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The Condom Conundrum: Barriers to Condom Use Among Commercial Sex Workers in Durban, South Africa

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ABSTRACT

We examined socio-cultural and economic determinants of condom use among 100 female South African commercial sex workers. The symbolism and dynamics of condom use between sex workers and their clientele were explored. These issues were also investigated when sex workers negotiated sex with their personal partners. An additional focus was the extent to which HIV/AIDS influences women's condom use in these situations. Results demonstrate considerable contrast between factors influencing condom use in professional versus private sex situations. With clients, practical issues such as financial strain were the major obstacles to condom use. With personal sex partners, sex workers avoided condoms due to their negative symbolism. Condoms were seen as suggestive of filth, disease, infidelity, and mistrust. HIV/AIDS awareness had minimal impact on condom use. HIV/AIDS was viewed as a remote threat, overridden by immediate practical and emotional concerns. The intervention implications of condom symbolism and differential barriers to condom use are discussed. (*Afr J Reprod Health* 1997;1(1):74-88)

RÉSUMÉ

Le préservatif: Les barrières à l'utilisation du préservatif chez les prostituées de Durban en Afrique du Sud
Nous avons examiné les déterminants socio-culturels de l'utilisation du préservatif chez 100 prostituées Sud Africaines. Le symbolisme et la dynamique de leur utilisation ont été étudiés chez les prostituées et leur clientèle. Ces éléments ont été également appréciés au moment de la négociation pour l'acte sexuel entre les prostituées et leurs partenaires intimes. Un autre point d'intérêt a été l'importance de l'influence du VIH/SIDA sur l'utilisation des préservatifs chez les femmes dans ces situations. Les résultats montrent un contraste considérable entre les facteurs favorisant l'utilisation de préservatifs dans les situations professionnelles et ceux des situations intimes. Avec les clients, des problèmes pratiques tels que la contrainte financière constituaient les obstacles majeurs à l'utilisation des préservatifs. Avec leurs partenaires intimes, les prostituées évitaient les préservatifs du fait de leur connotation péjorative. Leur utilisation était perçue comme un signe d'obscénité, de maladie, d'infidélité et de méfiance. La connaissance du VIH/SIDA avait peu d'impact sur l'utilisation du préservatif. Le VIH/SIDA était perçu comme une menace lointaine masquée par des inquiétudes immédiates et émotionnelles. Les implications du rôle du symbolisme et des barrières différentielles sur l'utilisation des préservatifs ont été discutées. (*Afr J Reprod Health* 1997;1(1):74-88)

KEY WORDS: Condom use, commercial sex workers, risk, HIV/AIDS prevention, South Africa, Africa

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Introduction

This paper examines the dynamics of condom use among female commercial sex workers (CSWs) in Durban, a large coastal city in KwaZulu-Natal province. Our objectives were to explore the socio-behavioural determinants of condom use between CSWs and their partners, both in professional sexual relations with clients and in personal relationships with domestic partners. We also sought to examine the extent to which HIV/AIDS influences CSWs' condom use in these situations.

Reported here are the results from in-depth interviews with two groups of young black African CSWs. Our data illustrate the pivotal influence socio-cultural, conceptual, ideological, and economic factors have on condom use. These results also reinforce the necessity of considering such elements in the design—and ultimate success—of HIV intervention programs.

The state of HIV/AIDS in sub-Saharan Africa

Worldwide, an estimated 21.8 million individuals are currently living with HIV/AIDS.¹ The vast majority live in sub-Saharan Africa. HIV/AIDS figures for the region illustrate the situation in grim detail. By mid-1996, this region contained 63 percent (13.3 million individuals) of the total number of adult cases of HIV infection. Recent estimates suggest that 5.1 percent of sub-Saharan Africa's population is HIV positive. Moreover, the epidemic has not affected all members of the population equally; women account for more than half of all infected adults in Africa.¹

In recent years, South Africa has witnessed a dramatic increase in HIV infection rates. Between 1990 and 1995, seroprevalence in the country rose from 0.76 to 10.4 percent.^{2,3} In KwaZulu-Natal province, where this study was undertaken, the rate of increase is cause for even greater concern. During the same period, provincial seroprevalence underwent an eleven-fold increase, from 1.6 to 18.2 percent.^{2,3} This most recent provincial figure (18.2% seropositivity in 1995) reflects a 27 percent increase over the previous year's figures

(14.4% in 1994).⁴ Presently, KwaZulu-Natal has the highest (and rapidly increasing) prevalence of HIV infection in South Africa.

The commercial sex industry and HIV/AIDS

The commercial sex industry has long been associated with disease. In the early 20th century, U.S. social reformers and physicians attributed the spread of sexually transmitted diseases (STDs) almost solely to prostitution, and prostitutes⁵ were commonly known as "plague spots."⁵ The evidence used to support such claims was the high prevalence of STDs among women arrested for soliciting male clients. In addition to physical ailments, prostitution was frequently associated with mental and social afflictions. In 1911, the Vice Commission of Chicago published a report describing prostitution as "a disease scattering misery...leaving in its wake sterility, insanity, paralysis, blinded eyes of babes, the twisted limbs of deformed children, degradation, physical rot, and mental decay."⁵ Moreover, it appears that many of prostitution's negative associations have persisted well into the present.⁵⁻¹²

In medical and epidemiological research, CSWs are frequently targeted as a "high risk group" for STD and HIV acquisition and transmission. The picture portrayed is that of members of the commercial sex industry posing a significant public health threat through their professional (high risk) sexual behaviour. This threatening image is enhanced by the frequency with which CSWs are referred to either as a "reservoir" of infection or as a potential "bridge of infectivity" for STDs and HIV/AIDS.^{6,8,11,13-17}

What exactly is the general population's risk of HIV infection from the commercial sex industry? Two patterns of HIV infection among CSWs seem prevalent. In the developed world (North America, Europe, and parts of Latin America), studies have revealed low HIV seropositivity (less than 10%) among non-drug injecting CSWs.^{14,15,18-20} This is consistent with so-called Pattern I transmission of HIV/AIDS in which male homosexuals, intrave-

nous drug users (IVDUs), and their sex partners are those most affected.²¹ With Pattern I transmission there is generally a low (though increasing) female to male seropositivity ratio, and relatively few cases of vertical transmission of HIV.

In contrast, CSWs in developing countries in sub-Saharan Africa, the Caribbean, and most recently Asia have demonstrated extremely high seroprevalence (greater than 25%).^{6,20,22-24} These rates occur among CSWs who are *not* IVDUs and where intravenous drug use is uncommon in the general population. Such a profile conforms to Pattern II transmission of HIV/AIDS, characterised by heterosexual transmission, a nearly equal sex ratio of infection (or slightly higher female to male ratio), and high frequency of paediatric HIV/AIDS.²

African sex workers have received considerable attention in connection with the HIV/AIDS epidemic. Many researchers emphasise the increased risk of HIV acquisition and transmission specifically among African CSWs, their clients, and others in their sexual networks.^{10,19-29,b} There appears to be a certain amount of justification for such claims. Studies with African CSWs have revealed some of the highest recorded seroprevalence rates anywhere in the world.^{23,26,33}

Interpretation of variation in HIV patterns among CSWs must be undertaken cautiously. Lower seroprevalence in some areas may reflect the later introduction of HIV, not necessarily decreased risk for infection.²⁰ In addition, many seroprevalence studies among CSWs are clinic-based, decreasing the generalizability of results to the commercial sex industry as a whole. Plant cites research findings from work with European and Indian CSWs which defy expected trends and bring into question the strength of geographically-based associations between intravenous drug use and HIV.⁶ Moreover, Gillies and Parker point out that HIV seroprevalence among non-drug injecting female CSWs is consistently higher than among childbearing women in the general population in *both* Pattern I and Pattern II areas.³⁴

At the very least, this finding suggests that the link between HIV and commercial sex work must be explored more carefully among CSWs in Pattern I regions and among those that are IVDUs.

Despite—and in some cases due to—variation in HIV seroprevalence patterns, there is ample reason for examining sexual behaviour and sexuality related issues among members of the commercial sex industry.¹⁴ By definition, CSWs have multiple sex partners who may themselves have many partners. Commercial sex often takes place under risky circumstances (anally, without protection, in the presence of genital lesions, without access to adequate health care). Finally, it is well known that the most common mode of HIV transmission is through sexual intercourse, responsible for 86 percent of HIV infections. The majority of these infections (71%) are through heterosexual relations.³⁵

Africa, in particular, appears to merit close attention in exploring the link between commercial sex work and HIV/AIDS. Not only does the continent bear the majority of HIV/AIDS cases worldwide, but its commercial sex industry appears to be strongly associated with HIV infection. In the South African context, KwaZulu-Natal has a similar profile to much of the rest of sub-Saharan Africa, with its skyrocketing HIV seroprevalence rates. Although prostitution is illegal in South Africa³, those providing commercial sex services have by various means succeeded in circumventing the law, and a thriving industry exists throughout the country. For CSWs on the streets of Durban, extortion, incarceration, rape, and other forms of violence from police are daily threats. Most women in this study had been arrested or experienced violence from local law enforcement officers at some point during their working lives. However, such repercussions appear to have little long-term deterrent effect on CSWs, who view them as job hazards. Thus, focusing on HIV/AIDS related issues in Durban's commercial sex industry is certainly timely and necessary.

Condom use patterns and changing sexual behaviour

With no cure on the horizon and ineffective therapeutic measures available against HIV/AIDS, emphasising sexual behaviour change is one of the few potentially viable intervention options.³⁶⁻³⁸ A major focus of many intervention efforts—both in the commercial sex industry and in the general populace—has been the promotion of condom use as an effective means of protection against HIV infection. Within the commercial sex industry, however, condom use is a complex issue, dictated by multiple—and often conflicting—factors.

The frequency of condom use among CSWs varies considerably, and appears to follow a largely geographic pattern.⁴ Recent research has revealed the highest condom use rates are among CSWs in European countries and the United States^{6,20,23}. Studies in Scotland,^{10,11} England,^{17,39} Germany,⁴⁰ the Netherlands,⁴¹ Greece,⁴² Italy,¹⁹ and the United States^{28,43} have confirmed this trend.⁴⁴ Financial gain (particularly among those CSWs using drugs), client refusal, and avoidance of physical abuse from clients appear to be the primary reasons for waiving condom use.^{10,11,20,39}

By comparison, the frequency of condom use between CSWs and their clients in developing countries is generally much lower.⁸ Most studies from African countries reveal low condom use rates between sex workers and their partners. Abdool Karim et al. discovered condom use to be a rarity among South African sex workers.²⁴ Working with CSWs in Kinshasa, Zaire, Mann et al. found that two percent of women reported “frequent” use of condoms with clients.²⁸ Fischbacher and Njeru reported a 23 percent use rate among CSWs in an intervention study in Kenya.⁴⁶

Wilson et al. recorded low condom use rates among sex workers in Bulawayo.²⁹ In another study among CSWs in Harare, they found just over half of the CSWs in the study reported consistent condom use with clients.²⁷ Finally, Pickering et al. found varying condom use rates among Gambian CSWs (53–80%).²² The primary reasons that

CSWs engaged in unprotected sex with clients included limited access to condoms, financial incentive, clients’ objections and physical abuse, and low self-perceived risk for HIV infection.^{22,24,27,29,46,47}

Patterns of condom use in sexual relations between CSWs and their personal partners appear far more uniform than in commercial sex situations. Studies which have addressed this aspect of sex workers’ sexual behaviour have found a nearly universal avoidance of condoms.^{8,10,15,19,23,28,34,39,48} The primary obstacles to condom use in personal sex situations appear to be a perceived violation of trust and intimacy connected with requesting condom use, and sex workers’ need to disassociate themselves with professional (i.e., protected) sexual behaviour. Among African sex workers, little research has focused upon issues related to personal sex situations. Instead, available studies focus almost exclusively on CSWs’ professional sexual behaviour.

Intervention efforts frequently rely on education and heightened HIV/AIDS awareness as a means of effecting behavioural change among CSWs and their partners. The assumption underlying such approaches appears to be that provision of information about HIV/AIDS and its consequences is sufficient for individuals to make informed, rational, and ultimately safe choices regarding their sexual behaviour. Several studies cited here undertook surveys to establish a baseline of HIV/AIDS knowledge or emphasised HIV/AIDS education as part of intervention strategies.^{11,15,16,27,28,34,39,47} In most cases, HIV/AIDS related knowledge regarding means of avoiding HIV infection and the health consequences of risky behaviour appeared to be sufficient. However, a common finding was a minimal relationship between HIV/AIDS awareness and CSWs’ (high risk) sexual practices.^{8,10,16,29,39} Condom use rates remained low or erratic, particularly among African sex workers and in CSWs’ personal sexual relationships.

Though armed with the facts regarding HIV/AIDS risk, African CSWs use condoms inconsis-

tently, especially within personal sexual relationships. Two questions then arise. What factors *are* influencing CSWs' condom use? How—if at all—*does* HIV/AIDS fit into decisions concerning condom use? There is a pressing need for research aimed at answering such questions and identifying contextual and socio-cultural factors which influence sexual behaviour.^{48–54} Such an approach may shed light on the dynamics influencing sex workers' decisions to use (or not use) condoms both on the job and in personal relationships. It may also be a crucial step toward sustainable HIV/AIDS interventions in the commercial sex industry.

An anthropological approach

Anthropology offers an important alternative perspective in finding solutions to problematic HIV/AIDS-related issues such as condom use. An anthropological approach is significant for at least two distinct but inter-related reasons. First, it can provide an understanding of socio-cultural reactions to HIV/AIDS; that is, how societies conceptualise aetiology, symptoms, and treatment, and these factors' potential impact upon behaviours surrounding HIV/AIDS. Research by Farmer on Haitians' reactions to AIDS and AIDS victims,^{55,56} Green's work on African traditional healers' roles in dealing with AIDS-related issues and on local conceptions regarding STDs and AIDS,^{57–60} and research conducted by Schoepf⁶¹ among Zairian women at high risk for HIV infection are only a few excellent examples in this regard.^{52,62–64} All these works illustrate the potential health impact of socio-cultural responses to HIV/AIDS.

Second, qualitative anthropological studies are a vital complement to quantitative survey methodologies often employed in research on health-related issues.^{65,66} In many cases surveys provide a necessary descriptive baseline for understanding *what* people know and do with regard to sexual relations. Anthropology can be instrumental in elucidating *why* people behave the way they do,

and why adequate knowledge of potential negative health consequences appears to have little impact on reducing risky sexual behaviour. Given its characteristic holistic and ecological approach to the study of the human condition, anthropology is ideally suited to this purpose.^{67–76} In the case of HIV/AIDS, understanding the “whys” of human behaviour could be the key to the difference between life and death.

Anthropological studies of condom use

Anthropologists have recently begun exploring socio-cultural and ideological factors influencing condom use in the context of HIV/AIDS. Several recent studies have focused on condom use among American women considered at increased risk for HIV infection.^{48,77–79} Some research has also examined condom use in an African context.^{61,80–83}

Sobo explored risk denial for HIV infection and the self-perceived benefits of unprotected sex among impoverished urban African-American women.⁷⁷ Women's avoidance of condoms was interpreted as a psycho-social and economic strategy to maintain self-esteem and domestic economic stability. By denying risk for HIV infection and shunning protected sex, women created both a public and personal image of monogamous, secure, trustworthy sexual relationships. Admission of the necessity for condoms would require acknowledgment of steady partners' infidelity, leading to women's personal humiliation and loss of dignity.

Studies by Worth,⁴⁸ Sibthorpe,⁷⁹ and Pivnick⁷⁸ with intravenous drug users revealed similar conceptual and socio-cultural obstacles to condom use. Despite acknowledgment of their high risk for HIV infection, many women made a deliberate decision *not* to use condoms. Condoms threatened trust, intimacy, sexual satisfaction of both partners, and domestic and economic stability. Condom use also presented a barrier to fertility and childbearing, a practice contrary to the cultural value placed on motherhood.^{48,78} Due to these negative associations, protected sex was appropriate only in

casual sex situations and strictly avoided with personal partners.⁷⁹

In Pivnick's study, the bonding associated with unprotected sex was so important that condoms were avoided even within relationships where one partner was a suspected or confirmed HIV carrier. Men and women judged the emotional benefits of unprotected sex as more important than the risk of infection. HIV was viewed as a potential, and in some cases unavoidable, cost incurred when entering into an intimate sexual relationship; risk was part of the commitment made in what the author described as "conjugal bonding."⁷⁸

Anthropological studies have also begun to examine socio-cultural factors influencing condom use in an African setting. According to Taylor, Rwandan women's resistance to condom use was related to cultural notions of fulfilling personhood and social cohesion through the mixing of bodily fluids.⁸⁰ Condoms represented a polluting "blockage" to Rwandan men and women.⁸⁰ Thus, protected sex was an obstacle to the reciprocity necessary to maintain social stability.

Schoepf examined cultural barriers to condom use in Zaire.⁶¹ Among these were the value placed on fertility and polygyny, and men having multiple sex partners as a culturally sanctioned means of achieving status and gender superiority. In another study, Schoepf examined the potential role of involving Zairian traditional healers in promotion of HIV awareness and safe sex practices.⁸¹ By virtue of their respected status in the community, and being "legitimate interpreters of customary rules of conduct," traditional healers' advocacy of condom use could be a culturally appropriate means of effecting behaviour change.⁸¹

In South Africa, anthropological research has revealed condom use to be a problematic aspect of sexual negotiation among adolescent sex partners.^{82,83} Adolescent females avoided discussion of or attempts to use condoms out of fear of emotional rejection or physical abuse from partners, or of being branded promiscuous or HIV positive.⁸² Adolescent males refused condoms due to

the belief that they interfere with male control in a relationship. The need for condoms was also seen as a reflection of the *female* partner's status: untrustworthy, uncommitted, "dirty" (promiscuous and a carrier of sexually transmitted diseases).⁸³ These insights can be helpful in understanding the dynamics behind condom use among Durban commercial sex workers.

Methods

Fieldwork was undertaken in two sites. The first was an inner city section of Durban known to be frequented by commercial sex workers. The area was near the central business district, recreational areas, and hotels on the beachfront and Durban harbour.

The second venue was an industrialised suburb approximately 15 kilometres from the city centre. The area was characterised by a large truck depot, serving as the endpoint and way-station for truck routes from throughout southern Africa. Several hotels and bars frequented by locals, truckers, and CSWs were located near the truck depot.

Participants were black African, female, self-identified CSWs. The majority were Zulu or Xhosa-speakers. All women worked independently, either on the street or frequenting bars or nightclubs. The snowballing technique was used for selection of study participants.^h

Data were gathered using in-depth interviews (45), semi-structured questionnaires (100; 50 per venue),ⁱ focus groups (2), and participant observation. Questionnaire topics included HIV/AIDS-related knowledge and attitudes, and frequency of condom use. In-depth interviews and focus groups concerned issues related to condom use in professional and personal sexual relationships.

Study objectives were explained to each prospective participant and verbal consent obtained before enrolment. Questionnaires and interviews were conducted in Zulu or Xhosa with the aid of a young, black African male fieldworker.

Analysis of questionnaire data was undertaken using D-base and Epi-Info 6 statistical programs.^j

Transcripts from in-depth interviews and fieldnotes were examined and interpreted.

Results

Socio-demographic characteristics

One hundred women participated in the study (50 per venue). Mean subject age was 25.5 years. In the central city group, 73 percent were Zulu and 26 percent were Xhosa-speakers. In the suburban group, 56 percent were Zulu and 36 percent Xhosa-speakers.^k

Study participants had a mean of 6.4 years of schooling. Among central city CSWs, 90.2 percent identified sex work as their main income source. Seventy-six percent of suburban CSWs derived their income from sex work.^l Mean daily income was 148 Rand (\$32.30) for central city CSWs and 96 Rand (\$21.00) for suburban CSWs.^m

HIV-AIDS awareness and risk behaviour

All study participants knew of HIV/AIDS and were well-versed in means of acquisition, transmission, and prevention. Unprotected sexual intercourse was most frequently cited as a behaviour likely to facilitate HIV infection. Significantly, the vast majority (87%) of CSWs described AIDS as lethal, incurable, and preventable.

Subjects had a mean of 2.7 clients per day. Eighty-six percent of CSWs described themselves as involved in monogamous non-commercial relationships. Nearly the same number (85%) suspected or had proof that their steady boyfriend had multiple sex partners.ⁿ Intravenous drug use was not practised by any study participants.^o

Condom dynamics and symbolism

Most CSWs in both venues viewed condom use as a rule to be enforced whenever possible. Several CSWs noted their personal partners encouraged and even monitored their condom use with clients. One central city CSW described how her boyfriend counted the number of condoms missing from her purse and the amount of money brought home each night in an attempt to monitor the con-

sistency with which she used condoms during working hours.

Structured questionnaire data revealed low condom use rates among both groups. Among central city CSWs, 29 percent described themselves as "always" using condoms with clients; 14 percent of suburban CSWs similarly responded. A further 71 percent of central city and 80 percent of suburban sex workers "usually" used condoms with paying partners.^p

Several obstacles to consistent condom use were articulated in structured questionnaires. These included: threat of physical violence from clients (4%), clean and trustworthy appearance of prospective clients (8%), and financial incentives for unprotected sex (67%).

In both groups, financial problems appeared to be the primary reason for waiving the condom rule.^q Most CSWs calculated daily earnings, and many aspects of their finances—food, rent, or transportation—were dependent upon making a certain quota each evening. In the course of a night's work, a sex worker might become increasingly likely to accept an offer of extra payment for unprotected sex if the financial quota had not been achieved. Several women also described steady clients with whom they did not insist upon condom use in fear of losing the regular income.

Finally, in focus groups and in-depth interviews, many women identified high alcohol consumption and frequent use of *dagga* (marijuana) or mandrax as significant impediments to their ability to make decisions and enforce condom use with clients. Questionnaire responses revealed that 98 percent of sex workers in the study used alcohol (usually beer) on a regular basis, with an average 7.7 drinks consumed daily. Twenty percent of study participants reported regular (daily or weekly) use of *dagga* or mandrax. CSWs who used drugs and alcohol described substance use as necessary in order to muster courage to solicit clients and face other unpleasant working conditions.

Unlike professional sexual relationships, sex workers adamantly rejected condom use with per-

sonal partners. Nearly all (96%) study participants reported never using condoms in private sex situations. Avoidance was due both to CSWs' own dislike of condoms and partners' objections.

Sex workers viewed condoms as a means of maintaining the ideological barrier between professional sex with clients and personal sex with private partners. Most women described the conceptual necessity of dividing work and personal life, and of reaffirming their membership in conventional society outside of working hours. Condoms were seen as being in direct opposition to this, and associated with impersonal, professional, and usually unpleasant sexual interactions. A central city sex worker described condom use in the following way:

When I sleep with a client I use a condom because then I am not an ordinary person but a professional sex worker. There are no feelings or love involved and you don't expect to get any pleasure out of it. The pleasure is when you get money. That is *ukubhebha*;² when you [have sex with] a client you are not a full human being. But you cannot be a sex object 24 hours a day. You have to become a full, emotional, loving girlfriend... You have to make love (*ukulala*).³

Sex workers from the suburban group reaffirmed this viewpoint. One woman noted, "Condoms were made to keep flesh apart that isn't supposed to mingle." The use of condoms as a symbolic divider between personal and professional life among suburban CSWs was illustrated in yet another way. Many suburban sex workers described becoming personally involved with long-time trucker clients. The transition from client to personal partner was marked by a lapse in condom use. In respect to this, a suburban sex worker whose boyfriend had at one time been her client said, "Once he became my lover, I forgot to use condoms. I felt at home and safe."

