Empowering female sex workers in the city of Bogotá:
From Stigma to Empowerment, a Health Rights Approach

This project states and explains why stigma is a public health and economic issue for women in general and female sex workers (FSWs) in particular in the capital city of Bogotá. It also describes the social challenges and rights violation this population faces caused by different types of stigma present in the Colombian society. Additionally, it proposes a three phase plan to empower women by giving them access to technology with participatory methods such as photography and video. The social exposure of the project is intended to mobilize empathy and care ethics on a larger scale and question health barriers that FSWs and their children encounter. By making people aware of the problem of stigma we will be able to effect change on a political level through critical social inclusion praxis.

1. Introduction

"…for most people the 'L' neighborhood is a dumpster that has to be cleaned up
but they don't know that there are families there, there are children, there are women
living there because they have no place else to go.
When the President orders to clean the neighborhoods and take back the space
nobody asked us what we thought about that."
Stefanía Vinasco (2013), age 19

Every year 5% of the GDP (growth domestic product) of Colombia goes to victims of violent crimes and the direct and indirect costs associated with their treatment in health institutions. Research has come to prove that victims of violence suffer from more mental, behavioral and sexual problems, alongside with increased substance abuse related to violence-related traumas (Panamerican Health Organization [PHO], 2002). All of these issues are problems that women who do sex work suffer because of the stigma associated with their work.

This work states and explains how the problem of stigma affects women in general and female sex workers (FSWs) in particular in Bogotá, the capital city of Colombia located in the Global South. In the second part of the proposal, we will present a feasible and innovative approach to the solution of this problem through the empowerment of women by creating access to social transformation processes and technology. We employ an interdisciplinary lens of analysis drawing from the disciplines of Psychology, Economy and Anthropology.

Sex work is legal in Colombia. However, women involved in prostitution do not have their legal and human rights guaranteed. Moreover, sex workers with whom we work with belong to 'vulnerable' social groups such as women migrants escaping from rural areas where the armed conflict is especially

rampant, transgender women, young women, women of ethnic and/or racial minorities and women escaping from domestic violence and abuse[1]. Along with the stigma associated with their line of work, these socio-economic conditions further impede their access to basic human rights, health services and additional social protective systems (World Health Organization [WHO], 2005).

Our group's perspective on sex work and the psychological practice that guides it uses a Participatory Action Research (PAR) frame through which a collectivist, community-based perspective seeks to empower FSWs. By empowerment, we understand the process through which people gain control over their lives, organizations and community. We argue that sex work can be a form of self-determination for women instead of a source of stigma and discrimination (Burnes, Long and Schept, 2012; Weatherfall and Priestley, 2001). Conceptualizing sex work as exploitative endorses victimization and powerlessness. This approach has been defined and built throughout a process of working along-side FSWs and the recently launched NGO, community-based organization P.A.R.C.E.S. (peers in action-reaction against social exclusion, according to the acronym in Spanish) within which peer leaders work and fight against injustices within their community. Jointly we have led initiatives against police harassment, visibilization campaigns, and social cartography encounters, among others (Ritterbusch, 2013a).

2. Problem, relevance and negative impact on women's lives

Weatherall and Priestley (2012) defined sex work as one or several services in which sex is exchanged for money or goods. Specifically, sex work comprises but is not limited to street work, ship work, parlor work, escort work, working independently, mistressing, peep show work, stripping, telephone work and topless dancing. Of all these types of work, street workers have been severely depicted as deviant due to their sometimes present drug related dependencies and abuse. However, it is a common myth that sex workers fund their drug use through their work. Studies suggest that sex workers are likely to start or increase their drug use in order to deal with distress caused by activities associated with their occupation including the social pressure or discrimination associated with it (Burnes et al., 2012; Weatherall and Priestley, 2001).

[1] Review Annex 5.

Colombia is a Heteronormative Catholic and Christian society with a colonial past that inscribes women within multiple power imbalances in their home, work, schooling, and other public and private environments. Despite the increase of women in the labor force, shift duration, levels of education, income and unemployment mark the most persistent social inequalities in Colombia. For the first quarter of 2012, men had 20.2% higher wages than women and the latter had an unemployment rate 7.1 percent higher than men, reaching a 15.6% unemployment rate (one of the highest women's unemployment rates in Latin America). In a male-dominated capitalist society, women within all social categories and classes share disadvantaged social and economic positions and seek ways to secure income within these gendered-limited circumstances.

In Colombia, there is no reliable data on the sex work population. The lack of data and previous work on the underlying, structural and social problems leading to prostitution demonstrates the lack of interest of the State in proposing a solution or working to improve the quality of life and work of FSWs. The most recent study conducted by the Social Welfare Department (Departamento Administrativo de Bienestar Social - DABS) [2] in 2000 found 7,024 sex work establishments and 11,822 sex workers. Within this population 60% work in (more) formal establishments and 40% work on the street. The average age of female sex workers was between the range of 15 and 25 years old and the majority of these women are involved in sex work due to a lack of income and formal employment opportunities. Also, most of them come from rural areas largely due to forced displacement caused by the armed conflict or by extreme poverty conditions. According to Ibañez and Arias et al. (2013), structural exclusion suffered by young rural women puts them in a more 'vulnerable' position by forcing them to live in situations of poverty as a result of low educational level, having multiple children and living as single mothers. In Colombia, these situations are far worst if we take into account that young males are more often killed as a result of the armed conflict the country has endured for the past 50 years (Panamerican Health Organization, 2002).

Furthermore, stigma, as relationship and context-specific, results from the process of socialization in a specific environment (Reeve, 2013). Thus, the main problem that affects FSWs in the city of Bogotá is the stigma associated with their work intertwined with other features such as sexual

[2] A Government office encharge with the Formulation and execution of inclusion public policies, especially for people in 'vulnerable' situations.

orientation and gender (Sallmann, 2010), racial and ethnic background (Burnes et al., 2012), HIV/AIDS diagnosis or Hepatitis C diagnosis (King, Maman, Bowling, Moracco and Dudina, 2013; Whitaker, Ryan and Cox, 2011), migration status and poverty. Throughout this section we will review the three types of stigma (enacted sexual stigma, felt sexual stigma and internalized sexual stigma) and how they affect women related to sex work both within the public and personal spheres. Moreover, we will present the consequences of stigma and how they are inflicted upon 'vulnerable' populations by means of individual, interpersonal, social and administrative violence and discrimination (Major and O'Brien, 2005).

Herek et al. (2009) argue that heterosexual masculinity, traditional Christianity and political conservatism produce especially high levels of social and self-stigma in people perceived as breaking its social rules and standards. Additionally, some studies suggest that such gender structure and traditional morality creates a widespread acceptance of sexual double standards for men and women regarding sex, making women more culpable than men for participating in commercial sex. Hence, for women sex work becomes a stigma, an inherent deviant quality, while for men it is a 'normal' activity that ends when the sexual transaction is over (Sallmann, 2010). Such mentality emphasizes the belief that only sex in marriage is acceptable and sex work is immoral (Wong, Holroyd and Bongham, 2011).

Thus, stigma of FSWs or the 'whore stigma' (Pheterson 1993; Scambler 2007) derives from popular imaginings of the various ways in which women in general and female sex workers in particular contravene established, socially sanctioned norms regarding women's expected behavior such as having sex with strangers, having sex with multiple partners, asking for money in exchange for sex and, specifically as a woman, taking the sexual initiative and controlling the sexual encounter, being an 'expert' in sex, using one's abilities to satisfy male lust and sexual fantasies, being out alone with the express purpose of attracting male desire and being in situations with undesirable men who can either be handled (by vulgar women) or not (by women who are victims) (Wong, Holroyd and Bongham, 2011). Thus, FSWs are perceived to contravene institutional norms for women. Culturally, this is read as a rejection of mainstream values and norms that justifies violent practices against this population (Reeve, 2013).

