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“Bad for the Body, Bad for the Heart”:¹ Prostitution Harms Women Even if Legalized or Decriminalized

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With examples from a 2003 New Zealand prostitution law, this article discusses the logical inconsistencies in laws sponsoring prostitution and includes evidence for the physical, emotional, and social harms of prostitution. These harms are not decreased by legalization or decriminalization. The article addresses the confusion caused by organizations that oppose trafficking but at the same time promote prostitution as a justifiable form of labor for poor women. The failure of condom distribution/harm reduction programs to protect women in prostitution from rape, sexually transmitted diseases (STDs), and HIV is discussed. The success of such programs in obtaining funding and in promoting prostitution as sex work is also discussed.

Keywords: *decriminalization; New Zealand; prostitution; prostitution law*

INTRODUCTION

Can the physical, social, and psychological harms of prostitution be controlled or decreased by decriminalization, regulation, or other state monitoring? Is there any way to make prostitution safer? Is it possible to protect the human rights of those in prostitution? Does legalization or decriminalization decrease the dangers of prostitution?

In May 2003, prostitution was decriminalized in New Zealand (NZ) by a one-vote majority of its Parliament. Throughout this article, examples from NZ will be used to analyze arguments that decriminalizing prostitution would make prostitution safer for the women in it. Four of the five reasons proposed for the decriminalization of prostitution in NZ had to do with public health. In the law's language, these were to safeguard the human rights of

sex workers, to protect sex workers from exploitation, to promote the welfare and occupational safety and health of sex workers, and to create an environment that is conducive to public health. It was also alleged that the law would protect children from the exploitation of prostitution (New Zealand Justice and Electoral Committee, 2001).²

Underpinning laws that legalize or decriminalize prostitution is the belief that prostitution is inevitable. This notion is advanced from different quarters: from pimps and johns,³ governments, public health officials, and from sexologists and evolutionary psychologists. Pimps have, for example, promoted legalized prostitution with the following arguments:

Why make a married man who is looking for nothing more than an alternative to masturbation, get busted in a sting, have his name and picture be published in his local paper and have to explain everything to his wife? Isn't that destructive to society? Why have a legion of free-lance STD-spreaders when you could control and regulate sex-field workers' health? Why consume law-enforcement time and resources to the tune of hundreds-of-thousands of dollars per year instead of collecting at least an equal amount in real estate and income tax withholding? It only makes sense. (Patrick, 2000, p. 12)

Public statements by pimps emphasize that prostitution is here to stay, with Dennis Hof in Las Vegas, Nevada, and Heidi Fleiss in Sydney, Australia, repeating the mantra that "boys will be boys."⁴ A Canadian attorney defended legal prostitution stating that prostitution "is a bottomless market" (Young, 2003). These stereotypes about men not only normalize and trivialize prostitution but are also good business strategy, relieving johns of any doubts regarding the social acceptability of their sexual predation while at the same time inviting them to spend their money.

Prostitution has been proposed as development policy for newly industrializing and developing countries. Often, those promoting prostitution are sex industry businessmen and government officials. Sex businesses such as escort prostitution, massage brothels, strip clubs, phone sex businesses, and Internet prostitution have been described by Lim (1998) as the sex sector of a state's economy. In some countries, profits from the sex sector are included in estimates of its economic activity. For example, in

the Netherlands, the sex industry constitutes 5% of the GDP (Daley, 2001). Women in Dutch prostitution tell us that although legalization of prostitution was promoted as a way to improve their lives, they view it primarily as a way for the State to tax their earnings (Schippers, 2002). Often they do not think that their health has benefited or that they are offered more protection under legalized or decriminalized prostitution.

Some social scientists define the predatory behaviors of men buying women in prostitution as normal, maintaining that prostitution is simply part of human nature (Ahmad, 2001; Fisher, 1992; Masters & Johnson, 1973; Pheterson, 1996; Scambler & Scambler, 1995). This definition of *normalcy* is then reflected in public policy that defines prostitution as a form of labor (sex work), where prostitution is considered an unpleasant job but not different from other kinds of unpleasant jobs, such as factory work. From this perspective, prostituted women are viewed as simply another category of workers with special problems and needs (Bullough & Bullough, 1996; Kinnell, 2001; Nairne, 2000). The World Health Organization (WHO) defined prostitution as a dynamic and adaptive process that involves a transaction between seller and buyer of a sexual service (World Health Organization, 1988). WHO has since recommended decriminalization of prostitution (Ahmad, 2001). Much of the health sciences literature has viewed prostitution as a job choice (Deren et al., 1996; Farr, Castro, DiSantostefano, Claassen, & Olguin, 1996; Green et al., 1993; Romans, Potter, Martin, & Herbison, 2001; UN/AIDS, 2002). Yet the notion that prostitution is work tends to make its harm invisible.

Where did the idea that prostitution is work originate? In 1973, the U.S. organization COYOTE (Call Off Your Old Tired Ethics) declared that prostitution was legitimate service work. In the 1980s, COYOTE capitalized on the AIDS epidemic as a health crisis, keeping its organizational focus on increasing its customer base but shifting its strategy to educational outreach in addition to advocacy of decriminalization of prostitution (Jenness, 1993). These goals are reflected in the activities of the New Zealand Prostitutes' Collective (NZPC), one of many COYOTE offshoots that provide union-style organizing for those in prostitution. When prostitution is understood as violence, however, unionizing prostituted women makes as little sense as unionizing battered women.

Political parties have also adopted platforms defining prostitution as work. For example, the Green Party has championed prostitution as labor and those in prostitution as sex workers. A NZ Green Party member described the decriminalization of prostitution as a way of protecting prostitutes' rights as workers (Sue Bradford, Green Party public speech in Auckland, New Zealand, June 26, 2003). However, another sponsor of the NZ decriminalization bill admitted, "it's going to be the owners or the operators [of brothels and other sex businesses] who are going to be the long-term beneficiaries [of decriminalization]" (Else, 2003, n.p.). In this statement, the politician seems to acknowledge that workers' rights in prostitution are a political fantasy. While appearing to promote public health, the NZ law keeps the names of brothel owners secret, thus making public health inspections of brothels an impossibility. The outraged mayor of Auckland, New Zealand, wrote, "This so-called legitimate profession remains partly hidden behind a veil of secrecy [under the new law]" (Banks, 2003, n.p.). In fact, the law protects the privacy of pimps and generally represents the interests of johns.

Support for legalized prostitution comes from many who believe that legalization will decrease the harm of prostitution, like a bandage on a wound. People are genuinely confused about how to address what they intuitively understand to be the harm of prostitution. They ask, "Wouldn't it be at least a little bit better if it were legalized? Wouldn't there be less stigma, and wouldn't prostitutes somehow be protected?" For example, NZ Prime Minister Helen Clark was quoted as saying that prostitution is "abhorrent" while at the same time supporting her Labour Party's prostitution decriminalization bill as a way to reduce the harm of prostitution (Banks, 2003).

People are confused by the illogic of vaguely written public policies that claim to reduce the harm of legalized prostitution. For example, the NZ Accident Compensation Commission (ACC) establishes risk assessments for various occupations, setting amounts for what employers must pay to cover medical and rehabilitation claims. Prostitution has been categorized by the ACC as a safer job than child care attendant or ambulance staff (Dearnaley, 2003).

