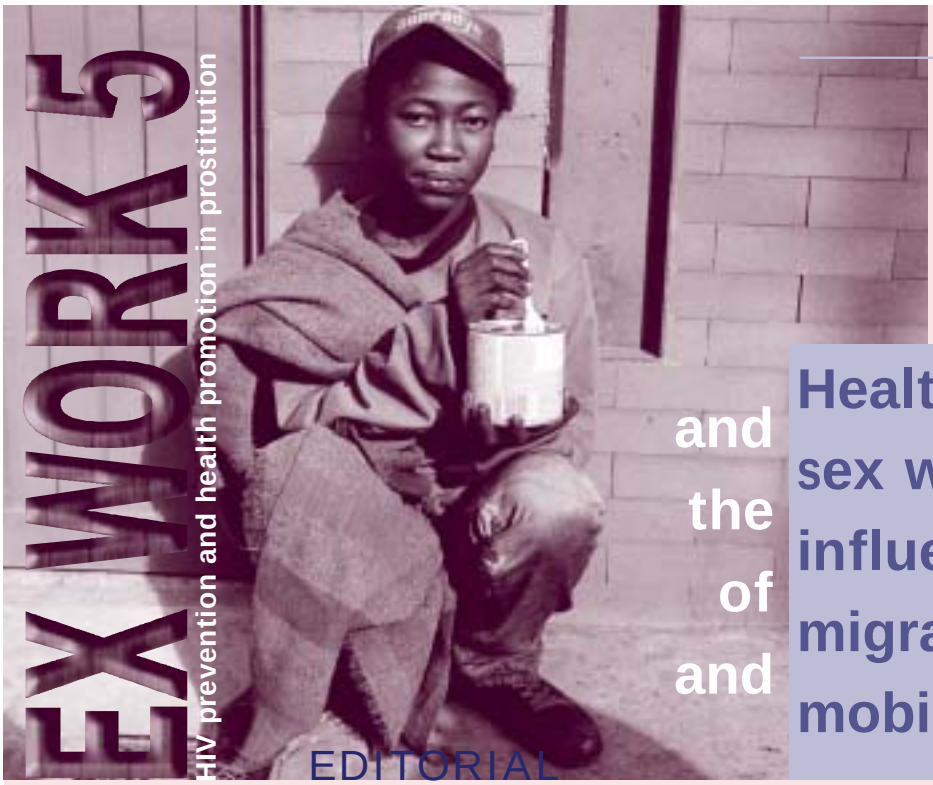
RESEARCH FOR SEX WORK 5
HIV prevention and health promotion in prostitution
JUNE 2002



Health, HIV and the sex work: influence of migration and mobility

EDITORIAL

In our research with Vietnamese sex workers in Cambodia we came across Vietnamese women who would go to Malaysia, Singapore or Macau to work there for a few weeks and then return. They would make the trip again if they needed money. One of the main problems they mention is the impossibility to talk with their clients. If you cannot communicate it is difficult to stand up for yourself. It is not always just the clients with whom there are communication problems, there are also problems with the police, all kinds of intermediaries in sex work and the staff of health care services.

Communication problems and cultural differences linked to the immigrant status of sex workers makes them extremely vulnerable. There is a need for more information here, because (as Laura Agustín writes in this issue), traditional research on sex work does not reveal the dynamics of how this vulnerability is created and maintained. To develop a clear understanding of how sex work, gender, health, migration policies and mobility are interrelated, some 15 contributions from all over the world have been brought together in this issue of Research for Sex Work.

Yes, sex workers are mobile

Mobility is a rule in sex work. In most countries sex work is criminalised and sex workers have to be mobile to make it difficult for the police to find them. The places where transactions can be made (bars, certain streets, parks, massage parlours, karaoke bars) may be the same, but the workers are mobile.
Sex workers are mobile, not only for their own safety, but also because some clients look for new faces and there comes a time for sex workers for moving on to a place where they will find better opportunities. This is illustrated in the contribution by Lee-Nah Hsu and Jacques du Guerney in which they describe how sex workers would start in the 'hot spots', but later move on to other places when the competition gets too tough. If they do not move on by themselves brothel owners may move whole groups of sex workers to other places they own in other parts of the country. This creates insecurities for the sex workers who will have to find their way again in their new surroundings. Also, when the clients move, sex workers may move with them.
Sex workers working with men employed in road construction move on with these construction men to the new construction sites. And women servicing truck-drivers use the free transportation offered to move to new places, as Anahí Dreser and his colleagues show in their contribution.

Stigmatisation

If sex work is legal (as it is in some countries such as the Netherlands), this does not mean that all sex workers are documented (i.e. have a legal permit to stay). Their right to work may be linked to legal status and therefore many sex workers have to remain mobile in order not to be caught. In the contribution by Thérèse van der Helm we see that two-thirds of sex workers in the Netherlands are migrants and what impact the more restrictive migration and prostitution policies in the Netherlands have on their mobility and health.

For the women with legal status the issue of stigmatisation may remain important. They may like to work in places where they do not live themselves, separating their personal from their professional life. This leads to another form of mobility. A few of the contributions in this issue show the same, such as the article on sex workers working on the markets in Niger by Sani Aliou and others.

Vulnerability

Mobility may bring sex workers into situations that pose a threat to them and increase their vulnerability. It is important to know the area in which you work. Where is it safe and where not? Where can you find possible support? Where are useful facilities located, for example health services? In new situations one becomes more quickly dependent on others, and these other people can play a role in mediating between new sex workers and their environment. The words of a Vietnamese sex worker living in Cambodia and travelling around Asia to work illustrate this: "I got a US$1500 loan to buy a Cambodian passport and for all the arrangements to migrate to Singapore. Another US$500 was used as pocket money for the first few weeks in Singapore. I agreed to pay back US$4000 to the man." Debts and dependency often create an opening for exploitation.

In research done in Vietnam we found that the first networks that women enter on arrival from rural areas in the cities are very important for the remainder of their stay. In some networks they are exploited, in others they find support. Laura Oso explains in her article in this issue that the Colombian prostitutes she interviewed in Spain often were trafficked by small networks of family members and friends. However, trafficking and exploitation are just around the corner and it is often difficult to see where free choices and personal decisions stop and coercion and exploitation begin.
For programmes involving sex workers it seems important to develop mechanisms for networks that are sex worker-friendly and that are easily accessible to them.

Globalisation
Globalisation of economies leads to increased exchange of information and products. One would also expect more movement and legal employment of people, but this is usually restricted to people from rich countries. People from Africa and many countries in Asia, Latin America and Eastern Europe find many restrictions if they want to travel and work abroad. Because of the globalisation of the world economy the poor sections of countries in the South are confronted with increasing poverty, while in rich countries there is an increasing need for cheap labour. The result is that people from the South are taking more and more jobs in the North but not on a legal basis.

While people in the North do the more desired work, the jobs for people from abroad are specifically the 3D jobs: dirty, dangerous and demanding. That is why two-thirds of the sex workers in the Netherlands come from countries outside the European Union (EU). Labour migration also shows an increasing trend of feminisation. Women appear to be more faithful in sending money home to support their families, and governments of poor countries often stimulate women in particular to go abroad.
It speaks for itself that sex workers are often caught in this process, paying money back for years and being unable to begin a new life (be it working for themselves, changing work or returning to their country of origin). In that sense migration policies in rich countries have an enormous impact on the conditions in which many sex workers have to work. Moreover, they seriously inhibit their access to health care, health education and other services. In her contribution, Melissa Ditmore writes about a project in France: "Grisélidis' outreach workers do not ask for too much information because they are concerned that asking too many questions will make immigrants with irregular status keep away from their services."

This issue
The contributions in this issue on mobility and migration illustrate how research can play a role in clarifying the relationship between migration and health. It is very encouraging to see an increasing number of contributions in which qualitative research methods are used. Such research approaches will give a greater guarantee that the voices of sex workers will be heard. They can tell their stories and will not have to force their knowledge into the narrow categories of questionnaires.

The next step is then to link such outcomes of research with better interventions and advocacy. Better interventions may be, among others, the development of networks that contribute to the well-being of sex workers instead of exploiting them. Finally, advocacy will have to lead to, for example, better migration policies.

Ivan Wolffers, editor Research for Sex Work

About the author
Ivan Wolffers is Professor of Health Care and Culture at the Vrije University of Amsterdam, the Netherlands. He is also involved in the Asian network CARAM (Coordination of Action Research on AIDS and Mobility).

Contact details
Vrije Universiteit medical centre, Section Health Care and Culture
Van der Boechorststraat 7
1081 BT Amsterdam, The Netherlands
Phone: +31-20-4448266
Fax: +31-20-4448394
E-mail: wolffers@cs.com

Acronyms
NGO: non-governmental organisation
CBO: community-based organisation
STI/STD: sexually transmitted infection/disease
EU: European Union
CEE: Central and Eastern Europe

CONTENTS

ANALYSIS

How immigration status affects sex workers' health and vulnerability to abuse

A comparison of two countries

Melissa Ditmore

In this article, Melissa Ditmore argues that the most profound influence on migrant sex workers' life and health is their irregular immigration status. It determines the access they have to health care, legal support and other assistance. It makes it also difficult for sex workers projects to approach them and offer suitable services.

Legal restrictions on free movement of people have unanticipated consequences, including actually promoting trafficking for people who are determined to migrate despite restrictions. Women emigrating from

Romania are faced with restrictions on women, preventing them receiving exit visas if officials suspect they will work as prostitutes abroad. This effectively forces some women who wish to leave Romania to use the services of agents (traffickers) to leave their country. Women leaving Thailand face similar scrutiny. Difficulty obtaining visas for immigration into the US, Japan and the European Union force many people to turn to agents who help them into these nations. Not all agents are scrupulous business people, some just take advantage of the difficulty in obtaining visas. The problems of migration faced by immigrant sex workers are compounded by the differential legal treatment of sex work.

Illegal aliens

Many migrants have valid reasons to camouflage their origins, based on social prejudices and precarious legal status. In the US, where prostitution is largely illegal, even legal immigrants can be deported if they are arrested. Eastern European prostitutes in France have been charged with pimping in cases where they have refused to testify against pimps.

A recently published paper by the French NGO (non-governmental organisation) Cabiria describes the difficulties faced by Eastern European sex workers in France, including official bias against giving them asylum and having no other way to obtain legal immigration status in the country.[1] They remain illegal aliens without recourse to visas which would legitimate their being in the EU, and the movement between all fifteen EU nations.

Recent anti-trafficking legislation in the US also affects sex workers, both US nationals and foreigners. Under the new Trafficking Victims Protection Act (TVPA, see the box), those who came to the US intending to be sex workers are more likely to be deported than those who came to work in 'sweatshops' (factories with sub-standard employment conditions). Sex workers in abusive conditions can receive government assistance, but 'sex trafficking' is singled out and broadly defined as any sexual act in which any party receives anything of value. This broad

In the US, where prostitution is largely illegal, even legal immigrants can be deported if they are arrested

definition could be interpreted to include even legal sex work such as stripping and, more absurdly, marriage.
Another law passed at the same time, the second Violence Against Women Act (VAWA), provides visas to immigrants in the US. This one has no stipulations about morality or participation in efforts to prosecute others, like pimps. This makes the visas provided under VAWA a better option for foreign sex workers in the US than the visas offered in the Trafficking Victims Protection Act, because VAWA does not have the anti-sex work stance of the TVPA.

Xenophobia

Bias is not limited to an anti-sex work stance. Immigrants everywhere are familiar with xenophobia, but some groups receive harsher treatment than others. Africans in France stand out more than Eastern Europeans and may bear harsh treatment because of this. Grisélidis (see the box on page 4), a project in southern France modelled after Cabiria, works with women from Eastern Europe and Africa as well as France. English-speaking African women frequently say they are South

TVPA

The Trafficking Victims Protection Act of 2000 (TVPA) has been devised to protect women, children and men who are the victims of human trafficking. Recently the US Department of Justice issued T visas, created by this Act. T visa will allow victims of severe forms of trafficking in persons to remain in the United States and assist federal authorities in the investigation and prosecution of human trafficking cases. The statute allows victims to remain in the United States if it is determined that such victims could suffer, "extreme hardship involving unusual and severe harm" if returned to their home countries. After three years in T status, victims of human trafficking may apply for permanent residency.

African, but many are actually Nigerian. It is especially difficult for Nigerians to obtain visas or asylum.
Many people, but Nigerians especially, camouflage their origins. Grisélidis' outreach workers do not ask for too much information because they are concerned that asking too many questions will make immigrants with irregular status keep away from their services. This could make it difficult to assess what kind of services would aid these women. At the same time, their tact in not asking too much helps the newcomers to trust them enough to keep getting condoms and coming back.

Vulnerability to abuse

Each situation described above is an example of irregular immigration status making a group of people more vulnerable to abuse. Similar stories abound around the world. Migrants in every type of work find various problems, but in some cases sex workers are dealt with more harshly. The Cabiria report mentioned before details the violence and constraints Eastern European women in France suffer from as a result of being dependent on the people who initially helped them leave their countries in search of economic improvement. These women do not approach the police for help for fear of deportation, or even, in the case of at least one Albanian woman, the fear of being tried for pimping because she did not offer enough information about her own pimp to the prosecution. The US anti-trafficking law virtually guarantees deportation for sex workers. The African sex workers encountered by Grisélidis are so wary of officials that nearly everything about them remains secret. Normalisation of their status would disable efforts to take advantage of their fear of officials, arrest and deportation.

The obvious answer to end problems of exploitation of irregular immigration status is to normalise immigration status regardless of occupation. Unfortunately, this is politically untenable. The next best solution is to offer protection and assistance to those who have been victimised because of their lack of immigration papers. This has worked for some groups, but is largely closed to sex workers because of morality clauses and the differential legal status of sex work. Until sex work is recognised as labour, the adverse effects of such differential treatment will continue. The combination of moralism and xenophobia renders migrant sex workers some of the least able to access official help in situations of violence and abuse.

Grisélidis

Grisélidis is a fairly new project in Toulouse, which was modelled after Cabiria. The project has a mobile unit to distribute condoms and lubricants to sex workers. Other efforts include visiting imprisoned sex workers and helping others with medical appointments and translation. At the moment, sex workers coming to the Grisélidis van mainly come from France, Eastern Europe, north Africa and sub-Saharan Africa.

Grisélidis
10 rue d'Ivry, 31500 Toulouse, France
Phone: +33-6-72823853
E-mail: griselidis@wanadoo.fr

Access to health care

In addition to the problems faced by sex workers in extreme situations, immigration status may determine the access to health care and the treatment available to sex workers and other migrants. Undocumented immigrants often have less access to public health care, including treatment for sexually transmitted infections and HIV. Many immigrants come from places with high rates of tuberculosis or other treatable diseases. Projects like Grisélidis and Cabiria help sex workers with and without papers to get comprehensive medical care. Harm reduction efforts include distributing condoms and lubricants and clean needles to sex workers as well as helping sex workers find doctors sensitive to their greater health needs. For some undocumented sex workers, this may be the only way they receive any health care at all.

Note

1. Cabiria, *Synthese du Rapport Concernant les Femmes Sous Contrainte, Subissant des Violences, Qui Arrive d'Europe de l'Est*. November 2001. See also the article by Gaëlle Téqui in this newsletter.

About the author

Melissa Ditmore is a member of the Network of Sex Work Projects and chair of the Advisory Board to the Urban Justice Center Sex Workers Project.

Contact person

Melissa Ditmore
PO Box 20853
New York, NY 10009, USA
E-mail: mhd12@cornell.edu
or nswp-us@raingod.com
Web: www.urbanjustice.org

PROJECT EXPERIENCES

Women, migration and health in France

The experience of Cabiria

Gaëlle Téqui and Françoise Guillemaut

Since 1999, the French sex workers support organisation Cabiria has been working more and more in the field of migration. This is due to the large number of women coming from Eastern Europe and sub-Saharan Africa, who are victims of trafficking or fleeing conflicts or poverty in their country. Cabiria has recently published a French-language report entitled 'Women and migrations: women coming from Eastern Europe' in which the NGO describes their living conditions in France as migrants and to what extent their health is affected.[1]

In France, living conditions for migrant sex workers are very hard. After their trip and some exhausting stays in different countries, they do not find any rest after their arrival in France. They often have health problems and need health care. The reason may be that they come from countries where the health system is not free, and where medicines are expensive or not even available. In addition, their living conditions speed up the deterioration of their health.
The main health problems sex workers face are gynaecological, but some are also linked with stress (digestive troubles, migraines, cardiovascular problems etc.) or with the lack of previous care (congenital or genetic problems not detected in their country of origin).

Low-quality treatments
Notwithstanding the problems they face, access to health care is not that simple for migrant sex workers in France. Unless NGOs take charge of them and help them find official medical facilities where they can be treated, they go to non-official facilities, especially when suffering from dental pain. In such places, they might undergo low-quality treatments, which can lead to more serious diseases. Some migrant sex workers, because of attacks and physical acts of violence, need to undergo surgery to repair fractured bones. Alcoholism may also be a consequence of their living conditions; they seek comfort in drinking which is also a way to forget the cruel reality for some hours.

