

**Agnès Binagwaho** is Permanent Secretary of Health, Republic of Rwanda, and a visiting lecturer at Harvard University.

**Mawuena Agbonyitor** is a Research Assistant at Harvard University.

**Aimable Mwananawe** is President of the Rwanda NGO Forum on AIDS and Health Promotion.

**Placidie Mugwaneza** is Head of HIV Clinical Prevention at TRAC Plus, Rwanda.

**Alec Irwin** is a researcher at Harvard University.

**Corine Karema** is Acting Interim Director General of TRAC Plus, Rwanda.

Please address correspondence to the authors c/o Agnès Binagwaho, Permanent Secretary, Ministry of Health, Republic of Rwanda, Kigali, Rwanda, email: agnes.binagwaho@moh.gov.rw and agnes.binagwaho@gmail.com.

Competing interests: None declared.

Copyright © 2010 Binagwaho, Agbonyitor, Mwananawe, Mugwaneza, Irwin, and Karema. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

## DEVELOPING HUMAN RIGHTS-BASED STRATEGIES TO IMPROVE HEALTH AMONG FEMALE SEX WORKERS IN RWANDA

*Agnès Binagwaho, Mawuena Agbonyitor, Aimable Mwananawe, Placidie Mugwaneza, Alec Irwin, and Corine Karema*

### ABSTRACT

*How governments should address sex work is a topic of current debate in Rwanda and other countries. Some constituencies propose harsher punishment of sex workers as the cornerstone of an improved policy. We argue that an adequate policy response to sex work in the Rwandan context must prioritize public health and reflect current knowledge of the social determinants of health. This does not imply intensified repression, but a comprehensive agenda of medical and social support to improve sex workers' access to health care, reduce their social isolation, and expand their economic options. Evidence from social epidemiology converges with rights-based arguments in this approach. Recent field interviews with current and former sex workers strengthen the case, while highlighting the need for further social scientific and epidemiological analysis of sex work in Rwanda. Rwanda has implemented some measures that reflect a rights-based perspective in addressing sex work. For example, recent policies seek to expand access to education for girls and support sex workers in the transition to alternative livelihoods. These policies reinforce the model of solidarity-based public health action for which Rwanda has been recognized. Whether such measures can maintain traction in the face of economic austerity and ideological resistance remains to be seen.*

### INTRODUCTION

Sex work is found in every country and culture and has been observed since the beginning of civilization.<sup>1</sup> However, across contexts, sex work does not always wear the same face. Commercial sex work currently ranges from small-scale self employment, practiced for survival, to multi-million-dollar international sex industries involving managers and power-holding intermediaries between sex workers and clients.<sup>2</sup> Both these extremes concern Africa: prostitution in the majority of African countries is a small income-generating activity while, at the same time, thousands of African women sell their bodies in the sex trade of Europe and the Middle East.<sup>3</sup>

Discussions of sex work and human rights often center on the issue of trafficking.<sup>4</sup> Despite the illegality of sex work in most countries, States clearly have not done enough to fight sex exploitation associated with trafficking. The majority of countries have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), which addresses the right to be free from sexual exploitation. As such, both source and destination countries involved in trafficking neglect their duty to protect women, as formulated in CEDAW Article 6, which expressly mandates that States must fight against the trafficking of women.<sup>5</sup>

Yet while trafficking is a critical area for human rights-based action, this is not the only aspect of sex work that creates grave legal, social, and public health problems. In Rwanda, prostitution generally compromises small-scale operations unconnected with the circuits of international sex trafficking. But this does not eliminate the threats posed by sex work to the rights, dignity, and health of many of the women involved. Rwandan women often enter prostitution in a desperate bid to escape abject poverty.<sup>6</sup> Too often this survival strategy backfires. Sex workers are exposed to a convergence of social exclusion and health risks that can have fatal consequences.

Threats to sex workers' health include alarming rates of HIV infection in this population. Sex workers are at high risk of HIV infection since they have multiple sexual partners and may not use condoms consistently.<sup>7</sup> Despite their vulnerability, however, sex workers continue to receive inadequate attention in international HIV prevention efforts. UNAIDS calculates that, historically, less than 1% of global funding for HIV prevention has been spent on issues related to sex work.<sup>8</sup> The need for strengthened prevention efforts addressing this population constitutes a key public health challenge and a critical area for the application of rights-based approaches informed by an understanding of the social roots of health and disease.

The question of how to address sex work is a topic of explicit policy debate today in Rwanda and other countries. These debates occur in a context marked by concern for public health, but also by highly charged disputes about morality. Developments such as Uganda's recently proposed legislation reinforcing criminal penalties for homosexuality have shown what is at stake in the design of policies targeting groups and practices seen as sexually deviant or subversive of public morals.<sup>9</sup> Some Rwandan lawmakers advocate a comparable hard-line approach to tackling sex work. These pressures confirm the importance and timeliness of grappling with sex work issues from a public health perspective informed by human rights.

Against such a backdrop, we pursue three main objectives in this article. First, we seek to make explicit the convergence of social exclusion and health vulnerability experienced by many sex workers in Rwanda, in substantial part by listening to the voices of sex

workers themselves, as captured in two recent series of field interviews.<sup>10</sup> At a second stage, we argue that protecting the health of Rwanda's sex workers (and with them, the broader population) does not demand intensified repression, but, on the contrary, a comprehensive agenda of medical and social support to improve these women's access to health care, reduce their social isolation, and expand their economic options. Human rights law and analysis provide support for this integrated approach. The final part of the article briefly describes some of the policy measures that are being implemented or proposed in Rwanda to advance a rights-based agenda addressing sex workers' health needs and their underlying social vulnerability. Whether these measures will achieve sustained political traction remains to be seen. If they do, they will strengthen the pro-equity public health model for which Rwanda has drawn international recognition.<sup>11</sup> And they will provide evidence from a low-income setting on how social epidemiology and human rights may be linked to drive policy action aimed at improving the health of marginalized groups.

