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Stigma to Sage: Learning and Teaching Safer Sex Practices Among Canadian Sex Trade Workers

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Introduction

Through the incorporation of a broad definition of safer sex to include physical, sexual and emotional aspects of prostitution, the study investigated how Canadian prostitutes acquire a working knowledge of safer sex practices and what that knowledge constituted by way of specific practices in learning to establish their autonomy and work safely (Hanson et al: 1995).[1] Utilizing feminist standpoint theory that takes women's experience to be an entry point for investigation and places a high valuation on women's strengths and capabilities, the practices of sex workers became the site of investigation of political struggle and a possible source of social change (Smith:1974, 1987). Divergence based on race and class established meaning of difference in addressing the specific interests of various subjects (Ng:1986; hooks:1990). Feminist standpoint theory was linked with experiential adult education theory to establish (a) how sex workers learn and to what extent they practice safer sex (b) whether it was possible for sex workers to function as pedagogical models in the transfer of skills and knowledge and (c) if the process of practicing safer sex provides agency and empowerment that could reframe sex work from a discourse of disease and deviance to one of knowledgable sexual service work.[2]

Interviews were conducted with 37 female and transsexual (male to female) sex workers in four cities in Canada. Ethnographic data was obtained in semi-structured interviews, open ended discussions and supplemented with the researcher's observations and interviews with other participants in sex work culture, medical personnel, community workers and policy experts. Experienced women as well as those new to the industry were interviewed within a variety of genres including street workers, brothels, massage parlours and incall-outcall escort services. Individual sex workers and representatives of sex workers' collectives were asked to serve as consultants to provide information, critique the analysis and assist in formulating recommendations.

The Historical Framing of Sex Trade Work

At the turn of the century, religious groups viewing prostitution as "sin" and feminists constructing prostitutes as victims suffering from venereal diseases focused the attention of the state on sex work (Hart:1977; Meaghan:2000).[3] Legislation was implemented to control working conditions and to protect the interests of clients, often at the expense of scapegoating sex workers. In what Max Weber referred to as a "rational" approach of bureaucracy, the culturally conservative framing of the state dealt with infection through medical discourses and deviance through community and religious interventions. The prostitute was classified, managed and treated in an effort to rehabilitate individuals and to respond to the moral panic in the culture (Bell:1994). Although the concept of "sin" was later replaced with a medical model of disease, a particularly compelling connection was established between infection and sex work that pathologized prostitution as a social problem. The problem of sex work was the problem of the sex worker, typically viewed as a victim of sexual abuse, disease and drug addiction that rendered prostitutes personally problematic and politically passive (Lerum, 1999:8-10).

Western government policies and practices encompassing prostitution were structured around elements of fear and danger that reinforced a negative view of sexuality and did not encourage sexual autonomy and pleasure (Pheterson:1989; Overall:1992; Anthony:1992). The focus was on the stigmatization of those who performed this kind of work and the health issues concerned with prostitution.[4] Viewed as "reservoirs of infection", sex workers were blamed for disease and disorder in society; rarely were they viewed as individuals possessing a specialized knowledge that could be useful in informing others about safer sex practices and sexual agency. Casting sex workers in medical, scientific and popular discourses as the focus of a social predicament resulted in their alienation from mainstream society. Lacking access to conventional cultural ways of contributing to the production of forms of knowledge supplanted the sex worker's experiences and curtailed the introduction of a sex worker discourse to compete with scientific and professional ideologies (Delacoste and Alexander:1987). As a result, policy makers and social service agencies were viewed with distrust and rarely collaborated with sex workers to foster a more complete understanding of safer sex practices.

By the late 1980s, Canadian health officials became concerned that the proportion of AIDS cases among adult women was increasing over time (Health and Welfare Canada:1991). The Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS) as well as other Sexually Transmitted Diseases (STD) were determined to be associated with similar risk behaviours.[5] UNAIDS reported that AIDS was the leading cause of death among women of childbearing age in many cities in Europe and North America (Wilton, 1994:89). Women were seen to be in danger of contracting HIV infections through unprotected sexual intercourse and infected blood (Panos Institute, 1990:12). The rate of AIDS cases among women equalled that of men by 2000, affecting some 6 to 8 million women worldwide (Schneider and Stoller, 1995:106; United Nations/World Health Organization:1999). Upon adopting the World Health Organization Global AIDS Strategy, Health and Welfare Canada initiated preventive, educational, supportive and treatment initiatives for the women and children who were increasingly at risk (Health and Welfare Canada:1996).[6]

Policy and planning concerning HIV/AIDS employed a heterosexual male "norm" in the AIDS discourse that constituted the male body as the recipient of a disease, conceptualizing seroprevalence initially in gay men and later including female sex workers (Patton, 1994:8).[7] Conflating sexual activity with disease transmission, a stigmatized lifestyle characterized by excessive sex and drugs was seen as the etiological basis of sexually transmitted diseases (Oskamp and Thompson:1996).[8] The notion that people who acquired HIV/AIDS had been intemperate provided heterosexual women engaged in non-commercial sexual activities with a false sense of security. A risk-based, intervention approach was adopted that stereotypically

blamed deviant subcultures consisting of "high risk" individuals while correspondingly insisting on their invisibility in society (Davis and Shaffer, 1994:2).[9] Concerns about sex workers as a source of infection surfaced particularly for heterosexual men, masking the real risks posed to sex workers by clients (Brock:1998). The simultaneous blaming of sex workers, dismissing

women's health needs and failing to acknowledge that opportunistic infections differ in women from men, obscured the rapid increase in female rates of sexually-related infection.[10]

Commercial Sex Work and Safer Sex Practices

Studies in Western nations including Denmark, Switzerland, Great Britain, Australia, New Zealand and the United States have found that female sex workers have remarkably high levels of condom use and low levels of HIV/AIDS infection (Darrow:1992; Morgan Thomas:1992; Fraser:1995).[11] Seroprevalence HIV rates were found in a United Kingdom study to be 5.7 percent among sex workers and 5.8 percent among non-sex workers; in both groups infection was associated with injection drug use or among women who had an ongoing relationships with men who injected drugs (Cohen et al:1989).[12] Canadian sex workers have similarly been found to more consistently use condoms than other populations comparable in age, race and sex (Bastow:1995). The U.S. Department of Health (2001) has invariably reported that 3-5 percent of sexually transmitted diseases are related to sex trade work, compared with 30-35 percent among teenagers. In the largest epidemiological study conducted by the Centers for Disease Control and Prevention (1989), it was found that HIV infection rates were low among female sex workers with no proven cases of HIV transmission from sex workers to clients (Blackfield Cohen and Alexander, 1996:199).