HIV vulnerability
As far as HIV is concerned, we noticed that migrants usually had not received much information on HIV, hepatitis B or C in their country of origin.
For that reason, prevention methods have to be of good quality and sometimes different for English-speaking African women, French-speaking African women or Eastern European women. We noticed that some African women have erroneous ideas about HIV and Eastern European women have the same about voluntary interruption of pregnancy (abortion). Once they are informed, some still have misunderstandings and sometimes they would like to be deliberately infected with HIV, in order to be granted health asylum in France.[2] They prefer to live in France for 10 years in better conditions above living all their life in bad conditions in their country of origin or die from hunger, during a slaughter or because of a stray bullet when their country is at war. It is therefore very important to inform them and to implement prevention strategies such as distribution of condoms and by providing them with brochures and counselling in their own language.

Booklet produced in France for Albanian sex workers

Access to antiretroviral treatment
When a migrant sex worker is unfortunately infected with HIV, it is very difficult for her/him to be properly treated. Hospitals give them medicines that are still being tested and whose secondary effects are not well known. They could buy fully tested medicines at drug stores but as these migrants do not have the right to work, they cannot afford them.
At the moment, in France, sex workers are in a situation where laws are not applied: prostitution is not illegal, it is considered as a private business; however, the French state fights against prostitution with a legal-social device. Soliciting is penalised, sex workers do not have the right to organise themselves, they have no minimum wages and their complaints against people who raped and/or attacked them are generally not taken into considera-

Cabiria
Cabiria is a community-based health NGO working with and for sex workers. It provides them with legal, medical and social support. Its outreach team works in the streets night and day distributing condoms, lubricants and prevention advice concerning HIV, STI, hepatitis and pregnancy. Its premises are open 5 days a week from 9 a.m. to 6 p.m. and a meal is cooked twice a week for sex workers. Cabiria's specific project for migrant women consists in providing them with all the items cited above with the help of two cultural mediators (an African and an Albanian refugee). Other people working at Cabiria who speak English, Spanish, Italian, Albanian and Russian, as well as two nurses, help to provide the support. The NGO has also implemented advocacy for the rights of sex workers with special emphasis on migrant sex workers in a gender perspective. In addition, Cabiria works to prevent violence from clients and pimps as well as institutional violence.

tion. How prostitution is currently regarded is the same as in the 1960s when it was defined as a social plague. In addition, even if the mechanism of social protection is supposed to be universal and accessible to all, social practice gives us daily proofs of discrimination in the access to universal rights (social security, pension, housing, health etc.).

In conclusion, we think that there is a direct link between the social situation of migrant sex workers and their capacity to remain in good health. The more people are in a state of economical instability, social disaffiliation, clandestine practices or dependence, the less they can adopt preventive behaviours. Women working in such insecure situations, and for whom prostitution is above all a way to survive, are all the more weakened and are consequently forced to accept non-safe practices asked by clients. Therefore, any policy contributing to make prostitution a clandestine activity would have extremely harmful consequences for sex workers' health.

Notes

1. Femmes et Migration. Les femmes venant d'Europe de l'Est. Editions Le Dragon Lune, 2002, 2-9513977-2-0. Available at Cabiria (15 euro): cabiria.international@wanadoo.fr

2. Undocumented migrants can apply for health asylum if they can prove with a document from their doctor that they have a serious disease. The final decision is taken according to the treatment accessibility in the country of origin.

About the authors

Gaëlle Téqui is Information and International Relations Officer with Cabiria. Françoise Guillemaut is Head of the Research Department.

Contact person

Gaëlle Téqui
Cabiria
7, rue Puits-Gaillot, PO Box 1145
69203 Lyon Cedex 01, France
Phone: +33-4-78300265
Fax: +33-4-78309745
E-mail: cabiria.international@wanadoo.fr
Web: www.cabiria.asso.fr

Migration and mobility of sex workers in the Netherlands

Thérèse van der Helm

Prostitution in the Netherlands has taken on an extremely international character in the last decades. During the 1960s, Dutch women were dominant in prostitution. Since the beginning of the 1970s many migrant prostitutes have found their way to the Netherlands. According to the data from a survey among around 20,000 sex workers, conducted in 1999 in the framework of EUROPAP, more than two-thirds of the sex workers were migrants. Of these non-nationals, 32% came from Latin America, around 28% from Central and Eastern Europe, 26% from Africa and 5% from Asia.[1]
Mobility within Europe is extensive. Almost every country in Europe is cited as being somewhere where prostitutes had previously worked, as well as being the country of origin. Certainly, among the Netherlands' neighbouring countries there is a lot of movement of prostitutes; like to and from Germany and Belgium. There is also mobility between the regions of the Netherlands; prostitutes do not always live where they work. Some commute between their residence and places of employment.

Reasons for mobility

The Netherlands is internationally recognised as having a tolerant policy toward (migrant) prostitution. The Dutch government has made an end to this by imposing regulations on the owners of brothels. One of these new laws is a prohibition on employing women who come from countries outside the EU, and who have no permit to stay. This law, which was introduced in October 2000, had a direct effect on these women. Women who do not have a residence permit are increasingly being arrested and deported (see the box on page 8). As a result, many of them have left 'controlled' (legalised) prostitution and started to work in illegal circuits like in illegitimate brothels or have moved to other places in Europe. This has led to a situation in which sex workers have become very mobile and do not remain in one place very long, but travel around to and from various cities in the Netherlands and abroad. Their ignorance of the local social services, the insecurity about their work or constantly being moved by pimps means that good health care can become a low priority for them.

Women who do not have a residence permit are increasingly being arrested and deported

To gather insight into the reasons for mobility among sex workers, their health risks (specifically for STIs), brief interviews were conducted

Table 1

Country of origin	Male sex workers	Transgender sex workers	Female sex workers
Netherlands			13
Other EU	4	1	4
Eastern Europe	10		18
Latin America		20	18
Africa			12
Total	*14*	*21*	*65*

with 100 prostitutes in three different countries in 1998. The majotity came from Eastern Europe and Latin America (Table 1). The sex workers were interviewed voluntarily and anonymously. In Amsterdam, they were approached in the 'window prostitution' zone, in the Living Room in the street zone and at AMOC Foundation, a centre for foreign drug users and for Eastern European male prostitutes. In Frankfurt, Germany, eight Eros centres were visited and in Antwerp, Belgium, the red light district was targetted.[1] Of the 100 interviewed sex workers, 26 said they had worked in different Dutch cities, and almost half (48) had worked in 13 different countries in total, both in and outside the European Union.

For 23 of the 100 sex workers, the reason for going somewhere else to work was their illegal status and the strict police controls; a number had fled from Belgium, France or Germany, and others left Amsterdam and started to work in Frankfurt and Antwerp. Four women had run away from their pimps. Twenty-two were seeking better work conditions; some of them sought adventure, others wanted to change location because of the cold streets, while still others felt too 'shown-up' in the windows. A number of sex workers was looking for better work places because other women's pimps had become too dominant in the area. For 80 sex workers, prostitution was the only source of income.

Health

A large number of the prostitutes in this survey had no health insurance; only 22 of the 100 were insured. Twenty-eight women made use of contraception other than condom use. The other women considered the use of a condom sufficient birth control. Despite the fact that there were regular accidents with the condoms and the women became pregnant accidentally or took antibiotics preventively, they did not want to use other methods of contraception. Two or even three abortions were not uncommon.

Of the 100 sex workers who participated in this study, only a small proportion went for regular tests for STIs. The low-threshold easy-access STI clinics in Amsterdam and Frankfurt are well attended by sex workers, but not with any regularity. Here too, it must be reported that a number of respondents indicated a preference for self-medication with antibiotics. This is related to their regularly switching work places and remaining unaware of the provision of medical services in their new places of employment. This indicates that their health needs do not have the greatest priority for them.

In 2001 another survey for EUROPAP was carried out. According to the data about mobility in that survey, there have been no major changes since 1999. There is still a high mobility/turnover among the, in particular migrant, prostitutes. One hundred sex workers in Amsterdam were interviewed and blood samples were taken to test for HIV, syphilis and hepatitis B and C.[2]
Twenty-three of these women and transgenders responded to the question about mobility by mentioning that they had worked in one or more countries in the EU, in Asia, in Latin America and in Central or Eastern Europe.

Stricter policies

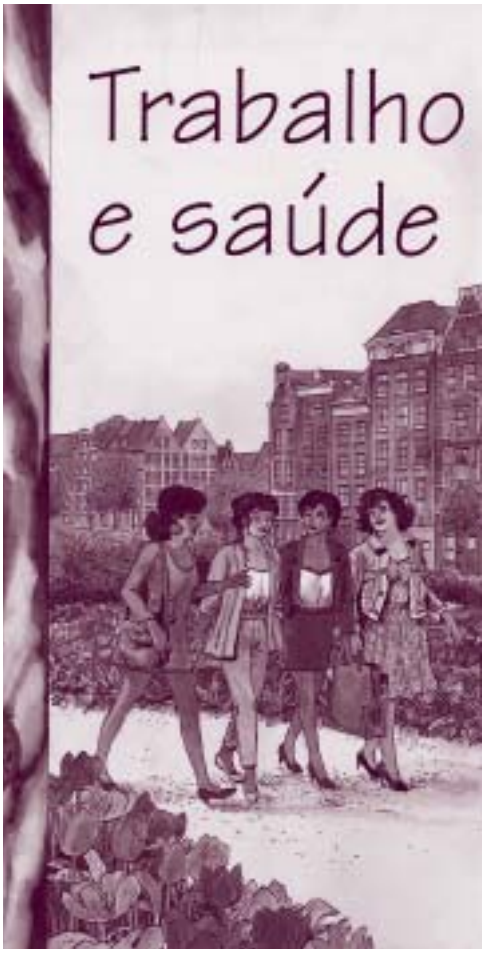
It may be concluded that in the Netherlands over the last few decades prostitution has become a profession mostly practised by migrants from countries with unstable economic or political situations. They find work, not only in Dutch prostitution sites but also in neighbouring countries, as well as other EU nations. Various Dutch cities have already implemented stricter policies toward the migrant prostitutes who do not have residence permits. As a consequence, these sex workers then move to places where it is still possible to work.
Public health services, in the meantime, are confronted with an increasingly drifting population, which does not find its way to the various services. Under these sorts of conditions, social work is definitely appropriate; easy-access facilities for sex workers are necessary; and there has to be concern for STI prevention and information also being available to illegal migrants. Social and health services for prostitutes in general and, in particular, good provisions for STI prevention and information should be an integral part of any new policy on prostitution. The legalisation of prostitution in the Netherlands has led to an increase in illegal brothels. The health services must take every opportunity to remain in contact with migrant sex workers in these establishments and on the streets. The new regulations and laws should not lead to these contacts becoming impossible.

EUROPAP

EUROPAP (European Intervention Projects AIDS/STD Prevention for Prostitutes) is a network of organisations in 18 European countries. The major concerns of the network are the prevention of STIs/HIV, health in general and appropriate services for prostitutes in Europe. The EUROPAP network has built up extensive experience in establishing and operating such projects. To bring health care and more specifically STI/HIV prevention closer to sex workers, many projects focusing on them have emerged all over Europe. The overall objective of the network is to get an idea of how these projects work, and what makes them successful, or makes them fail.

More information:
E-mail: europap@ic.ac.uk
Web: www.europap.net

EUROPAP



Booklet produced by the Dutch STD Foundation for Portuguese-speaking women in the Netherlands

Notes

1. Th. van der Helm & L. van Mens, *Mobility in prostitution in The Netherlands 1998-1999. An inventory done under the auspices of EUROPAP-TAMPEP 1998-1999,* Municipal Health Service Amsterdam, 1999.
2. Th. van der Helm & B. van Heusden, *Health risks in prostitution. A survey among 100 prostitutes in Amsterdam as part of a multicentred study for EUROPAP 2001,* Municipal Health Service Amsterdam, 2001.

About the author

Thérèse van der Helm is Co-ordinator of the Intermediary Project for Prostitutes in Amsterdam and National Co-ordinator of EUROPAP – The Netherlands.

Changes in the Dutch prostitution law and its consequences for migrant sex workers

The pragmatic approach of the Dutch government to the development of a new policy on prostitution has inevitably led to a debate on its regulation and legalisation. Some felt that the policy of tolerating existing brothels is hypocritical and contradicts the interest of national law. In the past, organised prostitution was forbidden, while in practice commercial brothels were allowed to operate with varying amounts of freedom. Controlling the excesses of the large and varied semi-legal prostitution circuit became increasingly difficult. The semi-legal status accorded to brothels gave owners the freedom to do business without enabling municipalities to impose punishment for operating infractions, such as the mental or physical mistreatment of employees or the lack of hygienic working conditions. At last, the change of the brothel law was carried out in October 2000.

The new brothel law offers advantages for prostitutes working in legal brothels. In these brothels, the women will work under hygienic conditions; they are easier to contact for education and medical care, for personal attention and if needed, for adequate referrals to social services. Moreover, by giving prostitution the status of a legal profession, labour laws will protect the women and they will be integrated into the social security system. However, the prohibition for prostitutes from outside the EU to work affects these women directly. Many of them have left the legal brothels and started to work in the streets, bars, illegal brothels or at home.

The VIPs (educators in prostitution) and public health nurses of the project Intermediary for Prostitutes

Contact person
Thérèse van der Helm
GG&GD
Groenburgwal 44
1011 HW Amsterdam, The Netherlands
Phone: +31-20-5555715
Fax: +31-20-5555751
E-mail: tvdhelm@soagggd.amsterdam.nl

PROJECT EXPERIENCES

Prostitution in Spain, health and policies

Angeles Rodriguez Arenas

In this article, Angeles Rodriguez of Doctors of the World Spain describes recent changes in the sex industry in Spain and explains the kind of activities that are necessary to assist migrant sex workers in the country.

Prostitution in Spain is changing profoundly due to the impact of migration. Every day we witness, through the mass media, incidences of trafficking in women by criminal networks and the Mafia. These women mainly come from sub-Saharan Africa (e.g., Nigeria, Liberia, Sierra Leone, Morocco), Latin America (e.g., Colombia, Dominican Republic, Brazil) and Eastern Europe (e.g., Ukraine, Russia, Czech Republic, Hungary, Rumania, Bulgaria and Slovenia). The European Union defines trafficking in women as the transport of women with the goal of sexual exploitation, be it legal or illegal, with consent or no consent.

Another category of sex workers that is more and more visible in the sex industry in Spain and which we should not forget is that of female transsexuals. Transsexuality is considered a gender problem and specifically, as a gender identity problem. The term transsexual is utilised for people who decide to change their sex surgically, as well as for people who do not take such a decision. The social exclusion and the marginality of the first group obliges them to seek jobs that permit them to pay the high costs of sex change treatments. In many cases, they turn to prostitution.

Finally, during the last few years a debate has started in Spain in the political as well as the social arena on the situation of street sex workers, basically in the cities, where local governments try to limit street prostitution to fixed places, far from where the general population resides.

Legal situation of prostitution

Except for eras of absolute prohibition, Spain has always tried to regulate prostitution by dictating laws that, with more or less determination and to a smaller or greater extent, regulated this activity. This approach, as well as the approach of prohibitionists, pushed the sex industry underground, to hidden spaces and under the control of large networks and with no possibility for disease control. The abolitionist views appeared at the beginning of the 20th century. Abolitionists believe that nobody agrees voluntarily to become a prostitute and that sex work can only take place in an environment of coercion exercised by pimps, which means that one should dictate laws against these people and not penalise sex workers. In 1956 prostitution was 'abolished' in Spain separating, from that moment, the fight against prostitution from the fight against sexual exploitation.

Now, from the punitive point of view, Spain is close to the abolitionist model, which is characterised mainly by not penalising the sex workers. The abolitionist model considers that it is essential to punish all people that benefit, gain or obtain economic advantages from prostitution; however, in Spain, only prostitution of children and disabled people, and prostitution by coercion is punishable.

A high percentage of sex workers in Spain is made up of irregular immigrants (without

New national network in Spain

In Spain in 2001 a national network of sex workers projects was created. This network, entitled National Network of Organisations and Projects working on Prostitution (ROPP), came into being after several organisations had acknowledged that mobility and migration have changed the sex industry in Spain enormously and that more national level co-ordination would be necessary to follow up on these changes. One of the main goals of the network is to share and distribute information among NGOs and to aid sex workers who are travelling around the country.
The network organised two meetings in 2001 and had another one on 24 and 25 May 2002. Training sessions and more meetings have been scheduled. Finally, it has published a leaflet for sex workers.

More information:
Beatriz Seisdedos de Vega
ROPP / Cruz Roja Juventud
Departamento Central
Rafael Villa s/n vuelta Ginés Navarro
28023 El Plantío, Madrid, Spain
Phone: +34-91-3354497
Fax: +34-91-3354455
E-mail: redropp@hotmail.com

papers), and although being a sex worker in itself is not punishable, being an undocumented alien is. The access to public health services for migrants in Spain is regulated by law 8/2000 of 22 December 2000. Article 12 of this law establishes the right to health attention for those immigrants that are registered in the municipality. This means that they should be in possession of a passport and a housing permit, which creates barriers for trafficked women who are working in prostitution.

The experience of Doctors of the World

The programmes for sex workers of Médicos del Mundo, the Spanish branch of Doctors of the World, began in 1993, basically because of the vulnerability of rejected women. In most cases they are marginalised from social and health services and they lack social and family support (outside the world of prostitution). The nature of their work, health, housing and economics, among other things, place them in a position of social exclusion.