The negative symbolism of condoms was clearly demonstrated in reasons provided for the neces-

sity of condom use with clients. Clients were considered "dirty," "untrustworthy," "promiscuous," and suspected carriers of "diseases" (AIDS or other STDs). Professional sex was viewed as undesirable for both personal and health reasons. Clients were assumed to have had multiple sex partners, and as a result to harbour STDs or HIV. In addition, the professional sex act was viewed by CSWs as impersonal and even morally repugnant. Thus CSWs felt it imperative to use condoms as a means of physical and emotional protection against intercourse with clients.⁴

Condoms' negative image was also demonstrated in reasons CSWs provided for the rejection of protected sex in personal relationships. Personal partners were viewed as "clean"⁵ and "trustworthy." Condoms were also seen as a threat to intimacy and commitment, in that requesting protected sex would introduce an element of distrust and suspicion into partner dynamics. Regarding condom use, the association between love, trust, cleanliness, and unprotected intercourse was cited in nearly half (46%) of CSWs' questionnaire responses and all in-depth interviews.

Trust in a personal partner was also the primary reason for not fearing AIDS from unprotected sex with personal partners. When asked about the degree to which HIV/AIDS influenced her choice of personal partners, a CSW retorted, "I only sleep with guys who are clean and trustworthy. So why should I be afraid of AIDS?" Such views are also articulated as follows:

Condoms take the trust away. How do I say to my boyfriend that I do not trust him? How would I feel if he didn't trust me?

It would be better to die of AIDS from someone you love than lose a loving guy for the sake of a condom.

Another prevalent theme was that requests for condom use with domestic partners suggest infidelity or the possibility of carrying HIV/AIDS.

One young central city CSW noted:

Because I am a CSW if I asked my boyfriend to start using condoms he would accuse me of having had unprotected sex with clients and say that I have AIDS. Or he might think that I suspect him of having it [AIDS].

CSW study participants were aware of HIV/AIDS, high risk sexual practices associated with it, and the potential consequences of HIV infection. However, this appeared to have limited impact upon sex workers' condom use, particularly in personal sex situations.

In both professional and private sex situations women were resigned to the risk of HIV infection from unprotected sex. The priority in personal sexual relationships was to maintain closeness and domestic stability. A popular sentiment was that the risk of AIDS is a responsibility which must be shouldered in a personal relationship. The cost of HIV risk did not outweigh the benefits of personal intimacy gained through unprotected sex.

Regarding professional sex situations, immediate concerns, such as financial gain, appeared to override any fear of contracting HIV/AIDS. Also, the threat of infection may not have been taken seriously due to the virus' long period of dormancy and AIDS' current lack of visibility in South Africa.⁷ The following are comments by central city CSWs in this regard:

I would rather die of AIDS in ten years' time than die of hunger next week...

Why should I care about a sickness [AIDS] that will only attack me years in the future? By that time I will be too old to do sex work anyway.

Discussion

This research illustrates the complex dynamics involved in these South African sex workers' condom use and the critical role socio-cultural and economic factors play in determining their sexual

behaviour. Thus, we may begin formulating answers to questions surrounding sex workers' condom-related decision-making and the role of HIV/AIDS in this process.

What factors were influencing Durban CSWs' condom use? In professional sex situations, study participants preferred protected sex. The primary barriers to CSWs' condom use with clients were practical and economic ones. Poverty, and thus the financial incentive to engage in unprotected sex, appeared to be the greatest obstacle. In addition, threat of physical abuse from clients and the debilitating effects of substance use were also factors hindering sex workers' ability to successfully negotiate condom use with clients.

Barriers to CSWs' condom use in personal relationships were much more complex. In this context, conceptual and symbolic issues determined (un)safe sex practices. Condoms' ugly connotations were an overwhelming component in women's decisions to avoid condoms. The negative symbolism of condoms was a significant deterrent to their use, and stood in direct opposition to what these women sought from personal sexual relationships. Condoms were associated with disease, infidelity, and impersonal, illicit, professional sexual acts. In stark opposition to such imagery, women looked to personal sex for purification, trust, intimacy, and affirmation of love. Thus, by definition, condoms were excluded from personal sexual relations.

Condom use was also conditioned by the conceptual categories into which sex workers placed their partners. Sex with clients was seen as dirty, illicit, and impersonal. Such interactions warranted the protection of a condom to avoid unwanted and potentially dangerous contact. Personal partners were viewed as clean, intimate, trustworthy, and offering invited physical acts of love and affection. In these situations condoms were anathema. Within such a conceptual framework, it is unsurprising that condoms were used as a logical divider between professional and personal life.⁸ Lack of skin contact might make the impersonal,

unclean professional sex act physically, conceptually, and emotionally invisible.

What role did HIV/AIDS play in Durban CSWs' condom-related decision-making? In both personal and professional sex the risk of HIV/AIDS appeared to have little bearing on women's condom use, but for very different reasons. In personal situations, sex workers looked to their relationships to fulfil personal needs crucial in maintaining successful equilibrium between professional and personal life. So strong were these needs that study participants preferred to overlook personal partners' high risk behaviour and maintain their relationships. Given their stressful life circumstances, potentially life-threatening personal sex was a rational cost-benefit analysis for Durban CSWs; the emotional benefits of unprotected sex outweighed the risks of HIV infection.^x

In contrast, Durban sex workers' views on condom use and HIV/AIDS in professional sex situations were tied to poverty and powerlessness. Despite women's fears of infection from clients and their desire to use condoms during professional intercourse, dire financial circumstances rendered them unable to enforce condom use. As a result of their dependence on sex work as a means of income generation, women approached the risk of HIV infection from professional sex somewhat fatalistically. It was considered an unavoidable job-related hazard, and the risk of infection was subsumed by day-to-day worries. In view of their immediate concerns and constraints, Durban sex workers saw HIV/AIDS as a remote danger which had little bearing on their daily professional or personal lives.

The fact that sex workers were unwilling to use condoms in personal sex relationships has significant ramifications for the progression of the HIV epidemic. It suggests that sex workers are at potentially greater risk for HIV infection from personal sexual behaviour than from professional intercourse. The HIV-related risks of sex workers' personal sexual behaviour have been suggested elsewhere.^{8,11,15,19,28,34,39-41} However, this study ap-

pears to be among the first to explore the differences between sex workers' personal and professional condom use, and the dynamics behind such contrasting behaviour, in an African context. Most published works concerning African CSWs focus exclusively on HIV risks surrounding sex worker-client relationships.^{9,26,27,29,47}

Conclusions

The differences between sex workers' professional and personal sexual relationships have significant ramifications for the structuring of HIV/AIDS intervention efforts focused on the commercial sex industry. In commercial sex, barriers to condom use are practical, environmental ones, external to sex workers' motivation to practice safe sex. Their preferences for condom use and the modifiable nature of barriers to protected sex are important characteristics to be considered in intervention frameworks. Women need not be convinced about the necessity of safe sex with clients, they need only be enabled to practice it. Environmental (political, legal, economic) change is the key.

Condom-related dynamics in sex workers' personal sex lives present a very different scenario. With intimate partners, barriers to condom use are deep-seated socio-cultural and ideological issues. Such obstacles to safe sex practices are likely to be more difficult to overcome than those in professional sex situations. Unprotected intercourse serves an important function both emotionally and in terms of self-esteem; condoms symbolise everything that is the opposite. For the women in this study, the well-being they derived from intimate unprotected sex actually allowed them to function more successfully in their commercial sex roles.

Given the HIV-related implications of sex workers' condom use with personal partners, intervention programs must begin focusing on the broader aspects of their lives. This means centring on women's personal lives and personal partners. Men (both clients and personal partners) are frequently overlooked in HIV/AIDS intervention programs targeting the commercial sex industry.^y Moreover,

intervention efforts taking into consideration CSWs' personal situations must adopt an approach centred on socio-cultural and ideological factors, not only practical, environmental ones.

This study among South African commercial sex workers illustrates the importance of examining socio-cultural, ideological, and economic factors influencing sexual dynamics and condom use. The work also demonstrates the significance of an anthropological approach in unravelling the inconsistencies between HIV-related knowledge, attitudes, and behaviour. Given that Africa bears the burden of the HIV epidemic, more qualitative work is needed to identify intervention strategies which reach beyond education and awareness to touch deep-seated socio-cultural and economic factors that influence sexual decision-making.

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NOTES

- a The terms "prostitute" and "prostitution" are used here for historical review purposes only.
- b The differences between Pattern I and Pattern II transmission have been attributed to various factors including lack of access to medical care and subsequent increased prevalence of untreated STDs in developing countries, population-specific biological differences, differences in virus sub-types, extreme poverty and poor material conditions, and African cultural patterns which emphasize fertility and sanction multiple sex partners (20–21, 24, 30–32).
- c Presently, escort agencies and massage parlours are the only sector of the commercial sex industry operating legally in South Africa. These are classified as "entertainment facilities" and require the same permit as movie houses, theaters, or night clubs. They are subject to periodic visits from health inspectors, and until recently could be raided by police without warrant if covert activities were suspected. Owners of such facilities rarely admit to supplying sex services on the premises, and claim that they have no control over employees during house calls or dates with clients.
- d Research by Estebanez et al. (20, 404), Campbell (28), and Jackson et al. (15) suggests CSWs' condom use with clients is positively related to the legalization or public toleration of commercial sex work.
- e See Gillies and Parker (34) for exceptions to this pattern in demonstrating high condom use rates among sex workers in Brazil and the Dominican Republic.
- f Due to variations in methodology and reliability, comparison of reported use rates is problematic. However, nearly all the European and U.S. studies cited here reported use rates of 80 percent or higher. Note also that some studies have demonstrated questionable reliability of self-reported condom use, with sex workers over-reporting and clients under-reporting frequency of use (22–23, 27).
- g See findings from research in India (44), Nicaragua (45), and Indonesia (16).
- h Due to the sensitive nature of the subject matter, random sampling was not possible.
- i Questionnaire results are reported here selectively, only as they pertain to condom-related topics addressed in in-depth interviews.
- j Questionnaire results will be reported as a combined figure from the two field sites unless otherwise noted.
- k Significant difference urban vs. suburban ($p < .001$)
- l Significant difference urban vs. suburban ($p < .002$)
- m Significant difference urban vs. suburban ($p < .002$); 1 US Dollar = R4.58
- n Confidential interviews with several boyfriends confirmed this. In the course of this research, 35 personal partners and clients (mostly truckers) were interviewed. These data are currently being analysed.

- o Interviews with local police and drug enforcement agents confirm that injectable drugs are currently a rarity in the communities where this research was undertaken.
- p Significant differences ($p < .001$)
- q Poverty was also the primary reason these women became involved in commercial sex work. Poverty and other reasons related to material circumstances accounted for nearly one half (48%) of study participants becoming involved in the commercial industry.
- r *Ukubhebha* is a vulgar Zulu term referring to sexual intercourse.
- s *Ukulala* (Zulu), "to make love"; positive, loving connotation.
- t Note one reason provided for *waiving* condom use was a client's clean and trustworthy appearance.
- u Connotations of "clean" and "dirty" refer both to physical appearance (dress and smell) and disease status (sores on genitals or appearing ill or wasted), and to a more symbolic notion of trustworthiness, intimacy, and purity. They are also related to the manner in which CSWs view their jobs (distasteful, abnormal, sinful, dirty) vs. their personal lives (removed from sex work, conventional, and pure).
- v In South Africa, the epidemic has yet to reach the point at which full-blown AIDS cases are a visible (and thus recognized) public phenomenon.
- w Jesson et al. have also suggested CSWs' reluctance to use condoms in personal sex is tied to the need to "confirm the demarcation between sex as work and sex as pleasure" (39, 8).
- x In this respect, our findings confirm those of Worth (48), Sibthorpe (79), Sobo (77), and Pivnick (78) among American drug users, and of Nataraj (44) among Indian sex workers.
- y Results of data collected in this study among male partners (boyfriends and clients) will be available by mid-year 1997.

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Sex Worker Briefing

11/5/97

Internationally

- vulnerability related to economic situation

Domestically

- prevalence of HIV related to prevalence of drug users
- question of ~~an~~ occupational safety
- PPG participation
~ get CDC to request/require addressing this issue
- research - CDC, NIMH, NAID
- no sex workers on IRBs (isn't there a requirement that studied population be represented)
- don't use sex workers as outreach workers
- treatment -
 - not oriented to responding to crack users (need immediate attention)
 - children/custody threats

PONY - Prostitute Organization of N.Y.
Network of Sex Worker Projects (International)
~~Co~~ Coyote
Int'l. Conf. on Prostitution

Australia ~

- proactive approach
- funding sex worker organizations to do HIV outreach / peer outreach
- South Wales ~ criminalized

domestic

- access to services based on being HIV+
- NAIDA - does disclosure of being a prostitute negatively impact on getting into treatment?
- certification courses ~ provide sensitivity training to sex workers
- same with health workers
- peer education x colliding with certification
- police abuse stopping prevention efforts

NAIDA - Outreach studies ~ cooperative agreements - what are results?

Where to from here? Possible follow on actions

1. Another meeting

-what would be discussed? Who would attend?

2. Minutes from previous meeting to be circulated

3. Position paper from existing sex worker organizations and projects

4. Change/review funding arrangements of key organizations (ie CDC, NIDA, NIMH) to promote peer education strategies, sex worker managed programs

5. HIV prevention planning groups in each state required to address issues relating to sex work. HIV planning councils similarly should consider treatment and care for sex workers, sex worker friendly services

6. Organization and Networking

-working group composed of sex workers and their organizations

-presently networking can take place via email-cost effective

-longer term strategies to create national information sharing/policy development body (ie National SexWorkers Health Alliance)

Related discussion issues from the New York Pre-Planning Meeting

peer education strategies key-however, recognition of diversity of sexworkers experiences and risks factors (ie IDU, other drug use, youth issues, sex barterers, sex for favours, survival sex, identification as 'sex workers' not always clear, gender including transgender, cultural factors)

Interagency training-much need for interaction between different kinds of peer educators, service providers, different sex worker 'communities'-sex workers as health educators for other service providers and the general community

Broad occupation safety approach-linked to harm reduction, Occupational Health Safety, Employee Assistance Programs-can encompass issues of violence as a safety issue and HIV prevention

**Successful HIV/AIDS Prevention Strategies
in Australia**

The Role of Sex Worker Organizations

Presented to White House Commission on AIDS

by

Dr Penelope Saunders

5 November 1997

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Successful HIV/AIDS Prevention Strategies in Australia The Role of Sex Worker Organizations

Introduction: General approaches to HIV prevention

Australia's response to HIV/AIDS has been described as 'proactive and effective' (Steven, 1994: 237). The rate of HIV transmission has, so far, declined to a steady state level and treatment and care programs work in conjunction with a system of cost-free, or low cost, universal health care. Overall, HIV/AIDS prevention and treatment programs have been successful because of the adoption of a 'partnership approach' which has linked federal government strategies to the activities and perspectives of community based organizations. In particular, the recognition that the design and delivery of prevention and education programs are most effectively carried out at the community level, by members of the groups most effected, has guided the creation of a series of three National HIV/AIDS Strategies.

The Strategies have constituted a framework for an integrated response to planning, policy and funding-the current National HIV/AIDS Strategy, entitled 'Partnerships in Practice', has been in effect since 1996. The partnership approach, therefore, has also been linked to a core funding arrangement between the Federal Government, States and community organizations. Each Australian State has developed it's own community based response to HIV prevention, primarily through the development of the 'AIDS councils' which are linked to a national networking and policy body known as AFAO, the Australian Federation of AIDS Organizations. Other communities, including intravenous drug users, sex workers, indigenous peoples, etc, have also formed local and national organizations and networks at times in collaboration with AFAO and the state based AIDS organizations.

HIV, STDs and Australian sex workers

Even though sex workers are frequently thought of as a 'high risk' group for HIV transmission, in the Australian context no case of transmission of HIV from a sex worker to client or a client to sex worker has been documented (Harcourt, 1997). Since 1992 information provided by metropolitan sexual health clinics has indicated that HIV prevalence has remained low among women identifying as sex workers, at around 0.1% with no evidence of any trends in HIV prevalence over this time (Annual Surveillance Report, 1997: 20). In general, sexual health terms Australian sex workers also

perform well often reporting lower rates of sexually transmitted diseases. (STDs) than the general population. For example, a 1989 study at the Brisbane Special Clinic in Queensland concluded that relative risk for female sex workers of developing acute bacterial STDs was half that of other female clinic attenders (Harcourt, 1994: 217). During the 1995 and 1996, the period that I was director of the Sex Industry Network program, Clinic 275, Adelaide's primary STD treatment clinic, reported that sex workers tested lower on all STDs than the general South Australian population.

Sex worker organizations and HIV prevention

However, sex workers in Australia have not always enjoyed such high standards of sexual health. For example, one study, carried out prior to the emergence of HIV/AIDS in the 1980s, found a weekly incidence of 10% of gonorrhea in Sydney brothel workers (Harcourt, 1994: 218). The spread of STDs was linked to relatively low use of condoms in certain sectors of the sex industry (1).

However, once HIV/AIDS emerged as a concern sex workers quickly formed their own organizations to promote safe sex, self determination for sex industry workers and progressive law reform. The Australian Prostitutes' Collective in Sydney, founded in 1983, was soon distributing information to sex workers in the form of newsletters and outreach programs conducted by sex workers and their supporters. In my own state of South Australia a grassroots organization, initially named the Scarlet Alliance (2), emerged for similar purposes, carrying out innovative health and peer education efforts, such as The Traveling Parlour Show, which were run by sex workers for sex workers.

Similar organizations were established in all Australian states and many of them eventually received funding to carry out HIV prevention. Primarily this occurred in the form of peer education, outreach work, needle exchange and the provision of safe sex equipment for free or at low cost. The effects of peer education strategies have been dramatic. For example, between 1985 and 1988 condom use by the clients of female sex workers in NSW increased from 5% to 88%, and another study which included brothel, escort workers, 'independents' and street workers, in 1991 found that 98% of participants reported using condoms for all commercial sexual interactions (Harcourt, 1994: 221). Currently, all Australian states have government funded sex worker health projects, many of which have expanded their areas of action to encompass far more than HIV prevention to include sexual

health programs, sex worker pride/culture initiatives, legal services, career advisory centers, and so forth. Other kinds of sex worker rights groups also exist in many states and they frequently act in tandem with sex worker health organizations (3). All of these sex worker organizations are members of the national network, known as the Scarlet Alliance.

Law reform and HIV prevention

However, while peer education strategies have been incredibly successful in and of themselves, these results probably could not have been achieved without liberal attitudes towards 'harm reduction' and changes to the enforcement of prostitution law in many Australian States. For example, Christine Harcourt, Senior Researcher at Sydney Sexual Health Centre and the Deputy Mayor of South Sydney, commented recently that "(s)cientific literature on the public health outcomes of prostitution indicates that the best results are achieved within a non-coercive environment in which sex workers have a large measure of control over their own work conditions... (f)rom a public health perspective the decriminalisation of brothel prostitution was an essential step in the process of harm minimisation and the maintenance of health improvements within the sex industry (Harcourt, 1997)." Whatever one's opinions about the sex industry, the Australian experience indicates that the repealing of anti-prostitution laws creates a climate in which the overwhelming majority of sex workers access health and welfare services, network about health concerns, and create safer working environments for themselves in consultation with business owners and managers.

Unfortunately, some sex workers and 'sex barterers' continue to work in marginalized and unsafe conditions in Australia. The South Australia State Legislature continues to debate the 'possibility' of law reform thus allowing the South Australian Police to arrest sex workers, confiscate condoms and other safe sex materials, and use them as evidence in the courts. Street sex work remains illegal in the state of Victoria and the Prostitute's Collective of Victoria (PCV) contends that decriminalization would allow specialist agencies and workers greater access to street prostitutes in order to provide them with services and strategies such as drug detoxification centers, exit and retraining programs, and housing programs (PCV, 1997). Young people who work in the sex industry or who find themselves homeless and swap sex for 'favors' but do not necessarily consider themselves 'sex workers', also constitute a highly marginalized group

at risk of HIV infection and numerous other health problems (Tschirren et al, 1996). Sex workers from non-English speaking backgrounds, some of whom have entered Australia on short term visas and/or work illegally, may be marginalized from mainstream services and sex worker organizations (Harcourt, 1994: 222-23). Currently, many sex worker organizations are developing new strategies, including interagency training, research, and networking with other community health providers (such as migrant health services and youth agencies) in order to address the needs of these groups.

Concluding comments

To conclude, creative strategies are being developed in the Australian context to ensure that our 'success story' in terms of HIV prevention and education continues. A network of funded sex worker health projects, linked together via a national organization, deliver services, carry out research and advise on HIV and sex work policy, has proved remarkably adept at meeting the majority of Australian sex workers HIV prevention needs. Additionally, the Australian government's bipartisan commitment to HIV/AIDS issues has fostered a relatively open environment for the development of 'harm reduction' strategies and consultation with the communities most affected by HIV. Steady advancements in terms of prostitution law reform have greatly facilitated the adoption of these strategies and the reduction of sex workers occupational risk.

Footnotes

(1) Harcourt (1994) notes that prior to 1986 it was generally accepted that 'independent' sex workers, including street workers, were better able to negotiate with condom use with their clients than brothel workers.

(2) In the second half of the 1980s the South Australian Scarlet Alliance became the Prostitutes' Association of South Australia (PASA). In 1996 PASA became the Sex Worker Action Group (SWAG).

(3) For example, in South Australia the Sex Industry Network (SIN) and the Sex Worker Action Group (SWAG) view themselves as 'sister' organizations with different but linked areas of action.

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North American Task Force on Prostitution

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Sex Workers and Sex Traders: Definitions

Prostitution is defined by law as the provision of sexual services in exchange for money or other economic consideration. Sex work is a broad term that includes both prostitution and pornography, and strictly speaking involves payment in the form of money. Sex trading or barter is a related activity in which a person engages in sexual activity in exchange for a place to sleep, food, or drugs. The behaviors and work styles included in sex work and sex trading are extremely varied, and a significant proportion of sex traders and sex workers who charge very low amounts do not identify what they are doing as prostitution or sex work, but rather as survival.

Sex workers' rights organizations estimate that approximately 70% of sex workers are biologically female, and 30% are biologically male, including transvestites, or male-to-female transsexual. Approximately 20% of sex workers contact clients on the street, with the overwhelming majority of sex work contacts and transactions taking place off the street, in brothels, massage parlors, bars, and clubs, through escort services, or in response to individual sex workers' ads.

Sex Workers and HIV: Context of Risk

Legal Status. All aspects of prostitution are prohibited in the United States, with the exception of counties with less than 400,000 population in the State of Nevada, where prostitution is legal in closed houses with mandatory testing for syphilis, gonorrhea, and HIV. The specific aspects of prostitution prohibited by law include: soliciting, engaging, or agreeing to engage in an act of prostitution; loitering for the purposes of (or with intent to commit) prostitution; living off the earnings of a prostitute or in any way acting as a manager of prostitutes or a prostitution business, and migrating or taking another person across state lines to practice prostitution. In New York State, patronizing a prostitute is a separate offense from soliciting. As of December 1994, 22 states had enacted legislation mandating testing for HIV for anyone convicted, or in some cases merely arrested, on prostitution charges, and 11 had enacted provisions to increase the soliciting charge to a felony for anyone so charged after testing positive and receiving the test results. At the present time, New Jersey is considering similar legislation.

