Condom use in context: women’s experiences in the massage parlour industry in Vancouver, Canada

Ingrid Handlovskya*, Vicky Bungaya and Kat Kolarb

aUBC School of Nursing, Vancouver, Canada; bDepartment of Sociology, University of Toronto, Toronto, Canada

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Investigation into condom use in sex work has aroused interest in health promotion and illness prevention. Yet there remains a dearth of inquiry into condom use practices in the indoor sex industry, particularly in North America. We performed a thematic analysis of one aspect of the indoor sex work by drawing on data from a larger mixed-methods project that investigated women’s health issues in the massage parlour industry in Vancouver, Canada. Using a ‘risk context’ framework, condom use was approached as a socially situated practice constituted by supportive and constraining dynamics. Three analytic categories were identified: (1) the process of condom negotiation, (2) the availability of condoms and accessibility to information on STI and (3) financial vulnerability. Within these categories, several supportive dynamics (industry experience and personal ingenuity) and constraining dynamics (lack of agency support, client preferences, limited language proficiency and the legal system) were explored as interfacing influences on condom use. Initiatives to encourage condom use must recognise the role of context in order more effectively to support the health-promoting efforts of women in sex work.

Keywords: condoms; indoor sex work; risk; STIs; women’s health

Introduction

Condom use has long been identified as protective against the transmission of many sexually transmitted infections (STIs) including HIV (Holmes, Levine, and Weaver 2004) and has been of much interest in the fields of health promotion and infection prevention within the commercial sex industry. In North America, much of this research has focused on condom use incidence and prevalence. The major focus of this literature has been on street-level female sex workers living with mental health problems and addictions, whose likelihood of contracting STI and HIV is correlated with severe social and economic vulnerabilities (Bucardo et al. 2004; Ford et al. 2002; Shannon et al. 2008; Varga 1997; Wojcici and Malala 2001). However, women working in the indoor sex industry do not necessarily face the same contexts of risk for STI as those working outdoors, as is indicated by lower reported rates of violent victimisation and less exposure to police arrest among indoor workers (Church et al. 2001; Lewis et al. 2005). Furthermore, the contexts of indoor sex work are not homogenous, varying with regards to: the level of support indoor workers receive for condom use from establishment owners or managers, the level of control indoor workers have over services offered, their access to health outreach.

*Corresponding author. Email: handlovs@interchange.ubc.ca

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workers within sex venues and the availability of condoms in venues (Albert et al. 1995; Ghose, Swendeman, and George 2011; Ragsdale, Anders, and Philippakos 2007). These markedly different risk contexts problematise assumptions that women’s experiences of condom use and negotiation with clients are uniform throughout sex work.

To date, there is little Canadian health-related research pertaining to condom use in the indoor sex industry, which is alarming given that approximately 80% of those engaged in sex work do so within indoor settings (e.g., massage parlours, escort agencies) (Hanger 2006). This oversight in health research has contributed to oversights in health service delivery among this hidden population (Bungay et al. 2011; Remple et al. 2007). Consequently, the present study aimed to assess women’s experiences with condom use and how these are situated within the social dynamics of their work in the indoor sex industry in Vancouver, Canada. Rather than try to isolate risk factors as static characteristics associated with STI infection, as has been done in much previous work (Bhattacharya 2004; Huang et al. 2004; Kulcrycki 2004; Varga 1997), we seek to move away from a reductive approach in order to identify and explore the more complex, fluctuating aspects of condom use as a socially situated practice. To do this, we conceptualised condom use as a process operating in a risk context: a context where supportive and constraining dynamics interface to influence condom use practices in the indoor sex venue setting.