#### METHODOLOGY

This article uses a multi-pronged approach to analyze the social background and health impacts of female sex work in Rwanda. Four sources of information serve as the primary evidence base for the article. The first is a review of the academic literature relating to the effects and causes of sex work, with a primary focus on sub-Saharan Africa. The second consists of national and international reports and policies on sex work. Third, we drew from qualitative analysis of interviews with representatives of associations of female former sex workers from rural Rwanda. The interviews were conducted under the auspices of the Treatment and Research AIDS Center Plus (TRAC Plus) and nongovernmental partners. The research was part of an effort to design rights-based interventions to fight HIV/AIDS among sex workers, while sensitizing leaders and parliamentarians at a time when Rwanda was debating legislation that would reinforce criminal sanctions against prostitution. Our fourth source of information consisted of analysis of the 2006 and 2008 Rwandan National Behavior Surveillance Surveys.<sup>12</sup>

Rigorous social scientific study of sex work in Rwanda is in its early stages. This paper and the research that underlies it do not attempt to present a comprehensive analysis of this complex social real-

ity. Our intention is to reflect, in an illustrative and exploratory way, experiences, views, and concerns expressed by some sex workers, in order to inform an ongoing political debate and stimulate additional research. Both additional scientific study and greater social mobilization among sex workers are needed urgently. Meanwhile, we believe it is already possible to point to suggestive convergences between some sex workers' expressed needs and the promise of an integrated, rights-based policy approach.

#### THE SOCIAL CONTEXT OF SEX WORK IN RWANDA: GENDER INEQUALITY, POVERTY, AND FRAGILE SOCIAL NETWORKS

In many settings, key drivers of prostitution include gender and economic factors in which poverty plays a major role.<sup>13</sup> Sex work is not limited to one gender; there are men and boy prostitutes whose clients are women or men who have sex with men. However, the majority of sex workers are female.<sup>14</sup> This pattern is linked to gender discrimination, which reduces many girls' access to education and training and thus their later opportunities in the formal economy. The literature suggests that social, financial, or family crises often influence women's decision to enter sex work. Frequently, women who become sex workers cite a lack of family support. In some instances, women who enter sex work may also have endured childhood trauma, including physical or psychological abuse.<sup>15</sup>

In Rwanda, the majority of sex workers interviewed for the TRAC-Plus-sponsored study entered sex work during adolescence, mainly between the ages of 17 and 22. For all of the female sex workers who shared their stories, the lack of social or familial support increased the financial pressures that precipitated their entry into sex work.<sup>16</sup> One informant described her experience in these terms:

I started prostitution when I was 17 years old. I had a husband, but we didn't stay together. We divorced on grounds of prostitution and infidelity. I went back to my family, but they rejected me. My family kept telling me to give my child back to his father. In this situation, I started renting my own house, where I received men. They paid me RWF 200 or RWF 300. [This income] enabled me to raise my child.

In Rwanda, 80% of sex workers cite survival as the reason they engage in this occupation.<sup>17</sup> The majority

of the women started sex work by having occasional exchanges of sex for money as a complement to their income; after a while, they report, they are unable to escape this lifestyle and become full-time sex workers.<sup>18</sup>

The sociodemographic profile of young prostitutes in Butare, Rwanda's second largest city, may be representative of the wider sex worker population in the country.<sup>19</sup> According to a study sponsored by the National AIDS Control Commission / Commission Nationale de Lutte Contre le SIDA (CNLS) and conducted by PSI Rwanda, sex workers in Butare generally went into sex work for economic survival in the face of events like unexpected pregnancy, often exacerbated by a withdrawal of support by family and community.<sup>20</sup> In Rwanda, as in other societies, premarital sex and pregnancy bring shame to a whole family.<sup>21</sup> When caught in such situations, some girls may be excluded from their families and previous social networks. One informant recalled,

I fell in love with a young man and during our relationship, he got me pregnant. He refused to marry me. After learning that my family was beating and mistreating me, demanding to know who impregnated me, he ran away. I gave birth to a baby girl. Afterwards, I had many problems that forced me into prostitution, due to the fact that the person who was supposed to assist me had run away, and my family had abandoned me.

The social vulnerability that can force women into sex work is compounded by patterns of gender bias in access to formal education. These patterns leave many young women with poor levels of education and skills, making it harder for them to find legal employment.<sup>22</sup> Girls' exclusion from education is often traceable to family poverty, which makes it difficult for families to pay school fees or buy uniforms and other materials. A former sex worker who grew up in a rural area explained,

Before going into prostitution, I went to [primary] school and passed exams for high studies. After senior one, I couldn't pay the school fees. Since my family was poor, I was forced to stay home. When I saw how other girls were living, and considering the fact that I was suffering

a lot, I started having sex with anyone who gave me some money to buy beauty lotions. I got used to this lifestyle, and when my family and people around started criticizing and isolating me, I decided to move away to town.

Such narratives confirm how participation in sex work, which may initially be catalyzed in part by inadequate social support, further reinforces social marginalization and uprooting for many of the women involved.