In 1995, there were 97,700 arrests on prostitution-related charges nationwide. Of those arrested, 61.1% were female, 38.9% were male, 36.6% were Black, 60.5% were white, including Hispanic, 0.5% were Native American, and 1.7% were Asian/Pacific Islander. The overwhelming majority of prostitution arrests are made on the street. Other charges on which sex workers are arrested include drug abuse violations, disorderly conduct, vagrancy, curfew and loitering law violations, and as runaways.¹

Impact of Law Enforcement on HIV Risk. When individuals are arrested on prostitution charges, they often modify their work behavior in an attempt to reduce their visibility to police. For example, they reduce the amount of time they negotiate before getting into a client's car, and they may agree to acts carrying a higher risk if it means more money, so that they can work a shorter number of hours and reduce the likelihood of being arrested again. As a result, they

¹ U.S. Department of Justice, *Sourcebook of Criminal Justice Statistics Online*, 1995, Tables 4.1, 4.8, 4.10.

become more vulnerable to pressure to not use a condom, as well as to violence from borderline clients. If they are arrested repeatedly, it can make it impossible for them to maintain a stable living situation, and if they contribute to the support of a partner, the loss of income can put enormous strain on the relationship, with a possible increase in the risk of domestic violence. With each arrest, the individual sex worker is likely to feel less in control of her or his life, which in turn is likely to result in an increase in depression and/or reliance on drugs to ease the anxiety. In addition, with repeated arrests, the likelihood increases that the individual will become homeless, with a further loss in control. All of this can have a negative impact on an individual's ability to insist on safer sex and/or drug using practices, as to do so depends on a sense of control/autonomy. For example, a homeless sex worker who smokes crack may be tempted to hang out in a crack house, just to stay off the streets, and women in crack houses are at high risk of repeated sexual assault.

Periods of intense law enforcement are often accompanied by increases in violence against sex workers. As discussed above, as the living situation deteriorates, there is an increased risk of domestic violence. In addition, sex workers who are dependent on drugs may go into debt with drug dealers, and if they are unable to pay them back, the dealers may engage in violence, including murder, to make an example of them. Finally, as "sweeps" continue night after night, some men who are on the edge (angry) take advantage of the anti-prostitution climate to commit violence against sex workers. In New York City, as Mayor Giuliani has intensified his "Quality of Life" law enforcement campaign, the staff of FROST'D's outreach programs have observed an increase in reports of rape and murder from 1-2 a month to 3-8 per month.

In most cities in the United States, as well as in many other countries, police routinely confiscate condoms during an arrest, sometimes to use as evidence, but often simply as a form of harassment. They also often confiscate injection equipment, even when the individual has a card identifying him or her as a registered participant in a legal syringe exchange program.

The mandatory testing programs discussed above have had little or no impact on the incidence of HIV. For example, in California, where anyone convicted of prostitution is required to be tested, out of 3,500 persons arrested on prostitution-related charges, 345 were convicted and tested, of whom 46 (13.3%) tested positive (Carol Stuart, personal communication). Indeed, in countries with mandatory registration or licensing and testing schemes, the large majority of sex workers work outside of the legal system, and a long history of such programs has made clear that they are of more symbolic than practical use.²

HIV Epidemiology and Sex Work

All over the world, the incidence and prevalence of HIV infection among sex workers is directly related to the economic level of the sex work and the background prevalence of infection. The factors associated with infection were established in a multicenter study of HIV prevalence among female sex workers in Southern Nevada, Atlanta, Colorado Springs, Los Angeles, San Francisco, Miami, South New Jersey, and North New Jersey, during the 1980s. Virtually all sex workers who tested positive for HIV in that study had a personal history of injecting drug use and/or a relationship with a male injecting drug user, and in fact, the prevalence of infection in each city paralleled that of women in similar situations who were not sex workers. The prevalence of infection ranged from 0.0% among brothel workers and applicants in Nevada to 47.5% among women tested in methadone programs, STD clinics, and through street outreach in North New Jersey. Overall, of 1,396 women tested, 12.3% tested positive. However, more than 1,236 of the women tested were street prostitutes (88.5%), and even in this population, outside of New Jersey, the

² See, Alexander P, "Bathhouses and brothels: Symbolic sites in discourse and practice." In, EG Colter, W Hoffman, E Pendleton, A Redick, D Serlin (Eds.), *Policing Public Sex: Queer Politics and the Future of AIDS Activism*. Boston: South End Press, 1996.

prevalence ranged from 2.0% to 15.0%. Consistently, the highest rates of infection in the United States are found among street-based workers, whether female, male, or transgender, in large cities with extensive drug use.³ In general, the incidence and prevalence of infection is significantly lower among sex workers in other industrialized countries, including Canada, Australia, New Zealand, and Western European countries, largely because of the early and widespread introduction of harm reduction programs, particularly needle exchanges (e.g., in the Netherlands, Canada, and Australia), and drug provision or substitution programs (e.g., in Switzerland). However, as in the United States, the sex workers who earn the least are the most vulnerable to HIV infection. Another factor that has helped to contain the epidemic in many of these countries has been the practice of governments funding sex worker-run organizations in many cities to operate HIV and STD prevention projects (e.g., Australia, New Zealand, the Netherlands, Germany).

In developing countries, the rate of infection among sex workers also is directly related to economic status, and is strongly affected by the prevalence of untreated ulcerative and inflammatory STDs, poor nutrition, and poor access to condoms and other preventative measures. In addition, the widespread use of unsterile needles in informal settings, and even at times in clinics and pharmacies, has contributed to the HIV pandemic. Another factor has been the practice of some sex workers to self-dose with antibiotics in an effort to prevent STDs, particularly in countries that have at one time or another practiced mass treatment of sex workers.

Effective Intervention Approaches

A basic principle underlying the effectiveness of HIV/AIDS and STD prevention interventions is that the intervention must meet the needs of the population(s) for which it is designed. The most effective way to do that is to ensure that representatives of the population are actively involved at all levels of organizations that develop such interventions. In Australia, for example, there is at least one sex worker-run organization in each state that is funded to develop HIV/AIDS and STD prevention projects, and a national umbrella organization, the Scarlet Alliance. Both the local and national organizations are affiliated with the Australian Federation of AIDS Organizations (AFAO). In Germany, sex workers' organizations have been funded in most cities, and there, too, they are linked in a national Network. In addition, there is an international Network of Sex Work Projects, based in London, that provides technical assistance, has published an operations guide,⁴ and tries to facilitate communication between sex work-related HIV/AIDS and STD prevention interventions internationally, particularly in developing countries.⁵

In keeping with this principle of involving sex workers in program development, From Our Streets with Dignity (FROSTD), in New York City, has organized an internship program, training former sex workers as peer educators and organizers, and hiring them full-time as positions open up and/or assisting them with obtaining full-time employment in similar programs. At the present time, a significant proportion of the staff are former sex workers, including in management positions. In addition, the Board of Directors includes representation from PONY, New York's sex workers' rights organization. The California Prostitutes Education Project (CAL-PEP), in the San Francisco Bay Area, was originally developed by members of COYOTE, another sex workers' rights organization, the majority of whom were former sex workers. Some of the first peer outreach workers/educators have gone on to

³ Darrow WW, Deppe DA, Schnable CA, Hadler SC, Larsen SA, Khabbaz RF, Jaffe HW, Cohen JB, Wofsy CB, French JF, Gill PS, Potterat JJ, Ravenholdt O, Sikes RE, Witte JJ. "Prostitution, IV drug use, and HIV infection in the United States." In MA Plant (ed.), *AIDS, drugs, and prostitution* (pp. 18-40). London: Routledge, 1990. See Also, Miller HG, Turner CF, Moses LE (eds.), *AIDS: The Second Decade*, Chapter 4, "Interventions for Female Prostitutes," (pp. 253-288). Washington, DC: National Academy Press, 1990.

⁴ Overs C, Longo L, *Making Sex Work Safe*. London: Network of Sex Work Projects and AHRTAG, 1997.

⁵ See, Alexander P, "Sex Workers Fight Against AIDS: An International Perspective." In BE Schneider, NE Stoller (eds.), *Women Resisting AIDS: Feminist Strategies of Empowerment*. Philadelphia: Temple University Press, 1995.

develop their own programs and/or have been hired to run mainstream institutions' programs. This demonstrates another contribution sex workers can make to the struggle to slow the spread of HIV infection—as educators for the general public.

A second basic principle underlying effective sex work-related interventions is a recognition of prostitution as work, and the development of goals and objectives related to occupational safety and health. Australia and the Netherlands are currently in the process of developing the first occupational safety and health regulations for sex work establishments (e.g., brothels, parlors, clubs). In addition, the sex workers' organizations in Australia have been able to act as Employee Assistance Programs (EPA) in assisting sex workers with problems not directly related to their work, such as drug-related services and child care. The two U.S. projects discussed above, CAL-PEP and FROST'D, have also worked within an occupational safety and EPA framework, bringing services to sex workers on the street via mobile units, and focusing on community organizing strategies through peer education and organizing.

Sex workers should be involved at the planning level, as well. The Centers for Disease Control and Prevention funds HIV/AIDS Prevention Planning Groups (PPG) at the state and local level. As cities and states develop these plans for their communities, it is essential that they recruit sex workers to serve on the PPG, specifically include sex work in their planning, and involve sex workers in the identification of effective strategies.

Useful Project Components

Specific HIV/AIDS and STD prevention interventions are most effective if they are embedded in projects that meet a range of sex workers' needs and interests. Those interests will vary according to the geographic area in which sex workers work, their income level, the stability of their lives, and the level of their drug use. It is important to recognize that all new sex workers would benefit from HIV/AIDS and STD prevention education, as well as training in efficient ways to work that minimize physical and emotional stress. This is true whether the work site is in a brothel, massage parlor, a worker's own apartment, on the street, or facilitated through an escort service.

For off-street workers, professional associations or guilds (e.g., the Cyprian Guild, in San Francisco), sex workers' rights organizations (e.g., PONY, in New York, COYOTE, in San Francisco, Seattle, and Los Angeles), and unions (e.g., the strippers' local in the Service Employees International Union (SEIU), in San Francisco, the sex workers' local in the Australian Liquor, Hospitality, and Miscellaneous Workers Union (LHMU), in the State of Victoria, Australia), serve an important function in providing support related to working conditions, which in turn has a big impact on the workers' risk of HIV/AIDS and STDs.

For street-based workers, street outreach projects (e.g., CAL-PEP, FROST'D, New York Peer AIDS Educators) and drop-in centers (e.g., STELLA, in Montreal, Maggie's, in Toronto, the Lower East Side Needle Exchange and the Positive Health Project, in New York) may be more effective. The most effective of these projects integrate HIV/AIDS and STD prevention education into programs that offer food, clothing, sleeping bags, showers, laundry facilities, hygiene kits, and other tangibles, in addition to counseling, case management, and either direct provision of, or referral to specialized agencies that provide, legal services, housing, health care, drug detox, methadone, and/or drug treatment/ rehab services, with the caveat that such services must be accepting of, or at least non-judgmental about, sex work. In addition, some projects have developed income-generating projects (e.g., EMPOWER, in Thailand) that enable sex workers to supplement their sex work-related earnings, and also to maintain a connection to a more mainstream employment option. As discussed above, many such projects, whether run by sex workers themselves or by "squares," have recruited sex workers as interns and/or peer educators, for other paid positions in the agency, and/or to serve on the Board of Directors.

FROST'D ~ FROM OUR STREETS WITH DIGNITY

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JOYCE I. WALLACE, M.D., F.A.C.P.
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Statement by Joyce I. Wallace, M.D., F.A.C.P.
Washington, DC, 5 November 1997

I believe I have the credentials to advise on this issue as I was the first person in the world to look for AIDS in women, and I have been working with street walkers in regards to AIDS since 1982. In the United States there is no substantial problem of female sex workers transmitting AIDS to their clients, as indicated by the continued low number of adult males diagnosed with AIDS who claim sex with a female sex worker as their only risk factor. Certainly all the data I have seen including my own agrees. I do feel that there is more of a problem of sex workers getting AIDS from clients. Our research, which I am enclosing, verifies this. In particular, women who perform fellatio at work more often than vaginal sex are at greater risk of contracting AIDS.

The greatest problem we have found in New York City in working with streetwalkers is that half of them are homeless and have no resources whatsoever. They do not know how to access welfare, and when they do, they find that it is insufficient for housing. The allowance for housing in NYC for a single adult is \$219/month. We know of no place that can be rented for \$219/month in NYC. This means that those who are not affected by HIV have virtually no chance of getting off the streets. Those who do show antibodies to HIV and are sick can become clients of the Division of AIDS Services and Income Support (DASIS). This agency offers people enough so that they may live safely, and not have to continue to work on the streets. However those who do not meet the federal definition for AIDS cannot become DASIS clients, and they are only able to learn that there are rent subsidies available if they are helped by an advocate.

When we find HIV positive women who are still working because they have not become DASIS clients we do two things: Firstly, we work to insure that they become DASIS clients and my being a medical doctor helps us complete the necessary form (M 11 Q) quickly. Secondly,

we make sure that the client always has ample condoms so that they can never be accused of knowingly spreading a disease. We expect to distribute 600,000 condoms this year. This policy has worked! In 1989 37% of clients were HIV positive. The prevalence now is 18%.

Prevention via education and condoms works.

The big problem is with the women who are uninfected! They have no where to go to try and live a life off the streets. We can get an infected woman off the streets in 24 to 48 hours because of the policy to house homeless people with AIDS immediately. This is not always a perfect solution since they are sometimes placed in Single Room Occupancies (SRO's) where there are unsafe conditions. Usually when men find out that a woman has been a prostitute they think that she is public property and it becomes unsafe for her.

However, NYC DASIS is contracting with many agencies such as ourselves to provide better transitional supported housing and permanent housing. It would not seem that HIV infected people could be less of a problem than HIV negative!, but, that is the case. Our agency has tried three times to open housing for uninfected ex-prostitutes. The first time was on the Lower East Side of Manhattan. We designed a project that was extremely cost effective and had a very good chance of being funded by HUD. Unfortunately people in the community said that there were no prostitutes in their neighborhood (the site of one of the city's major stroll districts) and a small organization called the East Side Chamber of Commerce wrote to HUD not to fund us. The project's NYS Division of Substance Abuse component, a drop-in center, was killed by the speaker of the House of New York State who is the Assemblyman from that district. Having powerful politicians responding to the requests of a few hostile constituents has the effect that projects cannot be sited anywhere.

The cost effective program we were proposing would have had a drop-in center on one floor and two floors of rooms transitional housing for prostitutes beginning the shift out of sex work. Women dropping in for services, including counseling, a hot meal, a shower, a talk with a social worker, could have learned that should they want to get off the street there was a comfortable room for them, providing they abide by the rules. The rules would serve to decrease drug use with help from a program and to enable them to enter into vocational training. Women could live with us till they had accumulated enough money to pay for an apartment with a

month's rent in advance and a month's security. This is a way to learn that step by step a person can achieve and in so doing, think better of themselves.

At any rate, the project was killed on the Lower East Side; moreover, the idea that there was no problem with prostitutes was belied by the fact that Joel Rivkin tortured and killed seventeen women from that same area two years later.

We then tried to develop a facility on West 12th Street in response to a New York City RFP for shelters. The plan was to shelter 12 women in the house while they were in school. The neighbors reacted as if life as we know it will end. It is this NIMBY that has killed many of our proposals, as well as many other organization's projects. We later tried to apply to do this under the HUD SUPER NOFA . But the people who thought they know what the needs were in NYC and screened the proposals did not submit our proposal. This is unfortunate. It is also a case where it would be better to bypass local politics. To have a shelter, a home for ex-prostitutes is relatively inexpensive, but cannot be run on the monies that the Human Resource Administration pays. We cannot house, feed, and supervise women for food stamps and \$219 per month.

To reiterate, one way to help women who are basically without any resources who work selling vaginal or oral sex on the streets of New York is to provide them with an alternative. At least half of these women are homeless and are just doing this to survive. Were they tougher they might be drug pushers, were they quicker, they might be thieves. When they're relatively nice and socialized they end up as hookers. I would remind this body that the term hooker derives from General Joseph Hooker who requested that prostitutes follow his troops in the Civil War.

Other factors that affect street walkers that could decrease the chance of their contracting AIDS have to do with the attitudes of police. They say they are sweeping the streets as if describing debris, not people. The police often ask for sexual favors when the women are helpless, their captives. They sometimes confiscate condoms. We need to build these women's self-esteem not break them down. New York especially has a problem because young women who are sexually abused or physically abused in their "homes" migrate to the city. Sociological studies have shown that between thirty and seventy percent of sex workers have a history of childhood sexual abuse (and/or were physically abused or neglected). As the women tell us, they might as well get paid for what they were forced to do at home. As prostitutes, they feel

somewhat more control over their lives, even though this is an illusion. After all, the next "john" could have the Jack the Ripper complex. What we need to do is provide a place where women can feel they have rights--a right to live, a right to eat, and a right to education, and we can allow them to exercise these rights. By saying this I am not saying that women who are sex workers should be castigated in any way. I have no fervor for the conversion of sex workers. There are many who have made a conscious decision to do this work, work in a professional manner, and pose little harm to themselves or disruption to the community. I know that many of the woman I work with started on the streets before they became addicts, but the constant risk of violence and arrest, and the rigors of street life forced the need for numbness. Others began as drug users, and had no choice because of the need for money to pay for their drug needs. In any case, for those who want out, especially those who are the most vulnerable to HIV and AIDS, we do not yet have enough ways out.

Enclosed:

Letter from JAPHA
Statistics about decrease of HIV seroprevalence
Abstracts, APHA Conference, November 1996

Women Resisting AIDS

Feminist Strategies of Empowerment

BY

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Sex Workers Fight Against AIDS: An International Perspective

Conceptualizations of "prostitution" and "the prostitute"¹ are likely to affect the way societies respond to prostitution in the context of AIDS. This paper discusses two distinct societal responses: the traditional STD-control model and a newer, community-based organizing model which comes directly from the work of prostitutes. Both responses are born in and affect discourses on prostitution, sexuality, and disease. The paper examines how the discourse is changing as a result of prostitutes' active involvement in the struggle to prevent the spread of this tragic disease. My thinking in this paper is the result of 17 years of research and activism in the prostitutes' rights movement, initially in the United States but, since 1986, increasingly on an international level.

CONCEPTUALIZATIONS OF "THE PROSTITUTE"

The nature of the discourse on prostitution has a profound effect on both the form and the outcome of AIDS prevention interventions, and thus on the course of AIDS. For most of recorded history, societies have defined prostitutes, culturally and through systems of law, as "other," a group often considered necessary for the functioning of society, but one that must be kept apart. Whether the legislative body was religious or civil, governments have often confined prostitutes to certain streets, held them within locked buildings or districts, or outlawed them altogether. During some periods of history, civic leaders have required prostitutes to wear special clothing or marks, whereas in other periods, they have castigated them for the clothes they wore.

Within any culture, religious and political authorities have used the concept of "other" to divide the "good woman," from the "bad." The whore is counterposed to the chaste wife and mother.² Deep-seated prejudices distinguish the black, Asian, or Jewish woman from the white or Christian. Defining the prostitute as "other," military victors have forced women

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captured from conquered and occupied towns or countries to work in brothels, both to "protect" their own country's women and to provide "variety" for their men.³

On the other hand, prostitutes have taken advantage of some forms of "otherness" to mask their stigmatized labor. For example, although for the last several thousand years many women have been forced to work in wartime brothels, some have volunteered, to avoid starvation or other consequences of war, to escape from their families or traditions, or even for less desperate reasons. For centuries, women have migrated from rural communities, where their activities (whether as prostitutes or as nonconforming sexual beings) would be more likely to be observed and commented upon, to cities that provide anonymity and privacy or to other countries where the traditional cultural norms mean less to them. To the extent that prostitutes are rebels against their societies' expectations regarding female sexual and other behavior, this "otherness" can provide the space for an independent and productive life.⁴ There is a difference, however, between prostitutes' manipulating "otherness" to protect themselves and policy makers' justifying repressive measures on the basis of prostitutes' "otherness."

In the context of AIDS, numerous writers in both the medical and the mainstream press have continued to perceive and describe prostitutes as a class with objectifying language (for example, as members of a "core group or high-frequency transmitters,"⁵ as "promiscuous," and as "reservoirs" or "pools of contagion").⁶ These terms have colored the way health care practitioners provide services, especially those related to sexually transmitted diseases (STDs), to women who identify themselves, or are perceived to be, prostitutes. Policy makers who think of themselves as "subject" and of prostitutes as "object" or "other" are likely to try to increase the state's control over "them," in order to protect the clients (who they *may* perceive to be more like themselves, even though such identification may cross class, nationality, and racial lines). They are much less likely to support or strengthen prostitutes' ability to protect themselves, for example, by controlling their working conditions. Such efforts to control the prostitute are, in turn, likely to increase the marginalization of prostitutes and to drive the world in which they operate underground, away from health promotion interventions.

A second, related conceptualization is the common perception of female prostitutes as intrinsically dirty and diseased. For example, clients commonly equate sex with prostitutes as "dirty" and therefore somehow more exciting. It is through this ideological equation of prostitutes with dirt and contagion that policy makers, novelists, journalists, medical writers, and others assume that prostitutes are, by definition, responsible for virtually all sexually transmitted diseases, including AIDS.⁷ In a rather bizarre twist, however, in countries where prostitutes are required by law to have regular

examinations for STD, often including HIV, clients may resist using condoms, justifying their refusal by saying that they know the prostitute is "clean" (that is, has been purified by the clean medical profession).

ONE OPTION, ONE DISCOURSE: THE REGLEMENTORY RESPONSE

The first thing that policy makers, sometimes including public health officials, tend to do in response to the spread of STD is to try to identify all infected prostitutes, treat those infections that are treatable, and bar prostitutes from working while infected. Although such programs could benefit prostitutes (if they reduced the duration of treatable infections and thus the incidence of complications), the primary agenda behind such schemes has always been, and continues to be, to protect the client. Since the current AIDS context is not the first time public officials have tried to control the spread of STD by controlling prostitutes, it may be useful to examine the historic record of such approaches.

The Historical Record

In the nineteenth and early twentieth centuries, governments in England, France, and the United States experimented with various control measures focusing on the prostitute. In 1864, England enacted the Contagious Diseases Acts, authorizing the police in some cities to take any woman suspected of being a prostitute to a special hospital ward, have her examined for sexually transmitted diseases, and, if she was found to be infected, keep her there until the infection was "cured" or, what is more likely, the visible signs of infection disappeared. The legislation made no reference to the clients, who were primarily sailors and other seamen who had sex with, and sometimes infected, prostitutes during their shore leave. The police often arrested women who were not actually engaging in prostitution, but who lived or worked in the same neighborhoods. Feminists became alarmed and objected to the system's stigmatization of working-class women. Led by Josephine Butler, they organized an effective campaign to overturn the Acts.⁸

In the nineteenth century, France established a formal *reglementation* system which required street prostitutes and women who worked in brothels to register with special health centers and report regularly to be examined for syphilis and gonorrhea. Feminists opposed this system as well, arguing that, by institutionalizing prostitution, the regulations kept women trapped in what was, to the feminists, an unacceptable profession. Nonetheless, the system continued to operate until it was dismantled after World War II.⁹ Under both schemes, many if not most prostitutes went to great lengths to avoid being identified and registered, preferring to remain "clandestine," a term that continues to be used to refer to the majority of prostitutes who work outside such registration schemes where they exist.

