspect, which is that of violence inflicted on sex workers in the current institutional context in France, and to consider sex workers as subjects having rights.***

The French policy consists of fighting primarily against procuring and proposing the reintegration of sex workers by stopping prostitution. The act of prostituting is not an offence, but considered a private business; however, prostitution is regarded as a form of social maladjustment. Thus, a particular directive on the protection of prostitutes in the exercise of their activity does not exist. In addition, police methods of investigation rest on the idea that it is through supervising or questioning prostitutes that one can collect information on procurers (traffickers and pimps). The mission of the Criminal Investigation Department is to track networks of traffickers and procurers, not to ensure the protection or the daily safety of sex workers. Finally, prostitution is implicitly regarded as disrupting public order and explicitly as a social plague (ordinances of 1960). Sex workers do not have access to social protection because of their activity, and even if safety devices such as Universal Health Insurance, jurisdictional assistance or social benefits are accessible to any citizen in a regular situation, various practical obstacles limit prostitutes' access to these rights. Access to housing is also limited for them most of the time because of the absence of documents proving income, social status and the laws on hotel procuring.

Taken together, these devices and social practices are factors which make possible and reinforce the various forms of violence against sex workers: institutional violence, which allows, with impunity, violence by police officers, clients or any individual on a daily basis. In the context of increasing xenophobia of the countries of the European Union, the situation of migrants is even more difficult.

### **Private business**

We do not doubt that there is a direct link between the social condition of prostitutes and their capacity to remain safe and in good health. In other words, the more people live in

***In the fight against trafficking, migrant sex workers are often the first ones to be persecuted***

a precarious economic situation or social isolation, the more they are clandestine or dependent on others, and the less they are able to adopt preventive behaviour. People in a situation of illegality and/or extreme precariousness, who are active under very insecure conditions and for whom prostitution is mainly a means of survival, are more at risk than others. Consequently, it appears that any policy that can contribute to making prostitution a clandestine activity can have only extremely harmful consequences for the general health of sex workers.

In our work as an NGO, our initial objective of HIV prevention is closely related to the fight against prejudice, stigmatisation, and the defence of human rights. Currently, in France, sex workers are without rights. Prostitution is not illegal, it is regarded as a private business, but the French State fights against prostitution through juridico-social means: soliciting is pe-

nalised, prostitutes cannot associate together, their incomes do not enter within any clearly defined framework (which can have serious consequences for them in terms of payment of back taxes), their complaints about aggression or rape are generally not taken into account. Finally, in spite of the prohibition of police registering, this remains a systematic practice in all towns of France.

Therefore, people who work on the street (the majority in France) are constantly in danger. They are at the mercy of aggressors who are seldom confronted. They are the principal targets of the police force during investigations. Urban policies in large cities develop zero tolerance perspectives and often proceed to cleaning up the town centres. Various measures are used: tickets for soliciting, arrests and various persecutions are used against sex workers. This only moves prostitution to the outskirts of large cities, where people are in even more danger.

### **Protection**

Policies to fight immigration are often confused with methods to counter human trafficking. In the fight against trafficking, migrant sex workers are often the first ones to be persecuted under the pretext that they know the networks: confiscation of their papers, arrests, and expulsion from the country, are the daily threats they must face. Consequently, fear of the representatives of French public services



brings them too often to seek the 'protection' of criminal networks.

Beyond the persecutions of sex workers, community health NGOs also become targets for the police force: recently, Cabiria's cultural mediator was arrested and ill-treated while working for our NGO, and employees and volunteers of the team underwent police questioning. What were they accused of? Helping foreign women in the process of normalising their administrative status.

When people are victims of trafficking and are forced into prostitution in our country, it is fundamental not to penalise their presence in France and to think about their protection in daily life: administrative protection, protection on the street, social protection and health protection.

#### **Moral order**

One of the recommendations which seem significant to us would be not to worsen the sit-

## ***The fight against violence would have, in all logic, to be accompanied by guarantees for sex workers doing their work***

uation of foreign people in France. They should be given the opportunity to be admitted to our country in a proper manner. They should not have to undergo forced repatriation. They should be able to benefit from residency and/or work permits, in particular if the person wishes to leave prostitution and escape the Mafia. This protection should not be negotiated, i.e., it should not be given in exchange for the names of those who had facilitated their arrival, because this practice endangers these women and especially their families at home even more. Violence against sex workers is permanent, it is the (rotten) fruit of a moral, social and political system, which despises them as women and sex workers.

One of the essential social functions of the fight against prostitution is to point out the moral and social order, in particular that which holds all women in a state of subordination. Gail Pheterson shows how the stigma of 'whore' shows women what their symbolic

place is.<sup>1</sup> Prostitution is considered as a fixed identity, whereas it is only an uncertain and temporary social status; prostitution is thought of as a negative characteristic of femininity, in order to divide women into 'non-honourable' and 'honourable'. The 'honourable' women are considered to guarantee the virtue and the honour of the whole category of women. The most rigid limitations concerning women are monogamy and reproductive sexuality, in a context of economic dependence and emotional ties to men. However, prostitutes transgress these limitations, they call into question the place of women in the family order. One often mentions the question of violence undergone by women in prostitution but one forgets too often that violence is above all the prerogative of the family, since at least two million women in France are victims of marital violence, and it is well-known that sexual abuse most often takes place among family members.

#### **Empowerment**

One can wonder then if the fact of associating prostitution in itself with violence against women does not function to mask the violence inflicted on women as a whole and to prevent asking the real question concerning the protection and security of sex workers. If the State, the police force and citizens, all became aware of the importance of the protection of sex workers as real citizens, the fight against violence would have, in all logic, to be accompanied by guarantees for sex workers doing their work. From this point of view, we suggest working on the empowerment of prostitutes, to support them in their efforts to gain autonomy, without being judgmental of their activity.

Finally, Cabiria condemns any form of constraint on procuring and trafficking and advocates a real emancipatory policy for the empowerment of female and male sex workers,

*Cabiria is an outreach project in Lyons, France, for sex workers of all genders, created in 1993. It operates a bus for outreach, distributing condoms and lubrication, as well as a drop-in centre. Cabiria employs nurses, legal professionals, psychologists, researchers and a cultural mediator who works with foreign sex workers and trafficked women in France. Sex workers are employed at all levels of the organisation.*

going beyond abolitionism and regulationism. Cabiria also advocates the creation of a national platform which would associate authorities, para-public organisations (National Health Insurance Fund etc), researchers, concerned NGOs, and especially sex workers themselves, French and foreign, in order to open real debate on this topic.

#### **Note**

1. G. Pheterson, *The prostitution prism*. Amsterdam University Press, Amsterdam, 1996.

#### **About the author**

*This article was written in French on behalf of Cabiria by Françoise Guillemaut, sociologist.*

*Translation: Léo Thiers-Vidal, Cabiria & Melissa Ditmore, Network of Sex Work Projects.*

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#### **COUNTRY EXAMPLE: INDIA**

The frequent police rounding up of sex workers, peer educators and sometimes even social workers in the South Indian city of Calicut (Kerala), was seen by the Center for Social Research and Development (CSR/D) a major barrier to implementing an STD/HIV intervention programme for street-based sex workers in that city. Although Kerala is one of the most literate states of India, there is an extreme social stigma attached to HIV infection, leading to incidents such as mob thrashing and tonsure of sex workers suspected of being HIV-infected. Many of the senior law enforcement officials believe that they have a right to forcefully test for HIV status of any suspect. To counteract officials' harmful perceptions and attitudes towards sex work and HIV, CSR/D started mediating with the police. In 1998, a special programme on HIV/AIDS, the law and stigmatisation of sex workers was run, in which 331 law enforcement officials participated.

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# Repressive laws and hidden women: migrant sex workers in Germany

Veronica Munk

**In 1999, the TAMPEP Project in Germany conducted a poll with a view to finding out about the living and working conditions of female migrant sex workers in the country. Analysis of the results has shown that at least 60% of women working as prostitutes in Germany are migrants. Just as in other European countries, the living and working conditions of foreign sex workers are very difficult, as most of the women have no right of residency. This situation gives rise to social isolation, dependency on pimps and brothel owners, exploitation, insecurity and fear.**

The repressive nature of European laws on immigrants and prostitutes also cause women to move from one city to another within a

***Because many women tend to change their workplace and place of residence rather often, it is very difficult to establish a lasting basis for medical treatment***

given country, or from one country to another within Europe or, indeed, from continent to continent. This only reinforces the lack of rights and protection of the target group. In addition, the situation is made worse through loss of orientation and communication problems, because they do not speak the languages of the countries they move to. A further consequence of this situation is that the women have limited access to medical care, as most of them have neither recognised health insurance nor access to information on available health services.