Legal strategies to promote prostitution as work may be framed as issues of prostitutes' human rights, further confusing

people. COYOTE proposed that to deny women the “right to prostitute” was to violate their civil rights (Jenness, 1993). For example, a 1993 Sex Workers Action Coalition (SWAC) flyer noted that the group opposed legislation against pimping because it violated the rights of prostitutes. SWAC further argued that even though johns could be seen to be “taking advantage of a prostitute’s economic vulnerability,” they opposed enforcement of antiprostitution laws against johns (SWAC, 1993). These strategies are best understood as attempts to remove all obstacles to conducting the business of prostitution. Laws against sex predators—pimps and johns—are seen as barriers to business operations.

The names of organizations advocating legalized prostitution are another source of confusion. Sex industry apologists calculatedly appropriate the titles of human rights or public health organizations. Although their names are similar, the Global Alliance Against Trafficking in Women (GAATW) promotes prostitution as sex work, while the Coalition Against Trafficking in Women (CATW) works for the abolition of prostitution and other forms of discrimination against women. Other organizations that accept or promote prostitution as a reasonable job for poor women include Dutch Foundation for Women (STV); Coordination for Action Research on AIDS and Mobility (CARAM/Cambodia); European Network for HIV/STD Prevention in Europe (EUROPAP); Transnational AIDS/STD Prevention among Migrant Prostitutes (TAMPEP; Netherlands, Italy, Germany, and Austria); CARE International; North American Task Force on Prostitution; Anti-Slavery International; Human Rights Watch; Amnesty International (USA); Amnesty for Women, Hamburg; Rights of Entertainers in Asia to Combat Human Oppression and Unjust Treatment, Hong Kong (REACH OUT); Bangladesh Women’s Health Coalition; Medecins sans Frontieres; From Our Streets with Dignity (FROST’D), New York; Coalition Against Slavery and Trafficking (CAST), Los Angeles; Prostitution Alternatives Counseling and Education (PACE), Vancouver, Canada; Nueva Era en Salud, Panama.⁵ United Nations organizations such as the WHO, UN/AIDS, and the International Labor Organization (ILO) have also supported legalization of prostitution and have generally regarded prostitution as work (Lim, 1998; South African Press Association, 2001). In

2001, Gilles Pומרول, WHO's Southeast Asian advisor in sexually transmitted infections, promoted the decriminalization of prostitution in Asia (Deutsche Press-Agentur, 2001).

Unfortunately, names cannot be trusted to tell the whole story. It is necessary to ask hard questions about who funds each group and how funds are used; about whether and what alternatives to prostitution are advocated; and whether the organization has any goal other than sexually transmitted disease (STD)/HIV prevention. Organizations must be asked what they know about violence in prostitution, whether they view prostitution as sex work, and about housing options and job training because these are what women tell us that they need most to escape prostitution (Farley et al., 2003).

According to advocates of legalization or decriminalization of prostitution, the primary harm of prostitution is social stigma against prostitution. Those on all sides of the debate agree that women in prostitution are stigmatized. Socially invisible as full human beings, those in prostitution often internalize toxic public and private contempt directed against them.

Some have suggested that legalization or decriminalization would remove this social prejudice against women in prostitution. Yet the shame of those in prostitution remains after legalization or decriminalization. The ways in which johns are legally and socially protected and their lack of accountability are also unchanged, regardless of prostitution's legal status.

No one wants the business of prostitution operating in his or her community. Thus, zoning of the physical locations of sex businesses is often a sine qua non of legalization or decriminalization. Political pundits were certain that the NZ law would not have passed without a last-minute amendment that enabled local jurisdictions to zone prostitution into the neighborhoods of those who could least afford the legal battle to keep it away from their homes. Since passage of the NZ law, conflict has arisen regarding the zoning of prostitution. Pimps often rent homes in suburban areas for the purpose of prostitution and trafficking. Homeowners, on the other hand, want prostitution zoned out of the suburbs and into city centers in Auckland and in the more rural Tauranga District (MacBrayne, 2003; *New Zealand Herald*, 2003).

The regulation of prostitution by zoning is a physical manifestation of the same social/psychological stigma that de-

criminalization advocates allegedly want to avoid. Reflecting the social isolation of those in it, prostitution is often removed from the mainstream. Whether in Turkish *genelevs* (walled-off multiunit brothel complexes) or in Nevada brothels (ringed with barbed wire or electric fencing), women in state-zoned prostitution are physically isolated and socially rejected by the rest of society. Often, when prostitution is *not* physically removed from other businesses, for example in the case of strip clubs, club owners deny that prostitution occurs in their venues.

Advocates of decriminalization argue that the health of those in prostitution will be improved by decriminalization because otherwise women will not have access to health care. It is assumed that women will seek health care as soon as the stigma of arrest is removed from prostitution. If the stigma is removed, advocates argue, women will then file a complaint whenever they are abused, raped, or assaulted in prostitution. They assume that the complaint will be followed with a police response that treats women in prostitution with dignity and as ordinary citizens. Unfortunately, health care workers and police too often share the same contempt toward those in prostitution that others do.

A former prostitute in NZ said to the Parliament: "This bill provides people like me . . . with *some form of redress* [italics added], for the brutalisation that may happen...when you're with a client and you have a knife pulled on you" (Georgina Beyer, speech, Wellington, NZ, June 26, 2003). The specific form of redress offered by the NZ decriminalization law was not described by the speaker, nor is it articulated in the law. The dilemma for the person in prostitution is not that there is no legal redress for coercion, physical assault, and rape in the new law or in old laws. The dilemma is that in prostitution there is no avoiding sexual harassment, sexual exploitation, rape, and acts that are the equivalent of torture.

Decriminalization in NZ was promoted as a means of providing those in prostitution with legal redress against violent johns. However, prostituted women could already take legal action under existing laws but rarely did so. Explaining this situation, a NZ Prostitutes Collective member stated, "They don't want to draw attention to themselves and what they're doing" (Else, 2003, n.p.). Women in the Netherlands have expressed similar sentiments, even though prostitution has been legal there for many

years. Their concern was the loss of anonymity that exists in legal prostitution. Once officially registered as prostitutes, Dutch women feared that this designation would pursue them for the rest of their lives. Despite the fact that if officially registered as prostitutes they would accrue pension funds, the women still preferred anonymity (Schippers, 2002). They wanted to leave prostitution as quickly as possible with no legal record of having been in prostitution (Daley, 2001). Similarly, despite attempts to unionize women in Germany's \$16.5 billion legal prostitution industry, the women not only avoided unions, they avoided registering with the government and they continued to engage in illegal prostitution in part because they felt that the remote areas where prostitution is zoned put them at increased, not decreased, risk of physical danger (Taubitz, 2004).

VIOLENCE IS PERVASIVE IN LEGAL AS WELL AS ILLEGAL PROSTITUTION

It is a cruel lie to suggest that decriminalization or legalization will protect anyone in prostitution. There is much evidence that whatever its legal status, prostitution causes great harm to women. The following sections summarize some of the many studies that now document the physical and emotional harm caused by prostitution.

In the past two decades, a number of authors have documented or analyzed the sexual and physical violence that is the normative experience for women in prostitution, including Baldwin (1993, 1999); Barry (1979, 1995); Boyer, Chapman, and Marshall (1993); Dworkin (1981, 1997, 2000); Farley, Baral, Kiremire, and Sezgin (1998); Giobbe (1991, 1993); Hoigard and Finstad (1986); Hughes (1999); Hunter (1994); Hynes and Raymond (2002); Jeffreys (1997); Karim, Karim, Soldan, and Zondi (1995); Leidholdt (1993); MacKinnon (1993, 1997, 2001); McKeganey and Barnard (1996); Miller (1995); Silbert and Pines (1982a, 1982b); Silbert, Pines, and Lynch (1982); Valera, Sawyer, and Schiraldi (2001); Vanwesenbeeck (1994); and Weisberg (1985).