**Sex work and risk as context: moving beyond studies of risk and risk behaviour**

Risk and risk behaviour are closely related terms. Risk is often defined mathematically, as the probability of an adverse event (Douglas 1992) and risk behaviour is generally understood as the decision-making process humans engage in to avoid such an event (Rhodes 1997; Slovic 1999; Taylor 1991). These definitions are, however, arguably simplistic due to assumptions of calculative and context-free risk rationality. These original formulations of risk have been heavily criticised for overlooking how behaviours are situated within social environments that both influence behaviour and result in differential exposure to negative outcomes or events (Rhodes 1997; Rhodes et al. 2005). The literature has since delved into exploration of the impact of social contexts on risk and risk behaviour, which have been primarily conceptualised as shaped by factors such as socioeconomic status, age, ethnicity and gender (Lupton 1999; Rhodes et al. 2005). While we agree that risk and risk behaviour are in some ways shaped by the above-stated factors, we hold that risk is better understood as interfacing with dynamic social contexts that influence people’s practices in relation to, and experiences of, negative outcomes. This approach allows us to supplement the research conversation on condom use in relation to likelihood of contracting STI by redirecting analysis from identifying static and reductive risk factors to the exploration of supportive and constraining social dynamics that operate to influence condom use behaviour in the risk context of indoor sex work.

Our work builds upon the growing global recognition that condom use is situated within social contexts consisting of interacting influences, including personal thoughts and beliefs, interpersonal relationships, social class and the surrounding environment. For example, in areas such as India and the Middle East, where condom use is associated with promiscuity, stigma was identified as a barrier to condom use (Bhattacharya 2004; Kulcrycki 2004). Studies in Brazil, South Africa and Mexico highlighted that despite possessing an understanding of STI transmission, women avoided condom use with their sexual partners due to fear of being suspected of infidelity (Sarkar 2008). Relationships have also been found to greatly impact condom use. Research in Africa indicated women’s reluctance to negotiate condoms was due to social and cultural barriers that situate men in
the position of greater control regarding sexual practices (Hebling and Guimaraes 2004; Varga 1997). Masculinity researchers have found that for some men, prolonged sexual intercourse without a condom is an indicator of sexual prowess (Khan et al. 2004). Furthermore, economic constraints have been found to be a barrier to condom use in developing and developed countries (Essien et al. 2005; Nemoto et al. 2004). These identified social and cultural dynamics have great implications for developing a contextually sensitive understanding of risk behavior in relation to the complexity of condom use and, thus, to ultimately inform STI-prevention efforts.

In light of the growing recognition that condom use is socially situated (Bhattacharya 2004; Khan et al. 2004; Kulcrycki 2004; Sarkar 2008), it is timely to investigate condom use as embedded within the social environment of the indoor sex industry. We utilised ‘risk context’ as a framework to recognise the constraining and supportive dynamics that influence condom-use practices. Although separated as analytic tools, it is important to note that these dynamics are not mutually exclusive. We endeavoured to present them here in such a way to reveal how they interact and influence the ongoing negotiation of whether a condom is used during a particular sex transaction. Using this approach, the study addressed two research questions: (1) How is condom use practiced in the massage parlour sex industry in Vancouver, Canada? (2) How is condom use as a social phenomenon situated within the nexus of supports and constraints in this setting?

Methods

Data collection

Women were recruited into the study through community outreach activities provided by community-based researchers and peer health workers who were women with previous or current sex-work experience. Sampling and recruitment occurred in collaboration with our community partner, the non-profit Asian Society for the Intervention of AIDS (ASIA) and, as such, immigrant women were targeted for participation. The data for this manuscript were drawn from a larger community-based project that involved a community-researcher partnership between, ASIA staff and community health workers, volunteers, university-based health researchers and health and social service practitioners. The purpose of the partnership, which was entitled Outreach and Research in Community Health Initiatives and Development Project (ORCHID), was aimed at developing STI- and HIV-prevention initiatives for indoor sex workers and clients. Full details of the sampling process have been published elsewhere (Bungay et al. in press; Remple et al. 2007). Community-based researchers and peer health workers visited establishments that were accessed via a detailed targeted sampling approach, the full details of which are published elsewhere (Bungay et al. in press), and offered a range of services including health education, health and social service referrals and STI/HIV testing. Women who accessed the services were informed about the study and invited to participate. Women were also recruited using a chain-referral procedure based on the social network of the participants. Once a participant agreed to participate and completed a questionnaire she was given three recruitment information vouchers coded in such a way that we could identify which seed they came from. The seed then handed out the recruitment information vouchers to a maximum of three co-workers. As part of the recruitment process we reviewed the inclusion criteria with the participants and provided them with a script to approach prospective participants, which included a brief introduction to the purpose of the study, the voucher and the contact number for an investigative team member should they wish to participate. Interested participants contacted a member of the investigative team who then reviewed the purpose
and overall study activities and arranged a time and location for data collection. After being enrolled, the recruit became a ‘recruiter’/participant and was assigned a different study code. All women who self-identified as working within the indoor sex industry, were 18 years of age or older and were able to participate in languages spoken by members of the outreach and investigative teams (primarily English, Cantonese and Mandarin) were eligible to participate.