When we began our work in 1993, 98% of the people that we served were of Spanish origin. However, this situation changed rapidly and by 1995 we found that an important proportion of women was of foreign origin, primarily from sub-Saharan Africa and Latin America. The important migratory flows that Spain has experienced in the last few years, have been reflected unmistakably in the sex work sector, in which the number of migrant sex workers has reached a huge majority.

During the year 2001, the programmes for sex workers of Doctors of the World reached a total of 8,106 different people, 88% of whom were women, 8% female transsexuals and 4% men, most of them between 18 and 34 years old. Two out of three women contacted by us were of foreign origin. Around 50% of the female transsexuals were foreigners and 27% of the men. It should be noted that the majority of the immigrants who used our services were undocumented migrants.

Harm reduction

Any health policies directed at the groups of sex workers mentioned above (trafficked women, undocumented migrants, transsexuals and street sex workers) should keep in mind the new characteristics of the sex industry and propose actions that tackle the conditions of vulnerability and marginality that aggravate the life of sex workers, such as lack of legal status, and drug addiction. We think that prostitution must be included as a priority in the political agendas of the Departments of Women, Health, Immigration, Drug Addiction and International Co-operation.

Without doubt in the last few years, harm reduction policies that have been set in motion have contributed to a decrease of the prostitution-drug addiction combination and of the incidence of HIV/AIDS among people that use drugs. Nevertheless, the close relation between HIV and injecting drug use and the high vulnerability experienced by women who are drug-dependent sex workers, confirms the need to implement programmes that are capable of reaching these women to reduce their risks, which would include the supply of free methadone or other opiates (even heroin) to this group.

Photo: François Fontaine, Médicos del Mundo

Gender violence

If there has been a general increase in gender violence in Spain, we have found that such violence is present among sex workers to an even higher degree. Consequently, interventions to be implemented to fight against violence should keep in mind the marginalised position of these women.
Migrant women usually have financial obligations towards their families and special programmes for women in this situation or those who are socially vulnerable should be promoted in order to avoid that they use prostitution as a way of life. Examples of such programmes are: economic support to families, support for nursery school and primary school, job placements, housing support, improvement of social skills, etc.

A study conducted by Médicos del Mundo revealed that women do wish to use preventive measures, such as condoms.[1] It is the female sex worker who possesses, proposes and uses condoms, while facing a lack of willingness on the part of boyfriends and clients. Therefore, in settings in which the woman has little decision power, for example in clubs, condom use is clearly less (as is often the case

Médicos del Mundo

Médicos del Mundo is a non-political, non-religious NGO based on humanitarian actions and voluntary work. We work with underprivileged groups in the Third World and in the Fourth World, which is the world of those people who are excluded from the welfare usually provided by society, and who are marginalised from resources in matters of health, law, nutrition or housing. The organisation pays special attention to drug users and sex workers through programmes of harm reduction and prevention of HIV/STIs. It also provides health and social services to immigrants and ethnic minorities without resources. We work in 18 cities around Spain. Médicos del Mundo is part of the international network of Médecins du Monde (Doctors of the World).

with Latin American women) than in situations in which she has more decision power.

Women originating from sub-Saharan Africa seem to be the group whose characteristics make them most highly vulnerable to HIV: coming from high-prevalence countries, youth, lack of integration in the country, isolation and lack of access to services, including HIV testing. The government should provide the means to overcome the barriers these women encounter when they try to access social and health services, including HIV tests with pre- and post-test counselling.
Finally, as all people working in prostitution should be given the opportunity to learn about their status regarding HIV and other STIs, the health sector should identify suitable approaches to reach the categories of sex workers mentioned in this article. In turn, health NGOs have an important role to play in the health promotion for migrant sex workers and the prevention of HIV and other STIs.

Note

1. A. Sánchez, A. Rodríguez, P. Ramón, M. Lorenzo, V. Palacio, P. Estébanez. Impacto de la inmigración sobre la prostitución y VIH/sida en España. *Pub. Of. Seisida*, Vol. 12, No. 4, pp. 251-253, 2001.

About the author

Angeles Rodriguez Arenas is a Medical Doctor at Médicos del Mundo España.

Contact person

Angeles Rodriguez Arenas
Desk de Cuarto Mundo, Médicos del Mundo
C/o Andrés Mellado, 31 Bajo
28015 Madrid, Spain
Phone: +34-91-5436033
Fax: +34-91-5437923
E-mail: angeles.rodriguez@medicosdelmundo.org
Web: www.medicosdelmundo.org

Colombian women, sex work and health in Galicia, Spain

Laura Oso

The image that dominates the media in Spain regarding immigration and sex work and which is reflected in popular beliefs is the one of the victim of trafficking. It depicts enslaved, captured, deceived and threatened women. However, this image does not put into perspective the complexity of the social reality of Colombian sex workers in Spain. It underlines almost exclusively the more sensationalist view, which reduces the figure of the migrant sex worker to a passive victim of trafficking and forced prostitution.

In this article I intend to question the image that tends to relate immigration with the goal of sex work exclusively to the more harsh form: trafficking with deceit and compulsion through large networks and the Mafia. The information I collected during field work among Colombian women in Galicia (a province in northern Spain) shows a panorama that diverges from this collectively held impression. The mechanisms of immigration of the interviewed women in Spain were diverse: from deceived and forced women, through indebted women that were trafficked via small-scale networks, to women who decided autonomously and voluntarily to invest their savings to work in the sex industry in Spain. Also, the people involved in trafficking of sex workers do not necessarily belong to big networks or organised Mafia. Small club owners, moneylenders or other immigrants might contribute to the migration of Colombian sex workers to Spain.

What I want to underline here is that these distinct types of women (trafficked, indebted and autonomous) differ considerably in their health conditions, their vulnerability to HIV/AIDS and their circumstances of work and life. I will concentrate mainly on the case of indebted women (who were trafficked on a small scale) and of independent migrants.

This analysis is based on the qualitative data obtained from a total of 42 semi-directed in-depth interviews: 31 with Colombian sex workers and 11 with people that are in direct contact with them, such as clients, health care workers and NGO representatives. The interviews took place in the framework of a sociological study financed by the Instituto de la Mujer (Women's Institute) in Madrid. The field work was carried out principally in the regions of La Coruña and Pontevedra in the year 2000.[1]

Indebted sex workers

Of the total of 31 interviewed women, only 3 said they were deceived when they came to Spain, without knowing the kind of job they were going to perform. Half of the women came to Spain in debt, and were trafficked through small networks. These women knew they were going to work in the sex industry. This type of trafficking is not related to large networks or the Mafia, but is basically sustained by the dynamics of migrant communities: these Colombian women were brought to Spain through the social networks of migrants (family members, friends, etc.).

Some of the interviewed indebted women had a more free and less dependent relationship with their moneylenders; however, we also encountered situations of forceful abuse and exploitation among trafficked Colombian women. This situation can become worse when the trafficking is directly ordered by the owners of clubs or when more extensive trafficking networks are involved. In these cases, for some of the interviewed women, their migration experience came close to the traditional image of trafficking, in which women are transferred from one club to the other, kept in seclusion, sold and deprived of their most basic liberties.

Strong control

For indebted sex workers in Spain, the conditions of work and life are much more difficult than for autonomous prostitutes. In general,

they stay in clubs or in the houses of the people who lend them the money, who can exercise strong control over them in their daily lives. One woman explained: *"They told me there [in Colombia] that I had to pay back some 3,000 euro (1000 euro = US$ 882), but when I arrived in Vigo it turned out to be 4,800. The woman took me first to a club, we lived with her, everyday she asked me: 'how much money did you make today?' Every day, I had to pay her 120 euro."*
The clubs are usually situated near the highways or in the outskirts of cities. The lack of autonomy, the social isolation, the lack of a space of their own, are some of the expressed sentiments. Women who were trafficked directly by club owners could be considered more under control, in the way that the owners had an interest in keeping their workers, at least until they had paid off their debts: *"There were girls there with debts, we were watched all the time. They did not let us leave, they locked us up. Sometimes they treated the girls well and sometimes badly"* (woman working in a club).

Club in Galicia. Photo: Alvaro Ballesteros

Half of the women came to Spain in debt, and were trafficked through small networks

The daily life of the sex workers that stay and live in clubs is usually centred on the work. The women tend to get up at 2 or 3 o'clock in the afternoon, eat, bathe and get dressed. The work starts at 6 o'clock in the evening and continues until 4 or 5 o'clock in the morning. The rhythm of the work in the period in which the women pay of their debts is fast; they see many clients per day and have few or no days off, even when they are ill. The obligation to pay off their debts forces some women even to work during their menstrual periods.

Without rubbers
The interviewed women were very aware of the importance of condom use as a tool in the prevention of HIV. However, their views collide with the ideas of clients, who frequently solicit their services 'without rubbers' by offering more money. This way, women who are in high need of cash, or who are under pressure by the debt payment schedule might be obliged to accept sex without a condom, in a situation of shortages of money and competition in the sex industry.

Once the debts had been paid off, the interviewed women in general obtained their liberty and integrated themselves in the battalion of independent sex workers who rotate from club to club on the highways of Galicia and other provinces of Spain. With the termination of the debts, a new strategy of social and work-related mobility comes into force: they start to work in contact apartments (rented flats run by a Madam) and they rent houses of their own.

Autonomous immigrants
The other half of the interviewed women emigrated to Spain in an independent way, thanks to the money they saved in their own country, a bank credit or mortgage they obtained, money they received from private moneylenders, family members or friends who had already emigrated. One woman who was working from an apartment said: *"Me, nobody brought me neither deceived me and I never had bad experiences like being hit or something else. I take care of myself, I have a private insurance and also Social Security. My life has been very tranquil."*
The fact that they migrated independently and are not under pressure to pay of a debt brings with it a better health situation and better work and living conditions. The women are usually able to work in an independent way, and sex work is an option or personal strategy that is not connected to force, deception or pressure on the part of others. The woman mentioned before added: *"I took the decision out of my free will, I have taken good care of myself. I work here independently. I am not proud of what I do, but I do it like a job. It's just a form of making money rapidly."* The absence of financial and personal dependence makes it possible for women to choose where and when they would like to offer their services. This way, independent prostitutes usually change business depending on the demand, the risk of police action and the work conditions, such as treatment by the owners, living environment, quality of the food, etc.

Independent immigrants choose if they want to serve a client or not and to take a break when they think it is necessary. They also work in a healthier environment and they are able to refuse clients that want to have sex without a condom. It is much easier to resist financial incentives offered by clients who want 'risky sex' if there are no debts to be paid, which makes their vulnerability to STIs and HIV less than for indebted migrant sex workers.

In the same way, the autonomy makes it possible to look for other types of sex work, away

The small-scale trafficking of immigrants is a very extended practice in Galicia. Colombian immigrants that have already settled and have arranged a certain legal stability in their lives, invest economically in the trip of other people (friends, family members or acquaintances in Colombia). This investment consists of facilitating the money necessary for the airline ticket and the payment of the 'bolsa de viaje' (sum required by the Spanish authorities to be able to enter the country as a tourist), as well as a letter of invitation and contacts to work in Spain.

from the highway clubs, as in contact apartments where the work conditions are more favourable. The contact apartments or 'tapadillos' ('hidden places') are discrete apartments in which various women offer their services, which are advertised in the press. In an apartment the clients are more relaxed. The women usually work only during daytime; it is not necessary to spend the night there, or to drink excessively, or to seduce and 'conquer' the clients in a bar. Moreover, autonomous migrant sex workers usually possess a space of their own, which makes their relationship with their work more 'contractual': they go to the club or apartment, work there for several hours, but return to their homes later on.

'La plaza' and health

However, the necessity and the wish to earn money (to save or to send back home) makes a lot of migrant sex workers, both indebted and independent, eager to keep up a strong rhythm of work, especially when they travel around to find 'a plaza' (literally: place).[2] The plaza consists of a period of 21 days in a club or apartment, where the woman stays permanently and works in an accelerated way and without rest. This type of work offers important economic benefits: some women earned up to 6,000 euro during one plaza. However, there are also drawbacks for the health of women and their work and living situation. Prostitutes that work continuously in plazas change places frequently and move around large areas of Spain, without creating a home of their own. This continuous geographical mobility contributes to their isolation and displacement. Other disadvantages of this kind of employment are the tiredness derived from the continuous work rhythm, such as a high number of clients per day and no rest at all during the 21-day stay, major dietary problems etc.

Social and health programmes in Spain should take measures to reach out to the two types of more isolated populations, indebted women and plaza workers, discussed in this article. In turn, HIV prevention projects should realise that it is necessary to raise the awareness of clients on the issue of condom use. After all, the figure of the client that demands services 'without rubber' poses the main risk of HIV/STI infection for (migrant) sex workers in Galicia.

Notes

1. L. Oso, 'Estrategias migratorias y de movilidad social de las mujeres ecuatorianas y colombianas en situación irregular: servicio doméstico y prostitución'. In: *Mujeres inmigrantes en la irregularidad. Pobreza, marginación laboral y prostitución*, Instituto de la Mujer, Madrid, 2000. Unpublished report. Some results of the research can be found online: http://www.imsersomigracion.upco.es/otros documentos/congreso/datos/estrategias.htm.

2. The women call them *plaza* because they might call and ask if there is a plaza (place) available for them to stay for 21 days, the period of time that matches their menstrual cycle (when they are not menstruating).

About the author

Laura Oso is Professor of Sociology at the University of La Coruña.

Contact person

Laura Oso
Facultad de Sociología, Universidad de La Coruña
Campus Elviña
15071 La Coruña, Spain
Phone: +34-981-167000
Fax:+34-981-167103
E-mail: osofac@udc.es

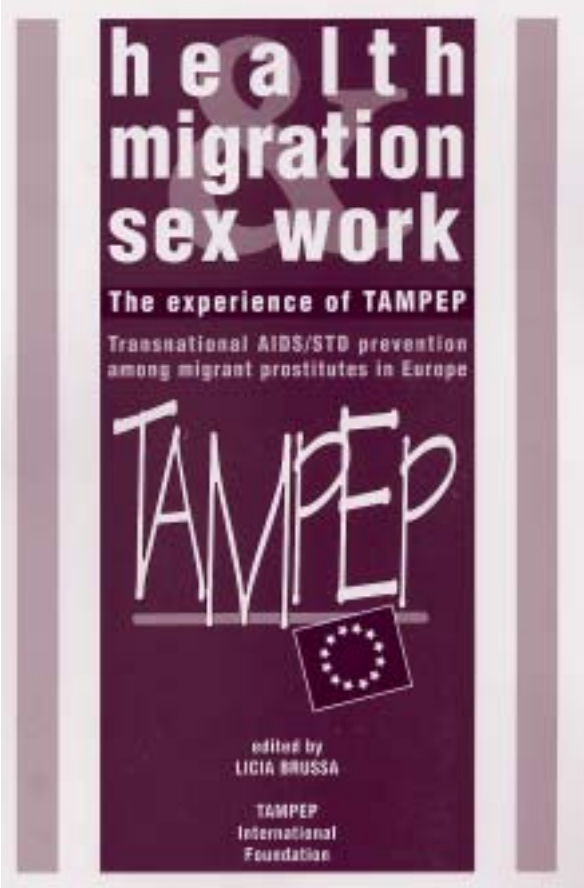
Migrant sex workers in Europe: STI/HIV prevention, health and rights

Licia Brussa

In this article, Licia Brussa describes the changes in the prostitution field in Europe since the fall of the Berlin Wall. Drawing from the experiences of the European network on migrant prostitution TAMPEP, she shows how the marginalisation of mobile and migrant sex workers by society undermines their opportunities to protect themselves against violence, abuse and HIV/STI infection and creates barriers to the practising of safe sex.

Over the last decade the sex industry has grown enormously in the countries of Central and Eastern Europe (CEE; the former East Block). As a result of economical and social changes in the region, particularly women are affected most by these transformations, which result in continuous increase in the number of women, girls and men who enter prostitution voluntarily or against their will. They engage in prostitution either in their own country, in other countries in the CEE region or they move (or are moved) to the countries that are situated in the European Union, the Middle East or other continents.

An important change in the prostitution scene has its origin in the enormous migration flows from Central and Eastern Europe towards Western Europe. At the moment the presence of Eastern European women in EU countries is on average 30-40% of the total population of sex workers. Another significant movement is the internal migration flow from Eastern Europe (e.g., Moldova, Ukraine) to Central Europe (e.g., Hungary, Czech Republic). Central Europe and above all the countries associated with the European Union constitute the main entrance to EU countries for non-EU women who are going to work as sex workers there.



The countries of Central Europe are at the same time destination, transit and sending countries. For example, many Ukrainian, Russian and Moldavian women come to work in the sex business in Central Europe and after some time they move to countries like Germany, Belgium or the Netherlands. At the same time women from Central Europe leave their countries and look for work in EU countries. In other words: we observe an enormous mobility of women looking for economical resources in the informal sector, such as sex work in their own country, within the region and at the transnational level.