Sexual violence and physical assault are the norm for women in all types of prostitution. Nemoto, Operario, Takenaka, Iwamoto,

and Le (2003) reported that 62% of Asian women in San Francisco massage parlors had been physically assaulted by customers. These data were from only 50% of the massage parlors in San Francisco. The other 50%—those brothels controlled by pimps/traffickers who refused entrance to the researchers—were probably even more violent toward the women inside. Raymond, D’Cunha, et al. (2002) found that 80% of women who had been trafficked or prostituted suffered violence-related injuries in prostitution. Among the women interviewed by Parriott (1994), 85% had been raped in prostitution. In another study, 94% of those in street prostitution had experienced sexual assault and 75% had been raped by one or more johns (Miller, 1995). In the Netherlands, where prostitution is legal, 60% of prostituted women suffered physical assaults; 70% experienced verbal threats of physical assault; 40% experienced sexual violence; and 40% had been forced into prostitution or sexual abuse by acquaintances (Vanwesenbeeck, 1994). Most young women in prostitution were abused or beaten by johns as well as pimps. Silbert and Pines (1981, 1982b) reported that 70% of women suffered rape in prostitution, with 65% having been physically assaulted by customers and 66% assaulted by pimps.

Of 854 people in prostitution in nine countries (Canada, Colombia, Germany, Mexico, South Africa, Thailand, Turkey, United States, and Zambia), 71% experienced physical assaults in prostitution, and 62% reported rapes in prostitution (Farley, Cotton, et al., 2003). Eighty-nine percent told the researchers that they wanted to leave prostitution but did not have other options for economic survival. To normalize prostitution as a reasonable job choice for poor women makes invisible their strong desire to escape prostitution.

Vanwesenbeeck (1994) found that two factors were associated with greater violence in prostitution. The greater the poverty, the greater the violence; and the longer one is in prostitution, the more likely one is to experience violence. Similarly, the more time women spent in prostitution, the more STDs they reported (Parriott, 1994).

Those promoting prostitution rarely address class, race, and ethnicity as factors that make women even more vulnerable to health risks in prostitution. Farley (2003a) found that in NZ, as

elsewhere, indigenous women are placed at the bottom of a brutal race and class hierarchy within prostitution itself. When the researchers compared Maori/Pacific Islander New Zealanders to European-origin New Zealanders in prostitution, the Pacific Islander/Maori were more likely to have been homeless and to have entered prostitution at a young age. Mama Tere, an Auckland community activist, referred to NZ prostitution as an "apartheid system" (Farley, 2003a). Plumridge and Abel (2001) similarly described the NZ sex industry as "segmented," noting that 7% of the population in Christchurch were Maori; however, 19% of those in Christchurch prostitution were Maori.

Women in prostitution are treated as if their rapes do not matter. For example, in Venezuela, El Salvador, and Paraguay, the penalty for rape is reduced by one fifth if the victim is a prostitute (Wijers & Lap-Chew, 1997). Many people assume that when a prostituted woman is raped, that rape is part of her job and that she deserved or even asked for the rape. In an example of this bias, a California judge overturned a jury's decision to charge a customer with rape, saying "a woman who goes out on the street and makes a whore out of herself opens herself up to anybody" (Arax, 1986, p. 1).

We asked women currently in prostitution in Colombia, Germany, Mexico, South Africa, and Zambia whether they thought that legal prostitution would offer them safety from physical and sexual assault. Forty-six percent of these women in prostitution from six countries felt that they were no safer from physical and sexual assault even if prostitution were legal. Brothel prostitution is legal in Germany, one of the countries surveyed. In an indictment of legal prostitution, 59% of German respondents told us that they did not think that legal prostitution made them any safer from rape and physical assault (Farley et al., 2003). A comparable 50% of 100 prostitutes in a Washington, D.C., survey expressed the same opinion (Valera et al., 2001).

It is not possible to protect the health of someone whose "job" means that they will get raped on average once a week (Hunter, 1993). One woman explained that prostitution is "like domestic violence taken to the extreme" (Leone, 2001). Another woman said, "What is rape for others, is normal for us" (Farley, Lynne, & Cotton, in press).

HEALTH EFFECTS OF VIOLENCE IN PROSTITUTION

Throughout history, regardless of its legal status, prostitution has had a devastating impact on women's health. In 1858, Sanger asked 2,000 prostitutes in New York about their health and concluded that premature old age was the invariable result of prostitution (as cited in Benjamin & Masters, 1964). Sanger described conditions of despair, degradation, decline, and early death among prostitutes who survived on average only four years after entry into prostitution. A physician, he wondered how they lasted that long (Benjamin & Masters, 1964). Making the same observation in the parlance of today's global marketplace, an anonymous pimp commented on the "brief shelf life" of a girl in prostitution.

Pheterson (1996) summarized the health problems of women in prostitution: exhaustion, frequent viral illness, STDs, vaginal infections, back aches, sleeplessness, depression, headaches, stomachaches, and eating disorders. Women who were used by more customers in prostitution reported more severe physical symptoms (Vanwesenbeeck, 1994). A Canadian commission found that the death rate of women in prostitution was 40 times higher than that of the general population (Special Committee on Pornography and Prostitution, 1985). A mortality survey of more than 1,600 women in U.S. prostitution noted that "no population of women studied previously has had a . . . percentage of deaths due to murder even approximating those observed in our cohort" (Potterat et al., 2004, p. 783). In this survey, murder accounted for 50% of the deaths of women in prostitution. Reviewing comparable studies, Potterat et al. (2004) noted that murder accounted for between 29% and 100% of all prostituted women's reported deaths in Birmingham, UK; Nairobi, Vancouver, Canada; and London.

Cervical cancer is common among women who have been in prostitution. Two risk factors for cervical cancer are young age at first sexual activity and overall number of sexual partners. Prostituted women have an increased risk of cervical cancer and also chronic hepatitis (Chattopadhyay, Bandyopadhyay, & Duttagupta, 1994; de Sanjose et al., 1993; Nakashima et al., 1996; Pelzer, Duncan, Tibaux, & Mehari, 1992). In a Minnesota study,

the incidence of abnormal Pap screens among women in prostitution was several times higher than the state average (Parriott, 1994).

Comparing sexual assaults against prostituted women with sexual assaults against nonprostituted women, Canadian researchers found that the sexual assaults against those in prostitution were more physically violent and more frequently involved weapons (Efendov & Stermac, 2003).

It is sometimes assumed that young women in prostitution are knowledgeable about reproduction and sexual behaviors. This is not necessarily true. Often, women who enter prostitution as adolescents know very little about pregnancy, birth control, and STD. Although they may have been cautioned about HIV, adolescents in prostitution often have had no reliable education regarding sexuality, pregnancy, and contraception and may lack information about non-HIV-related STDs.

Traumatic brain injury (TBI) occurs in prostitution as a result of being beaten, hit, or kicked in the head, strangled, or having one's head slammed into objects such as car dashboards. TBI has been documented in torture survivors (Jacobs & Iacopino, 2001) and battered women (Valera & Berenbaum, 2003). Half of a group of 100 Canadian women in prostitution reported violent assaults to their heads that resulted in alteration of consciousness (Farley, Lynne, & Cotton, in press). Likely sequelae of TBI reported by the Canadian women included trouble concentrating, memory problems, headaches, pain/numbness in hands and feet, vision problems, dizziness, problems with balance, and hearing problems. Many of these symptoms may be confused with other diagnoses commonly experienced by prostituted women, such as post-traumatic stress disorder (PTSD), depression, and substance abuse. TBI may be treatable but only after it is properly diagnosed.