Such studies confirm that female sex workers are not the major source of HIV/AIDS, since they are more likely to adopt preventive measures such as using a condom for vaginal sex and not engaging in kissing (thought to be a health risk for Hepatitis A, Glandular Fever, Herpes and Meningitis). They also perform fellatio (widely considered to be a low-risk activity), rather than exclusively engaging in intercourse and rarely engage in anal intercourse (Patton, 1994:20). Elieson (1992) observed that men who were identified as clients of female sex workers had twice the rate of condom use of clients who had sex with male sex workers. Day (1993:360) reported that among men in London who had sex with female prostitutes, 43 percent also had sex with men, 18 percent did not consistently use condoms and 2 percent had injected drugs. Clients rarely acquired a social identity as did sex workers, however, nor were they condemned for the spread of diseases, targeted with STD prevention initiatives and confronted with legal restraints. Given the significantly lower rate of female-to-male transmission of HIV/AIDS and the eagerness to use prophylactics displayed by sex workers, the risk to clients was found to be negligible (Padian et al:1991).[13]

In contrast to the repressive/censorship position that dominated the sex debates during the past two centuries, sex workers argue for diversity, choice and the primacy of pleasure (Rubin:1984; Valverde:1989).[14] To be successful in their occupation, they develop techniques which minimize danger and promote safer sex practices (Meaghan:1989; Hanson et al:1995). Since sexual self assurance and control are key considerations for sex workers, the majority learn safer sex alternatives such as frottage ("body slides") and masturbation ("hand relief") through mentoring, apprenticeship and peer education (Hanson:1997a). A study conducted in the United Kingdom found that one third of clients reported learning about STD risks and safer sex

practices through association with prostitutes (Panos Institute, 1990:91).

Professional sex workers with expertise, a strong commitment to long term work and the greater likelihood of being able to persuade clients to accept condom use are less likely to be HIV-infected than novices; both groups may be at greater risk of other STDs if they are street workers (Cohen:1992:76-7).[15] The ratio of on-street to off-street sex workers varies with geographic location, laws and customs, but usually accounts for approximately 10-20 percent of the female sex workers in North American cities (Shaver:1993). Sex workers make distinctions between work and personal relations; generally they do not perceive that they are at risk in the latter relationships. They are no more likely than other women to use protection in their personal relationships and they as likely or more vulnerable to be subjected to domestic violence (United States Department of Health:2001:4).

Police surveillance and apprehension impedes the development of safer sex practices and increases the danger particularly for street workers, since working safely cannot be established in an atmosphere of fear and stigmatization.[16] Legal restrictions render women more vulnerable to client pressure for unprotected sex in exchange for additional remuneration (Alexander:1990). Criminalizing sex work results in women being driven into poorly lit and deserted areas of work and being less able to report and seek prosecution if they are subject to abuse by their customers. Since the sex worker's fear of arrest is paramount compared to issues of health and safety, women who must negotiate quickly are less able to evaluate the health status of their clients. Stigmatization interferes with promoting safe sex by driving sex workers underground without legal recourse if they are physically assaulted or robbed. Marginalization increases the likelihood that impoverished women (the homeless, those injecting drugs or heavy users of alcohol) will be pressured into "barebacking" as a form of survival sex (Brieseman, 1999:8).[17]

Commercial sex work with an emphasis on autonomy and consent need not be risky – coercion and abuse are components of specific human relations in a context of illegality.[18] Some sex workers describe violence in the form of verbal abuse, assault and coercive sex that restricts their capabilities to protect their health and safety (Bernard, 1993:684). The U.S. Department of Health (2001:2) reports that among street sex workers, 80 percent have been physically assaulted. The study indicated that 60 percent of abuse was perpetrated by clients, 20 percent by the police and 20 percent in domestic relations. The mortality rate for females in prostitution is 40 times that of the population at large (Davis and Shaffer, 1994, 10). Among men who are HIV positive and those who have committed date rape, it is not surprisingly to find that they are less likely to practice safe sex (Gorna, 1996:282). Rendering women more vulnerable through increased penalties and the establishment of a criminal record further reduces employment opportunities for those who leave the industry.

Learning to Work Safely in the Canadian Sex Industry

Subjects in this survey ranged from 18-38 years of age (with a median age of 26 years),

generally were unmarried, mostly educated at the high school level and had previously been engaged in sales, clerical and factory work. The majority had worked for five years or less in the business with three-quarters employed in brothels, escort agencies and as independents. Slightly more than one half of the women had children and approximately a third were living with a spouse or co-vivant. A significant number reported that they routinely had voluntary health checks for sexually transmitted diseases. Eight percent reported contracting gonorrhoea, 6 percent reported contracting chlamydia, 7 percent reported contracting genital warts, 6 percent reported contracting Hepatitis B and 4 percent reported contracting pelvic inflammatory disease (rates consistent with the general population). Approximately one half the sample had been charged with prostitution-related offenses and 38 percent reported being physically or sexually assaulted in the course of their work.

There was a range of knowledge and skills among the women interviewed. One young woman who was working in an Edmonton park suggested that HIV/AIDS was a genetically inherited disease. At the other end of the continuum, a very savvy and sophisticated woman working out of a luxury hotel in Toronto boosted that she was able to put a condom on clients with her mouth and without their knowledge. Typical of the women in this survey, Sandra, a middle-age, Caucasian woman working for six years with an out-call, escort service in Hamilton remarked that unlike women in the population at large "prostitutes screen clients and set limits concerning the acts they will perform".