In the United States during the nineteenth and early twentieth centuries, many cities established or permitted zones of toleration where brothels flourished (New Orleans' Storyville, San Francisco's Barbary Coast). The one formal effort modeled after the French reglementation system, in St. Louis in 1872, was stopped very quickly, again in response to community outrage about the institutionalization of prostitution.¹⁰ After the turn of the century, in the period prior to World War I, many cities tried to control STD by closing brothels and brothel districts.¹¹ When that failed to end either prostitution or STD, one state after another enacted legislation prohibiting prostitution.¹² Although legislators and other officials often used feminists' concerns about "white slavery" to justify their actions, they were in fact responding more to pressure from a military concerned about the potential impact of venereal diseases on the ability to mobilize for the coming war. Of course, Prohibition also failed to reduce the prevalence of STD (which rose slightly), and prostitution continued to flourish underground. As brothels were closed, prostitutes worked increasingly on the street, where, as a result of the increased need to be furtive and to negotiate quickly to avoid coming to the attention of police, they were less able to evaluate the health status of their clients or to insist on condoms or other disease or pregnancy prevention practices (such as vaginal sponges soaked in lemon juice). Closing the brothels also significantly interfered with the women's ability to collaborate to protect themselves from STD, pregnancy, and especially violence, forcing them to rely increasingly on men to protect them.

The Response to AIDS

From the first moment that epidemiologists realized that AIDS might be a sexually transmitted disease, they singled out prostitutes as the primary source of infection. However, men who have sex with prostitutes usually have other nonmarital partners as well. It is often only the assumption that prostitutes are diseased that produces the conclusion that men with HIV who report having had sex with both prostitutes and nonprostitutes could only have become infected through their contact with a prostitute.¹³ Moreover, due to the repression of homosexuality in most societies, married men diagnosed with HIV or other STD often claim contact with a female prostitute as "the source," as such behavior is less stigmatized than either homosexuality or injection drug use.¹⁴

Many countries have enacted new laws or added provisions to existing STD laws, requiring all prostitutes to be tested for HIV infection. The tests are done either following an arrest or a conviction, in countries where prostitution is illegal,¹⁵ or as part of a compulsory registration system. By 1989, mandatory testing of prostitutes was in place in 13 states in the United States,¹⁶ including Nevada, which tests both legal prostitutes, working in brothels, and those who work illegally everywhere else. Sweden, Austria, and Germany, where prostitution is legal in some circumstances, require

registered prostitutes to be screened regularly for HIV infection. Sweden quarantined at least one woman who continued to work after testing positive, although no effort was made to determine whether she actually engaged in high-risk practices.¹⁷

In Asia, several countries have mandatory registration and examination schemes, often tied to carefully carved out exceptions to the prohibition of prostitution (entertainment or hospitality workers). In Thailand, for example, women who work in bars, nightclubs, and brothels must register and have a current health card showing that they have had a recent test. When women test positive for HIV or other STD, the clinics withhold their certificates and tell the women not to work until the infection has cleared up. If women test positive for HIV infection, they are told to stop working permanently, although, with few economic alternatives, it is questionable how many can afford to stop working as prostitutes.¹⁸ Some merely move on to another city and work until they are again examined, after which they may move on again. In any case, the highest rates of infection are among women working in low-income brothels catering to local clients. Many of them are young, working to pay off debt bondage agreements for their families; increasingly they come from the hill tribes that live across the Myanmar border. In 1992, there were widespread reports that the Thai government deported some Burmese women after they tested positive and that the Myanmar police executed them when they returned to their own country.¹⁹

In the Philippines, women who work in bars and nightclubs serving the U.S. military bases are more likely to register than women working for establishments patronized by Filipino clients.²⁰ In Singapore, women who work for bars and brothels, most of whom are immigrants with temporary visas, register, whereas at least an equal number of women who work for massage parlors do not.²¹ Indonesia requires prostitutes to register and to receive what is called "prophylactic" treatment, whether or not they have a diagnosed STD—although anecdotal reports suggest that fewer than 30 percent of prostitutes actually register.²²

After finding high rates of infection among women who live and work in brothels catering to local clients in Madras, New Delhi, and, most alarmingly, in Bombay (where more than 70 percent of over 700 women who had been arrested, taken to Madras, jailed, and forcibly tested, were infected), India's first official response was to call for mandatory testing and the arrest and incarceration of women who continued to work after testing positive.²³

In Latin America, several countries, including Peru and Uruguay, have long-established registration systems, particularly for brothel workers. In Mexico, one project established its own registration system, providing health certificates to women who registered with their project.²⁴

Although the authors of papers reporting on registration schemes often claim that registered prostitutes have less STD than unregistered or clandestine workers,²⁵ and therefore recommend the approach, such claims may not

have much meaning. For example, in Indonesia, although the government claims that registered prostitutes have lower rates of STD than unregistered workers, anecdotal reports suggest that the opposite is true, despite the mass treatment.²⁶ The unregistered prostitutes in Singapore have lower rates of STD, perhaps because they rarely provide more than a hand-job, while the registered prostitutes usually engage in vaginal sex, often without condoms, despite their regular contact with health care workers.²⁷

In virtually all registration systems, the majority of prostitutes resist being registered and in many cases avoid STD clinics in order not to come to the attention of the officials who are supposed to register them. For example, in Nevada, approximately 350 women who work in legal brothels are registered and regularly screened for gonorrhea, syphilis, and HIV, whereas an estimated 3,000 continue to work illegally, being tested only if and when they are arrested.²⁸ In Athens, about 350 of an estimated 3,350 women were registered after they were arrested.²⁹ In Dakar, Senegal, 800 to 900 out of an estimated 16,000 female prostitutes are registered.³⁰ This is true even where registration is backed up by the threat of arrest.³¹

Prostitutes resist registration for a variety of reasons, always including the refusal to be officially identified as a prostitute because of the lifelong stigma associated with the label. Since the repercussions of being registered are the same as those resulting from being arrested and jailed for prostitution—for example, the loss of one's children, eviction from one's home, and denial of the right to international travel—most women prefer to take the chance that they will not be caught. Thus, the category of "clandestine prostitute" remains vast, its members beyond the reach of researchers, and data on their STD unavailable, while the authorities delude themselves that they are in control.

Shifting the Focus from Control to Prevention: An Ideological Debate?

Many voices are calling for increased medical interventions, with a little education on the side, to "control" STD, rather than the intensive behavioral change interventions needed to prevent it. This agenda is part of an increasing medicalization of AIDS prevention. However, AIDS is only one STD, and not the only one that is either barely treatable or not treatable at all. The mortality rate may be more devastating, but for the individual woman who dies of preventable cervical cancer, the devastation is just as great. The only sure way to stop the spread of sexually transmitted diseases is to prevent them from occurring in the first place. By the time any individual's STD is diagnosed and treated, he or she can already have given it to others, unless the behavior that permitted the initial infection is changed. Better diagnostic and treatment protocols, after the fact, will not stop the spread of HIV, herpes, or human papilloma virus.

Better and more accessible provision of STD services might mean that

more people would get examined and treated. Good STD services are those provided by a nonjudgmental and compassionate staff, at convenient locations and times (not in the morning, when prostitutes are likely to be asleep), at affordable cost, providing accurate diagnoses and effective treatments matched to the diagnoses. However, several observers have told me about visiting STD clinics where prostitutes are examined on a kind of assembly line, with the speculum merely swished around a bit in a pail of water, possibly containing some disinfectant, between examinations.

It is not that providing STD services for prostitutes is a bad idea in itself. In fact, most prostitutes prefer to be examined on a more or less regular basis, for their own peace of mind. One of the worst aspects of the current situation is that prostitutes, especially those who are women, are stigmatized, marginalized, and often denied adequate health care services through either neglect or hostility. It is important that a full range of health care services, including health care for their children and not just STD services, be made more accessible—and acceptable—to prostitutes.³² However, if they are to be examined with unsterile speculums, or injected with reused and unsterile syringes, advising prostitutes to be examined regularly for STD could actually increase their risk of a variety of STDs, and HIV.³³ There is a need for good epidemiological research to investigate the implications of the possible use of unsterile injection equipment, either in STD clinics in poor countries, where electricity is often unreliable, or in the highly popular but informal injection sites that are common in many countries where seroprevalence is high.

If the only reason for providing prostitutes with STD services is to protect others from them, nothing will change. Sex workers will continue to get the message that their lives are valued less than those of the heterosexual men they serve or their future children, and they will be reluctant to trust or participate in AIDS prevention interventions.

ANOTHER OPTION, ANOTHER DISCOURSE: COMMUNITY-BASED EDUCATION AND ORGANIZING

A second response to AIDS and other STDs, and one which is relatively new, emphasizes education and community organizing rather than medical examinations. In the context of prostitution, it means involving both sex workers and clients in efforts to change the community behavior norms in such a way as to reduce their vulnerability to HIV infection and other STD.

Some countries have been wary of establishing prostitutes' projects because of the legal status of prostitution. However, the reality is that, regardless of the laws, commercial sex occurs in every country and culture, its extent determined largely by economic forces, not by laws. No effort to eliminate prostitution has ever been successful, although the more repressive the system, the less safe are the working conditions and the more difficult it is to reach the workers or support their efforts to change their

behavior. However, it is possible to establish sex workers' projects no matter what the legal structure, and effective interventions have been established even where police harassment is extensive, as it is in the United States.

Despite the often-hostile legal situation, a number of community-based projects were developed in both industrial and developing countries in the mid-1980s, some by existing prostitutes' organizations, others by new organizations formed for that purpose. As a result of the success of some of the early projects, governments, international donor organizations, and private foundations are increasingly providing support to similar projects around the world, facilitating the diffusion of a new approach. Many countries have now established voluntary interventions targeting sex workers which focus on helping the prostitutes protect themselves from HIV infection. Some of the best-received intervention projects were developed by sex workers' organizations, and others have employed current and former sex workers to both participate in the design of the projects and provide the outreach and education.

Sex workers' involvement is crucial because, in any country, they know more about the industry than any outsider.³⁴ Moreover, they can take advantage of their knowledge of human, and especially male, sexuality to overcome resistance to condom use, whether by other sex workers, by managers, or by clients. As workers on the front lines, prostitutes know best the obstacles to behavioral change, whether it is the frequency with which police confiscate or damage condoms; sex workers' belief that ingesting semen keeps one young, healthy, and attractive³⁵; managers' fear of lost business; or clients' belief that health certificates guarantee noninfection.

Prostitutes Respond: In the United States

As soon as it became clear that AIDS might be sexually transmitted, COYOTE,³⁶ the prostitutes' rights organization based in San Francisco, began to advise prostitutes to use condoms to protect themselves. At its 1985 national convention, COYOTE adopted several resolutions dealing with AIDS. At the same time, the organization began providing technical assistance to Project AWARE, a research project looking at women's risk for AIDS. This study charted new territory by involving prostitutes in the development and implementation of the study, including hiring prostitutes as interviewers and as participants in analyzing the results. As the study got underway, it became clear that police often confiscated condoms when arresting prostitutes, or punctured holes in them and gave them back. In 1986, COYOTE, AWARE, and several other community agencies met with police representatives and convinced them to stop confiscating condoms and bleach containers as evidence of intent to commit prostitution.³⁷

In 1987, members of COYOTE formed the California Prostitutes' Education Project (CAL-PEP), in order to accept a government grant to do outreach

and education to street prostitutes. CAL-PEP's basic premise was that, as experts on sex work, prostitutes are the best people to serve as educators and role models for other prostitutes and to begin the process of changing the norms of sex work practices to ensure safety for both prostitutes and clients. As a result, a majority of both the staff and the governing board were current or former sex workers. The project used a combination of face-to-face street outreach and education, during which peer educators distributed both condoms and small bottles of bleach, and more-or-less-monthly workshops which permitted more in-depth discussions. In 1989, with its first private foundation grant, CAL-PEP purchased a large camping van to use as a mobile unit, to bring peer educators, condoms, and a private space for counseling (and health care provided by Project AWARE) to women on the stroll.³⁸

During that same period, the Whitman-Walker Clinic, in Washington, D.C., a gay men's health organization, initiated the AORTA Project to do outreach to female and male injection drug users, including those who were prostitutes. Most of the outreach workers were former (and sometimes current) prostitutes or injection drug users, or both. The project developed some innovative approaches to ongoing training and support for street outreach workers in order to reduce the high turnover common to such projects.

By 1989, the strategy of prostitutes' serving as peer educators was well established in the United States, and similar projects operated often with government funds, in a number of cities, including Boston, Denver, Honolulu, Los Angeles,³⁹ New York, and Phoenix.

Prostitutes Respond: Around the World

By October 1986, when the International Committee for Prostitutes' Rights (ICPR) organized the Second World Whores' Congress, in Brussels, Belgium,⁴⁰ prostitutes and prostitutes' rights organizations in many countries were heavily involved in the fight against AIDS.

As early as 1985, the already-existing Australian Prostitutes Collective (APC), in Sydney, and the Prostitutes Collective of Victoria (PCV), both of which had been formed and coordinated by a coalition of current and former prostitutes and nonsex-worker allies, received government funding to establish sex workers' AIDS prevention projects. They provided a range of services, including legal assistance, referrals to decent health care providers and drug treatment agencies, and distribution of sterile injection equipment, as well as emotional and sometimes practical support.

An innovative and widely imitated component of the Australian strategy was what they called a "Safe House Endorsement" scheme. The collectives held meetings with owners and managers of brothels and other sex establishments, to convince them it was in their self-interest to support the routine use

of condoms in their establishments. To reward those businesses that both agreed to an all-condom policy and had relatively decent working conditions, they issued Safe House Endorsement stickers and camera-ready logos that the businesses could use in their advertisements. Although this strategy became unnecessary as condom use became the norm in Australia, it has been adapted by a number of projects in other countries, because it was so effective in reducing the pressure on individual sex workers and businesses to forgo condoms in order to remain competitive.

Both collectives publish a magazine or newsletter containing articles by and about prostitutes, updated information about AIDS, and information about dangerous clients through an "Ugly Mug" list that enables prostitutes to inform their colleagues about uncooperative or dangerous clients. After the list was in existence for a while, the police began to take crimes reported by prostitutes more seriously and to step up prosecution efforts. This component has also been adopted by sex worker projects in a number of other countries.

By 1988, every state in Australia had at least one prostitutes' collective, funded by the government to do AIDS prevention work, with similar organizations in each state of New Zealand. At a national conference that year, the collectives founded the Scarlet Alliance to act as an umbrella organization. The alliance has played an important role in law reform efforts, as well as in facilitating communication between the state organizations, and has also begun collaborating with projects in Thailand, the Philippines, and Indonesia to exchange information and explore ways to help Southeast Asian women who migrate to work in Australia's sex industry to work safely.⁴¹

While COYOTE (funded by individual donations and volunteer labor) and CAL-PEP (with government and foundation funding) divided up the political and AIDS service tasks, the Australian organizations took the position that it is impossible to separate AIDS prevention from efforts to change the prostitution laws. In fact, most states in Australia are reviewing and modifying their laws in rational ways. At the time of this writing, the Australian Capital Territory is considering legislation that would decriminalize all aspects of prostitution and extend standard occupational safety and health and other workplace regulations to cover sex work businesses. This stands in sharp contrast with the United States, which continues to use draconian methods.

In 1986, members of the Canadian Organization for the Rights of Prostitutes (CORP), in Toronto, formed the Prostitutes' Safe Sex Project (PSSP) and received funding to do a street outreach project. PSSP's policy was that it was important that most, if not all, outreach workers and educators be currently working prostitutes, to demonstrate that it was actually possible to change one's practices and continue working. They developed a variety of educational materials, including buttons that prostitutes (and their friends) could

wear with pride, bearing such slogans as "I'm a Safe Sex Pro." These have become popular with sex worker projects (and allies) in many countries. They also developed the first wallet-sized card that prostitutes could give to clients to convince them to use condoms, another approach that has been used by many projects.

Meanwhile, in Europe, prostitutes were actively involved in both research and interventions. For example, members of the Comitato per i Diritti Civili delle Prostitute collaborated with a number of research projects in northern Italy, and in 1986 the organization began publishing articles about AIDS and AIDS prevention in its newsletter. More recently, they have begun collaborating with a Dutch allies' organization, *de Graaf Stichting*, to study the impact of migration on sex workers' safety in both countries and to develop strategies to reach and involve the migrant workers, who are often the most vulnerable to arrest.

De Rode Draad,⁴² in the Netherlands, received funding from the government to work on a variety of issues affecting prostitutes, including AIDS prevention. As the most visible form of prostitution in the Netherlands is that involving storefronts, or windows, in red-light districts, the project developed a sticker promoting condom use, that women put on their windows to let clients know of the requirement to use condoms before negotiations begin. More recently, as the AIDS prevention work done by government agencies has proved to be appropriate and well accepted, *De Rode Draad* has shifted its focus back to the more overarching issue of prostitutes' rights and law reform.⁴³

A group of current and former prostitutes who worked on the design, implementation, and analysis of a university-based research project in Edinburgh,⁴⁴ eventually left the university to form Scot-PEP, an AIDS prevention and community support project. In addition to the traditional outreach, education, and condom and needle distribution, the project offers a part-time STD clinic and drop-in center. The coordinator of the project is also actively involved on the board of the International Coalition of AIDS Service Organizations (ICASO).

Aspasie,⁴⁵ in Geneva, Switzerland, opened a clinic for prostitutes in the primary sex work district, organized outreach, and published AIDS education materials, including a comic book and a magazine, *Mots de Passe*. Like *De Rode Draad*, they devised a condom promotion sticker whose design prostitutes have used in their ads, again to let clients know of the condom requirement before any contact is made.

One of the first projects in Africa to involve peer educators was started in Yaoundé, the capital city of Cameroon. Two physicians were approached by the health ministry and asked to start "something." As neither had any experience working with prostitutes, they were rather daunted at the prospect. However, when one began spending time talking to women working in the bars and hotels, he soon realized that they were ordinary

people and that he rather liked them. He identified a number of women who seemed to be natural leaders in the community, some of whom were already members of an informal network, and trained 20 of them to serve as peer educators. At first they met with their colleagues in bars and clubs, talking with them about AIDS prevention and teaching them how to use condoms properly. When the original grant for the project ran out, the women kept meeting, kept organizing, and eventually formed a theater group. The group, Les Amies de Douglas et Rose, developed and performs a play about women working in a bar, their relationships with clients and bar owners, and how they negotiate condom use with clients. The play is enormously popular, and the project has since expanded to several other cities in Cameroon.⁴⁶

In Calabar, Nigeria, a study of sex work-related behavior grew into a peer education project and has been organizing women who work in small hotels in Calabar and in larger hotels in the neighboring city of Ikom. Recognizing that AIDS is only one issue that affects sex workers, the project staff has also met with the police department to discuss problematic incidents between prostitutes and police, with a resulting decrease in the level of police harassment. In addition, they have worked to get better STD services for prostitutes.

When the project first began, many of the women expressed serious concerns about the potential loss of income if they rejected clients who offered them no protection. Many women felt that they were being exploited, and many of the women felt quite trapped. After some discussion, they decided, as a group, to raise their prices in order to make up for lost business, raising them again some months later. The project staff was able to convince the owners of the bars and hotels not to raise the room charges commensurately, thereby enabling the women to realize a greater share of the income from their work. As a result, many women began to feel much more in control and less helpless about their situations, and in some cases began to like their work. This kind of change is important if sex workers are to be able to protect themselves from AIDS. Because of the high rate of migration between Calabar and cities across the border in Cameroon, the projects in these two countries are hoping to work jointly to ensure that women in either country will be able to protect themselves and their partners from HIV infection.⁴⁷

In Bulawayo, Zimbabwe, what began as a study of both prostitutes and clients became a peer education project (with 48 trained peer educators, 38 women and 10 men). By mid-1992 it had expanded to four additional sites, and by the beginning of 1993, nine projects using the same model had been initiated in Zimbabwe, Namibia, and other countries in the same region. Using dance, drama, and music, like the Cameroon project, they have provided education, motivation, and condoms to some 15,000 sex workers in bars and hotels, as well as to clients in bars and at work sites that employ

large numbers of men. This addition of a client focus has been in response to the consistent complaint of prostitutes, in virtually every country in the world, that too many clients refuse to use condoms. Both the Nigerian and the Zimbabwean projects have focused on strengthening the skills of some of the peer educators, to enable them to take over control of the projects.⁴⁸

In Ethiopia, after the Department of AIDS Control discovered alarmingly high rates of HIV infection in a number of cities among groups of women who worked in bars and sometimes engaged in prostitution, they assigned two women to develop a community-organizing intervention. At that time, each city in Ethiopia had a formal network of neighborhood organizations (*kebeles*) that were involved in community development and health care projects. In a pilot project in Nazareth, about 60 miles from Addis Ababa, the neighborhood organizations in districts with large numbers of bars held meetings with women from each bar. They identified and trained women with leadership potential in each neighborhood to act as peer educators and to sell condoms to their coworkers at a low, subsidized price. During a preliminary evaluation of the project's impact, 81 percent of the prostitutes interviewed said that they used condoms with their clients. What was striking about the women's reports was the reasons they cited for using condoms: they felt cleaner, they noticed that they had fewer episodes of STD, and the condoms meant they could stop taking birth control pills, which had made them feel ill.⁴⁹ The project is being expanded to some 23 cities in other parts of the country. Since the change in government has resulted in the disbanding of the kebele structure, the coordinators of the project have encouraged cities to identify particularly effective peer educators and hire them to take on some of the local coordination of the projects.

In Latin America, the prostitutes' rights organization Prostitution and Civil Rights,⁵⁰ in Rio de Janeiro, Brazil, developed educational materials, including one of the first *fotonovelas* for female prostitutes and two comic books aimed at male hustlers and transvestite prostitutes, respectively, before they had identified a reliable source of funding. The organization also developed guidelines for physicians on how to provide good health care for sex workers. By 1990, they had received sufficient funds to launch an educational outreach and condom distribution in several districts in Rio. In Uruguay, the Asociacion Meretrices Publicas del Uruguay (AMEPU), which has more than 300 members, operates a residence for prostitutes with AIDS and other life-threatening illnesses and publishes a newsletter containing writings on a variety of issues, including information about AIDS and AIDS prevention.⁵¹

In Nicaragua, a community-based AIDS organization, Fundacion Nimehuatzin, involved prostitutes in the development of locally relevant strategies. These include pressuring sex work hotels to provide condoms in guest rooms and providing prostitute-sensitive STD services in several cities. When the project staff realized that the closing of the brothels several years

earlier had increased the danger and isolation of prostitutes' work, they began helping women to develop *cooperativas* to increase their control over their working conditions, including keeping a larger share of the income.⁵²

One of the oldest projects in Asia is EMPOWER, in Thailand. EMPOWER is a community development organization that was originally formed to help female prostitutes find other occupations. However, they soon realized that not all prostitutes wanted to change occupations, and that even for those who did, it was not always possible to find other ways to make a living. Therefore, they felt it was important to improve prostitutes' living conditions even while they continued to work in the sex industry. As a result, EMPOWER began providing English lessons for the women who worked in the bars and nightclubs of the Pattpong district of Bangkok, so that they could negotiate more effectively with their clients. When the first cases of AIDS were diagnosed in Thailand, EMPOWER recognized the importance of adding AIDS prevention activities to its agenda.