Chronic health problems generally result from physical abuse and neglect in childhood (Radomsky, 1995), from sexual assault (Golding, 1994), battering (Crowell & Burgess, 1996), untreated health problems, and overwhelming stress and violence (Friedman & Yehuda, 1995; Koss & Heslet, 1992; Rasmusson & Friedman, 2002). Prostituted women suffer from all of these. Many of the chronic symptoms of women in prostitution are similar to the

long-term physical consequences of torture (Peel, Hinshelwood, & Forrest, 2000; Vesti, Somnier, & Kastrup, 1992).

ARE THERE DIFFERENCES IN STREET, BROTHEL, AND STRIP-CLUB PROSTITUTION THAT AFFECT WOMEN'S HEALTH AND SAFETY?

It has been assumed that decriminalization/legalization will decrease street prostitution and that prostitution will then move indoors, where it will be physically safer for those in it. Those promoting legalized prostitution suggest that women will be safer in indoor prostitution than they are in street prostitution. However, women in Chicago reported the same frequency of rape in escort and in street prostitution (Raphael & Shapiro, 2002).

No research has demonstrated that legal prostitution decreases illegal (street and brothel) prostitution. Following legalization of prostitution in Victoria, Australia, although the number of legal brothels doubled, the greatest expansion was in *illegal* prostitution. In 1 year (1999), there was a 300% growth of illegal brothels (Sullivan & Jeffreys, 2001).

It is an error to assume that women in prostitution sign up for prostitution in one location and stay there. In fact, they move between different kinds of prostitution, depending on the location of johns, the level of police harassment, and where the most money can be made (e.g., near military bases or during political or business conventions). Kramer (2003) found that 59% of 119 U.S. respondents had been in one or more types of indoor prostitution (such as strip club, massage parlor, escort prostitution) in addition to street prostitution. Thirty-three percent of Kramer's respondents had been prostituted indoors for the longest period of time, while 66% were involved in street prostitution for the longest time. In similar findings, Farley (2003a) found that 46 NZ interviewees had been in many different kinds of prostitution, including escort, strip club, phone sex, Internet prostitution, peep show, bar prostitution, street prostitution, brothel prostitution, and prostitution associated with a military base. Twenty-two percent of these interviewees had been domestically trafficked from one region of NZ to another, and 6% had been trafficked from another country into NZ (Farley, 2003a).

Some studies have found differences in the level of violence in street as opposed to brothel prostitution, with more incidents of violence in street than in brothel prostitution. These findings are relative, however. Most of us would not consider any predictable and systematic violence acceptable in our jobs. While 83% of 303 NZ respondents interviewed by Plumridge and Abel (2001) experienced some type of violence in prostitution, 27% of those in street prostitution and 8% of those in brothel prostitution reported rape. Forty-one percent in street prostitution and 21% in brothel prostitution had been physically assaulted.

It is likely that the low rape incidence reported in some studies is a result of unclear definitions of rape. We found in our research that even women in prostitution themselves assume that rape cannot occur in prostitution when, in fact, it occurs constantly. Future research on prostitution should behaviorally define rape. For example, if rape is defined as any unwanted sex act, then prostitution has an extremely high rate of rape because many survivors view prostitution as almost entirely consisting of unwanted sex acts or even, in one person's words, paid rape.

Like Plumridge and Abel in NZ, we (Farley, Baral, et al., 1998) found more physical violence in street prostitution compared to brothel prostitution in South Africa. However, we found no difference in the incidence of PTSD in these two types of prostitution, suggesting that the emotional experience of prostitution is intrinsically traumatizing regardless of its indoor or outdoor location. Documenting the profound emotional distress experienced by women in two kinds of prostitution, a Canadian study compared strip club prostitution and street prostitution. The authors found that women prostituted in strip clubs had higher rates of dissociative and other psychiatric symptoms than those in street prostitution (Ross, Anderson, Heber, & Norton, 1990). In a separate study, we compared strip club/massage, brothel, and street prostitution in Mexico and found no differences in the prevalence of physical assault and rape in prostitution, of childhood sexual abuse, or symptoms of PTSD (Farley, et al., 2003). We also found no differences in the percentages of Mexican women in brothel, street, or strip club/massage prostitution who wanted to escape prostitution.

Vanwesenbeeck (1994) also observed great emotional distress among women in legal indoor prostitution in the Netherlands.

Investigating emotional distress in women who were prostituted primarily in clubs, brothels, and windows, Vanwesenbeeck found that 90% of the women reported "extreme nervousness".

Just as we know that violent men from all social classes batter women, so we also know that the difference between pimps who terrorize women on the street and pimps in business suits who terrorize women in gentlemen's clubs is a difference in class only, not a difference in woman hating. Generally, it is class prejudice to assume that street prostitution is far worse than what is called high-class escort prostitution. Boyer, Chapman, & Marshall (1993) suggested that women in indoor prostitution (such as strip clubs, massage brothels, and pornography) had *less* control of the conditions of their lives and probably faced greater risks of exploitation, enslavement, and physical harm than women prostituting on the street. Some women have said that they felt safer in street prostitution as compared to brothels (in the United States and in NZ) where they were not permitted to reject customers. They explained that on the street they could refuse dangerous-appearing or intoxicated customers. On the street, they reported, friends could make a show of writing down the john's car license plate number, which they considered a deterrent to customer violence. A john could be easily traced using such methods, whereas a brothel customer's identity would likely be protected by the brothel owners, making it difficult to prosecute him for violent behavior.

Women in brothels or clubs are not encouraged to complain about violence to pimps/owners. Sometimes, they are fired for these protests, even after being raped. In 2000, a dancer in San Francisco was raped in a private booth at the Mitchell Brothers strip club. When she complained to the owners about the rape, they fired her. Promoting an atmosphere that winked conspiratorially at sexual exploitation, harassment, and violence, the club had distributed advertisements that told customers, "What you do on your side of the curtain is your little secret" (Sward, 2000). In 2004, a woman prostituting at a Nevada brothel filed civil lawsuits against a john who assaulted her and against pimp Dennis Hof because he failed to call police and because the panic button in her room was not working (Associated Press, 2004)

Brothel owners and advocates of escort prostitution are well aware of the dangers of these kinds of prostitution, although they

rarely admit it publicly. For example, an organization in South Africa that advocates decriminalization of prostitution, Sex Workers' Education and Advocacy Taskforce (SWEAT), addressed the dangers of escort prostitution by distributing a list of safety tips for women. These included the recommendation that while undressing, the prostitute should accidentally kick a shoe under the bed, and while retrieving it, should check for knives, handcuffs, or rope. The SWEAT flyer also noted that fluffing up the pillow on the bed would permit searching there for weapons.

A brothel owner in the Netherlands complained about an ordinance requiring that brothels have pillows in the rooms: "You don't want a pillow in the [brothel's] room. It's a murder weapon" (Daley, 2001, p. 1). Familiar with how customers treated women in prostitution, this Dutch pimp understood that johns are regularly murderous toward women.

People often assume that prostitution does not occur in strip clubs. Yet the lines between prostitution and other sexually exploitive activities such as stripping have become increasingly blurred. The amount of physical contact between customers and women who strip has escalated since 1980, along with an increase in sexual harassment and physical assault. Touching, grabbing, pinching, and fingering of dancers removes any boundaries between dancing, stripping, and prostitution (Lewis, 1998). Holsopple (1998) documented the verbal, physical, and sexual abuse experienced by women in strip club prostitution, which included being grabbed on the breasts, buttocks, and genitals, as well as being kicked, bitten, slapped, spit on, and penetrated vaginally and anally during lap dancing. In most clubs, customers can buy either a table dance or a lap dance where the dancer sits on the customer's lap while she wears few or no clothes and grinds her genitals against his. Although he is clothed, he usually expects ejaculation. The lap dance may take place on the main floor of the club or in a private room. The more private the sexual performance, the more it costs, and the more likely that violent sexual harassment or rape will occur. At one strip club, a woman reported, "We know when [prostitution] happens [during private lap dances]. Then four songs are played instead of two" (Son, 2003, n.p.).