The TAMPEP poll also showed how unequally the migrant sex workers are spread across the Federal Republic of Germany. In Northern Germany where most of the local health authorities offer voluntary, anonymous and free STIs health care services, the proportion of migrant sex workers is substantially higher.

However, in Southern Germany where, until December 2000,<sup>1</sup> there were laws requiring all sex workers to undergo regular physical examinations, the proportion of migrant prostitutes was quite a bit lower. That proves again how repressive measures are responsible for the marginalisation of this group of women.

### Access to health care

Because many women tend to change their workplace and place of residence rather often, it is very difficult to establish a lasting basis for medical treatment. Very often a course of medical treatment will be initiated, but never taken to its conclusion – for the reasons stated above. Many women know very little about STIs, HIV/AIDS and other infectious diseases or the proper use of contraception. This means that working as a sex worker can be potentially very risky for the migrants. Not only are

they liable to end up contracting sexually transmitted diseases, but they are also liable to have unwanted pregnancies.

### Repression

Massive police manoeuvres against foreign sex workers drive the migrant women to become completely dependent on third parties that use the situation to exploit and abuse them. The women are holed up in hidden workplaces and therefore cannot be reached for consultations on preventative health care.

Their life of secrecy in the illegal underworld leaves the migrant women open to all kinds of violence. The number of attacks on migrant sex workers is therefore increasing. Nevertheless, the perpetrators of these crimes go mostly unpunished, as they fear deportation or losing their anonymity if they go to the police and press charges.

Many women complain therefore of physical ailments of every kind, which doctors often diagnose as being psychosomatic. The women suffer from depression, anxiety attacks, breathing difficulties, dizziness and skin rashes. Some women try to cope with these illnesses and conditions by drinking alcohol and taking drugs.

### Local health authorities

Due to the isolation and illegal status of the migrant sex workers, the only place they can usually get any sort of health care, i.e., physical examinations and treatment, is from the local STIs health services. Migrant women also approach these health clinics with their psychological problems and expect support and



The repressive nature of European laws on immigrants and prostitutes cause women to move from one city to another within a given country, or from one country to another  
Photo: Piet den Blanken

## TAMPEP

*The Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP) started in 1993 in four European Union countries. Currently, the focus of the programme is on the implementation of the project's methodology through a network of organisations in fourteen EU countries and in seven countries in Central and Eastern Europe.*

*The project:*

- provides migrant sex workers with culturally appropriate HIV/STD education,
- seeks to increase empowerment and self-esteem among migrant sex workers,
- educates social and medical establishments to better respond to migrant sex workers' health needs,
- investigates the social, legal and working conditions of migrant sex workers.

*TAMPEP works with two trained professionals: the cultural mediator, a person from the migrant community who acts as a bridge between members of that community and the social and medical institutions, and the peer educator, a sex worker who receives training for passing on information and increasing empowerment among her peers.*

*The continuous acquisition of empirical data has allowed the network to draw a detailed updated map of migration movements within the prostitution industry in Europe, and a map of the demographic composition of the different groups.*

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understanding as well. However, most of these places have little experience in dealing with migrant women, not only because of the lan-

guage barrier, but also, and mainly, because of cultural differences.

Therefore, the complementary role of NGOs is extremely important regarding the social and legal counselling and support for migrant sex workers.

### Prerequisites for assistance

The migrant scene described shows that effective prevention work and medical treatment are only possible if you can 'get through' to members of this group in every way. You have to go looking for them and find them wherever they work so that you can give them information materials and address lists of support

organisations. This can only be done by regular fieldwork activities. You also have to 'communicate' with them in order to win their trust, so that you are better able to understand and improve their situation as well as carry out your work in preventative medicine.

Therefore, when working with migrant sex workers, the main objective should be to strengthen the self-confidence and self-esteem of the target group, enabling them to deal with different and difficult situations. Nevertheless, this can only be attained if their needs and their culture are respected and understood.

### Note

1. Since 1 January 2001 there is a federal legislation which determines that all STI service providers have to offer their services anonymously and voluntarily, to everybody, including sex workers.

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## Violence against female sex workers in Brazil

### *Preliminary findings from a Horizons study*

*Paulo Longo and Paulo Telles'*

Most projects to prevent HIV/AIDS transmission have adopted health promotion strategies comprised of educational activities to inform sex workers and their clients about sexual health, combined with condom promotion and access activities and improved health services with a particular focus on the treatment of STIs.<sup>2</sup> Other projects have adopted community development strategies whereby deliberate efforts are made to achieve community participation in the design and implementation of the intervention, in the belief that empowering sex workers is the key to ensuring the long-term success of reducing sex workers' vulnerability to HIV and other STIs.<sup>3</sup>

In response to the debate about the essential features of interventions for sex workers and their clients, Horizons initiated, in August 1998, a case study of the *Sonagachi Project* in West Bengal, India.<sup>4</sup> This study seeks to provide insights into the processes and outcomes of community development efforts used by this famous project to reduce HIV transmission through commercial sex. Another Horizons study in Cambodia proposes to focus on activities that support the initiation of community identity among sex workers, documenting this essential prerequisite for collective action by sex workers in order to contribute towards an eventual reduction of their vulnerability to HIV.<sup>5</sup>

### Community development

The research described in this article utilises and builds upon the methodology established during the study with the Sonagachi Project, using a non-experimental pre- and post research design at three distinct sites. Horizons is studying interventions that strive to strengthen or introduce community development strategies by and for sex workers and that are supported by the NGO Programa Integrado de Marginalidade (PIM) and the sex workers organisation Fio da Alma in Rio de Janeiro, Brazil. The research began in March 2000, with an adaptation and refinement of core indicators developed from the Sonagachi study and made appropriate to local site conditions. Data for these indicators will be collected during three cross-sectional observations (two before the start of the interventions and a third 14 months after the interventions have been introduced), through both quantitative methods (structured questionnaire) and qualitative methods, including focus group discussions and in-depth interviews. The first round of data collection has already taken place and preliminary results are being analysed.

Study results will be utilised to improve services and contribute towards the development and evaluation of interventions for sex workers in Rio de Janeiro State and elsewhere. The primary anticipated outcome of this study is an improved understanding of the processes and results of community development approaches in interventions to reduce HIV/STI transmission through commercial sex.

### Proposed intervention

The intervention proposed for this research is the introduction or enhancement of community development at three sites in Rio de Janeiro where PIM, together with Fio da Alma ('the soul's string'), currently conducts health promotion programmes. These sites are 1) Duque de Caxias, an urban centre outside the city of Rio including the town market place and arcade, with an estimated 200 sex workers, 2) Downtown Rio, which includes the main train station, a local park and nearby streets, with an estimated 400 sex workers, and 3) Quinta da Boa Vista,

a large park near the national football stadium that is particularly active after dark, with an estimated 100 sex workers.

The current PIM intervention includes trained health agents who are peer educators distributing condoms and providing other sex workers with sexual health information and support services such as referring or

## *Of those who have experienced any violence recently, most refer to police harassment or events related to other sex workers*

accompanying them to medical and social assistance agencies. The health agents are key 'change agents' in addition to their supporting the implementation of health promotion.

Sex workers at each site will receive financial and technical support to enhance community development. The communities will identify and define issues that affect their quality of life and develop and implement community responses to them through a process of participatory learning and action. Support will be available for a programme of cultural, educational and self-help activities aimed at improving communication within the community, developing its external relationships, and its capacity to develop and implement practical ways to enhance sex workers' quality of life including, but not limited to, health-related outcomes such as increased condom use.

### Preliminary findings about violence

At the first round of data collection, held in September 2000, project staff interviewed 482 female sex workers at the three sites. Findings about violence show some interesting indicators of 'perception' of violence and experienced violent events.

When asked '*Did you experience any kind of violence within the last four months?*' 78.6% answered 'No' and 21.4% said 'Yes'. Similar figures appeared when the women were asked if they '*have seen any violent event recently*' at the sites, 77.6% reported 'No' and 22.4% reported 'Yes'. Of those who have experienced any violence, the majority (75.7%) *did not search for any help*. Being afraid of not being helped in any public institution because of their condition as sex workers does not seem to be the reason for not searching for help, as the majority (more than 90%) does not refer this as the main reason. It is more likely that help is not searched for because the women do not know *where* to search for help. Almost half of the sample interviewed (40.9%) say that they do not know where to seek for help with regard to violence. An even more striking result is that the majority of the women do not know where to search for help with regard to human rights violations (88.5%) or where they can get legal aid (81.2%).