The vast majority of women in this study exhibited high levels of knowledge and efficacy regarding safer sex practices. Every woman surveyed was knowledgeable about the risks of venereal diseases, the technical use of condoms, the need to utilize nonpenetrative sexual techniques, the necessity to negotiate with clients and the desire of self control related to the use of drugs and alcohol. The most common sexual activity they engaged in was oral sex and the least common was anal intercourse; these activities were rated as least and most unsafe. With the exception of one woman, all were aware that the HIV/AIDS virus was concentrated in bodily fluids, people can transmit STDs who do not appear ill, washing prior to sex does not significantly reduce the risk of STDs and people at risk of contracting STDs have unprotected intercourse with an infected partner.

While working in a brothel, Sarah learned how to use latex condoms, combining them with water-based lubricants such as K-Y jelly and spermicides (containing nonoxynol-9) while maintaining spontaneity and sexual arousal. Servicing five to six clients a day in a five-day work week, she is comfortable in demanding a safe sex norm in her workplace. At times, she will diplomatically quiz a client about his sexual past and initiate discussions concerning risk reduction in a way that does not cast aspirations on the client. The negative aspects of condom use are overcome by demonstrating "caring and concern" for both parties and making the condom into a fetish object as part of foreplay. Without fail, she will hold the rim of a condom carefully while withdrawing a flaccid penis after ejaculation. Her negotiation skills and communication abilities help her to resist the pressure to engage in unprotected sex, use drugs

recreationally or have anal intercourse. Stating that she has instructed other sex workers and clients who do not attend health clinics about safer sex practices, she stresses the importance of clarify her position with clients, refusing to comply if pressured for sex without a condom and

seeking agreement when suggesting alternative safer sex behaviours. When questioned as to whether she had ever been approached by health officials in her area to serve as a community sex worker, she laughingly replies that "you are dreaming in colour if you think medical people would work with us".

Vaginal sex formed 63 percent of service to clients, oral sex 21 percent, masturbation 13 percent and anal sex was not reported as a service provided by women in this survey. All the women described using male latex condoms (although not with 100 percent consistency) together with water-based lubricants. A few reported using female condoms (Femidom) with a variety of lubricants. Variance in condom usage ranged from 92 percent among street workers to 95 percent for women in brothels and escort services. Most women recounted successful condom use with few incidents of breakage. They described a 92 percent rate of condom use for vaginal sex, 87 percent for fellatio and 17 percent for masturbation.

Tanya, a young Black woman, working in a Toronto massage parlour suggested that the best way for her to be protected was to quickly take the lead in an encounter. She establishes authority by controlling the conversation and maintaining eye contact. Emphatically stating that she is paid for specific acts and not the general use of her body, she encourages the client to state what sexual services are desired. She sets boundaries by insisting on negotiating specific acts and she retains the right of veto over acts she is unwilling to perform. Relying on her intuitive skills, she makes a series of quick decisions relating to issues of health, ability to pay and safety. Nor does her attentiveness cease when business is concluded; each step of the encounter is scrutinized and if danger seems imminent she will terminate service. Clients who have poor personal hygiene are enticed to engage in a sexual fantasy that includes a shower. Utilizing a preliminary massage as an "ice breaker" allows her to check the clients body for ulcers or warts around the genitals, penal discharge and "nits" (crabs) in the pubic hair. The detection of such problems will prompt her to engage in "trick sex" (involving the use of her hand or the space between her legs), creating the impression that the client's penis has been inserted in her vagina.

Most of the women in this survey demonstrated confidence, self-efficacy and excellent negotiating skills, traits essential if they are to affect people's behavioural choices and persist with clients who want to have unsafe sex. Excluding the women working on the street, 97 percent of those working in massage parlours, escort services and independently made comments that sex trade work led to "liking myself better, feeling more confident" and "having higher self esteem" than prior to taking up such work. One women expressed the notion that "thinking in good ways about myself" helps to establish a psychological climate in which she is able to avoid risky sexual situations.

As an independent sex worker and founding member of the Sex Workers Alliance of Niagara (SWAN), Sarah, shared the attention to detail she devotes to establishing personal relations and attending to the psychological needs of her clients. As a "spiritual prostitute", she has a complexity of friendships in relationships with her clients, some of whom have assisted her to move her household, been invited to dinner in her home and acted as role models for her young son. To avoid entrapment by the police, client contacts are established through elaborate cellular telephone ruses or through e-mail communiques prior to meeting. This very personable and experienced also has a number of women in the Niagara region who apprentice with her in order to win her approval to work in the business as well as to become proficient at their craft.

By inquiring about favourite lingerie, wine and music, she establishes the expectation that the client will have a unique and rewarding experience. In anticipation of spending quality time with her characterized as a "great treat", she informs her clients that encounters are only affordable on an occasional basis. Through polite and courteous behaviour, she sets the tone concerning self-affirming activities that nullify risk-taking behaviours. Understanding that most men are intrigued by her very, physically-fit physique, she concentrates on assisting clients to define and verbalize their sexual interests. On one occasion she pretended to be a stranger who was picked up in a restaurant; in another instant she redecorated her bedroom in a harem motif to cater to a client's fantasy. Continuous "small talk" of a friendly nature and flirtation are reported to go a long way in setting boundaries and netting Sarah a $250,000 income last year.

In order to ensure safe contacts, most women in this survey exerted control over the encounter by securing payment prior to services being rendered, and they attempt to elicit client compliance by using an assertive, business-like stance that communicated the terms of the encounter in explicit detail. The degree of control individual woman were able to exert during sexual encounters varied with age, experience, self-confidence and location of work. A commonly employed strategy while working on the street was to ask another woman to take down a client's license plate, to use a cellular phone to "report" their whereabouts in the customer's presence and to carry a nail file or sharp object in their purse.

