Structural and Environmental Barriers to Condom Use Negotiation With Clients Among Female Sex Workers: Implications for HIV-Prevention Strategies and Policy

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Women account for an increasingly disproportionate number of HIV infections worldwide. United Nations’ agencies use the term the “feminization” of the HIV pandemic to refer both to the highly gendered nature of the vulnerability to HIV infection and to women’s increased biological susceptibility through sexual transmission. Women’s risk of HIV infection is hypothesized to be mediated by macro- and micro-level factors exogenous to the individual that interact to increase vulnerability to HIV infection, factors such as gender, cultural and economic inequities, prohibitive government policies, and institutionalized racism and poverty.

Recent public health calls highlight the need to move beyond a sole focus on individual-level risk to an understanding of risk as negotiated interactions,6 embedded in contextual factors,5,7 As such, a conceptual shift from individual-focused HIV prevention, such as behavior change communication, to environmental–structural HIV prevention emerged in the 1990s, particularly among female sex workers and their male clients.2

Environmental–structural interventions aim to mediate macro- and microlevel factors that facilitate “enabling environments” for individual HIV risk reduction.2,8 Although several environmental–structural interventions targeting female sex workers and clients have shown significant promise in improving condom use in sex work establishments,2,9,10 most notably the Songachi model in West Bengal, India,11 these interventions have proven difficult to translate to other settings12 and, to date, have almost exclusively targeted indoor female sex workers in resource-poor settings. Furthermore, although some interventions, such as the 100% condom campaign, were initially heralded as model HIV prevention programs in Thailand,13 subsequent evidence suggests that not all sex workers may have experienced the same reductions in HIV prevalence.14 In fact, the policy may have adversely impacted marginalized sex workers through increased corruption, police raids, and mandatory HIV testing. These challenges and limitations may reflect the inability of interventions to adequately address the dynamic ways in which environmental and structural factors interact with microlevel factors in producing individual HIV risk.15

Among street-level sex work markets both in Canada and worldwide, women have been subjected to alarming rates of violence and victimization over the past decades16–18 and to enhanced rates of health- and drug-related harms, including increased rates of HIV infection among women who smoke and inject drugs.19,20 A significant amount of research has identified individual-level factors that predict consistent condom use; however, there remains a paucity of evidence surrounding the role of prostitution policies and work environment on sexual HIV risk in street-level sex work.

Government policies that prohibit solicitation in public spaces, including those in North America, the United Kingdom, and parts of Australia, have been shown to increase police presence and crackdowns and to displace street-based sex-work markets to outlying areas.10,17,21 As a direct result of displacement and legal restrictions on working indoors in managed or supported settings, more marginalized sex workers are pushed to work in dark and deserted alleys and isolated spaces with limited lighting, poor sanitation, lack of protections from violence and exploitation, and reduced access to health and social support services.

Given growing human rights and public health calls globally to address the failings of criminalized or quasi-criminalized prostitution on the health and safety of sex workers, we investigated the relationship between environmental–structural factors and condom-use negotiation with clients among female sex workers.

Methods. We used baseline data from a 2006 Vancouver, British Columbia, community-based cohort of female sex workers, to map the clustering of “hot spots” for being pressured into unprotected sexual intercourse by a client and assess sexual HIV risk. We used multivariate logistic modeling to estimate the relationship between environmental–structural factors and being pressured by a client into unprotected sexual intercourse.

Results. In multivariate analyses, being pressured into having unprotected sexual intercourse was independently associated with having an individual zoning restriction (odds ratio [OR]=3.39; 95% confidence interval [CI]=1.00, 9.36), working away from main streets because of policing (OR=3.01; 95% CI=1.39, 7.44), borrowing a used crack pipe (OR=2.51; 95% CI=1.06, 2.49), client-perpetrated violence (OR=2.08; 95% CI=1.06, 4.49), and servicing clients in cars or in public spaces (OR=2.00; 95% CI=1.65, 5.73).

workers,16–18,22,23 and recent charter challenges to Canada’s federal prostitution laws, we aimed to examine the association between environmental–structural factors and the negotiation of condom use with clients among street-level sex workers.