### Police harassment

Although the data analysed so far are very preliminary, some conclusions can be drawn if compared to the in-depth interviews and open-ended questions. Of those who have experienced any violence recently, most refer to police harassment or events related to other sex workers (like competition for the working place). In-depth interviews show that domestic violence or violence by a client tended to be seen as 'normal'.

### MALE SEX WORKERS: POTENTIALLY VIOLENT?

When we started Programa Pegação, a health promotion project for male sex workers in Rio, in 1990, we called the local gay group looking for a partnership. The reply was quite a surprise: "We don't want to work with male sex workers because they are all violent. Your clients kill ours". Ten years later it is still a perception in a large part of the gay community, that most hustlers are potentially violent. In a research conducted in 1994 with the State University of Rio de Janeiro and with the support of WHO, we found some different results. A large group of boys involved in the sex industry referred to at least one violent event within the last four months and, in most of the cases, they were attacked. It is perhaps presumed that they would lie at the interview, but another indicator is very important: Programa Pegação lasted eight years and involved direct, regular and personal contact between health agents and street male sex workers. A brief analysis of 5,000 reports from the health agents shows almost the same: 70% refer to a violent event with most boys (average age: 15 to 20 years) complaining that they were forced to do things not agreed to in advance, such as sexual activities or using drugs or alcohol. This just shows that assuming that male sex workers are responsible for violence is a bit naive, as the violence used by their clients is more or less ignored.

Paulo Longo

Some women reported clients throwing stones from a car as being usual. They also do not seem to perceive being banned from bars or restaurants as violent acts. Women who have witnessed any violent

## ***Of those who have experienced any violence, the majority did not search for any help***

event, rated the police as acting the most violent, followed by other sex workers, and only then the occasional client.

This may show that violence is still perceived as something related to police action, while other sorts of violence are perceived as being part of the work.

### **Notes**

1. With the collaboration of Cheryl Overs (Network of Sex Work Projects), Deanna Kerrigan (Horizons), Naomi Ruttemberg (Horizons), Chris Castle (Horizons), Helena Torres (SEPED), Zélia Caldeira (SEPED) and all the women of PIM and Fio da Alma.

2. C. Evans, *An international review of the rationale, role and evaluation*

*of community development approaches in interventions to reduce HIV transmission in sex work*. Prepared for the Horizons Project, Population Council, New Delhi, India, January 1999.

3. Network of Sex Work Projects (NSWP), *Making sex work safe*. Published by Healthlink (formerly AHRTAG), London, 1997.

4. Horizons Study #8: *The role of community development approaches in ensuring the effectiveness and sustainability of interventions for sex workers: case study of the Sonagachi Project*, 2000.

5. Horizons Study #76: *Building community identity among debt-bonded sex workers in Cambodia*, 2000.

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# ***The impact of violence on HIV prevention and health promotion: The case of South Africa***

*Helen Alexander*

***Suraya did not know the client but he looked okay, so she decided to go with him. He agreed to pay her 100 Rand (10.6 US\$) for sex with a condom. On their way to her room, he was very quiet and looked straight ahead of him. However, he went past her room and continued driving for another 30 minutes. She tried to reason with him but he became verbally abusive. When they eventually stopped at a secluded spot, he grabbed her, beat her, held a knife to her throat and raped her. He stole her money, then threw her out of the car and left. Suraya had to walk back and by the time she reached Woodstock it was 3 AM. Like many other sex workers, Suraya did not bother going to the police. She knew they would not take her seriously and would just say that a sex worker cannot be raped.***<sup>1</sup>

Suraya's story is unfortunately all too common amongst sex workers. Violence is an everyday part of many sex workers' lives. The severe physical, emotional and psychological trauma aside, there is another very serious consequence which violence potentially has on sex workers: HIV/AIDS. Due to the nature of the work, sex workers need to be espe-

cially well informed about HIV prevention and need to be extremely proactive in taking precautions against contracting the virus. However, there are a number of ongoing environmental factors which influence safer sex intervention programmes for sex workers and which prevent sex workers from practising safer sex. Significant amongst these is violence against sex workers.

Communications with sex workers have made it abundantly clear that sex workers are particularly vulnerable to violence.<sup>2</sup> The fact that most sex workers are women, that their work is illegal in South Africa, and that they are shunned by the non-sex working communities increases the sex workers' vulnerability to exploitation and abuse.

Violence against sex workers takes many forms and comes from various quarters. Police harass sex workers, sometimes forcing them to offer free services in exchange for not being arrested. Pimps and managers threaten and coerce the women to do things that they do not want to do. Clients force sex workers to perform sex acts other than those originally agreed to and may even take back the money they paid once the encounter is over. Community members verbally abuse sex workers whom they regard as a nuisance. Gangs force sex workers to sell drugs for them. Sex workers are further at risk from their partners who may physically, emotionally or economically abuse them.<sup>3</sup>

## Criminalisation

Although not all policemen, pimps, clients, partners and community members are violent, sex workers regularly find themselves in violent situations. The criminalisation of the industry and the stigmatisation of sex workers mean that few sex workers are able or willing to report incidents of violence to the police or to access health and support services.

*SWEAT, the Sex Workers' Education and Advocacy Taskforce*, is an NGO providing services and information to sex workers. SWEAT's work with sex workers in the Cape Town region has indicated that violence against sex workers affects their chances of contracting HIV in a number of ways. The most direct and obvious threat is that a sex worker may contract the virus if she is raped (whether by a local gang, a client or a policeman). In a study on street sex workers in Cape Town in 1998, researchers found that 11 of the 41 participants had been forced to have unprotected sex.<sup>2</sup> The sex worker's inability to access health services means further that she is highly unlikely to receive immediate anti-retroviral treatment after being raped.

The threat of violence from a client or manager/pimp if a sex worker refuses to have sex with a client without a condom also affects her ability to practise safe sex. The threat of physical or sexual assault will often result in a sex worker 'agreeing' to have sex with a client without a condom, thus potentially exposing her to HIV. This is exacerbated by the fact that clients have economic power over sex workers and will often offer more money for unprotected sex.

A further link between violence against sex workers and exposure to HIV/AIDS lies in the extent to which sex workers are often disempowered as a result of the criminalisation of sex work and the stigma attached. Consequently, they often lack the ability to negotiate condom use. This

It is clear that being safe is more than practising safe sex. Sex workers attending the 'South African Conference on Commercial Sex Work: The Health Issues' in February 2001 in Pretoria, South Africa, wrote a statement complaining about the lack of attention in the conference programme for issues that interested them, as the talking was mostly about HIV/AIDS.

From the 42 comments in the sex workers statement, over one-third concerned issues such as police violence, stigmatisation and harassment by the community, and the need for legalisation and decriminalisation of prostitution.

A selection of the remarks:

- 1 We know we have our issues, but the presenters are almost only talking about HIV/AIDS.
- 2 We get harassment from the community and the police.
- 3 Help facilitate organising so prostitutes who are in the closet, who don't work with our group will work with us to uphold standards. We get assaulted because some girls don't use condoms and customers compare us. For this we need resources, working with the miners union and union experts to help.
- 4 Set up meetings with people who have influence with the police such as the Commissioner of Safety and Security so that we can talk to them about police violence and harassment.
- 5 Legalise for us. We need a safe environment free of police.

On the following day, participants were asked to discuss about and make recommendations on three major themes, one of which was dealing with issues of safety and police harassment.

*SWEAT considers the empowerment of sex workers and the decriminalisation of the sex industry as the most important steps towards protecting sex workers from violence and increasing their ability to practise safer sex. SWEAT thus actively supports sex workers who are willing to stand up and defend their rights and continues to advocate the decriminalisation of adult commercial sex work.*

is particularly true with regards to underage sex workers. The underground and violent nature of the sex industry thus impinges on safer sex practices.

## Lack of services

There are numerous other environmental factors that impact on a sex worker's ability to negotiate condom use. Most prevalent amongst these in South Africa are poverty, drug dependence, myths about young girls and an inability to access safer sex support services.<sup>4</sup> The lack of HIV prevention and health promotion services directed at sex workers means that sex workers find it difficult to obtain condoms and access safer sex and health information which they cannot obtain from traditional sources because of stigmatisation and fear of being arrested. This lack of services is exacerbated by the fact that these services that are available are inhibited by the underground and potentially violent nature of the sex industry.