Since drinking and using drugs encourages risky sexual behaviours that can lead to the transmission of diseases, unintended pregnancy and violence, most of the women reported that they avoid such indulgences. Women at risk were more likely to be young street workers who reported occasionally engaging in high-risk activities with clients when offered extra money for sex without condoms. Arlene, a Native women who began working the streets of Winnipeg to sustain her habit of "shooting coke with friends" is an example of a woman more at risk than most sex workers in this survey. Periodically, when desperate to raise money for drug consumption she admits to not practicing safe sex. As a result of using drugs over the course of six years, she has also on occasion shared injection equipment.

Without translating the dangers of street work into a discourse on victimhood, Arlene tries "to remain aware of what is happening around me", especially when taking clients to her

home. A number of her clients and the police have made disparaging remarks about sex with a "drunken Indian", highlighting the manner in which gender inequality is eroticized and racialized. She takes for granted that as part of her working conditions she will be periodically "hassled by the cops" and that she will be required to "pay money or give free sex to them to keep working" without arrest.[19] Her omnipresent concern is not about contracting an infection, but concern that she will be beaten by a client or arrested again "because the cops always crackdown on us Natives". Having been arrested close to a dozen times and been in jail on three occasions, she is persecuted in ways that uphold racialized and gender hierarchies of class power. Each arrest puts her closer to relinquishing custody of her son and daughter to the Children's Aid Society.

Since condoms serve both as a physical and symbolic barrier in sex workers' professional lives, the majority of women did not apply the same safer sex standards in their private lives. Some 23 percent indicated that they consistently used condoms for vaginal sex with regular partners. With respect to varying attitudes of risk perception and self-cleansing, these women negotiate differently and use less or no prevention with their partners than with occasional clients (with regular clients falling mid way between the other two groups). These findings are similar to other studies that suggest the rare use of condoms by sex workers with a primary partner due to issues of intimacy and trust (Bailey et al:1992; Murray et al:1996).

The key debate appears to hinge on the rationale for policies of discrimination that control and regulate sex workers, driving them underground and putting them further at risk. Although little attention has been paid to the behavioural aspects of sex work, this field study found that sex workers take the initiative to obtain information and engage in safer sex practices. Within their community, educational messages are advanced by peer group educators rather than through traditional health education systems. Accessing information, services and skills training and enhancing self-respect provide important lessons of empowerment. Although these influential educators are a invaluable source of safer sex educational information, they appear to be ignored in mainstream policy-making, research and educational programs. Continued marginalization and stigmatization, however, makes it more difficult and dangerous for them to continue prevention work.

The New Zealand Prostitutes Collective: Promoting Safer Sex and Social Change in the Sex Industry

Sex workers previously surveyed in New Zealand view sexuality as an interactive, negotiated social transaction concerning partner choice, kinds of sexual experience, contraceptive use and disease prevention (Hanson:1996a;1997b). In the course of their daily work, most women acquire skills to deal with issues of intimacy, decision-making, communication, negotiation and assertiveness (Hanson et al:1995). Since self-assurance and control are key considerations, the majority quickly learn from each other with respect to the occupational health and safety issue of "no condom, no sex" as a non-negotiable practice

(Hanson:1997b). To some extent, contact with clients and reading trade magazines supplement their repertoire of skills. Hanson (1996b) advocates that there are a number of lessons non-industry women could learn such as taking control of sexual situations and introducing condoms, using water-based lubricants to minimize breakage and informing someone in a bar that they are leaving with a man.

With the advent of the HIV/AIDS "crisis" in New Zealand, the impetus for establishing the New Zealand Prostitutes Collective (NZPC) in 1987 came from sex workers.[20] New Zealand sex workers were mostly involved in direct relations with clients; many parlour workers and those working for escort agencies exhibited a high degree of independence from owners. Generally experiencing less exploited than sex workers in other parts of the world may have contributed to the eagerness with which they took responsibility for their own health and engaged in peer education. Health professionals primarily concerned to prevent the spread of infection within the general population invited the Collective to work with the government in the promotion of safer sex practices (Barwood:1998).[21] The fact that sex workers were at personal risk and perceived a threat to their business may explain their interest in forming a partnership with various departments of the Ministry of Health to prevent the spread of sexually transmitted diseases.

Members of the NZPC recognized the benefit of working in a government-endorsed organization that utilized state funding, infrastructure and support services for sex workers, clients and the public. Catherine Healy, National Coordinator of the NZPC, and World Health Organization consultant, remarked "since the publicity drive against AIDS began there has been a general downturn in the industry. While statistics suggest that sex workers have no greater likelihood of being HIV positive than the general population, clients are fearful of contracting AIDS" (Barwood, 1998:8). Several studies conducted between 1983 and 1998 in four New Zealand cities (by the AIDS Epidemiology Medical School), discovered "no discernable infection among New Zealand born, female sex workers" (Lichtenstein, 1999:57).

Serological findings gave credibility to the notion that sex workers were leading proponents of disease prevention.

An essential feature of the Collective was that is was staffed by workers who were currently or formerly part of the industry, thus ensuring that workplace culture was understood and the concerns of sex workers were paramount. Healy remarked that "there are so many things you don't understand if your haven't worked in the industry" (Barwood, 1998:8).[22] Since most women were self employed and worked outside of the law, the information provided by the NZPC focused on health and safety issues. In regional drop-in centers such as Wellington, Christchurch, Auckland, Tauranga and New Plymouth, advice and counselling were offered together with HIV/AIDS testing, health support services, self defense instruction, needle exchanges and legal services. One of the NZPC's motto of "No Joe No Go" which stressed the need for clients to wear a condom in each sexual encounter, reflected actual safety conscious

practices that exceeded those in the population at large (Healy and Reed:1994).

