

“Where have you been? No one ever asks us these questions, no one ever wants to know.”

An ecological approach to the risks of female sex workers in rural Kenya

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DEDICATION

For Dagmar Zirfas-Steinacker, Gerd and David Steinacker:
Weil ihr nicht seid wie alle anderen.

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ABSTRACT

Medical discourse has long dominated research and policy design targeting commercial sex workers in efforts of HIV prevention. Such an approach has generated solutions to the problem of disease transmission conceptualized in terms of individual knowledge and behavior rather than the broader ecology of social, economic, and political forces driving risky behavior within sex work. These ecological forces faced by sex workers include poverty, physical abuse, lack of legal protection, and stigmatization. Ignoring these forces leads to two types of problems for the design of policy solutions. First, policies that ignore the ecological forces of commercial sex work will misconstrue the pathways to risky sexual behavior and thus jeopardize the effectiveness of disease-control efforts. Second and related, those policies will neglect the gaping welfare deficiencies sex workers face, which demonstrates the failure to safeguard sex workers' basic human rights. This thesis investigates the ecological risk forces of 99 female sex workers in rural Kenya through qualitative and quantitative interviews. A rich tableau of their quotidian and long-term challenges depicts the micro-level forces and the larger structures of inequality driving sex workers' behavior. It supports the main argument of this thesis, that consideration of ecological forces must be central to the design of policies and interventions to increase disease-control efficacy and to realize sex workers' basic human rights.

1 INTRODUCTION

The study of commercial sex work has been extensive, spurred by scholars and policy-makers of public health, epidemiology, law and human rights. In 1985, predating the emergence of HIV as a major global health concern, researchers concluded that “prostitutes are a major reservoir of sexually transmitted diseases in developing nations” (D’Costa et al., 1985, 64)¹. With the recognition that sex workers constitute a key population at higher risk for the acquisition and dissemination of sexually transmitted infections (STIs) came an appreciation of the central role that sex workers might assume in the response to the global HIV epidemic. Thus emerged a chorus of calls for research and intervention on disease control among sex workers and their clients and partners (D’Costa et al., 1985; Hawken et al., 2002; Lau, Tsui, Siah, & Zhang, 2002; Chen et al., 2005).

Subsequent studies of the roots and nature of sex work revealed a complex network of harmful ecological forces and risks far beyond STIs: cycles of financial instability, physical, psychological and sexual abuse, a lack of legal protection, and abuse at the hands of police (Alexander, H., 2001; Alexander, P., 2001; Shara Ho, 2001; Tep, Ek, & Maas, 2001; Chacham, Diniz, Maia, Galati, & Mirim, 2007; McMillan K. & Worth, H. 2010). While the activist approach and to some extent the academic gaze

¹ In January 2011, UNAIDS released their updated guidelines to preferred terminology for stakeholders working in the global response to HIV. These guidelines discourage the use of phrases such as “sexually transmitted disease”, “fight against HIV”, “high risk groups”, and “prostitution”. In adherence to their recommendations, I will use “sexually transmitted infections”, “response to HIV”, “key populations at higher risk”, and “commercial sex” or “sex work”, respectively, throughout this paper (See UNAIDS, 2011).

have shifted from mere disease control to a more comprehensive accounting of sex workers' lives, policies and strategies for interventions have largely lagged behind. Most interventions treat sex workers as a means to an end, as a focal point of an infection network, instead of treating their behavior as a response to a complex social and economic environment. While "the question of how to address sex work is a topic of explicit policy debate today" (Binagwaho et al., 2010), the daily realities of women and men who do sex work are often placed on the back burner of analysis (Elmore-Meegan, Conroy, & Agala, 2004; Agha & Nchima, 2004; de Zaluondo, 1991).

Ignoring the totality of sex workers' lives leads to two kinds of problems. First, ignoring exogenous and structural factors potentially jeopardizes the success of existing interventions. To illustrate, many interventions seek to reduce the transmission of sexual infections through the distribution of condoms. However, police forces that use condoms as evidence for commercial sex charges risk scaring sex workers into prioritizing their personal freedom over protected intercourse. Ignoring this structural component of legal enforcement strategies directly compromises the efficacy of health interventions (Lau et al., 2002). Secondly, the indifference to the full ecology of risks renders policies and interventions ignorant to myriad violations of sex workers' basic human rights to health, well-being, and security of person. For example, willful ignorance of pervasive violence against sex workers by exploitative clients and police officials forces sex workers to oblige to risky, unprotected sexual practices to avert immediate danger (Shannon & Csete, 2010) instead of encouraging women to report such human rights violations. If current

strategies focus too narrowly on disease control, thus effectively reducing the efficacy of HIV prevention efforts, how might policies and interventions be broadened to address the comprehensive ecology of risks and rights of individual sex workers?

The research presented here is an attempt to illustrate through real world data the complex risk environment of women in the sex industry, and to reach systematic conclusions for future research and policy-making. I present an original study of the ecological risks of 99 female sex workers in Kenya, including but not limited to factors such as household dynamics, condom use, police treatment, legal enforcement practices, and organized support groups. I use this study, and studies from other countries of the ecology of sex work, to assess the forces driving the women's risk environment. I suggest that if academic and policy work as well as the implementation of both is to benefit sex workers and the larger community, disease control efforts must be synthesized with a more holistic analysis of the risks and needs of those most vulnerable—the sex workers themselves. This will both maximize the effectiveness of disease control efforts, and expand the objectives to realize the basic human rights of sex workers.

The thesis adheres to the following structure. First, I describe a theoretical framework to understand the importance of a public health perspective informed by human rights, and from a socio-political perspective the larger ecology of forces affecting sex workers. Second, I discuss evidence from a range of studies that sex workers are highly vulnerable populations, at risk not only of disease infection, but of economic deprivation, physical and psychological abuse, stigmatization and discrimination by

society, and lack of protection under the law. Third, I outline existing interventions addressing sex workers, and I describe the extent to which they respond to the evidence presented prior. Fourth, I describe the study design of the present research and explain its quantitative and qualitative findings, for example the pervasiveness of sexual violence against sex workers by customers as well as the police. Finally, I discuss the implications of the research, and describe in detail the importance of two forces driving sex workers' risks: laws and stigma. I argue for a more holistic lens of research and policy agendas in addressing the risks and realizing the human rights of sex workers.

2 THEORIES, EVIDENCE, INTERVENTIONS

Theories

A Public Health Perspective Informed by Human Rights. Every seminal international human rights agreement throughout the 20th century enshrined the right to health, well-being, and security of person as global standards: the Universal Declaration of Human Rights (Articles 3 and 25), the International Covenant on Civil and Political Rights (Article 9), and the International Covenant on Economic, Social, and Cultural Rights (Articles 9, 11 and 12). Kenya has ratified all of the above agreements, as well as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), in 1984. While the outbreak of the HIV epidemic in the 1980s pushed for the inclusion of ecological factors in the realm of public health (Rhodes, 2002), in the case of sex workers, most policies still fail to address the threats posed by this profession to the basic human rights and dignity of the people involved (Binagwaho et al., 2010).

In 2000, the World Bank Report *Voices of the Poor* called for more attention to the holistic environment experienced by the poor as a means of better understanding the “interlocking multidimensionality” of poverty (Narayan, 1999, 7). For example, lack of education, lack of access to health care, and lack of savings or collateral to borrow interact with unanticipated seasonal changes to keep many poor farmers poor (ibid). Similarly, lack of monetary independence, lack of negotiation power and lack of legal

protection interact with the impunity of violence against women to keep many female sex workers in a complex, treacherous risk environment.

The interlocking multidimensionality of sex work raises concern for public health and has attendant consequences of moral and social gravity, such as public disputes over sexually deviant practices and overt ostracization of a minority. Comparably charged policy debates targeting groups and practices seen by some as subversive of public morals, such as the proposed criminalization of homosexuality in Uganda, “confirm the importance and timeliness of grappling with sex work issues from a public health perspective informed by human rights” (Binagwaho et al., 2010). Though no one intervention can take into account the entire web of influential factors at once, the pragmatic goal of academics and policy-makers should be to shed light on the most salient pressures acting upon individual sex workers’ behavior in order to design successful strategies to respond to public health risks and realize sex workers’ human rights.

An Ecological Approach to Forces on Behavior. Theories from social psychology, social epidemiology, and public health converge on the idea that understanding and influencing individual behavior hinges on an appreciation of the motivating and restraining forces acting on each individual in her immediate environment. Such ecological approaches underline the intersections of psychological, socio-economic, cultural, and political factors interacting to constitute behavior patterns.

To identify more specifically the origin of individual behavior, social psychologist Kurt Lewin's channel theory postulates the importance of tracing back the "channels" that give rise to the conditions conducive to the situation. Within these channels pivotal "gate sections" ruled by "gatekeepers" can determine the trajectory of events, and are thus the key points to change the ultimate situational outcome (see Lewin, 1943, 292-298).

To visualize this analysis, a "risk environment" matrix can be employed to clarify "factors exogenous to the individual" (Rhodes, 2005, 220; Rhodes & Simic, 2005; Cox & Whitaker, 2009). These factors have been aptly typified into four types and two levels. Types include the physical, social, economic, and policy realm. Levels are divided into micro and macro: the micro-risk environment addresses decisions on an individual level, as well as influences of community norms and practices, while the macro-risk environment represents structural forces, including laws and economic conditions (see Rhodes & Simic, 2005). Towards the end of this paper, I will summarize my findings in a matrix similarly divided into micro and macro level risk factors affecting sex workers.

Advocates of ecological approaches have astutely argued that social change interventions aimed at individual behavior might reduce their own efficacy (Rhodes, 2002; Rhodes & Simic, 2005; Cox & Whitaker, 2009; Burris, 2009). Instead, they argue change is produced by altering the constellation of forces (Lewin, 1943, 300). Applied to behavioral health outcomes this approach thus calls for an "ecologically oriented analysis of disease causation" to "delineate more clearly what elements of inequality determine

health, through what pathways they operate, and what intervention can reduce the causes or block the pathways.” (Burris, Kawachi, & Sarat, 2002, 504). This call was echoed by the WHO landmark 2008 report on social determinants of health, which began to marshal an evidence base for successful policies (WHO, 2008).²

An ecological approach is useful for mapping the myriad of forces affecting sex workers’ decisions and for assessing the most effective force to harness to produce change. With regards to sex workers, channel theory can be applied in at least two ways: as depicting the pathways into the sex industry, and as pathways to certain risky behaviors, ie. sex with a client without a condom. Investigating the gates and gatekeepers of pathways into each situation helps to find strategies to prevent them. Identifying and altering pathways to high risk behaviors is one area in particular where policy-makers have not fully accounted for the full range of forces impinging on the situation. In attempts to reduce the risk of sexually transmitted infections (STIs), scores of interventions have chosen widespread distribution of condoms as a combat strategy. Without independent enforcement mechanisms, however, male abuse of gender power dynamics will continue to hamper consistent use of protection, despite the provision of condoms. At the same time, rigorous condom policies alone risk “inadvertently pushing more marginalized sex workers underground through police raids, surveillance and

² However, the report only mentions sex work once when it briefly describes the successful Sonagachi Project with sex workers in Kolkata, India (WHO, 2008, 117), which I outline in the next section *Interventions*.

mandatory testing, re-creating barriers to violence prevention and condom negotiation” (Shannon & Csete, 2010. 574). Lewin’s method for identifying a constellation of forces might point to other potentially potent strategies involving the immediate family, the wider community, the clients, the socio-economic as well as cultural background, legal rules and regulations, and the effects of international policy.

With the emergence of HIV and AIDS worldwide, the push for the inclusion of ecological factors in assessing risk situations has gained renewed significance. It is precisely a shift towards an ecological approach that must be advocated within the policy realm of interventions targeting sex workers. Theories based on an ecological approach must be incorporated into theory-based intervention programs.

Evidence

As recently as the past decade, have studies begun to highlight the significance of behavioral factors in the etiology and prevention of disease, and to discover the ecology of risks confronting sex workers every day. Together, these risks depict the panoply of factors that constitute the crucial backdrop to designing effective interventions.

Micro Level

Background Characteristics. A sex worker’s demographic background and household dynamics have the potential to determine her dependency on the sex trade. To illustrate, life-circumstances such as being a widow, the head of a household of nine,

or living by oneself can weigh heavily on a woman's economic and social status. For example, a study of sexual risk behavior of South African adolescents found a higher likelihood of being involved in the sex trade for orphans than for non-orphans (Thurman, Brown, Richter, Maharaj, & Magnani, 2006).

Pathways into Sex Work. Understanding the primary pathways leading into the industry can help explain ongoing motivations to remain in the business and point to entry points for prevention efforts.³ The overwhelming evidence of financial deprivation as a major reason for entering sex work underlines the difficult economic dimension of the profession. Early research into sex work lacked an economic perspective on the industry. As William-Navarro aptly criticizes, economists' initial proclivity to consider sex workers' 'illicit' behavior as largely irrational prevented researchers from considering monetary incentives and disincentives driving individuals' choices in the sex trade (2006). The resulting lack of data on this economic dimension "helped feed policies aimed at criminalizing sex work or rehabilitating sex workers, rather than at addressing the constraints and needs of sex workers, or the larger context in which they work" (William-Navarro, 2006, 19).

Exploratory studies that inquire about the pathways into sex work or the incentives for risky behavior with clients unanimously underline the significance of

³ It should be noted here that while trafficking is central to many discussions on sex work and human rights as a forced pathway into sexual exploitation, discussing the issue here would go beyond the scope of this paper. Nonetheless, countries' lack of serious fight against trafficking and sexual slavery represents a glaring failure to safeguard human rights.

economic reasons: financial incentives are primary motives to enter the business and to engage in unprotected sexual activities (Cox & Whitaker, 2009; McMillan & Worth, 2009; Elmore-Meegan et al., 2004; de la Torre, Havenner, Adams, & Ng, 2010; Rao, Gupta, Lokshin, & Jana, 2003; Gertler, Shah, & Bertozzi, 2005; Ntumbanzondo, Dubrow, Niccolai, Mwandagalirwa, & Merson, 2006).