Common issues

What are the common issues and features in these countries? Typical characteristics of the CEE countries are: the rapid development of prostitution in the past decade, the specific and various forms in which it is organised, the presence of local and mobile sex workers, the extreme mobility of the various groups of sex workers and the presence of local or foreign criminal organisations that organise and control the market. And last but not least: the growing repressive response toward this reality by national governments that choose either to criminalise prostitution or to push it deeper into the outskirts of society, out of the view of 'normal' citizens (who might be at the same time the prostitutes' clients). Also, in order to control prostitution they introduce models of strong regulation with mandatory health testing, registration of sex workers, administrative laws against prostitution and the creation of prohibition areas. All these measures have a common element: they can be considered ad hoc policy, without a vision of social consequences, no capacity to carry it out, no control of corruption effects and no respect for the human and civil rights of prostitutes.

Abusive environment

The reality in which projects have to operate has become more and more complicated: there is a strong territorial dispersion of sex workers, the prostitution scene is extremely diverse, the working conditions of prostitutes are usually bad and the presence of local, mobile and migrant sex workers creates tensions. Also, sex workers have various levels of vulnerability: some are trafficked, others have pimps, again others are migrants, depend on drugs, or are HIV-positive. In some countries sex workers are treated as criminals who are a danger to society; in most societies they are marginalised. Many prostitutes perform sex work in a violent and abusive environment, especially if they are minors or trafficked women.

The countries of Central Europe are at the same time destination, transit and sending countries

All these factors undermine sex workers' chances to implement a strategy of self-protection (for their health and well-being) and autonomy in doing sex work, while at the same time they form a barrier for the practice of safe sex. For this reason we need a holistic approach, broader possibilities for intervention, differentiation in work strategies and finally, strong political and financial support.

Social exclusion

If we want to promote a new and comprehensive approach we have to clarify our vision on sex work first. Traditional perspectives on prostitution have been repressive, moralising and controlling, perceiving sex workers and their clients to be objects rather than active subjects, excluding them from discussions and decisions around policy and legislation. The marginalised and often illegal status of the sex industry has led to the social exclusion of sex workers. Health and social care cannot be effectively provided within such a repressive or judgmental framework.

The social exclusion of sex workers exacerbates the situation of the more vulnerable groups among them, such as minors, drug users, ethnic minorities or migrants, and finally the people who are under the total control of pimps and/or traffickers. All these groups face the pressure of repressive legislation, which often excludes them from the legal, social and health care facilities available to the general population. A prerequisite of the *social inclusion* of sex workers, including the above-mentioned groups, is the recognition and protection of their human and civil rights, regardless of whether they are migrant, local, drug-using or homosexual people.

Femmigration – Legal Agenda for Migrant Prostitutes and Trafficked Women on the Internet

The Legal Agenda project is a multi-year project carried out by the four TAMPEP founders: the Netherlands, Italy, Germany and Austria. The project directly addresses NGOs dealing with women who want to migrate or who are already in the migration process. The Femmigration website provides these organisations with the most important legal information about the different legislation systems in these four countries regarding issues off migration, prostitution and trafficking in women. The objective of the site is to offer migrant sex workers reliable and up-to-date information on their legal rights, their residence and working options and also a list of support organisations. This year, three more European countries will join the project: Spain, France and Finland.

More information:
E-mail: info@femmigration.net
Web: www.femmigration.net

TAMPEP

TAMPEP (Transnational AIDS/STI Prevention amongst Migrant Prostitutes in Europe Project) is an international networking and intervention project operating in 24 countries in Europe, including 9 countries in Central and Eastern Europe. It aims to act as an observatory in relation to the dynamics of migrant prostitution in Europe, advocate for the human and civil rights of prostitutes, facilitate the sharing of knowledge, experience and good practice among members and develop and implement effective strategies of HIV and STI prevention among migrant sex workers across Europe.

About the author

Licia Brussa is the co-ordinator of TAMPEP International Foundation and one of the editors of Research for Sex Work.

Contact person

Licia Brussa
TAMPEP International Foundation
Westermarkt 4
1016 DK Amsterdam, The Netherlands
Phone: +31-20-6247149
Fax: +31-20-6246529
E-mail: tampep@xs4all.nl
Web: www.mrgraaf.nl/tampepframe.htm

Holistic strategies

Taking into account the aforementioned facts and the new reality of prostitution in Europe, we urgently need to develop holistic strategies for interventions covering different areas: HIV/STI prevention, health promotion, legal and social support and human rights protection. The NGOs active in this field should be empowered in their efforts to carry out special services for sex workers, and should be supported in the development of comprehensive activities and strengthened in the identification of priorities for policies, strategies and interventions.

The TAMPEP network (see the box) has been able to identify, through the analysis and evaluation by its members of the different country situations, the common context of prostitution in Europe, which is: how HIV/STI prevention at this particular moment is directly connected with migration, mobility, trafficking and the vulnerability of sex workers. We need to see this connection at the transnational level, because the mobile nature of sex work, the influence of criminal networks, local prostitution policies, repressive laws etc., determine directly the true elements of danger in the lives of sex workers.

Because dangers are so numerous and diverse, specific risks of violence, infection, pregnancy, humiliation and lack of self-determination are beyond the control of prostitutes. We learnt that it is not realistic to expect that a sex worker who is in direct danger, e.g., from deportation, imprisonment, pimping, will give priority to her health and to safe sex. However, if the health promotion project in her environment is directed towards her total protection, she can be given the opportunity to manage her own risks and to gain more control of her own life. This is the way we work: for us, empowerment is the primary method of prevention of exploitation and of HIV/STI prevention. In order to apply these protection strategies, our network members carry out social mobilisation activities and try to influence policies. In this way the advocacy role of the network is directly integrated into our health promotion strategies.

We also need to promote strongly anti-discriminatory policies. Sex workers should be accorded human and civil rights within society that ensure that they are not vulnerable to exploitation and abuse by their clients, pimps or traffickers. In addition, they should not be perceived as objects for exclusion and/or abuse by health and social workers or police officials.

It is therefore essential to overcome the marginalisation of sex workers and ensure the provision of effective legal, health and social services that are mindful of their human rights and go beyond focusing on them solely as carriers of sexually transmitted infections (STIs). Responding holistically to the needs of sex workers is the most effective instrument against their exploitation and thus against trafficking in women.

Migrant prostitution in Poland

Migrant sex workers in Poland mainly come from the Ukraine. There are also Belorussians, Romanians and Russians, and more and more Moldavians can be seen. According to police records there are over 2,000 migrant women working in prostitution in Poland, although their numbers are probably much higher. Most foreign sex workers work on the streets, mostly on the highways, but some also work in escort agencies. They are allowed to stay in Poland for 1 to 3 months legally, after which they usually continue working until they get caught and are deported. The situation of many such women is much worse than that of Polish sex workers, as Eastern European women are often trafficked, and they are extremely dependent on their pimps, who might exploit them and treat them badly.

One of the few organisations offering support to migrant and trafficked sex workers is TADA. This NGO provides services to sex workers in six cities in Poland and at the German-Polish border. According to TADA, foreign sex workers have limited access to public health services if they are not insured and do not speak Polish. Also, pimps or traffickers might be reluctant to let the women visit health care institutions. Private health care services offer good-quality services; however, these are neither anonymous nor free of charge. The general objective of the TADA programme is to prevent HIV infection and other STDs through the promotion of safer sex behaviours. The organisation provides, among other things, counselling to street-based sex workers, condoms, lubricants and leaflets and refers sex workers to (specialised) health services.

Source: TAMPEP 5 Final report 2000-2002

More information:
Anna Nowak
TADA
ul. Ma kowskiego 9/2
70-305 Szczecin, Poland
Phone: +48-91-4334458
E-mail: tada@free.ngo.pl
Web: www.tada.pl (Polish only)

More information about prostitution in Poland: A. Nowak, Political transformation in Poland. The rise in sex work. In: Research for Sex Work 2, 1999. Available online at http://www.med.vu.nl/hcc.

The vulnerability to HIV/AIDS of migrant sex workers in Central America and Mexico

Anahí Dreser, Marta Caballero, René Leyva and Mario Bronfman

In ports, cities and border areas of Central America and the south of Mexico, a high percentage of sex workers is mobile. Working temporarily and looking for the best economic opportunities, they create circuits of local, regional and international mobility, depending on the characteristics of demand in different times of the year in specific communities (associated with harvests, festivals etc.).

This study analyses the conditions and consequences of the mobility of sex workers in Central America (Belize, Guatemala, El Salvador, Honduras, Nicaragua, Costa Rica and Panama) and at the frontier with Mexico, to find explanations for their social and HIV/AIDS vulnerability. The results of our study form part of the project *'Mobile Populations and HIV/AIDS in Central America, Mexico and the United States'*, which is co-ordinated by the Mexican National Institute of Public Health.[1]

The research took place in 11 transit stations in Mexico and Central America during the months of January and February 2001. Some of these stations are the 'sister' cities Tecún Umán and Ciudad Hidalgo, at the Guatemalan-Mexican border; the port of Panama City; and the border towns San Cristóbal de la Frontera in El Salvador, and La Cruz in Costa Rica. The sites studied were selected by the national AIDS programmes of the participating countries, on the ground of their containing communities with a high population mobility and a high density of bars and brothels. On each site an ethnographic research and a population survey were carried out, as well as in-depth interviews with informants from the local community, mobile populations, sex workers and representatives of organisations. In total, 145 sex workers were interviewed. The interviews were transcribed and coded to identify the contexts of vulnerability associated with sex work and population mobility.

Sex workers' background

The majority of sex workers interviewed were young women, with low levels of education and who were undocumented. Their life histories contained stories of economic problems, incidences of sexual or physical abuse, rejection by the family, as well as the presence of children or other economically dependent people in their areas of origin. Most of the women thought that they were doing sex work temporarily and they did not perceive themselves to be sex workers.

In the study sites, a high percentage of sex workers came from communities in the interior of their country as well as from other countries. In Panama for example, the sex workers are principally from Colombia and the Dominican Republic. In Costa Rica, the majority of sex workers come from Nicaragua and, less frequently, from Honduras and El Salvador. In Guatemala, prostitutes can be found from El Salvador, Honduras and Nicaragua. In Belize, as well as at the Mexican frontier, the sex workers mainly come from Guatemala and Honduras, but to a lesser degree also from Nicaragua and El Salvador.

Unsafe working conditions

The characteristics of the work place vary greatly. Some women work in fixed establishments, such as bars and brothels, other women wait for their clients in the streets or on the highways, and have sex with them in highway motels and inside their vehicles, such as is often the case with truckers. As a rule, sex work is highly associated with the consumption of alcohol; these unsafe working conditions promote unsafe practices. Sex workers suffer from violence, alcoholism and drug addiction, which makes the negotiation for condom use more difficult.

Two big mobility circuits can be described for sex workers. The first is the external circuit, which stretches from the areas of origin of the women to the cities where they work. The mobility of these sex workers responds primarily to structural factors: the countries in the region with less socio-economic development are the ones that expel more women over their borders. The transit stations represent places where these women can earn more money than back home and where, by being able to work anonymously, their perception of social rejection is reduced.

On the other hand, the sex workers also create circuits of internal mobility, that is, within the same locality or between neighbouring communities. This responds principally to the necessity of renewal of sex workers in bars. The periodical change in supply of prostitutes in bars is ordered by bar owners to answer to the demands of their clients, who like to see

Newspaper clippings from southern Mexico

new faces occasionally. Moreover, the demand for sex work is associated with population movements arising from agricultural cycles and local festivities, as well as with migratory flows. A lot of clients of sex workers are themselves mobile populations, such as truckers, sailors, farm workers and undocumented 'transmigrants', who are on their way up north, to the United States. It is important to note that truckers contribute to the mobility of sex workers by transporting them in their trucks from one place to another, including from one side of the border to the other.

Stigma and rejection

One of the elements that facilitate the mobility of sex workers is the existence of sex workers' networks. Through these networks, women receive the contact details of new establishments. However, due to the intense mobility of sex workers, these networks do not consolidate themselves as support networks. The sex workers do not establish relationships of trust with members of the local communities, nor can they demand conditions for protection and security in their work. Moreover, the female sex workers present at the sites studied, were highly stigmatised and rejected for being foreigners, for the type of work they carried out and for being considered vectors of HIV/AIDS.

Migration processes and prostitution circuits are quite different. While deportation or an inability to migrate does not seem to be the principal factor leading women into sex work, sometimes migrant women must turn to commercial sex work at least temporary.
One 19-year-old Guatemalan sex worker stated: "I was going to the other side, up north [United States], then they grabbed me in Mexico and deported me. They deported me three times and when I saw myself without money or clothing because they stole my luggage, I decided to stay here and work in a night-club. I thought it would be the fastest way to get some money and then go see my daughter. I used to work in a maquila [export-oriented factory] and people told me: 'Go, your daughter gets sick often and the money just isn't enough, go to Tecún or Mexico, there are bars there and you will make more money'."

Another observation is that the migration laws of Belize, Costa Rica and Honduras strictly prohibit sex work. For this reason, the women operate in a concealed way, for instance by pretending they are waitresses or vendors. In other countries, where there is more tolerance towards sex work in frontier areas (Mexico, Guatemala, Panama), the sex workers are forced to submit themselves to 'health regulation' processes (such as mandatory registration and testing for STIs). For undocumented sex workers, these regulations occasionally turn into practices of persecution and intimidation on the part of the authorities. As a result, these women have to operate in a non-regulated way, which limits their access to medical services and testing for HIV and STIs.

The sex workers do not establish relationships of trust with members of the local communities

In this context, there are only a few organisations that respond to the needs of mobile sex workers. One of these organisations is the *Casa de la Mujer Tja-Qya* located in Tecún Umán, Guatemala. This NGO, which is directed by a catholic congregation of nuns, the *Sisters Oblatas*, attends to the needs of women in prostitution and/or migration and offers them vital support as well as capacity-building. Other tasks are to create support networks with other human rights and health care organisations and to sensitise the population to the difficult position of sex workers and migrant women.

Contexts of vulnerability

Sex workers in the region of Central America and Mexico show a high mobility within and between their countries, and create circuits as temporal workers. This mobility facilitates their access to new work places but does not permit them to create support networks, which makes them more vulnerable socially. Their undocumented character, the high mobility, the stigma, and the lack of responses from the part of organisations, inhibit their access to health care services and to information about HIV/AIDS. Women that work in a hidden manner are particularly vulnerable, especially those who work inside the vehicles of their clients, which leaves them unprotected.

The interaction with other mobile populations is an important factor in the dynamics of the dissemination of HIV; however, it also offers us an opportunity to distribute information about HIV/AIDS.[2] All these factors shape the contexts of vulnerability of mobile sex workers to HIV/AIDS, and determine their risk situation and practices. It is therefore necessary to develop projects at a regional level that attend to these conditions as consequences of the mobility of sex workers.

Notes

1. M. Bronfman and R. Leyva. *Poblaciones Móviles y VIH/SIDA en Centroamérica, México y Estados Unidos.* Research project protocol. Mimeo. Cuernavaca, Morelos, México, 2000. The final report of the research project will be available mid-2002. For further details please contact Mario Bronfman, project co-ordinator.
2. Truck drivers who are regular clients of sex workers in most of the transit stations studied, have been identified as a group that may become a strategic 'vehicle' to disseminate preventive information and safe sex practices among both truck drivers themselves and the different contacts they establish. (M. Bronfman and R. Leyva, *Truck-drivers at the Mexico-Guatemala Border: STDs/HIV/AIDS and the use of condom.* XIII International AIDS Conference. Durban, South Africa, July 2000).

About the authors

Anahí Dreser, Marta Caballero, René Leyva and Mario Bronfman are with the Centro de Investigación en Sistemas de Salud of the Instituto Nacional de Salud Pública (Centre for Health Systems Research, National Institute of Public Health), Mexico.

Contact persons

Anahí Dreser and Mario Bronfman
Centro de Investigación en Sistemas de Salud, Instituto Nacional de Salud Pública
Av. Universidad # 655, Col. Santa María
Cuernavaca, Morelos, 62508, Mexico
Phone: +52-777-3111140
Fax: +52-777-3111156
E-mail: anahi@insp.mx, mbronfman@insp.mx
Web: www.insp.mx

Human rights issues in semi-legal foreign sex work in Panama

Carmen Carrington-Betts and Claude Betts

During a qualitative research project conducted in early 2000 among sex workers in Panama,[1] our association Nueva Era en Salud (New Era in Health) stumbled across an old 'official' Panama Canal Company flyer, dated January 13, 1923, with a large heading that read: "Warning! Beware of Whores!"

The content of the flyer is worthy of an anthropological study on mainstream gender mindset in the twenties. Even though the flyer was supposedly aiming for prevention of STIs, no mention whatsoever was made of a 'condom'. Instead, the flyer used expressions such as, *"…you wouldn't touch a woman that was covered with leprosy…well, many of these women have something worse than leprosy inside…"*

Today, in the scenarios of formally established sex work in Panama, things have changed for the better since 1923 in some aspects, but not in others. We are still a long way from achieving adequate levels of respect for human rights of women and adherence to basic labour rights and working conditions for women in the commercial sex business.

Compulsory testing

The legal status of sex workers in Panama is ambiguous and will not be discussed in depth in this article. In practice, women from abroad enter the Republic of Panama with a time-limited 'legal work permit', which allows them to provide services to a specific adult entertainment establishment during the duration of their permit.