METHODS

The Maka Project was developed as a community-based HIV prevention research partnership with the aim to examine the impact of current programs and policies on the health and safety of survival sex workers in Vancouver, British Columbia. The term survival sex work is used to refer to the exchange of sexual services for money, drugs, or shelter as a means of basic subsistence. A detailed description of the Maka Project methodology has been published elsewhere.24 Briefly, between April and September 2006, 205 female sex workers were recruited and consented to participate in a prospective cohort (response rate of 93%), which included an interview questionnaire and voluntary HIV screening. Given the known difficulties in accessing a representative sample of sex workers because of the unknown size and boundaries of this population, initial mapping of working areas with more than 60 female sex workers was used to identify sex work stalls for targeted outreach and recruitment. Time–space sampling25 was used to systematically sample all women (inclusive of transgender women) working at staggered times and locations along these stalls. Based on previous research that identified 100% substance use among street-based female sex workers in Vancouver,26 eligibility criteria was defined as being a woman aged 18 years and older who smoked or injected illicit drugs (excluding marijuana) and actively engaged in street-level sex work.

Study Instruments

At baseline, trained peer researchers (former or current female sex workers) administered a detailed semistructured questionnaire to elicit responses from the participants related to demographics, health service use, working conditions, violence and safety, and sexual and drug-related harms. In addition, voluntary HIV screening with the new point-of-care rapid INSTI test (Biolytical, Vancouver, BC; specificity = 99.3%; sensitivity = 99.6%) was conducted by the project nurse and was supported by extensive pretest and posttest counseling. Finally, at the time of the baseline visit, women were provided with a map of Vancouver and asked to indicate (using the past 6 months as a reference point) areas in which they (1) worked and lived, (2) considered high and low risk to their personal safety, (3) avoided because of violence and policing, and (4) accessed syringes and accessed health services. Results were compiled with ArcGIS version 8 (ESRI, Redlands, CA) software and Geographic Information System street maps were provided by the City of Vancouver.

The dependent variable for all analyses was reporting being pressured by a client into unprotected vaginal or anal intercourse in the past 6 months.

Explanatory Variables

The risk environment framework,8 which postulates that macro- and meso-level factors exogenous to the individual mediate negotiation of individual HIV risk, formed the theoretical basis for the selection of independent variables for all analyses. We considered specific environmental–structural factors based on literature about female sex workers and qualitative documentation of street-based sex workers’ risk environment, as well as a priori hypothesized relationships.

Environmental–structural factors derived from questionnaires included harassment by security guards and place of servicing client (i.e., car or outdoor public space [park or alley] and indoor settings [hourly room, sauna, hotel]). In addition, environmental–structural factors derived from individual mapping variables for each woman included (1) type of working area (main street, residential setting, alley or side street, industrial setting), (2) having a “red zone restriction” (individual zoning restriction) prohibiting working in the Downtown Eastside core because of previous solicitation or drug charges, and (3) having moved working areas away from Downtown Eastside core because of policing or police harassment. The Downtown Eastside core, considered among the poorest postal codes in North America, has become known for a highly concentrated open drug market, socioeconomic disadvantage, and health inequities, as well as extensive community and health resources. Importantly, the Downtown Eastside core is bordered to the east by industrial areas and to the north by loading docks along waterfront that have become synonymous with “skid row.”

Based on qualitative evidence of intimate partners (noncommercial partners) limiting sex workers’ ability to negotiate HIV risk reduction through reduced access to resources,27,28 we examined the microlevel practice of “having a male intimate partner who scores drugs for you” in bivariate analysis. Additionally, we examined the safety initiative of working with other women or having a “spotter” (i.e., another worker who takes down clients’ information or license plates). Other microlevel drug practices previously shown to enhance sexual risk of HIV included borrowing a used crack pipe and exchanging sexual services while high on drugs. Finally, we defined client-perpetrated violence (i.e., a “bad date”) as emotional, physical, or sexual violence by a client. Respondents who answered yes to having experienced a bad date in the past 6 months were asked which of the following they had experienced from a client: verbal harassment, abduction or kidnapping, sexual assault, rape, strangulation, physical assault or beating, assault with a weapon, or being thrown out of a moving car.