SWEAT is currently the only such service provider in South Africa. A non-profit human rights organisation, SWEAT aims to empower sex workers, advocate the decriminalisation of adult sex work, increase sex workers' access to police, legal, health and social welfare systems, assist in the creation of fair and safe working conditions for sex workers and promote safer sex work. SWEAT's ability to distribute condoms and provide sex workers with safer sex information is hampered by the fact that certain managers and pimps deny the SWEAT fieldworkers access to sex workers. This problem has been exacerbated in recent years with the increased involvement of gangs in the sex industry in Cape Town. Access to underage sex workers is particularly limited in this regard.<sup>4</sup>

A further hindrance to SWEAT's outreach work is the fact that many of the sex workers are extremely suspicious of outsiders because of the illegal nature of the sex industry. Fieldworkers are thus required to spend a great deal of time winning the sex workers' trust. This limits the number of sex workers the fieldworkers can reach at any time.

## Empowerment

In two recent court cases, SWEAT supported sex workers in actions against abusive police officers and an abusive brothel owner. In both cases the sex workers were successful in obtaining court orders to prevent the other parties from assaulting, threatening or harassing them or other sex workers.

These cases mark a small but important development in the protection of sex workers from abuse and the empowerment of sex workers. For the first time sex workers were able and willing to stand up for themselves against the police and brothel management and the positive outcomes of these cases are likely to encourage other sex workers to stand up for themselves in the future.

SWEAT's efforts to provide safer working environments for sex workers will hopefully ensure that sex workers are somewhat less vulnerable to violence and more capable of insisting on condom use. However, while the sex industry remains illegal, sex workers will continue to be marginalised and will remain unprotected from violence and coercion, and health promotion and HIV prevention programmes will continue to be



Photo: Nadine Hutton

obstructed. Until sex workers have full and unhindered access to protection, health and legal services, they will not be in a position to insist on safer sex practices and will remain at risk of contracting HIV.

#### Notes

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## Murderous clients and indifferent justice Violence against sex workers in the UK

Hilary Kinnell

Several UK studies have shown that sex workers experience high levels of violence, and these findings are reflected in the day-to-day experience of those running projects for sex workers. In my role as UK co-ordinator for *EUROPAP*<sup>1</sup> I have collated information about violence against sex workers, particularly murders. Fifty-one women and girls killed since 1990 have been identified and a further five women are known to me as 'missing presumed dead'. This total rises inexorably: four new names have been added since 1 January 2001. It is likely to be a considerable underestimate, since my information comes from sex work projects or from press reports. There are no publicly available statistics on murders of sex workers in the UK.

Levels of violence against sex workers are rarely measured systematically, and there has been little analysis of the variables that influence sex workers' risk of experiencing vio-

### **Available studies show that street workers are at much greater risk of violence than indoor workers**

lence. Available studies show that street workers are at much greater risk of violence than indoor workers. In 1993, a study in Birmingham showed that all forms of assault, robbery and kidnapping were much more common amongst street workers than indoor workers.<sup>2</sup> However, indoor workers are not immune from violence. Analysis of reports of violence in London over a ten-year period, showed that such reports from sex flats and brothels had escalated in recent years, but also, that much of this violence was related to robbery, rather than being sexual violence.<sup>3</sup> The perpetrators of these 'property motivated' attacks have clearly identified sex flats and brothels as premises where considerable amounts of cash are to be found – far more than will be carried by a lone street worker

who does business for a fraction of what is charged indoors. They may also be aware that indoor sex workers will often be unwilling to report robberies to the police, as they do not wish to draw the attention of police to premises used for sex work.

#### Street dangers

The 1993 Birmingham findings have recently been reinforced by a study by Stephanie Church and others of indoor and street workers in Glasgow, Edinburgh and Leeds.<sup>4</sup> This study found that street workers in Glasgow were six times more likely to have been attacked than indoor workers in Edinburgh. They also showed that the location of work

#### Safety initiatives

*Most projects for sex workers in the UK are funded to promote sexual health, and few resources are available to tackle other problems sex workers face. The danger of physical violence, rape, even murder, has often been regarded as a marginal issue, only within the remit of sexual health if it can be shown that there is some connection to risks of STDs or HIV. Despite this, sexual health projects have pioneered safety initiatives with sex workers, such as leaflets containing safety tips; free or cheap attack alarms; training programmes on personal safety, and lists of violent clients. These lists, known as 'Ugly Mugs' or 'Dodgy Punter' lists, were started by a Birmingham sex work project in 1989, and were a direct import from the Australian 'Ugly Mug' scheme started by the Prostitutes' Collective of Victoria. The lists give descriptions of men (very rarely women) who have attacked sex workers, for distribution amongst other sex workers. These are useful but very limited responses to the levels of violence.*

(indoor or outdoor), not the sex worker's age, drug use, length of experience in sex work, nor the particular city, was the crucial factor in determining risk of violence.

These findings are immensely important, since it is often assumed that the sex worker's own problems or behaviour make her a likely target for violence, rather than her location of work. It is suggested that because drug use can

impair judgement, users will be more likely to be victims, or that the more experienced will be less at risk than the 'new recruits', or that violent private relationships will predispose sex workers to violence in other contexts. Certainly amongst the 51 murdered women, drug use was common, but so was motherhood, and working away from their home area. However, the most common characteristic amongst

## *Too often, violence against sex workers is not taken seriously*

these murdered women was their mode of work: out of 44 where working style is known, 37 (84%) were street workers.

In the UK, at least outside London, it is now clear: indoor work is much safer than street work. It is also clear that, while some sex workers have violent personal relationships, or live in a violent sub-culture involving drugs and other criminal activity, the majority of murders are committed by men who approach women as clients. Of the 51 cases, in only 29 do I know that charges have been brought: eighteen were clients (62%); five were partners (17%); three (10%) were 'other', and three (10%) unknown. Canadian statistics on murders of sex workers show that of 86 cases (1992 to 1998), 56 (65%) were committed by clients.<sup>5</sup>

### **Not taken seriously**

In only sixteen of the UK cases is it known that there has been a conviction and in six cases the accused was acquitted. In half of these cases, the men had previous convictions for violence, including murder, manslaughter, rape and assault. This suggests that men who murder sex workers may frequently have a past history of violence against sex workers and others, and shows how important it is that all violence against sex workers is investigated with the utmost diligence.

Too often, violence against sex workers is not taken seriously. Poor relationships with the police mean that attacks are often not reported: the recent study in Glasgow, Edinburgh and Leeds found that only 34% of sex workers had reported any attack to the police.<sup>4</sup> Members of the public are rarely willing to come to the assistance of sex workers if they hear a disturbance; police do not always

respond quickly or appropriately; the suspect may not be remanded in custody, thus leaving the victim prey to intimidation and reprisals; state prosecutors may deem sex workers unreliable witnesses and refuse to pursue the case; defence lawyers will attack the truthfulness and reliability of the women, and juries may be unwilling to convict perpetrators.

### **Criminalising clients**

Targeting clients is often seen as introducing gender equity into control of sex work, and sometimes has the support of those who regard sex workers primarily as victims of male exploitation. However, increasing the criminalisation of the client merely increases the dangers for the sex workers: no attempt is made

Research on the criminal careers of clients arrested for kerb-crawling suggests that under 6% had a record of any previous criminal offences.<sup>6</sup>

Clients, like sex workers, are important potential witnesses in murder investigations, but the more they are publicly shamed, the less incentive they have to come forward. In one UK city where police are investigating an unsolved murder, they have complained in the press of little co-operation from sex workers, clients, or the general public, but at the same time they have conducted a vigorous anti-client campaign, bringing kerb-crawlers to court in the week before Christmas. Why are they surprised that no one wants to be associated with sex work in this atmosphere?



to target clients who are known to be violent. Neither should it be assumed that because many attacks are perpetrated by clients, a high proportion of clients is potentially violent.

### **Anti-prostitution campaigns**

All hostile approaches to prostitution effectively demonise sex workers, and this may be associated with increasing levels of violence.

#### **DODGY PUNTER LIST**

In 1996 the Women's Drop-in Centre was started as a form of health risk reduction project to care for the street prostitutes in Middlesbrough, a seaport in the North of England. This centre opens on Friday evenings between 18:00-21:00 hours. The sex workers come to the centre where they are given condoms, biscuits, cold and warm beverages. Those who request have screening for STIs and HIV. Two outreach workers make contact with the prostitutes on the streets and give them condoms.

Since the centre opened five years ago it has recorded several episodes of violence suffered by these prostitutes from their clients, partners and drug peddlers. In a survey conducted in 1997, 28% of the prostitutes reported recent episodes of violence – physically, rape or had their money stolen.