NZPC staff distributed literature including the publication of Siren (Sex Industry Rights and Education Network) containing a column which discussed disease prevention. A frequently appearing article entitled "Sexual Health Update" suggested specific ways that sex workers should exercise precaution against acquiring infection from clients (Siren, 2000:16). An "Ugly Mugs" list that warned of uncooperative or dangerous clients was also available in NZPC offices. Catherine Healy and Anna Reed (1994) suggested that while sex workers were perceived to be reservoirs of HIV/AIDS infection for the general population, this distorted view whipped up public hysteria. They cautioned that men who refused to wear condoms, engaged in high-risk sexual practices and used commercial sexual services (when travelling to countries with high rates of HIV/AIDS infections), were more at risk of spreading disease in the community than sex workers. They advised that sex workers should supply and use condoms to protect themselves, their clients and the sexual partners of these men.

The NZPC had a broader objective in establishing their cooperative beyond issues of health and safety - they wanted to create an organization that would empower sex workers and advance their political and legal rights. The approach by the health department had simply accelerated informal discussions previously undertaken by sex workers to establish a support group. The Collective was determined to counter negative public images of the sex industry and to decriminalize prostitution by actively working to repeal existing laws of the Summary Offences Act (1991) concerned with soliciting, the Crimes Act (1961) related to brothel keeping, living off the earnings of prostitution and procuring sexual intercourse and the Massage Parlours Act (1978) (Prostitution Law Reform, 2000:1).[23] Founded in part to foster pride among sex workers and to combat the scapegoating of sex workers by the Wellington police for example, the Collective threatened the government with discontinuing its safer sex work and exposing acts of persecution to the media if a discussion of decriminalization was not put on the agenda.

Of the numerous problems faced by sex workers, Healy points out for example that under the Paid Parental Leave Bill, sex workers who were parents were excluded and ineligible for a twelve week paid leave at 80 percent of salary. Despite the fact that they were encouraged to register and pay taxes, sex workers were simply not recognized by the Inland Revenue Department. Prior to the establishment of the Collective, sex workers had made several unsuccessful submissions to parliament to establish decriminalization. Based on the demand for full recognition of women's human rights (discussed at the First World Whores Congress in 1995 held in Amsterdam), the work of Catherine Healy and Catherine O'Regan helped to draft a 1997 bill that began the process of decriminalize.[24] Tim Barnett, Labour MP and author of the bill remarked "the dangers in the sex industry relate to health and the abuse of power... I contend that the current law creates victims and protects perpetrators. It is unenforceable and it is implemented inconsistently" (Prostitution Law Reform, 2001:1).[25],[26] In recognition that stigmatization and legal prosecution prohibit harm reduction and disease prevention, the Select

Committee of the parliament in a vote of 87 to 21, moved to decriminalize prostitution through the introduction of a bill that passed into law in May, 2001.[27]

Reframing Sex Work Pedagogy as a Model for Safer Sex Education

Altering social perception and motivating behavioural change is currently envisioned as a complex task that needs to incorporate a variety of conflicting messages which cannot be

abstracted from a larger social environment (Karka:1994). Preventative programs must be comprehensive, multifaced and integrated within a wide variety of community services. Effective campaigns depend upon knowing what motivates sexual behaviour, comprehending the factors influencing risk taking and emphasizing an educational approach that takes into account individual decision making within a specific cultural context. Such programs call for changing the social climate to optimize learning that will facilitate behavioural modifications. Recognizing that sexual ignorance gives rise to inappropriate behaviour, and sexual knowledge is acquired continually through formal and informal learning processes, safer sex prevention programs are moving away from information-based strategies to a more holistic approach (that deal with multiple determinants of behaviour and reflect varied learning styles) adapted to different patterns of sexual activity (di Mauro:1995).

Traditional health education programs have generally been counter-productive because they fail to connect sexual behaviour with deep-seated feelings and to engage in active and interactive learning that will enhance confidence-building and social skills (Beattie:1990). Conventional education discourses are either insipid and equate sex with reproductive biology or they are based on fear arousal attempting to dissuade sexual activity. Both approaches are individual in orientation, utilize prescriptive top-down" methods and overlook the social environment (Marland:1990). Standard sex education programs further lack a discussion of women's sexual needs, alienate women from their bodies, omit discussions of male control over female sexuality and reproduction and fail to suggest how men's behaviour puts women at risk (Kitzinger, 1994:127). For women in particular, programs of low-intensity intervention that do not provide for discussion of risk and individualized practice around condom negotiation are likely to be ineffective in terms of translating knowledge into behaviour (O'Leary and Jemmott, 1995:5).[28]

Two centuries of public policy have produced and maintained gender appropriate sexual behaviour (including the notion of sex as vaginal intercourse), which has accorded primacy to male desire, given men an assumed "right" of sexual access to women and socially controlled women's sexuality (Ehrenreich and English:1973). Dominant discourses such as state documents have constructed female sexuality as passive in opposition to male sexuality depicted as active. The media constitutes boundaries by presenting women as sexual purists engaged in heterosexual monogamy and in need of protection, or correspondingly as deviant women engaged in illicit activities (Lupton, 1994:122).[29] The hierarchal nature and the ideological agenda of the medical

profession has contributed to the social construction of gender that has led to women having little choice about whether or not they will engage in sexual activities with men. Public health authorities targeted sex workers as sources of infection and instituted mandatory testing and coercive approaches to close businesses engaged in commercial sexual activity (Gostin and Webber:1998; Meaghan:2000) Power relations embedded in sexual relations in compulsory heterosexual practices suggest why it has been difficult for women to assert their sexual and health interests. Despite socio-economic and gender inequality that limits a women's power to negotiate sexual practices with their partners, women have been disproportionately charged with the responsibility for behavioural change within relationships (Panos Institute, 1990:88).