Coney (2003) described the NZ Department of Occupational Safety and Health measures as a "farce" with respect to protecting

women in prostitution from violence. The NZ prostitution bill's provision to allow health officers entry to brothels would not permit surveillance of violent acts occurring behind closed doors. The panic buttons in massage parlors, saunas, and brothels can never be answered quickly enough to prevent violence. Panic buttons in brothels make as little sense as panic buttons in the homes of battered women. A bouncer in an Australian (legal) brothel said that when the women ring the buzzer, he breaks the door open, but there is really no way to prevent violence and, according to this bouncer, johns beat women with some regularity (Jeffreys, 2003). A woman who was in escort prostitution (where customers call phone numbers listed in the phone book or advertising section of newspapers, and a meeting place is agreed on) stated that her driver "functioned as a bodyguard. You're supposed to call when you get in, to ascertain that everything was OK. But they are not standing outside the door while you're in there, so anything could happen" (Raymond, Hughes, & Gomez, 2001, p. 74).

Specifications in the Australian Occupational and Safety Codes (OSC) for prostitution betray the danger in prostitution, which is not the same as that in any other job. The Australian OSC recommend self defense for women in prostitution and promote classes in hostage negotiation skills. The Australian OSC, while suggesting that a woman use her intuition to predict which johns will be violent, also distribute a list of violent johns to police, social workers, and prostituted women (Jeffreys, 2003).

VERBAL ABUSE RESULTS IN INCREASED HEALTH RISKS IN PROSTITUTION

In most sexual assaults outside of prostitution, women are characterized as prostitutes. In prostitution, women are called the same names that all women are called by violent men. For the sex predator, the names justify the violence, just as racist names justify racist violence. Along with humiliation of the victim, verbal abuse also eroticizes the john's violence (Baldwin, 1993).

The harm of toxic verbal assaults (primarily from johns) against those in prostitution is emotionally devastating, often outlasting the physical injuries. The verbal abuse in prostitution is socially invisible, just as other sexual harassment in prostitution is

normalized and invisible. Yet it is pervasive: 88% of 315 prostituting women and adolescents in Canada, Colombia, and Mexico described verbal abuse as intrinsic to prostitution (Farley et al., 2003). Verbal assaults in all types of prostitution are likely to cause acute and long-term psychological symptoms. Explaining this process, one woman said that over time "it is internally damaging. You become in your own mind what these people do and say with you. You wonder how could you let yourself do this and why do these people want to do this to you?" (Farley, 2003b, p. 267).

PTSD IS A CONSEQUENCE OF PROSTITUTION

Laws that justify legalization or decriminalization of prostitution to safeguard women's health fail to address the psychological harm of prostitution. Although the traumatic effects of rape and other violence to women who are *not* in prostitution are well established, the same trauma is not well understood among women in prostitution. Research on the traumatic effects of rape applies to women in prostitution. Aosved and Long (2003), for example, found that women who experience rape resulting from coercive tactics such as abuse of authority, arguments, or social pressure experience the same high levels of depression and PTSD as women who have been raped as a result of force and threat of force.

The diagnosis of PTSD encompasses symptoms resulting from traumatic events, including the trauma of prostitution. PTSD can result when people have experienced

extreme traumatic stressors involving direct personal experience of an event that involves actual or threatened death or serious injury; or other threat to one's personal integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. (American Psychiatric Association, 1994, p. 424)

PTSD is characterized by anxiety, depression, insomnia, irritability, flashbacks, emotional numbing, and hyperalertness. Symptoms are more severe and long lasting when the stressor is

of human design. PTSD is normative among prostituted women. Farley et al. (2003) found a PTSD prevalence rate of 68% among those in prostitution in nine countries. This rate was comparable to the rates of PTSD among battered women seeking shelter (45%, Housekamp & Foy, 1991; 84%, Kemp, Rawlings, & Green, 1991), rape survivors (70%, Bownes, O’Gorman, & Sayers, 1991), and survivors of state-sponsored torture (51%, Ramsay, Gorst-Unsworth, & Turner, 1993). Illustrating a severe symptom of PTSD, one prostitution survivor said, “For the first few months I worked [in prostitution] I had a lot of nightmares involving mass numbers of penises” (Williams, 1991, p. 75). Many years after escaping prostitution, an Okinawan woman who was purchased by U.S. military personnel during the Vietnam War became agitated and had flashbacks of sexual assaults on the 15th and the 30th of each month—those days that were U.S. military paydays (Sturdevant & Stoltzfus, 1992). A third survivor described an altered consciousness of time that may be understood as a symptom of PTSD: “When you are a prostitute, you do not think of tomorrow, you just think of now” (Karim et al., 1995, p. 1523).

PROSTITUTION CAUSES OTHER PSYCHOLOGICAL HARM, IN ADDITION TO PTSD

Description of the psychological harm of prostitution sometimes comes from its advocates. For example, the NZPC wrote in an unpublished flyer that people in prostitution know they should take a break from prostitution “when every client makes your skin crawl, when your jaw aches from clenching your teeth to prevent yourself spitting in the bastard’s face . . . [or] when you can’t stand what you see when you look in the mirror” (NZPC flyer by Michelle, circa 1994).

Most women who have been in prostitution for any length of time experience sexual dysfunction with their chosen partners. Feelings are disconnected from sexual acts. It becomes nearly impossible to view partners as anything but johns. Funari (1997) worked in a mirror-walled booth, naked. In this type of prostitution, there is no physical contact between prostitute and john, yet it still adversely affected her view of her self, her sexuality, and her attitude toward men. A thick glass wall separated Funari from

the peeping men, and when the shutters went down every 30 seconds, they paid again to watch her and to masturbate. In peep shows and in pornography/prostitution booths, men's booths are hosed down with Clorox after each customer. Funari described the effects on her after less than a year in peep show prostitution:

At work, what my hands find when they touch my body is "product." Away from work, my body has continuity, integrity. Last night, lying in bed after work, I touched my belly, my breasts. They felt like Capri's [her peep show name] and they refused to switch back. When [her partner] kissed me I inadvertently shrunk from his touch. Shocked, we both jerked away and stared at each other. Somehow the glass had dissolved, and he had become one of them. (p. 32)

To retain her self-respect, Funari resisted emotional connection with men who considered her to be essentially worthless. Yet she felt "poisoned" by the contempt of customers. Her sexual feelings for her boyfriend waned.

Dissociation occurs during extreme stress among prisoners of war who are tortured, among children who are sexually assaulted, and among women who are battered, raped, or prostituted (Herman, 1992). Dissociation, depression, and other mood disorders are common among prostituted women in street, escort, and strip club prostitution (Belton, 1998; Ross et al., 1990; Vanwesenbeeck, 1994). Dissociation in prostitution results from both childhood sexual violence and sexual violence in adult prostitution. At the same time, dissociation is a job requirement for surviving prostitution.