The work permit requires registration in the 'Social Health Clinic' Programme of the Ministry of Health, comprised of compulsory weekly health examinations for registered sex workers, which includes lab tests for STIs. Tests must be negative for women to be allowed to continue working. Women with positive tests for curable STIs are treated and can only return to work once tests come out negative.

Any woman with a positive HIV test will be immediately deported back to her country of origin. Health inspectors of the Ministry of Health regularly visit establishments checking that all women are in good standing with the programme.

About these compulsory tests women in one of the focus groups stated, *"…every three months we get an HIV test, which, if positive, immigration officials will immediately deport us back to our country…however, prior to the HIV tests we receive no pre-test counselling and we don't get to see our results, even though we are the ones who pay for the lab tests."* Women in another of the focus groups stated, *"…the brothel manager checks our health cards to see if we passed the social health clinic, but he doesn't check the hygienic conditions of the brothel."*

> ***"Prior to the HIV tests we receive no pre-test counselling and we don't get to see our results"***

Foreign women, mostly of Colombian and Dominican origin, work primarily in brothels and pick-up bars, whereas Panamanian nationals are predominant on the streets and in massage parlours. Most of our research took place in the scenarios where the women worked, comprising 324 individual interviews. Informed consent and complete information was obtained from 278 women, of which 103 were Panamanian, 83 Colombian, 80 Dominican and 12 of other nationalities. Five focus groups were held, comprising a total of 80 women who attended 'Social Hygiene Clinics', with participation and support of health clinic personnel. Focus group meetings were held in rooms with total privacy; confidentiality and total freedom of opinion were guaranteed.

Complex scenarios

Foreign women, in particular, had strong characters and were very resourceful, attributes needed in order to survive in a strange country and to operate successfully in complex scenarios with many levels of interactions. Women interacted with immigrations officers, health inspectors, police officers, social health clinic personnel, clients of all sorts, brothel owners and administrators, their families abroad, to mention a few.

The actors mentioned above (and many others) play important if not decisive roles in shaping risk factors, as well as supporting protective factors, in each scenario. The behaviour of each actor responded to his or her paradigm regarding commercial sex work. That was the main reason for Nueva Era to link its research of sex workers with training and gender sensitisation of police officers, involvement of health personnel, brothel owners and administrators, the media, international observers, among others.

Safe sex service

We observed that interactions among women and between women and other actors in the sex business, both in brothels and on the streets around the brothels, represented an intricate network of relationships and functions aimed at achieving the final outcome: a safe, uneventful and commercially productive sex service. This desired outcome, however, is achieved at very different levels in the various scenarios of sex work.

Women working in brothels (86% of which were foreigners) reported much greater control regarding their interactions with clients, than women working on the streets (91% of which were Panamanian). This was reflected in data of reported cases of rape on the job: 2.6% among Dominican, 8.5% among Colombian and 23.3% among Panamanian nationals. Rape on the job in street scenarios was 40%.

Brothels provide a certain level of protection when clients tend to be abusive with a sex worker. One woman stated, *"… once a client took his penis out of me, took the condom off and wanted to penetrate me without a condom…he grabbed me by the neck to force me, so I defended myself by giving him a low blow, and I immediately called the brothel security and the client was kicked out of the brothel…"*

Debts

Foreign women avoided illicit drugs and excess alcohol consumption much more than Panamanian women. In this study, use of illicit drugs was strongly associated with the increased risk of being raped on the job. On the other hand, foreign women tend to work more days and longer hours than Panamanians. Women in a focus group stated, *"foreign women working in live-in brothels come to Panama with a contract with the brothel management and have to work seven days a week and an average of 8 to 12 hours a day."*

In this regard, interviews were conducted with eleven brothel owners and managers. Managers of live-in brothels (who contract foreign women exclusively, mostly of Colombian origin) stated, *"…we invest approximately US$1,000 to bring a women from abroad to work for us, which must be paid off in two instalments, out of the women's earnings during the first 3 months…"*
Conversely, managers of pick-up bars (who contract services of both foreign and national women) stated, *"foreign women must pay US$1,000 when they arrive at the airport, but we don't run this kind of risk…"* Therefore, women in these scenarios make their own arrangements to cover such expenses, but they still have an obligation to work in a certain establishment. The labour ties with pick-up bar management are less controlling than those with live-in brothels, but just the same, a woman's debt creates self-imposed long working hours in order to pay off the debt as soon as possible and before the work permit expires in 6 to 12 months.

No condom, no sex

As far as condom use is concerned, both Panamanian and foreign women reported very high levels of systematic condom use with clients (97.8%), but less than one third used condoms with their 'stable' partners. The requirement of condom use by all clients and a 'No condom, no sex' policy in brothels has total commitment of sex workers and active support of brothel management.
Women in focus groups stated, *"For any service with penetration, condom use is a must…If a client refuses to use a condom, I will not provide him with my services…"*
Many women expressed, *"…if a client refuses to use a condom or if he offers to pay more for sex without a condom, this might mean that he has a disease, so we will not run this risk…we have had friends who died from AIDS, we will not run the same fate…"*

High awareness

Awareness of the risk of HIV/AIDS and other sexually transmitted infections was found to be very high. Women in different focus groups stated, *"before we have sex, we examine the client's genital area and his penis, to see if he has ulcers, signs of gonorrhoea such as pus, or other visible signs like genital warts…We have seen clients with blood coming from their penis and bad odours…"* Some women stated, *"When I have come across clients with these signs, I definitely do not service them and the brothel has given the client his money back..."* Other women stated, *"…in situations like these, I only masturbate the client…"*

The requirement of condom use by all clients and a 'No condom, no sex' policy in brothels has total commitment of sex workers and active support of brothel management

Low HIV rates

These observations may partially explain very low HIV prevalence rates among registered sex workers ranging from 0.0% to 0.3%, while various community-based prevalence studies among pregnant women in urban centres have shown rates of up to 0.8%.[2]
These findings were similar to very highly publicised programmes, such as the '100% Condom Use Programmes' that have been developed in Thailand and elsewhere, and yet, no programme of the sort has ever been promoted in Panama. Every brothel owner and administrator that was interviewed stated something to the effect of, *"…you [Nueva Era team members] are the first public health people that have ever approached us to ask our opinion on how to prevent HIV/AIDS in our line of business…".*

The 'success' in very high rates of condom use and apparently low rates of HIV seroprevalence, was closely linked to a combination of factors:
1. Sex worker awareness, due to friends and colleagues affected by HIV/AIDS
2. The commercial need for marketing of a 'safe product' in a business adversely affected in recent years by client's fear of catching HIV
3. A 'Social Health Clinic' Programme that provides the commercial sex businesses with a kind of 'safe product' certification, which ultimately serves as a marketing incentive for establishments to make sure sex workers use condoms with all clients.

Addressing needs

But achieving 'success' of consistent condom use and HIV/STI prevention is still a long shot away from adequately addressing the health and well-being needs of men and women in sex work scenarios.
Participants of focus groups were unanimous in responding to the research team's question regarding HIV/AIDS/STI training, *"we would gladly accept to participate in a training programme in prevention of HIV/AIDS and other STIs…"* However, women also wanted training on other topics as well: (1) alcoholism and drug addiction; (2) how to set up a worker's compensation fund, spending and economic issues; (3) legal issues; (4) self-esteem; (5) how to build unity; (6) how to help others; (7) how to deal with a drunk person. These were a few of the most frequently mentioned topics. Most of these topics would be of equal interest for working class men and women in all lines of business, be it sex work, working in a factory, in the field, in an office, or in a household.

In summary, the line that supposedly separates commercial sex work from all other categories of the labour force is becoming thinner every day. As scientific evidence accumulates and social mobilisation brings to the table the need to address issues of basic labour and human rights of working women, the current mainstream paradigm, based on gender and social discrimination however disguised, must be changed: it is no longer sustainable.

Notes

1. Published in *Research for Sex Work*, Vol. 4, pp. 29-31, 2001.
2. G. Guerrero, *Revision de Estudios de VIH en Panama, Informe de Consultorio* (Review of HIV Studies in Panama, Consultancy Report). PASCA, BUCEN, 1998.

About the authors

Carmen Carrington-Betts and Claude Betts are President and Executive Director of Nueva Era en Salud, respectively.

Contact person

Carmen Carrington-Betts
Apdo. 6-655 El Dorado
Panama City, Republic of Panama
Phone/fax: +507-2612938
Cell: +507-6724509
E-mail: carmen@nueva-era.org or bettscarr@aol.com
Web: www.nueva-era.org

Displacement and Risk in Colombia

Young people selling sex in the streets of Bogotá

Timothy Ross

Fundación Renacer is an NGO that works with street children in several cities in Colombia, most of whom are internal refugees who are involved in the sex trade. Timothy Ross describes the problems surrounding HIV/AIDS care and support for young sex workers on the streets and the services his organisation provides to them.

It has been recognised for many years that refugees and people displaced by violence within their own countries face especially serious health problems, and since the late 1990s increasing attention has been given to the reproductive health of war-affected populations – and especially to the potential for increased risk of HIV and other STI infections. At the same time it has been found that measuring these impacts, let alone taking preventive action, is especially difficult. First, precisely because of the social disruption and impoverished, chaotic and unstable living conditions of displaced and refugee populations and second, because of the dangers and difficulties for researchers and health professionals that may be posed by conflict and combat.

Young people are particularly vulnerable to conflict and the long-running social, political and criminal violence in Colombia has a particularly dangerous impact on children and adolescents. More than 60% of displaced people are estimated by the government to be under the age of 18, and many have lost parents or other close family members, may have suffered violence directly or witnessed killing or torture, and have been uprooted from their communities. They usually have had to relocate to new surroundings in extreme urban poverty and sub-standard living conditions, with high levels of crime and unemployment and few services.

The murder rate in Colombia is (conservatively) estimated at over 80 per 100,000 per year, compared to European averages of less than 2 per 100,000. People displaced by the violence over the past ten years total about 1,700,000.

Young sex workers

Behavioural difficulties related to psychological trauma are common to the children and adolescents attended by the Fundación Renacer in Colombia, young sex workers in the northern cities of Cartagena and Barranquilla and in the capital, Bogotá. Increasing numbers are being found on the streets after arrival as refugees from the fighting in the north, the eastern plains and the centre-west coffee zones that are contested by leftist guerrillas, government security forces and right-wing paramilitary gangs linked to drug production. The average age of those entering the Renacer treatment programme (see box) has dropped since 1999 from over 15 years to about 13 years 5 months.

We also noticed that the numbers of sexually transmitted infections are rising steadily among these adolescents. In late January 2002 at a free medical clinic, 5 out of 12 attending were found to have gonorrhoea. One pregnant 14-year-old girl had gonorrhoea, chlamydia and trichomonas, and a 13-year-old boy was treated for gonorrhoea of the throat for the second time. Over one month 10% of children attending had generalised lymphadenopathy, suggesting possible HIV infection, 36% of girls and 27.8% of boys had signs and symptoms of gonorrhoea and chlamydia. There is also evidence that the prevalence of HIV infection is rising from 10% of girls and 58% of boys found four years ago,[1] with the average age of infection dropping. The difference in the infection ratio between boys and girls seems to lie in part in the greater number of sexual relations per day in boys, but more in the Bogotá gay prostitution culture which rejects condom use and attributes a mystique to being HIV-positive. Studies of adult female sex workers in

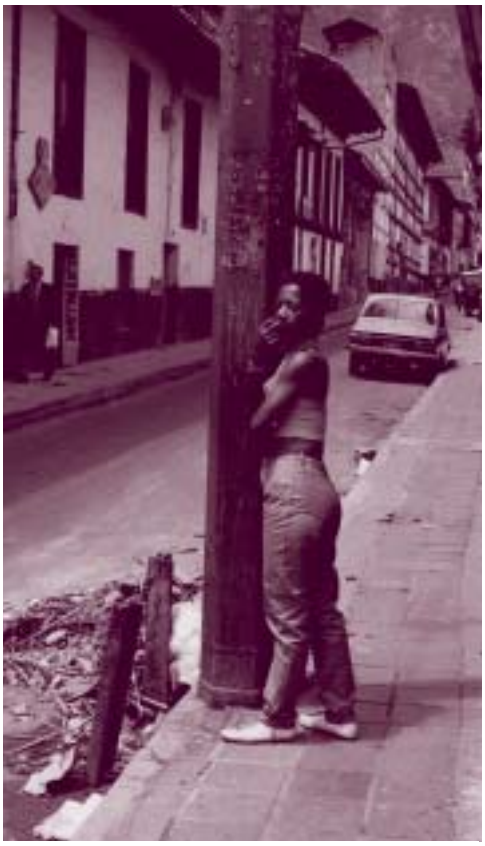


Photo:Timothy Ross

Fundación Renacer

The Renacer outreach programme offers services in the day centres to meet expressed needs such as doctors' appointments, literacy classes, training courses, health-care workshops or food and showers, but without pushing the children too forcefully and as secondary to street work. When outreach contact and day centre attendance begin to create an attachment to the organisation the adolescent may be offered a visit to a residential home and a discussion about long-term options in life. The treatment programme includes individual, group and family therapy, schooling, and vocational training with work experience in the Foundation's own micro-businesses and in collaborating commercial companies (e.g., dress-making, graphic arts and printing, and restaurant work).

Up to 140 children at a time live in the homes, with about 350 in street programmes and day centres and 450 more in aftercare. The average stay is under two years, but some arrive with such serious damage and developmental difficulties from profound early abuse that they need three to four years for recovery.

Colombia have also given prevalence figures of around 10%. Some terminal AIDS cases are now as young as 16, and treatment compliance is extremely poor among those still on the street – so much so that most hospitals refuse anti-retroviral drugs to HIV-positive

Young male sex workers. Photo:Timothy Ross

people who are not in residential programmes, to prevent proliferation of drug-resistant strains.

HIV care

Children living in Renacer homes are registered with the state child protection agency and entitled to medical care, including triple antiretroviral drugs for those who are HIV-infected and counselling on possible consequences of non-compliance. Many young people choose not to take the drugs. Perhaps this is because of adolescent feelings of invulnerability coupled with denial as well as the physical malaise often felt in the first months of treatment. Those who remain on the streets when HIV-positive are given special attention by outreach workers, counselling on their own health and that of sexual partners, supplies of condoms and constant encouragement to enter Renacer or another residential programme.

Street strategies

Over 7,400 sex workers under 18 have been counted in Bogotá, but Renacer's residential homes can only house 140 young people at one time. The question is therefore how to develop strategies to reduce risk and harm for all those still on the street, where selling sex is part of a complicated pattern of adventure, danger, drugs and survival.

Renacer outreach workers go to where they are, to be with them on their terms and in their space, and learning from them as much as trying to teach. Condom use and condom negotiation are worked on with the children as vital elements in improving their chances of avoiding HIV and other fatal infections, as well as the use of lubricants to minimise tissue damage, ways to reduce drug harm and improve nutrition and other practical issues.

Our philosophy regarding street work is offering affection and respect, and foster the development of honest, caring relationships in which young people can begin to work out their own options and to make autonomous decisions about their lives. For those who do not want to leave the streets non-judgmental support is continued and advocacy is often needed to back their efforts to gain access to health care, or to defend themselves against human rights abuses.

Ethical considerations

Working with underage sex workers clearly produces some ethical contradictions as international agreements (e.g., the Convention on the Rights of the Child) and Colombian laws, establish the duty of the state and all adults to protect minors from abuse and exploitation. It can be very hard for an outreach worker to see a young adolescent engaged in deeply self-destructive behaviour, such as selling sex without protection and sharing syringes. Over-eager efforts to wean children away from sex work, however, often generate resistance and distrust, and only unconditional caring creates the confidence and sympathy that can allow a realistic look at consequences of the lifestyle.

Research in psychotherapy shows the personal qualities of the therapist contribute more to positive outcomes than the theoretical approach used, and in outreach – sometimes the first stage of a longer therapeutic relationship – the same applies. Genuine warmth and accurate, uncritical empathy are more useful than persuasiveness. Renacer's para-professional Indigenous Outreach Workers (peer educators, see box), who share the same background and experiences but have no formal training, therefore have a vital role to play in harm reduction.

If violence continues growing in Colombia, the numbers of children forced to migrate from the country to the cities and from their homes to the streets will inevitably also grow, and sexually transmitted infections can be expected to climb sharply. Renacer is thus preparing a research study on HIV prevalence and correlations with drug use, migratory status and family disruption to help improve strategies for attention to those most vulnerable to the impact of war and displacement.

Note

1. In the past, all children entering the Renacer programme were encouraged to agree to voluntary tests with pre- and post-test counselling. Unfortunately, the deteriorating Colombian economy has reduced health care budgets and it is now only possible to test those with clearly indicative symptoms. Lack of research funds means there are no accurate current prevalence figures.

About the author

Timothy Ross is Health Co-ordinator and outreach worker of Fundación Renacer.

Contact person

Timothy Ross
Fundación Renacer, ECPAT Colombia
Calle 41, No. 25-75
Bogotá, Colombia
Phone: +57-1-3688141 or 2445490
Fax: +57-1-2445492
E-mail: renacer@latino.net.co
Web: www.fundacionrenacer.org

Renacer is a member of ECPAT International, a network of organisations and individuals working together for the elimination of child prostitution, child pornography and trafficking of children for sexual purposes.