Interventions must address the power imbalance that can restrict a woman's ability to exercise control and express desire in sexual situations. No attempt to deal with safer sex for women will be successful unless issues of structural discrimination and inequality are taken into account. Unfavourable labour market conditions, the feminization of poverty and unpaid labour within the family increasingly cause women to use sex as currency in the informal economy. Women's ability to practice safer sex is constrained by dominant cultural constructs of acceptable female sexuality and the social and economic marginalization which presents few alternatives for women. Freely consenting to sexual acts and experiencing sexuality devoid of physical and emotional violence may be of greater concern for some women than the long term risk of infection. It is currently recognized that the best approach to establishing safer sex practices needs to educate and motivate people to make low-risk choices (based on the realities of their lives), by also acknowledging, as sex workers suggest, that sexuality can be explicit, erotic and safe.

A cooperative alliance between "pro-sex and choice" feminists and sex workers could go a long way to providing sex workers with access to resources, to recognizing their skills as educational resource agents and to confronting poverty, discrimination and marginalization for all women. Sex workers who are vulnerable, exploited and politically disenfranchised are unlikely to have the highest health status; women who are autonomous and able to take charge of their lives are most likely to be at the forefront of social change. Feminist support for decriminalizing sex work could assist to deconstruct the negative images of sex workers, end the social stigmatization arising out of the separate spheres of "madonna" and "whore" and afford these women dignity, human and labour rights and legal protection against assault and police harassment.

In discrediting myths of irresponsibility and practitioners of unsafe sex, New Zealand sex workers socially repositioned themselves as health care specialists. Demonstrated skills and knowledge together with epidemiological reports (testing for HIV seropositivity that found no reported cases of infection among New Zealand sex workers) gave legitimacy to sex workers' claims as safer sex professionals. Through contact with medical personnel, government officials, politicians, academics and the media, members of this prostitutes' rights organization gained confidence and organizational skills that helped them link public health agencies and sex

workers. Aligned with government personnel in a campaign to protect public health, attention became focused on the behaviour of clients and the police. Sex work discourse was not only employed to ensure safer sex practices, but also served as an instrument of empowerment to create a supportive environment for political advocacy. Challenging and undermining hegemonic discourse reversed public opinion and resulted in the inclusion in public policy formation of a formerly marginalized group. By offering specialized services for sex workers, conducting surveys with academics and addressing the government's concerns with respect to health issues, the NZPC was able to make the case for the establishment of the political and legal rights of sex workers through decriminalization.

The Canadian government might profit from the lessons learned through the successful partnership established between the NZPC and the New Zealand government to recruit sex workers as peer educators. Traditional approaches of policy makers in Canada, however, have targeted sex workers as disease bearing and have excluded the contributions they could make to learning safer sex practices. The Canadian government has recently proposed in a working paper entitled Dealing with Prostitution in Canada to make laws more rigorous with tougher penalties for prostitution (Davis and Shaffer, 1994:3; Bastow, 1995:2).[30] Removing criminal penalties would empower those who sell sexual services and would provide for safer working conditions, prevent the acquisition of a criminal record and eradicate the double standard between sex workers and clients. The manner in which Canadian sex workers challenge the formation of sexuality, create autonomy for themselves, demonstrate high sexual literacy and learn to work safely suggests the potential for expanding the definition of adult educators to include this group in policy construction and program planning. A paradigm shift that reframes Canadian sex workers as transmitters of sexual diseases to a view which posits them as sexual experts, provides a way for sex workers to become an essential part of a public campaign to establish safer sex practices.

Focusing on the knowledge of sex workers raises questions about the possibility of developing a prostitute-centered pedagogy of safer sex practices. In contrast to dominant discourses that stigmatize and ignore the experiences of sex workers, prostitute pedagogy affirms the right of women to control the conditions of work and further recognizes the skills and knowledge of that work (Meaghan:1999). It also raises issues about whether sex work practices constitute an alternative body of knowledge that could be utilized as a community resource concerning safer sex interactions in informal and formal educational systems. Providing sex workers with an opportunity to have input into public policy and the design and delivery of prevention programs would be a useful way to transmit their skills and knowledge to other sectors of the community including clients, health and social service workers and adult populations at large. Such knowledge might not only serve in transformational learning to generate innovative social sexual practices, but could also provide sexual self-determination that might result in greater desire, knowledge, resistance, agency and empowerment in other aspects of women's lives.

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Endnotes

1. Priscilla Alexander (1998) notes that hazards among sex workers do not simply constitute sexual and reproductive health concerns, but also include occupational hazards such as repetitive injuries, respiratory infections and emotional stress related to managing stigmatization.

2. Adult education literature concentrates on how adults learn in a social context and in collaboration with others (Tough:1979; Acosta:1987). During the past two decades, the focus has shifted from educator and pedagogy centered to self-directed and egalitarian relationships among adult educators and learners (Karka:1994).

3. The term sex work is a Western term used to shift the debate away from an emphasis on morality and positions it as paid sexual labour within an industry that also has clients, managers and police (Morgan Thomas:1992). Theorizing sex work in this manner utilizes the concept of a worker (when such a social and economic role may not exist), together with the establishment of the capitalist notion of a public/private split (where such a division of labour may not be present). The concept of work, however, does not explain exchanging sex for economic support (as occurs in many developing parts of the world) or the renegotiation of sexual relations taking place under global economic transformations.

4. Stigmatization involves ridicule, shaming and shunning in everyday interactions that subordinates, demeans and devalues sex workers (Davis, 1993:3-5). It results in their exclusion from "respectable" society, making them vulnerable to legal prohibitions, causing them to hide their occupation from family and friends and excluding sex work experience on their curriculum vitae (Morgan Thomas, 1992:73).

5. Sandra Aral and Jeanette Wasserheit (1996:18-20) suggest that STDs such as genital ulcer diseases (GUD), herpes, chancroid, trichomoniasis, syphilis and gonorrhoea facilitate HIV transmission by providing points of entry created through lesions in the genital skin. Of the twenty diseases spread by sexual contact, women are more likely than men to acquire STDs, more prone to serious complications such as genital cancers, infertility and death in infants, less likely to seek care (because they tend to remain symptomless longer than men) and more stigmatized than men as a result of STD infections (Panos, 1990:15).