Health. Given the nature of their work, sex workers face a plethora of health risks on a daily basis. Most widely discussed is their vulnerability to STIs (D'Costa et al., 1985). Less often mentioned are other reproductive concerns such as difficulty with obtaining effective contraception, unintended pregnancies and unsafe abortions (Bautista et al., 2008). Moreover, the constant threat of physical and sexual abuse can render sex workers vulnerable to psychological distress and traumata. While the impact of sex work itself on mental health has been contested (Romans, Potter, Martin, & Herbison, 2001), cases of sexual violence and physical harassment rampant within the industry have been shown to have strong psychological effects (Ulibarri et al., 2009; Farley et al., 2003). Ulibarri et al found that "physical and sexual abuse were significantly associated with higher levels of somatic symptoms" (2009, 400). Similarly, Farley et al concluded that the severity of post-traumatic stress disorder symptoms was significantly linked to the number of various types of violent attacks (2003, 34).

Finally, the interaction of the factors above can lead sex workers to resort to drug abuse as a coping mechanism to tackle their risky conditions (Romans et al., 2001; Blankenship & Koester, 2002; Burris & Xia, 2009; Cox & Whitaker, 2009). Practices

associated with drug abuse, especially in the case of injection drugs, can heighten exposure to disease (Rhodes, 2002), economic deprivation (Baseman, Ross, & Williams, 1999), and psychological vulnerability (El-Bassel et al., 1997).

Practices. The nature of their daily work-related practices determines sex workers' ability to protect themselves. For example, violence against sex workers perpetrated by clients including the police exposes them to physical and psychological vulnerabilities that directly undermine good health. Data from around the world testifies that physical abuse, both violent and sexual, is an undeniable quotidian risk for sex workers (Wahab, 2005). Commonly, the ubiquity of violence "reflects institutionalized social inequalities and injustices" (Simic & Rhodes, 2009, 1), part of which are police enforcement practices. Since legal enforcement practices are "to some extent, independent of the written laws" concerning commercial sex, sex workers are at the mercy of policemen's "discretion and dexterity to deploy a wide variety of criminal and public order laws to accomplish their street control" (Burris & Xia, 2009, 184). Research has shown that such measures often include violence and harassment at the hand of the police (Ratinthorn, Meleis, & Sindhu, 2009; McMillan & Worth, 2010; Shannon & Csete, 2010).

Moreover, local cultural attitudes and beliefs often condone violent treatment of sex workers by their clients (Wahab, 2005; Karandikar & Pospero, 2010; Elmore-Meegan et al., 2004; Dalla, Xia, & Kennedy, 2003; Miller, 1993; Williamson & Folaron, 2001, 2003; Romero-Daza, Weeks, & Singer, 2003). Concomitant psychological effects and the

perceived threat of such violence diminish the capacity for harm-reducing behavior (Decker et al., 2010), for example through the internalization of stigma, leading sex workers to adapt negative beliefs expressed by those around them that they deserve bad treatment (I discuss the effects of stigma in more detail below). Still, the rampant frequency and significance of violence often go “undocumented and unnoticed” (Ratinthorn et al., 2009, 249). The criminalization of sex work in many countries often acts as a catalyst for violence (Rekart, 2005) by policemen and clients who enjoy impunity when it comes to punishment.

Finally, the offence of “pimping” gets much less attention in the criminal justice system than sex work itself. Far from all sex workers are controlled by pimps but those who are often face brutality and coercion, including physical and emotional abuse, at their hands (May, Harocopos, & Hough, 2000).

Competition, Cooperation, and Networks. The degrees of competition and cooperation amongst sex workers can increase or decrease the likelihood of risky behavior, respectively. Driven by the objective of economic gain, sex workers’ consciousness of strong competition for clients, fueled by factors such as attractiveness, services offered, and prices, often leads to riskier practices such as unprotected sex (Wojcicki & Malala, 2001). Strong cooperation and social networks of support, on the other hand, can promote solidarity and cohesion amongst sex workers (Jana, Basu, Rotheram-Borus, & Newman, 2004).

Macro Level

Laws and Legal Enforcement Practices. Scholars of legal practices and public health have presented the link between human rights, law and health outcomes (Burris, 2002, 2009; Burris, Kawachi, & Sarat, 2002). Interest in this relationship emerged with the work of the late epidemiologist Jonathan Mann, who postulated that on the one hand, (1) public health policies, programs and practices affect human rights, and that, on the other hand, (2) violations of human rights have health impacts. Mann concluded that (3) promoting and protecting human rights is inextricably linked to the challenge of promoting and protecting health (see Burris, 2002, 499). Scott Burris and his colleagues have since championed a closer look at the reciprocal association of law and health outcomes⁴.

The array of laws affecting sex workers expands far beyond regulations on commercial sex. Definitions and laws governing sex and consent, assault and rape, as well as those regulating education, employment and even housing can have indirect effects on the lives of sex workers (Blankenship & Koester, 2002; Miller, 2002; Burris & Xia, 2009). Most importantly, researchers have pointed out that the authority of statutes, court decisions, and enforcement practices generates incentives or disincentives

⁴ A factor indirectly affecting health outcomes is that the illegal status of sex work often pushes large segments of the sex industry underground, which exacerbates the difficulty of determining its exact size. In the case of China, the actual number of individuals employed in sex work is estimated to be a ten-fold increase from official figures (Burris & Xia, 2009). This renders designing appropriately scaled health interventions difficult.

for specific behaviors (Burris et al., 2002). Frequent incarceration can affect women's future housing prospects and employment possibilities through their criminal record, which indirectly influence their immediate economic necessity. Time spent in jail might also lead sex workers to seek compensation for lost income through riskier behavior, as discussed in more detail below.

Moreover, the fear of arrest has the potential to shape health-related activities (Blankenship & Koester, 2002). The illegality of sex work increases the necessity for secrecy of sexual transactions. The criminal nature of their work might drive sex workers to choose more remote places to interact with customers, which increases their risk of violence and coercion (Miller, 1993; Miller 2002). Additionally, due to fear of arrest sex workers report fewer human rights violations, especially of a sexual nature, including incidents occurring at work and in their private life (Blankenship & Koester, 2002).

Furthermore, empirical research has shown that legal enforcement practices, especially police procedures, are a major determinant of the risk environment of sex workers (Blankenship & Koester, 2002; Blanchard et al., 2005; Rekart, 2005). For example, the legal authority and culturally condoned impunity of policemen enables them to use force or the threat of force to benefit from gratuitous sexual services – which means no income for the sex worker – or to demand risky sexual practices – which means an increase in HIV risk for both parties. Simic and Rhodes found that there was a common perception in Serbia that sex workers, “by virtue of their unacceptable

occupation” had “given up their citizenship rights to be protected” and thus, “the police *had a right* to beat them” (2009, 6, emphasis in the original).

Similarly, in their study of the role of law as it pertains to commercial sex workers in China, Burris and Xia found that law enforcement practices have the potential to increase the risk of HIV transmission through corruption present among law enforcement officials, funding mechanisms behind law enforcement, as well as the limited protection of human rights (2009, 182). In this case, legal policies and police enforcement strategies that criminalize even the possession of contraceptives risk affecting the willingness of sex workers to carry condoms (see Lau et al., 2002).

Stigma. Stigmatization and the self-internalization of stigma are catalysts of myriad effects on sex workers. Cultural values and beliefs about sexuality, as well as the illegal status and nature of sex work, render many individuals working in the trade vulnerable to stigmatization and discrimination (Rekart, 2005; Zalduondo, 1991; Scambler & Paoli, 2008). At the 10th meeting of UNAIDS’ Program Coordinating Board in 2000, executive director Peter Piot formulated as his number one priority of most pressing items, “a renewed effort to combat stigma” because “effectively addressing stigma removes what still stands as a roadblock to concerted action, whether at local community, national or global level” (2000, 13). Piot was referring to what has been discussed in numerous works as the detrimental effect of HIV and AIDS-related stigma on interventions that seek to combat the epidemic (Parker & Aggleton, 2003; Herek, 1999).

As a starting point to most discussions on stigma related to HIV and AIDS, Goffman's seminal work "Stigma" of 1963 provides a definition of a stigmatized person as someone seen as having "an undesirable difference", judged by society's norms of "deviance", which results in a "spoiled identity" of that individual.⁵ In most of the literature this departure point has led to a concerted conceptualization of stigma "as a negative attribute, (that) is mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society" (Parker & Aggleton, 2003, 14).

The understanding of being negatively valued in society leads individuals to internalize stigma, suffering physical, emotional and psychological ill effects (Goffman, 1963). To illustrate, sex workers who internalize the stigma imposed by their community are at risk of experiencing reduced self-efficacy and depression (Marton, 2003). Ill effects can be physical, emotional and psychological (Goffman, 1963). Thus, determining the intensity and nature of stigmata can guide the design of effective interventions (Parker & Aggleton, 2003).

Interventions

The estimated annual economic value of transactions within the sex trade worldwide is almost \$190 billion ("Prostitution", November 27, 2010). With increased

⁵ It has been noted that Goffman's vague formulation has led certain interpretations to suggest that stigma is a "static attitude" rather than "a constantly changing (and often resisted) social process", which has "seriously limited the way in which stigmatization and discrimination have been approached in relation to HIV and AIDS" (Parker & Aggleton, 2003, 14).

attention to the large-scale international market of sex work, parts of which are largely underground, came a slew of trial and error interventions targeting sex workers as part of the response to HIV. A large number of interventions are ignorant of the complexity of sex workers' risk factor network. A review of the effectiveness of twenty-eight HIV and other STI prevention interventions in female sex workers in resource poor areas categorizes interventions into (1) behavioral interventions with condom promotion, (2) addition of vaginal microbicide, (3) addition of STI treatment, and (4) structural interventions (Shahmanesh, Patel, Mabey, & Cowan, 2008). Shamanesh et al find evidence for superior efficacy of multi-component interventions, i.e. a combination of sexual risk reduction, condom promotion, and improved access to STI treatment. Moreover, they conclude that ecological interventions such as policy change or enabling female sex workers to claim their own rights, though few in number, appear to reduce the prevalence of STIs and HIV. Similarly, Parker, Easton, and Klein call for more documentation and evaluation of the effects of such structural interventions, as well as innovative, interdisciplinary approaches "that can move beyond the limited successes of traditional behavioral interventions and explicitly attempt to achieve broader social and structural change" (2000, 22). This sentiment seems to echo Burris' and Xia's urge for interventions that address contextual risks, rather than assisting sex workers in coping with a context that has not changed (Burris & Xia, 2009). Next, I will discuss two interventions that fared better at addressing ecological factors and have produced successful results.

The 100% Condom Program. One particular approach, heralded as “one of the most acclaimed structural interventions of any type” (Parker, Easton, & Klein, 2000, 28) was the 100% Condom Program in Thailand. Both the structure and reported outcomes of the program merit a closer examination. In 1991, after the proportion of brothel-based sex workers infected with HIV had tripled in only two years, the National AIDS Committee led by Thailand’s prime minister launched a collaborative effort with health officials, brothel owners, and policemen to hamper the spread of the disease (Brown, 2004). Establishments distributed condoms by the government, and, despite the illegal status of commercial sex, local police organized informational meetings with health officials, sex workers and brothel owners. These meetings provided education on HIV and proper condom use, and communicated the program’s benefits. In new cases of men seeking treatment for STIs in government clinics, the police traced the establishments they had visited. Failure to adopt the condom policy could result in the closure of the establishment, though authorities report they “generally preferred to cooperate with the brothels rather than alienate them” (Brown, 2003, 25). After rapid early successes as the incidence of STIs plummeted, the Thai government adopted the policy on a national scale. Widespread public education campaigns through television and radio advertisements sought to warn male clients of the dangers of unprotected sex. The results of this joint effort appear numerically convincing: the number of new STIs decreased from 200,000 in 1989 to 27,597 in 1994; rates of condom use in brothels across Thailand soared from 14% in early 1989 to more than 90% in 1992 (Brown, 2004, 25).

While it remains uncertain whether the 100% Condom Program is replicable in different settings, the reported figures paint a clear picture of success. Experts attribute a large portion of the favorable outcome to contextual factors such as Thailand's hierarchical social structure, its relatively open attitude towards sexuality, a prospering economy during the early 1990s (Parker et al., 2000), the elaborate structure of the Thai sex industry, and the already existing infrastructure of STIs services (Brown, 2004). Yet even if the context was favorable, the program was exceptional in addressing a range of ecological factors. Firstly, the national scale-up of the program⁶ would not have been possible without the strong political will backing the campaign and the close cooperation of commercial sex establishments with governmental officials (Parker et al., 2000). This form of official cooperation presupposed on the part of the government the public recognition of the health problem at hand and the determination to tackle it holistically. Secondly, national education targeted at male clients on condom use and health-related dangers of unprotected sex constituted a vital part of the campaign. Rather than charging women with the sole responsibility for protection, this approach acknowledged and responded to the power disparity in negotiations of condom use. Thirdly, involving the police in the educational trainings provided officers with information on the conditions of sex work and endowed them with a stake in and responsibility for alleviating the health problem. This potentially decreases the chances of police forces

⁶ Despite its large scale, the campaign only targeted sex workers employed in brothels, excluding individuals working the streets, which renders an evaluation of the benefits for sex workers more generally difficult.

exploiting sex workers. Fourthly, the active employment of the media allowed for public discourse to broach the issue of safe sex.