This cyclical deepening of social exclusion has intergenerational effects. Intergenerational transmission of risks is shown, for example, through the problems that children of sex workers face in succeeding at school due to issues such as discrimination on the part of teachers and classmates.<sup>23</sup> Rigorous studies on the educational success of the children of sex workers have not yet been undertaken in Rwanda. However, sex workers interviewed for TRAC Plus repeatedly drew attention to this issue. One said,

Sometimes, my child comes back from school being very sad because of how he has been treated by the other pupils. I don't have enough to give him all he needs, so that he could be like the other children, who have fathers who can provide for them. All this affects our children . . .

Compromised educational success is especially dangerous for the female children of sex workers, as it may continue the cycle of poor, uneducated women who join the underground work of prostitution to survive.

Many sex workers and former sex workers interviewed for the TRAC Plus study described suffering discrimination on the part of public authorities, including the police and judicial system. Such discrimination emerged, for example, when sex workers tried to obtain police and legal support to confront client violence. One interviewee noted, "What I can add is that authorities reject us just because we're prostitutes. Even when you're right in your complaint, they don't consider it; they're more likely to stick you in prison."

## HEALTH IMPACTS OF SEX WORK IN THE RWANDAN CONTEXT

It is widely recognized that sex workers face social stigmatization. However, the health consequences of this pattern are too rarely acknowledged in public debates in Rwanda or elsewhere. Neither the health impacts of sex work on individual women nor the wider public health implications receive adequate attention. We argue that these health dimensions must be made central to any responsible discussion of how to address sex work through public policy.

Extreme poverty itself is associated with numerous negative health impacts, as a large body of literature has made clear.<sup>24</sup> In addition, sex workers face specific forms of social exclusion and specific work-related exposures that greatly heighten their health risks, beyond those common to most members of low-income communities. Sex workers face underlying structural vulnerabilities due to their social and economic position, coupled with additional risks at the level of what some analysts have called "intermediate" health determinants, that is, more proximal factors that grow out of structural socioeconomic roots. One such intermediate health determinant is the health care system itself, and the differential access and quality of care it provides people based on their social, economic, and gender status.<sup>25</sup>

Sex workers are frequently the direct victims of inequitable treatment within the health system. After repeated experiences of discrimination, they may become reticent to seek assistance from the formal health system at all, no matter how desperate their need.<sup>26</sup> Many TRAC Plus interviewees cited personal experiences in this regard. Health workers, if they know a sex worker's profession, often refuse to treat her in an appropriate manner. One informant noted,

I live in the center of town, where most health workers live, and I run into them all the time. [At the clinic,] if they know you haven't given up prostitution, they can refuse to serve you, because they suspect you've been with their husbands. They keep grabbing other people's files and passing you over, because you're a prostitute.

Such systematic discrimination has a destructive public health impact, denying women access to informa-

tion and family planning services, as well as prevention, care, and treatment for HIV and other sexually transmitted infections (STIs).

### HEIGHTENED HIV RISK

For many female sex workers, social exclusion and health risk converge in HIV infection. In some settings, HIV prevalence among sex workers can reach 60 to 90%.<sup>27</sup> The health consequences for individual women are devastating, while at the population level, these trends constitute a critical public health concern.<sup>28</sup>

In Rwanda, a TRAC Plus research program found an HIV rate of 71% among sex workers.<sup>29</sup> Meanwhile, another study revealed that some 95% of Rwandan sex workers surveyed fully understood their risk of HIV infection.<sup>30</sup> Despite knowing the dangers, the sex workers questioned did not feel they could leave sex work. While HIV might kill them slowly, they explained, without an income they and their children would immediately face starvation and homelessness.<sup>31</sup> One TRAC Plus informant summarized the situation starkly:

When you [are] in prostitution, the only thing that matters is money. You act like a businessman. . . . So when you get one client with a condom and another client without, you welcome them all. You don't care about HIV/AIDS. . . . When you're poor and can't buy food or pay your rent, you never care about HIV/AIDS. The only thing you care about is getting money.

If sex workers do become infected with HIV, compounded discrimination based on their profession and HIV status can make it hard for them to adhere to treatment. This is especially so when HIV-positive sex workers are jailed. As one interviewee stated:

When you're arrested, they just throw you in prison. Sometimes you're not able to talk to a policeman and tell him that you'll miss your doses. The worst thing is when you are arrested at the beginning of the weekend. Then you spend the whole weekend without seeing any policeman till Monday.

Informants emphasized that, even when they had a chance to talk to policemen about their medication

needs while in detention, their requests were often ignored, putting the continued efficacy of their treatment at risk.

### PUNITIVE PUBLIC POLICIES AND WOMEN'S ABILITY TO LEAVE SEX WORK

The same social and economic pressures that often push women into sex work later make it hard for them to exit this form of employment, even if they want to do so. In many countries, the traditional response to prostitution is almost wholly punitive, involving arrest and incarceration.<sup>32</sup> This strategy is based on the assumption that if women are punished harshly enough for participation in sex work, they will be persuaded to leave it and adopt alternative ways of providing for themselves and their children. Interviews with sex workers and former sex workers in Rwanda point to the fundamental flaws in this strategy, which ignores the economic and social constraints that determine many poor women's "choices" about sex work.

In general, temporary detention only interrupts sex work activities for a short time, without providing sex workers with sustainable solutions to leave prostitution. Once out of prison, women may have to pay back the debts accrued while incarcerated, such as those involving the needs of their children. Ironically, then, instead of facilitating women's departure from sex work, repressive incarceration policies may actually lock women more rigidly into the cycle of selling sex for economic survival. One TRAC Plus interviewee recalled,

One day, they put me in jail, and my child ended up sleeping outside. He wasn't able to open the door of our house by himself ... so he slept on the doorstep. That's where they found him the next morning. In jail, I spent the whole night crying. I swore I would quit prostitution. I said, "I'll look for a job in construction or agriculture." . . . So when I was released from jail, I was determined to quit. But when I got home, my children and I didn't have anything to eat. That same evening I got a call from a client. We were hungry, so I had no choice. I accepted and ended up resuming prostitution.