The centre has since liaised with the police who have provided a woman police constable as a liaison officer. The officer comes in the centre in civilian clothes every week. Any prostitute who is attacked is encouraged to fill a 'Dodgy Punter' awareness form. The form includes data such as probable age, hair colour, build any distinctive features etc. The police officer is informed and the other prostitutes are briefed of the profile of the attacker.

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**Two-thirds of all prostitutes have experienced violence and more than a third have been attacked within the last six months, according to research. Only 34%, however, have ever reported the assaults to police. The findings, in the first study in the UK, have led to calls for an overhaul of social and judicial attitudes towards prostitution in the UK.**

The results of the recent study by Stephanie Church et al created a lot of media attention in the UK.

Source: Kirsty Scott, 'Prostitutes left at risk of attack', The Guardian, March 2, 2001

Frequently the language used at public forums to discuss prostitution descends to slander and abuse: women are referred to as 'scum' and 'filth to be cleared off the streets'. Collusion with such attitudes gives permission to those who hate and fear women to vent their aggression on sex workers. Studies in Vancouver have demonstrated that escalating murder rates of sex workers there coincided with increasing anti-prostitution campaigns and hostile public attitudes.<sup>5</sup>

Aggressive policing and public hostility also damage efforts to bring health and safety services to sex workers. Possession of condoms is still being used as evidence of prostitution offences; in Birmingham, the outreach team has been banned from the street soliciting area

due to residents' intimidation; and everywhere there are signs that prostitution is going underground – and therefore becoming less accessible – in response to ill-conceived efforts to eliminate it.

It is social policy and law enforcement practice that determine whether or not women can work indoors and with other people present, which also determine risk of violence, yet public policy and debate on prostitution rarely concerns itself with anything other than moral offence and public nuisance. In the context of street work, these two factors prevent adoption – or even discussion – of zones of tolerance: public nuisance is cited as the justification for hostile policing of street prostitution, but moral offence prevents consideration of ways in which street work could be made safer.

Public policy makers must recognise and address sex workers' rights to protection under the law. The European Convention on Human Rights imposes on public institutions the duty to protect life: since it is clear and evident that current UK law and policing strategies neither eliminate prostitution nor protect the safety of those involved, a major review of such strategies is needed.

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#### SAFETY TIPS

"Sex workers are often exposed to violence in the course of their work. Projects can help sex workers to protect themselves in a number of ways including: posting bulletins of bad clients, education, training and advocacy.

*Safety tip leaflets.* Sex workers have been involved in collecting safety tips and the design of leaflets relevant to the local scene.

*Bulletins of bad clients.* Sex workers can report incidents of violence which can be made into broad sheets – descriptions of the assailants, car makes and numbers, which can then be displayed in the drop-in, or circulated to all sex workers in contact with the project, hopefully to enable them to look out for dangerous characters and avoid them."

Other things sex workers' projects can do:

- Develop report sheets for violent incidents
- Design buddy systems
- Provide self-defence classes
- Advocate for better police response to crimes against sex workers

Source: 'Hustling for Health. Developing services for sex workers in Europe'. European Network for HIV/STD Prevention in Prostitution, 1998.

Available online: [www.europap.net/hustling/hustling.htm](http://www.europap.net/hustling/hustling.htm)



#### COUNTRY EXAMPLE: CANADA

"How do prostitution laws affect the spread of HIV among prostitutes? The criminalisation of sex for money means that hookers who are subject to abuse from their customers are less able to report their abusers. It also makes it difficult for them to insist on condom use with their customers, and thus increases their chances of becoming infected. In conversations I had with a number of women who were raped by their customers, without condoms, they said that because their work is illegal they are not willing to prosecute these men. Instead, they maintain a 'bad date' list and disseminate it to other hookers. In contrast, it has been found that decriminalisation of prostitution enables those in the sex trade to practice safe sex, and will ultimately result in lower infection rates."

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# Studying violence to stop it

## Canadian research on violence against women in Vancouver's street level sex trade

Leonard Cler-Cunningham and Christine Christenson

The reality for a woman offering sex for sale on the streets of Vancouver, Canada, is that she can be murdered and there's little chance that anyone will be prosecuted. She can be raped knowing that the police will likely not protect her. She can be chased from neighbourhood to neighbourhood as the purveyor of disease, destroyer of families, or a brainwashed victim to be rescued from the ravages of patriarchy. Residents feeling under siege, a rate of rape and assault that would shame third-world nations, an expanding list of murdered and missing women, and an international embarrassment of infectious disease transmission rates are the consequences of misguided laws and ill thought out social policies.

Four years ago the Downtown Eastside of Vancouver was declared a medical health disaster with the highest reported HIV/Hepatitis C infection rates in the Western world and the subsequent US\$ 1.9 million spent on HIV prevention services is accepted as having had little or no impact. Over 4,700 injection drug users are estimated to live in the area and, until a recent drop, overdose deaths outstripped all other North American cities. Research in Vancouver indicates that 80% of female IDUs report being active in the sex trade, and this population accounts for one of the highest proportional increases of new HIV infections in Canada.

A report released in March 2001 by the British Columbia Centre for Excellence in HIV/AIDS established that Vancouver is the only city in the developed world where the HIV infection rate among female injecting drug users far outstrips that of men – a consequence ascribed to our street-level sex trade conditions.<sup>1</sup>

The prostitution law in Canada was created in 1984, and it is important to remember that while prostitution is legal in Canada, the 'bawdy house' section makes it against the law to buy or sell sex in off-street settings and the 'communicating' section does the same for the buying or selling of sex in public.

Since 1989, a Vancouver newspaper has identified at least 35 sex workers who have been

murdered. If one included information from Vice Unit files and RCMP (Canadian police agencies) data, the number increases to 60 murdered sex workers since January 1982 – the majority of their murders remain unsolved.<sup>2</sup> It is our opinion that the system of quasi-criminalisation bears a direct responsibility for the violent conditions suffered by women in Vancouver's street level sex trade.

### PACE

In 1994 Paige Latin brought together former sex workers and their allies committed to doing something about the lack of relevant services and opened Prostitution Alternatives Counselling and Education (PACE) Society. With a mandatory minimum of one-third for-

Within seven years, and with no support from the City, PACE began to garner recognition. An independent evaluation of the Ministry of Children and Families' Vancouver Action Plan on Sexually Exploited Youth called for immediate expansion of their outreach and advocacy programme, targeting youth in the survival sex trade. In a national report on the sex trade their innovative method for working with resident groups and neighbourhood police was recognised as a model for dealing with the impact of sex workers on residential neighbourhoods. The Mount Pleasant community, a residential neighbourhood in which they are based, appreciated their contribution enough to give them the service agency of the year award in 1998.

### Violent acts research

In Vancouver violence against street level sex trade workers has long been accepted as pervasive. We wanted to gain a better understanding of the conditions under which this violence occurs. Who is committing these violent acts? What is being done about the violence? Why is this level of violence allowed to continue? How was this allowed to happen? We were looking for a new model of doing research that could respond to the issue of violence – one that was propelled by the needs of the women and not the researchers desire to collect data.

Thus, we chose to investigate rates of eight different violent acts, based upon Canadian Criminal Code definitions, and three non-violent categories – harassment, robbery, and

## Four years ago the Downtown Eastside of Vancouver was declared a medical health disaster

mer or current sex workers on their board of directors, PACE presciently recognised the limitations of agencies relying on top-down programmes developed by 'experts', opting to embrace innovative bottom-up peer-based programmes. One of these programmes is the PACE Health Network for drug injecting sex workers (see box).

### PACE Health Network

The PACE Health Network is a two-year peer-driven demonstration project for women whose involvement in the sex trade is primarily to finance their injection drug habit (SWIDUs). It attempts to:

- 1 identify and develop messages and strategies for HIV/AIDS/HEPC/STD prevention,
- 2 staff and operate a SWIDU-based needle distribution,
- 3 develop and deliver prevention education/resource materials,
- 4 have weekly board meetings and monthly general membership meetings,
- 5 increase condom usage by SWIDUs, their partners and clients, and
- 6 assist with the development and implementation of improved reporting/tracking of HIV/AIDS/STDs in order to improve the potential effectiveness of treatments.

The PHN will also look at establishing a co-operative non-profit brothel.

refusal to wear a condom. In an attempt to gauge the gulf between acts of violence suffered and acts of violence reported we also explored police response from the point of view of the women.<sup>3</sup>

### Aboriginal women

Our sample size was 183 and data collection took place over almost a year and a half, making the information collected fairly reflective of conditions. Our youngest contributor was 15 and the oldest was 51. In an industry where youth is a commodity it is not surprising that over half were 24 and under.