The results of the campaign were unprecedented.⁷ Still, there is room for improvement by expanding the risk factors addressed. The primary goal of the campaign was to reduce the risk of STI and HIV infection (UNAIDS, 2000a). While occupying the foci of almost all global interventions targeting sex workers worldwide, this objective by itself too often is plagued by negligence of other health-related risk factors, for example violence against sex workers. This points back to the two problems outlined at the beginning: firstly, ignoring the widespread violence sex workers face impedes directly on the efficacy of HIV prevention efforts (Decker et al., 2010). Secondly, reducing violence against citizens involved in the sex trade as part of the effort to improve their overall well-being should be an objective in itself because violence is a human rights violation. Yet, research and interventions addressing physical, psychological and sexual violence against sex workers are disproportionately scarce (Ratinthorn et al., 2009). Some recent evaluations of the 100% Condom Program have suggested that it is counterproductive to efforts seeking to prevent violence by “inadvertently pushing sex workers underground

⁷ Some note, however, that the causal link of the effects continues to be unclear. While STI rates dropped steeply in the period investigated by most reviews of the program, so did the proportion of men who reported having sex with a sex worker in the preceding year (Nelson et al., 1996). Furthermore, given the time and place, it could have been the witnessing of the first AIDS-related deaths of acquaintances that caused this reduction in brothel visits, or alternatively, the mass media education efforts (Nelson et al., 1996). Given the threat of possible sanctions imposed on establishments, condom rates reported by both sex workers and clients could be suspect to inaccuracy.

through police raids, surveillance, and mandatory testing” (Shannon & Csete, 2010, 574). The program is a prominent example of the considerable effectiveness of attending to the ecology of risks through various channels – officials, the media, education of male clients - and of the complexity of factors that must be taken into consideration when designing effective interventions.

The Sonagachi Project. Another noted example is a multilateral intervention conducted in the Sonagachi district of Kolkata, India, an area known for the largest red-light district of the city with a long-standing tradition in the sex trade industry. In 1991, the Indian Government’s All-India Institute of Hygiene and Public Health collaborated with 18 NGOs to launch a community-run HIV and AIDS project that, after 19 years, remains one of the largest of its kind in the world. The project, titled the STI/HIV Intervention Program (SHIP) aimed to offer sex workers “a safer environment in which to live and work” (Durbar Mahila Samawaya Committee & All-India Institute of Hygiene and Public Health, 2003, 45). At its inception, SHIP was novel because it reframed the problem of HIV “from an issue of individual motivation, will, or behavioral commitment to a problem of community disenfranchisement” (Jana et al., 2004, 407). Starting with 12 sex workers who were trained as peer educators to educate fellow sex workers, the collective now includes over 430 trained peer educators and in 1997, became Asia’s first organization of sex workers, the Durbar Mahila Samawaya Committee (DMSC). The educators have reached out to the rest of the sex worker community by offering lectures on HIV prevention, distributing free condoms, and referring fellow workers to clinics that

provide free STI treatment and exams. Simultaneously, the intervention has offered education sessions for male customers, which emphasize the importance of protection. The DMSC also conducts a literacy program and an immunization initiative, and manages the Usha Multipurpose Cooperative Society, providing loans to sex workers. Children and family members of sex workers received free health care at partner clinics, while caring for children of sex workers became a high priority (Jana et al., 2004, 409). Finally, the sex worker collective created a cooperative where the sex workers could shop without the overcharge they face due to discrimination on the ordinary commercial market. Since the community witnessed the evolvement of the program over time, concerns about the intervention being a threat to social order ceased and community members began to endorse the program (Durbar Mahila Samawaya Committee & All-India Institute of Hygiene and Public Health, 2003, 45).

Apart from gaining knowledge of STIs as well as negotiation skills with customers, sex workers are enabled to communicate with other sex workers and organize through the collective. Participating sex workers reportedly have felt an increase of self-respect, dignity, and authority, as well as a new social identity (Durbar Mahila Samawaya Committee & All-India Institute of Hygiene and Public Health, 46). Furthermore, the connecting power of the collective has created cohesion and trust amongst peer sex workers, which forms the backbone for long-term mobilization (Jana et al., 2004, 408).

The informal assessment of the peer educators showed an increase in condom demand, and HIV infection in Sonagachi is said to have dropped from 30% to 9% in one decade (Durbar Mahila Samawaya Committee & All-India Institute of Hygiene and Public Health, 45). Through its multi-sectoral approach, the intervention addressed community-level barriers by changing societal attitudes towards sex workers and mitigated constraints such as illiteracy; it changed social relationships amongst the sex workers and with the “community power brokers”; and it improved individual competencies of sex workers by raising literacy rates, and by giving authority and responsibilities to the sex workers themselves (Jana et al., 2004, 408). This kind of treatment led to a shift in sex workers’ own value expectations (ibid., 409). Finally, children of sex workers were included in the intervention to break the cycle of sex work, including poverty and disease.

While these widespread, largely positive evaluations refer to the early years of the Sonagachi Project, some have criticized the recent operations of brothels run by the DMSC for, among other things, condoning the employment of young girls as sex workers (Kristof & WuDunn, 2009). Nonetheless, I include the Sonagachi Project as an example of best practices on paper and at its conception. Further research could illuminate what factors, if any, have prevented the translation of the project’s mission into sustainable action.

So far, I have argued that the majority of interventions that target sex workers trying to reduce HIV transmission ignore the fact that individuals’ behavior responds to

a complex social and political environment. By treating sex workers merely as a focal point of an infection network, these interventions reduce the likelihood of success of their own health objective since risk factors interact strongly. I also argue that these interventions fail to address human rights violations of sex workers, such as the constant threat to their own physical security because of widespread violence by clients and police. I presented two exceptions: the 100% Condom Program in Thailand, and the Sonagachi Project in India. Apart from being comprehensive, ecologically-oriented approaches, they represent interventions that, *inter alia*, involve the police force, in the former case, and create strong hubs of solidarity for sex workers, in the latter case. Through the present study, I will outline the plethora of interacting forces and risk factors affecting the behavior of female sex workers in Nakuru, Kenya.

3 RESEARCH METHOD

Introduction

Nakuru town is the provincial capital of the Rift Valley province in Western Kenya. The recent 2009 Kenya census estimated roughly 500,000 inhabitants in the large Nakuru district, which includes communities as far out as Solai in the north-east, and Njoro in the south-west of the province (Kenya Census, 2009). Nakuru is the fourth largest town in Kenya, following Nairobi, Mombasa, and Kisumu. The most recent Kenya Demographic and Health Survey (KDHS) found HIV prevalence rates in the Rift Valley at 6.3% for women, and 2.8% for men (Kenya National Bureau of Statistics, 2010). For women across Kenya who had exchanged sex for money or gifts in the 12 months prior the previous KDHS found the HIV prevalence rates to be as high as 11.2% (Kenya National Bureau of Statistics, 2004). Due to its geographic location, Nakuru is a popular destination for truck drivers, who frequent the town and its highway while passing through to Uganda. Nakuru town itself is home to a range of clubs, bars and lodges, most notably along Kanu Street, a long stretch of road infamous for being a hot spot for sexual transactions.

In Kenya, as on the global level, the majority of studies and interventions targeting sex workers as a vulnerable group have focused primarily on the link between sex work and the transmission of sexually transmitted infections (STIs), including HIV, or efforts to prevent it (Gilks et al., 1996; Kimani et al., 1996; Ngugi, Wilson, Sebstad, Plummer, & Moses, 1996; Voeten et al., 2002; McClelland et al., 2005; Yadav et al.,

2005; Thomsen et al., 2006). There are currently two support programs for female sex workers in Nakuru town: the local non-governmental organization Family Aids Initiative Response (FAIR)'s program PAMBAZUKO (Kiswahili: *dawn*) and Family Health Option Kenya (FHOK)'s support network for sex workers. In my research, I worked in collaboration with FAIR and FHOK, as well as reproductive health peer educators of the local non-governmental organization REPACTED. My study seeks to shed light on the comprehensive risk environment of female sex workers in Nakuru to understand the forces interacting to drive their behavior. This will help identify the most pressing risk factors that interventions tend to neglect, both in their effort to reduce HIV transmission and as a matter of realizing basic human rights.

Design of the Study

The study is based on interviews with 99 female sex workers (n=99) in Nakuru. This sample includes 8 participants with whom I conducted preliminary semi-structured interviews, 26 participants who participated in a focus group, and 65 participants whom I conducted in-depth interviews with. All participants identified as female sex workers. Prior to the interview period, I consulted with the local service providers at FAIR and FHOK, and familiarized myself with the local context of sex workers by observing and attending sex worker organization meetings. This preparatory phase, including the preliminary interviews and focus group, significantly informed subsequent procedural

decisions such as specific interview questions for the in depth interviews. Peer educators of the Nakuru-based, non-governmental organization REPACTED with competence in reproductive health and marginalized populations advised me on the suitability and sensitivity of questions for the final questionnaire. I held preliminary meetings, interviews, and the focus group between July and August, 2010, and conducted the in depth interviews between October and November, 2010. All meetings occurred on location in Nakuru. Two female research assistants of REPACTED joined me to form an interview team. Both local researchers had previous research experience and received special training for this particular project.

Participants

One local peer educator acted as the liaison between the interview team and the research participants. Participants were recruited via introduction through peer recruitment, and chain referrals by FAIR and FHOK. Preliminary interviews and focus group participants were all part of the PAMBAZUKO group run by FAIR. In-depth interview subjects were identified using peer networks in the Nakuru townships Bondeni and London, as well as through chain referrals by FAIR and FHOK. Eligibility was limited to female sex workers over the age of 18. Participants represented a range of ethnic groups, though the majority was Kikuyuu (41.5%) or Luo (24.6%). Ages ranged from 19 to 42 (average of 26.6). All participants had been exposed to some amount of

formal education, and just over half of the participants (50.8%) had exposure to secondary school (average of 9.4 years of education). Almost all of the participants (92.3%) identified themselves as the head of their household. Although the majority was single (84.6%), most of the participants (92.3%) had children (an average of 2 children). More than half of the participants were part of an organized support group for sex workers (70.8%). Some had been affected by the violence in the aftermath of the 2007 presidential election, and almost all participants were poor, naming their economic instability as a motivation to engage in sex work.

Interview procedures

Participants who gave verbal informed consent were interviewed in private locations for between 30 and 90 minutes. Interviews were conducted in English, Kiswahili and Sheng, the local Kiswahili dialect, according to the preference of each subject. Answers to the questionnaires were recorded in English and Kiswahili, and were translated and processed by the principal researcher, while all preliminary interviews and the focus group discussion were audio-taped. By the end of the interview, researchers reimbursed each participant with 200 Kenyan Shilling (ca. US\$2.50) as a gift for participation. The questions employed yielded both qualitative and quantitative information to collect rich data on the nature of sex work in the area and the diverse risk environment of female sex workers.

Background Characteristics. Questions about participants' basic background information generated data on their demographics, socioeconomic situation, and household dynamics. Given the sensitive nature of tribal associations in Kenya since the ethnically motivated post-election violence of 2007, the local researchers inferred participants' tribes from their Swahili dialect and by asking them what part of Kenya they are from originally.

Pathways into Sex Work. We prompted each participant to describe the circumstances that led her to engage in sex work for the first time. If the answer was general ("Problems.") the researcher asked the participant if she would like to elaborate. If it was not clear from her narrative, the participant was asked about the involvement of other people in the process: "Without naming any names, were you encouraged by anyone in your decision to take up sex work?"

Health. A host of questions gauged participants' experience with issues of HIV and AIDS, maternal health, and visits to health clinics. Straight-forward yes or no questions asked about unwanted pregnancy, abortion, possible complications and the occurrence of STIs. While some questions asked for participants' advice ("If a new sex worker approached you and asked what HIV is and how it gets transmitted, how would you explain it?"), others inquired about their own experiences at clinics ("What have your interactions with clinic staff been like?") and specifically discrimination by clinic staff ("When you do inform the clinic staff about your work, do you feel treated nicely?").

Practices. We asked a wide range of questions about participants' practices and prices while at work. After asking where and for how long participants usually meet a client, the researchers asked about different types and rates of services offered to their clients: "If you have different rates for different services, how much do you charge for different services?" Participants would name a host of practices (vaginal sex, oral sex, specific positions, "romance") and attribute the fees they charge. Rating on a 4-point scale (1 = Never, 4 = Always), researchers asked participants about their drinking behavior while at work: "How often do you drink alcohol before having sex with a customer?" If the participant gave spontaneous comments about her reasons the researcher hand-recorded these on the questionnaires.

We asked several questions about participants' protection practices and their power of decision-making. Researchers asked about family planning and protection methods separately. This was prompted by the common local perception of condoms primarily as a form of protection against disease, not a form of family planning, as was confirmed by many responses: Most women who asserted they usually use condoms to protect themselves from HIV negated using any method of family planning, including condoms. We measured participants' power of decision-making through 3 different questions. Rating on 4-point scale ("1 = All the time, 4 = Almost never") researchers asked: "We've talked to a lot of women who say it's difficult to always use condoms. How often do you feel you are in a position to negotiate to use a condom with the customer when you want to?" After asking about reasons that might hinder her to use a

condom when having sex with a customer, we tried to gauge the influence of a monetary incentive on her decision-making: “When a customer offers more money for sex without a condom, how often do you feel like you can refuse? If there is a price at which you would accept having sex without a condom, what would it be?” If the participant had indicated that she had a stable, intimate, non-paying partner, the researchers proceeded to ask similar questions about her power of decision-making in the use of protection with this partner. Finally, the researchers gauged the availability and efficacy of condom distribution: “Do you feel you have access to condoms whenever you need them, and if not what would be the most effective way to distribute condoms to sex workers?”