Concern for their children's welfare may prompt women to seek escape routes from sex work. But in

the absence of viable economic alternatives, the very same pressure pushes many women right back into selling sex. The experiences narrated by Rwandan sex workers confirm reports from women in other settings that the stigma surrounding social identification as a prostitute makes it harder for sex workers to obtain more socially acceptable jobs.<sup>33</sup>

#### DISCUSSION: FRAMING A MORE ADEQUATE POLICY RESPONSE

How to address sex work has spurred political discussions in Rwanda, where influential voices have recently advocated a hard-line strategy of punitive measures against sex workers. We speak deliberately to this context in this article and argue for a different approach, one we believe will be best for Rwanda and also valid elsewhere.

Crucial to tackling the issue of sex work effectively is placing the public health dimension of the problem at the center of debate. And key to resolving the public health challenge is a policy perspective guided by the best available science on how health outcomes are shaped by social factors. The evidence base to guide policy in this area has been strengthened in recent years, particularly with respect to options for low- and middle-income countries. The landmark 2008 report of the WHO Commission on Social Determinants of Health (CSDH) marshaled a robust body of evidence on successful policies to strengthen health equitably across whole populations, reducing health gaps between privileged and disadvantaged groups.<sup>34</sup> The CSDH analysis supports a multi-pronged approach that reinforces access to medical services for marginalized people, but also tackles the structural factors that expose vulnerable groups to disproportionate health risks in the first place. Prime areas for structural intervention include gender equity, education, and economic empowerment.<sup>35</sup> Tackling structural determinants is by definition challenging, both technically and politically. However, the CSDH and subsequent research have identified evidence-based options and examples of successful practice in the relevant areas for countries at all levels of income.<sup>36</sup>

The situation of female sex workers in Rwanda requires the application of precisely this model. As we have argued, Rwanda's female sex workers suffer compounded forms of social exclusion, economic deprivation, and gender discrimination that translate into heightened health risks. These risks can only be

substantially reduced by acting on their social and economic roots.

Such an approach implies a fundamental rethinking of how many governments have traditionally dealt with sex work. Instead of fighting sex workers, governments should focus on fighting the causes of sex work. Imprisoning sex workers is not a solution. If governments and parliaments wish to criminalize prostitution, justice dictates that they go even further by arresting the clients of sex workers, since these men are the ones buying illegal services — otherwise, the demand for commercial sex will persist. However, in a context marked by poverty and HIV/AIDS, instead of incarcerating sex workers and/or their customers, public policy should aim first to secure the public's health. This means pursuing two simultaneous, mutually reinforcing priorities:

1. Bring health services and prevention interventions to sex workers in a participatory manner, advancing universal access to HIV prevention, care, and treatment, and protecting sex workers and the general population against HIV and STIs; and
2. Accelerate policies in appropriate sectors to address the structural issues of poverty and gender discrimination that currently leave female sex workers in Rwanda with few credible paths to alternative livelihoods.

The international human rights framework provides arguments for this multidimensional approach. The 1946 WHO Constitution already acknowledged that the right to health implies not only access to medical care, but — just as fundamentally — the creation of health-enabling social and economic conditions for all people.<sup>37</sup> This insight has been refined through a series of declarations, covenants, and other human rights instruments, notably including the 1978 Alma-Ata Declaration and the UN Committee on Economic, Social and Cultural Rights General Comment 14, on the right to health, issued in 2000.<sup>38</sup> The implications of these positions have been worked out by human rights scholars and jurists, including in the pages of this journal.<sup>39</sup> A growing consensus has emerged that the implementation of a human rights-based approach to health requires deliberate action on the social factors that shape health opportunities and outcomes.<sup>40</sup>

This does not mean that a tension-free relationship exists between rights-based models and a public

health agenda oriented to the social determinants of health. The articles gathered in this issue of *Health and Human Rights* highlight divergences and potential conflicts, as well as positive resonances, among social epidemiology, social medicine traditions, and human rights. These contrasts stem in part from these approaches' distinctive historical trajectories, which have been closely intertwined but are not identical. From the pragmatic standpoint of health policy-making, several factors could weaken the emerging synergy between social determinants analysis and rights-driven health action. Perhaps most important, a public health approach emphasizing multiple social determinants could exacerbate the "fuzziness" that has historically plagued the notion of the right to health, and which, in some circles, has damaged the credibility of rights-based approaches to health policy.<sup>41</sup> As Alicia Ely Yamin has argued, proponents of the right to health are often tempted to blur the distinction between health and overall well-being or quality of life.<sup>42</sup> This tendency to include practically everything good and desirable under the rubric of "health" may enable us to score rhetorical points in the short term but, ultimately, it limits the precision and efficacy of rights-driven arguments in the health policy sphere. If handled without appropriate analytic rigor, social determinants language in public health could exacerbate this dilution of the concept of the right to health. A social determinants agenda enlarges the boundaries of health action to include policy objectives in gender discrimination, poverty, housing, and education, for example. Yet this expansion of the notion of health action must not become an excuse for intellectual laziness. The terms "health" or "health determinants" must not be brandished indifferently to designate "everything we might value in a 'good life.'"<sup>43</sup>

The conceptual and legal rigor of a human rights-based analysis is precisely what is needed to avoid this trap. Human rights analysis takes the emerging scientific picture of how social and economic factors influence health outcomes and translates these scientific findings into specific, concrete objectives for policy and social action. Among the many social factors that influence health, and on which in an ideal world it might be desirable for policy to act, rights-based analysis tells us which factors are actionable within countries' existing legal frameworks and political structures. In this sense, human rights-based analysis mediates the passage from scientific description and social aspiration to political action, that is, from recognizing the multiple social factors

that influence people's health to formulating policy and programming measures that can achieve political traction and so bring change on the ground. The expansion of the conceptual and political space connected with health underscores this critical clarifying role of human rights.