Almost a third of our sample had been working in the sex trade for less than two years. One in seven had started in the sex trade before they were even teenagers and a full 70% of our sample had begun before they were old enough to drink legally. The average age of entry into the sex trade was 17.

There is an immense overrepresentation of Aboriginal women in the street level sex trade (31%). According to the 1996 Census data from Statistics Canada, Aboriginals constitute only 1.7% of Greater Vancouver's population. The Aboriginal population of Canada is largely formed by North American Indian, Metis (mixed North American Indian and Indo-European descent) and Inuit people.

Almost three-quarters of the women had left their parents' or guardians' home permanently at age 16 or younger. Almost two-thirds do not have a high school diploma. We found that 58% identified themselves as working to feed a drug habit. When asked if they had to give money to somebody to be able to work either on or off-street the majority of women (over 80% of women on the street and over 70% of women off-street) replied 'No'. 89% reported that someone has refused to wear a condom within the past year.

The following table shows an exceedingly small sample of the data we collected. It presents for 10 categories of violence the percentage of women responding:

- 1 that a violent incident has happened to them more than once in the past year,
- 2 that they did not report any of the incidents to the 'bad date sheet',
- 3 that they did not report any of the incidents to the police, and,
- 4 that nobody was ever convicted in any of the instances reported to the police.

Incidence of violence (in %) <sup>4</sup>	More than once in the past year	No report to bad date sheet	No report to police	No conviction
Harassment	85.1	54.7	68.3	93.8
Robbery	53.2	56.8	74.7	93.1
Physically threatened	73.2	63.4	77.9	93.5
Threatened with a weapon	60.3	59.5	72.2	88.4
Physically assaulted without a weapon	47.3	58.0	75.6	92.9
Assaulted with a weapon	47.6	68.4	77.6	91.3
Forced to have sex against their wil	56.7	60.5	77.8	94.3
Forced to have sex against their will with a weapon involved	38.8	63.8	72.1	86.2
Kidnapped/confined	30.9	65.7	64.8	87.1
Attempted murder	35.9	56.9	59.6	88.9

### Pro-active initiatives

Ultimately the goal was not to simply study the violence, but to use the information to hasten its end. Throughout this project former and current sex workers used the information to identify, develop and implement a variety of pro-active initiatives:

- On Monday 26 April 1999, over 35 youth from Vancouver who were, or had been, involved in the survival sex trade came together at the Mount Pleasant Neighbourhood House. The focus group identified missing necessary services and called for immediate and easy to implement changes in the policy and practices of welfare, the police, and the Ministry of Children and Families' Adolescent Services Unit.
- *Towards a Common Ground* is an opinion survey that was completed by over 500 Vancouver residents and business owners that attempted to discover what they agreed should be done in response to the sex trade: who should be allowed, where it can happen, what is acceptable, and what cannot be allowed to happen?
- In December 2000, a Sex Trade Liaison Officer policy proposal was presented to the Mayor and the Vancouver Police Services Board. The police were ordered to report back to the Board within three months proving that they have made substantive changes and women from PACE are now training the next generation of police officers.

Researchers from throughout the world should flock to Vancouver, as it is difficult to think of another city that offers so much to learn from. The question to be explored is how authorities of one place could have sustained such venal incompetence with such horrific consequences

for so long. Perhaps the lesson to be learned is to look at what they've done and to do the exact opposite.

### Notes

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3. A copy of the report can be requested by sending an e-mail to one of the authors. The executive summary will be available from the PACE website soon.
4. All percentages are expressed as a valid percentage (missing responses removed).

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# Taking a look at sex work, risks and violence in Brazil

Maria Waldenez de Oliveira, Joyce Moreno and Luciana Furlanetto Pereira

*“Seria bom que os homens lessem isto” (It is going to be fine if men read this)* Joyce, sex worker

***This article is the result of a dialogue on risks and violence between two staffs of the ‘Prevention and Health’ project and one of the sex workers reached by this project in São Carlos, Brazil. The authors describe the social and cultural factors that influence the safe sex practices of sex workers in this country. The subordinate position of women in society, the competition between sex workers, the social acceptability of violence as a means to solve conflicts and the lack of support for victims of sexual violence are all interrelated and pose a threat to the well being of sex workers in Brazil.***

Many Brazilian sex workers run daily risks of sexual violence, of being forced to have sex against their will or being left without payment after the sexual intercourse. On some occasions they even run the risk of being murdered. The aggression experienced and the threat of violence influences the behaviour of the women in the work situation and the risks they take. The sexual and economic hierarchies and the related inequalities that are existing in Brazilian society are visible in the sex sector as well. Inside a power relationship, the Brazilian female sex worker shares with other women the social reality of being subordinate to men. In this context, when she realises the risk of aggression is present and the possibility of control (by the State or the police) is absent, the sex worker makes use of the kind of control she has learned to exercise: she tries to negotiate and to reach an agreement by being flexible and obedient. She tries to change the conversation matter, she speaks softly and – to avoid being beaten or raped – she offers to have sex with the client for free.

Some clients think they can do anything because they pay. Some of these men cross the line between expecting and demanding. If the women refuse to do what their clients demand, the violence used is seen by some of these men as a way of solving the conflict. If sexual intercourse between man and wife is seen as one of the marital obligations, sexual intercourse with clients in a sex work setting is seen as an obligation as well, or as a debt.

In Brazilian society, sexual violence is socially accepted as a way to take what is rightfully yours, be it in the marriage or in the sex work situation.

## **Discrimination and social injustice**

The sex work world is an underworld, because women living in this world do not have the same rights as other people. The prostitute is a woman who no one trusts. Her word is not worth anything. In Brazil, the society discriminates against women but doubly discriminates against female sex workers – as women and as sex workers. As the testimony of a woman who has suffered from domestic sexual vio-

lence is worth almost nothing – because society demands that as well as being beaten or raped, she must prove she was brutally injured – the testimony of female sex workers is worth even less and they are not listened to.

Thus, if a sex worker has been raped and/or abused by a client it is almost impossible for her to reach the Justice system and to go to court and have the violent client convicted. The testimony of a sex worker, perhaps, could mean something to her family or in front of a particular judge. But, as with many other cases of violence against women, how would her words reach this judge's ears?

## **Condom use**

It is often obligatory for sex workers in brothels to drink alcohol with their clients. There are women who drink to be able to face the work, to convince themselves that their clients are beautiful men, or to feel pretty themselves. But there are also women who only drink because the brothel manager puts pressure on them and they don't want to lose their jobs. One way or the other, the use of alcohol and drugs



It is often obligatory for sex workers in brothels to drink alcohol with their clients

Photo: Piet den Blanken

*The Prevention and Health project's objective is to talk with sex workers about human and sexual rights, to fight against discrimination, to increase self-esteem and promote health in a comprehensive way – taking into account social-cultural, economical and psychological-biological factors.*

*The project has been running since 1991. The female sex workers work in São Carlos brothels. For planning the activities the team does an investigation (each semester) about knowledge and expectations of the sex workers, using a collective interview. To ascertain the inclusion of the sex workers' reality into the dialogue, participatory and group strategies and continued evaluation methods are used.*

disturbs the mind and makes the women forget their prudence.

Most women will strive to use condoms in all their sexual contacts with clients. However, many men ask for sex without a condom. Some will treat the sex worker as a princess, other try to manipulate her or they offer more money, in the hope she will agree to condomless sex. In this case, the woman could try to persuade him to use a condom. If she is not successful, the client will threaten to find another girl who is more co-operative.

In their relationships with boyfriends, most sex workers have sex without a condom – just as many other women do. The difference between a boyfriend and a client is that the first is kind, he listens to the woman, takes her out of the brothel and gives her money. If the relationship develops, the woman stops charging her customer-boyfriend for the sex and stops negotiating about safe sex, because she likes him. This leads some men to pretend to be boyfriends just to be able to have sex without a condom. For the woman, a man who pays the 'fine' set by the brothel to take a girl out (so she is not available to other clients) is a dream come true, especially if he gives her some money and if he does not visit other prostitutes.

#### **The relationship between colleagues**

Usually, the 'women of the night' see each other as enemies. They are often looking at other sex workers: how they are dressed, who they are with, etc. They would often like to take over the others' regular clients. After a visit, they try to find out if the client is a good one. If he is, they will try to catch him the next time he shows his face in the brothel. For this reason, it is not logical for sex workers to tell their colleagues about a good, non-violent, generous client. Also, when a client is difficult and abusive, and a woman warns her colleagues about him, her advice could be translated as a lie, because the others might think she likes to keep a good client for herself. So it can happen that a woman listens to the warning and believes she might be in danger but, if the client offers good payment, his money

speaks louder than her colleague's advice. This woman will discover for herself what kind of client he is.