Multiple questions inquired about participants’ experience with harassment and violence both by clients and at the hand of the police. Researchers asked about participants’ greatest worry while looking for work (“1 = If you will get a client, 2 = If you will earn enough money, 3 = If your client will be violent, 4 = If you are seen by a friend or family member, 5 = Harassment/arrest by the police”), and the amount of times she had experienced a violent customer in the past month. To put participants into the role of a peer educator while talking about potentially sensitive experiences, researchers asked about their advice for other sex workers: “If a new sex worker asked you about your experiences with violent customers and about your advice, what would you tell her?” Direct yes or no questions asked whether in the past month, the participant had sex with a customer when she did not want to, whether a customer left without paying for her services, and whether she feels safe in her interactions with the

police. If the participant indicated concern with the police, researchers investigated whether it was fear of arrest, fear of harassment, or fear of rape. Finally, participants were asked to describe what their interactions with the police have been like.

Competition, Cooperation and Networks. We measured the impact of competition between sex workers, as well as informal cooperation between sex workers within circles of friends and formal networks such as sex worker support groups. Researchers asked about the direct points of competition: “Do sex workers compete against each other? If yes, what is the competition about?” The answer key turned out not to be exhaustive (“1 = prices, 2 = attractiveness, 3 = services offered, 4 = age, 5 = other – please elaborate”) and was complemented by participants’ answers. Informal cooperation was measured by a qualitative description: “Do you cooperate with other sex workers? If yes, in what ways?” After asking about the specific services a support group has offered the participant, researchers gauged their impact once again through a qualitative description: “If you belong to an organized group of sex workers, how has that changed your work?”

Wishes. Finally, researchers encouraged participants to express their own wishes with regards to educating the police, their clients, and their immediate community about the conditions of sex work: “If the police/your clients/your community were to get an education about your situation, what would you like that education to be about?” Since their social marginalization tends to silence sex workers’ needs and concerns, we hoped to hear the issues most pressing on their minds, which they felt were ignored by the

three respective groups. We also anticipated potential suggestions for the content of education programming aspects of interventions.

Data Analysis

The data for the study were collected through interviews, a focus group, and my field observations. The preliminary interviews and the focus group were audio-taped, and partly transcribed. The results of the 65 in-depth interviews were recorded on a standardized questionnaire, the responses to which are the basis for the quantitative results of the present study. In the following, all statistical figures are based on this sample of 65 in-depth interviews, as analyzed with STATA. Quantitative data were subjected to univariate analysis, which provided simple descriptions of the characteristics of the sample. Descriptive data is based on all interviews as well as my field notes. All data were analyzed in a cyclical continuous process including data reduction, data organization and interpretation. In my presentation, I combine quantitative and qualitative results to complement each other. I have grouped results into themes of background characteristics, pathways into sex work, health, practices, competition and cooperation, and wishes. I used verbatim quotes from the participants to substantiate particular interpretations and to provide a rich picture of the risk situation of all participants.

4 RESULTS

All subsequent descriptive statistical figures are based on the sample of 65 one-on-one interviews. The qualitative findings are based on the whole sample population of 99 female sex workers.

Background Characteristics

Table 1: Background Characteristics

	Min	Max	Average
Age	19	42	26.2
Number of children	0	7	1.9
Years of education	5	14	9.3
Members in household	1	9	3.4
Average income per week	KSH 150 (\$1.90)	KSH 12,500 (\$154.00)	KSH 1958 (\$24.10)

Figures are based on the sample of 65 participants from the one-on-one standardized interviews, for whom we have demographic data.

As Table 1 shows participants' age range spanned a difference of 23 years, with the youngest participant at 19 years old and the oldest participant at 42 years old (average = 26.2 years). Many participants indicated they began sex work in their early twenties, (average age = 21.5 years) with little education: while most participants attended secondary school for some period of time, eighteen (27.7%) completed secondary school, 2 of which (3.08%) went on to tertiary education, and thirteen participants (20%) did not finish primary school. Sex workers mentioned that because of their poor educational qualifications they had severe difficulties finding a job in the formal sector, rendering sex work their only viable option to generate income. As other

studies have suggested, patterns of gender bias in access to formal education can be a compounding factor in the network of social vulnerabilities that drive women into sex work (see Binagwaho et al., 2010).

Children constituted a major concern in most participants' lives. Only 4 participants (6.2%) had no children at all, while 22 participants (33.8%) had 2 children, and one participant had 7 children. Many women commented on their responsibility to provide food and school fees for their children or for younger members of the household. Most confirmed that this economic necessity sways their decision-making in whether or not to see a client or to engage in risky but better compensated behavior on a daily basis. Some participants worried most about the community's stigmatization of their children, and underlined the feeling of shame and fear that their children will suffer from the discrimination in the neighborhood and at school. The ubiquity of the issue of children in almost every interview underscores both children's impact on sex workers' decision-making and their own vulnerability to the cycle of poverty, ill-treatment, and disease.

A majority of 55 participants (84.6%) indicated that they are single, 8 (12.3%) are divorced, and 2 (3.1%) are widowed. No participant stated that she is married. This significant finding corresponds to participants' household dynamics: nearly all identified themselves as the head of their household. Ten participants (15.4%) are the only member of their household, 24 participants (36.9%) live in a household of more than 3 members, the average members in the household being 3.4.

Details about their familial background, most notably participants' marriage status, emphasize the socio-economic context of their situation: marriage is a Kenyan woman's source of respect and financial security. In the rural areas particularly, patriarchal structures dictate a traditional division of labor, where the husband ordinarily generates income and the wife is expected to fulfill household duties. Single-parent, women-headed households are plagued by obstacles to women's ownership of property entrenched in the law, as well as their lack of education and an unfavorable position in the labor market, which contribute to economic deprivation (Odhiambo & Odhiambo, 2006). As shown in the present study, single mothers caring for an average household of 3.4 without the support of an earning husband face exacerbated difficulty in making ends meet due to socio-economic and cultural barriers.

Table 2: Distribution by Tribal Affiliation

	Frequency	%
Kikuyu	27	41.54
Luo	16	24.62
Other	9	13.85
Luyah	8	12.31
Kalenjin	5	7.69

Twenty-seven participants (41.54%) are Kikuyu, followed by 16 Luo (24.62%) (see Table 2). This is a diverse sample with a slight overrepresentation of Kikuyu and

Luo participants in comparison to the overall distribution in Nakuru.⁸ This could be due to the peer recruitment and chain referral method employed to recruit participants.

Pathways into Sex Work

The duration for which participants have engaged in sex work varies widely, from 2 months up to 20 years. The average number of years in the industry across the participant pool is 4.9 years. Twenty-nine participants (44.6%) said they had been encouraged to take up sex work, 28 of whom mentioned the encouragement came from a friend, while one said she was encouraged by a pastor. Most elaborated that encouragements usually included allusions to the economic benefits of the job. The prospect of quick compensation, even if for sexually highly risky practices, provided the women with economically lucrative solutions to their abject poverty. None of the women reported being encouraged to enter sex work by a pimp, nor being currently controlled by a pimp. Overall, forty-nine participants (75.4%) indicated that it was their own choice to enter sex work, while 15 (23.1%) said it was not. Almost all who described it as their own choice, however, added that while they could not think of any person who coerced them into choosing this job, they felt forced by their circumstances to begin work in the sex trade.

In their descriptions of these circumstances, nearly all participants mentioned economic hardship, including lack of money to support themselves and their family, and

⁸ Kikuyu constitute 20.78%, Luo 12.38% of the Kenyan population, respectively (<http://kenya.rcbowen.com/people/population.html>). These numbers are comparable to the distribution in Nakuru (Mwangi, 2003).

difficulty in finding a job. Formal employment opportunities in Nakuru are scarce, leading to the large part of the working population being involved in the informal sector. Many of these informal activities result in conflicts with municipal officials because of the lack of licenses. Unemployment rates are high and increasing, as is urban poverty (Mwangi, 2003).

A large number of participants indicated that the death of either a parent or a partner pushed them into financial problems. For others, a sudden or unplanned pregnancy deprived them of monetary support from either their partners or parents, and led to destitution. In some instances, the onset of pregnancy forced participants to leave school, forgoing their education, while in others, the consequences of raising a child exacerbated financial insecurity. Sex work appeared to be a solution to participants' economic problems. Mothers in particular indicated that they specifically entered sex work to be able to feed their children. A number of participants mentioned a combination of the above-mentioned factors:

“I was abused by my stepmother, got married, divorced, and then fell pregnant. I tried to commit suicide, but then someone introduced me to sex work and suddenly, I could make money.” (Alice ⁹, 35 years old)

“I was still very young; I was 16. My father was dead, my mother was dead. I was the first born at home. My siblings were very small and they depended on me, but I didn't have a job. I didn't go to school because nobody could pay the fees for me.” (Beatrice, 25 years old)

“While I was still in school, I fell pregnant, so I had to get married to the father. After 9 months I delivered a baby girl - but he wanted a baby boy. Culture says

⁹ All names have been changed to ensure confidentiality of participants.

you should have a boy. We started quarreling, until he didn't give me any money anymore. So I started having affairs. Then there was a friend of mine who was a prostitute. She introduced me.” (Ann, 24 years old)

Life-circumstances and lack of economic opportunity interact with cultural notions of child-rearing, the traditional importance of marriage and geographical conditions to intensify economic marginalization of women in rural Kenya. These mechanisms lie at the root of the gateway into sex work and are examined in more detail in the Discussion section of this paper.

Health

When prompted for their health concerns while at work, 49 participants (75.4%) stated that they are concerned about sexually transmitted infections (STIs). Forty-three (66.2%) specifically mentioned HIV, 21 (32.3%) mentioned pregnancy, and 8 participants (12.3%) mentioned violence at work as a health concern. While general consciousness of STIs has risen in recent years due to community-wide awareness efforts, sex workers' recognition of violence as a violation of their rights and as a danger to their own health has lagged behind.¹⁰

Almost all participants (95.4%) indicated that they know their HIV status,¹¹ and most of the sex workers had a reasonably accurate basic understanding of how HIV is

¹⁰ The World Health Assembly declared violence a growing public health concern and its prevention a global public health priority in 1996 in its Resolution 49.25 (http://www.who.int/violence_injury_prevention/resources/publications/en/WHA4925_eng.pdf)

¹¹ No participant was asked to reveal her HIV status.

transmitted. Those who could offer slightly more nuanced descriptions were all participants who are part of a sex worker support group.

On the topic of maternal health, 34 participants (54.0%) stated that they have not experienced an unwanted pregnancy. Still, 29 participants (44.6%) have experienced between one and six unwanted pregnancies. Many of them stated that they continued working and seeing clients while pregnant since they could not afford to forego income for nine months. Out of those who had unwanted pregnancies, 17 participants (35.5%) indicated that they have had at least one abortion, with one participant estimating that she has had approximately 6 abortions. Many of the abortion procedures were not done at a health facility because of legal or financial constraints. Participants described using herbal plants (*mefungi*) and sticks to terminate the pregnancy vaginally. Most participants described various complications during the process, including excessive bleeding, pelvic and abdominal pain, often lasting many days after the abortion. In one case the participant indicated an unsafe abortion procedure led to her infertility.

Insufficient knowledge of and access to a variety of contraceptive methods exacerbates the rates of unwanted pregnancies and subsequent complications. Some women were under the impression that family planning strategies were to be used only when one in fact intends to have a baby. Half of the participants (52.3%) reported they currently use contraceptive injections, which provide protection against pregnancy for 2-3 months, yet the women indicated they are not able to obtain these injections on a regular basis. Many who had used contraception at some point prior to the interview

were no longer using it because they had experienced complications. Especially those sex workers who at some point had hormonal implants, customarily implanted in the upper arm, reported discomfort, pain, abnormal bleeding and unreliable protection against pregnancy. Only 3 participants currently use the birth control pill. Community health workers confirmed that sex workers often obtain illegitimate contraceptive products sold cheaply on the black market, and that lack of adequate user knowledge as well as community myths concerning contraception (e.g. “The birth control pill is used for dogs in America”) hamper proper use of a variety of contraceptive methods.

On the topic of past infections, 17 participants (27.4%) stated that they suffered from an STI in the past year. The chances of infection, as well as genital injury, are heightened by excessively dry intercourse due to lack of vaginal arousal and lack of lubricant.

‘When a client cracks you when entering and keeps going out and coming in, it is so painful because you are injured and dry. After that, it is so hard to go with another client. You are feeling the pain, you want to go to the hospital but you have to see your next client. You just have to go through with it.’ (Ida, 24)

Almost all participants (93.6%) confirmed that when they do have an infection they go to a health clinic. Of those participants, 91.4% said they tell health professionals about their occupation as a sex worker. The majority of participants (90.6%) indicated that when informed about their work, clinic staff treats them nicely. Many participants underlined their good relationships with health workers who are non-judgmental towards them and their work, and who offer advice on safe sex protection and STI treatment.

Some participants made a clear distinction between the reaction and treatment they receive in private health clinics (generally supportive) and those they have experienced in governmental facilities (generally negative). A few mentioned the FHOK health clinic specifically as offering confidential, non-judgmental services and advice. Most participants stated that they would feel safe to go to the hospital if they had a problem with a customer, which underlines the importance of training health staff in compassionate and confidential treatment of sex workers.

“(In government clinics) they refuse to treat you, saying it’s your fault. They don’t understand.” (Destiny, 29 years old)

“Some tell you that God will curse you because you are destroying another person. And in defense...you become rude and fight with (the clinic staff).” (Grannis, 24 years old)

A few participants talked about the psychological stress of their work, with some admitting they had attempted suicide, and their concomitant drug use. Many women mentioned using alcohol to deal with the daily ordeal of sleeping with their clients. Almost half (41.5%) said they drink alcohol before meeting a client “most of the time.” On the other hand, 32% indicated they harbor such deep concerns about losing self-control in the vulnerable state of being with a client that they never drink alcohol for fear of rape, robbery, or beatings. Most descriptions of their psychological strain focused on complete lack of self-efficacy and internalized shame. For example, one participant in particular described as her most pressing emotional concern the deep shame she felt

about her work, yet she must work for her seven children, whom she hoped would never find out about her involvement in sex work. This highlights the severe psychological ill effects caused by the quotidian physical ordeal sex workers endure and by the internalization of stigma. Finally, it reiterates the central vulnerability of the children of sex workers to become part of the vicious cycle.