Such perceptions of sex work create a behavioral and moral disposition that leads to the perception that women act deviantly because they are deviant (Reeve, 2013), which socially justifies

violence inflicted upon them. Moreover, discrimination is reflected in language and the ways used to refer to certain people (Whitaker, Ryan and Cox, 2011). The women we work with complain persistently of the 'addict' and 'whore' labels conferred to them by others, including health care personnel. Such linguistic practices prevent people from seeing them as who they are (moms, sisters, girlfriends or friends) (Ritterbusch, 2013a).

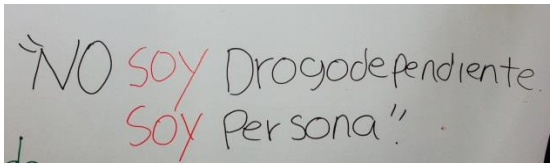


Figure 1. "I am not drug-dependent…I'm a person," Source: Focus Group CESED (GMIAP-UNIANDES/ PARCES) (Ritterbusch, 2013b)

Stigma is considered to be an attribute that is discrediting for the bearer and reduces him/her to a tainted and discounted person (Goffman, 1963). Moreover, stigma is seen by others as something inherent to the person or inside the person, rather than something that can be place on or imposed by others. Such an attribute is thought to spoil the identity and disqualify the person from full social acceptance (Link and Phelan, 2001). Consequently, stigma involves social rejection and negative perceptions both in a public and personal sphere for stigmatized individuals (Sallmann, 2010).

Most children learn stigma and behavioral rules during the socialization process. This process takes place in the environment and is mediated by the dominant values and ideology of a culture, such as Heterosexism (Herek, Gillis and Cogan, 2009). Therefore, people's social conduct and attitudes (the psychological tendency to evaluate a particular entity with some degree of favor or disfavor) will be judged against those learned values. Thus, socialization teaches how to judge others according to their looks, conduct or habits. Heterosexism is an ideology that reflects power and status inequalities and works to produce disadvantages among social groups according to their perceived features (Herek, 2007; Herek, Gillis and Cogan, 2009).

There are two types of institutional stigma that endorse prejudices against the stigmatized group or person. Institutional stigma refers to the administrative violence coming from social organizations or State Institutions limiting social opportunities: access to health care, exclusion from housing or desirable jobs (Herek, Gillis and Cogan, 2009; Sallmann, 2010). There are two forms in which this stigma manifests: i) enacted sexual stigma: a behavioral action of rejection such as overt discrimination

and violence; and ii) felt sexual stigma, the constriction of the range of conducts of behavioral options that a person has to avoid being perceived as something undesirable (Herek, Gillis and Cogan, 2009).

Enacted sexual stigma against FSWs includes daily acts of police violence, harassment, and prosecution. They experience beatings, rape and theft from clients, they are often turn to the streets due to family and social isolation and face denial of access to health care, child care, social services and judicial systems within mainstream society (Burnes, Long and Schept, 2012). Among a sample of FSWs, 60%–93.5% of the members admitted being victims of violence perpetrated by clients, partners, and pimps (Rhodes, Simic, Baros, Platt and Zikic, 2008; Sallmann, 2010).

Another example of enacted sexual stigma is the social cleansing campaigns that target FSWs. Such practices have been present in Colombian society since the 1970's and is directed towards 'disposable' social groups: recyclers, thieves, drag queens, transsexuals, homeless people, prostitutes, HIV-positive populations, drug-dependent or drug-users, among others. These practices are attributed to criminal organizations, paramilitary groups, allies of State Institutions or community members that do not approve of sex work that hire professional hit men to perform the killings. Police reports state these are many times acts of intimidation that leave no casualties; however this contradicted by our work and by the social groups affected by this type of violence as we have lost numerous peer leaders within the sex work community to social cleansing killings. Social cleansing acts as a way to discipline a community through violence, further arguing they remove the rotten or damaged elements from the social tissue of society[3].

Furthermore, within land use plans and other urban planning schemes such as '*Plan Centro*' or the strategic plan for the 'improvement' of the center of the city, poor communities, 'undesired' and deviant inhabitants are pushed out of public space and visibility within the city in the name of urban improvement. The majority of these street dwelling populations are displaced from other regions of the country: more than two thirds of the internally displaced persons (IDPs) in Bogotá cannot return to their homes and end up as permanent, yet unwanted 'residentss' of the city (Programa de las Naciones Unidas para el Desarrollo [PNUD], 2013). This logic of urban planning seeks to integrate the city center with the rest of Bogotá by increasing housing supply, further securitizing and privatizing public space and conserving historic and cultural property (Town Hall of Bogotá, 2011).

[3] View Annex 1.

These practices respond to stigma, which permits the dehumanization of these social groups allowing their removal from public space on moral grounds. Moreover, institutional stigma exerted by Government Institutions implicitly backs and enacts stigma discourses.

During the demolition of the former 'El Cartucho' neighborhood – known as one of the most dangerous places in Latin-America for drug expenditure and illegal activities-, it was described as the home of rats and burglars, an evil focal point of deviance, drugs and criminality that needed to be destroyed (Semana Magazine, 2012). The logic of modernization underpinning the renewal of this place was based on hygienic, pathological discourses and plans aiming to clean "difficult" urban spots and purge the city of its waste and filth (Corbusier, 1942). Let us note that words such as cleansing, "clean" and "dirty" are also used by health care professionals to refer to FSWs (Whitaker, Ryan and Cox, 2011).

> *"They began to knock down houses and we began making shacks to sleep in…many people…were forceably, violently disappeared…the disappearances became frequent…this space [the Cartucho] turned into a war zone…with wounded, dead, sick…moreover today this is all the [El Parque] Tercer Milenio)* (Adriana Guarumo, Exploratory Interview, 31 March 2010).

On the other hand, examples of felt sexual stigma encompass all the behavior and acts associated with concealing sex work from family members, health care professionals and authorities, among others (Major and O'Brien, 2005). As a result, women may not disclose their involvement in prostitution when accessing service providers and may even avoid seeking services because of the risks that exposing their work causes, including being vulnerable to the loss of such services, removal of their children, termination of parental rights and expulsion from social support systems (Weiner, 1996). Evidence also suggests that some women are denied services because providers accept stereotypes that portray FSW as addicts (Ritterbusch, 2013a), self-sufficient criminals or carriers of disease (Sallmann, 2010). Thus, socialized conceptualizations of sex work translate into violent health practices for women and their children, as well as a re-victimization and isolation of this group of people (Lazarus, Deering, Nabess, Gibson, Tyndall and Shannon, 2012).

Studies reveal through both quantitative and ethnographic methods that sex workers experience an array of negative health outcomes but remain unattended by the health sector. In a study by King,

Maman, Bowling, Moracco and Dudina (2013) in Russia, 31% of FSWs revealed that doctors refuse to treat them and 51% revealed that doctors refuse medical care to intravenous drug users. Also, 95% reported that they don't feel they can openly discuss some problems with doctors and 49% had never discussed their involvement in sex work. Moreover, 58% recognized they had missed a health-related appointment because they worried they would be treated badly and an additional 50% of street-based sex workers reported barriers to access health services due to their line of work (Lazarus et al., 2012).

A severe consequence of such a restriction in health services is the limited access that children of FSWs receive, thus affecting their health and well-being. Although they are not the target population of stigma, they inherit the violence caused by it. This is the reason stigma is associated with infant mortality and health care problems in children from 0-5 (WHO, 2005). Many FSWs avoid taking their children to such service institutions for fear of discrimination, termination of parental rights or removal of their children. Violence and hostility are also present in the language used in everyday life: "son of a bitch/whore" or "bastard".