Individual variables considered as potential confounders because of their known or a priori hypothesized relationship with negotiation of condom use and at least 1 or more independent variables included HIV status, type and frequency of drug use, pregnancy history, and early sexual and physical abuse. In light of recent evidence of enhanced rates of HIV seroconversion among Aboriginal people in this setting,29 we examined Aboriginal ethnicity (e.g., First Nations, Metis, or Inuit) compared with non-Aboriginal ethnicity. Similar to previous analyses,26 drug use patterns included any cocaine, heroin, or crystal methamphetamine injection in the past 6 months. Because all respondents reported smoking crack cocaine, we examined daily versus less-than-daily use. Finally, we adjusted all models for age because of previous evidence suggesting potential confounding with sexual HIV risk and 1 or more police enforcement strategies.27

Statistical Analyses

We inputted mapping data into ArcGIS to provide a geographic representation of
women’s working areas by clustering of “hot spots” for being pressured by clients into unprotected sexual intercourse. Specifically, we calculated hot spots by using the Getis-Ord Gi* statistic and z scores (with standard deviations from the mean) and mapped them by the variable, women’s working areas. To elucidate specific environmental—structural factors associated with the negotiation of sexual HIV risk, we used descriptive and univariate analyses to examine associations with being pressured by a client into unprotected sexual intercourse.

We analyzed categorical and explanatory variables with the Pearson χ² test, we analyzed normally distributed continuous variables with the t test for independent variables, and we analyzed skewed continuous variables with the Mann–Whitney U test. We used bivariate analysis to examine associations between each of the explanatory variables and to test for collinearity and effect modification. Given significant collinearity between displacement because of policing and working in industrial areas, we only entered displacement into the multivariate model. Similarly, exchanging sexual services while high on crack, and borrowing a used crack pipe were highly collinear, and thus, we only entered borrowing a used crack pipe into the model based on significance (P<.05) and likelihood ratio test.

We used the Pearson χ² test to verify associations between each independent variable and the outcome measure. Variables found at the univariate level (P<.01) to be associated with being pressured by a client into sexual intercourse without a condom were entered into the logistic regression model to obtain adjusted effects by using forward conditional procedures and the likelihood ratio test. We set α<.01 because of the relatively small sample size. All reported P values are 2-sided and odds ratios (ORs) are reported with 95% confidence intervals (CIs).

RESULTS

As indicated in Table 1, of the 205 women eligible for analysis, 81 (40%) self-identified as Aboriginal, with no statistical differences in likelihood of being pressured into unprotected sexual intercourse by ethnicity (P=.716). The median age at the time of interview was 37 years (interquartile range [IQR]=27–42 years) and the median age of sex work initiation was 16 years (IQR=14–22 years). A total of 68% of women had been pregnant in their lifetime with a median of 4 pregnancies (IQR=2–5), and 31 (22%) had at least 1 child living with them, with no differences in likelihood of being pressured into unprotected sexual intercourse by number of pregnancies (P=.131) or support of a child (P=.138). Seventy-four women (36%) had been homeless in the past 6 months, with similar prevalence of homelessness among both groups (P=.227). One hundred fifty-two women (77%) reported ever having injected drugs, and the primary drug of choice was crack cocaine (81%). Importantly, no associations were observed between drug use practices and being pressured by a client into unprotected sexual intercourse.

Among 205 women who reported sexual transactions with clients, 25% reported having been pressured by a client into not using a condom for sexual intercourse in the past 6 months. Figure 1 provides a map of women’s working areas, by clustering of hot spots for being pressured into unprotected sexual intercourse, with standardized z scores of 1.96 or more. The positive z scores show an increased probability (or hot spot) of being pressured by a client into unprotected sexual intercourse among women working in areas both outside the Downtown Eastside core and in industrial public spaces along the northeast and south.