More information

E-mail: info@ecpat.net
Web: www.ecpat.net

Indigenous Outreach Workers

Renacer regularly employs several peer educators, called Indigenous Outreach Workers. They only engage in street outreach when their own rehabilitation is consolidated and they are teamed with professionally trained adults, to limit the risk of relapse. Two HIV-positive young men have worked in the Bogotá programme for over five years as peer educators, working with children at the day centre, arranging health care appointments and taking weekend shifts in the homes. Cultural similarity, shared values, language and style, makes a peer leader often more effective in transmitting health messages and motivation for change to people from the same group, while their own experience gives them greater inside knowledge and commitment to their peers than the professional can easily attain.

A profile of mobile sex workers in Belo Horizonte, Brazil

Alessandra Chacham and Mônica Maia

In this paper we present the results of a survey conducted with 178 sex workers from the main red light district of Belo Horizonte (State Capital of Minas Gerais, Brazil) in 1999.[1] This area is located in the city's downtown and it has almost 20 hotels where over 2,000 women make a living as sex workers. These women are the target population of a project for AIDS/STI prevention developed by the NGO MUSA (Women and Health, see box) and the survey was used as an evaluation tool for this project. The women were selected by convenience sample and were interviewed about their knowledge, attitudes and practices with the use of a KABP questionnaire.

According to our results, the vast majority of the women interviewed (86%) were internal migrants (from Brazil) and 43% had worked as sex workers in more than one city in the last three years. They explained this high mobility as a search for better work conditions, seeking higher gains and less harassment from the police. We identified two different types of migrants: permanent and transient migrants. Permanent migrants are women who migrated to Belo Horizonte and live here now. Out of the 118 who lived permanently in Belo Horizonte, 91 were migrants. Most of the migrants (85%) were born in the countryside or in small towns and the rest in other state capitals in Brazil.

A third of the women interviewed formed a group that we called 'transient' migrants, women who lived either in other state capitals or in the countryside, and who came to Belo Horizonte periodically to work in the sex industry. The period they stayed varied from 1-3 weeks each month (57%) to 1-3 months (32%) or 4-6 months (11%). Two-thirds of these women lived in the same hotels where they worked during the time they resided in Belo Horizonte.

more exposed to the educational materials distributed by other NGOs and governmental organisations from outside Belo Horizonte (see Table 1).

This may be explained by the fact that transient migrants – and to a smaller extent permanent migrants – are much more likely to have engaged in commercial sex in cities other than Belo Horizonte than women who have always lived there. Nevertheless, it is clear from these results that we have to pay special attention in our work to the transient women in the area, to make sure they are visited by our monitors on a regular basis during their stay in the city.

Table 1 – Percentages of sex workers who had been exposed to health education

	non-migrants	permanent migrants	transient migrants	total
knowledge of MUSA monitors	**48%**	**44%**	**22%**	**37%**
knowledge of MUSA materials	**44%**	**42%**	**21%**	**35%**

Table 2 – Percentage of sex workers who had regular partners, and who always or never used condoms with these partners

	non-migrants	permanent migrants	transient migrants
had boyfriends/regular partners	**60%**	**40%**	**40%**
with whom they:			
- always/frequently used condoms	44%	34%	37%
- never used condoms	36%	28%	32%

MUSA

MUSA (Mulher e Saúde – Centro de Referência em Educação para Saúde da Mulher) is a feminist NGO in Belo Horizonte, Brazil. It was created in 1991 with the objective to promote a comprehensive approach to women's health. MUSA's main goal is to contribute to the reduction of the female mortality and morbidity by curable causes related to sexual and reproductive health. MUSA's educational project with sex workers is called 'In the Battle for Life' and it is financed by the Brazilian Ministry of Health. The project basically trains sex workers or former sex workers to act as peer counsellors to educate about reproductive health issues and HIV and STIs prevention. They are trained in a continuous process, with weekly meetings, to act as health educators. They are paid to do this work and to frequent the meetings. The peer counsellors distribute educational materials produced by MUSA about reproductive health issues and AIDS/-STIs, as well as materials and condoms sent by the Ministry of Health.

Health education

On average, the women in our sample were young, single, of black or mixed race, with a low educational level, were from poor families and from small towns/countryside. In relation to their exposure to our educational work and to the work of other NGOs and governmental organisations we found significant differences with regard to their migratory status. Relatively more permanent residents (both non-migrants and permanent migrants) knew our monitors (peer counsellors) and educational materials than transient migrants did. On the other hand, transient migrants were

These fairly high levels of exposure to information may be responsible for the fact that we did not find significant differences in the level of knowledge about AIDS (how to prevent it and means of contamination) in the three groups of women, either in their attitudes toward AIDS or safer sex practices. Our results also indicate that the majority of the women interviewed were reasonably informed about most questions relating to STIs/HIV/AIDS, including methods of prevention. However, some forms of transmission such as maternal-foetal and their possible means of prevention are not well known, pos-

sibly due to the emphasis given to the sexual means of transmission in this specific group.

Boyfriends

Almost every one of the women interviewed (over 98% in the 3 groups) declared that their clients always use condoms during vaginal, oral and anal sex. However, almost 70% of them said that they occasionally put two condoms on at the same time as extra precaution. They do that when they decide the penis is too big or too thick, or for anal sex, or if they suspect the client may have some disease. Also, a significant number of them (64%) affirmed that they never or rarely use condoms with their regular partners. Non-migrant women were more likely to have boyfriends or regular partners and to live with them. Over one-third of non-migrant women declared that they always used condoms with these private partners. Fewer permanent and transient migrants declared the same. On the other hand, we also found a higher percentage of non-migrant sex workers (40%) than migrant sex workers who admitted never using condoms with their boyfriends (see Table 2).

The most common reason presented for not using condoms with a partner was that they are seen as a barrier to intimacy (43%). Another 43% declared that their boyfriends

refused to wear condoms. In our analyses we were not able to find any relationship between the use of condoms with a regular partner and any demographic variable such as age, place of birth or residence and migrant status. Only the educational level of the women had a slightly positive influence on the use of condoms with private partners.

While these results indicate the importance of educational programmes developed by NGOs, they also point to the inadequacy of campaigns directed at sex workers that focus exclusively on the use of condoms with clients. When we work with prostitutes and consider only their professional lives we ignore the fact that they face the same problems as other women in an intimate relationship.

When we work with prostitutes and consider only their professional lives we ignore the fact that they face the same problems as other women in an intimate relationship

There are no simple answers about how to handle the questions relating to gender identity and inequalities that arise in any heterosexual relationship.
However, it is urgent to discuss new approaches in the AIDS educational and preventive work that take into consideration gender-related issues, especially now when AIDS infection rates among heterosexual women in Brazil are getting higher.[2]

Notes

1. A. Chacham and M. Maia, *Sexual Practices and the Prevention of AIDS/STDs among Sex Workers in Belo Horizonte, Brazil.* XXIV General Population Meeting – IUSSP. IUSSP, Salvador, 2001.
2. S. Diniz and W. Villela, Interfaces entre os programas de DST/AIDS e saúde reprodutiva: o caso brasileiro. In: *Saúde, Desenvolvimento e Política*. R. Parker, J. Galvão and M. Secron Bessa. ABIA, Rio de Janeiro, 1999.

About the authors

Alessandra Chacham and Mônica Maia are with Grupo MUSA in Belo Horizonte, Brazil.

Contact person

Alessandra Sampaio Chacham
MUSA
Rua Itacolomito 83
Belo Horizonte, Minas Gerais, 31010 Brazil
Phone/fax: +55-31-34675875
E-mail: musasa@terra.com.br
Web: www.musa.org.br

Some online resources on sex work and health

Hustling for Health: Developing services for sex workers in Europe
European Network for HIV/STD Prevention in Prostitution (EUROPAP/TAMPEP), London 1999
English: www.europap.net/hustling/hustling.htm
Spanish: www.europap.net/download/Trabajandoporlasalud.pdf
Also available in 8 other languages (check out: www.europap.net)

100% Condom Use Programme in Entertainment Establishments
WHO Regional Office for the Western Pacific, 2000
English only: www.wpro.who.int/pdf/condom.pdf

Sex Work in Asia
WHO Regional Office for the Western Pacific, July 2001
English only: www.wpro.who.int/document/FINAL-Sex Work in Asia.doc or: www.med.vu.nl/hcc/sex_work_asia.pdf

Female Sex Worker Projects in the Asia-Pacific Region: 3 case studies
UNAIDS Case Study, November 2000
English only: www.unaids.org/publications/documents/care/general/JC-FemSexWork-E.pdf

Prostitution et Sida
Infotheque Sida/AIDS Infothek, journal of the AIDS Info Docu Switzerland, Vol. 12, no. 6, 2000
French: www.aidsnet.ch/download/00-6f.pdf
German: www.aidsnet.ch/download/00-6d.pdf

Services in the window. A manual for interventions in the world of migrant prostitution
Transnet - Transnational Empowerment of Local Networks project, 2001
English: http://transnet.exclusion.net/handbook/en.asp (pdf)
Italian: http://transnet.exclusion.net/handbook/it.asp (pdf)
Russian: http://transnet.exclusion.net/handbook/ru.asp (pdf)

All links can be accessed through the Research for Sex Work homepage: www.med.vu.nl/hcc

Niger: sex workers at the market

Sani Aliou, Mahazou Mahaman, Ibrahim Adamou and Fadima Soumana

Niger is a country situated in the heart of West Africa. It is a transition zone between the Maghreb countries of the north and the Sahel in the south. Society is primarily based on agriculture and internal and external mobility is a strategy of life for many young people. In 2000, following social tensions that succeeded the installation of Islamic rule in the northern states of Nigeria, thousands of sex workers of different nationalities found refuge in Niger.

To be able to formulate a support project for these refugees, CARE Niger has carried out a small-scale prospective study.[1] In February 2002 a focus group discussion and individual interviews with six sex workers were conducted by field workers at two sex work sites in the border regions of Zinder and Maradi, in the south of Niger close to the Nigerian border. The goal of these interviews was to identify the risk of HIV of sex workers, the economic routes they take as well as their access to health care.

The market: vital place and space of liberties

Without doubt, one of the places of economic and financial opportunity is the market. A typical market in Niger takes place at a fixed site once a week, during daytime or in the evening. Everybody goes there with something to sell, or to buy. This hot place of exchanges also creates the opportunity for all kinds of meetings, in particular for those who are in search of romance for one day. Sex workers find there an ideal space to weave a web of clients.

The income per market varies between US$3 and $15, according to Hassia[2] whose clients are primarily merchants. Each week, a sex worker frequents two or three markets, that are sometimes situated long distances away from the place where she lives.

The danger is for the others

When the issue of sexually transmitted infections was brought up with Salamatou, she said: *"I have never had an STI..., except for one time when I was sick. I had a lot of pain in my 'lower stomach'; I had to be treated at the health centre."* She continued: *"I heard people talking about AIDS but I do not know this disease. I pray to God to protect me; I use a condom if the client wishes so... but never with my boyfriend!"*

This attitude and behaviour can be found among other young women. Some of them said they used 'gris-gris', amulets, to protect themselves against infections, some of them denied running any risks of contracting a disease: *"the danger is for the others"*.

In Niger, the population in general uses the services of traditional healers and mobile medicine vendors as a first resort in case of disease, before they turn to the health centre. Also sex workers avoid health services, notably because of the prejudices, taboos and hostility expressed by health care personnel. It is also a fact that even when the health centres do work properly, they are too expensive and unadjusted to the tasks ahead (e.g., nurses are not always trained to manage STIs).

Reducing stigmatisation

The strategy of mobility sex workers use will become more important in the future in Niger. It constitutes a possibility for prostitutes to reduce the stigmatisation connected to the sex trade: a sex worker who moves around is less visible. Besides, the installation of Islamic law in Nigeria has provoked a massive movement of prostitutes to towns in Niger. More and more, the subsequent increase in competition between sex workers forces them to look for clientele far from their homes. When people move or migrate, the socio-cultural rules that define human relations and in particular sexual relations change significantly, opening up new opportunities for contact and sexual encounters and exposing more people to an increased risk of HIV and STIs.[3]

Innovative approaches

For mobile populations, the fight against AIDS requires new reflections and new approaches that are capable of offering a global solution. Interventions for mobile people should be innovative in order to identify relevant approaches for the spread of health messages and an appropriate mission. Therefore, CARE International will start a pilot project which is adapted to the environment of mobile sex work in Niger. When it started the pilot project 'AIDS and migration' in 1993, CARE was the first development organisation in Niger that showed interest in the relationship between population mobility and transmission of HIV and STIs.

The new project will develop interventions in the fight against AIDS among groups of refugee prostitutes in Niger and in general in the sex work scenes in the area bordering Nigeria.

Market place in Niger. Photo: Calista Ophilia Croos

The case of Hassia or the broken dream

"I am 21 years old and I went to school for three years. I started working in this business a few years ago after a family conflict: my father got married for the second time and my mother had to leave the matrimonial house. I had found the man of my life but the second wife of my father didn't want this marriage. I had to leave the family and to make the story worse, I turned out to be pregnant. My dream was broken... the man did not want me anymore, I suffered a lot, but luckily the delivery was without major problems.

I have chosen to tour rural markets because you earn enough money there. Actually I work on three markets on a regular basis. My first time was with a man I met at a car park. He showed me a woman that could rent me a cottage to meet my clients for about US$1,5 a day. My clients are locals but especially merchants. At each market, I pick up two or three clients, which gives me an income of 3-15$ per day, but sometimes certain regulars give me money without wanting sex in return.

I have never had sexual diseases, but when I go to the hospital they check my urine and give me a prescription for medicines that I have to buy; they also give me condoms. In truth, I do not demand condom use from my clients: it is up to the man to insist... I do not even know how to put a condom on! Those who want to use them know how to do it!

My life project, my new dream, is to get married and have children. Since my first child was born six years ago, I have not been pregnant. With this trade that I do I think that there is a divine protection because I do not take any contraceptives… If I would have been married and there would be another wife and I would remain like this without getting pregnant, I would say she had bewitched me! (laughs)."

Recorded by Sani Aliou

The aims are to develop good relationships between sex workers and health services and to identify and develop alternative economic opportunities for women. The project's key outputs include: a good access to HIV and STIs prevention (voluntary counselling, testing) and curative services, encourage sex workers and their partners to change their sexual behaviour and put in place a sustainable saving and credit system.

Notes

1. Projet Espoir. Document de Proposition Phase 1, Mai 2001, CARE Niger, 2001.

2. To respect the anonymity, all names in this article have been changed.

3. G. Herdt (ed.), *Sexual cultures and migration in the era of AIDS: anthropological and demographic perspectives*. Clarendon Press/Oxford University Press, Oxford/New York, 1997.

About the authors

Sani Aliou, Mahazou Mahaman, Ibrahim Adamou and Fadima Soumana are with CARE Niger.

Contact person

Sani Aliou
CARE Niger
PO Box 10155
Niamey, Niger
Phone: +227-754830 or 754556
E-mail: ci-niger@intnet.ne

STUDY RESULTS

'Like plastic that blows in the wind'

Mobile sex workers in southern Africa

Louise Robinson and Tamara Rusinow

Sex workers who move from one location to another in southern Africa lose their existing social networks. In new locations, they are ostracised and stigmatised by their neighbours both because they are considered outsiders, and because of their means of livelihood. In one border area in Lesotho, the sex workers are referred to as 'plastic' – as they are said to "move from place to place, blowing in the wind like a piece of plastic".

This article explores some of the issues faced by female sex workers from Lesotho in southern Africa, which came up during a series of semi-structured interviews and focus group discussions held in the course of the work of the CARE-implemented SHARP! programme.[1] A participatory learning assessment (PLA) took place in 2000 and 2001 in each of the sites in which the programme operates. Semi-structured interviews and focus group discussions were carried out with sex workers during the course of these assessments. More recently, project staff facilitated a further three focus group discussions in each of the three project sites: Ficksburg in South Africa and Maputsoe and Maseru in Lesotho.

Lesotho, a mountainous kingdom, is one of the smallest countries in Africa. It is completely surrounded by its larger, more dominant neighbour South Africa, which provides 90% of Lesotho's imports and absorbs about 50% of its exports. Lesotho's major towns are located in lowland areas bordering South Africa and each has a neighbouring town on the opposite side of the border. Separated only by a river, they have become more like large extended towns than separate entities. The Basotho, as Lesotho's inhabitants are called, live on either side of the river in two different countries, yet share the same language and culture.

Cross-border migration is common with large numbers of people from Lesotho travelling to South Africa in pursuit of employment, including miners who leave their homeland for work

SHARP!

The Sexual Health And Rights Promotion programme (SHARP!), managed by CARE International in Lesotho and South Africa, was initiated in 2001 in response to issues identified from assessment work carried out by USAID and FHI (Family Health International) as well as participatory learning and action appraisals undertaken by CARE in border sites.

The SHARP! programme adopts a community development approach and incorporates both prevention and care strategies. One component of this programme is its work with sex workers which includes peer education, capacity building of CBOs and service providers (such as police, teachers, nurses and traditional healers) and the development of community home-based care strategies. The programme has a rights-based focus and is specifically developing strategies to address issues of stigma, discrimination, gender violence, access to health care and access to fair treatment before the law.

in the goldmines and sex workers who seek new employment opportunities in what is perceived to be a more affluent nation. A number of these sex workers operate out of border towns and move back and forth regularly, whilst others have travelled as far as Cape Town or Johannesburg.