Human rights-based legal analysis tells us what claims are actionable within legal and policy structures. It thus helps us set realistic and achievable goals for policy rather than invoke "pie-in-the-sky" aspirations with no political weight. Rights-informed legal analysis identifies those areas where public health evidence and social demand can achieve leverage, not just theoretically, but through the actual accountability mechanisms that mediate relations between citizens and government. Thus, as Yamin and others have argued, a human rights lens can actually begin to change how members of disadvantaged communities experience their position vis-à-vis public authorities. Rather than passive victims of external forces, citizens operating within a rights structure become active protagonists participating in the identification, implementation, and evaluation of political solutions. Yamin writes that "what a rights framework most distinctively adds to mounting work from the fields of social medicine and social epidemiology is precisely to demand justifications and accountability," recasting public health inequities as violations for which people are empowered to seek legal redress.<sup>44</sup>

The situation of female sex workers constitutes a test case for human rights-based policy approaches, precisely because of the multiple forms of social exclusion and the compounded health risks these women face. In many settings, these risks converge in extremely high levels of HIV infection among sex workers.<sup>45</sup> However, examples from a range of international settings suggest that policy measures informed by a human rights perspective can yield significant reductions in HIV prevalence among sex workers, along with other health benefits for this population. Additional research is needed to quantify the impact of specific rights-based program components on health outcomes among target populations. Already, however, the picture emerging from a number of recent studies on HIV prevention among sex workers is encouraging. Findings suggest that programs' application of key human rights principles, such as participation by sex workers in program design and implementation, have been associated with substantial reductions in HIV epidemics.<sup>46</sup>

Successful HIV prevention campaigns targeting sex workers and their clients have recently been undertaken in Kenya, Botswana, Côte d'Ivoire, and other countries.<sup>47</sup> Many of these programs have embraced participatory models informed by human rights norms and have used participatory, community-based approaches to promote condom use along with regular testing for STIs. These campaigns have reduced HIV prevalence among sex workers and, in some countries, appear to have contributed to reducing national prevalence. As a result of its campaign, for example, Kenya saw a reduction in HIV incidence among sex workers, from 25–50% to 4%.<sup>48</sup> The widely hailed “100% condom” campaign in Thailand led to a general reduction in national HIV prevalence and achieved its greatest successes during the program’s early phases, when collaboration with local stakeholders and active participation by sex workers were at their height.<sup>49</sup> In India, the “three R’s” of the Sonagachi program — “respect” for sex work, “reliance” on sex workers, and “recognition” of sex workers’ rights — improved condom use among sex workers from 27% to 86% and decreased HIV prevalence in this population.<sup>50</sup>

These successes are encouraging, and there is reason to believe that even better results can be obtained, if the scale up of targeted HIV prevention services is linked to policy action on the structural social and economic factors that shape sex workers’ heightened HIV risk in the first place.<sup>51</sup> This multi-pronged strategy, linking improved clinical and prevention services with action on social determinants, is the approach we recommend for Rwanda. Encouragingly, Rwanda has begun to take steps in the direction of such a model, although much remains to be achieved, and some political and social constituencies continue to resist.

Among the most important policy processes supporting the integration of HIV prevention with action on structural social determinants of health is the implementation of Rwanda’s Economic Development Poverty Reduction Strategy (EDPRS 2008–2009). A recognition that economic and social conditions drive differential health vulnerability has been foundational to this strategy, which explicitly integrates measures against HIV into all 12 national economic sectors.<sup>52</sup> The broad aim of the strategy has been to improve the economic situation of all Rwandans, and the consequences of its successful implementation will include reducing the number of women who are forced to enter sex work due to abject poverty.

The interviews with sex workers cited earlier suggest that constraints in access to education have played a significant role in pushing some women towards sex work. Recently adopted policy measures in Rwanda also seek to increase educational opportunity across all socioeconomic levels and so strengthen equity in access to this decisive social good. Rwanda has instituted nine years of free and mandatory universal education for all the country’s children.<sup>53</sup> This will allow more girls to gain skills and learning that will increase their chances of employment in the formal economy. Educational reform measures will also provide children and young people with improved reproductive health information, as these topics are introduced as part of the formal curriculum. Rwanda has also produced mass media campaigns targeting adults and children to increase intergenerational dialogue and decrease risky sexual behavior. These measures seek to foster an environment of increased social support for children from parents and communities, while clearly explaining the risks associated with multiple sexual partners and unprotected sex.<sup>54</sup> In this way, policy makers and program implementers are seeking to ally necessary basic measures in HIV prevention, including the dissemination of accurate information about reproductive health and risks, with structural strategies to expand educational opportunities, in particular for girls.