In a sex work environment there is no place for a woman's life projects, for her plans for the future. Instead, there is place for fear about

### ***If the client offers good payment, his money speaks louder than her colleague's advice***

losing her job and even her life, and about the certainty of an early and compulsory 'retirement' (usually on age 30 to 35). In this context, living with insecurity, an individualistic stance and tolerance of suffering introduce themselves as ways of survival.

#### **Illusions about the future**

Like elsewhere, female sex workers in Brazil do not have a legal contract and workers' rights. They can have a good income for some months, but this is not fixed. In this work few girls worry about the future. Only some of them try to save some money each month to be able to start their own businesses or for other future plans.

Most of the girls dream of marrying a rich man. Unfortunately, in this work it is possible to sleep with a rich man, but the chances of getting married to one are poor. Today, these girls are at the top, they applaud themselves about how much they earn – but they spend all their money and do not have a bank account or health insurance. They think the future will start once they get married and it will begin in the brothel. This way of thinking makes a female sex worker believe that one day she will meet a kind client, who has money to spend, who will treat her well and who will take her out of the brothel. If she finds this man, she will agree to be his 'girlfriend' and

will allow him to have sex with her without payment and without a condom.

In this job, there are a lot of girls who do not have money in their pocket. They have only a suitcase filled with clothes and a mind filled with illusions. These illusions can make the night a very dangerous time.

#### **About the authors**

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#### **Book 'Some Mother's Daughter. The hidden movement of prostitute women against violence'**

This book published by the International Prostitutes Collective states that one in four female sex workers are raped and over half assaulted for being sex workers. The book includes an interview with the mother of a murdered sex worker, accounts of women seeking asylum in the UK from rape and exploitation by pimps, a first-hand account of the successful first private prosecution for rape in the UK brought by two sex workers, and the story of the San Francisco Task Force on Prostitution which recommended a shift in police priorities by vigorously enforcing laws against rape and other violence.

*For a book review in British Medical Journal of March 2001, see:  
[www.bmj.com/cgi/content/full/322/7285/561/a](http://www.bmj.com/cgi/content/full/322/7285/561/a)  
To obtain a copy (\$14.5 outside UK) write to:  
English Collective of Prostitutes, Crossroads  
Women's Centre  
P.O. Box 287, London NW6 5QU, United Kingdom  
Fax: +44 171 2094761*

# Risk and violence in different scenarios of commercial sex work in Panama City

Carmen Carrington and Claude Betts

***The Republic of Panama is best known for the famous Panama Canal, through which 12,000 ships transit between the Atlantic and the Pacific Oceans every year. Less known, however, is the long-standing network of brothels, bars, and other sites, including certain street corners, that exist to provide sexual services to seafarers, military personnel, businessmen, tourists, as well as many Panamanians. A study in the City of Panama showed that, although condom use with clients is almost 100%, sex workers are still vulnerable to HIV and STI infection. This is because they seldom use condoms with their steady partners and because they are at risk of rape by clients, especially when they consume a lot of alcohol or drugs and work on the streets.<sup>1</sup>***

For decades, public health centres have run an STI programme for sex workers called the 'Social Hygiene Programme'. It is a compulsory programme for all women who work in brothels, bars, night-clubs or other sites related to commercial sex work. It consists of a weekly vaginal examination with a Gram stain test to supposedly detect gonorrhoea and a syphilis and HIV blood test every three months. Every so often health professionals give lectures on STIs and HIV/AIDS to the women attending the Social Hygiene Programme.

Other than a few STI and HIV seroprevalence studies, there had been almost no research regarding the issue of commercial sex work in Panama. Late into 1999 a small grant was awarded by the Pan American Health Organisation to the NGO *Nueva Era en Salud* (New Era in Health), to address this issue. This resulted in a qualitative and quantitative study that provided an enormous wealth of information, relevant not only for public health, but also for areas such as labour, immigration, human rights, education, child care and support, physical violence, institutional neglect and abuse, to mention only a few.

## Identifying actors

The research addressed commercial sex work using a 'scenario' (setting) approach. This approach allowed the research team to address the relevant actors of a given scenario within a comprehensive framework. Therefore, the female sex worker was seen as only one of many actors in a scenario, which included brothel owners, administrators and other staff, clients, immigration officers, police, health service providers and public health officers, family members of sex workers, policy makers, and so forth.

Even though some of these actors had never been physically present in the settings themselves, all had influence and many times decisive influence over what happened in the scenario. This included the effect of either increasing or reducing the risk of HIV exposure and infection in the scenario itself and beyond, which could occur with or without the awareness of the responsible actors.

Quantitative data were gathered by conducting face to face surveys on a sample comprised of all sex workers who were present in each of the different scenarios that were previously defined. These scenarios were:

- 1 the streets,
- 2 massage parlours,
- 3 live-in brothels,
- 4 brothels with rented rooms for sexual encounters only, and
- 5 pick-up bars.

Verbal informed consent, and complete and consistent information was obtained from 278 sex workers in Panama City (86% of the sample). Qualitative methods included: focal groups, with a total of 80 sex workers, and non-structured ethnographic interviews with key informants, such as members of health teams, owners and administrators of brothels, bars, massage parlours, etc., members of the police force and immigration officials.

We also collected contextual information on each scenario. These included issues such as: the perception of sex workers' health risks when they provided sexual services for clients and when they had sex with their 'stable' partners, having been forced to have sex against their will, and facilitating and inhibitory factors associated with consumption of alcohol and drugs, among others.

## High rates of rape

On average, each sex worker provided economic assistance to three other persons, mostly family members (81% had children to support).

***Overall, one in eight sex workers mentioned having been forced to have sex against their will while exercising commercial sex work***

Regular attendance of the compulsory weekly medical examinations was over 90% in all scenarios except for women on the streets, amongst whom attendance was only 42%. Almost all sex workers (99%) report-



"What will the people that depend on my income do if I stop receiving this money?"

Photo: Piet den Blanken

ed consistent use of condoms with their clients, even when offered a higher price for unprotected sex. However, only one quarter of the sex workers used condoms with their stable partners.

Overall, one in eight sex workers mentioned having been forced to have sex against their will while exercising commercial sex work. However, experience of rape on the job was 40% among sex workers on the streets, and 41% among women who used drugs.

### Street workers more at risk

Almost all sex workers interviewed considered commercial sex work as something temporary and were waiting for an opportunity to leave the business. However, many sex workers were worried about: *"What will the people that depend on my income do if I stop receiving this money?"*

An important finding of the research is that women on the streets are much more vulne-

rable than women working in other commercial sex scenarios. This is because they:

- 1 consume more drugs,
- 2 have less formal education,
- 3 have to support a greater number of children,
- 4 work for a longer time in the sex industry,
- 5 have a greater risk of being raped.

### 100% condom use

The perception of being exposed to a health risk with clients was overwhelmingly high among almost all sex workers who participated in this study, which was reflected in consistent condom use by clients of almost 100%. Likewise, brothel owners, administrators and staff shared that same perception of risk and acted on it by maintaining a constant supply of condoms, enforcing condom use with all clients and backing up sex workers to not provide services to clients who were not willing to use condoms.<sup>2</sup> However, with stable partners, the perception of risk was much less among sex workers. In the focus groups, women who knew they were at risk said that they did not have the power to demand condom use by their stable partners, for fear of violence, economic adversities for their dependants and themselves, vulnerability to stigma by society for 'losing' their partner, and much more.

*Nueva Era en Salud (New Era in Health) is a non-profit NGO dedicated to research, training, and technical assistance, helping to build consensus among those who create, sustain, and change scenarios that affect the living and health conditions in such scenarios. Nueva Era builds upon decades of rich experiences and lessons learned from many countries, even though it was formally created in May 1998. The following are among its achievements:*



- a The development of a project involving 14 public and private organisations from the maritime sector and uniformed service organisations. Nueva Era, with a small grant from the International Civil Military Alliance and support from the community, helped each organisation develop its own comprehensive strategic planning process for reducing the risk of STI/HIV/AIDS among its constituents, families and communities.
- b The design and implementation of a study addressing different scenarios of commercial sex work in Panama. Nueva Era did the study with a small grant from PAHO/WHO and support from the community.
- c Contribution to the national legislative debate and regulation of new STI/HIV/AIDS law in Panama. Nueva Era mobilised support from the community and particularly from the organisations that had worked with Nueva Era to develop their strategic plans.