6. A Health and Welfare Canada (1996) study found that 60 percent of female AIDS cases were attributed to heterosexual contact, 25 percent were due to blood transfusions and 6 percent were as a result of injection drug use. Unprotected sexual intercourse placed women at great risk than men. Twenty-seven percent of females reported that they had sex without a condom with someone they did not know well, and 56 percent responding that they had sex with two or more partners in five years and had not adopted safer sex practices.

7. Two distinct approaches of public health have been utilized to contain the AIDS epidemic. The classical approach follows a strategy of control, isolation and legal regulation similar to the mandatory testing in Canada, England and Australia of sex workers under the Contagious Diseases Acts (Metzenrath, 1999:35-6). A more recent approach emphasizes prevention and education, stressing inclusion and harm-reduction, voluntary testing, protection of privacy and support for those infected (Wellings and Field:1996).

8. The incidence of substance abuse and addiction in the U.S. vary widely from 1 to 84 percent among sex workers. While substance abuse is common among street workers (50 percent) and rare among women working off the streets, 50 percent of street workers claim to have used drugs prior to taking up sex work (Panos Institute:1990:4; United States Department of Health, 2001:14).

9. Societal determinants of STD/HIV rates include levels of economic development, urbanization, social upheaval, unemployment and poverty, educational attainment, the status of women and accessibility of health care services (Aral et al, 1992:24-9). Individuals thought to be at high risk of STD and HIV infections have blood transfusions, inject drugs (particularly if syringes are shared) and/or are exposed to infected partners through unprotected sex. Unprotected sex with multiple partners, nondiscriminating sex partner recruitment patterns, a high frequency of intercourse and intercourse during menses have also be noted as etiological factors. Only a few individual behaviours confer risk, however, with the greatest hazard associated with anal intercourse, less risk attached to vaginal intercourse, a significantly lower risk for fellatio and cunnilingus and a negligible risk for hand genital encounters.

10. A myriad of deficiencies in the health care system result in services for women being fragmented, poorly distributed and of an uneven quality of care. Beth Schneider and Nancy Stoller (1995:16) argue that it was not until 1993 that the U.S. Centers for Disease Control and Prevention recognized women's distinctive clinical and social experiences and extended the list of HIV related illnesses to include gynaecological abnormalities and cervical cancer.

11. The situation in developing countries reflects low rates of condom use, a high prevalence of HIV and other STDs and little evidence of injection drug use. One study conducted in Nairobi, Kenya found that rates of infection varied from 31 percent among higher class sex workers to 66 percent among working-class sex workers (Simonsen et al:1990).

12. Mary Chiasson et al (1989) found increased rates of both syphilis and HIV infections among women who used crack cocaine.

13. Men who frequent sex workers usually have other partners. In a New York STD clinical study, the rate of HIV infection in men who had contact with female sex workers (when all other risk factors were eliminated) was found to be in the 1 percent range. This rate was far below that attributed to gay contact [62 percent], injection drug use [21 percent], non-commercial

heterosexual contact [3 percent] and blood transfusion [2 percent] (Centers for Disease Control and Prevention:1993).

14. At the height of the sexual revolution in the 1960s, sexual freedom and pleasure became part of the rallying cry of the women's movement. Over the next two decades, feminists such as Catharine MacKinnon (1987) argued that women's oppressed was based on sexuality while Kathleen Barry (1979:6) patronizingly suggested that prostitutes exhibited "false consciousness" and were unable to comprehend their own exploitation. As a result, feminism ignored sexuality as a proper sphere of exploration and began to address issues of the family, employment discrimination and reproductory freedom. Only recently has a progressive sexual politic emerged based on sexual choice and diversity of sexual desire (Smyth:1992).

15. Although Jillian Catania et al (1992) found no differences in the use of condoms by way of racial/ethnic background, condom use was related to socioeconomic status as reflected in levels of educational attainment.

16. Alexander (1995:118) cites the fact that numerous studies have found that sex negotiated on the street usually involves "hand and blow jobs".

17. Sex workers routinely report that they must observe prohibitions (refraining from specific conduct), zoning bylaws, curfews, health regulations and submit to supervision and treatment. They are also subject to registration, arrests, fines and incarceration on charges of "loitering", "public nuisance" and "soliciting", a double standard of regulation that is less likely to be employed with male sex workers and rarely with clients (Lowman, 1993:64). A criminal conviction, however, affects a woman's ability to obtain alternative employment, travel, bank loans and ultimately to move out of the industry (Prostitution Law Reform, 2000:2).

18. Cara Gillies (2000) points out that violence in not inherent to the sex industry but is a result of the stigmatized status of prostitution. Fran Shaver (1988) notes that danger is often a consequence of a sex worker's vulnerability as a woman rather than as an result of their profession.

19. Arrests related to sex work in the U.S. involve 70 percent female sex workers, 20 percent male sex workers and 10 percent customers. A disproportionate number of sex workers apprehended and sent to jail are women of colour; 85-90 percent work on the streets (United States Department of Health, 2001:2). Lowan (1993:64) similarly reported in a 1990 Vancouver study that 1,648 charges were laid against prostitutes and 532 against customers (a ratio of 3 to 1).

In Montreal and Toronto in the same period, the ratios of arrests were 2 to 1 and 5 to 4 respectively.

20. The idea that prostitutes were "reservoirs of disease" was a long standing notion in New Zealand as in other parts of the world. This perception emerged during the nineteenth century struggle to control syphilis among "licentious" Maori women who had contracted the disease from Europeans. With the passing of the Contagious Disease Act (1969), prostitutes were forcibly confined in order to undergo compulsory medical examinations (Lichenstein, 1999:39-40). With the shifting priorities of government policy, the idea of prostitutes as "vectors of infection" was transformed in favour of working with sex workers in disease prevention (Lichtenstein, 1999:55).