Practices

Participants discussed a range of locations that they frequent to look for customers. Fifty-four participants (83.1%) meet customers at clubs and bars, while 22 participants (33.9%) indicated they tend to look for customers on the street. While 9 participants (13.9%) stated that sexual interaction sometimes occurs at their own home, the majority takes customers to rented rooms. This unfamiliar setting reduces sex workers' bargaining power in the case of violence and condom use since they are unlikely to be able to find assistance in dangerous situations (Agha & Nchima, 2004).

Sexual interactions are usually termed "a short" or "a long:" short sessions range between 15 minutes and 2 hours, while long sessions last between 3 hours and an entire night. Participants explained various ways of deciding on the rates they charge: many negotiate with the customer, taking into account his appearance to discern age and social class, as well as his general behavior. A more sophisticated appearance will result in higher rates, as will higher age. Prices then correspond to the specific services offered or to time spent with the sex worker.

“It differs because customers bargain a lot and often you have to go with what they say because you have to feed the kids.” (Naomi, 23 years old)

“I use the candle method: there are different marks on the candle. When it burns down to one mark while a customer is with me, I charge for one short; when it takes the whole candle, I charge five shorts.” (Janet, 23 years old)

The variability of their pricing makes the women’s income inherently dependent on their negotiation power and ultimately the clients’ agreeableness. One participant explained that, while she discusses fixed prices for certain services with fellow sex workers to maintain autonomy and eliminate competition, it is impossible to stick with such prices when in an economically dire position that necessitates she takes a certain client’s low payment offer.

Many participants reported offering an array of various services, the scope of which differed with every individual participant. All offer conventional vaginal intercourse with a condom, while more than half (55.6%) stated that there are instances where they have sex without using a condom. In addition to conventional intercourse, some participants offered oral sex, body massage, and various “styles” or sexual positions. While some women reported having anal sex with customers because it paid more, most did not consider this part of their usual services because it was more painful than vaginal intercourse. Many attributed cultural backgrounds to certain sexual preferences. Women reported that Whites and Indians tend to demand oral and anal sex, and were able to pay more for it than Kenyan customers.

Many sex workers mentioned they offer “romance” to those customers who request

it: this service includes romantic talk and caressing during the sexual encounter to create an atmosphere of intimacy. According to some participants, married men are most likely to request this service, as well as unusual styles that deviate from the traditional intercourse they have with their wives. Sex workers speculate that this high demand from married men for such a diversity of traditionally deviant sexual activities points to a cultural incongruence between the expression of sexual desires and curiosity, and the accepted discourse on sexuality within traditional Kenyan marriages (including knowledge of safe sex). Nonetheless, while the majority of debates about discussing sexuality in the public and private sphere in Kenya tend to articulate social discontent about the attack on gerantocratic power structures, they recently appear to coincide with a small niche of “positive discourse on sexuality...praising the vitalizing force and bonding intimacy that comes from sex in relationships” (Spronk, 2007, 4). A weekly magazine column targeted at married and unmarried couples exemplifies this niche, explicitly detailing sexual positions, types of gratification, and “foreplay, fantasy and sexual variation to enhance female pleasure” (ibid.).

The average income per week is KSH 1,958 (\$24.10), with a minimum of KSH 150 (\$1.90), and a maximum of KSH 12,500 (\$154.00).¹² As Table 3 shows, amongst all participants, the lowest rate charged for any of the services above is KSH 30 (\$0.40).

¹² This figure might be affected by overestimation on the participants’ part. Many participants had difficulty estimating an average income per day and per week, and this particularly high calculation of average weekly income did not correspond to the number of customers and prices the participants reported. Without this outlier the average income per week drops to KSH1,792 (\$21.60) and the maximum is KSH5,000 (\$60.10).

The average price for a short session is KSH 325 (\$4.00). The minimum charge for a long session is KSH 200 (\$2.50); the maximum is KSH 3,600 (\$44.30). To put this into context, the cheapest lunch at a local restaurant, for example, *ugali na maharagwe* (a simple maize flour dough with beans) costs around KSH40 per person. Buying 2kg of *ugali* to take home to the family costs around KSH150.

Table 3: Services and Prices

	Min	Max	Mean
Short session (15 minutes - 2 hours)	KSH 50 (\$0.60)*	KSH 1,000 (\$12.30)	KSH 325 (\$4.00)
Long session (3 hours - one night)	KSH 200 (\$2.50)	KSH 3,600 (\$44.30)	KSH 930 (\$11.40)
Without condom	KSH 100 (\$1.20)	KSH 4,500 (\$55.40)	KSH 970 (\$12.00)
Oral sex	KSH 200 (\$2.50)	KSH 2,500 (\$30.80)	KSH 1,050 (\$12.90)
“Romance” (romantic talking and caressing)	KSH 200 (\$2.50)	KSH 1,500 (\$18.50)	KSH 800 (\$9.80)
Styles (eg. “Dog-style”, “Fifty-fifty”)	KSH 30 (\$0.40)	KSH 4,000 (\$49.20)	KSH 984 (\$12.10)
Body massage	KSH 200 (\$2.50)	KSH 1,500 (\$18.50)	KSH 730 (\$9.00)

* Dollar prices based on currency conversions at <http://www.xe.com>

Participants indicated that they see between one and ten customers per day.

When asked what type of protection against infections they use during intercourse with a customer, almost all participants (98.5%) indicated they use a conventional condom, and 31 participants (47.7%) also stated they use female condoms. While every single participant indicated that she prefers using a condom when having sex with a customer,

the majority stated that customers offer more money for unprotected intercourse, an economic benefit the women by and large cannot reject. Twenty-three participants (35.4%) do not feel they are always in a position to negotiate to use a condom with a customer when they want to. Almost half of the participants stated that they do not feel comfortable to refuse when a customer offers more money for a style the participant does not like, including sexual practices, positions, and unprotected sex. Most cited financial necessity as the reason they feel pressured to comply with the customer's demands, with some indicating they would have unprotected sex for a price of KSH 100 (\$1.20), while others would only accept a minimum of KSH 4,500 (\$55.40).

This maximum for one-time sex without a condom is higher than the price for a "long" session lasting an entire night of protected sex (KSH 3,600). That means a "short," unprotected encounter can be of much higher economic compensation to the sex worker than a long, protected transaction. Many participants indicated that not using protection usually doubles their income. Given the volatile power dynamics of decision-making between the sex worker and her customer, the exact direct cash benefits of unprotected sex are hard to determine. Still, if high enough, the extra cash offer directly incentivizes a sex worker to engage in risky practices, including unprotected sex.

"At first, I try to refuse sex without a condom, but if the customer insists and I need the money, I have to accept it." (Kaya, 20 years old)

"When a customer does not want to use a condom, I tell him the advantages and disadvantages of using one. If he still insists, I cannot refuse – I need the money." (Layla, 33 years old)

While most participants admitted they are unlikely to calculate future health costs to treat infections incurred through unprotected intercourse into their daily decision-making, some participants voiced their thoughts about the trade-off of foregoing income in the future in order to mitigate the risk of illness:

“I look at my health first, so I have never had sex without a condom. How long will I live off that extra money? Not long. And if I have sex without a condom with someone who is infected, how much shorter will that make my life? Very short.” (Lydia, 28 years old)

Participants who displayed more knowledgeable assessments of the direct health impact of risky behavior were those who were members of support groups and had experienced workshops focusing on reproductive health. This points to the importance of educating sex workers on the immediate and proximate dangers associated with unprotected sex and riskier sexual practices, including dry and anal sex.

Some participants said they first heard about the importance of consistently using condoms during sex from a fellow sex worker, while others cited a client or boyfriend. Many others stated that their first education about protection came from peer educators and community health workers, with some citing the sex worker support programs at FHOK and FAIR in particular. No participant indicated that she had first discussed safe sex with a family member or, in particular, her parents. This points to what some term a recent cultural shift in Kenyan society, which bestows the responsibility of sex education onto parents. However, due to the traditional taboo on

sexuality due to a lack of sexuality communication skills, including knowledge, comfort and confidence, many parents are yet unprepared to deliver (Otwoma et al., 2004).

Forty-one of all participants (63.1%) currently have a stable, intimate, non-paying partner. Almost all participants indicated that they have access to condoms whenever they need them. Those in support groups largely cited their organizations as their primary source for condoms, while others mentioned shops and health facilities. Despite the relative access to condoms, almost half of the participants (47.6%) stated they do not use a condom with their intimate partner, mostly explaining it was their joint decision not to use protection because they had “trust”. Since this concept of trust alludes to the danger of genital infection, this trend underlines the perception of condoms purely as a method of protection against disease transmission, rather than a contraceptive. Similarly, a study of men’s attitudes and practices regarding sex in Thika, Kenya, showed that although 85% believe that sex is vital for reasons other than procreation, condom use with spouses and girlfriends is low at 13% and 26%, respectively (Meroget al., 2000). Some participants described that using a condom implies that either one party is “dirty” or “infected,” which means that according to local customs, asking their partner to use a condom in a stable relationship would raise suspicion. This points to a certain stigma attached to the use of condoms signaling the risk of disease rather than a positive safety measure for any sexual intercourse.

Participants’ most-cited concern while out looking for customers was violence or abuse by a customer (58.5%). Similarly, half of all participants (49.2%) fear harassment

or arrest by the police. These major concerns are followed by fear that a customer will not pay enough (35.4%), that there will be no customer at all that night (30.8%), or that a friend or family member might see the participant while out looking for customers (16.9%).

Table 4: “In the past month, did you have...”

	Frequency	% of total
...a customer leave without paying for your services?	48	77.4%
...a customer get physically violent?	46	71.9%
...sex with a customer against your will?	37	58.7%

This widespread concern about violence largely hinges on participants’ experiences. As Table 4 shows, in the past month, the majority of women (71.9%) stated that they had experienced a physically violent customer and more than half (58.7%) had been raped by a customer. Additionally, a large proportion of participants (77.4%) experienced a customer leave without paying for their services, or a combination of the above. Violence was by far the topic of discussion most often raised by the participants during their descriptions and anecdotes. Many expressed resignation at the imbalanced power dynamic between them and their customers as soon as violence comes into play. While the women’s involvement in sex work is, in its most basic form, a struggle for financial survival, many described that the pervasiveness of violence perpetrated against them turns their condition into a struggle for safety, too.

“Sometimes, customers have sex with me, and after that they beat me up and do not leave any money. It happens about three times a month.” (Fatima, 33 years old)

“When customers don’t feel like paying they get violent. Sometimes they suddenly ram beer bottles into your vagina.” (Nungari, 27 years old)

“I dont like wearing high heels because I cannot run away if I have to. And I do not wear scarves because customers might strangle me. Some customers tell you that you cannot leave; they keep you. Sometimes there are many of them who have sex with you even though you do not want to.” (Joyce, 35 years old)

“Even though in our organization we get taught about our rights, sex work is still illegal so going to the police to report harassment or violence is not an option for us. So what should we do?”(Shannon, 26 years old)

Most of the participants (64.5%) stated that they do not feel safe to go to the police if they have a problem with a customer, and almost all (79.4%) do not feel safe while with a customer when a policeman is approaching. They cited fear of arrest (89.7%), harassment (55.2%) and rape (31.0%) as reasons for their concern. Participants were encouraged to describe their interactions with the police in detail. Their collective insights revealed a pattern of violence, discrimination, and exploitation on behalf of policemen towards the sex workers. Many participants reported that they have experienced arrest on contrived charges such as loitering, drunkenness, and inappropriate dress code. They reported that after the police have charged them on the basis of these artificial offenses, officers request bribes. On most accounts they indicated that they are sexual demands. Many women explained that the police “demand sex in exchange for (their) freedom.” While some participants clearly named the violations in their

descriptions, such as “bribe” (29.3%), “rape” (18.5%), “harassment” (13.8%), and “violence” (10.8%), others chose to circumscribe them, for example as “giving small gifts” to the policemen. Some participants described having formed relationships with the police where the trade of sex and money in exchange for freedom is an understood reciprocity.

“I usually identify a policeman in an area that I want to look for clients, and then I have sex with him so that he will tell others not to arrest me.” (Irene, 42 years old)

Most who described their interactions in these latter terms were the participants who had been working as a sex worker for more than five years. It appeared that their expectations of benevolent treatment by the police had ceased, and had been replaced by the assumption of violence. This self-ascription of negative value is likely to have been spurred both by their experiences of harmful treatment and the internalization of stigma that had continuously signaled their low worth, as I discuss in more detail later.

“Police often shout at me, using very bad language. They know we are sex workers. So we have to bribe them so that they do not arrest us. Often, they demand sex from us in exchange for our freedom.” (Fatima, 33 years old)

“(The police) want to know how much cash you have on you. When they don’t get a small gift, they beat you up and rape you. Because of their uniform they can do it anywhere, even outside.” (Rehema, 25 years old)

“Even if I just wear suggestive clothing, policemen accuse me of being a prostitute and then say if I want to be free I have to have sex with them. This happens many times a month.” (Lisa, 24 years old)

Participants explained that they have no way of reporting any of the violations,

since the police can readily arrest them for artificial offenses as well as charges of living on the earnings of commercial sex. When caught by the police while together with a customer, participants reported that they are the only party facing blame and consequences, while their male customers are usually let free. Some explained that in cases where they did report abusive or violent customers, the police had taken sides with the customer. This partial treatment implies a double standard of punishment, and puts the blame solely on the supply side of the sex trade without recognition of the demand.