Questionnaire data was collected by an interviewer-administered comprehensive 150-item cross sectional questionnaire that assessed standard sociodemographic variables, sexual practices, HIV/STI-related knowledge, employment characteristics and sexual health and health-seeking behaviours that included condom use pertaining to individual sex practices and commercial and non-commercial sex partners. We also undertook conversationally-oriented 30–60 min interviews with participants who were purposefully selected (Maxwell 1998) from women who had completed the questionnaire to represent a diversity of venues and length of time in sex work. Interviews were recorded and transcribed verbatim. Most interviews were individual but, when appropriate, group interviews with 2–3 women were undertaken where women expressed a desire to share their experiences together to support one another in the process. Key topics addressed in the interviews included condom-use practices in commercial sex exchanges and a diversity of factors that influence condom use at personal, interpersonal and structural levels.

Prior to participating in research, we provided written details concerning the study and women’s rights as participants, including their rights to refuse to answer any question and to halt participation at any time, and reviewed these with each woman. We encouraged women to ask any questions for clarification and, once all questions were answered, verbal consent was obtained. Few participants requested clarification and many commented on the importance of the study. All data was collected either at the participants’ workplace or in a location of their choice. For women who were not proficient in English, an interpreter was provided. All participants received an honorarium of CA$ 25 for their expertise and to supplement potential loss in their earnings. Ethical approval for the research protocol was obtained through the University of British Columbia and Simon Fraser University behavioural research ethics councils.

Data analysis
All questionnaire responses pertaining to demographic information and condom use practices were entered into an SPSS database (v.17, SPSS Inc.) and data were analysed using descriptive statistics. Interviews were transcribed and checked for accuracy and uploaded to NVivo 8™ for coding. Three members of the investigative team reviewed interview results collaboratively. Initial coding of interviews focused on identifying interpretive thematic codes (Thorne 2008) that highlighted condom use practices (e.g., whether or not women used condoms) and factors that either appeared to constrain or support condom use. Questionnaire and interview data were compared for similarities and differences with regards to condom use practices. As the coding continued we grouped the themes into more abstract theoretical and conceptual categories related to the personal (e.g., thoughts and beliefs) and interrelated social dynamics of the commercial sex exchange. We specifically identified the social dynamics that occurred within the level of sex seller-sex buyer interactions that supported or constrained condom use and also examined the varying degrees that other social environmental dynamics (e.g., the economy) influenced condom use. By examining the risk context of condom use, we illustrated that condom use is situated within dynamics linked closely to: the process of condom negotiation; accessibility to
information on STI and availability of condoms; and financial vulnerability. In what follows, women’s experiences with condom use are explored as situated within these dynamics.

Results
Over the course of several months, 129 women working in commercial sex venues in Vancouver completed the questionnaire, while another 21 took part in face-to-face interviews. Of the 80 survey participants who indicated that they were born outside of Canada, 50 stated China as their country of origin. For the interview participants, more than half indicated being born in an Asian country and 11 disclosed having limited English language proficiency. The mean age of participants was 30. The full demographic profile of participants is available in Table 1.