Crocodiles of the Queen

Sex work in Lesotho and in South Africa, as with many other countries, is illegal. In addition, the prevailing culture stigmatises women who engage in such work. Many are ostracised by their neighbours and all respondents said they keep their means of livelihood a secret from their families. In Maputsoe, sex workers are labelled as 'plastic'. In Maseru, some sex workers complained that people whisper about them to their children. They say that they are referred to as 'crocodiles of the queen', or 'the greatest money seekers of all time'. Both terms are derogatory; the first implying that they come out at night, clean and looking beautiful like the queen, but that they bite like a crocodile. Some people make gestures biting their finger as they go past, implying that they might be good at sex but they 'bite' by passing on STIs. Although this stigmatisation applies to all sex workers, those operating in border areas suffer disproportionately due to the lack of community safety nets or traditional support structures.

New support networks

Sex workers crossing the border to Free State (South Africa) may not face issues of having to learn a new language or adapt to a new

Each area has its own social and cultural norms and practices that create vulnerability for a newcomer

currency or culture, but without contacts in the new area their vulnerability is exacerbated. The assumption that a shared language and culture will make adjustment to a new life easy can obscure the reality that each area has its own social and cultural norms and practices that create vulnerability for a newcomer.

Most sex workers say they receive support only from their co-workers who assist them when they are in trouble, are sick or have no money for food. However, even this support network is lost when a woman moves to a new area. In such situations the sex worker has to re-establish herself and her family with new support networks.

Two of the project peer educators with a village chief in a border town of Lesotho

In border areas, 'chiefs' carry responsibility for a constantly changing, mobile population, compared with the relatively static makeup of rural villages. Women working in the border areas can therefore retain some anonymity, but feel unable to seek support from these traditional elders.

None of the sex workers interviewed in Maseru knew their local chief in the town, but all knew the chief of their rural home. The situation was somewhat different in Maputsoe where the SHARP programme has been operating for almost one year. Here the chief and the village committee are said to have become more supportive of the sex workers, providing some assistance with their problems.

Access to health care and legal support

The vulnerability of sex workers working outside their own country is further exacerbated

One of the major concerns was the sex workers lack of recourse to the legal system

by their lack of recourse to the formal support systems such as health services and the legal system. Indeed the negative attitudes and behaviours of the health service providers consistently discourage sex workers from seeking treatment in both countries. Despite having current symptoms of STIs our respondents were reluctant to seek assistance. Some reported that access to health care was better in South Africa as it was free unlike in Lesotho. No one had been refused treatment nor asked for an ID in South Africa. In Lesotho however, cost as well as stigma prohibits treatment-seeking.

One of the major concerns to come out of the discussions was the sex workers lack of recourse to the legal system. Despite sex work being illegal in both countries, few sex workers interviewed had actually been arrested for their work. They admitted that there seemed to be more enforcement of this law in Lesotho than in South Africa, but that it was not consistent. Several women described being taken into custody in Maseru and being made to clean the police station overnight before being released in the morning. Indeed, women in all sites described members of the police force as being their most frequent clients.

More worrying, however, their illegal working status has led many sex workers to be unwilling to report crimes. Most sex workers feared reporting any crime against them and instead tried to take the law into their own hands. Some sex workers reported trying to 'beat'

the suspected culprits themselves (as a group) or with the assistance of regular 'boyfriends'.

Violence

Startling descriptions of rape and physical attacks were recounted, creating concern about the level of violence that is tolerated or accepted as the norm. Some said that some policemen offered to accompany them at night but then raped them. One woman said *"what can I do when he shows me his gun?"* The women appeared fatalistic stating *"God will deal with them"*.

Many reported being raped when travelling home from work. This has led to some using taxis to go home after business – using sex as a method of payment. Some had tried to report rape but had been fined 300 Rand (US$30) for sex work; others had been asked by police officers *"what did you expect when you were playing with your vagina?"* In general, police response in South Africa was considered to be slightly better than in Lesotho.

With its work on either side of the border the SHARP! programme is in a unique position to collaborate with a wide group of stakeholders such as sex workers, police and health service providers to develop rights-based approaches that *respect, protect and fulfil* basic human rights so that even if the women in these border areas move 'like plastic' they are assured their basic human rights will be met wherever they 'land'.

Note

1. Sexual Health And Rights Promotion (SHARP!) is a cross-border programme covering five major towns on the Lesotho/South African border – Maputsoe, Maseru and Mafeteng in Lesotho and Ficksburg and Ladybrand in South Africa.

About the authors

Louise Robinson is HIV/AIDS & Reproductive Health Co-ordinator, South Africa & Lesotho with CARE International. Tamara Rusinow is Regional Programme Manager for Southern & West Africa with CARE International.

Contact person
Louise Robinson
CARE International
PO box 682
Maseru 100, Lesotho
Phone: +266-314398
Fax: +266-310195
E-mail: lrobinson@care.org.ls
Web: www.care.org

Pulane's story

Pulane left her home in the mountains to seek employment in the factories in a border town. When she arrived in the town she struggled to find work or accommodation. She met up with acquaintances from her home area, who allowed her to stay with them in their rented accommodation. Quickly Pulane felt guilty, as she was unable to contribute to the costs of the household. One of the women offered to show her how she could make money and introduced her to sex work – showing her how to approach clients. She feared her friends would chase her away if she came home empty-handed. She now has between one and five clients per day.
Pulane has just given birth to her second child who stays with her in the rented home. The father is a client who refuses to bear any responsibility for the child. Most of her clients refuse to use condoms and with the recent charges for family planning she has been unable to protect herself from becoming pregnant. Pulane says she has been attacked, beaten and raped by her clients and also by the police. She feels unable to protect herself from this abuse or to report the crimes. In many ways she would prefer to move back to her home area so that her family will assist her with the care of her child but she feels ashamed. Here in the town, Pulane says the only support she gets is from other sex workers who help her with food if she has no money, and with companionship.

Articles with a special focus on migration/mobility in previous issues of Research for Sex Work

No. 1: Peer Education
Some problems concerning peer education

No. 2: Appropriate Health Services for Sex Workers
Migrant sex workers in Europe

No. 3: Empowerment of Sex Workers and HIV Prevention
Migrant sex workers in the Netherlands speak out
Vietnamese sex workers in Cambodia

No. 4: Violence, Repression and Other Health Threats. Sex Workers at Risk
Different mindsets, different risks. Looking at risk factors identified by Vietnamese sex workers in Cambodia
Some conditions influencing HIV/AIDS prevention and health promotion in Hong Kong
Filial piety and Vietnamese sex workers in Svay Pak, Cambodia
Repressive laws and hidden women: Migrant sex workers in Germany

All these articles can be found online at http://www.med.vu.nl/hcc.

Rehabilitation of girls with HIV/AIDS

Maiti Nepal, an NGO working for the prevention of girl trafficking, rescue, rehabilitation and reintegration of trafficked victims, established a hospice called 'Sneha Griha' – Home of Affection – in Jhapa District in 1999 to rehabilitate returned trafficked girls infected with HIV/AIDS.
The objective is to provide a separate shelter and proper care for these girls.

The hospice has a Primary Health Care Centre which provides limited but immediate medical attention to the hospice residents, as well as simple and affordable basic health services to the local people. The hospice can accommodate up to 60 persons in six wards. Maiti Nepal has bought some land adjacent to the hospice. The girls use this land to grow vegetables, thus making themselves self-reliant. There is also a pond for fish farming. Besides this, Maiti Nepal conducts various skill-oriented training programmes for these girls.
In the end, some of the girls are integrated into their communities; however, there is a great lack of follow-up for the most of them.

Trafficking and HIV/AIDS: The case of Nepal

Padam Simkhada

In recent years, hundreds of thousands of women and girls have been trafficked across borders and within countries. The problem is particularly acute in South Asia. Nepal has been designated as 'sending' country in the regional web of trafficking. Every year some 5,000-7,000 Nepalese girls are sold to Indian brothels and more than 200,000 Nepalese girls are currently involved in the Indian sex trade.[1]

Women of all castes and classes become sex workers, although those who are trafficked or migrated to India come primarily from ethnic minority groups in the hills. Contrary to popular belief, not all females working in the Indian or Nepali sex industries have been trafficked as a result of abduction, drugging or deception. Many young women and girls are sent into sex work by their families because they can earn relatively high wages that can be remitted back home to support families in impoverished villages.

Every year some 5,000-7,000 Nepalese girls are sold to Indian brothels

HIV vulnerability

The most frequently highlighted association between trafficking and HIV is the increased likelihood of HIV infection in women and children trafficked for purposes of prostitution. There are little reliable data available on the rate of HIV among trafficked women and children. Rates of HIV infection among sex workers in urban areas range from 17% in Nepal to as high as 72% in trafficked Nepali sex workers under 18 in Mumbai, India.[2] A study of sex workers in the Terai (in southern Nepal) found that 4% of sex workers overall were HIV-infected while 17% of those who had worked in India were HIV-positive.[3]

Although the data on the rate of HIV among trafficked women and children are scarce, it is reasonable to assume that after a while, trafficked sex workers would have higher HIV prevalence rates than the local sex workers in the place of destination because trafficked women are more vulnerable to abuse. A study in Thailand found the highest incidence of HIV seroconversion to be in the first six months of sex work.[4] The authors postulated that this is due to customers who perceive new sex workers to be at low risk of infection and therefore do not use condoms, thereby taking advantage of trafficked people's dependence on traffickers and/or brothel owners. Also the relative lack of experience and skills among new sex workers to negotiate for condom use might play a role. Both would apply to young, trafficked Nepali girls.

Young trafficked girls are even less likely to be able to negotiate with their partners than older women, since they also face unequal power relations between younger and older people. In addition, trafficked women and girls are presumably less likely to be beneficiaries of sex worker interventions and empowerment movements due to their forced working conditions, debt bondage, and language barriers.

Even those women and children who are trafficked for purposes other than sex work are subject to sexual abuse and are therefore at increased risk of contracting HIV. Trafficked women and children are not able to control even the most basic aspects of their lives, least of all to negotiate safe sexual relations. Studies have shown that brothel sex workers are most likely to become infected during the first six months of work, when they probably have the least bargaining power and therefore have more customers and fewer customers who use condoms.[4] As seen in other migrant groups, language barriers and displacement from family and community support systems increase vulnerability and subsequent risk of HIV infection. In addition, those who are trafficked internationally are usually classified as illegal immigrants in their country of destination and are further marginalised with less access to education, services, and protection. If they seek help, they may be subject to prosecution for the crime of illegal immigration, rather than assisted as victims of trafficking.

Trafficking prevention

Although trafficked persons take on the risk of HIV associated with marginalised mobile populations and/or mobile sex workers, emphasis on this risk in prevention and education programmes may not be in their best interest. Messages that highlight the risk of HIV associated with migration and trafficking increase stigma, both for returned victims and other migrants. In the past, Nepalese women who left sex work could reintegrate into their communities with relatively few problems, especially if they returned with some wealth.

Nowadays, AIDS prevention messages by NGOs in Nepal often emphasise trafficking for the purpose of prostitution. Many of the educational materials utilise gruesome descriptions of sex work and HIV infection. These messages use fear to prevent women from leaving their homes, rather than giving practical advice on decision-making in the difficult circumstances from which they may want to escape. Some organisations also associate trafficking with contracting HIV without regard for the stigma that this may falsely create for those who migrate.[5]

Some NGOs encourage girls to stay in their villages to prevent trafficking, urging them not to be so modern, work hard, be patient, and stay at home. However, a lot of adolescent girls, especially those with higher levels of education, do not want to reside permanently in their current villages.[5] This suggests that trafficking prevention messages that encourage adolescent girls to stay in the village may not be relevant to their needs and aspirations. Since many girls are likely to travel and/or migrate at some time in the future, it is essential to provide the information and skills necessary to navigate the outside world safely for gainful employment.

Support of returnees

The current panic associated with the AIDS epidemic in Nepal is such that women returning from India are stigmatised as carriers of HIV, regardless of whether they have been engaged in sex work. The individual sex worker is highly stigmatised and often barred from ordinary employment, marriage and social interaction, and her children are

rejected by other children at school. It has been observed that girls attempting to return from brothels are usually ostracised by their community. They have little hope for their future and many are seen as a burden to society. Furthermore, sex workers are subject to police harassment and arrest. In many districts, the common perception is that "a returnee from Mumbai is a carrier of AIDS".

Care and support programmes primarily aim to return girls and women to their communities, but NGOs acknowledge that not all of them want to or can return. Some girls leave difficult or abusive family situations. Others are reluctant to return due to the high level of stigma associated with trafficking, sex work, and HIV and the publicity (often by the NGOs themselves) given to the link between working in India and being HIV-infected. This raises the questions of how to best facilitate a return to the community when appropriate and what to do for girls who are unable or unwilling to return. Most NGO programmes tend to be prescriptive, telling returned girls what they should do, counselling them to return home, and advising families to accept them back. Family assessment is insufficient or ad hoc. There is little emphasis on exploring a girl's feelings or working through family problems, or on follow-up once they leave a shelter.

Most vocational training offered to returnees tends to emphasise traditional skills, such as sewing or knitting, which often do not provide adequate income. Options are very limited for girls who do not return home; most remain in residential homes on a long-term basis. More research and resources are required to determine the situation of returned girls and to develop effective support and care strategies.[5] Also, clear guidelines for the care of HIV-positive returnees should be developed. HIV-infected girls are faced with the double stigma of trafficking and HIV. Current laws and policies in Nepal do not include guidelines for HIV testing, pre and post-test counselling, confidentiality, or continuing care and support for HIV-positive returnees.

Notes

1. T. McGirk, Nepal's Lost Daughters, 'India's soiled goods'. *Times*, 27 January 1997, Vol. 149, No 4.

2. UNAIDS, *Report on the Global HIV/AIDS Epidemic*. UNAIDS, Geneva, 2000.

3. FHI, STD *and HIV Prevalence Survey among Female Sex Workers and Truckers on Highway Routes in the Terai, Nepa*l. Family Health International, Kathmandu, Nepal, 2000 (unpublished).

4. P.H. Kilmarx et al., Seroconversion in a prospective study of female sex workers in northern Thailand: continued high incidence among brothel-based women. In: *AIDS*, 112, 1998, pp. 1889-1898.

5. P. Bhattarai, V. Mahendra et al. Trafficking and Human Rights in Nepal: Community Perceptions and Policy and Program Responses. Horizons Research Summary. New Delhi: Horizons/Population Council and The Asia Foundation, 2001. http://www.popcouncil.org/horizons/ressum/traffickingsum1.html

About the author

Padam Simkhada is a PhD student in the University of Southampton and vice president of the Society for Local Integrated Development Nepal (SOLID Nepal), a national NGO working with young people

Contact person

Padam Simkhada
Department of Social Work Studies, University of Southampton
Highfield, Southampton, SO17 1BJ United Kingdom
Phone: +44-23-80592739, fax: +44-23-80594800
E-mail: pps1@soton.ac.uk

Mapping for the health and well-being of mobile sex workers and the communities they serve

The case of Cambodia

Lee-Nah Hsu and Jacques du Guerny

Many efforts to help sex workers in their health problems are designed as if they always worked in the same location, whereas in many developing countries they are a highly mobile population. This results often in ineffective health services to the detriment of the sex workers. For example, they have difficulties in accessing health services or in continuing treatments when they change work locations.

In 1999, the Cambodian National Centre for HIV/AIDS, Dermatology and STD (NCHAD), in partnership with the UNDP South East Asia HIV and Development Project (see box), conducted a mapping assessment along National Routes 1 and 5 of Cambodia to assess the HIV vulnerabilities of people along the route.[1]

After a national training workshop conducted in Phnom Penh on mapping methodology for mobility, the NCHAD staff and provincial AIDS Secretariats staff along the routes jointly conducted a mapping exercise with local communities, using a standardised questionnaire, between late August to early September 1999.

Subsequent to the assessment, consultations with local communities and national dissemination workshops were conducted. Through this participatory approach, responses have been devised and implemented since 2000 to remedy the identified HIV vulnerabilities. An impact evaluation was conducted to ascertain whether there were any actions taken based on the mapping findings locally and if so, what were the impacts.[2] This article reflects the findings from the mapping impact evaluation in Cambodia.

Putting services on the map

In Cambodia, rather than just targeting sex workers in a brothel, a broader strategy has been evolving that covers the various types of sex work, situates them in their environment and recognises the fact that they often move from town to town. The local AIDS authorities conceived of such a strategy after a mapping assessment of both the entertainment and health services along national Highway Route 5 and conducting a behavioural survey to identify the factors of vulnerability to HIV infection.

For example, between the capital, Phnom Penh and the Thai border, along the 300 km of Route 5, 99 brothels were found which were strategically located from a business and leisure perspective. To these numbers, one has to add many karaoke lounges, guesthouses, night-clubs and beer bars. Hospitals, health centres, STI clinics and private clinics were located and marked on the same map as the entertainment places. The researchers and local community could thus visualise relationships between the locations of supply (health services) and the places of demand (sex work establishments) as well as the movement of sex workers from town to town.