Perceived self-stigma enhances when FSWs face drug consumption and HIV-positive diagnosis in their lives or the lives of loved ones. HIV-related stigma is also a barrier to access health services for this population (King et al., 2013). However, Lazarus et al. (2012) report that in Canada of a total of 252 women, 141 (55.9%) reported occupational sex work stigma (defined as hiding occupational sex work status from family, friends and/or home community), while 125 (49.6%) reported barriers to accessing health services in the previous six months. Moreover, qualitative research with FSWs in Dublin revealed that drug users who engage in sex work tried to hide their drug use due to felt stigma and that this stigma was reinforced by the language used by health care professionals (Whitaker, Ryan, and Cox, 2011). Moreover, UK narratives of sex workers reveal that fear of privacy and disclosure of their sex work status, including distrust of authority and fear of prosecution further prevents them from accessing and using health services (Day and Ward, 1997).

> "[…] *And they took me to the hospital, "Culi", she was the one that took me there, when they said: Oh no, here we don't accept junkies and I said: what? What do you mean no!?"* (Andreina Francisca, Exploratory Interview CESED, 2012).

Finally, iii) internalized stigma is the personal acceptance of the stigma as a part of the self-concept and value system (Herek, Gillis and Cogan, 2009). Internalized stigma or self-stigma

comprises the process whereby negative social attitudes are internalized and cause shame, low self-esteem and avoidance of services (Sallmann, 2010). Moreover, stigma has been related to poor mental health, physical illness, academic underachievement, infant mortality, low social status, poverty, financial concerns and lack of safe sex practices (Burnes et al., 2012; Major and O'Brien, 2005). Also, internalized stigma may cause feelings of despair, depression, anxiety and powerlessness (Burnes et al., 2012). In general, members of stigmatized groups are at a greater risk for mental and physical health problems that include hypertension, coronary heart disease, and stroke (Krieger, 1990). Additionally, there is a growing body of evidence suggesting that stigma itself can be an important contributor to ill health in individuals and to the production of health disparities in populations.

It is in this sense that these multiple lived experiences of stigma continues to further increase gender-based and socio-spatial inequalities between different populations in the city. Promoting gender equality in society is of utmost importance in terms of meeting the gender-oriented Milennium Development Goals in general as well as formulating and advocating for public policy generation that conceptualizes the empowerment and improvement of the quality of life and work of women as progress and as a fundamental component of economic development and productivity in the labor market. As stated in the *World Development Report 2012:* "Economic development alone is not sufficient for the reduction of gender ineuqality: it is necessary to articular corrective policies that specially tackle the persistent gender inequalities within society" (World Bank, 2012). This approach takes stigma as the point of departure for combatting the deepest and most persistent gender inequalities experienced in society.

Following the stated, the most appropriate approach to stigma needs to be structural in nature considering that for stigma to exist the following interrelated components concur: i) people distinguish and label human differences; ii) dominant cultural beliefs link labeled persons to undesirable characteristics; iii) labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from "them."; iv) labeled persons experience status loss and discrimination that lead to unequal outcomes; v) stigmatization is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination. Accordingly, stereotypes and stigma are often "automatic" (Fiske,

1998). ***So how can we construct an effective, sufficient social intervention that attacks what people don't even realize is there?***

3. Proposed Solution: From Stigma to Empowerment, a Health Rights Guarantee

The structural nature of stigma must be addressed relationally, as part of a social world inhabited not just by the stigmatized but also by those who exert the power to label and discriminate (Rao Biradavolu, Blakenship, Jena and Dhungana, 2012). It requires a pro-active, multilevel approach to advocacy for sex workers' health that involves responding to both immediate health needs and to the social and structural problems that perpetuate barriers (Wong, Holroyd and Bongham, 2011).

Additionally, the success of sex work collectivization and empowerment in reducing HIV risk in some developing country settings have been attributed in part to their ability to confront social stigma (Halli, Ramesh, O'Neil, Moses and Blanchard, 2006; Jana, Baau, Rotherdam-Borus and Newman, 2004). Furthermore, the Precaution-Adoption Process Model (Bartholomew, Parcel, Kok and Gottlieb, 2006) argues that different tactics are needed in different stages of change. When people and social institutions are unaware of the problem like in the Colombian case, media messages about the hazards and precautions of the problem are pertinent and useful. This approach is relevant due to the invisible and naturalized state of stigma discrimination. By giving visibility to stigma, social groups are able to understand their behavior through a different light. Such strategy is especially effective when reaching resistant groups, as might be the case within the context of health professionals and the Colombian society we described earlier.

Thus, this project intends to generate consciousness and act against stigma throughout its three phases of development that empower women by means of social mobilization processes and access to technology. The three stages are: i) an auto-photographic registry and street mobile exposition of FSWs lives and everyday experiences, ii) a participatory video with a selected group of 5 women in which they tell their story and how they've been affected by stigma combining it with footage of people's reactions to the mobile photo exposition in different parts of town; and finally, iii) the social exposition in social media, health institutions and other organizations of both the photographic documentation of women's lives and of the video. Thus, the material products of the intervention will be a mobile auto-photo exhibit intended to occupy different city scenarios, a video of FSWs lives and health access

barriers they encounter put together with footage of people's reactions to their pictures and finally, a social and political acknowledgement of the stigma they endure.

Our objective is that by giving these women access to technology (both in research methods, social exposition technology, social media and diffusion media) they will be able to portray themselves as who they want to be perceived and thus social stigma will be confronted and contested in particular, strategic spaces in the city. This access to technology will continue to benefit them after the project ends by empowerment sustainability but also by assembling different social actors in the work and guarantee of their rights and social mobilization processes. Furthermore, access to technology will endure in the social influence it achieves. The social exposure of the project is intended to mobilize empathy and care ethics on a larger scale and question health barriers that FSWs and their children encounter. Also, it seeks to generate consciousness in popular and elite spaces in the city by making people aware of the problem of stigma. Thus, we will be able to effect change on a political level through critical social inclusion praxis (Bartholomew et al., 2006).

Thus, our group suggests that different social science disciplines enable 'vulnerable' groups to speak by themselves through media and research technologies that privilege experience such as ethnography, community photography and video (Das, 2004; Greenhouse, 2002). However, the representation attempt fails if the intent to capture individual voices ends up representing the generalized discourse of 'vulnerability' and 'vicitmization' related to poverty, hunger and violence. Such discourses further victimize people that have been forced to endure and live through difficult situations, such as FSWs.

Massive communication media such as radio, internet and television are the major representatives of such discourses of FSWs. These hegemonic and discriminatory narratives that endorse stigma are still common and active within the Colombian society through journalism, documentaries, photography and academic research. However, we believe that "…the human cannot be captured through the representation, and we can see that some loss of the human takes place when it is 'captured' by the image" (Butler, 2004, 145).

Journalism and mainstream media feeds stigma by a lack of analysis of the social causes of poverty and exclusion, thus creating a naturalization of violence and a miscomprehension of the violent dynamics imposed on women. Hence, our project looks to avoid the normalization of the crisis speech

and the invisibilization of the complex factors behind places such as the neighborhood '*El Cartucho*' and social groups known as 'disposable' (Jimenez, 2008). We propose the use of hegemonic tools that thus far have been used to reproduce stigma and turn them into means of empowerment and participatory praxis. Photography and video have the capacity to make the lives and voices excluded from institutional and social discourses to be heard and known through technology and social media (Butler, 2004).