It was clear that women recognised the importance of employing condoms in their everyday work, with the majority of participants indicating regular use of condoms in the work setting as illustrated in Table 2. However, interview data illustrated that women’s ability to negotiate condom use with clients was complicated by various constraining and supportive dynamics. These dynamics occur in an integrated fashion and sometimes require women to make in-the-moment choices between competing and often interrelated needs, such as financial need and maintaining personal health. Here we report on the

Table 1. Participant demographics.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth country ( (n = 129) )</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>49 (38.0)</td>
</tr>
<tr>
<td>Other</td>
<td>80 (62.0)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>31 (7.54)</td>
</tr>
<tr>
<td>Years lived in Canada ( (n = 76) )</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>5 (6.91)</td>
</tr>
<tr>
<td>Proficient in speaking English</td>
<td></td>
</tr>
<tr>
<td>Age at first sex work ‘job’</td>
<td>99 (76.7)</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>27 (8.06)</td>
</tr>
<tr>
<td>Total months in sex work</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>33 (38.42)</td>
</tr>
<tr>
<td>Number of clients/week</td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>12 (7.75)</td>
</tr>
</tbody>
</table>

Table 2. Condom use practices with clients.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use - vaginal or anal sex ( (n = 127) )</td>
<td></td>
</tr>
<tr>
<td>Consistent (no exceptions)</td>
<td>104 (81.9)</td>
</tr>
<tr>
<td>Condom use - oral sex ( (n = 129) )</td>
<td></td>
</tr>
<tr>
<td>Consistent (no exceptions)</td>
<td>93 (72.1)</td>
</tr>
<tr>
<td>Confidence: insisting on condom</td>
<td></td>
</tr>
<tr>
<td>Completely sure – first encounter</td>
<td>124 (97.6)</td>
</tr>
<tr>
<td>Completely sure – client under influence of alcohol or other substances</td>
<td>119 (93.7)</td>
</tr>
<tr>
<td>Confidence: purchasing condoms</td>
<td>124 (96.9)</td>
</tr>
</tbody>
</table>
constraining and supportive dynamics identified in the three analytical categories noted above. We structured our analysis using these categories to illustrate how dynamics of support and constraint operate in a day-to-day fashion.

**The process of condom negotiation**

Women’s capacities to negotiate condoms were supportive for condom use in commercial sex exchanges. Women assumed responsibility for initiating condom use and perceived this as a personal responsibility and as a means to exercise control over their health and minimise the potential for, and associated worry pertaining to, possibly contracting an STI:

> No I don’t worry about [STI]. My rule is to use condoms if clients want a full service. It is the same for a blow job, whatever the clients want, I need to ensure my own health and safety. (Hailey, age 36)

Participants indicated the necessity of condom use to clients through a variety of strategies. For example, for those women who worked independently and out of their homes, the requirement of condoms was made clear during the booking process with clients:

> In the telephone, he would ask if they want full service, does he need to wear condom; I would tell him yes. (Jennifer, age 29)

In other situations, participants simply placed the condom on the client in the absence of any dialogue to indicate that condom use was non-negotiable:

> I guess I could explain it, I’m not very nice to clients. I sort of go in there and automatically take control of the situation and that’s that, right. I’ve only had a couple clients in my entire history of working that didn’t want to use [a condom] and it’s just too bad. There’s really no negotiating whatsoever. (Rachel, age 19)

Additionally, by placing the condom on the client, women ensured not only that a condom was used, but that it was placed correctly in order to minimise the possibility of slippage or breakage.

One troubling scenario that contributed to a constraining dynamic was deceptive removal of the condom by the client. As discussed more fully elsewhere (Bungay et al. 2011), more than half of the participants indicated that there had been at least one incident where despite initial agreement to employ a condom, men attempted to deceptively remove the condom once the encounter was underway. These situations prompted women to cultivate strategies to protect themselves from STI. This required acquiring greater control over the encounter by ensuring visibility of the condom to verify it remained situated on the client. Such a level of control was made possible by how women physically positioned themselves during the encounter:

> A lot of the girls in there, they like, they wouldn’t do it doggy style or anything like that, they have to be in control so they would do like the on top thing and stuff ’cause then they are in full view of his hands and he couldn’t get in there and slip anything off. (Hannah, age 31)

Condom negotiation was further constrained by clients’ resistance to condom use. Participants believed this to be the case due to the fact that condoms were noted to minimise sensation and added that some clients articulated a belief that they were not getting what they ‘paid for’ if a condom was involved:

> Like they think if you use condoms, it’s like a business, if they feel a little less discomfort, they feel like they get more value for their money. (Becky, age 24)

As such, women cultivated strategies to manage this situation, where some participants framed themselves as the source of risk:
I told my clients ‘It is dangerous for you not to wear a condom. Maybe I am a problem [diseases].’ (Hailey, age 36)

Although the practice of placing the source of risk on oneself may be viewed as unfairly stigmatising, women stated that this approach offered a level of control over the situation by ‘scaring’ the client and appealing to his self-interest in maintaining personal health. In doing so, women were able to convince clients to use condoms as a means to minimise their own STI risk.