Table 2 shows the unadjusted and adjusted associations for being pressured by a client into unprotected intercourse. In the final multivariate logistic regression model, adjusted for age, being pressured by a client into sexual intercourse without a condom was associated with having a zoning restriction because of previous solicitation or drug charges (OR=3.39; 95% CI=1.00, 9.36), moving working areas away from the Downtown Eastside core or main streets because of policing (OR=3.01; 95% CI=1.39, 7.44), borrowing a used crack pipe (OR=2.51; 95% CI=1.06, 2.49), client-perpetrated violence (OR=2.08;...
DISCUSSION

Our results demonstrate several structural and environmental barriers that significantly elevate women’s sexual HIV risk through being pressured by a client into unprotected sexual intercourse. Importantly, the mapping of hot spots for being pressured into unprotected sexual intercourse by working areas highlights the role of work conditions in shaping women’s sexual HIV risk. At the macro- and microlevels, women who moved working areas away from main streets because of local policing and those with zoning restrictions (because of previous solicitation or drug charges) experienced a 3-fold increase in odds of being pressured into unprotected sexual intercourse, and those servicing clients in cars or public spaces experienced a 2-fold increase in odds. Among microlevel practices, borrowing a used crack pipe and client-perpetrated violence both doubled the odds of being pressured by a client into unprotected sexual intercourse.

Sociolegal Policy Reform and Enforcement-Based Strategies

Our findings support the urgent need for structural- and environmental-level HIV-prevention efforts in street-level sex-work markets, including legal and policy reforms that facilitate sex workers’ abilities to negotiate condom use in safer sex-work environments. The adverse impact of enforcement-based drug policies in facilitating drug-related HIV risk in open drug scenes have been well documented and include an increased likelihood of risky injection practices (such as syringe sharing), confiscation of drug-use paraphernalia without arrest, and disruption of social networks.

Our findings further suggest that enforcement of prohibitive sex-work policies, alongside prohibitive drug policies, promote sexual risk of HIV infection in open street-level sex-work markets. These findings offer empirical evidence to support qualitative and ethnographic work, as well as legal policy analyses, in both Vancouver and other criminalized or quasi-criminalized prostitution settings that document increased harms, including violence, exploitation, and drug-related HIV risk, in street-level sex work as a result of enforcement of prohibitive sex-work legislation.

Although the buying and selling of sexual services has never been illegal in Canada, the contradictory laws governing prostitution mean that sex work continues to operate in a highly prohibitive environment. In an effort to remove the visible presence of street prostitution, the federal government enacted the “communicating” provision in 1985 that made it illegal to communicate in public spaces for the purposes of sexual transaction. In light of current legal challenges to the communicating code (s.13) in Canada, it is noteworthy that our findings suggest that enforcement of this provision may be increasing women’s sexual risk of HIV infection.

Furthermore, the increased risk of being pressured into unprotected sexual intercourse among women servicing clients in public spaces and cars compared with those servicing clients in indoor settings highlights the public health imperative of reversing laws that restrict sex workers’ ability to legally work indoors in managed or cooperative settings. The current “bawdy house” provisions (s.210 and s.211) in Canada broadly prohibit “keeping or transporting a person to a common bawdy-house,” and section 212 prohibits “procuring” or “living off the avails of prostitution” making it illegal for sex workers to work together indoors (e.g., in brothels) and extends “living off of the avails” of sex work to partners, family members, friends, and coworkers.

The Joint United Nations Programme on HIV/AIDS supports the decriminalization of sex work in situations in which there is no exploitation as necessary to effective HIV
The significant public health implications of street-level sex work in this setting highlights the need for zones to be supported by harm-reduction policies, similarly documented in recent consultations in the United Kingdom. Also, to ensure that policing in managed sex-work zones supports criminalizing exploitation by clients and third parties rather than further harming sex workers, policies should be developed with the direct involvement of sex workers.

**Gender-Specific HIV-Prevention Strategies**

In addition, gender-specific prevention and harm-reduction interventions are needed that consider power dynamics in the negotiation of HIV risk and the intersection of sexual- and drug-transmission risk in settings in which open drug use and sex-work markets coexist.

Our findings suggest that the process of female sex workers borrowing used drug-use paraphernalia from clients is associated with elevated odds of sexual HIV risk through being pressured into unprotected sexual intercourse. The synergistic relationship between crack cocaine and survival sex work has been extensively documented and shown to elevate the likelihood of exploitation and violence for female sex workers. Although surveillance data suggest that injection drug use remains the primary route of HIV transmission.
among substance users in Canada, a quarter of female sex workers in this setting were pressured into unprotected sexual intercourse within the past 6 months, suggesting increased potential for sexual transmission of HIV, which deserves attention.