The photographer is in a privileged position of control over the actions, the stage, and the framing of the picture. A photographic representation reflects aesthetic decisions by means of composition: a person, an angle, a reproduction. The photography is interpreted by the people that come in contact with it and such interpretation is built on what is known. This process of interpretation affects what is represented and how it is seen. Hence, through a picture the complex relation with what is observed becomes altered (Berger, 1977 in Bleiker, Kay, 2007).

According to Bleiker and Kay (2007) there are several photographic methods that can be used with 'vulnerable' populations. The first is a naturalistic one that claims to be neutral and value-less through an objective representation of what is photographed. However, pictures are taken at a certain time and with a certain frame that compose the essence of the photograph. Another type of method is the humanistic one that tries to capture shocking scenes of suffering to produce compassion in the audience. Although compassion can be a positive engine for change, humanistic photography methods conceal colonial features of representation that produce more shame than compassion; in addition to connote a distance between the observer and what is observed (Bleiker and Kay, 2007). As a result, the audience turns to apathy by interpreting that crisis and misery are totalizing experiences that cannot be altered.

Colombian journalism has used mainly humanistic photography methods to represent FSWs. With these images the focus is put on misery, not on the achievements and accomplishments of 'vulnerable' groups that prevail through violence and build empowerment (Patton, 1990 in Bleiker and Kay, 2007). Images of suffering additionally connote moral judgments, resentment and fear, reminding the audience

of the distance that separates it from other social groups[4]. By the representation of the consequences of social exclusion as something distant, stigma becomes further endorsed (Bleiker and Kay, 2007).

However, Bleiker and Kay (2007) propose an alternative method to work with social groups based on pluralism. Such photographic method called pluralistic photography intends to represent multiple social knowledge and praxis by breaking down hierarchies and power relations pervasive in social media. This method proposes to give the camera to the 'represented'. By permitting FSWs as a part of a 'vulnerable' community to explore their experience through the picture, a politic, ethic, social and psychological dialogue is built with the observer of the photographic records. This method of representation translates the agency to the FSWs and forces others to see what they want to show and how they want to be represented. The result is the exposure of violence they endure but also of what allows them to resist and empower themselves as women and members of a 'vulnerable' community (Bleiker and Kay, 2007).

With the necessary precautions, this method brings certain benefits: i) local validation of knowledge, ii) increased self-worth, iii) improvement of gender equity indicators, iv) social reflection and group solidarity in defense of others' rights (Prins, 2010). Hence, this photographic method helps communities counteract the negative effects of stigma on personal and social levels. Human relations are embedded in power relations but pluralistic photography minimizes the oppressive effects of these dynamics by problematizing representations. The collaborative character of this project can provide several ways to make visible and validate perspectives of FSWs that have been stigmatized.

Thus, the first part of our project consists of using pluralistic photography to work with FSWs participants to create a photographic record that acknowledges and represents who they are, the troubles they encounter and the health rights violation they and their children have to endure because of discrimination based on the three types of stigma previously described. Pluralistic photography's objective in this intervention is to expose a problem ignored thus far by social and government institutions. Also, pictures will enable a dialogue between the observer and the observed, making possible the identification with "the other", humanizing what social cleansing speeches, discrimination and stigma have naturalized. Pluralistic photographic methods have been used before with FSWs in Bogotá with very positive results and due that it has been their suggestion, it is possible to conclude

[4] Review Annex 6 and 7.

that this project will be well received by community members and peer leaders[5]. Additionally, pluralistic photography is the first step towards FSWs empowerment and access to technology by permitting them to represent themselves as they want to be perceived.

The second phase of the project's intervention is planned in two different steps. The objective of this phase is to expose the problem of stigma and how it affects FSWs. The first part of this phase consists in the filming of a video with five (5) representative cases from the FSWs community in which they tell their story, what they want people to know and what they want to change in their community. Video, like photography, has been previously used with the FSWs with whom we work, resulting in processes of collaboration and mobilization for their rights. As the perceived need of health care access in which this project is based was expressed by them it is expected they will be willing to collaborate and talk about it in the video. As part of this first step it is also intended to show the photographic records produced in phase 1 in a mobile street exposition both in community places and elite urban areas inhabited by different social groups. The negotiation of exposition spaces will be taken directly with the owners of the spaces of the exposition. The objective of this phase is to generate the social dialogue that access to technology and participatory research methods permit, breaking the public and personal spheres division and generating an impact on stigma in the different parts of the city where actors are located.

The second step of this second phase is to film people's reactions to the photographs in each place they are exhibited. This footage will be put together with the one taken in the first step, composing a final video product that reflects not also the testimonies of FSWs but also the reactions of people to their pictures. The video is intended to enforce the identification between the observer and the observed to delegitimize violence infringed upon FSWs and the institutional, interpersonal and personal stigma discourses that support it. The video, in addition to prioritization of their voices is intended to be put in social media and social networks through the contact networks of P.A.R.C.E.S. NGO, the University and the peer leaders' contacts. This second step permits the acknowledgment of stigma by means of exteriorization and representation, as well as the acknowledgement at a social level of the basic human rights violation that certain groups of people encounter just by inhabiting certain urban areas or practicing certain jobs.

[5] Review Annex 8.

The third phase of the project is to take the video to the health institutions that are in direct contact with FSWs. We are aware that this will take certain lobbying but we are confident that through the contacts of the University and those of peer leaders and P.A.R.C.E.S. NGO it will be possible. This phase is directly intended to sensitize and generate consciousness in the health sector personnel. By the time the project reaches this phase, the video will be found in several social networks such as facebook, twitter, youtube and others available to P.A.R.C.E.S. NGO members and followers, fellow students and others. The objective is to make this a viral video that strategically exposes the 'whore stigma' present in the city's population. In this way, technology is used in a constructive way to mobilize resources and different networks of people.

According to the studies and authors consulted, projects and interventions that affect multiple social levels and promote strategies that expose stigma facilitate empowerment. Thus, technology can be used as a method of relating to others and as a way of denouncing the social exclusion problems that FSWs face. As an additional result we expect to summon local organizations that can help with the stigma problem that FSWs and their children endure when accessing health care.

Note: We thank the principal research actors that made the PAR project possible and participated in the selection of qualitative data excerpts included in this project. Empirical quotes included in the proposal draws from the doctoral dissertation work in 2008-2012 of Amy Ritterbusch, supported by the National Science Foundation under Grant No. BCS-0903025. Financial support for doctoral research was also granted by the Fulbright U.S. Student Program and Amy Ritterbusch held an American Fellowship from the American Association of University Women (AAUW) for dissertation writing. Due to the participatory nature of our work, these initial projects are currently ongoing and our contact with the research populations maintains constant. The information cited in this proposal remains a relevant representation of the challenges and realities of their daily lives.

4. References

Bartholomew, L.K., Parcel G.S., Kok G. & Gottlieb N.H. (2006) *Planning Health Promotion Programs: an Intervention Mapping Approach.* San Francisco: Jossey Bass.

Bleiker, R., & Kay, A. (2014). Representing HIV / AIDS in Africa: Pluralist Photography and Local Empowerment, *International Studies Quarterly 51(1),* 139–163.

Buitrago, M. C. (2009). *Estado de derecho, seguridad y marginalidad: Representaciones en prensa sobre el fenómeno de la limpieza social en Colombia 1988-1996*. Tesis M.A. Bogotá: Universidad Javeriana.

Burnes, T.R., Long, S.L. & Schept R.A. (2012) A Resilience-Based Lens of Sex Work: Implications for Professional Psychologists. *Professional Psychology: Research and Practice Vol. 43, No. 2*, 137–144. doi: 10.1037/a0026205

Butler, J. (2004). *Precarious life: the powers of mourning and violence*. London: Verso

Corbusier, L., & Sert, J. L. (1942). Carta de Atenas. IV Congreso de Arquitectura Moderna CIAM. Retrieved the 10th of December 2013: http://htca.us.es/blogs/htca0114/files/2011/11/1942_carta_de_atenas.pdf.