Additional strategies employed by women when faced with condom resistance included providing alternatives to full service (vaginal or anal intercourse) without a condom that were viewed as lower risk for infection transmission, such as oral or manual (hand) sex. By providing a choice, women had the opportunity to exercise control over their own health as well as that of the client’s, without losing the client. The ability to assert control over condom use was associated with experiential learning in the industry, as women identified that over time they gradually developed the skills to assume authority regarding condom use. These skills included physical positioning, learning to appeal to a client’s self-interest to promote condom use, the development of alternative choices that the sex worker controlled in terms of minimising STI-transmission risk while preventing loss of income (e.g. providing choice between manual sex without a condom or condom use for other forms of sex) and ability to refuse service. These strategies all contributed to a dynamic of support for condom use that was actively developed to counteract the constraining dynamic introduced to the scenario by some clients’ preferences to not utilise condoms.

**Accessibility to information on STI and availability of condoms**

Many participants articulated dissatisfaction and frustration with the lack of support for safer sex practices on the part of work venues. Of all sources of information about STIs, employers were reported the least supportive resource, with fewer than one quarter providing such information to workers as demonstrated in Table 3. Women instead reported relying on information from media sources, clinic-based doctors and nurses, friends and co-workers. In the face of lack of venue support, these alternate resources were central for contributing to a supportive dynamic for condom use. In addition, women communicated that many places of employment did not encourage condom use or provide information about STIs and that this was particularly a problem for women new to sex work. The lack of support from establishments with regards to condom use is illustrated in the following excerpts from interviews:

"Especially [when you are new to the business] . . . you kind of don’t understand this business and think oh, if I don’t use condoms is this client going to come back? So you have to learn this by your own experience, [employers] never explain it to you. But they could. I mean,"

<table>
<thead>
<tr>
<th>Source</th>
<th>STD ((n = 125)) n (%)</th>
<th>HIV/AIDS ((n = 127)) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>My boss or employer</td>
<td>20 (16.0)</td>
<td>31 (24.4)</td>
</tr>
<tr>
<td>Street nurses</td>
<td>33 (26.4)</td>
<td>33 (26.0)</td>
</tr>
<tr>
<td>My co-workers</td>
<td>52 (41.6)</td>
<td>51 (40.2)</td>
</tr>
<tr>
<td>My friends</td>
<td>53 (42.4)</td>
<td>50 (39.4)</td>
</tr>
<tr>
<td>A doctor/nurse</td>
<td>77 (61.6)</td>
<td>70 (55.1)</td>
</tr>
<tr>
<td>TV, radio, newspaper or magazine</td>
<td>89 (71.2)</td>
<td>90 (70.9)</td>
</tr>
</tbody>
</table>
I could, now if a new girl comes in I could explain … ‘Oh, don’t worry, if you don’t use condoms the client still comes back’. So the parlours don’t care. (Becky, age 24)

The lack of education provided by parlours pertaining to STI was articulated by this participant:

I would like somebody to tell me something about [STI], and show me, and help me to take a test. … And educate me about that … (Hannah, age 31)

In light of the fact that venues frequently do not encourage condom use or provide education about STIs, it comes as no surprise that many women reported that venues generally do not provide employees with condoms, either. Without condoms readily available for use, a marked barrier is evident in the feasibility of engaging in safer use practices:

… I brought my own before I started there and I literally ran out of a box because the girls were running out of condoms, so I’m like here take them. So I ran out of my condoms and I didn’t even have a session there, ‘cause I was giving the box. They didn’t have their own, you have to buy your own there. (Hannah, age 31)

This situated the responsibility on employees to obtain condoms for work purposes. For venues that did provide condoms, some were noted to actually sell them to employees for a fee. This paradoxical situation represents a marked barrier to condom use in that women are required to use their own earnings to support safe-sex practices within their place of employment.