“When a customer gets violent and harasses you, the police always supports the man and harasses you in another way. They say the fastest way for them to help you is to have sex with them. If you refuse, they arrest you and use your condoms as evidence.” (Kawira, 24 years old)

Many participants described that carrying condoms can become a risky predicament since some policemen use the existence of condoms as evidence for charges of commercial sex. This type of policing practice is detrimental to efforts seeking to curb disease transmission, as well as it considerably hampers sex workers’ autonomy to protect themselves.

“My friend was arrested because she was carrying condoms. The police told her she was the one spreading the HIV virus. At the same time, the police rape us all the time. But you can’t go and report them because they are the government.” (Faith, 24 years old)

“To the police, carrying a condom is evidence that you’re a prostitute. If they find them they arrest you.” (Emma, 32 years old)

The results demonstrate coexistence among sex workers and police with reciprocal demand-supply relationships, as well as oppression, including corrupt demands

for sexual favors and monetary bribes on the part of the police in exchange for the sex workers' freedom. The sex workers lack power relative to the policemen's enforcement authority, and are thus vulnerable to their unlawful conduct. This has direct effects on their physical and psychological health. In conjunction with their economic instability this condition is a breeding ground for risky sexual behavior. Notwithstanding the actual illegality of soliciting commercial sex, evidence has shown that despite sex work's inherent necessity to consist of two parties, law enforcement officials routinely choose to ignore the criminal act of the male customer, while the female sex worker faces the consequences (see also Burris & Xia, 2009). The present study confirms this: sex workers' lives are fraught with extensive harassment and violence at the hands of the police and particularly unfavorable punishment in relation to their male customers.

Another substantial force affecting sex workers' lives is the interactions with their respective communities. Most participants described these relationships as largely dependent on whether neighbors know about their involvement in sex work. Many mentioned that their work attire signals their job to members of the community, while others indicated they have managed to keep their work private. A large majority of those whose community is aware of their occupation reported discrimination and stigmatization from neighbors. Others recited constant fear of involuntary disclosure. A number of participants recounted that they experience name-calling, including "husband snatcher," "a curse" for the family or the community, and "prostitute," on the streets of their neighborhoods. Some women explicitly articulated that their communities'

treatment affected their own self-esteem. Others mentioned that the discrimination extends to their children when other parents in the neighborhood prohibit their kids from playing or interacting with them. This underlines that the community's behavior towards sex workers can be a significant determinant of the well-being of their children. The systematic stigmatization of sex workers amounts to the community's large contribution to perpetuating the cycle of sex work. Through the internalization of their stigma, sex workers perceive low self-efficacy, which leads to increased risky behavior, and a reduced incentive to claim their basic rights:

“If even the perception the sex workers have themselves is that what they are doing is a bad thing, then some - because of the culture, the environment -, they will not come out to say they have been sexually harassed – they keep quiet. If they keep quiet we are not able to address (these violations)...it's a problem, we have to sensitize the sex workers, the community, and the law enforcers.”
(Director of PAMBAZUKO, November 5, 2010)

Competition, Cooperation and Networks

Amongst the participants patterns of competition as well as of cooperation were present. Every single participant confirmed that there is competition between sex workers: on the other hand, almost all (95.4%) said that they also interact and cooperate with other sex workers. Competition is largely about attractiveness (76.9%), followed by prices (41.5%), services offered (26.2%), sex workers' age (20.0%), and the social class of their clients (10.8%). Participants described their positive interactions with other sex workers as largely a source of exchange of experiences and advice. Many mentioned they

share negative experiences of violent customers with their fellow sex workers, mostly as a form of warning their friends and to discuss how to behave in problematic and dangerous situations. Others reported they confer about prices, services, dress codes, and how to deal with the police. More than half of all participants (55.4%) have not told their immediate family about their work, but almost all confide in their friends or co-workers.

Besides informal cooperation amongst sex workers, two support groups in Nakuru provide a chance for formal organization and support for sex workers. Of the sample pool, 46 participants (70.8%) were part of one of the groups. A large part of the program at the Family Health Option Kenya clinic is the peer educator initiative. FHOK, similarly to FAIR, initially identified sex workers at the hotspots of Nakuru and diagnosed that the women largely lacked basic reproductive health services: family planning, STI treatment, and access to condoms. Based on this needs assessment, FHOK devised a training program for the women focused on reproductive health to prepare them as peer educators so that they could train fellow sex workers. Via peer recruitment, the women can refer fellow sex workers in need of health services to the clinic for free services related to reproductive health, including special referrals for rape cases and gender-based violence. When prompted about the benefits of such a program, many participants explained that they learned about protection during intercourse and about recognizing and treating STIs. Some contextualized this in a deeper understanding of the importance of their own health and well-being. Moreover, participants mentioned

learning how to negotiate better with customers, and being trained as peer educators as a positive affirmation that they can fulfill a useful purpose in the community.

“I have understood how to use a condom correctly. I now know the importance of going for check-ups in case of any illness, and that when you are being raped you can use a spray, sand and throw it to the eyes of the person raping you. Since learning about the importance of my health compared with money, I have come to a decision that health is more important.” (Sherry, 42 years old)

Women elaborated on the role of sex worker collectives in creating a sense of solidarity; many reported that the group setting provided a safe space for sharing experiences of harassment, violence, and stigmatization to somewhat alleviate the psychological strain of their realities. Furthermore, out of the support groups sprang a few collectives seeking to collaborate in income generation: members of the FAIR initiative mentioned “merry-go-round” systems, a collective loan strategy where participants of a group contribute a set amount of money to the group every month, and all members take turns in benefiting from the overall amount. Collectives like this model provide economic opportunities to women, enabling them to take financial necessities into their own hands, such as paying their children’s school fees or paying a visit to the health clinic.

Wishes

In most accounts, two recurring themes were: participants feel widely misunderstood by their environment, and their behavior is justified by their conditions and should be respected. Many described their frustration at the common misconception about their reasons to enter the sex trade. For example, community members accuse sex

workers of choosing this type of work because they are promiscuous sex addicts, while almost every single participant (96.9%) stated that if she did not have to worry about financial means, she would stop her job as a sex worker immediately. In addition, participants feel unjustly judged and ostracized based on the nature of their job, with community members readily accusing the women of being “filthy whores” while the male demand side of the sex work equation appears to go largely disregarded.

“My Muslim community keeps telling me to stop working. But I tell them that I cannot – I need to feed my family!” (Eunice, 28 years old).

“Sex workers are just women like others. They just fetch men to feed their kids. The community should stop discriminating – they do not see the other side of the story.” (Elizabeth, 24 years old)

At the end of every interview, participants were asked to imagine that the police, their clients, and their communities were to get an education about the situation of sex workers. In describing some of their wishes about what this education should include, participants shared the following:

“I want the police to know that I am not doing this because I want to. It is a job, and the circumstances are forcing me to do it. They should not harass me in the street and not threaten me with their job, but pay me for the sexual services they demand.” (Lisa, 24 years old)

“I want the police to know: sex workers would prefer to sleep as well. But it is because of our problems that we cannot sleep but must work.” (Yolisa, 28 years old)

“My clients should understand that sex workers are human beings, so they must not be violent towards me. There is no difference between them and us prostitutes, and should learn to respect that.” (Esther, 24 years old)

“Clients need to know how to use a condom and why it is better to use them. Also, they need to understand that sex workers are not their wives. So when you see me with another man, do not accuse me - I am not your wife!” (Tanya, 35)

“The community should take sex workers as their own children, brothers and sisters because it’s not our fault. I would like my neighbors to trust that a sex worker can change and become a role model in the community and educate others about our experiences.” (Maureen, 26 years old)

Like many of the participants, one expressed particular gratitude and relief after her interview:

“Where have you been? No one ever asks us these questions, no one ever wants to know.” (Ann, 29 years old)

5 DISCUSSION

The present study shows that female sex workers in Nakuru are exposed to a wide range of risk factors because of their occupation. Their single marital status and a lack of professional opportunities exacerbate their state of financial deprivation. The nature of sex work subjects them to severe health risks, including STIs and strains on their mental health. Additionally, the women experience physical and psychological violence, including sexual harassment, abuse, and exploitation at the hands of customers as well as the police. The stigma of sex work exposes the women to social marginalization and personal humiliation, both in the private realm and the public sphere, at health facilities and in their home communities. These forces interact to put the women's safety at stake, yet they are scarcely considered by the police or community: reactions to these risks are not properly reflected in laws or policies.

In this discussion, I will examine two ecological forces in more detail: the law including legal enforcement policies, and stigmatization and its effects. Next, I will explain more explicitly the channels affecting sex workers' individual decision-making, especially those that force women in rural Kenya into the sex business in the first place, and those that drive them to engage in risky sexual behavior. Finally, I will generate a matrix for the ecology of risks facing female sex workers in Nakuru, Kenya, to summarize my findings.

With regard to the present study, two ecological effects merit detailed contextualization: the power of law and legal policies, and the role of social norms and stigma.

Laws and Legal Enforcement Practices

Legal policies and local enforcement practices are potentially strong determinants of health outcomes (Blankenship & Koester, 2002; Burris et al., 2004; Burris & Xia, 2009). Burris delineates clearly the differences between law “on the books” and law “on the streets” (Burris & Xia, 2009): the former comprises “formal, written, legal rules – statutes, constitutions and regulations – as well as court decisions interpreting the law” (Burris & Xia, 2009, 180). The latter includes “training, work rules, policies and standard procedures..., practices, knowledge, attitudes and beliefs of the line personnel who are expected to enforce the law” (Burris & Xia, 2009, 181). There is sufficient difference between the two concepts to call the process from one to the other “policy transformation” (Burris et al., 2004). The present study demonstrates the deleterious effects potentially produced in the process of such policy transformation.

To analyze these effects, first, it is imperative to look at the law “on the books” in Kenya. Although selling sex itself is not illegal, it is worth examining what activities involving commercial sex the Penal Code qualifies as felonies. Under the chapter on offenses against morality of Cap 63 in the Kenyan Penal Code, Sections 153 and 154 specify that every male or female person “who...knowingly lives wholly or in part on the

earnings of prostitution” or abets the sale of sexual services is guilty of a felony (Interpol, 2006). Furthermore, men who “persistently solicit...for immoral purposes” or “live with or [are] habitually in the company of a prostitute” may be charged with a felony (ibid.). In effect, while selling sex is not illegal, soliciting or abetting the sale of sexual services, and knowingly living on the earnings of commercial sex are illegal activities.¹³ The status of legality of commercial sex has a direct effect on the size of demand for transaction; studies have shown that higher levels of police vigilance and crack downs lead to decreasing numbers of potential customers. This means sex workers have to weigh their immediate economic necessity against the opportunity for another exchange more critically (Blankenship & Koester, 2002).

Second, the policy transformation process turns the procedure “on the streets,” into an arbitrary implementation that differs widely from their written formulation. As Burris & Xia find, “police generally have the discretion and the dexterity to deploy a wide variety of criminal and public order laws to accomplish their street control and public safety missions” (2009, 184). As the present study demonstrates, condoms are frequently used as evidence for commercial sex. Rather than reducing the amount of women who *knowingly* live on the earnings of commercial sex, the prospect of accusation mainly lowers women’s willingness to carry and use condoms (Lau et al., 2002). This

¹³ Interestingly, it appears that soliciting commercial sex as a woman is not illegal. This is likely based on the cultural norm and expectation that customers of sex workers are exclusively male. Some participants in the present study reported that women had asked them for sexual services, though only one participant stated that she provided such services to female customers. Most participants indicated they consider homosexual acts as “against God” or “immoral”.

directly increases their physical health risk. The example shows that legal policies can both directly influence the distribution of condoms among the population by determining their availability, and indirectly affect the possibilities of negotiation when they are available by making them a threat of arrest (Blankenship & Koester, 2002).

Furthermore, the policy transformation reverses the purpose of the written law when Kenyan police forces on the street exploit sex workers for their own sexual needs, demanding services for free. As echoed in this study, police in Kenya have shown little impunity in their interactions with female sex workers. Violence, coercion, and corruption employed to obtain free services and to negotiate freedom constitute a clear violation of the rights of Kenyan citizens. On the one hand, written laws on sexual abuse and rape dictate what constitutes a violation and ultimately, who can report one. On the other hand, local practices determine who will listen and whom will be believed. The extent and severity of policemen's impunity – in effect acting against the very laws they are charged to protect – as well as the generally accepted limited protection of human rights exacerbate the risk environments of sex workers, particularly with regards to HIV and STIs (Burris & Xia, 2009) as well as their emotional and psychological well being.

Moreover, the nature of criminal laws and enforcement practices can impede on the capabilities of public health care providers to assist sex workers because of the content of available interventions or prohibitions on who to serve (Burris & Xia, 2009). For example, strict restrictions on abortions drive the majority of procedures that sex workers require to terminate multiple dangerous pregnancies underground. While the

reproductive health consequences of complications of such unsafe abortions are injurious, many of them might be averted by a reformation of the legal framework.

Finally, both the official laws and the local legal enforcement practices have a significant impact on community values and can thus hamper or promote discrimination and stigma against sex workers. The code of conduct exhibited by the local police force can be a model to members of the community. Especially the level of impunity with which police perpetrates violence and abuse against sex workers affects the community through “social control strategies,” which increase stigmatization of sex workers (Blankenship & Koester, 2002, 553). As Miller reports from Sri Lanka, “the sex workers had no recourse when victimized, and the men on the street were well aware of this. This made the women safe victims of abuse” (2002, 1060). Thus, through official law-making decisions as well as local enforcement strategies there exists a “set of attitudes and practices that constitute a de facto regulatory system” (Burris & Xia, 2009, 186) of commercial sex, which starkly affects the lives of sex workers by condoning their victimization and stigmatization.