EMPOWER, which now has four branch offices in different parts of the country, supports women who work in the sex tourism sectors and who have Thai clients. It is staffed by a combination of prostitutes and nonprostitutes and is becoming increasingly involved in representing the full range of prostitutes' concerns. For example, the organization has begun providing information to women who are thinking of migrating to other countries—about working conditions, immigration laws, and strategies for getting help if conditions are not as good as they seem. It also provides legal assistance, which can provide legal assistance to migrant prostitutes.⁵³

Many organizations that originally were formed to fight "trafficking in women" quickly recognized that the problems they faced were not simply those of women victimized by "traffickers." Often women migrate with the conscious intent to work as prostitutes in the host country, as a way to improve their own economic status or to help their families at home. However, the laws against prostitution, as well as limits on legal immigration, leave them extremely vulnerable to serious economic exploitation, unsafe working conditions, and physical abuse. Thus, such organizations as Vrouwenhandel Stichting in the Netherlands and Amnesty for Women in Germany are increasingly focusing on the same work-related issues as do prostitutes' rights organizations.⁵⁴

Talikala,⁵⁵ a sex worker-initiated project in Davao City, Philippines, has been providing AIDS seminars to hospitality workers, both male and female, in the context of a broader range of services, such as financial assistance to women who are unable to work because they have an STD. Among other things, they publish a journal with articles by and about the lives of the women affected by their project. There are two other projects in the Philippines, both of which have focused on finding ways to strengthen sex workers' ability to control their working conditions, Kabalikang Pamilyang Pilipino Foundation, in Metro Manila, and a project based in the City Health

Department in Olongapo/Angeles City. Although most of the international spotlight on prostitution in the Philippines and Thailand has focused on sex tourism, most prostitution in fact involves local men, who are much less willing to use condoms than tourists. Although HIV prevalence remains quite low in the Philippines, some groups of prostitutes have a high rate of other STD, which means that they are vulnerable to HIV infection.⁵⁶

In India, some of the first projects that worked with prostitutes did little more than test them for HIV infection. Unfortunately, in some cases, the spokespersons for these projects felt it necessary to publicly announce when they found someone who tested positive and, in at least one case, to identify a brothel as an "AIDS house." Thus, when other projects tried to arrange to offer AIDS education sessions in brothels, they were initially met with distrust. At least two projects, one in Madras and another in New Delhi, were able to overcome this distrust and to begin organizing the women in working-class brothels to adopt the practice of using condoms on a communitywide basis. However, the Madras project found that working with the women was not sufficient, because of client resistance. Therefore, they began holding educational sessions at truck stops and other gathering places for groups of men.⁵⁷

In all of these projects, prostitutes have played a central role. Most projects have found themselves focusing on more than just the promotion of condom use and other safe-sex practices. They have dealt with police problems, put pressure on the health care system to provide better services and to treat prostitutes with more respect, and helped the women to establish community-based self-help and self-advocacy organizations. In 1991, representatives of sex work projects decided to form a Network of Sex Work-related HIV/AIDS Projects, in order to facilitate the sharing of information, strategies, and other ideas between projects around the world, especially in developing countries. In conjunction with the 8th International Conference on AIDS in Amsterdam in July 1992, the network organized a one-day meeting of representatives of sex work projects from around the world, as well as a three-session minicourse on sex work-related issues; both were well attended. At the time of this writing, they are working on the first issue of a newsletter and collaborating with local sex work projects to organize similar satellite meetings in conjunction with regional AIDS conferences.⁵⁸ They also plan to develop ethical guidelines for research involving prostitutes and to review the ethics of existing research.

TARGETING CLIENTS: THE NEXT STEP

All over the world, the most consistent obstacle to the use of condoms in sex work is client resistance, and it is clear that condom promotion efforts that target only sex workers, and not clients, will be only partially successful.⁵⁹ That is, if only the prostitute half of the prostitution dyad is educated, some

clients will continue to offer more money not to use condoms or to boycott sex workers who insist on safer sex practices. By 1989, only a small number of projects reported singling out clients for education efforts,⁶⁰ and even then, the first instinct for some was to say to clients, "Don't have sex with prostitutes."⁶¹ The result of such an approach is equivocal, at best, if it depresses the market and leaves sex workers increasingly vulnerable to clients who offer extra money to engage in unprotected sex. A more positive approach is that of a Dutch project, Men in Prostitution, started by a small group of men who were sex work clients. Essentially, their strategy is to have clients approach other clients in the legal red-light districts, handing them condoms and providing them with safe-sex information.⁶²

The number of sex work projects that recognize the need to educate clients is slowly increasing, particularly in developing countries, and more of them have begun to do outreach to and hold workshops for clients in bars, at truck stops, and at companies that employ large numbers of men, such as factories and trucking companies. In Ethiopia, the Department of AIDS Control developed a client project after prostitutes complained about client resistance. They identified and trained men to serve as peer educators and motivators in their workplaces, as well as to sell condoms at a low, subsidized cost. They also held major condom promotion events at sports stadiums and other public locations.⁶³ In Kenya, Tanzania,⁶⁴ Nigeria, and India, intervention projects are focusing on both truckdrivers and the people who provide a variety of services at truck stops. In some cases, as the project staff spends informal time with the target audiences, they are learning that there is more variety to the transactions involved in sex work than traditional KABB studies have identified (not everyone does only vaginal sex, and in some sites, homosexual as well as heterosexual prostitution takes place).⁶⁵

Projects that have targeted clients and men likely to be clients, have found that such targeting makes a difference. For example, prostitutes in Benin reported that client resistance to condom use declined after a condom promotion campaign began to be aired on the radio.⁶⁶ In Ethiopia, when the project approached prostitutes first, the women complained about client resistance. However, when the project started out by targeting men in their workplaces and then later approached prostitutes, the women were happy to take the condoms, saying that their clients had been asking for them and sometimes bringing their own.⁶⁷ Although the evidence is still somewhat spotty, it suggests that it is not as difficult to convince heterosexual men to modify their behavior as it once seemed. For example, in Switzerland, which has had a continuous, highly visible, and entertaining condom promotion involving billboards, commercials in movie houses, and television, more than 60 percent of 17- to 30-year-olds in 1990 reported using condoms some or all of the time with casual partners, compared with less than 35 percent in 1987.⁶⁸

CONCLUSION: WHAT DOES IT ALL MEAN?

An important result of sex work-related projects and of the active role prostitutes have been playing in AIDS prevention campaigns on every continent, is the beginning of changes in the discourse around the issue of prostitution and disease. Whereas the first reports of interventions were framed in the context of protecting clients, now the focus is increasingly on the need to organize prostitutes in their own interest. Similarly, whereas the early viewpoints tended to focus only on the prostitutes' role, most projects today are increasingly stressing the importance of educating clients and men likely to be clients. Increasing attention is also being paid to the owners and managers of sex work-related businesses, so that the task of preventing the spread of this disease can be shared by all the players.

Perhaps the most important result is that, as governments have begun funding prostitutes' organizations and other organizations that give voice to prostitutes, the sex workers' point of view is gaining prominence. In other words, the concept that prostitutes have the right to be protected from disease—by routine condom use, by safe and clean working conditions—is beginning to supplant the age-old idea that it is only the health of clients (and their "innocent" wives and girlfriends) that matters.

However, prostitution remains almost universally illegal and tightly regulated, even if the enforcement of the laws varies considerably from place to place. The result of regulation—which is particularly severe in the United States, is a perpetuation of the stigma and intimidation of those prostitutes who want to work for change but are threatened with arrest if they go public. In addition, the stigma of being a "whore" compounds the already existing stigma of being female and conflicts with the need for the approval of men, on whom most women depend for survival. AIDS and the money that has been available for projects for prostitutes have created an opportunity for change.

Major modifications of sexual behavior require profound changes in the way we think about sex, about women, about men, about ourselves. Peer education projects, in which working prostitutes are seen as sex workers, professionals in a recognized field, with knowledge worth sharing among their colleagues and clients and with other people, are part of a long process that will change all of our thinking. These community-based projects are based in the perspective that women have a right to engage in sex and to do so safely.

The prostitutes' rights struggle, born before AIDS but strengthened as a result of AIDS, is part of a global struggle to change the terms of female sexuality. Until a woman who suggests using a condom is not distrusted as a whore, and until a whore is not considered expendable, how can we hope to stop HIV and other STD? Until we stop seeing AIDS, or herpes, or even

pregnancy,⁶⁹ as women's (or gay men's, or injection drug users') just punishment for wayward behavior, these diseases will continue to plague us, the "innocent," along with the "guilty." The destigmatization of prostitutes and those on the margins of sex work is essential.

As the number of projects focusing on sex work increases, community organizing must become integrated into the AIDS prevention model. If interventions are done in the traditional, paternalistic ways of the past, the demand for behavior change will seem to be one more face of the almost universal oppression of prostitutes. But, if prostitutes are organized in their own interest, as both workers and members of a sexually active community, the behavior that makes them vulnerable will change.

Those of us who are prostitutes have the central role in all this. But those of us who are not prostitutes also have an important role to play. As allies, we can and must work together to convince police not to confiscate condoms or to use them as evidence, to get public health officials to dismantle forced testing programs, to pressure health care providers to change their attitudes toward sex workers who come to them for help, to ensure that funders allocate money to support the efforts of sex workers to organize, and to support sex workers' efforts to get the laws changed. In the end, those of us who are not prostitutes must recognize that our own sexuality is affected as much by the condemnation of prostitution as by the fact that prostitution exists, and that all women will benefit from the empowerment of prostitutes, whether in the fight against AIDS, the fight against brutal or exploitative pimps, or the fight against the laws that control women's sexuality.

NOTES

¹I have used both terms, *sex worker* and prostitute, throughout this paper, in order to make it clear that prostitution is work, not a sexual characterization. I am indebted to Carol Leigh, also known as Scarlet Harlot, for the term *sex work*, which also includes performers in pornography, another form of sexual activity for income.

²Throughout history, male prostitution has functioned alongside female prostitution, whether in religious or in secular sites. However, as the history of efforts to regulate, control, and abolish prostitution make clear, prostitution is identified in most minds as a strictly female phenomenon. Nonetheless, some of these same arguments apply to male prostitution.

³For example, Japanese soldiers "recruited" Korean women during World War II to act as "comfort women" for Japanese soldiers occupying Korea or to work in brothels in Japan (David E. Sanger, "Tokyo Cringes as a Japanese Says He Seized Korean Women," *International Herald Tribune*, 10 August 1992; George Hicks, "A 'Comfort Women' Screen Hides the Enduring Shame," *International Herald Tribune*, 14 April 1993). Lest anyone think this is a situation unique to Japan and its conquered territories, one has only to look at the role of the U.S. military, which organized prostitution near U.S. bases during the Civil War and the westward expansion (Anne M. Butler, *Daughters of Joy, Sisters of Misery: Prostitutes in the American West* (Cham-

paign, IL: University of Illinois Press, 1985); the U.S. occupation of Japan after World War II, and Vietnam and Thailand during the Vietnam War (Thanh-Dam Truong, *Sex, Money and Morality: Prostitution and Tourism in South-east Asia* (London: Zed Books, 1990)); Cynthia Enloe, *Bananas, Beaches & Bases: Making Feminist Sense of International Politics* (London: Pandora Press, 1989); the Philippines until the eruption of Mt. Pinatubo in 1991 (personal communications with representatives of AIDS prevention projects in the Philippines, numerous newspaper articles over the years); and Honduras during the counterrevolutionary actions in Nicaragua (an article in the *San Francisco Chronicle* about the sudden appearance of AIDS among female prostitutes working near an American base in Honduras, probably in 1984 or 1985).

⁴Luise White, *The Comforts of Home: Prostitution in Colonial Nairobi* (Chicago: University of Chicago Press, 1990).

⁵The term *core group of high-frequency transmitters* was first used in a paper on the control of gonorrhea in 1978. It has gained wide usage only with AIDS, for example, in the writings of Frank Plummer's group at the University of Nairobi and King Holmes, of the University of Washington in Seattle. Until very recently, it was used almost exclusively to refer to female prostitutes, despite the well-documented greater efficacy of male-to-female transmission of all STD, including HIV, over female-to-male transmission. More recent articles have used it to refer to "truckdrivers," but the problem of viewing people as vectors who need to be controlled, rather than people who may be at increased risk of STD and therefore in need of good health care services, is the same.

⁶The terms *reservoir* and *pool of contagion*, which have been applied almost exclusively to women, are interesting in that they appear to view women as passive bodies, waiting to endanger he who invades them, I suppose. Perhaps it is a reincarnation of the mythic vagina dentata. The linguistic shifts from passive to aggressive are fascinating.

⁷Steffen Johncke, "Prostitutes and the Precariousness of Policy: AIDS and the Stigmatization of Prostitutes/Sex Workers" (Paper presented at the AIDS and Anthropology Group Conference on Culture, Sexual Behaviour and AIDS, 24-26 July 1992, Amsterdam). See also Gail Pheterson, "The Social Consequences of Unchastity," in *Sex Work: Writings by Women in the Sex Industry*, ed. Frederique Delacoste and Priscilla Alexander (San Francisco: Cleis Press, 1987).

⁸Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge: Cambridge University Press, 1980). Feminists who organized to repeal the Contagious Diseases Acts were concerned that female prostitutes were being falsely blamed, inasmuch as many of their clients spent long months at sea, isolated from women, and might very well be engaging in homosexual activity and infecting each other, only to infect the prostitutes when they were on shore leave (p. 130). It is possible that a similar dynamic may be at work in regions now said to represent exclusively heterosexual transmission (Randall M. Packard and Paul Epstein, "Medical Research on AIDS in Africa: A Historical Perspective," in *AIDS: The Making of a Chronic Disease*, ed. Elizabeth Fee and Daniel M. Fox (Berkeley: University of California Press, 1992, p. 353).

⁹Jill Harsin, *Policing Prostitution in Nineteenth Century Paris* (Princeton, N.J.: Princeton University Press, 1985).

¹⁰Ruth Rosen, *The Lost Sisterhood: Prostitution in America, 1900-1918* (Baltimore: Johns Hopkins University Press, 1982) 10. See also Mark Thomas Connelly, *The Response to Prostitution in the Progressive Era* (Chapel Hill: Princeton University Press, 1980), 81.

¹¹Nell Kimball and Stephen Longstreet, *Nell Kimball: Her Life as an American Madam* (New York: Macmillan, 1970). See also *Mableine: An Autobiography 1919* (New York: Persea Books, 1986).

¹²Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880* (New York: Oxford University Press, 1985); "A Historical Perspective," in *AIDS and the Law: A Guide for the Public*, ed. Harlon L. Dalton and Scott Burris (New Haven: Yale University Press, 1987); and "AIDS: From Social History to Social Policy," in *AIDS: The Burdens of History*, ed. Elizabeth Fee and Daniel M. Fox (Berkeley: University of California Press, 1988). See also Thomas Connelly; Rosen.

¹³S. Moses, F. A. Plummer, E. N. Ngugi, et al., "Controlling HIV in Africa: Effectiveness and Cost of an Intervention in a High-Frequency STD Transmitter Core Group," *AIDS*, April 5, 1991, 407-411. In this article, the authors report that one man became infected with HIV after a single contact with a prostitute. After a number of people who had visited the University of Nairobi projects told me they had reservations about that conclusion (one person said that men with STD in Nairobi always say they had sex with a prostitute; another said that this particular man didn't even say that, it was enough that he lived in the same district with prostitutes), I questioned Plummer, whom I met in Amsterdam, about the conclusion. His response was, "It's probability."

¹⁴Kenneth Castro et al., "Investigations of AIDS Patients with No Previously Identified Risk Factors," *Journal of the American Medical Association* 259 (March 1988):1338-1342. See also Joyce I. Wallace et al., "HIV-1 Exposure Among Clients of Prostitutes" (Paper presented at IVth International Conference on AIDS, June 1988, Stockholm, no. 4055).

¹⁵Prostitution arrests are almost always for the offense of soliciting, not for actually engaging in any sex act or for receiving (especially not for paying) any money. Many laws now carry fairly stiff penalties for an arrest subsequent to testing positive for HIV—up to 20 years in Nevada, regardless of whether the accused ever engaged in an actual risk behavior (such as unprotected vaginal intercourse).

¹⁶In 1991, the California Supreme Court upheld that state's law, finding that the public health interest in identifying HIV-positive prostitutes, and permitting the disclosure of test results to prosecuting attorneys and others in the law enforcement system, outweighed the accused's right to confidentiality. The same court upheld confidentiality protections in another case, in which survivors of people who died of AIDS contracted through blood transfusions tried to identify the donors as part of their lawsuit against a California blood bank. Thus, blood donors' confidentiality was protected even though a death had resulted, while the prostitutes' confidentiality was violated in the absence of evidence of either exposure or transmission, let alone death.

¹⁷Numerous studies have found that substantial majorities of prostitutes in Western countries use condoms for vaginal and anal sex, and often for fellatio as well, most or all of the time, and that a substantial proportion of the sex negotiated on the street involves only hand and blow jobs. Male prostitutes are not generally targeted by

registration systems; they also are less likely to be arrested when prostitution is illegal.

¹⁸Diane Smith, "Green Cards for Sex Workers," *World AIDS*, July 1990, no. 10, Panos, London.

¹⁹Deanna Hodgkin, "Activists Sound Alarm over Fate of Prostitutes in Thailand," *The Advocate*, 16 June 1992, p. 30. At the VIIIth International Conference on AIDS, in Amsterdam, members of the International Committee for Prostitutes Rights (ICPR) organized a demonstration to protest these and other brutal violations of prostitutes' human rights. Unfortunately, press coverage credited ACT-UP, instead of the ICPR, effectively silencing prostitutes from speaking out on their own behalf.

²⁰Privileged communication with representatives of AIDS prevention projects in the Philippines.

²¹Privileged communication with a representative of Singapore's medical scheme.

²²Meurig Horton, World Health Organization, Global Program on AIDS, personal communication.

²³Shyamala Nataraj, "Indian Prostitutes Highlight AIDS Dilemmas," *Development Forum*, November-December 1990, pp. 1, 16.

²⁴Patricia Uribe et al., "Analysis of Factors Related with HIV Infection in 961 Female Sexual Workers" (Paper presented at VIth International Conference on AIDS, San Francisco, June 1990, Th.D.777).

²⁵See papers presented at VIth International Conference on AIDS, San Francisco, June 1990, dealing with registration systems: Hans W. Doerr et al., "Prevalence of HIV Infection in Prostitutes from Frankfurt/W. Germany," FC626; I. N'Doye et al., "Sensitization Surveillance of STD: Its Implications for AIDS Control in Senegal," 3178; Russell Reade, Gary Richwald, and Nancy Williams, "The Nevada Legal Brothel System as a Model for AIDS Prevention Among Female Sex Industry Workers," SC715; and Anastasia Roumeliotou et al., "Prevention of HIV Infection in Greek Registered Prostitutes, a Five Year Study."

²⁶Privileged communication with an AIDS prevention specialist who visited Indonesia to provide technical assistance to the government.

²⁷Privileged communication with a representative of Singapore's prostitution medical scheme.

²⁸Russell Reade, Gary Richwald, and Nancy Williams, "The Nevada Legal Brothel System as a Model for AIDS Prevention Among Female Sex Industry Workers" (Paper presented at VIth International Conference on AIDS, San Francisco, 1990, SC715). Also, the author's analysis of arrest statistics in the United States between 1973 and 1987, and estimates by police and prostitutes in a number of cities concerning the proportion of prostitutes who work in different parts of the industry. See my article "Prostitution: A Difficult Issue for Feminists," in *Sex Work: Writings by Women in the Sex Industry*, ed. Frederique Delacoste and Priscilla Alexander (San Francisco: Cleis Press, 1987) for a more extensive discussion.

²⁹G. Papaevangelou et al., "Education in Preventing HIV Infection in Greek Registered Prostitutes," *AIDS* 1(1988): 386-389.

³⁰Edwige Bienvenue, formerly of the STD service, in Dakar, Senegal, and King Holmes, University of Washington, Seattle, personal communications.

³¹The historic record suggests that the ratio of "registered" or "official" prostitutes to "clandestine" workers is fairly consistent over time and geographic distance. See, for example, Brandt; Harsin; Frank Mort, *Dangerous Sexualities: Medico-moral Politics in England since 1830* (London: Routledge & Kegan Paul, 1987); and Walkowitz.

³²Some specialists in occupational health and safety issues have begun to look at other aspects of prostitutes' health related to their work, including back and foot problems related to standing and walking for long hours, particularly while wearing high heels, and working on bad beds, as well as respiratory problems due to being out in inclement weather.

³³Packard and Epstein.

³⁴There are a number of books containing first-person accounts of sex work, including Frederique Delacoste and Priscilla Alexander; Roberta Perkins and Garry Bennet, *Being a Prostitute* (Winchester, Mass.: Allen & Unwin, 1985); and Claude Jaget, ed., *Prostitutes—Our Life* (Bristol, England: Falling Wall Press, 1980). However, even reading the first-hand accounts cannot substitute for the knowledge that comes from direct experience. In addition, these books are difficult to obtain in many countries.

³⁵This belief was reported to me by a consultant working for the World Health Organization who had interviewed women working in a number of African countries. In addition, a number of African studies have found that both women and men complain that using condoms changes the meaning of sex, which doesn't seem "real" to them unless there is skin contact and ejaculation within the woman's body.

³⁶COYOTE is an acronym for "Call Off Your Old Tired Ethics." Margo St. James told me that the reason she chose an organization name without the word *prostitute* in it was that, in 1973, it was controversial to even say the word on television. In addition, the term *coyote* has a certain resonance for prostitutes. The coyote, in American Indian belief systems, is a trickster, often seeming to be something different than it is, so that the name fits the aspects of prostitution that are related to illusion. In addition, it echoes the slang term for client, *trick*, and the practice of "turning a trick." In addition, the coyote and the prostitute are both endangered species. Finally, the person who smuggles people from Mexico into the United States is called a "coyote." For a history of COYOTE, see "COYOTE/National Task Force on Prostitution," in Frederique Delacoste and Priscilla Alexander; and Margo St. James, "Preface," in *A Vindication of the Rights of Whores*, ed. Gail Pheterson (Seattle: Seal Press, 1989). For an account of how COYOTE became aware of and responded to the early AIDS epidemic, see Priscilla Alexander, "A Chronology, of Sorts," in *AIDS: The Women*, ed. Ines Rieder and Patricia Ruppelt (San Francisco: Cleis Press, 1988).

³⁷San Francisco Police Department, Department Special Order 87-13, W/06140, "Seizure of Condoms and Bleach Containers Pursuant to Vice Arrests," 10 April 1987.