The lack of agency involvement was also found to contribute to inconsistent condom use practices by employees at some of the venues. This reported inconsistency created difficulty when negotiating with clients:

Sometimes [clients] … say ‘Oh I don’t want to have a condom with you to have sex because I do some other girls without condom’. And so, so, that’s happen[ed] a lot. (Sharon, age 39)

In the interviews it became apparent that the lack of venue support for education on STIs and condom availability acted in a constraining way on women’s condom use. This constraining dynamic was amplified by the fact that when some women did not use condoms, this in turn disrupted other workers’ assertions that condom use was mandatory.

The issue of condom availability in the massage parlours was attributed in part to the impact of the criminal justice system. In Canada, prostitution is not illegal but many related activities are, including operating a bawdy house (see Bungay et al. 2011; Pivot Legal Society 2006). When asked why condoms are not kept in the rooms where services are delivered, this participant stated:

… to avoid the city hall police and some RCMP police [Royal Canadian Mounted Police] … in case they come and search for them [condoms] … (Hailey, age 36)

As noted by the participant, many massage parlours refuse to stock condoms in rooms where services are delivered for fear of the event of a police raid. For the women working in these establishments, this cumbersome arrangement presented a physical barrier to condom use: if a client changed his mind from requesting a massage to requesting full service, this required the woman to dress herself, exit the room, obtain a condom and return to the room. These legal restrictions also mean that establishments may face incrimination if they somehow advertise to clients that condom use is mandatory. Thus, rather than situating responsibility on the venues for condom use by clients and thereby enhancing workplace safety, this becomes the responsibility of workers. As such, it is apparent that legal sanctions and venue policies affecting condom availability must be understood as interactively contributing to a dynamic of constraint.
Financial vulnerability and condom negotiation

The impact of financial stability, or lack thereof, on condom use was expressed repeatedly. For example, when faced with client resistance to condom use, women developed strategies to circumvent resistance as a means to promote condom use without losing the customer. Such strategies included emphasising the importance of condoms to clients by approaching the topic carefully and highlighting the benefits:

We are doing these things for money, many people every day, so kind of safe for you only and also you can go home with your wife without condom. But here if you have condom it’s very safe for you. Kind of [yeah] smooth the situation. (Hailey, age 36)

Others expressed the benefit of condom use for both parties:

When you put a condom on them you always say, it’s good for both of us. You don’t make them feel that they are dirty. But for our girls, we really just try to protect ourselves, we’re not doing that for them, like, if I have a disease, I probably care more about if he has a disease, but when I say it, I say it’s good for both of us. (Becky, age 24)

Another situation noted by a number of women and confounded by financial constraint was the propositioning of larger sums of money by clients to forgo condom use. Some women adamantly refused the offer, as exemplified by the following response:

Why you have to do that, I am not your wife. Go F[uck] your wife … not worth it. (Eleanor, age 33)

However, because financial constraint raised concerns over losing the customer, women sometimes felt compelled to offer services viewed as ‘less risky’ such as bareback oral sex. This demonstrated how women navigated the constraints situated within the economic context to make decisions based on what they perceived as better for their health:

And I take the offer [of more money] when it’s blow job. I do not take the offer when it’s having sex. (Maria, age 27)

Participants expressed particular concern for women new to the industry with regards to accepting the offer of money to neglect condom use for several reasons: some of these women did not have an adequate understanding of the importance of condom use, experienced a language barrier, had not yet had the opportunity to cultivate negotiation skills and were more fearful of losing customers. Participants drew on their own experiences when they spoke of this issue, as many had been new to Canada at one time. One participant provided her insights with regards to women recently arriving from China:

Girls from China do not negotiate condoms and are more at risk to violence. They are not going to complain to managers because they need the money and very little opportunity to earn elsewhere. They will also not insist on condoms because they are unaware of the health risks of not using one and are not willing to lose the opportunity for a client to come back … (Becky, age 24)