Regardless of the variations in the type of prostitution, women feel that they have to rent out the most intimate parts of the body to anonymous strangers to use as a hole to jerk off in. The women try to keep themselves as unharmed as possible from this massive invasion by maintaining a distance from the customer. (Hoigard & Finstad, 1986, p. 132)

If anything a prostitute treats herself like a chair for someone to sit on. Her mind goes blank. She just lies there. You become just an object. . . . After a while it becomes just a normal thing. (McLeod, 1982, p. 39)

Prostitution is like rape. It's like when I was 15 years old and I was raped. I used to experience leaving my body. I mean that's what I did when that man raped me. I went to the ceiling, and I numbed myself because I didn't want to feel what I was feeling. I was very frightened. And while I was a prostitute I used to do that all the time. I would numb my feelings. I wouldn't even feel like I was in my body. I would actually leave my body and go somewhere else with my thoughts and with my feelings until he got off, and it was over with. I don't know how else to explain it except that it felt like rape. It was rape to me. (Giobbe, 1991, p. 144)

A New Zealand pimp of 25 years, B—, reported that after turning one trick, almost all of her girls knew whether they could survive prostitution. According to this pimp, 30% of women absolutely could not endure prostitution. It is likely that this 30% who could not continue were those who could not dissociate. Making a similar observation about women in the Netherlands, Vanwesenbeeck (1994) noted that what she called a dissociative proficiency contributed to a "professional attitude" among women in Dutch prostitution (p. 107). A Thai woman said, "You make yourself empty inside" (Bishop & Robinson, 1998, p. 47).

[In prostitution] I would just go someplace else mentally as well as emotionally. Soon I just lost track of days at a time. When I was awake, I started feeling "invisible." When I would come back home from a call, I used to stand in front of a mirror and pinch myself just to see if I was real. Spending months with people just looking at your body can make you wonder if "you" exist at all. (Williams, 1991, p. 80)

"Memory is an amazing thing. I leave here [brothel] and I can't remember a thing" (Farley, 2003a). Another woman described the gradual development of a dissociated identity during the years she was prostituted in strip clubs:

You start changing yourself to fit a fantasy role of what they think a woman should be. In the real world, these women don't exist. They stare at you with this starving hunger. It sucks you dry; you become this empty shell. They're not really looking at you; you're not you. You're not even there. (Unnamed woman, personal interview, May 10, 1998)

It is confusing to many, including governments, that women in prostitution appear to consent to prostitution. It is only when one

looks carefully at the context of the consent, as well as past traumatic abuses, that this apparent consent to and promotion of prostitution by some women in the sex industry can be understood. Playwright Carolyn Gage (in press) has written about the relation between incest, dissociation, and advocacy of prostitution in the life of one woman:

Angie . . . had sexually serviced, she estimated, about two thousand men. She owned a home, which she referred to as "the house that fucking built." As a prostitute, Angie had become a spokeswoman for prostitution. She described herself as a "poster child" for liberal organizations advocating for legalization of prostitution. She was, apparently, their model of the happy, healthy hooker.

Angie's prostitution was socially supported and paid well. To understand herself as a former child victim would be to see that her seemingly autonomous, even rebellious choices were, in fact, programmed responses to previous torture and captivity. The elements of choice and free will so critical to her sense of personhood were not as she had seen them. With every act of so-called sexual liberation, she was reinscribing her trauma.

For three decades, Angie had had no memories of her sexual abuse as a child. Growing up in the Midwest as the only child of Christian fundamentalist parents, she had not remembered anything extraordinary about her childhood. . . . Later, she married and began to participate in group sex and partner-swapping. It was the Sixties, and Angie considered herself liberated. (n.p.)

Angie's memories of chronic sexual abuse returned only after she had stopped prostitution. Until that time, the memories of childhood abuse were completely split off from her normal consciousness. Later, she met a supportive friend and took a class in which she began to write about her life. At this point, memories of the sexual abuse surfaced. For a time, she felt that she had betrayed other women by her previous advocacy of prostitution as a glamorous career choice.

A primary function of dissociation is to endure and manage the overwhelming fear, pain, and systematized cruelty that is experienced during prostitution in addition to earlier abuse by separating these atrocities from the rest of the self (Ross, Farley, & Schwartz, 2003).

The dissociated identity has a profound investment in denying that it is split off, because the original stakes were usually nothing

less than survival. For this reason, the dissociated personality can be very persuasive. When Angie said she loved being a prostitute, loved servicing her clients, would have done it even without pay, she was persuasive because she believed it—and because she believed it, she was very credible. (Gage, in press, n.p.)

CAN WOMEN IN PROSTITUTION BE PROTECTED FROM HIV?

There is extensive medical documentation that HIV is transmitted from john to prostitute via vaginal and anal intercourse. Rape by customers is a primary source of HIV infection among prostituted women, adolescents, and children. Yet one of the lies about prostitution is that *she* is the source of infection. Although there has been an intense focus on the HIV risk posed by the prostitute to men who buy her, at the same time there has been a lack of attention to psychological and physical violence against women in prostitution.

In the HIV literature from 1980 to 2000, most authors minimized or ignored HIV risk posed by the customer to the woman in prostitution. Most also failed to mention alternatives to prostitution as a means of improving women's health. For example, Karim and colleagues (1995) interviewed women who were prostituted at a truck stop located between Durban and Johannesburg, South Africa. This group of researchers found that women were at a higher risk for physical violence when they insisted on condom use with customers. Ignoring their own finding of the dangers to women who attempted to persuade customers to use condoms, the researchers recommended that women in prostitution learn negotiation and communication skills to reduce HIV risk. It seems tragically likely that this particular project, and others with comparable recommendations, may result in additional injury, even death, to some women in prostitution.

From the time that HIV was recognized as an epidemic in the early 1980s, HIV education programs focused on what has been called safer sex education or safer sex negotiation, assuming that if the woman in prostitution can be taught to be more assertive, then she can persuade the customer to use a condom. What many HIV prevention programs fail to address is the customer's demand for sex without a condom in situations of vastly unequal

power where the woman in prostitution does not have the physical or economic power to refuse him. Eighty-nine percent of Canadian customers of prostitutes refused condoms in one study (Cunningham & Christensen, 2001). Because customers paid more money for not using condoms, extremely risky sex acts "can always be purchased" (Loff, Overs, & Longo, 2003). In another study, 47% of women in U.S. prostitution stated that men expected sex without a condom, 73% reported that men offered to pay more for sex without a condom, and 45% of women said that men became abusive if they insisted that men use condoms (Raymond, Hughes, et al., 2001). "It's 'regulation' to wear a condom at the sauna, but negotiable between parties on the side. Most guys expected blowjobs without a condom" (Raymond et al., 2001, p. 72).

In public health circles it is still assumed that the health consequences of prostitution are primarily STD- or HIV-related and that male condom use will solve the overall health problems of prostituted women (Hsu & du Guerny, 2002; Wolffers & van Beelen, 2003). Yet in 2003, the AIDS Epidemiology Group at Otago University reported no association between HIV/AIDS and prostitution in New Zealand (Coney, 2003). Many now understand that women in prostitution will do everything they can to avoid HIV and other STDs. When not physically prevented from using male condoms and when female condoms are made available, women in prostitution use barrier methods of protection from STD and HIV. Proponents of legalization/decriminalization rarely mention that the woman in prostitution is most often infected by the john, not because she deliberately avoids condoms, but because he raped her without a condom or because he persuaded or coerced her by paying her much more for sex acts without a condom.

A UN/AIDS and WHO campaign in Thailand began in the late 1980s to ensure 100% condom use. (In prostitution, 100% condom use is an oxymoron.) According to women in prostitution, under this policy they suffered the same social contempt as always but with additional coercive tactics such as being taken to clinics for health checks under police or military escort. The campaign humiliated women by posting their photographs in brothels so that johns could inform pimps which of the women had agreed to

have sex without a condom (Loff et al., 2003). Johns' culpability for their own failure to use condoms was ignored.