Both the mapping and the survey were carried out through participatory research. Instead of using mostly outside experts to conduct the research, information was collected and analysed mainly by local people, including sex workers.

Understanding social networking

This exercise was co-ordinated in the context of the Cambodian 100% condom expansion programme to understand the social networks along Routes 1 and 5. Routes 1 and 5 are the major East-West highways linking Phnom Penh with Thailand to the west, and with Vietnam to the east. The Ministry of Public Transport and Public Works was also involved in facilitating the mapping study. The NCHAD staff contacted the available karaoke bar owners, pimps, sex workers, brothel owners, clients, taxi drivers, guesthouse receptionists and local authorities including police and health centre staff. Available sex workers and clients at the time of assessment were approached in a friendly manner with the assistance of pimps and brothel, guesthouse and karaoke bar owners.

The brothels are often located along a stretch of a street. For example, in one of the cities along Route 5, the brothels are clustered along the railroad behind the major railway station where rail carriages are parked. The entire stretch of the road is lined with entertainment facilities on both sides. Prostitutes sit on the benches or chairs along the road outside the facilities to chat with potential clients as well as to solicit passers-by. The entertainment facilities are frequented by local residents as well as by passing visitors.

Locally driven surveillance

Some snacks or drinks were provided to informants but no direct monetary payments. The data collection staff of AIDS committees, however, were provided with transportation to reach the sites. The initial mapping assessments were conducted locally within a few days by local staff who already were familiar with the local people. However, the post-assessment efforts were done monthly with the community as they determined that was what they wanted. It is now a regular gathering since the local consultation efforts began.

The assessment resulted in stimulating a sexual health system surveillance that is locally driven. Through participation of local people and sex workers, the communities were better able to identify gaps of services and other problems that induced sex workers' HIV vulnerabilities. They were able to find solutions which are practical and feasible in local circumstances.

Shift of focus

It became clear that it was to every one's best interest to promote sex workers' health instead of singling them out as source of HIV infection while overlooking the role of local residents, who are the clients, in sexual health-related problems. This is a critical shift of focus because sex workers are usually from other communities (relatively distant rural areas or other countries – mostly from Vietnam but recently there were other foreigners coming into the trade) with few local women serving local men. Cambodian sex workers tend not to do their trade within their own hometowns. They migrate to towns away from home so as not to bring shame to their families. This is another factor contributing to the frequent movement of sex workers in and out of a location because they do not belong to the communities where they work. Local communities and officials often felt little if any commitment or obligation to sex workers' health, as they do not 'belong'. The combined effect of the frequently found stigma against sex work with the indifference or hostility towards outsiders creates barriers for sex workers to access local health services in order to maintain their health. Local health officials came to realise that simply having health facilities available in local communities does not equate access for sex workers, who face real and perceived obstacles in using these services.

An enabling environment

Through the improved understanding of the reality of behaviours rather than acting upon desirable images of social behaviour, the attitudes of police, health and other officials changed towards sex workers. The importance of creating an enabling environment for sex workers emerged. Now the local communities realised that to protect the health of their own community, they must reduce barriers for sex workers to seek early diagnosis and treatment for STIs, improve HIV prevention by promoting condom use, etc. As a consequence, sex worker health education improved with reduced discrimination. Today, the local health authorities have positive attitudes towards the sex workers and they are obliged to provide effective HIV prevention to the workers by decree of the 100% condom policy, which is prominently displayed at the entrance of each brothel. Also, the sex workers receive check-ups by the local health services. If they were found to have an STI or HIV, the owners of their establishment would be visited by the local authority to improve compliance to the 100% condom policy (see box).

UNDP South East Asia HIV and Development Project

The UNDP SEA HIV and Development Project covers the ten ASEAN member countries of Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam, and the People's Republic of China. The project focus is on the reduction of HIV vulnerability among mobile populations. Mapping has been carried out for Cambodia, Vietnam, Lao PDR, Guangxi-China, Indonesia and the 'BIMPS cluster' countries (Brunei, Indonesia, Malaysia, Philippines and Singapore). Most of the publications are available from the website: www.hiv-development.org.

Instead of feelings of shame, the sex workers realised that they ought to seek information on STIs, HIV/AIDS and monitor their own health status. The officials became less authoritarian and began collaborating with entertainment establishment owners and staff in introducing 100% condom use at entertainment facilities. This enabling environment also increased the clients' safety and health. Furthermore, with health officials monitoring sex workers' health, the officials were then able, through discussions with all involved, to encourage prostitutes to check their STI status and to alert the clinics on the numbers of visits to expect. This ensures a better coverage and services for sex workers.

The risks of 'non-hotspots'

The mapping results have also shown that sex workers normally do not stay for more than a few months in any one town because the clients want new faces. One of the patterns which emerged along Route 5 was that the youngest or freshest entrants to sex work tend to be found in major towns with the most business. Over time, sex workers slowly move to less desirable and less lucrative business settings where their earnings decline

100% Condom Use

The Cambodian 100% Condom Use Programme was modelled after the successful Thai programme, which started in the beginning of the 1990s. The programme requires brothel-based sex workers to refuse unprotected sex on the instructions of the brothel owners and managers. It is based on the presumption that sex establishment owners should be part of the solution, not the problem. In Cambodia, a pilot project that started in 1998 in Sihanoukville proved equally successful, and the Cambodian government is currently expanding the programme nation-wide.

accordingly. Meanwhile, their risk of exposure to HIV and other STIs increases. Sex workers who move frequently either do not have the opportunity to get regular health check-ups or tend to discontinue treatments started in one place as they move on to another.

There are multiple implications for these sex workers and for public health programmes and services. For example, there is a commonly held belief and practice in resource allocations that resources and services should be devoted to 'hotspots' where many entertainment establishments are concentrated, resulting in 'quieter' towns being overlooked. As the risks of STIs and HIV increase with the length of service of sex workers, the level and frequency of STI infections among sex workers in less lucrative towns can actually be higher than among the new entrants who tend to serve the more prosperous locations.
According to available annual HIV and STI statistics, we found that the HIV prevalence among sex workers was higher in towns located some distance from major towns along Route 5.

It is thus critical to ensure that, in less popular entertainment towns, health services are able and ready to serve incoming sex workers who have rotated from 'hotter spots'. For sex workers, this is important as, just when they need these services the most, this type of policy and programming would ensure that services would be available where they might not have been otherwise. Finally, it would also necessitate the health services of different towns keeping contact with one another to provide referral on treatment and care. It also requires facilitating access to services, thus reducing loss to follow-up, cases of incomplete treatment and the development of resistant strains.
In conclusion, linking local health services in towns along major highways in Cambodia plus introducing a participatory and enabling environment for sex workers can improve the protection of health for all members of a community. The way Cambodian health officials handled the mapping assessment is a good example of good governance and highest level political commitment as well as local follow-through.

In addition, using mapping of HIV vulnerabilities allows intervention projects to identify HIV vulnerable communities which are not otherwise considered on the basis of commonly selected indicators of 'hotspots'. In this case, where the sex workers migrate is an important indicator to ensure capturing the communities that are most vulnerable to HIV.

Notes

1. Cambodia HIV Vulnerability Mapping: Highways One and Five, NCHAD, Cambodia and UNDP South East Asia HIV and Development Project, January 2000, www.hiv-development.org/publications/cambodia_mapping.asp.
2. The impact of mapping assessments on population movement and HIV vulnerability in South East Asia, September 2001, www.hiv-development.org/publications/mapping.asp.

About the authors

Lee-Nah Hsu and Jacques du Guerny are Manager and Consultant, respectively, of the UNDP South East Asia HIV and Development Project.

Contact person

Lee-Nah Hsu
United Nations Building
Rajadamnern Nok Avenue
Bangkok 10200, Thailand
Fax: +66-2-2801852
E-mail: leenah.hsu@undp.org
Web: www.hiv-development.org

The (crying) need for different kinds of research

Laura Agustín D'Andrea

Researchers wanting to study migrant sex workers find receiving funding difficult if they do not stick to themes related to HIV/AIDS, 'trafficking' or violence against women. Laura Agustín shows how these frameworks distort a multiplicity of realities and argues for doing research from a migration perspective.

In October 2001, while on a trip to Australia and Thailand, I met five Latin American women with some connection to the sex industry: the owner of a legal brothel and two migrants working for her in Sydney, and two women in a detention centre for illegal immigrants in Bangkok. These five women were from Peru, Colombia and Venezuela; they were from different strata of society; they were of very different ages. They also all had quite different stories to tell.

The brothel owner now had permanent residence in Australia. Her migrant workers had come on visas to study English which gave them the right to work, but getting the visa had required paying for the entire eight-month course in advance, which meant acquiring large debts. The Madam was very affectionate with them but also very controlling; they lived in her house and travelled with her to work. She was teaching them the business; the outreach workers from a local project did not speak Spanish.
Of the two women detained in Bangkok, one had been stopped in the Tokyo airport with a false visa for Japan. She had been invited by her

sister, who had been an illegal sex worker but now was an illegal vendor within the *milieux*. The woman had been deported to the last stage of her journey, Bangkok; there she had been in jail for a year before being sent to the detention centre. The second detained woman had been caught on-camera in a robbery being carried out by her boyfriend and others in Bangkok, after travelling around with them in Hong Kong and Singapore; she had just completed a three-year jail sentence before being sent to the centre (and she also had completely false papers, including a change of nationality).
Both detained women were waiting for someone to pay their plane fare home, but no one was offering to do this, since their degree of complicity in their situations disqualify them from aid to victims of trafficking, and not all Latin American countries maintain embassies in Thailand. Only one person from local NGOs visiting the detention centre spoke Spanish.

How can we understand these stories?
Given the very different stories these women have to tell, labelling them *either* 'migrant sex workers' or 'victims of trafficking' is incorrect and unhelpful to an understanding of why and how they have got into their present situations. The placing of labels is largely a subjective judgement dependent on the researcher of the moment and is not the way women talk about themselves, something like the attempt to make complicated subjects fit into a pre-printed form. The following descriptions illustrate this complexity.
While the two new migrants in Sydney seemed accepting of the work they had just begun doing, there was clearly ambiguity about the significance of the language course on which their visas were based, and their debts did not leave them much choice about what jobs to do. The migrant to Japan believed she would not have to sell sex, but her own family had been involved in getting her the false papers, and she was suffering from considerable guilt and anguish. The woman caught in the robbery seemed to have sold sex during her travels, but without any particular intention or destination being involved, nor did she attach much importance to the matter. The total number of outsiders implicated in their journeys and their jobs was large; nationalities mentioned were Pakistani, Turkish and Mexican. The need for research to understand how all these connections happen is urgent, but funders are unlikely to finance research that does not fit into one of the currently acceptable theoretical frameworks: 'AIDS prevention', 'violence against women' or 'trafficking'.

These frameworks reflect particular political concerns arising in the context of 'globalisation', and they are understandable. *Elements* of the stories of people such as those I have described may share features with typical discourses on 'trafficking', 'violence against women' and 'AIDS', but these are prejudiced, moralistic frameworks that begin from a political position and are not open to results that do not fit (for example, a woman who admits that she knew she would be doing sex work abroad and willingly paid someone to falsify papers for her).
The desires of young people to travel, see the world, make a lot of money and not pay much attention to the kind of jobs they do along the way are not acceptable to researchers that begin from moral positions; neither are the statements by professional sex workers that they choose and prefer the work they do. Yet ethical research simply may not depart from the claim that the subjects investigated do not know their own minds.

Why do we do research, anyway?
A theoretical framework refers to the overall idea that motivates services or research projects. For service projects with sex workers this framework might be a religious mission to help people in danger, a medical concept of reducing harm or a vision of solidarity or social justice. Most projects with sex workers focus on providing services, not doing research, though often the line between them is not easy to draw. Service projects accumulate a lot of information over time, but it seems as though the only thing governments want to know about is people's nationalities, how old they are, when they first had sex and whether they know what a condom is. Many NGO and outreach workers would like to publish other kinds of information, research other kinds of things. But where, how? If their research proposal does not reflect one of the existing research frameworks regarding migrant prostitution – 'AIDS prevention', 'trafficking' or 'violence against women' – it will be hard if not impossible to find funding.

Many NGO and outreach workers would like to publish other kinds of information. But where, how?

Some of my own research concerns people who work with sex workers, like the people who read this publication. There is a small minority that is really *only* interested in preventing infections and is therefore satisfied to produce graphics on rates of STIs per nationality. But even many people interested only in epidemiology are frustrated, because so much research continues to focus on street workers and reproduce the same information over and over again. And to study women like the ones I met last October, none of the frameworks mentioned above is at all adequate. AIDS prevention and their health may be important to them, but no more than to anyone else, and no one has done violence to them. So that leaves 'trafficking', but not only did they participate in the planning of their trips, they enjoyed parts of them and were willing to do sex work in order to visit places like Tokyo and make the kind of money they could not earn anywhere else.

Now if these women were described as travelling to work and seeing something of the world at the same time, it would at least be possible to tell their stories. On the way, quite a number of injustices, most of them structural, would be revealed, and researchers could be happy to have them exposed. But also the aspect of these women's lives that we never hear about would be brought out: their leading role in their own life stories, complete with making decisions about taking risks in order to get ahead in life – what academics call *agency.*

We do not need more research imposed by people who believe they know best how other people ought to live

Research without prejudice

The goal of research is to answer questions that will help societies understand themselves better, and these questions cannot avoid existing within some kind of framework. For example, interviews with sex workers about their lives can be carried out within a frame of 'life histories', the goal being to publish voices that have been marginalised before. Or interviews with police can attempt to show how they perceive their jobs, inside a criminological framework. There can be ethnographies of brothels (anthropology), surveys on how sex club owners view the business (urban studies), comparative work with people before they work in the sex industry and after (labour studies, psychology), investigations on how small family-and-friends networks function to facilitate migrations (sociology). The list of possibilities is endless, and *all* would be useful for improving our understanding of the sex industry and the people who work in it. However, whatever 'field' the frame belongs to, we do *not* need more research imposed by people who believe they know best how other people ought to live and who have already taken a moralistic position before research is begun. An example is the statement "We began this work from the perspective that prostitution itself is violence against women."[1] On the contrary, we need a lot of research undertaken by people who are very close to sex workers' lives, or who are sex workers themselves, but who will above all commit themselves to honestly recording all the different and conflicting points of view and stories they run into during the research.

Migration as a research framework

In my view, migration studies is the research framework that makes the most sense for thinking about the five women I met last October, as well as for the great majority of those I've met who work in the sex, domestic and 'caring' services (for children, the elderly and the ill). When I lived in the Caribbean, it was common to talk to people who were thinking about going abroad to travel and work as migrants, and these are the *same people* who are working now in Europe, Australia, Japan.

By locating these women as migrants rather than 'sex workers', whether exploited or not, it is possible to include them in the growing body of research on diasporas, globalisation, immigration law and international relations. A migration framework allows consideration of all conceivable aspects of people's lives and travels, locates them in periods of personal growth and risk-taking and does not force them to *identify* themselves as sex workers (or as maids, or 'carers', for that matter).

The publication of research that looks at migrant sex workers' lives *in a myriad of ways* would eventually affect how society at large considers them. It would inevitably reveal that a minority suffers from disease and violence, while the majority can be seen as resourceful entrepreneurs or pragmatic workers trying to make their way within government policies and structures that are all against them. Harm reduction and other social projects could concentrate on supporting such people at a specific stage of their lives but could also expand into different areas and not be forced to continue to work uncomfortably inside stigmatising frameworks (those that construct all migrants as victims of trafficking or risk groups for the transmission of disease). It's worth a try.

Note

1. M. Farley, Prostitution in Five Countries: Violence and Post-Traumatic Stress Disorder. In: *Feminism & Psychology*, Vol. 8, No. 4, p. 406, 1998.

About the author

Laura Agustín is a life-long migrant and former educator in Latin America who now researches on the sex industry, is affiliated with the Open University, lives in Spain and has been contracted by the ILO and the European Commission to evaluate sex work-related programming. She moderates a romance-language e-mail list called IndustriadelSexo.

Contact person
Laura Agustín
Phone: +34-958-296327
E-mail: laura@nodo50.org

COLOFON

Research for Sex Work is a newsletter designed for sex workers, health workers, researchers, NGO staff and others who professionally have to do with HIV/AIDS prevention and/or sex work. This special issue on migration and mobility was produced with financial support of Hivos, the Netherlands.

Editors:
Nel van Beelen (VU medical centre)
Ivan Wolffers (VU medical centre)
Licia Brussa (TAMPEP)

Design:
Nicole van den Kroonenberg

Photo cover:
Timothy Ross

Printing:
Den Haag offset, The Netherlands

Back issues:
1. Peer education, June 1998
2. Appropriate health services, August 1999
3. Empowerment, June 2000
4. Violence, repression and other health risks, June 2001

Back issues or extra copies of this issue can be ordered for free. Please specify which issue(s) you would like to receive. Issue No. 5 is also available in Spanish.

Contact person:
Patricia Brinckman
Department of Health Care and Culture
Vrije Universiteit medical centre
Van der Boechorststraat 7
1081 BT Amsterdam, The Netherlands
Phone: +31-20-4448266
Fax: +31-20-4448394
E-mail: p.brinckman.social@med.vu.nl
Web: www.med.vu.nl/hcc