The need for money upon arriving in a new country was noted to greatly influence the ultimate decision to use a condom. By compromising women’s ability to turn away clients who refuse to use condoms, financial vulnerability contributed to a dynamic of constraint. This dynamic is exacerbated if women have few opportunities for employment elsewhere. Furthermore, lack of experience in the sex industry, limited STI knowledge, lack of venue support for education and condom use, as well as having a language barrier all interface with financial vulnerability to severely limit women’s ability to advocate for condom use with clients.
Discussion

This study explored women’s experiences with condom use in the context of the indoor sex industry. This is necessary research given the lack of investigation in this area and, to our knowledge, this study remains one of the only Canadian-based investigations of condom use in this setting. By exploring women’s experiences within this particular environment, we sought to unveil the intricacies involved in condom use to ultimately inform effective support services and resources for women in the industry. Condom negotiation, however, is inherently complex. To fully appreciate the nuances of this practice it was necessary to enlist a novel perspective, which in essence involved drawing from contemporary views that highlight the importance of social context with regards to condom use. The research we drew on pointed out the shortcomings of behaviourist perspectives that weighed heavily on cause-and-effect logic and stressed instead the influence of social context (Bhattacharya 2004; Kulczycki 2004; Lupton 1999; Rhodes 1997; Rhodes et al. 2005; Sarkar 2008). However, this research remained too linear for our purposes, conceptualising use as shaped by individual static factors.

This study emphasises that it is essential to move away from viewing condom use as shaped by factors because this suggests that the factors are mutually exclusive and may be isolated to analyse their individual impact (Bhattacharya 2004; Kulczycki 2004; Lupton 1999; Sarkar 2008). By drawing on the work of Rhodes (1997), who proposes a situationally relative nature of risk environments, it was possible to situate condom use amidst a risk context. Doing so enabled us to demonstrate in a compendious fashion the inextricable nature of dynamics that impact the social context and, ultimately, condom use practices. This approach is essential to develop effective and meaningful initiatives that impact the day-to-day experiences of women in the indoor sex industry. Addressing one influential dynamic without appreciating the involvement of another is not an effective approach. Rather, resources must be developed in a comprehensive fashion, mapping out how supportive and constraining dynamics interface to influence use practices. Recognising, for example, that information on STI, condom availability and the criminal justice system are interwoven is crucial in developing initiatives and resources that are actually helpful to women.

Our findings support the growing movement that emphasises women’s recognition of the importance of condom use in indoor sex work and the consequent proficiency women exhibit in employing condoms during commercial sex encounters. The findings here add to the literature highlighting women’s agency in the context of indoor sex work (Bungay et al. 2011; Campbell 2000; Ghose, Swendeman, and George 2011) and support the assertions of Campbell (2000), who suggests that speaking of women in the sex industry as powerless, as has been the case in many international-based studies (Joesoef et al. 2000; Varga 1997; Wojcicki and Malala 2001), fails to capture the magnitude of coping strategies and support networks women in the sex industry develop to address the many health challenges they face. Women in this study navigated the risk context of indoor sex work and adopted creative strategies to promote condom use by their own accord due to minimal agency support with health promoting efforts. In essence, women relied on personal experience and their own ingenuity to contribute to a supportive dynamic.

Initiatives to support women in their health-promoting efforts must be encouraged and supported to bolster present efforts to advocate condom use. The most obvious of actions that would contribute to a supportive dynamic in the context of indoor sex work would be for facilities to provide education about STI, necessitate condom use and have condoms readily accessible. The positive impact of venue involvement with condom use amidst
indoor commercial sex venues has been demonstrated in the literature (Albert et al. 1995; Ghose, Swendeman, and George 2011; Ragsdale, Anders, and Philippakos 2007). However, the legal context of indoor sex work in Canada disrupts the feasibility of incorporating such initiatives at the agency level as most indoor sex venues operate under the guise of legitimate licensed businesses, including massage parlours, escort agencies and exotic dance clubs (Bungay et al. 2011). It has been suggested that shifting from municipal licensing of massage parlours to public health departments is a means to enhance women’s health in the context of indoor sex work (Nemoto et al. 2004). The notion is that by shifting the monitoring activities to public health, management adherence to policies that create a safe work environment could potentially be fostered (Nemoto et al. 2004). There is, however, concern that this approach in fact increases police presence and disempowers women within indoor commercial sex venues (Bungay et al. 2011; Lewis and Maticka-Tyndale 2000). As stated by Bungay and colleagues (2011), shifting from municipal licensing to the health sector may be beneficial to enhancing women’s health, but what is of central concern are the intersections of health policy, licensing and criminalisation. The complexities inherent to these interactions require further analysis, which we are presently undertaking. In doing so, we seek to explicate how all levels and types of policy can be altered in a compatible manner to ultimately promote the health of sex workers.