Das, V. (2004). State and its margins. In V. Das, & D. Poole, *Anthropology in the margins of the State* (pp. 3-35). Santa Fe: School of american research press.

Day S., & Ward H. (1997). Sex workers and the control of sexually transmitted disease. *Genitourinary Medecine 73*, 161–168.

Fiske S.T. (1998). Stereotyping, prejudice, and discrimination. In D.T. Gilbert and S.T. Fiske (Eds.) *The Handbook of Social Psychology*, Boston, MA: McGraw Hill, pp 357–411.

Folch C., Lazar C., Ferrer L., Sanclemente C. & Casabona J. (2013) Female sex workers and access to social and health services in Catalonia: Influence of region of origin and place of work. *AIDS Care: Psychological and Sociomedical Aspects of AIDS/HIV, 25(8)*, 1033-1038, doi: 10.1080/09540121.2012.748872

Ghose, T., D. Swendeman, S. George, and D. Chowdhury. (2008). Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: The boundaries, consciousness, negotiation framework. *Social Science & Medicine 67*, 311–20.

Goffman E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. New York: Prentice Hall.

Greenhouse, C. (2002). Altered states, altered lives. In C. Greenhouse, E. Mertz, & K. Warren, *Etnography in unstable places: Everyday lives in contexts of dramatic political change*, pp. 1-37. Durham: Duke University Press.

Halli, S.S., B.M. Ramesh, J. O'Neil, S. Moses, and J.F. Blanchard. (2006). The role of collectives in

STI and HIV/AIDS prevention among female sex workers in Karnataka, India. *AIDS Care 18, no. 7,* 739–49.

Hallgrimsdottir, H.K., R. Phillips, C. Benoit, and K. Walby. 2008. Sporting girls, streetwalkers, and inmates of houses of ill repute: Media narratives and the historical mutability of prostitution stigmas. *Sociological Perspectives 51 (1),* 119–38.

Herek G.M. (2007). Confronting Sexual Stigma and Prejudice: Theory and Practice. *Journal of Social Issues, Vol. 63, No. 4,* 905-925.

Herek G.M., Gillis J.R. & Cogan J.C. (2009) Internalized Stigma Among Sexual Minority Adults: Insights From a Social Psychological Perspective. *Journal of Counseling Psychology,Vol. 56, No. 1,* 32–43

Ibañez, A. M., Arias, M.A., Caro, A., Farah, M.A., Henao,A., Muñoz, J.S., & Peña, X. (2013) Las mujeres jóvenes rurales en Colombia. *Documentos CEDE, Vol. 28, 1-40*

Jana, S., I. Basu, M. Rotheram-Borus, & P. Newman P. (2004). The Sonagachi project: A sustainable community intervention program. *AIDS Education and Prevention 16, no. 5,* 405–14.

King E.J., Maman S., Bowling J.M., Moracco, K. & Dudina V.(2013). The Influence of Stigma and Discrimination on Female Sex Workers' Access to HIV Services in St. Petersburg, Russia. *AIDS Behavior, 17,* 2597–2603. doi 10.1007/s10461-013-0447-7.

Krieger N. (1990). Racial and gender discrimination:risk factors for high blood pressure? *Social Science Medicine. 30,* 1273–81

Lazarus L., Deering K.N., Nabess R., Gibson K., Tyndall M.W. & Shannon K. (2012) Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care, 14:2,* 139-150, doi: 10.1080/13691058.2011.628411

Link B.G. & Phelan J.C. (2001). Conceptualizing stigma. *Annual Reviews of Sociology, 27,* 363–385.

Major B. & O'Brien L.T. (2005). The social psychology of stigma. *Annual Reviews of Psychology. 56,* 393–421 doi: 10.1146/annurev.psych.56.091103.070137

Organización Panamericana de la Salud [OPS]. (2002). Informe mundial sobre la violencia y la salud. *Resumen.* Washington D.C.: Biblioteca de la OPS.

Pheterson, G. (1996). The whore stigma. In G. Pheterson, *The prostitution prism,* Amsterdam: Amsterdam University Press, pp. 37-64.

Prins, E. (2010). Participatory photography: A tool for empowerment or surveillance? *Action Research, 8(4),* 426–443. doi:10.1177/1476750310374502

Profamilia & The George Washington University (2013). Prevalencia del VIH, comportamiento sexual, y circuncisión en hombres que tienen sexo con hombres en Bogotá [HIV Prevalence, sexual behavior and circumcision in men who have sex with men in Bogotá]. Retrieved March 4th of 2014 from:
http://www.profamilia.org.co/index.php?option=com_content&view=article&id=537

Profamilia ENDS-10 [National Survey of Demography and Health] (2010). Capítulo 14: Afiliación, Percepción y Uso de Servicios del Sistema General de Seguridad Social en Salud [Chapter 14: Affiliation, Perception and Use Of General Social Security Services in Health]. Retrieved March 4th of 2014 from: http://www.profamilia.org.co/encuestas/Profamilia/Profamilia/index.php?option=com_content&view=article&id=147&Itemid=117

Programa de las Naciones Unidas para el Desarrollo [PNUD] (2013). Población desplazada: De la emergencia al desarrollo. Retrieved March of 2014 from: http://www.pnud.org.co/sitio.shtml?x=71631#.UzroGaiSyUJ

Rao Biradavolu M.R., Blankenship K.M., Asima Jena A. & Dhungana N. (2012). Structural stigma, sex work and HIV: contradictions and lessons learnt from a community-led structural intervention in southern India. *Journal of Epidemiology Community Health, 66,* 95-99. doi:10.1136/jech-2011-200508

Reeve, K. (2013) The Morality of the "Immoral": The Case of Homeless, Drug-Using Street Prostitutes. *Deviant Behavior, 34 (10),* 824-840, DOI: 10.1080/01639625.2013.781442

Rhodes, T., M. Simic, S. Baros, L. Platt, and B. Zikic (2008). Police violence and sexual risk among female and transvestite sex workers in Serbia: Qualitative study. *British Medical Journal 337,* 1-6. doi: 10.1136/bmj.a811.

Ritterbusch, A.E. (2013a, noviembre). *¿Cómo se percibe y se vive en la "L"?: Narraciones sobre territorios y sus habitantes*. Ponencia presentada en: Foro la "L" y el "Bronx": Buscando otras miradas sobre el consumo de SPA para movilizar nuevas políticas e intervenciones. Foro entre actores, academia e instituciones, Universidad de los Andes, Bogotá: Colombia.

Ritterbusch, A.E. (2013b). "La Guerra de los Niños de la Calle: Diagnóstico Participativo del Consumo de Drogas en Niños y Adolescentes en el Centro de Bogotá". Universidad de los Andes: CESED.

Sallmann, J. (2010) Living With Stigma: Women's Experiences of Prostitution and Substance Use. *Affilia, 25 (2),* 146-159. doi: 10.1177/0886109910364362

Scambler, G. (2007). Sex work stigma: Opportunists migrants in London. *Sociology 41, (6),* 1079–96.

Vinasco, S. (2013, November). How is the 'L' neighborhood perceived and lived? Narratives of territory by its people. Presentation at The 'L' and 'The Bronx' beyond 'bazuco' and glue. *Looking for different perspectives on inhalants consumption to mobilize new politics and interventions*, Bogotá, Colombia.