Stigma

Stigmatization of sex workers, partly exacerbated by injurious policing practices, is worth looking at in more detail to examine its power within the overall ecology of risks. Sex workers are often considered to be a particularly vulnerable sub-group of HIV and AIDS-related targets of stigmatization, even if individuals are not themselves HIV-

positive, since a “double stigmatization” can occur, where “female sex workers are marginalized even within an already lower prestige in-group of women in general” (Mayer, 2008, 20). For those sex workers who choose not to reveal their involvement in the industry to people around them, their “concealable stigma” (Mayer, 2008) bears the potential for additional anxiety given the burden of secrecy, which leads to heightened psychological stress (Quinn, 2009).

The origin of this marginalization reveals a story of social and cultural conditions of the place in question: “Stigma is deployed by concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality” (Parker & Aggleton, 2003, 18). In this present study, police forces and other deviant customers abused present inequalities to validate their own social standing to the detriment of the individuals dependent on the sex trade.

Equally discrediting sex workers’ value in society is the regular perpetuation by mass-media reinforcements of negative stereotypes of sex workers. Clay Muganda degrades commercial sex workers to “highway robbers” in the national Kenyan newspaper *The Daily Nation*, when he writes:

“Inasmuch [sic] as these young and old women who expose thighs that are big as their arms on our streets would want to claim that they are commercial sex workers, I want to differ, without begging, and simply call them highway, or commercial sex robbers...their supposed trade is illegal and, just like violent robbers who are not licensed to kill, they are not licensed to thrill...NGO-wallahs back them up by blaming the society in general, and men, who are the victims, in particular, yet we know that it all boils down to choice” (Muganda, C., January 10, 2011).

According to Goffman, the understanding of being negatively valued in society leads individuals to internalize stigma, suffering physical, emotional and psychological ill effects (1963). This internalization of stigma imposed on female sex workers often translates into shame, guilt, and self-hatred, themes that emerged in numerous interviews with participants of the present study. Their contrived self-perceptions can discourage women from claiming their basic rights, and can directly influence their health-seeking behavior:

“Women report that (stigmatization by the police) leaves them with the feeling that their lives mean nothing to police officers, which, in turn can lead to a sense of hopelessness and reduce their desire to take care of themselves including protecting against HIV” (Blankenship & Koester, 2002, 554).

On a broader level, social control strategies that seek to utilize stigma to undermine relationships amongst sex workers are at high risk of exacerbating health risks for the whole community. Police activities aimed at manipulating sex workers’ perceptions of one another and themselves in the community can “disrupt ... peer networks...causing individuals to take on new risks” (Blankenship & Koester, 2002, 553). As a solution, for some sex workers the act of confiding in a trusted person can begin to break the silence. Participants of the present study described their relief at having friends to talk to about their daily lives and challenges, especially getting mutual support from fellow sex workers.

Focus groups can serve to relieve stress, reduce the internalization of stigma, and thereby mitigate the impact that internalized stigma can have on sex workers’

willingness to engage in risky behavior. Many interviews mentioned health care providers as trusted contact persons. In fact, almost all participants indicated they feel safe to go to a health clinic when they have a problem with a customer. The clear distinction made by many participants between public and private clinics, however, is striking. No participant reported courteous treatment at government hospitals. This points to the importance and effectiveness of organized support groups for sex workers and of training for health staff on the intricacies of the particular psychosocial needs of sex workers.

Channels into Sex Work.

After illustrating the two broad forces of the law and stigma, I will now turn to Lewin's channel theory to elucidate in more detail the mechanisms through which the above-mentioned factors interact with others to affect sex workers' individual decision-making through various channels. Lewin underlines the inextricability of numerous forces pushing and pulling through various channels to produce individuals' behavior. First, this can be applied to understanding pathways into the sex trade. According to the participants' own evaluation, poverty – driven by various channels - is the main factor that incentivizes them to earn income through selling sex in order to support themselves and their families.

One channel comprises the women's current marriage status; none of the participants are currently married, which necessitates that the women generate their own income. Although more than half of the women indicated they have a stable, intimate,

non-paying partner, none of them rely on this partner for financial support. In fact, nearly all participants (92.3%) identified themselves as the head of their household. The lack of marriage as a source of financial stability for women bears strong cultural consequences, often including monetary implications. All participants reported that monetary scarcity impeded on their daily survival.¹⁴ Their traditional, economic dependence on husbands can drive women into sex work if they are unable to marry, survive their husband, terminate their marriage or do not want to get married (Agha & Nchima, 2004).

Another channel to economic deprivation, as some recounted, is a death in the family, often of a parent or a husband, which marked the starting point of their financial trouble. Laws regulating inheritance rights disadvantaged Kenyan women across the board until the passing of the constitutional referendum in August 2010. Prior to the referendum, the constitution hampered women's ability to inherit property or claim joint assets in the case of death (Association for Women's Rights in Development, 2010). In these cases, the responsibility to provide for themselves and their families was abruptly transferred to women without any legal framework for support.

From a socio-cultural perspective, strict customary duties of child-rearing constitute an additional channel leading to economic marginalization. While child-rearing is traditionally seen as a collective activity in Kenya, this applies mainly to the support

¹⁴ Those who did not head their own household considered a relative to be the head of the household, and out of these five participants, all but one indicated, too, that financial means are not sufficient to provide for basic needs.

from other females who are not the mother. Primary responsibility is bestowed on women, nonetheless, and the cost of childcare uniquely influences mothers' participation in market work (Lokshin, Glinkskaya, & Garcia, 2000) in Kenya as in other developing countries:

“Labor force participation rates of women with children are lower than they are for other population groups. Rates of male employment are significantly higher than the rates of female employment across all age groups. About 70 percent of men in 26-35 years age category work, compared with only 33 percent of women with children in the same age category. ” (ibid., 5).

Finally, the responsibility to support a child without the financial support of the father, caring for younger siblings or for elderly family members confers further economic strain on women, exacerbating the financial necessity to enter sex work (Agha & Nchima, 2004).

Geographic conditions constitute a channel to economic instability in three ways. First, the abrupt demographic transition of migrants often disrupts their financial security. Migrant women in Kenya who are separated from their families face additional vulnerability. For example, one participant in the present study, a Sudanese immigrant, had resettled in Kenya in search of a job to provide for her seven children. Without a husband or family, she turned to the only activity generating enough income to head her household. Finally, if household members in immigrants' country of origin depend on remittances being sent home, this increases monetary pressure on migrant women.

The second way in which geography affects financial means is the nature of tourist attraction sites. Although the present study does not focus on such a locale, places like the coastal city of Mombasa attract both hordes of foreigners and abundant local driver-tourguides. Sex tourism has skyrocketed on the Kenyan coast due to the high demand by Westerners. Given the prices tourists tend to pay, rates that are unparalleled by most local men, in conjunction with the scarcity of other job options available, working in the sex trade is economically more lucrative for women living in tourist regions (IRIN News, February 23, 2007).

Thirdly, the geographical location of Nakuru as a regional transport corridor of East African trade generates multiple hot spots frequented by truck drivers. These drivers are highly mobile, travel long distances and spend long periods of time separated from their families. These conditions are conducive to engaging in multiple sexual transactions while in stop-over towns along the way (Gysels, Pool, & Bwanika, 2001; Marck, 1999). On main passages crossing through Nakuru, such as Nairobi Road from East to West, or Solai Road from North to South, an abundance of female sex workers can be observed awaiting truck drivers as they halt for a break. Truck drivers' relative solvency make them a profitable target for sex workers, and a constant economic opportunity that is difficult to turn down.

Underlying all of the above-mentioned channels of pathways into sex work is the economic infrastructure on a national level: high national unemployment rates of 40%¹⁵ as well as gendered distribution of jobs exacerbate the lack of economic opportunity in Kenya. These channels provide a departure point to understand the lack of economic means and opportunity, which incentivizes women – especially the rurally situated, single-earning mothers of the present study – to earn income through selling sex.¹⁶ The women indicated almost unanimously that they would like to stop their work immediately if it were not for their financial concerns.

Channels into Risky Behavior

Various channels lead to conditions conducive for sex workers to make the decision to prioritize risky sexual behavior over their personal physical and psychological health and well-being. One channel is the perceived cash incentive. As has been shown in other studies (Rao et al., 2003; Gertler et al., 2005; Ntumbanzondo et al., 2006), almost all participants of the present study indicated that riskier sexual behavior generates more money. This extra cash offer incentivizes a sex worker to engage in risky practices, including unprotected sex. Within this economically-driven channel, income compensation of health shocks is one particular force pushing sex workers into risky sexual behavior. Robinson & Yeh found that sex workers' willingness to engage in

¹⁵ Estimated for 2008, CIA World Factbook

¹⁶ Two women confirmed financial difficulty, however not to obtain basic needs but to be able to match friends' dress codes and expensive life styles.

certain practices is significantly dependent on unexpected health shocks such as a household member falling ill (2011). They found the following reactions of sex workers to such health shocks:

“Women are 3.1% more likely to see a client, 21.2% more likely to have anal sex, and 19.1% more likely to have unprotected sex...in order to capture the roughly 42 Kenyan shilling (US \$0.60) premium for unprotected sex and the 77 shilling (US \$1.10) premium for anal sex” (Robinson & Yeh, 2011, 36).

Robinson & Yeh argue that as a measure of consumption smoothing to compensate for the income shortfalls incurred by health shocks in their home, the sex workers engage in sexual behavior that is better compensated but riskier and more unpleasant. Some participants in the present study reported similar behavior:

“I had sex when I didn’t want to three times this month because my mother was sick, so I had to force my body to do it.” (Joyce, 35 years old).

Another channel leading to risky sexual behavior is comprised of social norms and the expectations they elicit. An anonymous Nairobi-based sex worker who blogs at *Nairobi Nights* puts it poignantly, when she writes: “On the social scale prostitutes are ranked lowly; somewhere near the proverbial alley cat which can’t tell who fathered its kittens” (Nairobi Nights, January 3, 2011). As exemplified by responses in the present study, overarching societal judgment of sex work as an immoral activity colors the expectations of both customers and sex workers themselves. As one participant reported:

“Some customers say ‘You are a prostitute, you’re not supposed to be paid, you’re supposed to be used.’ (Ruth, 24 years old)

Most participants unambiguously recounted that their interactions with the police were permeated with corrupt demands for bribes and sexual intercourse as well as harassment, abuse and humiliation. A small number of women, however, reported similar patterns but chose not to describe their interactions as explicitly negative. In fact, their descriptions seemed to be based on their expectations to receive such violent treatment in the first place. Their expectations led them to describe their interactions as “not bad” because, while violence and arrest are rampant, sex and money are means of negotiation with policemen. Such socialized norms and expectations lead sex workers to assess a situation as less dangerous, and to assume that the risky behavior, such as unprotected or anal sex, is expected and “normal” for a sex worker to engage in.

Lastly, local policing practices are another channel creating conducive conditions for sex workers to engage in risky sexual behavior. The corruption and abusive treatment described in the present study hinge on the authority underlying the police’s unlawful conduct. Their impunity creates the conditions for risky sexual behavior. When an officer demands unprotected or risky intercourse, the sex worker makes her decision not only based on an increase of her income, but to negotiate her basic freedom and to forego violence. The anonymous *Nairobi Nights* blogger extends her metaphor of social hierarchy to the police as well (*askari* = Swahili: soldier):

“But if prostitutes be the alley cats then the city council *askari* are the alley mice....it’s a feeling encouraged by the dismissive and you-are-not-human beings way the *askari* treat us....Unfortunately for now they have more ways of getting back at us than we have of them...(they have) the handcuffs, whips, guns, cells and when necessary the law” [*sic*] (Nairobi Nights entry, January 3, 2011).

Most customers who demand dangerous sexual practices by forceful means remain exempt from punishment. While sex workers regularly experience violence and rape (71.9% and 58.7% respectively), the majority (64.5%) does not feel safe to report such incidences.

“My friend had one experience when a man came in looking very nice...he had a briefcase and a suit. After an agreement on the price they went to a room. He removed his clothes, and...she was very surprised because he had wounds all over his body. The customer demanded only sucking, no sex. My friend didn’t want to suck him, because even the penis had wounds. But suddenly, he pulled out a gun and threatened to kill her. So she had to suck him... She was afraid the next day that she was sick, so she went to the doctor. After several visits, she found out she had been infected with HIV.” (Ruth, 42 years old)

I have discussed three channels that lead to conditions conducive for sex workers to engage in risky sexual behavior. Economic necessity leads sex workers to react to the extra cash incentive of high-risk sex, at times as a coping mechanism in reaction to health shocks. Social norms concerning sex work create expectations, both in customers and in sex workers themselves, that alter the women’s perception of danger in risky situations. Finally, local policing practices provide a channel through which the impunity of individual customers and members of the police force condones risky behavior. Scott Burris aptly summarizes the inextricability and relationships of cause and effect between the forces and outcomes I have discussed above:

“From the point of view of social epidemiology, a society’s pattern of ill health is a mirror: disease reflects how a society produces and distributes wealth, creates conditions for human health (or its antithesis), constructs social norms, and organizes its peoples and communities.” (2002, 505)

In Table 5, I have summarized my findings to visualize the ecological approach towards risk factors affecting sex workers' behavior.

Limitations of the Study

There is a host of challenges involved in research with marginalized, vulnerable populations, especially sex workers. Given its underground character, the true size of the overall population of sex workers remains uncertain, which makes it difficult to find a representative sample. The present study, too, does not constitute a representative example of sex workers in all of Kenya. Furthermore, the current legal status of commercial sex in Kenya renders members of the sex industry vulnerable to stigma and safety concerns, which might have prevented some women from participating or impeded on the reliability of their answers in order to maintain privacy. Automatically, this means the methods of recruitment I employed yielded participants who were more cooperative, and felt less at risk of any consequences.