³⁸Priscilla Alexander, *Prostitutes Prevent AIDS: A Manual for Health Educators* (San Francisco: CAL-PEP, 1988). This manual, which was distributed by the San Francisco AIDS Foundation, as well as by CAL-PEP, was purchased by more than 200 agencies in the United States, Europe, Asia, and Africa by the Fall 1989.

³⁹See Reback article, elsewhere in this volume.

⁴⁰Gail Pheterson.

⁴¹The problems of migrant prostitutes are generally more severe than those of local sex workers, in part because of language, but also because of immigration laws which

deny them the right to work legally, even when some or all aspects of prostitution are legal for citizens of the host or receiving country. As a result, the businesses that hire them are likely to be farther underground and have worse working conditions.

⁴²Hansje Verbeek and Terry van der Zijden, "The Red Thread: Whores' Movement in Holland," and Marjan Sax, "The Pink Thread," in Frederique Delacoste and Priscilla Alexander.

⁴³The negotiations with the government that appeared to be leading to a rational change in the law to permit prostitutes to organize for more control over their working conditions broke down following the appointment of a conservative minister of justice. Instead of giving more control to the prostitutes, the minister, in trying to appease right and left, has proposed keeping the laws against prostitution businesses on the books but permitting cities to carve licensing exceptions in a system that gives more control to the owners and denies women from non-EC countries the right to work legally. This leaves them even more vulnerable to abuse than in the current blind-eye approach.

⁴⁴Ruth Morgan Thomas, "AIDS Risks, Alcohol, Drugs, and the Sex Industry: A Scottish Study," in *AIDS, Drugs, and Prostitution*, ed. Martin Plant (London: Tavistock/Routledge, 1990).

⁴⁵Aspasie was organized by a group of prostitutes and health care and social workers to provide both services for and advocacy on behalf of the women who work in the main sex work street in Geneva. The organization is named after Aspasia, "perhaps the most famous prostitute of classical Athens," according to Nickie Roberts, in her groundbreaking book, *Whores in History: Prostitution in Western Society* (London: Harper Collins Publishers, 1992), the first major survey of the history of prostitution written by and from the point of view of a sex worker.

⁴⁶Marcel Monny-Lobé et al., "Prostitutes as Health Educators for their Peers in Yaoundé: Changes in Knowledge, Attitudes and Practices," WGO21, and "The Use of Condoms by Prostitutes in Yaoundé-Cameroon," WDP87 (Papers presented at the Vth International Conference on AIDS, Montreal, June 1989), and personal communication, October and November 1989; Lisa Mbele-Mbong, personal communication, April 1992.

⁴⁷Many conversations with Eka Esu-Williams, founder of the Cross River State Commercial Sex Work Project and President of the Society for Women and AIDS in Africa (SWAA). Cf. Eka Esu-Williams et al., "Sexual Practices and HIV Infection of Female Prostitutes in Nigera" (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, WGO24); Eka Esu-Williams et al., "Nigeria: Empowering Commercial Sex Workers for HIV Prevention" (Paper presented at the VIth International AIDS Conference, Florence, 1991, WD4041).

⁴⁸Many conversations with David Wilson, Department of Psychology, University of Zimbabwe, Bulawayo. Cf. David Wilson et al., "A Pilot Study for an HIV Prevention Programme Among Commercial Sex Workers in Bulawayo, Zimbabwe," *Soc. Sci. Med.* 31 (1990): 609-618.

⁴⁹Fekerte Belete et al., "Social Mobilization and Condom Promotion Among Sex Workers in Nazareth, Ethiopia," *The Ethiopian Journal of Health Development* 4(1990):219-224. Also, personal communications with Fekerte Belete, Almaz G/ Kidan, and Carol Larivee.

⁵⁰Gabriela Silva Leite, "Women of the Life, We Must Speak," in Pheterson.

⁵¹Several issues of AMEPU's newsletter, as well as privileged communications with a representative of Montevideo's STD service.

⁵²Many conversations with Rita Arauz, coordinator of Fundacion Nimhuatzin.

⁵³Many conversations with Chantipwa Apisuk, founder of EMPOWER; Andrew Hunter, coordinator of the Scarlet Alliance; and Cheryl Overs, coordinator of the Network of Sex Work HIV/AIDS Projects.

⁵⁴This change in focus is reflected in such publications as the *VENA Newsletter* issue on "Traffic in Women" (vol. 1, no. 2, November 1989) and *ISIS' Women's World* devoted to "Poverty and Prostitution" (no. 24, Winter 1990/91).

⁵⁵*Talikala* is an old Cebuano word for "bonding" or "chain."

⁵⁶Conversations with Elizabeth O'Brien, coordinator of Talikala. Cf. Marvic R. Desquitado, *Behind the Shadows* (Davao City: Talikala, Inc., 1992), and articles published in Talikala's newsletter.

⁵⁷Many conversations with Sundararaman Swaminathan, coordinator of the project. Cf. Sundararaman Swaminathan and G. Kumaresan, "Shifting Needs: Prostitute Intervention to Client Intervention" (Paper presented at VIIth International Conference on AIDS, 1991, WD58).

⁵⁸Cheryl Overs, Network of Sex Work HIV/AIDS Projects, personal communications.

⁵⁹Tidiane Siby et al., "Surveillance Education Sanitaire des Prostituées au Senegal" (Paper presented at Vth International Conference on AIDS, Montreal, June 1989, WDP91); Nzila Nzilambi et al., "Evaluation of Condom Utilization and Acceptability of Spermicides Among Prostitutes in Kinshasa, Zaire" (Paper presented at Vth International Conference on AIDS, Montreal, June 1989, WAP96); Marcel Monny-Lobe, "The Use of Condoms by Prostitutes in Yaounde-Cameroon" (Paper presented at Vth International Conference on AIDS, Montreal, June 1989, WDP87); Christl Praats et al., "Female Prostitutes in Antwerp: A Risk Group for Infection" (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, MAP49); Stephen T. Green et al., "Glasgow Street Prostitutes: A Study of Sexual Behavior and Injected Drug Use" (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, ThDP3).

⁶⁰Hilary Kinnell et al., "Male Clients of Female Prostitutes in Birgmingham, England: A Bridge for Transmission of HIV?" (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, WDP41); Arletty Pinel, "Sexual Behavior Survey of Brazilian Men That are Clients of Transvestite Prostitutes (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, TDP78).

⁶¹Elizabeth Petterson et al., "Twilight Phenomena—A Project Concerning Men as Buyers of the Services of Prostitutes as a Risk Factor" (Paper presented at the Vth International Conference on AIDS, Montreal, June 1989, ThDP21).

⁶²Privileged communications with representatives of Men in Prostitution at a Dutch STD Foundation conference in 1989 and the European Prostitutes Congress in 1991.

⁶³Fekerte Belete et al.

⁶⁴George K. Lwihula, "AIDS and the Trucking Industry in Tanzania: Long Distance Truck Drivers, Their Sex Partners and HIV Transmission in Tanzanian Truck Stops" (Paper presented at the Conference on AIDS & Anthropology: Culture, Sexual Behavior and AIDS, Amsterdam, 24–26 July 1992); Christopher L. Mwaijonga et al.,

"HIV/AIDS Education and Condom Promotion for Truck Drivers, Their Assistants and Sex Partners in Tanzania" (Paper presented at VIth International Conference on AIDS in Africa, Dakar, Senegal, 16–19 December 1991).

⁶⁵The denial of homosexual activity in Sub-Saharan Africa (by epidemiologists, modelers, Africans, and Europeans) is phenomenal. However, one East African researcher told me that, after listening to me, he had asked some of the women in his project if they knew of any male homosexuals, and they said, "Oh yes, over there." In another East African country where officials deny any homosexual activity, visiting Western gay men are propositioned frequently by local men. Whether either anecdote reflects "homosexuality" in the American sense, with a fully delineated identity, is unlikely, but there is clearly some homosexual activity, the epidemiological weight of which remains unknown. There is also documented homosexual behavior in Kenya and Nigeria, some of which involves crossing genders, and a multiracial gay rights organization is active in South Africa. Some Africans more or less dismiss the homosexuality by ascribing it to Arab influence, while the North African countries, where Arab influence is greatest, also deny that homosexual activity occurs. Cf. T. D. Moodie, "Migrancy and Male Sexuality on the South African Gold Mines," in *Hidden from History: Reclaiming the Gay and Lesbian Past*, ed. M. Duberman et al. (New York: New American Library, 1989); S. Nanda, *Neither Man nor Woman: The Hijras of India* (Belmont, CA: Wadsworth, 1990); A. Schmitt and J. Sofer, eds., *Sexuality and Eroticism Among Males in Moslem Societies* (Binghamton, NY: Harrington Park Press, 1992); G. Shepherd, "Rank, Gender, and Homosexuality: Mombasa as a key to understanding sexual options," in *The Cultural Construction of Sexuality*, ed. P. Caplan (London: Tavistock Publications, 1987).

⁶⁶Privileged communication from an anthropologist who has worked with the sex work project in Benin.

⁶⁷Personal communications with Fekerte Belete and Almaz G/Kidan.

⁶⁸D. Hausser, F. Dubois-Arber, and E. Zimmerman, "Assessing AIDS Prevention in Switzerland," in *Assessing AIDS Prevention*, ed. F. Paccaud, J. P. Vader, and F. Gutzwiller (Basel: Birkhäuser, 1992).

⁶⁹In my reading of the discourse within the anti-abortion movement, I have seen many references to women's needing to accept unwanted pregnancy as the consequence of or punishment for their waywardness, if they have been so unwise as to engage in sex outside of marriage or without using effective contraceptives. Thus, although pregnancy is quite different from disease, much right-wing discourse equates them as punishments for "bad" women.

**RESPONDING TO SEX WORKERS' NEEDS
CAN SLOW THE INCIDENCE OF HIV INFECTION
AMONG STREET-BASED FEMALE SEX WORKERS**

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Objective:

- To determine the annual incidence of HIV infection among female street-based sex workers in New York City, during the first fifteen years of the epidemic.
- To examine the impact of outreach, HIV/AIDS prevention education, promotion and distribution of condoms, bleach, needles, and other prevention materials, and provision of case management services on the annual incidence of infection.

Methods (1982-1988):

- In 1982 the author and workers from the New York City Department of Health recruited 33 female prostitutes working from bars and brothels in Manhattan and Brooklyn, in order to evaluate their immune status through T-cell phenotyping.
- From 1985 through 1988, FROST'D recruited and offered to test 169 women working on Manhattan's Eleventh Ave stroll, with the newly available ELISA and Western Blot tests. The Eleventh Avenue Stroll is an area with a low prevalence of injecting drug use.

Results (1982-1988):

- In 1982, **15.2%** of 33 women working in bars and brothels showed indications of immune suppression, as identified through T-cell phenotyping. Although injecting drug use is generally not common in off-street sex work venues, it was relatively common among these women.
- Between 1985 and 1988, 14 of 169 (8.3%) of women working on the Eleventh Street Stroll tested positive.
- The annual incidence of HIV infection declined from **18.2% in 1985** to **5.4% in 1988**.

Table 1. Incidence of Immune Suppression (1982) and HIV infection (1985-88) among Selected Groups of Female Prostitutes in New York City

Year	Location	Work Site/Category	No. Tested	% with immune suppression*	% HIV+ **
1982	Manhattan-Brooklyn	Indoor (Bars and Brothels)	33	15.2%	
1985	Eleventh Ave., Manhattan	Street, low injecting drug use	22		18.2%
1986	"	"	43		9.3%
1987	"	"	67		6.0%
1988	"	"	37		5.4%
1985-88	"	"	169		8.3%

*by T-cell phenotyping

**by ELISA with confirmatory Western Blot

Methods (1989-1996):

- In 1989, FROST'D received a grant from the State Department of Health's AIDS Institute to begin a formal project of counseling, testing, and promoting condoms and safer drug use techniques, to women who engage in street-level sex trading in low-income neighborhoods in New York City for HIV infection. The counseling and testing program operates out of the Care Van, a minivan donated by Ansell America, the condom manufacturer. **Between 1989 and July 1996, FROST'D counseled and tested more than 3,451 women.**

- In 1991, FROST'D received a grant from the New York State Office of Alcohol and Substance Abuse Services (OASAS) to develop a more comprehensive service project. In the OTSMU-Options van, we offer women food, clothes, sleeping bags, identification papers, emotional support, and referrals to agencies that provide drug treatment, health care, shelter, and public assistance. **Between July 1995 and mid-October 1996, OTSMU-Options provided services to more than 2,342 women (6,408 contacts).** We reviewed the records of 529 women who visited the OTSMU-Options project during the months of April-July 1996, to determine the current prevalence of HIV among women working in the districts served by that project who had both used OTSMU-Options services and been tested by the Care Van staff.
- In 1995, FROST'D received a grant from the State Department of Health's AIDS Institute to begin operating a legal needle exchange out of the Care Van, two days a week. **Between July 1995 and September 1996, 128 women had participated in 673 needle exchanges.**

Ethnicity of Women Using OTSMU Case Management Services
1995-96

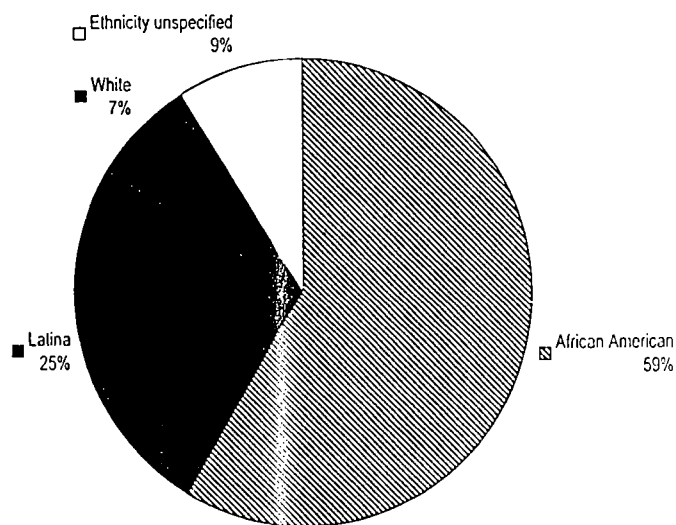
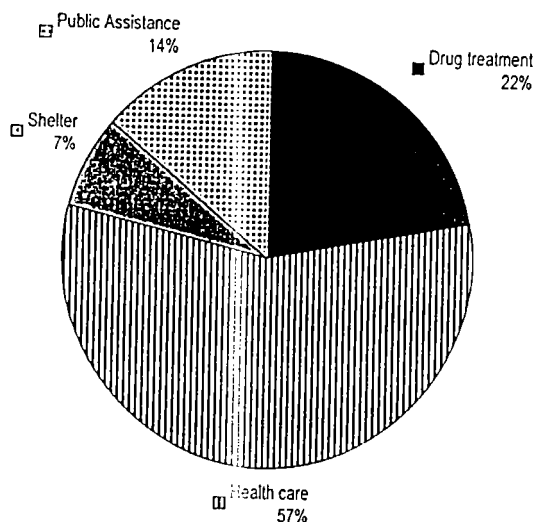


Table 2. Materials and Services Provided - July 1995-October 1996

	Care Van	Needle Exchange	OTSMU- Options	Total
HIV Prevention Materials				
Condoms	38,491	12,912	149,964	201,367
Dental Dams	50	535	2,372	2,957
Lubricants			1,242	1,242
Bleach kits	52	537	197	786
Needles		18,914		18,914
Survival Materials				
Food (bag lunch)	1,193		5,148	6,341
Clothes	39		229	268
Sleeping bags			11	11
Toiletries kits			351	351
Making Changes				
Birth certificates	23		163	186
Social Sec. Cards	23		115	138
Referrals				
Drug treatment	51		142	193
Shelters	9		48	57
Health care	88	5	343	436
Public assistance	3	1	84	88

OTSMU Referrals to Other Agencies



Results (1989-1996):

- From 1989 through July 1996, the annual incidence among the women we serve has declined from 36.2% to 18.1%.
 - 96.1% of the women use at least one psychoactive drug (39.5% use needles), and 26.3% are homeless or on the edge of being homeless.
 - 91.3% perform fellatio at work, and 63.1% report that they mostly perform fellatio with clients. Of those who perform fellatio, 57.7% report always using condoms and 37.8% report using them some of the time.
 - 72.2% perform vaginal intercourse for clients at least some of the time, with 13.1% reporting that vaginal intercourse is the primary service they provide. Of women who engage in vaginal intercourse at work, 49.4% always use condoms and 42.2% use them some of the time.
 - Condom use with personal partners continues to be lower than at work: 24.8% report always using condoms for fellatio with personal partners, 17.9% sometimes, and 24.0% always use condoms for vaginal sex with personal partners, 16.2% sometimes.
 - Anal intercourse is rare in both work (2.0%) and personal (2.5%) relationships.

Table 3. Incidence of HIV among Low-Income Female Prostitutes in New York City, 1989-30 July 1996

Year	Location	Work Site/Categor y	No. Tested	% HIV +		
				All	History of Injecting Drug Use	No Injecting Drug Use
	New York City - four boroughs	Street, low- income, high drug use				
1989			668	36.2%	56.6%	17.4%
1990	"	"	712	37.2%	60.1%	20.5%
1991	"	"	437	32.0%	48.2%	21.9%
1992	"	"	197	36.3%	58.1%	19.1%
1993	"	"	195	28.3%	42.3%	21.9%
1994	"	"	142	27.2%	50.0%	17.2%
1995	"	"	403	18.1%	24.0%	13.0%
1996*	"	"	358	17.6%	24.2%	13.7%

*January-July 1996

Among 529 women who visited the OTSMU-Options project during the months of June and July 1996, 178 had been tested since 1989 by the Care Van counseling and testing project; among them, the prevalence of HIV infection was 29.2%.

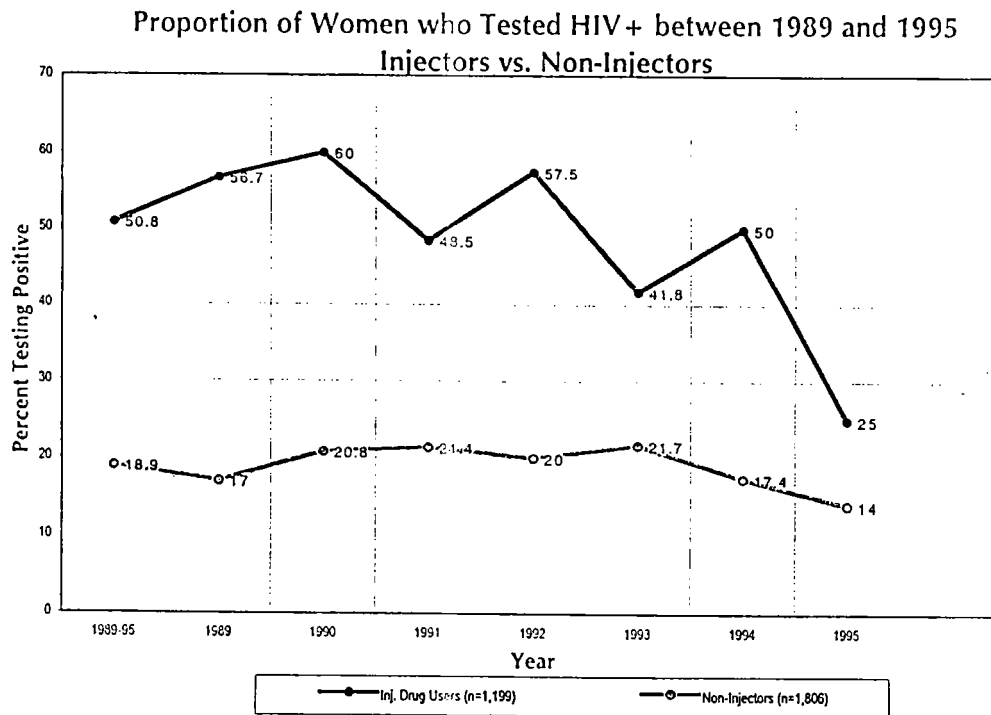


Chart #1 (07/96)

Conclusions:

- The significant decline in the incidence of HIV among the women reached by our project between 1989 and 1996 indicates that providing condoms, bleach kits, and sterile injection equipment, and accurate information about preventive measures, within the context of a program that responds to a range of their needs, can effectively help many women in this population survive this epidemic.
- While FROST'D reaches approximately 2,500 women a year (> 7,000 contacts), an estimated 5,000-7,000 women and men engage in street-based sex trading in New York City, and 5-10 times as many work off the street, and there are few programs to reach them.

- There are many cities without even one program designed to help street prostitutes protect themselves, and their partners, from HIV infection and other STDs, or to help them protect themselves from violence.
- Given the high vulnerability to HIV infection among street-based, female sex workers, there is an urgent need for more projects to work specifically with women and men involved in sex trading, including both prostitution and barter for drugs, whether they earn money for sex, pay for sex, or are supported by someone who earns money for sex.

Women at Risk

Issues in the Primary Prevention of AIDS

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Female Sex Workers

Scapegoats in the AIDS Epidemic

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INTRODUCTION

From the volume of stories in newspapers, and studies reported in medical and health journals, one could conclude that prostitutes are a major influence in the spread of the epidemic of HIV infection. Women who earn their living by selling their sexual services have been portrayed in both media as "reservoirs" or "pools" of infection, "vectors" for the sexual transmission of HIV to unsuspecting heterosexual men and their "innocent" wives and children. Even in the absence of evidence, print media leaders such as *The New York Times* and *The Washington Post* have printed many stories supporting the thesis that heterosexual prostitution plays a major role in the HIV epidemic in the United States (King, 1990). A recent search of the Centers for Disease Control and Prevention National AIDS Clearinghouse NEWS database found 452 separate articles with references to prostitution that had been included in the CDC AIDS Daily Summary since 1988. A common subject of these articles is that a female prostitute has been charged with attempted murder, or willful endangerment of an undercover officer, because even though she tested positive for HIV at some point in the past, she continued to stand on street corners. In none of the articles was there any evidence that the woman in question had either infected anyone or engaged in any behavior likely to permit someone to be infected. It was enough that she was identified as a "prostitute."

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The purpose of this chapter is to examine the evidence on HIV infection among women who work in the sex trade in this country, and in some other countries, in terms of both their own risk of infection and the risk of their transmitting HIV infection to others. Some of the questions to answer include: What is the prevalence of infection among women who sell sex? What kinds of sex workers, and in what geographic areas, show significant rates of HIV infection? How do women in the sex trade become infected? What is the likelihood that a female sex worker with HIV infection will infect a customer? What kinds of programs are in place that can help reduce sex workers' risk of infection? And what are the public policy issues raised by prostitution in the age of AIDS?

Definitions

Before we address those questions, it may be useful to define such terms as "prostitution," "sex work," "sex trade," and "sex exchange," terms that are not entirely interchangeable in either meaning or social value.