Current national policy also includes additional structural interventions to address the economic constraints that often make it difficult for women to leave sex work. In telling their stories, female sex workers often emphasize that they wanted to leave sex work, and made multiple attempts to do so, but were forced back into this form of employment by sheer economic necessity and the absence of other ways to produce income for themselves and their families. In response, Rwanda has introduced a special income-generating activities program to help sex workers leave prostitution. This initiative is led by the CNLS, which facilitates the creation of associations of commercial sex workers willing to leave prostitution in all districts, and mobilizes funds to facilitate income-generating activities for them through cooperatives.<sup>55</sup> Most of these women, when given the chance to quit sex work, are willing to leave it. However, for them to succeed in making the transition, they need to receive support and follow-up until they are able to maintain their new income generating opportunity.

Meanwhile, for women who do choose to engage or remain in sex work, an environment must be created



that empowers them to negotiate safe sex, maintain their health, and protect themselves from violence. These measures will achieve better public health outcomes and promote greater welfare in the general population by reducing HIV and other sexually transmitted infections. Such an environment has not been fully created in Rwanda; some parliamentarians currently call for the criminalization of prostitution, and sex workers are still subject to imprisonment, which prompts them to go underground and not seek health information and services.

## CONCLUSION

How public authorities should address sex work remains a topic of active political debate in Rwanda, as in other countries. Some constituencies continue to argue that strict enforcement of exemplary punishments is needed to dissuade women from exercising the immoral “option” of engaging in sex work. The voices of sex workers and former sex workers included in this article reveal the fallacies of this approach.

The women who speak in this article provide illustrative insights into the realities of sex work in Rwanda. They shed light both on sex work’s social and economic roots in this setting and on its health consequences for individual women and the wider population. Additional research is needed to consolidate these early insights and fully apply the qualitative and quantitative analyses that can give us deeper understanding of the social dynamics and public health impact of sex work in Rwanda. Already, however, the stories told by Rwandan female sex workers suggest fundamental lessons for public policy. These lessons are consistent with research findings in other settings.<sup>56</sup>

Sex work should not be framed as a question of individual women’s moral character but as a public health concern shaped by structural social and economic determinants. These determinants notably include gendered inequalities in access to education and economic opportunities. The most effective way to fight prostitution is to prevent it by tackling its roots: poverty, gender inequality, lack of social support, and lack of education.<sup>57</sup>

The human rights framework provides powerful arguments in favor of this approach. Fortunately, Rwanda’s constitution and legal structures incor-

porate strong human rights guarantees that give a foundation for rights-based policy solutions. Full use should be made of these mechanisms to construct and implement public policies that will reduce the health threats associated with sex work by fostering social and economic conditions in which women are no longer forced to sell sex for survival.

Rwanda has taken promising initial steps in this direction. Whether these positive moves will be pursued and brought to fulfillment remains to be seen. In times of widespread economic distress, such as the current global economic downturn, it is tempting to ignore the health needs of social groups seen as marginal or deviant, including sex workers. However, such an approach is ultimately self-defeating, particularly in an HIV epidemic. In other areas of public health policy, such as the construction of its successful *mutuelles* system of health insurance, which currently covers more than 90% of the population, Rwanda has been hailed as a model of solidarity in public health action.<sup>58</sup> By expanding human rights-based policies to protect the health of female sex workers, Rwanda can reinforce this inclusive model, offering an example that would resonate far beyond the country’s borders.

## REFERENCES

1. O. Olufayo and B. Omotosho, “Women trafficking and women prostitution in selected local government areas in Mid-West Nigeria,” *Journal of Social Sciences* 20/3 (2009), pp. 175–182. Available at <http://www.krepublishers.com/02-Journals/JSS/JSS-20-0-000-09-Web/JSS-20-3-000-09-Abst-PDF/JSS-20-03-175-09-889-Olufayo-O-O/JSS-20-03-175-09-889-Olufayo-O-O-Tt.pdf>.
2. Joint United Nations Programme on AIDS (UNAIDS), *UNAIDS guidance note on HIV and sex work* (Geneva: UNAIDS, 2009). Available at [http://data.unaids.org/pub/BaseDocument/2009/jc1696\\_guidance\\_note\\_hiv\\_and\\_sexwork\\_en.pdf](http://data.unaids.org/pub/BaseDocument/2009/jc1696_guidance_note_hiv_and_sexwork_en.pdf).
3. Olufayo (see note 1).
4. T. Zheng (ed), *Sex trafficking, human rights and social justice* (New York: Routledge, 2010).
5. International Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180 (1979). Available at <http://www2.ohchr.org/english/law/cedaw.htm>.