Responding to pressure from HIV educators that women should initiate and enforce condom use with customers, a group of Nicaraguan women in prostitution urged that customers, not prostitutes, be compelled to use condoms (Gorter et al., 2000). This recommendation rarely comes from pimps, brothel owners, HIV educators, and government regulators, who instead unite to enforce women's sole responsibility for condom use, rather than holding male customers accountable.

Globally, the incidence of HIV seropositivity among prostituted women is devastating. Homeless children and adolescents in Romania and Colombia, for example, are at highest risk for sexual predation as well as HIV. Piot (1999) noted that one half of new AIDS cases are people younger than age 25 years, and that girls are likely to become infected at a much younger age than boys, in part, because of the acceptance of violence perpetrated against girls and women in most cultures.

Violence against women is a primary risk factor for HIV (Garcia-Moreno & Watts, 2000; Matsamura, 2003; Piot, 1999; United Nations, 2003). Aral and Mann (1998), at the U.S. Centers for Disease Control, emphasized the importance of addressing human rights issues in conjunction with public health campaigns against STD. They noted that because most women enter prostitution as a result of poverty, rape, infertility and subsequent abandonment, or divorce, public health programs must address the social factors that contribute to STD/HIV. Gender inequality in any culture normalizes sexual coercion thereby promoting domestic violence and prostitution, ultimately contributing to women's likelihood of becoming HIV infected (Pyne, 1995; Raymond, 1998)

Understanding the connection between partner violence, rape, and HIV/AIDS is crucial to understanding the continued vulnerability of women in prostitution, despite condom distribution programs. For example Kalichman, Kelly, Shaboltas, and Granskaya (2000) and Kalichman, Williams, Cheery, Belcher, and Nachimson (1998) noted the coincidence of the HIV epidemic and domestic violence in Russia, Rwanda, and the United States. STD and HIV have increased exponentially in states of the former Soviet Union since 1995. From 1987 to 1995, fewer than 200 new

HIV infections per year were diagnosed in Russia. In the first 6 months of 1999, 5,000 new cases of HIV were reported (Dehne, Khodakevich, Hamers, & Schwartlander, 1999). In the city of Kaliningrad, Russia, 1 in 3 people infected with HIV was a woman, and 80% of the infected women were in prostitution (Smolskaya, Momot, Tahkinova, & Kotova, 1998). It is likely that this massive increase in HIV resulted from an extremely high rate of violence against women in Russia (Hamers, Downs, Infuso, & Brunet, 1998). In Russia, women are treated as "office prostitutes" via job requirements that require them to tolerate sexual harassment (Hughes, 2000).

In Senegal, prostitution is government regulated based on the assumption that regulation will reduce rates of HIV. Women are required to register as prostitutes, to have monthly medical checks, and to receive HIV counseling. They are also supplied with condoms. In a study comparing registered women who had received HIV education with those who were unregistered and uneducated about HIV, researchers found higher HIV infection rates among the registered women (Laurent et al., 2003). This study raises questions about the efficacy of HIV education programs.

HIV/AIDS EDUCATION AND THE PROMOTION OF PROSTITUTION

Some prostitutes' organizations such as the NZPC have done valuable HIV/AIDS education, needle exchange, and condom distribution (Coney, 2003). This is a contribution to public health and has undoubtedly saved lives. On the other hand, there is an ominous side to the HIV education activities of groups who claim to represent all women in prostitution while they simultaneously promote prostitution as a job.

Alexander (1996) commented that the AIDS epidemic brought with it certain advantages to those promoting prostitution. The HIV epidemic has indirectly facilitated the growth of the commercial sex industry by creating funding opportunities for HIV education and outreach programs. Government funding for programs promoting both HIV education and legal recognition of prostitution has taken place in Brazil, Cambodia, Canada, Germany, the Netherlands, Mexico, Australia, New Zealand, China,

Panama, Bangladesh, Austria, India, Russia, and the United States, among others. Groups such as the New Zealand Prostitutes Collective (NZPC), SWEAT in South Africa, and the California Prostitutes' Education Project (Cal-PEP) have benefited from funding that has supported their efforts to legalize or decriminalize the sex industry. These programs have created unions and lobbying opportunities for decriminalizing prostitution. SWEAT, for example, distributed a pamphlet in 1995, the goal of which was to "assist you in your career in the [sex] industry." Funded with HIV prevention monies, SWEAT offered training in sexual massage.

Other programs operate much like SWEAT. Although designed to prevent STD/HIV among those in prostitution, such organizations not only distribute condoms but promote prostitution as well. For example, a European publication titled "Hustling for Health" recommended drop-in centers, condoms, and coffee as necessary services for those in prostitution (Bloem, 1999, p. 7). However, the options of housing, drug treatment, or escape from prostitution are not mentioned in the pamphlet. The best possible outcome for those in prostitution is assumed to be a frank, casual chat with peers in prostitution. The pamphlet tacitly assumes the recipient's continuation in prostitution.

The NZPC was founded in 1987 as a lobbying organization for sex businesses and to improve the working conditions of women in prostitution. Since 1987, the NZPC has been funded by the NZ Ministry of Health to provide HIV education to those in prostitution and to distribute clean needles. In the process of funding the NZPC, the NZ Health Ministry was educated about prostitution exclusively by that one organization and subsequently became aligned with the political goal of the NZPC: to decriminalize prostitution. Representatives of the NZ Health Ministry told me that they knew everything they needed to know about prostitution via information received from the NZPC. In this case, the links are clear: First, there is public health funding for AIDS outreach, then the organizations conducting the health outreach lobby for decriminalization or other legal recognition of prostitution, and subsequently government agencies adopt the perspective that prostitution is a form of labor rather than a human rights violation.

The distribution of public health funds for HIV prevention has occurred with little oversight of recipient goals, program

implementation, or ethics. Public health educators may negotiate with pimps to ensure that they will be able to enter brothels to distribute condoms to women and even to children in prostitution. Sometimes deals are made, for example in Kerala State, India, where social workers had to obtain permission from brothel pimps to hand out condoms. In exchange, the social workers agreed to ignore the presence of prostituted children and not to advocate escape from prostitution by informing the women about available services (Friedman, 1996).

Bargaining with brothel owners and pimps also occurred at the Calcutta-based Sonagachi Project. Jana, Bandyopadhyay, Saha, and Dutta (1999) explained that in the Sonagachi Project,

Prostitution was accepted as a valid profession and no attempt was made at discouraging sex workers to practice prostitution or at rescuing or rehabilitating them. This reassured the other stakeholders in the sex trade that we outsiders were not going to disrupt their business. (p. 23)

An alliance between pimps and others who use HIV education monies to promote prostitution is also clear in the case of Cal-PEP. By 1993, Cal-PEP had received US\$1.6 million in state and federal grants to work on AIDS prevention among prostitutes. The founder of Cal-PEP was a member of COYOTE, a U.S. organization promoting decriminalization of prostitution. Furthermore, the agency was directed by the founder's former pimp who had a felony conviction for running an interstate prostitution business (Marinucci & Williams, 1993). This Oakland, California, project continued to receive state HIV-prevention funding in 2003.

Although it provides comprehensive health and HIV-prevention services, the Tan Bazar brothel in Bangladesh is in reality a prison encampment. The Tan Bazar brothel advertises the following services for prostitutes in a clinic attached to the brothel: contraceptives, counseling, condoms, STD/HIV treatment, abortion, antenatal and postnatal checkups, infertility care, gynecological care, and treatment of minor ailments. A children's clinic is included (Ahmed, 2001). This huge brothel, the largest in Bangladesh, locked women and their children inside and essentially functioned as a prison for poor women in prostitution. They lived most of their lives in the brothel, constantly available for purchase but out of public view.