"Sex work" is a term that has come into use in recent years, first used by a San Francisco sex worker, performance artist, and activist named Carol Leigh, also known as Scarlot Harlot (Alexander, 1987). Leigh first used the term in order to focus attention on the fact that prostitution is a form of paid sexual labor, or work, that is affected by forces similar to those that affect other kinds of paid labor. Rapidly claimed as a self-representative term by prostitutes and other sex workers—dancers, strippers, pornography models and performers, and some sex therapists—it also came into wide use in the international arena of AIDS research and prevention politics. In the context of AIDS, "sex work" is a useful term to clarify the issue of workplace and occupational risk. That is, sex workers, like health care workers, may be at risk due to occupational hazards or because of their behavior off the job. For example, health care workers may be at risk of HIV infection through needle sticks, invasive procedures, and other occupational activities, but may also be at risk because of sexual or drug-use practices in their personal lives. So too, sex workers may be at risk due to unprotected sex on the job, or through unprotected sex with their personal partners and/or needle sharing behavior unrelated to their work, as well as through blood transfusions and/or injections with unsterile equipment, especially in countries without the capacity to ensure blood safety or sterile conditions in the health care system.

At the same time, many people who engage in behaviors that outsiders clearly identify as "prostitution" do not, themselves, see it that way, or think of themselves as professional prostitutes or sex workers with the

responsibility and ability to prevent disease. Nonetheless, some public health researchers have used very broad classifications—e.g., "a woman who has exchanged sex or sexual services for money or drugs at least once since 1978," used by the Centers for Disease Control and Prevention for its multicenter study of the epidemiology of HIV infection among female prostitutes (Darrow *et al.*, 1990). Such a definition includes women who have, on rare occasions, had sex with a friend who gave them money to help with the rent, or who have used sex to secure a place to sleep for the night, or to obtain a meal, as well as women who went to work on a regular basis in a stroll district, massage parlor, or other sex-work venue. The more often such a "sex exchange" or "sex trade" takes place, the more likely it is that one of the partners will be infected with HIV or some other sexually transmitted disease (STD). However, to the extent that the participants define the exchanges as the normal run of things, or possibly as a question of survival, they are unlikely to see these actions as recognized "risk behaviors" or as "prostitution" and are therefore less likely to think of protecting themselves, or their partners, from AIDS, or indeed any STD.

Some of the terms used around the world to refer to people who engage in some sort of sexual activity in exchange for some kind of economic support include: "women who go out" and "free women," both common in sub-Saharan Africa; "bar ladies," "bar workers," and "working girls" or women, common in many countries; "ladies of the evening," "nightwalkers," and "streetwalkers," and the terms related to covert businesses, such as "masseuses," "hostesses," "hospitality workers," "escorts," "guides," and "entertainers." Then there are the more familiar terms, such as "prostitutes," "sex workers," "hookers," "whores," "putains," and "putas." In any case, although many of the terms, translated into local languages, are understood by many to refer to "prostitutes," in fact many of the practitioners, who may use some of those terms to describe themselves, may not consider themselves "prostitutes." In many parts of the world, women live in communities that have grown up around the major trucking routes, communities that become, as it were, "truck stops," where they may provide a haven for a number of drivers in succession, their home away from home, receiving "help" with the rent and the cost of the food they provide. In societies where male polygamy is the norm, these women are polyandrous, but are they, or do they see themselves as, "prostitutes"? In this country, among the women who roam the streets, homeless, having sex is often a way to sleep in a warm room for the night (or a cool one, depending on the city and the season), and perhaps get a meal, and a bit of money to help them through the next day. Is that "prostitution"? And when is the line crossed between the normal barter of American life and

an overtly commercial transaction, for women who have sex with the men who provide them with the nirvana of heroin or crack? The point is, every one of these situations carries the potential for HIV to move from one person to another, and every one of these people needs to know how to protect herself, or himself.

Meanwhile, most research, whether in this country or elsewhere, blurs the distinction between sex *work* and sex *exchange*, failing to recognize significant differences in behavior between the two extremes, and in fact conflating the extremes under the general term "prostitution." This practice can result and has resulted in serious misreadings of some research data.

To summarize, a wide variety of cultural and economic conditions influence sexual behavior, and only a small portion of sex with others that involves some kind of extrinsic exchange is defined as "sex work" by those involved. Moreover, the risk of transmission of any STD is independent of such labels as "prostitution" or such factors as "payment." The risk is strictly dependent on (1) the probability of infection in either of the parties involved and (2) the nature of the sex act and whether or not it is protected. Other factors that become subsumed under the mythic resonance of such terms as "prostitution," and to a lesser extent "sex work," include the types of services provided, how often the services are provided and under what conditions, and the extent of the provider's control over each transaction. That having been said, what follows is a review of some of the research regarding HIV infection among women involved in various parts of the sex trade and, to a much lesser extent, men who identify as clients.

EPIDEMIOLOGY OF HIV INFECTION IN THE CONTEXT OF PROSTITUTION

Estimates of the number of prostitutes—male as well as female—working in the United States range from about 150,000 to a million or more. More than 100,000 people are arrested on prostitution charges annually in the United States, 65–70% of them women, perhaps 20–25% male prostitutes, and 10% or so male clients. Almost all these arrests are made on the street, which the National Task Force on Prostitution (NTFP) estimates as representing between 10% and 30% of prostitution, depending on the community. However, since prostitution is an illegal occupation, outside a few small towns in Nevada, no agency has been able to collect accurate statistics about it, and few people identify themselves as "prostitutes" on IRS forms, in general population surveys, or other venues that could provide such statistics. In terms of clients, if you accept the lowest estimate of

the number of prostitutes, the NTFP estimates that the actual number of individual men who engage in commercial sex transactions in 1 year could be anywhere from around 800,000 to more than 12 million, depending on, for example, the average number of clients a prostitute sees per day and the average frequency with which the client seeks the services of prostitutes. When you move outside the United States, particularly into countries with much less of an obsession for statistics, it is even less possible to estimate the overall size of either population.

In the absence of clear information about the number of people engaging in something called "prostitution," and its myriad forms, it is almost impossible to get a representative sample of either population. As a result, all the studies that have been done to be understood as snapshots of particular groups of sex workers or clients, in specific sex work contexts, at specific points in time. Most studies in this country have focused on the easiest "prostitutes" to identify—women who work on the street, many of whom were contacted in jail, in drug treatment programs, and in STD clinics, further skewing their representativeness. Studies that have used "outreach," in an effort to be more inclusive, have also tended to focus on the women working on the street in recognized stroll districts. In the United States, only a small number of studies have looked at women working in massage parlors or brothels or for escort services, although in developing countries, most research has focused on women who work in off-street venues. Even fewer studies have looked either at male sex workers or clients of workers of either gender (e.g., of 134 separate abstracts listed in the index of the 1993 International AIDS Conference, only 37 were listed under the entry for clients and 18 under the entry for male prostitutes).

The largest study of the epidemiology of HIV infection among female sex workers in the United States, conducted in eight cities, was coordinated by the Centers for Disease Control from 1986 through 1989 (Darrow *et al.*, 1990). Women were recruited from a wide range of sites, including brothels, STD clinics, drug treatment programs, escort services, and streets with a reputation for being prostitution "stroll" districts. HIV infection rates were generally low, although they ranged from zero among brothel workers in Nevada—a state with a very low population prevalence of HIV infection—few of whom had ever injected drugs, to a high of 47.5% among women recruited in a methadone maintenance program and an STD clinic in northern New Jersey, most of whom had a history of injecting drug use (Table 1). Without the data from New Jersey, however, the range was from zero to 15%, the prevalence among women in a Miami detention center. The prevalence among the entire study population was 12.3%. However, the infection rate among those who had injected drugs was 19.9%, while

Table 1. HIV Prevalence among Female Sex Workers in the United States and Europe

Location/date	Study	HIV+/all women tested (%)	Data collection source
Europe			
Amsterdam, Netherlands (1990)	van Doornum et al. (1990)	2/472 (0.4%)	STD clinic
Ghent, Belgium (1988-1989)	Mak et al. (1990)	1/123 (0.8%)	Windows, bars, clubs, saunas
Catalonia, Spain (1990)	Casabona et al. (1990)	8/71 (11.3%)	Sex work bars
Vienna, Austria (1989)	Stary et al. (1991)	0/713 (0.0%)	Registered prostitutes
United States (1986-1989)			
Southern Nevada	Darrow et al. (1990)	0/37 (0.0%)	Brothels, brothel applicants
Atlanta		1/123 (0.8%)	Street and call girl outreach; tabloid advertisements
Colorado Springs		2/98 (2.0%)	STD, methadone, and HIV screening clinics
Los Angeles		12/300 (4.0%)	Detention center
San Francisco		10/212 (4.7%)	Street outreach
Miami		66/440 (15.0%)	Detention center
South New Jersey		6/28 (21.4%)	Methadone and STD clinics; street outreach
North New Jersey		75/158 (47.5%)	Methadone and STD clinics; street outreach
TOTAL		172/1396 (12.3%)	

the rate among those who had not was 4.8%; indeed, a personal history of injecting drug use and/or an ongoing sexual relationship with a man who injected drugs, or both, were the two factors associated with a positive test result. The marked difference in infection rates among women in different geographic areas who injected drugs—1.5% in Atlanta vs. 58.3% in northern New Jersey—reflected the context of injecting drug use in the different cities and was consistent with the prevalence of diagnosed AIDS cases among other women who injected drugs or had other identifiable risk factors in each area. The factor most closely associated with higher rates of infection was the use of "shooting galleries," a milieu more common in the cities around New York and New Jersey than elsewhere. In all the cities, researchers found high rates of condom use with clients (Darrow *et al.*, 1990; Darrow, 1992; Miller, Turner, & Moses, 1990).

One of the participating centers was the San Francisco Bay Area, where the research group had been looking at HIV seroprevalence among women, including both sex workers and non-sex workers, since 1985. In 1985-1986, the infection rate among both groups of women was 4.4%, rising in 1987-1988 to 5.8% in women who had not engaged in sex work and 5.7% in those who had. Consistently, among the women who had traded sex for money, HIV infection was associated with the women's own injecting drug-use, in contrast to the situation for non-sex-workers, some of whom had only sexual-contact risk factors (Cohen *et al.*, 1989).

The situation in other industrialized countries is quite similar. The prevalence of infection ranged from zero among 101 women tested in Copenhagen, Denmark, and 387 women tested in Sydney, Australia, to 77.8% among 18 women tested in Zurich, Switzerland. As in the United States, HIV infection was closely associated with both injection-drug use and the context within which the drugs are injected. For example, in Madrid, Spain, 1.5% of 165 women who did not inject drugs were infected, in contrast to 70.9% of 148 women injectors (Darrow, 1992).

The picture in developing countries appears to be quite different, however. Studies conducted in sub-Saharan Africa, Southern and Southeast Asia, and Latin America (Table 2) have found the factors associated with HIV infection to be low rates of condom use and a high prevalence of infection with other STDs, with little or no evidence of Western-style injection-drug use either by the women themselves or by their ongoing partners. As in industrial countries, the rates of infection varied widely according to the population studied, the locus of their work, and the geographic region. In sub-Saharan Africa, none of 89 women tested in Mogadishu, Somalia, 0.5% of 767 women tested in Borno, Nigeria, 16% of 50 women in Juba, southern Sudan, and rising sharply to 87.9% of 33 women in Ngoma, Rwanda, tested positive. In one city, Nairobi, Kenya, the infec-

Table 2. HIV Prevalence among Female Sex Workers in Africa, Asia, and Latin America

Location/date	Study	HIV+/all women tested (%)	Data collection source
Africa			
Yaoundé, Cameroon (1989)	Kaptue et al. (1989)	12/168 (7.1%)	Peer-recruited effort, bar workers
Mogadishu, Somalia (1990)	Burans et al. (1990)	0/89 (0.0%)	STD clinic
Mogadishu, Somalia (1990)	Ahmed et al. (1991)	1/155 (0.6%)	Four-district sample
Nairobi, Kenya (1985)	Simonsen et al. (1990)	259/418 (62%)	Pumwani district sex workers' STD clinic
Arusha and Moshi, Northern Tanzania (1991)	Nkya et al. (1991)	75/106 (73%)	Not available
Kinshasa, Zaire (1988)	Nzila et al. (1991)	432/1233 (35%)	Sex workers' STD clinic
The Gambia (1989)	Pepin et al. (1991)	6/355 (1.7%)	Not available
Asia			
Delhi, India (1988)	Singh et al. (1990)	1/701 (0.1%)	STD clinic
Philippines (1985)	Hayes et al. (1990)	203/25,391 (0.8%)	Registered prostitutes
(1987)		N/A (0.2%)	Registered prostitutes
Sydney, Australia (1986-1988)	Philpot et al. (1991)	0/231 (0.0%)	STD centre
Changmai, Thailand (1989)	Siraprasitri et al. (1991)	87/238 (36.5%)	Workers at 14 brothels
Latin America			
Tijuana, Mexico (1989)	Guerena-Burgueno et al. (1991)	2/415 (0.5%)	Not available
Tegucigalpa, Honduras (1990)	Venegas et al. (1991)	8/181 (4%)	Registered prostitutes
Mexico City (1992)	Juarez et al. (1992)	0/482 (0.0%)	Not available
São Paulo, Brazil (1990-1991)	Fernandes et al. (1992)	66/600 (11%)	Not available
Buenos Aires, Argentina (1987)	Mullare et al. (1989)	12/199 (6%)	Street workers

tion rate among 26 higher-class sex workers, women who work with businessmen and tourists, was 30.8% compared with 65.6% among 64 working-class prostitutes, most of whose clients were migrant workers and others living in the same impoverished neighborhood. In the latter group, infection rose from 8% in 1980 to 59% in 1985 (Simonsen *et al.*, 1990), even though the women were participating in a long-term study of STDs.

In Asia, the rate of infection ranged from 0.1% of 701 women tested in an STD clinic in Delhi, India, to 36% of 238 female brothel workers tested in Changmai, Thailand. Although injection-drug use was closely associated with the early cases of HIV infection in Thailand, many researchers say that it is not a factor related to infection among female sex workers. It is interesting to note that the high rate in Changmai exists even though prostitutes are regularly examined for STDs by physicians. In Latin America, the infection rate ranged from zero among 482 women working in Mexico City to 11% of 600 women, most of whom worked in bars or on the street, in São Paulo, Brazil.

Although the prevalence of infection is high among some groups of prostitutes in each geographic region, the prevalence of infection is relatively low among other groups in each region. In each region, the prevalence of infection is greatest among the women who earn the least money, a factor that is also associated with higher rates of other STDs, and, in Latin America and the industrial countries, with injection-drug use.

The Nature of the Risk to the Workers

In the industrial countries, the risk of HIV infection for sex workers is most directly related to behavior, especially injection-drug use, that is not directly connected to their work. Data from the CDC multicenter study show that the rate of infection is 4 times higher among women who report a history of injection-drug use (19.9%) than among those who do not (4.8%) (Darrow *et al.*, 1990). The study of women working in Nevada's brothels (Darrow *et al.*, 1990) and other studies among call girls in Miami (Fischl, Dickinson, Flanagan, & Fletcher, 1987) and New York City (Seidlin *et al.*, 1989) found no HIV infection among women who had no injection-drug use history.

More recently, increased rates of both syphilis and HIV infection have been found among women who used crack, a smokeable form of cocaine, associated with increased numbers of both paying and nonpaying partners (Chiasson, Stoneburner, Telgak, Hildebrandt, Schultz, & Jaffe, 1989). One factor that may affect the women's vulnerability to HIV infection through fellatio is that many of them have cuts and burns on their lips, and burns

on the roofs of their mouths, leaving a portal of entry for the virus (Judith Porter, personal communication; Joyce Wallace, personal communication). A 1991 review of research on crack cocaine use and STDs, including HIV infection, found that in five studies, it was increased sexual activity/number of partners, rather than selling sex, per se, that was associated with HIV infection (Marx, Aral, Rolfs, Sterk, & Kahn, 1991). However, in three of the five studies reviewed, the populations studied had other confounding markers of risk, such as injecting drug use or pelvic inflammatory disease, that made it more difficult to interpret the results.

In terms of sexual transmission, for sex workers as for any other population, the risk of HIV depends on a variety of factors including the background prevalence of infection in the population from which one or the other partners comes and the nature of the sexual encounter itself. It is generally agreed that the risk of infection from unprotected sex is greatest for anal intercourse, less high for vaginal intercourse, significantly lower for fellatio or cunnilingus, and negligible for hand genital contact, and that the use of condoms and other latex (or in some cases polyurethane) barriers substantially reduces that risk [Alexander, 1993 (draft)]. Therefore, where the predominant sexual activities are those at the lower end of the risk scale, and where the use of condoms and other barriers is high, the workplace risk to the sex worker should be low. Although the frequency with which female sex workers provide anal intercourse in their work is not well documented, most of those who have been asked this question have said they do not offer this service. Those who do generally charge more for it, which may reduce the demand. In terms of condom use, studies in the United States have found that 70–90% of sex workers report using condoms with clients (Darrow and Fischbein, personal communication). *usually, like a joint condom, I use it*

Indeed, the greatest sexual risk prostitutes face in industrial countries appears to be from primary and casual personal relationships with men who are infected, primarily men who inject drugs but in some cases men who also have sex with men. Prostitute women, like most other women, are least likely to use condoms during sex with a primary partner, for reasons having to do with the nature of intimate relationships and issues of trust, common to all women, as well as the need for a way to distinguish between work sex and personal sex (Bailey, Fox, & Oliver, 1992; Cohen *et al.*, 1989; Day, 1988).

In terms of occupational risk, there is some evidence that the relative risk for HIV and other STD infection differs according to the work setting, the level of professionalism, the type of sexual contact involved, and the relationships between the partners (Cohen, Derish, & Sweat, 1992). In most countries, next to nothing is known about the prevalence of infection among the general population of heterosexual men from whom clients come, al-

though a few studies have looked at specific subpopulations, such as truck drivers, military men, and migrant laborers. A limited amount of ethnographic information suggests that there are both class and cultural differences in the types of sexual services preferred by clients. The majority of transactions between sex workers and clients who contact each other on the street and in bars involve manual stimulation or fellatio (usually with a condom) and take less than 15 minutes. On the other hand, transactions involving sex workers and clients who connect through escort services or individual workers' newspaper ads involve greater privacy and a wider variety of sexual techniques and are more likely to last an hour or more. In this context, condom use has also become the norm, except in those establishments in which the management does not support, or actively discourages, routine use of condoms (Miller *et al.*, 1990; Shedlin, 1987). Thus, to the extent that sex workers define much of their sexual activity as occupational, risk of transmission of all STDs is reduced.

In general, however,

From Prostitutes to Clients?

Since 1978, epidemiologists and others who have written about STDs have used such terms as "core group of high-frequency transmitters" and "reservoirs of infection" to describe female prostitutes (D'Costa *et al.*, 1985; Holmes & Aral, 1991; Ronald & Aral, 1992; Yorke, Hethcote, & Nold, 1978). One particularly telling statement was this one in Piot *et al.*, (1987):

Prostitutes are a major reservoir of STDs in Nairobi and are now probably playing an important role in the spread of AIDS virus as well. In this retrospective survey, evidence of AIDS virus infection was detected earliest in prostitutes and at a higher rate than in men with STDs, who are their customers. Prostitutes have probably contributed significantly to the introduction and dissemination of HIV in Nairobi.

The question is, if it was detected first in prostitutes, does this mean it first appeared in prostitutes? Or does it mean that prostitutes were studied first? Sometimes it seems that many epidemiologists think that prostitutes become infected from mosquitos. Nonetheless, it is important to know whether prostitutes are, in fact, playing a major role in the spread of the epidemic to others. As much as researchers have looked at the prevalence of infection among female sex workers, however, and expressed serious concern about the risk they pose to men, far fewer have conducted similar studies among clients or among groups of men likely to be clients.

One factor likely to affect client risk is the lower efficiency of female-to-male transmission than of male-to-female transmission (Padian, Shiboski, &

Jewell, 1991). It is therefore obvious that where the prevalence of infection is low among sex workers, the risk to clients from their prostitution connection will be negligible, and there is some indirect data that indicate that the risk of HIV infection is extremely low for male clients in industrial countries. For example, one study, in an STD clinic in New York City, found the same rate of infection (1.4%) among 138 men who reported no risk factors for AIDS except contact with female prostitutes as among 222 men who reported no risk factors at all (e.g., contact with either female sex workers or other men or injection-drug use)¹ (Chiasson *et al.*, 1988). In another study in New York City, 6 of 340 men (2%) who reported an average of 94 contacts with female prostitutes were HIV+. Upon further questioning, however, 3 of the 6 admitted other risk factors. The other 3 each had an average of 575 contacts with female prostitutes (Wallace, Mann, & Beatrice, 1988).

Looking at the statistics concerning diagnosed AIDS cases in the United States, as of September 1993, there were 27,783 AIDS cases initially reported with no identified risk. After attempts were made to follow up these cases, information remained incomplete for 15,184; of 12,599 who were followed up, 11,943 were reclassified as having become infected through the standard identified practices, 17 were probable health-care-setting infections, and 639 remained as unidentified risk. Of these, 342 adult males were interviewed, of whom 123 reported contact with a prostitute (sex unspecified). These 123 men represented 0.04% of 292,665 adult and adolescent males diagnosed with AIDS, which was a smaller proportion than the 0.8% reported in September 1987. Thus, the proportion of reported AIDS cases that may be attributed to sexual contact with a female prostitute is much lower than the proportion attributed to for example, homosexual contact (62%), injection drug use (21%), documented heterosexual contact (3%), and even blood transfusion (1%). Of course it is possible that there are additional cases in which unprotected sex with a female sex worker was the mode of transmission, but other risk factors were reported that were higher on the CDC ordering of priority (Castro *et al.*, 1988; Centers for Disease Control and Prevention, 1993).

There remains, however, the question about the level of risk to uninfected clients who have sex with female sex workers among whom the prevalence of infection is relatively high. There are some indications that

¹There is some evidence that crack may alter that picture, as a 1989 study found that HIV+ men (66.7%) were more likely to report contact with a female prostitute than men who were not infected (40.7%). However, the small sample size of men with HIV ($N = 12$), in contrast to the larger sample size of uninfected men ($N = 428$), makes it difficult to generalize from the study result (Chiasson *et al.*, 1989).

the risk to the male clients is lower than the risk to female sex workers in developing countries, as well. For example, in Nairobi, Kenya, in 1986, 38 of 340 men (11.2%) who reported "frequent contact with prostitutes" were seropositive, at a time when 85% of the prostitutes in the same community were infected, even though condom use was rare (Simonsen *et al.*, 1988).

In the end, however, whether the risk to either prostitute or client is high or low, if we are to control the spread of HIV, it will be important to reduce that risk still further. Therefore, it is appropriate to develop prevention interventions that enable female (and male) sex workers to protect themselves from infection and, if they are infected, to protect their sex partners—paying or not—from HIV and other STDs.

PREVENTING THE PREVENTABLE: SEX-WORK-BASED INTERVENTIONS

Most of the research related to HIV and prostitution has focused on determining the prevalence of infection among female sex workers, with relatively little emphasis on determining the best approaches to take to reduce their risk. To some extent, this focus obtains because of a kind of bias in favor of "research" over the less quantifiable process of trying to change community-wide behaviors. However, to some extent, research in this area is complicated by the illegality of some or all aspects of sex work in most countries, not to mention the stigma that can affect researchers almost as much as it does sex workers.

Nonetheless, there are quite a large number of projects around the world. When one of the authors was with the World Health Organization Global Programme on AIDS, she reviewed the literature and talked with countless consultants and representatives of such projects, identifying 138 projects in 55 developing countries. Although industrialized countries were not included in the review, she was also in contact with representatives of more than 25 sex work projects in Europe and 10 in Australia and New Zealand. Before we review the characteristics of projects that have been well received by sex workers, we think it is important to look at the legal context within which such interventions have to be designed and implemented.