21. The NZPC was not the first prostitute collective to organize around issues of stigmatization, labour and legal repression. As early as the 1980s, Margo St. James organized COYOTE (Call Off Your Old Tired Ethics) in California. This was the forerunner of CAL-PEP (California Prostitutes Education Project) organized in 1995 by Priscilla Alexander. CAL-PEP provided mobile, safe sex workshops including condom demonstrations and negotiation training, distributed condoms, lubricants, bleach and educational material and made referrals for STD testing and other health care services (CAL-PEP:2001; Stoller and Chapkis:1993). By 1985, the Australian Prostitutes Collective (APC) provided legal assistance, referrals for health care and drug treatment. The Collective also called for a "Safe House Endorsement" in which owners and managers of brothels provided condoms and established suitable working conditions. At the same time, Valerie Scott, of the Canadian Organization for the Rights of Prostitutes (CORP), formed the Prostitutes' Safe Sex Project to fund Toronto street outreach (Alexander:1995). She suggested that sex work was similar to other jobs, although these workers lack legal, security, health and safety protection as well as human rights (Blackfield Cohen and Alexander:1995).

Another example of a prostitute-led service, ScotPEP (Scottish Prostitutes Education Project) offers health advice, skill building and engages in advocacy for law reform (Gorna, 1996:270). Comitato per i Diritti Civili delle Prostitute of Italy publishes an AIDS prevention newsletter (Alexander:1995), De Rode Draad (The Red Thread) in the Netherlands has a mobile van in Amsterdam that provides STD testing, condoms, methadone treatment and emergency health care (Vebeek and van de Zijden:1987) and Aspasia in Switzerland organizes outreach AIDS educational material (Roberts:1992).

22. Mary Barnard and Nancy McKeganey (1995:105) suggest that peer education for sex workers is more effective than an agency-based approach. The former is non-judgmental in approach, more broadly defines safer sex to include screening clients, demonstrates condom use, teaches non-penetrative sex negotiations, identifies sex workers with skills to support and train others and circulates resources and information through informal networks that encourages grass-roots involvement. Professionals can provide resources, expertise and facilitate in planning, but the objectives of the organization and the content must originate with community members. In contrast, traditional health clinics open only in the day may not be convenient for those who work predominantly at night and they are usually staffed with medical experts who

are focused on "genito-urinary medicine".

23. As early as 1949, the United Nations passed a resolution in favour of decriminalizing prostitution that was ratified by fifty countries. In 1973, the U.S. National Organization for Women (NOW) also advanced a resolution supporting the decriminalization of prostitution (United States Department of Health: 2001). Decriminalization would result in the repeal of all existing criminal code offenses regarding voluntary prostitution between consenting adults. Most sex workers support decriminalization making it possible to advertise and sell sexual services, decrease criminal activity and provide some measure of control over working conditions (New Zealand Prostitute's Collective:2000). Decriminalization would also ensure that sex workers are eligible for health insurance, workers' compensation, social security, disability insurance and pensions (American Civil Liberties Union Foundation:1990).

Legalization, on the other hand, essentially involves a system of control with the state regulating, taxing and sometimes licensing specific forms of prostitution. It results in a two-tiered system of legal activities for some sex workers and illegal, underground criminal activities for others (Prostitution Reform Bill, 2000:1). Christine Overs (1997:18), spokesperson for the English Collective of Prostitutes, suggests that models of partial and full legalization are "intended to provide a pool of infection free women". Often greater restrictions are placed on sex workers by owners and managers (in massage parlours and brothels) through the application of arbitrary rules as well as unfair dismissals, fines and withholding payment. Sex workers face problems in obtaining a license and they may lack the fundamental human right to refuse a client. Municipal licensing often increases police presence, disempowering sex workers from being able to take action to enhance to health and well-being (Lewis and Maticka-Tyndale:1999).

24. Many sex workers prefer decriminalization over legalization, given that the latter often leads to restrictive conditions in brothels with the state accused of "pimping" off sex work through taxation and mandatory health assessments.

In a personal communique with Catherine Healy (2001), she notes "it is distressing to hear people want legalization as it usually translates into outlawing the more 'independent' sex workers and registering others. Sex workers who call for legalization as opposed to the more progressive decriminalization models are often intent on booting out the perceived competition. They use expressions like the 'industry needs to be more professional' and 'cleaned up' ... which results in parlour owners who are bond bullies and lay off their staff for chipped nail polish."

25. An explanatory note for this piece of legislation states that the "Bill recognises the need to reform the law relating to prostitution in New Zealand. The aims of the Bill are to decriminalize prostitution, to safeguard the human rights of sex workers and protect them from exploitation, to promote the welfare and occupational health and safety of sex workers, to create an environment which is conducive to public health, and to protect children from exploitation in relation to prostitution" (Prostitution Reform Bill, 2000:1).

26. The New Zealand sex industry will not be without regulation, notably it will contain provisions for making child prostitution illegal. The Prostitution Reform Bill (2000:2) suggests that much of the activity of the industry falls within the scope of existing legislation such as the Employment Relations Act (2000), the Resource Management Act (1991), the Health and Safety in Employment Act (1992), the Crimes Act (1961) and the Summary Offences Act (1981).

27. Catherine Healy and Jody Hanson (2001), personal communications.

28. In a study by Jane Kelly et al (1994), teaching condom use, modelling interventions in risk situations and practicing skill-building negotiations resulted in an increase from 26 percent to 76 percent of condom use among women.

29. The social construction of the category "woman" has been produced through historical and social processes in a way that ideological interests are served but appear to be natural. Constructs of the "good" woman, who is sexually passive and a receptor of infection are contrasted with the "bad" woman, who actively infects men and is in need of regulation. The results produce fears concerning women's sexual liberation while falsely providing a view that "risk" occurs outside of mainstream society.

30. Countries with the most restrictive legal systems regarding prostitution including the United States have the most problems associated with violence, theft against sex workers and pandering and solicitation of juveniles. Those countries that conversely have few restrictions such as the Netherlands, Germany, Sweden and Denmark have the least problems (Alexander, 1996:347).

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