The importance of elucidating microlevel negotiation of sexual HIV risk in epidemiological analysis, rather than individual-level practice of unprotected sexual intercourse, was further evidenced by an event analysis of female substance users’ most recent sexual exchange transaction in which the male client’s motivation to use condoms and worker–client discussions were key predictors of consistent condom use. Similarly, the practice of clients offering more money to not use a condom and of female sex workers charging more money for unprotected intercourse has been documented in several settings with evidence suggesting that both drug use and poverty are driving these practices.26,41

Limitations

There are several limitations that should be considered when one interprets these findings. First, this study is cross-sectional in nature, and therefore, causal relationships cannot be drawn. However, the direction of the association between enforcement of prohibitive sex-work policies and women’s sexual HIV risk is supported by extensive legal policy analyses and qualitative and ethnographic work.17,18,22 Second, the relatively small sample size may have compromised power. Third, self-reported practices may be subject to social desirability bias, although it is likely that this would have served to underestimate associations toward the null.

Fourth, our findings may not be generalizable to indoor sex-work venues or other outdoor sex-work markets that do not operate under a similar legal framework. Additionally, this was not a random sample, and thus, generalizations to other sex-work settings may be limited. However, the mapping of working areas and time–space sampling strategies likely helped to ensure a representative sample and to minimize selection bias. Fifth, the mapping of hot spots for clustering of sexual HIV risk by working areas does not describe the environmental–structural characteristics of these areas. However, the multivariate logistic modeling helps to disentangle the specific environmental and structural barriers to condom-use negotiation with clients that could be subsequently explored in further spatial analyses.

Conclusions

Given high rates of violence, murder, and adverse health-related outcomes among women in street-level sex work in Canadian cities over the past 2 decades22 and global calls to address the failings of legislation that criminalizes sex work on the health and safety of sex workers, our findings offer important empirical evidence to suggest that the current sex-work laws and enforcement-based policies may be directly increasing women’s sexual HIV risk. In particular, our findings support the urgent need to move beyond a solely individual-level HIV-prevention approach, such as condom distribution, to structural–environmental HIV prevention that facilitates female sex workers’ ability to negotiate their risk environment in safer sex-work settings and more actively criminalizes abuse and harassment by clients and third parties.

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This article was accepted July 30, 2008.

Contributors

K. Shannon conceptualized and drafted the original article, integrated the coauthors’ comments, and responded to the reviewer concerns. S. A. Strathdee, J. Shoveller, M. Rusch, T. Kerr, and M. W. Tyndall contributed to the writing and revision of the article. M. Rusch provided support with the Geographic Information System mapping analyses.

Acknowledgments

The Maka Project Partnership was supported by an operating grant (FRN 74917) in community-based HIV research from the Canadian Institutes of Health Research (CIHR). K. Shannon was supported by Doctoral Research Award from CIHR, a Senior Graduate Research Award from the Michael Smith Foundation for Health Research (MSFHR), and a Doctoral Fellowship from the Integrated Mentorship Program in Addictions Research Training, a strategic initiative of CIHR. M. Rusch was supported by a CIHR Fellowship Award. J. Shoveller was supported by a CIHR Applied Research Chair in Public Health. T. Kerr was supported by a CIHR New Investigator Award and an MSFHR Scholar Award. M. W. Tyndall was supported by an MSFHR Senior Scholar Award. We would like to thank all the women who participated in the Maka Project Partnership and contributed their time and expertise. We particularly thank our community partner, the Women’s Information Safe Haven Drop-In Centre Society, our Community Advisory Board, and our peer research team: Shari, Debbie, Adrian, Shaw, Chanel, and Rose. We also thank Kate Gibson, Jill Chettiar, Devi Parsad, Hayley Sinclair, Erin Gilbert, Katherine Chan, Nabela Khan, Ruth Zhang, and Calvin Lai for their community advisory and research assistance.

Human Participant Protection

The research was approved by the University of British Columbia/Providence Healthcare Ethics Board.

References