The Legal Context of Sex-Work Interventions

As is the case with some other populations that are highly vulnerable to HIV infection—men who have sex with men and injection-drug users (IDUs)—there is a long history of efforts to control or abolish the activity.

In terms of prostitution, one of the oldest laws was incised on clay tablets some 3244 years ago, in Sumer, requiring that good women be veiled on the street and prohibiting independent prostitutes from veiling themselves. After more than three millennia of dress codes, zoning laws, curfews, health regulations, banishments, and outright prohibitions, prostitution continues to flourish, affected more by economic up- and downturns than by police or health department activities. In no country is prostitution treated in the same way as other occupations, with the same paid vacation and sick leave, health insurance, workers' compensation, retirement pensions, and OSHA regulations found in other occupations.

Laws prohibiting prostitution are on the books in all 50 states in this country,² although the enforcement of the laws varies widely. Moreover, there are minor variations in the basic laws, as some states make it a crime to agree to, as well as to solicit or engage in, the exchange of sex and money or other compensation, while other states have yet to legalize such entrapment. Moreover, some states have enacted laws requiring anyone convicted on prostitution charges to be tested for HIV—a law that routinely bypasses clients, as their charges are routinely dismissed—and, in some cases, laws making it a felony to continue to work after testing positive. California is one of those states, and in the spring of 1994, 20 people, including 12 women and 8 men, were serving time in state prison on felony prostitution charges (Teri Goodson, personal communication). Such measures have curbed neither the spread of HIV or other STDs nor the prevalence of prostitution (Alexander, in press; Institute of Medicine/National Academy of Sciences, 1988). The threat of such restrictive actions, however, may cause the persons most at risk—the homeless women, the injecting drug user working to pay for her drugs—to avoid HIV testing, and even routine health care, in order to escape identification. Moreover, where extensive police crackdowns have been implemented, prostitutes have

²As noted before, Nevada is the only state in which any form of prostitution is legal. The state law grants rural counties with less than 250,000 population the option to legalize brothels locally, with a mandatory health scheme requiring weekly examinations for gonorrhea and monthly examinations for syphilis and HIV, all at the workers' expense. As is the case in the Philippines, Thailand, Senegal, and other countries where mandatory health checks are in place, the examinations are often brief, perfunctory, and provided in a rude manner. Nor do most health examiners respond to other health care problems (Laurie Anderson, personal communication). The prevalence of STDs was stable, at a rather low rate, for most of the life of this system; however, when the state enacted a law requiring clients to use condoms, the low rate dropped almost to zero (Alexander, 1987), suggesting that condoms, not regular checkups, should be the primary prophylaxis against STDs.

tended to move elsewhere, to the next town or across a national boundary, until the repression lets up.

Mandatory health schemes, in which prostitutes are required to register with police or public health units, are often implemented in conjunction with prohibition, with the police, or special public health enforcement units, having the responsibility to check on sex workers' health and to arrest them if their health cards are not up to date. However, such schemes have a sorry history and have never had much success in reducing the prevalence of STDs (Brandt, 1987; Gibson, 1986; Harsin, 1985). The authors have been repeatedly impressed with the high incidence of STDs, sometimes including HIV, in groups of sex workers who are regularly examined by health care providers (e.g., in Chiangmai, Olangopo/Angeles City, and Mombasa, where such examinations are mandatory, and even in Nairobi, where they are voluntary).

Centuries of repression, and centuries-old distrust, make it difficult to establish effective HIV and AIDS prevention interventions through law enforcement agencies and detention centers, or even in STD clinics and other health programs. If the message is delivered by those who have been hounding them, the sex workers have a hard time seeing the message as something new, something for rather than against them.

Sex workers are quick to detect when the primary motivation for an intervention is to protect the clients or, worse, the "general population," from them, and they will tend to stay away. Such efforts are often accompanied both by media campaigns designed to deter men from having sex with prostitutes, thus hurting business, and periodic police "sweeps," to clear the streets of prostitutes, thus hurting prostitutes' lives. In some cases, police have waited on the sidelines while outreach workers have distributed information, condoms, and sometimes sterile injection equipment, only to swoop down when they leave, arresting everyone who has the incriminating materials on them.³

Other Barriers to Interventions

Sex workers and clients find each other in a wide range of places and resort to even more places to complete their transactions. In almost every country, both the contact site and the transaction site are to a greater or lesser extent underground, as sex workers and clients try to avoid being

³The first night Project AWARE outreach workers walked through San Francisco's Tenderloin District, police rounded up all the women to whom the outreach workers had talked, a common complaint of outreach projects everywhere in this country.

harassed, or arrested and fined or incarcerated by police. The exceptions are so few they are notable, being pretty much limited to a few cities in Europe.

Living on the margins of society affects sex workers' vulnerability to HIV infection and their openness to HIV/AIDS prevention interventions. The average work life of female prostitutes seems to be about 4 or 5 years, no matter what the country, and every country has some very young workers and quite a few in their 30s and 40s (Delacoste & Alexander, 1987; Pheterson, 1989). Because sex workers are outside the law, their ability to negotiate for safer working conditions, if they work for someone else, is often sharply restricted [Alexander, 1987, 1993 (draft); Day, 1988]. Although the primary motivation for working as a prostitute is economic, and sex work usually pays better than other available work, many prostitutes are in a precarious financial position because of the need to remain one step ahead of the law or an endless pattern of work interspaced with incarceration. For those who use drugs, the need to earn money to pay for the next fix can sometimes be overwhelming. All these factors contribute to sex workers' vulnerability to clients' offers of extra money for unprotected, or otherwise riskier, acts (Leonard, 1990).

The predominant sex work transactions can vary, considerably, from one place to another. In the United States, hand jobs and fellatio have become the most common transactions, considered to be easy to provide in cramped quarters and easy to control (Alexander, 1987; Miller *et al.*, 1990). In Australia, on the other hand, vaginal sex is the most common transaction, again considered to be easy to provide and control (Julie Bates, personal communication). In Nairobi, Kenya, only a small percentage of women who work around the tourist hotels include fellatio in their repertoire (although that may change, as a group of women working in a poor, urban workers' community were quite impressed when one of the authors demonstrated how to put a condom on a client orally). On the other hand, AIDS prevention projects have introduced the fellatio-condom tactic in such sites as Olango and Angeles City, and it has spread to other working communities in the Philippines (Norma Ravelo, personal communication).

Community-Based Harm-Reduction Approaches

Because of the urgency of reducing the rate of transmission, and the failure of traditional, repressive approaches, many countries have adopted a "harm reduction" model of HIV/AIDS and STD prevention. The term was first used in relation to injecting drug users, as projects to distribute sterile injection equipment were set up in such places as the Netherlands,

Scotland, and Australia, to reduce the likelihood that drug users would share needles contaminated with HIV. Gay men in many countries organized on their own behalf, sometimes with and sometimes without government funding, to begin the process of shifting the norms of sexual behavior to reduce their risk of HIV. By 1985, prostitutes and other sex workers in Western, industrialized countries had also begun to look at the need to change their practices, to insist on the use of condoms and other barriers in the workplace. The goal of all these groups was not to eliminate prostitution—as is often the goal of police, for example—but to reduce the risk, or harm, that AIDS has brought to the work.

The earliest behavior changes were made by people who openly acknowledged their behavior—self-defined sex workers, gay men, injectors. However, the growing body of research from around the world, and the growing body of experience in the field, has made it clear that the sex trade is extremely diverse, including both independent and arranged, or organized, transactions, with full-time, part-time, and casual itinerant workers. Those who are the most "professional" about their work (i.e., usually those who work on a regular schedule over an extended period of time) are the first to adopt routine safer sex practices.

The programs with the greatest success in reaching the often "hidden" populations of sex workers have involved the more self-aware sex workers in the design and the carrying out of project activities. Sometimes called "peer education," the most successful forms of this approach become more and more involved in what is really "community organizing," over time, as the sex workers on the staff, and the sex workers being reached, identify obstacles to the workers' safety and work out solutions, where possible. Prostitutes' collectives in Australia came up with the idea of "Ugly Mug Lists," flyers or newsletters containing enough information about dangerous clients—men who have raped, or tried to rape, sex workers—to enable their colleagues to avoid working with them. Within only a few years, this strategy has spread to projects in other countries, in every region of the world, laying the groundwork for a collective, community response to violence against prostitutes. A project in Calcutta, and another in Kathmandu, are supporting prostitutes' efforts to form unions, to negotiate with the managers of brothels with bad working conditions. In Yaoundé, Cameroon, Accra, Ghana, and Davao City, The Philippines, sex workers formed credit unions to enable women faced with family crises to borrow money. In Nairobi, a similar credit union enabled women to take turns having a day off, a day to take care of themselves.

Some projects—in Australia, in the United States—have opened drop-in centers where street workers, often homeless women, can take a shower,

wash their clothes, even find some almost-new clothes in a clothing exchange, have a cup of coffee or something to eat, even take a much-needed nap. Many projects have used mobile vans—in San Francisco, New York, and Amsterdam, for example—to take services to the streets where the women are working, instead of waiting for the women to come to their offices. Vans are especially suited to providing health care, including STD diagnosis and treatment, anonymous HIV testing, methadone and other drug services, and emergency services to help women deal with the sometimes violent nature of their lives on the street. Sometimes, the van becomes a place of refuge, a way to get out of a neighborhood where police action is heavy or where there are drive-by shootings. And they are a good place to store large quantities of condoms, lubricant packets, bottles of bleach, and sterile needles to be distributed as you go.

Many projects have established good working relationships with drug treatment programs and have pressured the government to open additional programs, especially programs sensitive to women's needs, to reduce the time lag between applying and being admitted to them. It can also be useful to establish good relationships with other service providers, especially those that respond to violence against women (e.g., rape crisis centers and battered women's shelters), the staffs of which sometimes require sensitization before they can effectively meet the needs of sex workers without judging them.

When projects respond to a range of immediate needs, then the messages about AIDS prevention are easier to hear. However, it is important not to expect too much change too rapidly. One of the authors has been struck by the fact that many women, in many countries, have told her that it took them about a year before they completely shifted to safer sex practices, including condom use and lower-risk services. As with other populations, there is a lag between understanding the risk, understanding the need to use a barrier to prevent transmission, and changing the way they have sex. The changes are likely to happen first in the work situation, where it is relatively easy to tell a client, especially a new one, to use a condom, or even just assume the client's agreement to use one and put it on. It is not so easy to use condoms with regular clients, who are accustomed to not using condoms, or with lovers. With the latter, the decision to use a condom is complicated by the same issues of trust that other women face, as, despite the prostitution, the primary relationship is often emotionally monogamous. Moreover, after a day of exerting control over one client after another, most sex workers want to take off that mask and be themselves, spontaneous and intimate at the end of the day. For the behavior at home to change, their partners will also need to be involved (Alexander, 1987; *in press*; Day, 1988). It would also help to have a wider variety of barrier

methods available, including nonirritating intravaginal microbicides. The female condom, already available in some European countries and beginning to be available in the United States, may also make a difference.

CONCLUSION

In summary, sex-work-related interventions to prevent HIV/AIDS and other STDs need to be designed with the interests of the sex worker as the main agenda. They need to consider the legal context and the effect of years of repression on sex workers' ability to care about, and take care of, themselves. Education is only one part of AIDS prevention, which also has to involve community organizing to change the context of the way they work and live. Handing condoms out, for example, is not very effective if the police confiscate them or use their possession as evidence of intent to commit a crime, as they do in San Francisco, London, and Bombay. If police hound women to keep a health card up to date, the women are not likely to trust the clinic to which the police send them. Laws that force them to get tested and jail them if they have no option but to continue to work will further interfere with the development of effective interventions. These practices and policies have to change.

If interventions are to effectively reduce the spread of AIDS, the messages and the message sources must be trustworthy, meeting and reflecting the interests and needs of the target groups (i.e., sex workers, managers, and clients). Prevention messages that warn men not to have sex with prostitutes have never reduced either prostitution or STDs. The intervention must start with the recognition that selling sex is a transaction that involves buyers as well as sellers and has flourished throughout human history. By involving the sex workers in the design and implementation of a project, it is possible to overcome some barriers and to help the women begin to change the context of their lives. In terms of the clients, who are significantly male, they need to be told to use condoms—with prostitutes, with casual partners, with girlfriends, with their wives—and perhaps reminded that prostitutes are, after all, experts in the art of having pleasure safely.

The picture is not terribly encouraging, however. The Centers for Disease Control and Prevention is preparing for a new prevention initiative, to begin in the summer of 1995. States are currently working with community-based organizations to decide how to allocate those resources, and while many are discussing supporting projects to work with female sex workers, few are thinking about how to get heterosexual men—whether clients or not—to be willing, or even eager, to use condoms. Although safe

sex prevention messages are widely visible in some cities, such as San Francisco, they are all but invisible in others, such as New York. One of the authors has been dismayed that in more than a year, she has seen two subway ads promoting condoms and three television public service announcements in New York City, the epicenter of the epidemic in industrialized countries. One thing that has become clear, especially with the increase in reports that some gay men are negotiating away from the gold standard of 100% condom use—denying their risk in some relationships, daring the odds in others—is that HIV/AIDS and STD prevention campaigns and interventions have to be ongoing, for the long term. Virtually every study that has looked at the question has found that there is a major discrepancy between knowledge and behavior, something that should not surprise us, given that so many smokers continue to smoke. Changing community norms, which everyone agrees is necessary, requires more than ideologies and messages; it requires active, positive reinforcement in the communities and sites where people are most at risk.

In terms of sex work, policy makers need to address the impact of the law, and law enforcement practices, on the ability of sex workers to retain any control over their lives and, more specifically, their ability to insist on condom use with clients and to negotiate from a position of strength with lovers. A number of researchers are beginning to look at the impact of frequent incarceration on, for example, drug users' behavior when out of prison. Similar research needs to be done for prostitutes, especially those on the street, who also suffer from inordinate amounts of violence. One question that sex workers' rights groups are asking all over the world is, if prostitution were not a crime, and prostitutes were free to carefully negotiate with clients before they get in their cars, enter their hotel rooms, or let them into their homes/work spaces, would they be better able to recognize trouble before it starts and feel sure enough of themselves to get out of danger when it occurs?

In San Francisco, the Board of Supervisors formed a Task Force on Prostitution to examine the situation as it currently stands and to recommend some alternatives. If every city would do that, it might be possible to begin changing the laws or, barring that, to change local policies and procedures, such as confiscation or evidentiary use of condoms.

In the meantime, existing projects that work with sex workers need to be funded on a long-term basis, and funders need to consider a broader range of services than merely distributing condoms, information, and even needles. The stronger the community of sex workers is, the more will they be able to control the way they work, reducing both their own and their sex partners' risk of HIV infection and AIDS.

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EXECUTIVE DIRECTOR

Statement by Joyce I. Wallace, M.D., F.A.C.P.
Washington, DC, 5 November 1997

I believe I have the credentials to advise on this issue as I was the first person in the world to look for AIDS in women, and I have been working with street walkers in regards to AIDS since 1982. In the United States there is no substantial problem of female sex workers transmitting AIDS to their clients, as indicated by the continued low number of adult males diagnosed with AIDS who claim sex with a female sex worker as their only risk factor. Certainly all the data I have seen including my own agrees. I do feel that there is more of a problem of sex workers getting AIDS from clients. Our research, which I am enclosing, verifies this. In particular, women who perform fellatio at work more often than vaginal sex are at greater risk of contracting AIDS.

The greatest problem we have found in New York City in working with streetwalkers is that half of them are homeless and have no resources whatsoever. They do not know how to access welfare, and when they do, they find that it is insufficient for housing. The allowance for housing in NYC for a single adult is \$219/month. We know of no place that can be rented for \$219/month in NYC. This means that those who are not affected by HIV have virtually no chance of getting off the streets. Those who do show antibodies to HIV and are sick can become clients of the Division of AIDS Services and Income Support (DASIS). This agency offers people enough so that they may live safely, and not have to continue to work on the streets. However those who do not meet the federal definition for AIDS cannot become DASIS clients, and they are only able to learn that there are rent subsidies available if they are helped by an advocate.

When we find HIV positive women who are still working because they have not become DASIS clients we do two things: Firstly, we work to insure that they become DASIS clients and my being a medical doctor helps us complete the necessary form (M 11 Q) quickly. Secondly,

we make sure that the client always has ample condoms so that they can never be accused of knowingly spreading a disease. We expect to distribute 600,000 condoms this year. This policy has worked! In 1989 37% of clients were HIV positive. The prevalence now is 18%.

Prevention via education and condoms works.

The big problem is with the women who are uninfected! They have no where to go to try and live a life off the streets. We can get an infected woman off the streets in 24 to 48 hours because of the policy to house homeless people with AIDS immediately. This is not always a perfect solution since they are sometimes placed in Single Room Occupancies (SRO's) where there are unsafe conditions. Usually when men find out that a woman has been a prostitute they think that she is public property and it becomes unsafe for her.

However, NYC DASIS is contracting with many agencies such as ourselves to provide better transitional supported housing and permanent housing. It would not seem that HIV infected people could be less of a problem than HIV negative!, but, that is the case. Our agency has tried three times to open housing for uninfected ex-prostitutes. The first time was on the Lower East Side of Manhattan. We designed a project that was extremely cost effective and had a very good chance of being funded by HUD. Unfortunately people in the community said that there were no prostitutes in their neighborhood (the site of one of the city's major stroll districts) and a small organization called the East Side Chamber of Commerce wrote to HUD not to fund us. The project's NYS Division of Substance Abuse component, a drop-in center, was killed by the speaker of the House of New York State who is the Assemblyman from that district. Having powerful politicians responding to the requests of a few hostile constituents has the effect that projects cannot be sited anywhere.

The cost effective program we were proposing would have had a drop-in center on one floor and two floors of rooms transitional housing for prostitutes beginning the shift out of sex work. Women dropping in for services, including counseling, a hot meal, a shower, a talk with a social worker, could have learned that should they want to get off the street there was a comfortable room for them, providing they abide by the rules. The rules would serve to decrease drug use with help from a program and to enable them to enter into vocational training. Women could live with us till they had accumulated enough money to pay for an apartment with a

month's rent in advance and a month's security. This is a way to learn that step by step a person can achieve and in so doing, think better of themselves.

At any rate, the project was killed on the Lower East Side; moreover, the idea that there was no problem with prostitutes was belied by the fact that Joel Rivkin tortured and killed seventeen women from that same area two years later.

We then tried to develop a facility on West 12th Street in response to a New York City RFP for shelters. The plan was to shelter 12 women in the house while they were in school. The neighbors reacted as if life as we know it will end. It is this NIMBY that has killed many of our proposals, as well as many other organization's projects. We later tried to apply to do this under the HUD SUPER NOFA . But the people who thought they know what the needs were in NYC and screened the proposals did not submit our proposal. This is unfortunate. It is also a case where it would be better to bypass local politics. To have a shelter, a home for ex-prostitutes is relatively inexpensive, but cannot be run on the monies that the Human Resource Administration pays. We cannot house, feed, and supervise women for food stamps and \$219 per month.

To reiterate, one way to help women who are basically without any resources who work selling vaginal or oral sex on the streets of New York is to provide them with an alternative. At least half of these women are homeless and are just doing this to survive. Were they tougher they might be drug pushers, were they quicker, they might be thieves. When they're relatively nice and socialized they end up as hookers. I would remind this body that the term hooker derives from General Joseph Hooker who requested that prostitutes follow his troops in the Civil War.

Other factors that affect street walkers that could decrease the chance of their contracting AIDS have to do with the attitudes of police. They say they are sweeping the streets as if describing debris, not people. The police often ask for sexual favors when the women are helpless, their captives. They sometimes confiscate condoms. We need to build these women's self-esteem not break them down. New York especially has a problem because young women who are sexually abused or physically abused in their "homes" migrate to the city. Sociological studies have shown that between thirty and seventy percent of sex workers have a history of childhood sexual abuse (and/or were physically abused or neglected). As the women tell us, they might as well get paid for what they were forced to do at home. As prostitutes, they feel

somewhat more control over their lives, even though this is an illusion. After all, the next "john" could have the Jack the Ripper complex. What we need to do is provide a place where women can feel they have rights--a right to live, a right to eat, and a right to education, and we can allow them to exercise these rights. By saying this I am not saying that women who are sex workers should be castigated in any way. I have no fervor for the conversion of sex workers. There are many who have made a conscious decision to do this work, work in a professional manner, and pose little harm to themselves or disruption to the community. I know that many of the woman I work with started on the streets before they became addicts, but the constant risk of violence and arrest, and the rigors of street life forced the need for numbness. Others began as drug users, and had no choice because of the need for money to pay for their drug needs. In any case, for those who want out, especially those who are the most vulnerable to HIV and AIDS, we do not yet have enough ways out.

Enclosed:

Letter from JAPHA
Statistics about decrease of HIV seroprevalence
Abstracts, APHA Conference, November 1996

they cannot be applied directly to human immunodeficiency virus (HIV) infection, raise questions about the safety of unprotected receptive oral sex in humans. Although there are reports of seroconversion among adults after oral-genital sex,² epidemiological data are scarce. Wallace et al. reported in 1992 that, among female sex workers, smoking crack cocaine and inconsistent condom use while performing fellatio were both associated with a high risk of HIV infection.³

Although the relationship between crack smoking and the risk of HIV transmission through unprotected vaginal sex has been documented,⁴ research also shows that the risk of HIV transmission through unprotected oral sex may be increased among crack smokers due to their frequent lip and mouth injuries.⁵ Among female prostitutes who are heavy crack smokers, extensive lip and mouth injuries and frequent unprotected oral sex create a potential route of infection.⁶ Wallace's most recent data indicate that smoking crack and performing unprotected fellatio are significantly related to HIV infection among female sex workers in New York City who have no history of injection drug use.

Since 1988, FROST'D (Foundation for Research in Sexually Transmitted Diseases) has provided services and testing for HIV infection to female sex workers in low-income stroll districts in New York City. Clients are surveyed on issues related to drug use and sexual practices. Cumulative data from 1989 through 1995 show that 60.1% (1952) of the 3246 streetwalkers surveyed have never used IV drugs. Among sex workers who do not inject drugs, use of crack, performing mostly oral sex, and inconsistent condom use during oral sex are all significantly related to HIV seropositivity: 21.3% of those using crack are HIV positive compared to 13.2% of those who do not use crack ($P = .00$); 21.5% of those performing mostly oral sex are HIV positive compared with 15% of those who perform mostly vaginal sex ($P = .00$); and 25.4% of those who use condoms consistently during oral sex are seropositive

compared to 14.7% of those who report always using condoms for fellatio ($P = .00$). Among women with no history of injecting drugs and who perform mostly fellatio with clients, 23.9% of those who smoked crack are HIV positive compared with 16.7% among women who do not smoke crack cocaine. These data suggest the need for epidemiological studies of HIV transmission by oral sex, especially among crack smokers who frequently sustain lip and mouth injuries. □

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Oral Sex, Crack Smoking, and HIV Infection among Female Sex Workers Who Do Not Inject Drugs

Recent research on oral exposure to simian immunodeficiency virus (SIV) infection in macaque monkeys indicates that oral susceptibility is considerably higher than expected.¹ These data, though

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