Revista SEMANA (2012). El Tercer Milenio, un parque agridulce. Recuperado el 27 de marzo de 2014 de: http://www.semana.com/Imprimir.aspx?idItem=259081

Town Hall of Bogotá [Alcaldía Mayor de Bogotá]. (11 de Marzo de 2011). Plan Centro. Retrieved the 11th of November of 2013 from: http://www.bogota.gov.co/portel/libreria/php/x_frame_detalle.php?id=44855

Weatherall, A., & Priestley, A. (2001). A feminist discourse analysis of sex "work". *Feminism & Psychology, 11,* 323–340. doi:10.1177/0959353501011003005

Weiner, A. (1996). Understanding the social needs of streetwalking prostitutes. *Social Work, 41,* 97-105.

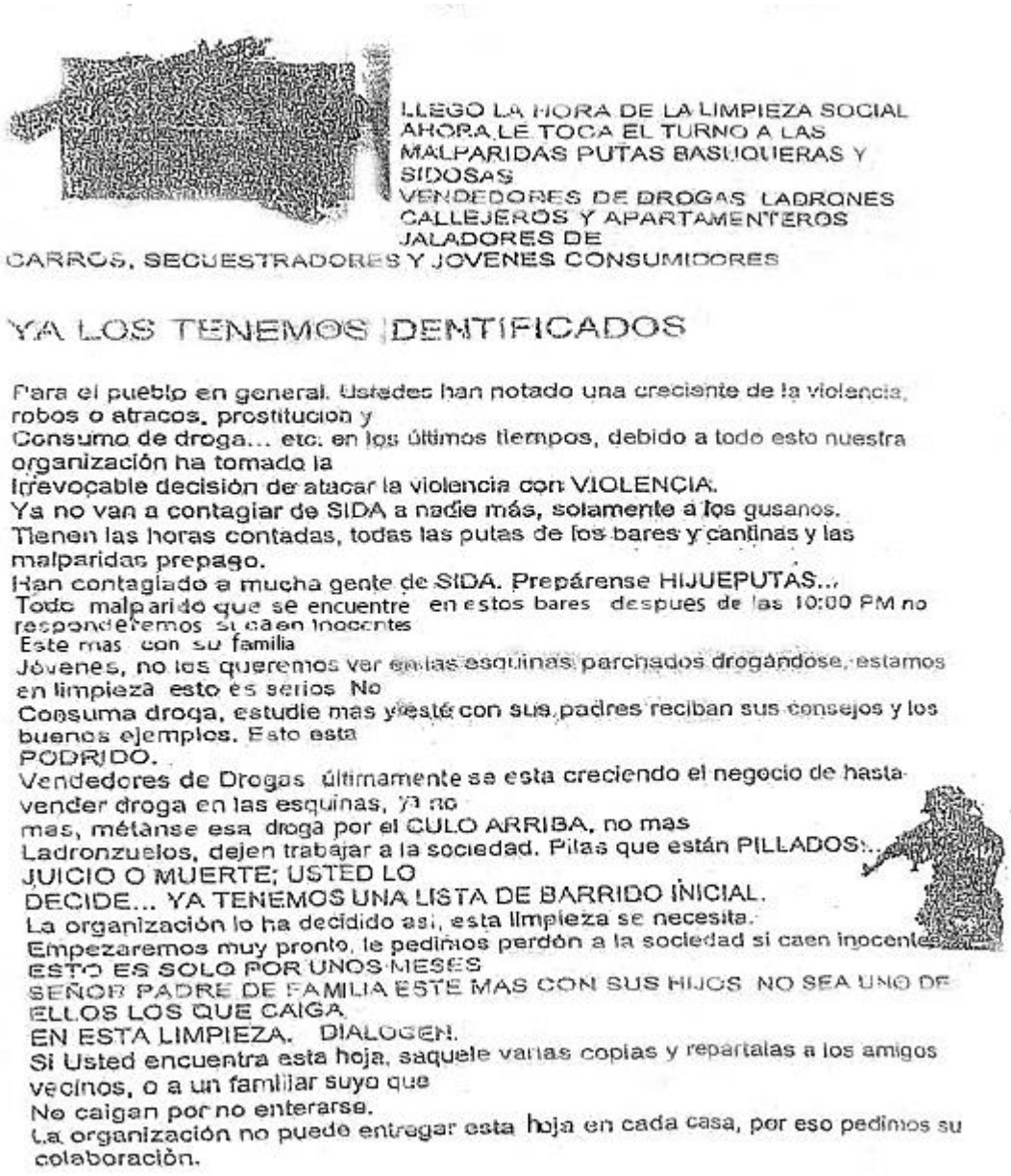
Whitaker T., Ryan P. & Cox G. (2011). Stigmatization Among Drug-Using Sex Workers Accessing Support Services in Dublin. *Qualitative Health Research, 21(8),* 1086-1100. doi: 10.1177/1049732311404031

Wong W.C.W., Holroyd E. & Bingham A. (2011). Stigma and sex work from the perspective of female sex workers in Hong Kong. *Sociology of Health & Illness Vol. 33 No. 1,* 50–65. doi: 10.1111/j.1467-9566.2010.01276.x

World Bank [WB] (2012). *Informe sobre el desarrollo mundial 2012: Igualdad de género y desarrollo.* Washington D.C: WB Press

World Health Organization [WHO] (2005). *Addressing violence against women and achieving the Millenium Goals*. Geneva: WHO Press.

1. Annex 1: Social Cleansing Flyer



LLEGO LA HORA DE LA LIMPIEZA SOCIAL
AHORA LE TOCA EL TURNO A LAS
MALPARIDAS PUTAS BASUQUERAS Y
SIDOSAS
VENDEDORES DE DROGAS LADRONES
CALLEJEROS Y APARTAMENTEROS
JALADORES DE
CARROS, SECUESTRADORES Y JOVENES CONSUMIDORES

YA LOS TENEMOS IDENTIFICADOS

Para el pueblo en general. Ustedes han notado una creciente de la violencia, robos o atracos, prostitucion y
Consumo de droga... etc. en los últimos tiempos, debido a todo esto nuestra organización ha tomado la
Irrevocable decisión de atacar la violencia con VIOLENCIA.
Ya no van a contagiar de SIDA a nadie más, solamente a los gusanos.
Tienen las horas contadas, todas las putas de los bares y cantinas y las malparidas prepago.
Han contagiado a mucha gente de SIDA. Prepárense HIJUEPUTAS...
Todo malparido que se encuentre en estos bares despues de las 10:00 PM no respondéremos si caen inocentes
Este mas con su familia
Jóvenes, no los queremos ver en las esquinas parchados drogándose, estamos en limpieza esto es serios No
Consuma droga, estudie mas y esté con sus padres reciban sus consejos y los buenos ejemplos. Esto esta
PODRIDO.
Vendedores de Drogas últimamente se esta creciendo el negocio de hasta vender droga en las esquinas, ya no
mas, métanse esa droga por el CULO ARRIBA, no mas
Ladronzuelos, dejen trabajar a la sociedad. Pilas que están PILLADOS:..
JUICIO O MUERTE; USTED LO
DECIDE... YA TENEMOS UNA LISTA DE BARRIDO INICIAL.
La organización lo ha decidido asi, esta limpieza se necesita.
Empezaremos muy pronto, le pedimos perdón a la sociedad si caen inocentes
ESTO ES SOLO POR UNOS MESES
SEÑOR PADRE DE FAMILIA ESTE MAS CON SUS HIJOS NO SEA UNO DE
ELLOS LOS QUE CAIGA
EN ESTA LIMPIEZA. DIALOGEN.
Si Usted encuentra esta hoja, saquele varias copias y repartalas a los amigos vecinos, o a un familiar suyo que
No caigan por no enterarse.
La organización no puede entregar esta hoja en cada casa, por eso pedimos su colaboración.

Figure 2. Social cleansing flyer from one of the neighborhoods of downtown Bogotá where FSWs work.