In another egregious case of misguided public health policy, Hernandez (2003) investigated the trafficking of Mexican girls to brothels near San Diego where criminal networks control at least 50 brothels including outdoor sexual exploitation camps for migrant farm laborers. During a 10-year period, hundreds of adolescent girls from rural Mexico were either kidnapped or tricked into crossing the U.S. border by coyotes, traffickers, and pimps. These girls were sold for sex acts not only to hundreds of farm workers who were transported to camps where they sexually assaulted girls in prostitution but also to U.S. tourists and U.S. military personnel.

A U.S. physician who worked for a clinic that provided health care to migrant workers said, "The first time I went to the camps I didn't vomit only because I had nothing in my stomach. It was truly grotesque and unimaginable" (Hernandez, 2003). Many of the girls were 9 or 10 years old. On one occasion, the physician counted 35 men paying to rape a girl during a single hour. After she reported the girls' sexual assaults in prostitution, the physician was instructed by U.S. public health officials that prostitution was not a migrant health concern. Advised by her superiors to work with the pimps, she limited her practice to "prevent[ing] HIV/AIDS and other venereal diseases in the exploited minor girls" (Hernandez, 2003). It is frankly criminal to address only STD/HIV and to ignore child and adolescent physical abuse, rape, kidnapping, trafficking, and child prostitution. Yet in public health clinics and STD/HIV clinics, this tunnel vision is the rule rather than the exception.

Bernard Trink, a U.S. expatriate living in Bangkok who is an avid customer of prostitution, writes weekly columns in the *Bangkok Post* about the Thai sex industry. Trink is an unlikely critic of groups such as SWEAT, NZPC, Cal-PEP, or EMPOWER in Bangkok, but he does not mince words when asked about the effectiveness of groups working against HIV among prostitutes:

EMPOWER is a bullshit operation . . . they're working on AIDS discrimination, which is fine, but it doesn't help the women. For them it is only money. *The only thing that would move them out [of prostitution] is a job that pays as well* [italics added]. (Bernard Trink, quoted by Bishop & Robinson, 1998, p. 184)

CONCLUSION

Legal sex businesses provide locations where sexual harassment, sexual exploitation, and violence against women are perpetrated with impunity. State-sponsored prostitution endangers all women and children in that acts of sexual predation are normalized—acts ranging from the seemingly banal (breast massage) to the lethal (snuff prostitution that includes filming of actual murders of real women and children). A report on the sexual exploitation of children noted that the presence of a thriving adult sex industry in a community had the effect of increasing child prostitution in that same community (Estes & Weiner, 2001). Nevada, the one U.S. state where prostitution is legal in 13 counties, had significantly higher rates of sex crimes than the rest of the United States in the 1990s (Albert, 2001).⁶

Johns who buy women, groups promoting legalized prostitution, and governments that support state-sponsored sex industries comprise a tripartite partnership that endangers all women. These groups collude in denying the everyday violence and subsequent health dangers to those in prostitution. One john, for example, rationalized prostitution as providing health benefits to women in prostitution: Dave (2003) opined that by providing breast massage, he would thereby improve the breast health of women in prostitution. He cited numerous medical studies justifying his (paid-for) sexual assaults as medically beneficial.

Those who promote legalization or decriminalization defend the customer base of sex industries with far-fetched rationalizations. Although duly noting the problem of “murderous clients” of prostitutes, Kinnell (2001) nonetheless suggested that legally targeting dangerous johns for arrest somehow increases the danger to those in prostitution. She stated that although “many attacks are perpetrated by clients,” we should still not assume therefore that “a high proportion of clients is potentially violent.”

Pimp states across the globe⁷ operate with sophisticated subterfuge in defending legalization or decriminalization of prostitution. Although violence has been declared a priority area of the New Zealand Health Strategy, no part of the NZ prostitution bill offers any specific protection from the violence that is intrinsic to prostitution. Giving lip service to protecting women’s health, the NZ prostitution law claims to protect everyone from HIV and

STDs, even though it has already been established that there is *no association between prostitution and HIV in New Zealand* (Coney, 2003).

The NZ human rights law has provisions that protect women from sexual harassment. It is a far more protective law than the NZ law that decriminalizes prostitution in the name of women's health, safety, and right to work. Because one of the job requirements of prostitution is tolerating sexual harassment, how will the NZ human rights law protect women in prostitution from sexual harassment? "What will be the . . . outcome of struggles against sexual harassment and violence in the home, the workplace, or the street, if men can buy the right to perpetrate these very acts against women in prostitution?" (D'Cunha, 2002, p. 41).

Prostitution is an institution that systematically discriminates against women, against the young, against the poor, and against ethnically subordinated groups. Prostitution cannot be made safer or a little bit better by legalizing or decriminalizing it (Raymond, 2003). It is a particularly vicious institution of inequality of the sexes. Understanding this, Nevada legislator William O'Donnell stated,

It bothers me that we're making money off the backs of women. Condoning prostitution is the most demeaning and degrading thing the state can do to women. What we do as a state is essentially put a U.S.-grade stamp on the butt of every prostitute. Instead, we should be turning them around by helping them back into society. (quoted in Albert, 2001, p. 178)

Does a john's payment of money to a woman in prostitution erase all that we know of sexual harassment, rape, and domestic violence? The adage *silence is consent* is mistakenly applied to women in prostitution. We blame those who keep silent for whatever happens to them because, the logic goes, they should have protested abuse. Women in prostitution are silent for many reasons. They are rarely given the opportunity to speak about their real lives because this would interfere with sex businesses. The silence of most of those in prostitution is a result of intimidation, terror, dissociation, and shame. Their silence, like the silence of battered women, should not be misinterpreted, ever, as their consent to prostitution.

NOTES

1. "Bad for the body, bad for the heart" was the way a young Thai woman summarized the effects of prostitution in *Hello My Big Big Honey: Love Letters to Bangkok Bar Girls and Their Revealing Interviews* (Walker & Ehrlich, 2000).

2. Legal prostitution cannot possibly protect children from being exploited. The existence of a neighborhood adult sex industry constitutes one of the risk factors for adolescents' entry into prostitution (Estes & Weiner, 2001).

3. What shall we call the men who buy the women and children in prostitution? They are socially tolerated sexual predators but are rarely identified as such. I use the word *johns* because that is the word most commonly used by women in prostitution for them. They're also called customers, buyers, clients, tricks, dates. The word *trick* is used because johns constantly try to trick, wheedle, or coerce women into performing more sex acts in prostitution than they are paid for.

4. In 2003, Heidi Fleiss celebrated the opening of a brothel franchise in Australia, where prostitution is legalized. Fleiss is a survivor of childhood sexual abuse and later prostitution who turned to pimping other women as a way out of prostitution for herself.

5. Organizations occasionally change their politics. If I have included any organization in error, I would be happy to hear about that.

6. Nevada's rate of rape per 1,000 population was .57 in 1997, while the overall U.S. rate was .36. Nevada's two largest metropolitan areas, Reno and Las Vegas, ranked far ahead in rapes than other popular U.S. tourist destinations, including Los Angeles and San Francisco. Reno and Las Vegas are adjacent to 2 of the 13 Nevada counties where prostitution is legalized (Albert, 2001, pp. 182-183, citing *Nevada Crime Statistics*).

7. By law, pimps are defined as those who support themselves via the earnings of prostitutes. Thus, when a government benefits from taxing the earnings of prostitutes in legalized or decriminalized prostitution, it is appropriate to bring the notion of pimping into the discussion, hence pimp-states.

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