### Alcohol and drug use

Around 8% of the sex workers reported using illicit drugs. The rate of illicit drug use varied enormously by national origin, for example, it was 3.7% among foreign sex workers in contrast with 17.1% (more than four times higher) among Panamanian sex workers. The rate of reported illicit drug use varied even more when we compared all other scenarios (4.8%) to sex workers on the streets, where reported illicit drug use was 38.1% (almost eight times higher). Two-thirds of the sex workers reported alcohol consumption during work hours, ranging from 30% in brothels with live-in quarters to 95% in pick-up bars. The proportion of sex workers that reported heavy consumption (more than 10 drinks) during working hours was 10%. However, in contrast to reported illicit drug use, reported alcohol consumption, including heavy consumption, did not influence rape figures.

This study presented unique characteristics of different scenarios of commercial sex work. The behaviour of sex workers, including sexual behaviour, use of intoxicating substances, and others, as well as the risks they are exposed to,

can be very different from one scenario to the next. Different risk factors are present or absent in each setting, far beyond the will, desire and intentions of the sex workers or of their clients. Health, disease, alcoholism, drug addiction, and other social and economical problems can be looked upon as risk factors, but quite frequently these are also an outcome of the social dynamics taking place in each scenario. Therefore, preventive interventions, including those targeting alcoholism and drug consumption, should be focused on each scenario and involve all social actors that can significantly modify a given scenario, reducing risk factors while stimulating healthier environments.

### Notes

1. The full report in Spanish is accessible in PDF format and can be downloaded from the Nueva Era en Salud web site.
2. The finding of such a high rate of consistent condom use came as a surprise to the Nueva Era team. Rates of reported consistent condom use with clients in other Latin American countries have been consistently much lower. In our research we found that there were no sex workers' organisations or NGOs supporting

the sex workers in any way, nor did the 'Social Hygiene Programme' provide free condoms to them. However, many sex workers that were interviewed stated that clients are more resistant to condom use outside the capital and the brothel administrators do not enforce condom use as much as the ones in the City of Panama. The outcome is greater exposure to unprotected sex.

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## Drug use and physical and sexual abuse of street sex workers in New York City

Nabila El-Bassel and Susan Witte

***In this article, Nabila El-Bassel and Susan Witte of the Social Intervention Group (SIG), examine the prevalence of physical and sexual violence by intimate partners and clients among 106 female sex workers recruited from a FROST'D van.<sup>1</sup> An additional purpose of SIG's study was to describe the relationship between socio-demographics, drug use, sexual behaviour, physical and sexual childhood abuse and physical and sexual violence from clients.<sup>2</sup>***

Our findings suggest that partner abuse is a common occurrence among sex workers. Two out of three street sex workers have experienced physical or sexual abuse by either an intimate partner or client. In addition, one 1 in 8 sex workers reported physical and sexual abuse by both intimate partners and clients during their lifetime. Our findings also support what other studies have shown: street sex workers live in poverty, derive their livelihood from exchanging sex for money or drugs, and tend to have been incarcerated and homeless at some point. These macro social factors increase vulnerability and may also enhance the probability that sex workers cope by using drugs.

While the prevalence of recent *physical* abuse by intimate partners was comparable to that of clients (20% versus 23.6%, respectively), the prevalence of recent *sexual* abuse by clients was 20.8%, which was twice as high as by intimate partners. We propose two possible explanations for this discrepancy. First, sexual violence by clients may occur more frequently because the clients perceive that they are entitled to sexually exploit women who trade sex. Moreover, sex workers may tolerate sexual abuse by these men because they view it as 'part of the job'. This is especially true for those who are homeless or whose primary source of income is prostitution. A second ex-

planation for the disparity in the reported prevalence of recent sexual abuse may be related to the women's tendency not to label, recognise, and define sexual coercion and rape in an intimate relationship as abuse and, consequently, such abuse is underreported. Sex workers who had an intimate partner reported fewer episodes of sexual and physical abuse by clients. We speculate that the woman's intimate partner may protect her from exploitation by clients, or he may be her 'pimp'.

### Abusive partners

Early trauma may make sex workers more vulnerable to sexual abuse. Sex workers who experienced childhood physical abuse and childhood sexual abuse were more likely to report being sexually abused by clients. As a result of early trauma, such women may habitually select abusive partners, and then use drugs to cope with the abuse. Sex workers who reported use of injection drugs and crack were more likely to report

## Social Intervention Group

*The Social Intervention Group (SIG) at Columbia University School of Social Work undertakes multidisciplinary research into social and behavioural aspects of HIV transmission, substance abuse and violence against women. The SIG conducts research in a collaborative way by forming close ties with community-based organisations that meet the needs of vulnerable populations.*



physical and sexual violence by their clients than those who did not use these drugs. The link between a woman's drug use and partner violence is not well understood. It is plausible that the altered state produced by illicit drugs directly leads to violence. However, we believe that social and contextual factors mediate violence among drug users. Two pathways may explain the association between drug use and partner violence. Crack/cocaine use may increase a woman's hostility towards her partner, which may evoke a negative response in him including paranoia, impaired judgement, revenge, or a distorted interpretation of social cues. A substance-abusing lifestyle may lead to partner violence because of associated behaviours such as procuring and selling drugs, visiting 'shooting galleries' and 'crack houses', conflicts around splitting drugs with intimate partners and clients, or being forced to supply drugs for an intimate partner through sex trading. Stealing or 'hustling' increases the woman's risk of experiencing violent traumas of all types, including rape and physical assault by drug dealers and clients.

Visiting 'crack houses' was found to be related to either physical or sexual abuse by clients. We found that the number of sex exchanges and being HIV-positive were related to being physically abused by clients, but not being sexually abused. Condom use was not related to sexual or physical violence by clients; however condom use was low with any type of partner. Sex workers who were homeless in the last year, obtained their livelihood from sex work, traded sex in 'crack houses', used injection drugs in the last year or who were HIV-positive were more likely to be at risk of combined physical and sexual abuse.

### Implications for HIV intervention

Our study demonstrates that sex workers are especially vulnerable to physical and sexual abuse by both intimate partners and clients. Public health interventions for street sex workers have to integrate basic services such as housing, public assistance, education, viable

employment opportunities, and prevention of drug abuse and partner violence. There is a relationship between partner violence, drug use, and risks of HIV/STDs among street sex workers. It is crucial to pay close attention to these relationships so that more effective policies and programmes to serve sex workers can be developed.

For example, there has been a recent increase in the level of awareness of partner violence among staff in drug treatment programmes, community organisations, and outreach programmes for sex workers. However, such violence is rarely addressed in the assessment protocols and treatment approaches by the staff in these settings. Unlike domestic violence agencies, which tend to refer clients out to drug treatment programmes, addiction counsellors rarely refer clients to domestic violence agencies; instead, they attempt to deal with partner violence within the context of the drug treatment programme.

Increasingly, drug treatment programmes view violence as an addiction, which allows them to justify not considering partner violence intervention as separate from addiction treatment. In spite of this viewpoint, few drug treatment programmes offer in-service training and consultation on partner violence. Better and more effective services would recognise the importance of screening and assessing for partner violence and HIV/STD risk at drug treatment programmes and other services for street sex workers.

### Skills training

In order to prevent partner violence and reduce its prevalence among drug abusing sex workers, it is also essential that prevention efforts include education for these women about their heightened risk of partner violence and strategies on how they might increase their safety. Efforts should include skills training such as problem solving, coping, and help-seeking. Sex workers need to be provided with alternative coping mechanisms and safety planning for risky situations.

Moreover, prevention efforts should consider how to make an impact at the community level. Sex workers can often work together with agencies to warn other sex workers against soliciting previously violent clients.

Building community social norms against violence may help reduce the occurrence of physical or sexual violence against street sex workers. Partner violence prevention efforts should also be extended to all community-based and outreach programmes, including drug treatment programmes, casualty treatment centres in hospitals, homeless shelters and soup kitchens.

### Notes

1. FROST'D offers a complete spectrum of prevention and medical services to sex workers, including a mobile van outreach programme that delivers health and social services to street sex workers 'on the stroll' in New York City. See also the article by Melissa Ditmore in this issue.

2. The full results of this study have been published in the paper 'Correlates of partner violence among female street-based sex workers: Substance abuse, history of childhood abuse, and HIV risks', by N. El-Bassel, S. Witte, T. Wada, L. Gilbert and J. Wallace. In: *AIDS Patient Care and STDs*, Vol. 15, No. 1, pp. 41-51.

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## C O L O F O N

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