6. Rwanda Ministère de la santé, Programme National de Lutte Contre le SIDA and Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs, *Définir les voies pour la prévention du VIH/ SIDA au Rwanda: Leçons apprises sur les aspects comportementaux: Une revue de la littérature dans la période post-génocide, 1994–2000* (Kigali: Johns Hopkins University Center for Communication Programs, 2000).
7. UNAIDS (see note 2).
8. Ibid.
9. D. Hughes, “Africa’s culture war: The fight over Uganda’s anti-gay bill,” *The World Newser, ABC News* [blog report] (December 14, 2009). Available at <http://blogs.abcnews.com/theworldnewser/2009/12/africas-culture-war-the-fight-over-ugandas-antigay-bill.html>.
10. Treatment and Research AIDS Center Plus (TRAC Plus), Interviews with sex workers and former sex workers [Unpublished audio recordings and transcripts] (Kigali: TRAC Plus, 2009); K. Hawkins, G. Nsengiyuma, and W. Williamson (Participatory Ethnographic Evaluation and Research), *Making the transition: From good girl to good wife — Young women and sex workers’ narratives on social life, sexuality, and risk: Byumba, Rwanda* (Rwanda: Options Consultancy and Population Services International/ PSI, 2005). These two studies are the sources for all direct quotes by sex workers in this article.
11. D. McNeil, “A poor nation, with a health plan,” *New York Times* (June 14, 2010). Available at <http://www.nytimes.com/2010/06/15/health/policy/15rwanda.html>.
12. On the source for the TRAC Plus data (the third item on this list), see note 10. Interviews focused on the six major variables found in the literature review, mainly lack of social support, gender inequalities, socioeconomic factors, dangers inherent in sex work, dangers to the children of sex workers, discrimination as a barrier to access social services, and difficulty of leaving sex work due to stigma. The female sex workers interviewed gave informed consent for their quotes and names to be used nationally and internationally.
13. H. Benjamin and R. Masters, *Prostitution and morality: A definitive report on the prostitute in contemporary society and an analysis of the causes and effects of the suppression of prostitution* (New York: Julian Press, 1964); J. James, *Juvenile female prostitution: Final report* (Seattle, WA: University of Washington, 1978). Available at <http://www.ncjrs.gov/App/Publications/abstract.aspx?ID=78277>; see also, W. Pomeroy, “Some aspects of prostitution,” *The Journal of Sex Research* 1/3 (1965), pp. 177–187.
14. Rwanda Ministère de la santé (see note 6); A. Binagwaho, J. Chapman, and Y. Utazirubanda, et al., *Exploring HIV risk among MSM in Kigali, Rwanda* (Chapel Hill: Carolina Population Center, University of North Carolina at Chapel Hill, 2009). Available at [http://www.phishare.org/files/8959\\_tr\\_09\\_72.pdf](http://www.phishare.org/files/8959_tr_09_72.pdf).
15. Destiny’s End, “Risks to women in prostitution” (Kalamazoo, MI: Western Michigan University, 2010). Destiny’s End is a nongovernmental organization created to provide sex workers with support in seeking alternative livelihoods; TRAC Plus, *Enquête de surveillance des comportements relatif au VIH/ SIDA (BSS) auprès des jeunes, des professionnelles de sexe et des transporteurs routiers au Rwanda, 2000 & 2006* (Kigali: TRAC Plus, 2006).
16. J. Oyefara, “Food insecurity, HIV/AIDS pandemic and sexual behaviour of female commercial sex workers in Lagos metropolis, Nigeria,” *Journal of Social Aspects of HIV/AIDS* 4/2 (2007), pp. 626–635. Available at <http://www.sahara.org.za/index.php/Download-document/286-Food-insecurity-HIV/AIDS-pandemic-and-sexual-behaviour-of-female-commercial-sex-workers-in-Lagos-metropolis-Nigeria.html>.
17. Rwanda Ministère de la santé et al. (see note 6).
18. Ibid.
19. TRAC Plus (see note 10).
20. Ibid.
21. Olufayo and Omotosho (see note 1).
22. C. Williamson, *Entrance, maintenance and exit: The socio-economic influences and cumulative burdens of female street prostitutes* (Indiana: Indiana University, 2000).
23. Destiny’s End, “Costs of prostitution to society” (Kalamazoo, MI: Western Michigan University, 2010). (see note 15).
24. P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Berkeley, CA: University of California Press, 2003).
25. Commission on Social Determinants of Health

- (CSDH), *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health* (Geneva: WHO, 2008). Available at [http://www.who.int/social\\_determinants/final\\_report/en](http://www.who.int/social_determinants/final_report/en); J. Vega, O. Solar, and A. Irwin, "Determinants of health and disease: Overview and framework," in R. Detels, J. McEwen, R. Beaglehole, and H. Tanaka (eds), *Oxford textbook of public health* (Oxford/New York: Oxford University Press, 2009).
26. UNAIDS (see note 2); World Health Organization, *Violence against women and HIV/AIDS: Critical intersections, violence against sex workers and HIV prevention* (Geneva: WHO, 2005). Available at <http://www.who.int/gender/documents/sexworkers.pdf>.
27. UNAIDS (see note 2).
28. World Health Organization, "New online tool kit on HIV/AIDS prevention for sex workers" [press release] (Berlin/Geneva: WHO, 2004). Available at <http://www.who.int/mediacentre/news/releases/2004/pr80/en/>.
29. F. Shumbusho, Family Health International [personal communication, September 13, 2010], summarizing data included in the poster presentation; L. Bangendanye, C. Niyonteze, J. E. Price, et al., *Enhanced Syndromic Management of STIs in Sex Workers: A Dual Opportunity for Service Provision and Prevention of HIV* (Kigali: Commission Nationale de Lutte Contre le SIDA [CNLS], 2007).
30. Présidence de la République du Rwanda, Commission Nationale de Lutte Contre le SIDA, *Etude sur l'identification, l'analyse des comportements des travailleuses de sexe face au VIH & SIDA et l'accès au services de santé dans les districts de Nyaruguru, Rusizi et Rubavu au Rwanda* (Rwanda: Mission of Hope, July 2008).
31. Rwanda Ministère de la santé (see note 6); see also, Présidence de la République du Rwanda (see note 30).
32. World Health Organization (see note 26).
33. UNAIDS (see note 2); Williamson (see note 22).
34. CSDH (see note 25).
35. Ibid.
36. Ibid. Compare other recent studies, including Joint Learning Initiative on Children and HIV/AIDS, *Home truths: Facing the facts on children, AIDS, and poverty* (Boston/Geneva: JLICA, 2009). Available at <http://www.jlica.org/protected/pdf-feb09/Final%20JLICA%20Report-final.pdf>.
37. Constitution of the World Health Organization, 14 U.N.T.S. 185 (1946).
38. WHO and UNICEF, Declaration of Alma-Ata, Alma-Ata, Kazakhstan (1978). Available at [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf); Committee on Economic, Social and Cultural Rights, General Comment 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000). Available at <http://www.unhchr.ch/tbs/doc.nsf/0/40d009901358b0e2c1256915005090be?Opendocument>.
39. P. Farmer, "Challenging orthodoxies: The road ahead for health and human rights," *Health and Human Rights: An International Journal* 10/1 (2008), pp. 5–19; P. Hunt and G. Backman, "Health systems and the right to the highest attainable standard of health," *Health and Human Rights: An International Journal* 10/1 (2008), pp. 81–92; A. Yamin, "Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why we should care," *Health and Human Rights: An International Journal* 10/1 (2008), pp. 45–73.
40. World Health Organization, *A human rights-based approach to health* [Fact sheet] (Geneva: WHO, 2009).
41. Yamin (see note 39).
42. Ibid.
43. Ibid., p. 48.
44. Ibid. See also the valuable sources cited by Yamin, including C. Jochnick, "Confronting the impunity of non-state actors: New fields for the promotion of human rights," *Human Rights Quarterly* 21/1 (1999), p. 59; and N. Krieger, "Why epidemiologists cannot afford to ignore poverty," *Epidemiology* 18/6 (2007), pp. 658–663.
45. A. Côté, F. Sobela, A. Dzokoto, et al., "Transactional sex is the driving force in the dynamics of HIV in Accra, Ghana," *AIDS* 18/6 (2004), pp. 917–925; W. Rojanapithayakorn, "The 100% condom use programme in Asia" [comment], *Reproductive Health Matters* 14/28 (2006), pp. 41–52.
46. UNAIDS (see note 2); World Health Organization (see note 28).