Supporting women’s efforts is integral to promoting women’s health in the commercial sex industry and has been documented in the literature, with research shedding light on support associations that provide encouragement for sex workers (Campbell and Mzaidume 2001; Wechsberg et al. 2006). These associations drew on the strengths and knowledge of women as they organised themselves in protecting their interests. Activities included health promotional meetings led by peers (who are members of grassroots organisations) to contribute to supporting dynamics for women’s health-promoting efforts in the industry. This internationally-based research, however, was not contextualised to the indoor sex industry. Research that did explore supportive dynamics for indoor sex workers included The Sonagachi project in Kolkata, India (Ghose, Swendeman, and George 2011). This project exemplified the efforts of building supportive networks to develop safer industry practices and effectively increased condom use resulting in 3–5-fold reductions in the prevalence of STIs and a low HIV prevalence when compared to neighbouring communities (Cohen 2004). Furthermore, Canadian research specific to the indoor sex industry demonstrated the efficacy of a community-led health promotion program focused on STI and HIV-prevention interventions for indoor sex workers and their clients (Bungay et al. in press). These results explicate the impact that facilitative efforts have on health outcomes and reflect the potential for further improvements with regards to women’s health amidst the indoor sex industry.

This study represents a preliminary investigation into women’s experiences of condom use in Vancouver’s massage parlour industry. Additional research is needed as there remains very little investigation into the topic within this specific setting. Particularly, our study identified the need to further explore the experiences of immigrant women. The findings here brought forth preliminary evidence to suggest this group faces unique constraining dynamics with regards to condom use in commercial sex encounters. The information shared by participants was predominantly second hand, but there is enough credence to emphasise the fact that limited English language proficiency is a constraining dynamic faced by immigrant women in their day-to-day work in the indoor sex industry, a notion supported elsewhere (Bungay et al. 2011) as limited English capability makes it nearly impossible for women to articulate the necessity of condom use to clients. Furthermore, economic constraint was noted to be an issue with immigrant women and has
also been cited in the literature (Bungay et al. 2011). Having recently arrived from abroad with limited social supports and few options to generate income can weigh heavily on decision-making around condom use, especially in the face of client resistance or offerings of money to forego condom use. The findings from this study urge the development of additional resources for immigrant women, including support with learning the English language as well as the need for financial buffering for newcomers to the country. Research that focuses exclusively on the needs of immigrant women working in the indoor sex industry is required to fully appreciate the constraining and supportive dynamics experienced by this particular group and is urgently needed, as indicated by the numbers of immigrant women currently working in the industry.

There are several limitations of this study that must be noted. Firstly, our work pertained to a specific geographic location and consequently represents the sociocultural milieu of Vancouver, Canada. Furthermore, the results are specific to massage parlours and are not representative of women’s experiences in other settings. We also recognise that the opinions of male sex-buyers are neglected in this particular analysis and thus the need for investigation into men’s attitudes and experiences with regards to condom use in the indoor commercial sex setting is necessary to develop effective and appropriate means for supporting use. At present, there exists preliminary investigation into men’s attitudes and perspectives with regards to condom use practices, with the majority of the data pertaining to the indoor sex setting (Atchison 2010). However, the need for additional work in this area, particularly comparison work that explores the attitudes and perspectives of both the female sex seller and the male sex buyer, is greatly needed. By gaining both perspectives on condom use in this particular context, an increased understanding as to the complexities inherent in the social exchange is possible. In turn, meaningful approaches to encouraging and supporting condom use may also be realised.

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References


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