Translation (We have translated this pamphlet as accurate as possible given the Colombian/street slang used originally in this note):

It's time for a social cleansing

Now it's the turn of the fucking AIDS-infected crack whores, drug dealers, street muggers, apartment robbers, car thieves, kidnappers and young consumers

WE HAVE YOU ALL IDENTIFIED

The population in general has noticed a growth in violence, robberies, prostitution and drug consumption etc. For all of these reasons, our organization has made the decision to fight violence with violence.

You won't infect with AIDS anybody else, only the worms. All escorts and club/bar hookers have limited time. You have infected too many persons, PREPARE YOURSELVES BASTARDS…

Every bastard that's in one of these bars after 10 pm, we won't answer if innocent people get hit too.

Spend more time with your family. Young people, we don't want to see you lying in a corner getting high, we are in a social cleansing, this is serious, don't do drugs, study more and be with your parents, listen to their advice and good examples, THIS (SOCIETY) IS ROTTEN.

Drug dealers, your business is growing up, you're even selling in every corner, no more, STICK YOUR DRUGS UP YOUR ASS

No more burglars, let society work, you are all IDENTIFIED

GOOD JUDGEMENT OR DEATH, IT'S YOUR CHOICE… WE HAVE A LIST OF THE FIRST CLEANING

The organization has decided to do it this way, this cleansing is necessary.

We'll start soon, we ask society for forgiveness if innocent people fall,

THIS IS ONLY FOR A FEW MONTHS

DEAR FAMILY GUY, SPEND MORE TIME WITH YOUR KIDS, HOPEFULLY NONE OF THEM WILL FALL DURING THE CLEANSING, DISCUSS YOUR PROBLEMS.

If you find this paper, make a bunch of copies and distribute them to your neighbors, family and friends, skip them the trouble of falling in this cleansing for not being informed. The organization can't deliver this paper in every house, so we ask for your collaboration.

2. Annex: Theory of Change for Project *'Empowering Female Sex Workers in the City of Bogotá'*

Theory of Change for Empowering female sexual workers in the City of Bogotá

Inputs	Process of Empowerment	Products	Results with general population
1. FSWs participants. 2. Funding. 3. Cameras. 4. Video equipment. 5. Video crew to back production. 6. Accompaniment. 7. Institutional articulation.	**Phase 1: Auto-Photo** 1. Selection of participants. 2. Auto-photography workshops. 3. Camera distribution. **Second process: Video** → **Step 1:** 1. Selection of participants. 2. Constitution of video crew and production team. 3. Creating the storyboard. 4. Filming video. 5. Photo exhibit in different sites. → Step 2: 1. Filming people's reactions of photo exhibit. 2. Production of final video. **Third proces:** 1. Institutional articulation with health institutions. 2. Video reproduction in institutions. 3. Access to techonology for FSWs.	1. Auto-photo exhibit. 2. Video documenting FSWs lives and stigma consequences. 3. Video display and reproduction at public and private health institutions. 4. Interinstitutional collaboration to reduce stigma.	1. Stigma acknowledgement towards FSWs. 2. Knowledge regarding health barrieres FSWs and their children encounter. 3. Change in attitudes towards FSWs. 4. Reduced health barriers for FSWs and their children. 5. Articulation with other organizations to sustain empowerment and social, techonological and political inclusion.

3. Annex: Perceived Need Analysis

Current situation:

- 60%–93.5% of FSWs report high rates of physical and/or sexual abuse perpetrated by customers, pimps and partners (Sallmann, 2010).
- In Rusia, 31% of FSWs agreed that doctors refuse to treat them and 51% agreed that doctors refuse medical care to injection drug users (King, Maman, Bowling, Moracco and Dudina, 2013).
- 95% reported that they don't feel they can openly discuss some problems with doctors and 49% had never discussed their involvement in sex work. Moreover, 58% recognized they had skipped the trip to see a doctor because they worried they would be treat them badly (King, Maman, Bowling, Moracco and Dudina, 2013).
- Moreover, more than half of street-based sexual workers report barriers of access to health services (Lazarus et al, 2012).
- In Canada of a total of 252 women, 141 (55.9%) reported occupational sex work stigma (defined as hiding occupational sex work status from family, friends and/or home community), while 125 (49.6%) reported barriers to accessing health services in the previous six months (Lazarus et al., 2012).
- Qualitative research with FSWs in Dublin revealed that drug users who engage in or had engaged in sex work, tried to hide their drug use due to felt stigma (Whitaker, Ryan, and Cox, 2011).
- In the UK, FSWs reveal fear of privacy and disclosure of their sex work status, including distrust of authority and fear of prosecution that prevents them from accessing and using health services (Day and Ward, 1997).

Problem:

Lack of access to health care caused by stigma

- Stigma:discrediting attribute that taints the person, spoils identity and disqualifies a person from social acceptance

Ideal Situation

- 0% of FSW report physical and/or sexual violence in any environment.
- 100% of FSWs and their children are granted access and satisfactory treatment in health institutions and by health professionals.
- 100% of FSWs are confident to share their line of work with health professionals, family and community.
- 100% of FSWs and their children keep medical appointments.
- 0% of FSW perceive or report barriers to access health care

4. Annex: Estimated Budget for all phases of the project[6]

Concept	Description	Value in colombian pesos	Value in CHF
Video			
Producer		We expect to receive help from members of PARCES with expertise in video willing to donate time and work	0
Director		We'll have help from a member of PARCES expert on this field that'll donate time and work	0
Camera assistant	Helper for the recordings	We expect to receive help from a members of PARCES willing donate time and work	0
Camera rental and accesories	Video cameras, tripod, microphone, etc.	85.000 camera per day (8) +50.000 sound per day (8)= 1'080.000	495,65
Hard drive and/or other means of storage	Storage for all the visual/digital material	3 hard drives X 150.000= 450.000	206,52
Video edition	Edition of the final video	1'500.000	688,41
Photography			
Photographer	Professional in charge of photo shoots guided by the participants, also in charge of a basic training in photography for the participants auto-photography fase	Laura Martínez expert on this field and member of the team will donate time and work	0
Camera rental and accesories	Camera, Flash, Tripod, etc.	85.000 per day (8) = 680.000	312,07
Compact Camera	Compact cameras for the auto-photography fase	2'000.000	917,88
Edition	Edition of the final photographs with Adobe Photoshop or any edition software	Laura Martínez expert on this field and member of the team will donate time and work	0
Exhibition			
Assembly materials	Materials needed for the itinerant exhibition	2'000.000	917,88
Printing	Printing the photos in the size and material for the exhibition	1'500.000	688,41

[6] Note: 1 CHF = 2 178,93 colombian pesos.