Table 5: Summary of Findings: Ecological Risks of Female Sex Workers in Nakuru

	Micro Level	Macro Level
Background	<ul style="list-style-type: none"> ★ Low educational qualifications ★ Unmarried ★ Head of household, income generator ★ Economic insecurity 	<ul style="list-style-type: none"> ★ High unemployment ★ Necessity of income generation ★ Migration
Pathways	<ul style="list-style-type: none"> ★ Divorce ★ Death of a family member ★ Pregnancy ★ Encouragement by others for the sake of economic benefits 	<ul style="list-style-type: none"> ★ Cultural and economic consequences of lack of marriage ★ Lone responsibility of child-rearing ★ High demand for sex work
Health	<ul style="list-style-type: none"> ★ Vulnerability to STIs including HIV ★ Exposure to physical and psychological violence 	<ul style="list-style-type: none"> ★ Negative attitude and insufficient training of local clinic health staff ★ Inadequate availability of protection methods
Practices	<ul style="list-style-type: none"> ★ Lack of decision-making power in matters of financial negotiation, protection, risky sexual practices 	<ul style="list-style-type: none"> ★ Exploitation and abuse by customers and police forces ★ Higher compensation for riskier sex
Community	<ul style="list-style-type: none"> ★ Stigmatization and ostracization of sex workers and their children by neighbors 	<ul style="list-style-type: none"> ★ Gender and social inequalities ★ Negative community attitudes towards sex work ★ Taboo on discussion of sexuality ★ Negative connotations with protection methods ★ Tacit condonation of violent treatment of sex workers ★ Tacit treatment of community-wide gender-based violence, including rape
Policy	<ul style="list-style-type: none"> ★ Availability and distribution of condoms ★ Illegal tactics by local law enforcement when upholding laws on commercial sex 	<ul style="list-style-type: none"> ★ Laws governing commercial sex ★ Laws governing sexual assault and rape ★ Laws governing inheritance ★ Laws regulating alimony ★ Informal regulation of police treatment of sex workers ★ Impunity of local enforcement forces

6 POLICY CONCLUSIONS

This paper demonstrates that by and large, social determinants of inequality are the driving forces behind the ecological risks of female sex workers in Nakuru, Kenya. I hereby echo a number of similar academic works that have outstripped interventions in their recognition of the significance of contextual factors in health. Any health-related intervention must place emphasis on the inequalities and underlying structures perpetuating them and more studies must research these forces and examine how best to address them. An ecological approach to the behavioral forces affecting sex workers must guide policy both to increase the effectiveness of efforts to control disease, and to realize the basic human rights of sex workers. To this end, I reach the following policy conclusions.

Laws and Legal Enforcement Practices

Given the current interaction of the laws on commercial sex and the implementation of these policies, the Kenyan government must review the efficacy and negative effects of this legal framework. In its current permutation, it has deleterious effects on the lives of Kenyan citizens who are involved in the sex trade, especially female sex workers, and it simultaneously hampers efforts to address HIV and AIDS in the communities (see Blankenship & Koester, 2002).

While decriminalization might be unrealistic in Kenya at this time, reviewing the legal policies should include a reconsideration of the overall legality of commercial sex.

There has been considerable debate about the unique Swedish legal approach to the sale of sexual services, which criminalizes sex workers' clients, as well as about the legalization and licensing of commercial sex in the Netherlands (Norwegian Ministry of Justice and Police Affairs, 2004). Some research suggests that decriminalization is correlated with better coverage of health promotion programs for sex workers (Harcourt et al., 2010). However, to be sure to maximize positive outcomes with a view to safeguard the human rights of Kenyan citizens and to improve HIV prevention efforts, more rigorous population-based research in Kenya is needed.

Another pragmatic way to address the injuriousness of the law is by addressing its implementation, particularly local policing methods. Specifically, the abuse of power to elicit gratuitous sexual services and the impunity of gender-based violence perpetrated by authorities need to be addressed. Workshops and trainings for the police should be held to establish standards of conduct that clearly condemn such violence given its detrimental effects on the individual lives of sex workers and the larger community. Given that policemen's solicitation of commercial sex puts them at heightened risk for health issues, contributes to corruption, and undermines the authority of the law, it is in the police's interest to address this issue. Most importantly, mechanisms to monitor closely the enforcement practices of police officers, including credible threats from superiors to impose sanctions such as docked pay and discharge from service, can go a long way in eliminating procedures that seriously compromise sex workers' security and autonomy.

Under no circumstances should condoms be used as evidence to prove commercial sex. Firstly, this strategy directly undermines the importance of protected sex outside of the sex work industry. Secondly, such a practice explicitly discourages sex workers from obtaining, carrying, and using condoms. Condemning the possession of condoms as a form of local regulation has significant negative implications for the spread of HIV; it puts the health of both sex worker and customer at risk and directly fuels the spread of sexually transmitted infections (STIs) and undermines efforts to address HIV. The perils of such an approach to condoms must be included in police trainings, and measures monitoring police behavior must undercut its practice.

An example of effective police training to counteract violence and risky behavior comes from the Transex Project, an intervention with sex workers in Papua New Guinea. Formative research for the program revealed that sex workers' greatest concern was being gang raped by the police, a practice known as line-ups. In reaction to this, the Transex Project ran a focused one-year program targeted at police officers and their wives, educating both on the conditions of sex work and the perils of engaging in risky behavior, especially with regard to exposing the wives to a higher disease risk. High-ranking police authorities were included in the peer education and encouraged to take a lead in stemming the violence perpetrated by their subordinates. Together, education and domestic pressure from both their wives and superiors led police officers to reduce violence against sex workers in PNG (UNAIDS, 2000b). More large-scale efforts to

sensitize national police forces have been initiated by the Delhi State AIDS Control Society in India, and the Nepal Police Work Plan (see Project Parivartan, 2006).

Health Services

Providing adequate health services to sex workers and their families is imperative to countervail their heightened vulnerability to STIs, poor psychological health, and various forms of violence, and to realize their basic human right to health and well-being. This must include access to comprehensive sexual and reproductive health services, primary health care, psychosocial support, and specialized responses to rape and other forms of gender-based violence. Given sex workers' economic instability, this care must be made affordable. Programming similar to Family Health Option Kenya's free health care provision for sex workers, which incorporated a peer education scheme (trained sex workers educating other sex workers), provides sex workers with sexual and reproductive health services they desperately need to protect themselves at work.

Since sex workers react to household illnesses of family members by engaging in sexual behavior that is better compensated but riskier, such health shocks could be thwarted by health interventions aimed specifically at children and other family members of sex workers. Subsidized health care for dependents of sex workers is likely to increase their ability to cope with direct financial risks better (see Robinson & Yeh, 2011).

Condom provision through clinics and NGOs should be continued and the community outreach strengthened. National campaigns should place condoms in places more readily accessible for sex workers and clients, such as bathrooms of bars and hotels. In addition, police stations might consider becoming distribution points for condoms. Such support by the police would likely inhibit police practices targeting carriers of condoms, and encourage health-seeking behavior in the entire community, potentially reducing the negative association of condoms with sex work.

Finally, local health service providers need to be educated on sex workers' comprehensive ecology of risks, with a special focus on their sexual, reproductive and psychological health needs. Diagnostics and treatment of STIs must be a focus, as should training in competent and compassionate care for sexual assault survivors to provide adequate gynecological services and avert stigmatization. Sex workers should be consulted prior to such education efforts to help health workers understand their daily realities.

Direct Aid to Sex Workers

Education of sex workers about their own health, rights, and opportunities must be continued and expanded. This should include information on the benefits of using protection with non-paying partners as well. The system of peer education serves the dual purpose of putting an individual sex worker in a position where she perceives herself to be valued, while at the same time multiplying the reach of the educational training

devoted to her by providing this to other sex workers at a low cost. The knowledge and responsibility bestowed on the peer educator has the potential to help revitalize her self-efficacy and validate her utility to the community. Continuous follow-up sessions for all peer educators with trainers and health educators can reinforce a thorough understanding of the learned material, bring health-related facts up-to-date, and support effective dissemination to the sex worker community by counteracting any involuntary distortion of critical information.

Sex workers are at risk of internalizing the stigmatizing beliefs about them that are held and expressed by others. For example, sex workers might internalize the common belief that they have no rights and deserve to be used and abused, leading them to engage in more risky behavior. Messages like these can be fought on symbolic and material grounds simultaneously (Cornish, 2006): on the one hand, the symbolic claim that sex workers do, in fact, have rights is important for the women to conceptualize on an abstract level to internalize that they deserve better than the stigmatizing beliefs suggest. On the other hand, material alternatives to circumstances that feed these beliefs can challenge sex workers' stigmatization on a practical level: giving legal support to sex workers offers a tangible alternative to being left without the protection of the law, establishing that sex workers' human rights must, indeed, not be violated.

Workshops on gender-based violence specifically must be expanded. These workshops should include information about the Kenyan laws on sexual harassment, assault and rape, sex workers' rights to report such violations, and procedures for

reporting both in a health facility and at a legal authority. Again, including the police in such efforts can be essential to their effectiveness. An intervention scheme in the UK involving the police and sex worker outreach agencies was successful in increasing the reporting of violent incidents with customers, and in reducing the overall amount of violent incidents. Outreach workers were able to educate officers to better understand violent experiences of sex workers and to emphasize the need for support by the police in prosecuting the perpetrators (Penfold, Hunter, Campbell, & Barham, 2004).

Additionally, self-defense training might be offered for sex workers in particular, as well as the wider community. Programs offering free karate training for sex workers in the southern Indian state of Tamil Nadu reportedly boosted women's confidence and reduced their feeling of helplessness in the face of customer violence (BBC News, June 10, 2009).

Support groups can facilitate solidarity amongst sex workers with numerous positive outcomes. They can provide a safe outlet for the psychological stress of sex work and encourage cooperation instead of competition. Groups should facilitate the mobilization of sex workers around their needs and advocate for sex workers' inclusion in program and policy-making. The Sonagachi Project exemplified the unison and efficacy that sex worker support groups can generate amongst an otherwise scattered and marginalized group of the population (Basu et al., 2004).

Finally, economic support of sex workers can have a direct impact on the spread of disease. Based on the observation that sex workers lack basic formal and informal

means of coping with their vulnerabilities, providing them with mechanisms to cope with such risks could considerably improve sex worker welfare, and curb the spread of HIV (Robinson & Yeh, 2011). Collective loan strategies such as merry-go-rounds, where pooled money is given to one member of the group on a rotating basis, or specialized vocational training can break the cycle of dependency on working in the sex industry. Loans from merry-go-rounds have been effective tools for women residing in the Kibera slum of Nairobi to afford health care, schooling for their children and food for the entire family (IRIN News, April 13, 2010). This economic emancipation will increase sex worker's autonomy to choose not to engage in risky sexual behavior, with obvious positive externalities for wider public health.

Community-level Awareness

At the community level, two layers need to be addressed specifically. First, clients or potential clients of sex workers should become the focus of disease prevention efforts. That is, men should be held more accountable for contributing to the transmission of disease in the sex trade. Since the decision to use protection to minimize infections lies largely with male customers, men in the community should be educated especially on the importance and benefits of protection. Key client populations at higher risk, such as truck drivers, must be particular targets. A review of interventions for truck drivers suggests that efforts to increase sexual health-seeking behavior and condom use

are more effective than those seeking to reduce the number of sexual partners, as exemplified by the successful model of the Indian Free Tea Parlors (Marck, 1999).

Second, the wider community must be educated on the realities of daily sex work to effect change with regards to hostile attitudes. Sensitization campaigns seeking to eliminate stigmatization of sex workers must stress, amongst other things, the detrimental consequences of the tacit acceptance of gender-based violence. Moreover, they should debunk myths associated with sex work, raise awareness about the multitude of risk factors and educate on basic human rights of all citizens, including sex workers.

To this end, religious leaders could be mobilized to foster respect for all citizens amongst their respective communities. A study of church involvement in HIV prevention in Los Angeles concluded that religious leaders are promising avenues to engage the congregation in reducing stigmatization by the community (Derose et al., 2010). Similar research in Ghana showed that hearing a religious leader speak about HIV has a large effect on the provision of support by the community to people living with HIV (Bazant & Boulay, 2007).

Research

Research into any of the discussed forces and risk factors will shed further light onto how best to address them, and to monitor and evaluate such interventions. For example, studies could explore the exact determinants of police behavior towards sex workers, the impact of negative attitudes and arrest quotas, and specifically how sex

workers tackle police interference (see Burris & Xia, 2009). Similarly, more research is needed on the origins and role of stigma and how to best combat cycles of stigmatization and discrimination. Research on the diverse sexual cultures of key client populations at higher risk, such as truck drivers (Marck, 1999), needs to be carried out to inform the design of effective interventions. Moreover, research is needed to evaluate the impact of the interventions suggested above, including methodological designs that allow for causal inference, adequate indicators and long-term follow-up, to establish a record of best practices and to facilitate evidence-based policy making in the future (UNAIDS, 2000b).

Finally, in accordance with the main underlying argument of this thesis, it is imperative to understand the comprehensive ecological context of the sex worker populations targeted in any intervention and in any research endeavor. Female sex workers in rural Kenya were the focus of this study, but different combinations of risk factors are likely to apply for male or transsexual sex workers, as for sex workers in different countries. While there are similarities in risk patterns within groups and cross-nationally, the importance of regional socio-economic, political and cultural conventions should be studied and addressed.

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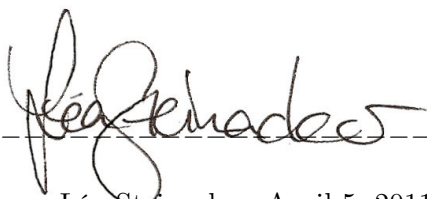
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Personal Interview with Zachary Kayah (November 5, 2010). Director of PAMBAZUKO at Family Aids Initiative Response.

This thesis represents my own work in accordance with University Regulations.

A handwritten signature in black ink, appearing to read 'Léa Steinacker', is written over a horizontal dashed line. The signature is fluid and cursive, with the first name 'Léa' being more prominent.

Léa Steinacker, April 5, 2011