47. World Health Organization, *HIV/ AIDS sex work tool kit* (Geneva: WHO, 2004). Available at <http://who.arvkit.net/sw/en/index.jsp>; N. Nagelkerke, P. Jha, S. de Vlas, et al., “Modelling HIV/AIDS epidemics in Botswana and India: Impact of interventions to prevent transmission,” *Bulletin of the World Health Organization* 80/2 (2002), pp. 89–96; P. Ghys, M. Diallo, V. Ettiegne-Traore, et al., “Effect of interventions to control sexually transmitted disease on the incidence of HIV infection in female sex workers,” *AIDS* 15/11 (2001), pp. 1421–1431.
48. World Health Organization (see note 47).
49. Rojanapithayakorn (see note 45); UNAIDS, “Sex workers mobilize to fight HIV/AIDS, UNAIDS says” [press release] (Geneva: UNAIDS, January 22, 2003). Available at [http://www.touchingbase.org/docs/swker\\_press\\_release.pdf](http://www.touchingbase.org/docs/swker_press_release.pdf); Ministry of Public Health, Thailand and World Health Organization, Regional Office for South-East Asia, *External review of the health sector response to HIV/AIDS in Thailand* (Delhi: WHO, Regional Office for South-East Asia, 2005).
50. D. Kakar and S. Kakar, *Combating AIDS in the 21<sup>st</sup> century: Issues and challenges* (Delhi: Sterling Publishers Private Limited, 2001), p. 32; S. Panda, “The HIV/AIDS epidemic in India: An overview,” in S. Panda, A. Chatterjee, and A. Abdul-Quader (eds.), *Living with the AIDS virus: The epidemic and the response in India* (New Delhi: Sage Publications, 2002), p. 20.
51. U. Tschoetschel and S. Erber, *Mainstreaming HIV and AIDS in the vocational training sector in Botswana* (Eschborn, Germany: German HIV Peer Review Group, 2007).
52. National AIDS Control Commission (CNLS) and United Nations Development Programme (UNDP), *Integrating HIV into the economic development and poverty reduction strategy, 2008–2012: Rwanda’s experience* (April 2008). Available at <http://www.cnls.gov.rw/pdf/EDPRS08.pdf>; Rwanda Ministry of Finance and Economic Planning, *Economic development and poverty reduction strategy, 2008–2012* (Kigali: Ministry of Finance and Economic Planning, 2007). Available at [http://www.undp.org.rw/EDPRS\\_2008-2012.pdf](http://www.undp.org.rw/EDPRS_2008-2012.pdf).
53. World Bank, “Rwanda, World Bank sign education development policy agreement” [press release] (November 3, 2009). Available at [http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22376634~menuPK:51062075~pagePK:34370~piPK:34424~theSitePK:4607,00.html?cid=ISG\\_E\\_WBWeeklyUpdate\\_NL](http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22376634~menuPK:51062075~pagePK:34370~piPK:34424~theSitePK:4607,00.html?cid=ISG_E_WBWeeklyUpdate_NL); Rwanda Ministry of Education, *Fee-free education* (Kigali: Ministry of Education, 2008). Available at <http://www.mineduc.gov.rw/spip.php?article21>.
54. National AIDS Control Commission (CNLS), “Communiqué de presse: La campagne Witegereza” (Rwanda: CNLS, July 18, 2008). Available at [http://www.cnls.gov.rw/index.php?subaction=showfull&cid=1216384958&archive=&start\\_from=&ucat=1&](http://www.cnls.gov.rw/index.php?subaction=showfull&cid=1216384958&archive=&start_from=&ucat=1&).
55. National AIDS Control Commission (CNLS), “Signature d’un protocole d’accord entre la CNLS et les districts encadrant six associations des ex-prostituees” (Rwanda: CNLS).
56. CSDH (see note 25); UNAIDS (see note 2).
57. Tschoetschel and Erber (see note 51).
58. McNeil (see note 11).