Logistics			
Transportation	Transportation of people and materials to the places of recordings, photographs, exhibition, etc.	1'000.000	458,94
Phone calls	Contacting people, participants, logistics, etc.	200.000	91,78
Office and workshop supplies	Copies, CD's, Paper, Markers, duct tape, cardboards, etc.	1'000.000	458,94
Assistants	Help with the assembly of the photo sessions, exhibition, recordings, etc..	We expect to receive help from members of PARCES with expertise in video willing to donate time and work	0
Meetings	Food and Beverages for the meetings/workshops	1'000.000	458,94
Participants compensation	Since the participants are using their work time with us, we have to give them a basic compensation so they don't lose their daily income	5 participants X 30.000 per workshop/day (11) = 1'650.000	757,25
Incidentals	Other expenses not calculated yet	1'500.000	688,41
Total		15'560.000 pesos	7141,11 CHF

5. Annex: Estimated data of FSWs in Bogotá gathered for project

Age of leaving home	Reasons to leave	Age start prostitution	Municipality of birth	Number of children	Years of education
8	domestic and sexual abuse	19	Juanchaco	1	9
18	violence	19	Granada, Meta	2	8
10	domestic abuse	12	Bogotá	0	7
14	domestic abuse	14	Ibagué	0	5
15	drugs		Bogotá	1	8
12	domestic abuse	13	Pereira	1	
14	domestic abuse and pregnancy	15	Cali	1	
15	domestic abuse	15	Bogotá	1	9
9	domestic abuse	11	Neiva	2	7
15	domestic abuse and gender discrimination	18	Saraen, Arauca	0	
10	father's death	11	Pereira	0	
14	domestic abuse	14	Bogotá		
8	sexual abuse and gender discrimination	18	Sincelejo, Sucre	0	
18	gender discrimination	18	Cartagena	0	
17	sexual abuse, domestic abuse and gender discrimination	19	Villavicencio	0	9
18	sexual abuse and poverty	14	Chocó	1	10
7	grandma's death and abandon	18	Bogotá	0	9
19	gender discrimination	15	Venezuela	0	11
14	abandon and domestic abuse	17	Bogotá	0	10
15	abandon	14	Cali	0	11
12	domestic abuse	15	Manizales	1	11
17	gender discrimination	17	Venezuela	0	
15	drugs	17	Bogotá	0	
15	domestic abuse	15	Bogotá	0	

Table 1. Violence-related variables and socio-demographic characteristics of FSWs with whom we work.

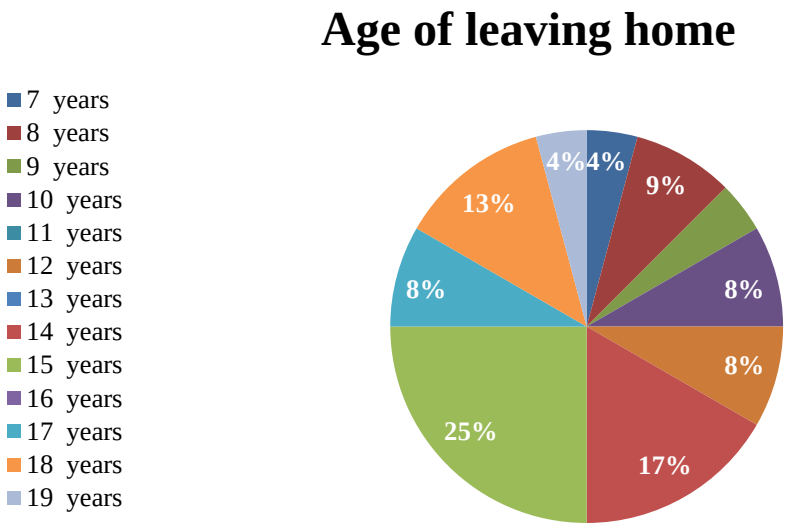


Figure 3 Age of leaving home for FSWs with whom we work.

Age	Frequency
7 years	1
8 years	2
9 years	1
10 years	2
11 years	
12 years	2
13 years	
14 years	4
15 years	6
16 years	
17 years	2
18 years	3
19 years	1

Table 2. Age and frequency for figure 3.

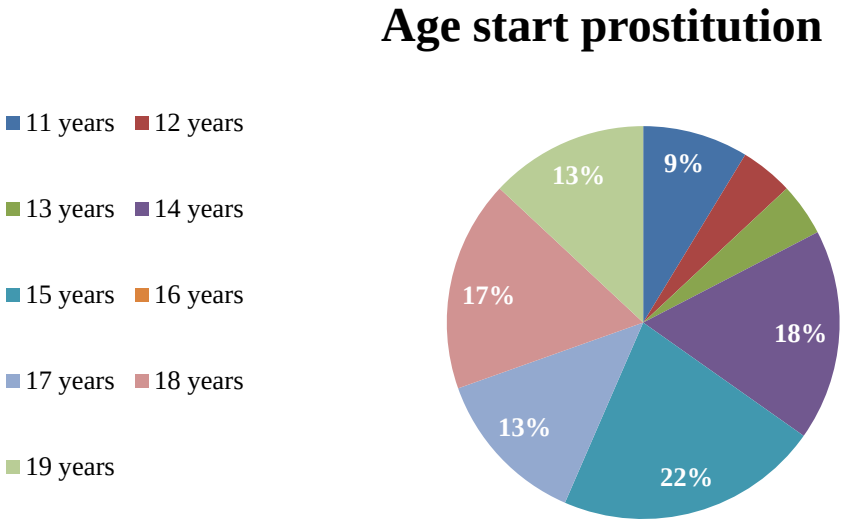


Figure 4. Age of start sex work

Age	Frequency
11 years	2
12 years	1
13 years	1
14 years	4
15 years	5
16 years	
17 years	3
18 years	4
19 years	3

Table 3. Age and frequency for figure 4.

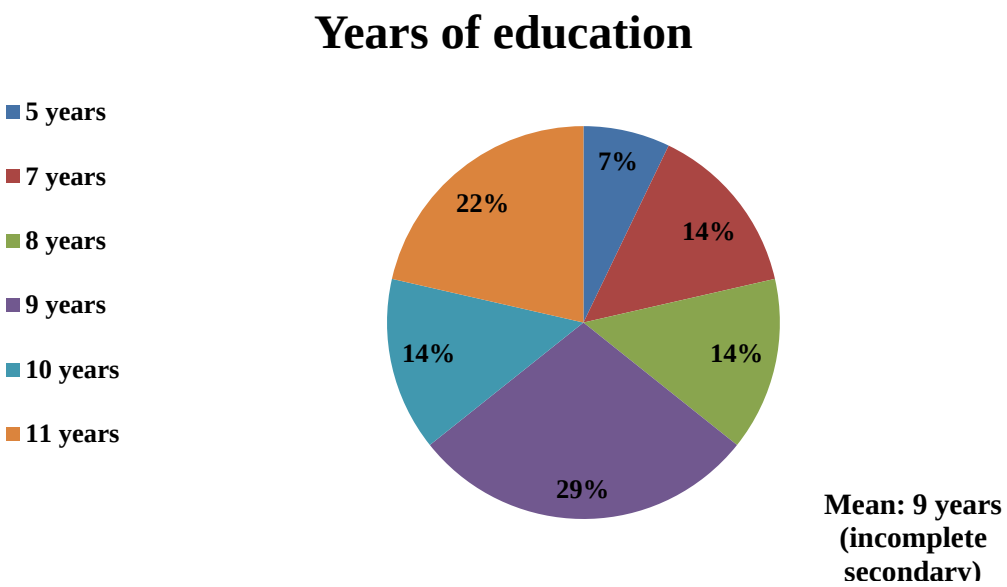


Figure 5. Years of education received by FSWs with whom we work.

Age	Frequency
5 years	1
7 years	2
8 years	2
9 years	4
10 years	2
11 years	3

Table 4. Age and frequency for figure 5.

6. Annex: Humanistic Photography of FSWs[7]

[7] EL TIEMPO News paper (2014). Traffic jams caused by erotic tours. Retrieved April 15th 2014 from: http://www.eltiempo.com/Multimedia/galeria_fotos/bogot4/trancones-por-culpa-de-los-tours-eroticos-_11718121-5

7. Annex: Humanistic Photography of FSWs[8]

[8] SEMANA Magazine (2013). Within the 'Bronx' neighborhood. Retrieved April 20th 2014 from: http://m.semana.com/cultura/galeria/galeria-en-entranas-del-bronx/272402-3

8. Annex: Pluralistic Photographs with peer leaders taken during different activities with P.A.R.C.E.S. NGO and other grass-root organizations. Taken by Laura Martinez (group member), 2013.