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Learning from women who trade sex in Kenya about the antiblackness of Global Health

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ABSTRACT

Sex work and violence have become co-constituted, routinized, and even sanitized in Global Health journals dispassionately advocating for intervention. This paper situates ethnographically shared experiences of Kenyan sex working women within the global condition of antiblackness. By grounding our conceptual analytic in Black Feminist scholarship, we illustrate how antiblackness subtends the conditions of possibility for women's entry into sex work, their subsequent experiences with interpersonal and institutional forms of predatory violence, and lack of recourse for their material needs and suffering. This analysis requires a meditation on the relationships between the types of violence conditioning Kenyan women's lives and the limitations of Global Health's conceptual logics and disciplinary practice. Our discussion reflects on the ways Global Health practice can neglect conceptual foundations in antiblackness, thus complicit in upholding violence against the very groups it purports to assist. In charging Global Health "as usual" as methodologically violent and sustaining global antiblackness, we call for disciplinary transformations beginning from a shared consciousness regarding the ways global antiblackness structures health inequities. Beyond critique, our meditation is an invitation for all committed to dignified Global Health to contribute creative, non-hierarchically collaborative work engaged with those in material, structural, and immaterial need.

Lilia[1] was born into a polygamous family in rural western Kenya. Her mother was the third of three wives, all of whom died of AIDS, as did her father. After her oldest sister also died, Lilia was left to care for her two younger sisters. After she was raped by one of the family's relatives, she left home and moved to a different town where she met a group of sex workers who taught her how to sell sex and navigate police surveillance and targeting. Lilia has been arrested and forced to have sex with police officers. She has been raped "so many times" that she thinks she contracted HIV through one of these violent experiences. Later, Lilia moved to Kisumu, where she enrolled in a health program for sex workers and began working as a peer educator at a donor-funded non-governmental organization (NGO). Although she earned "so many" certificates from various trainings through this NGO, without formal education and in the precarious grant funding environment of the Global Health enterprise, she was unable to earn enough to support herself and her family. Despite the continued threats of violence and Global Health intervention, sex work remained a viable economic option for survival. However, as we take up in this paper, sex work continued to expose her to violence, including through the very institutions ostensibly designed to help her. Lilia's story leaves us wondering: do existing Global Health frameworks have the capacity to change these conditions?

Globally, sex workers traverse a complex array of violence and vulnerabilities to survive adverse health, domestic, and political economic conditions (Deering et al., 2014; Platt et al., 2018; Shannon et al., 2015). For Lilia and multitudes of other women, these experiences are all too common. Sex work and violence have become co-constituted and even sanitized in Global Health journals dispassionately advocating for intervention. Even as this literature is replete with evidence-based interventions to reduce violence and improve the health of sex workers (cf. Beattie et al., 2010; Parcesepe et al., 2016), the violence persists. How are Global Health conceptual frameworks and associated practices implicated in the routinized violence women like Lilia endure?

This paper centers the experiences of Kenyan sex working women in Kisumu through occupational and state provider (police and hospitals) sources of violence to sharpen an analysis of antiblackness in Global Health research and practice. Grounding theoretical concepts from

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Black Feminist scholarship in ethnographic data, we explore the context of women's entry into sex work, their experiences with interpersonal and institutional forms of violence, and lack of recourse for their suffering to illustrate how colonial structures of antiblackness subtend Global Health inequities. We argue that women who engage in sex work experience gratuitous violence as an undergirding dimension of Kenyan social relations such that acts of public subjugation, institutional and private assault, public shaming, and other forms of violence are normalized and requisite to stabilize Kenyan society. We demonstrate that trading sex is an insurgent method of survival for women to meet their everyday needs even as they are socially cast as undeserving of respect and care. While these women's practices do not alter the global structures that harm them, we suggest their experiences illuminate a need to fundamentally reimagine Global Health. Our analysis urges a disruption of taken-for-granted constructs to understand how the depth and breadth of violence against sex workers is deeply rooted in global antiblackness. Redress requires new frameworks and methods in Global Health.

1. Antiblackness in global health

Antiblackness is an ontological and political framework that makes a structural argument about the nature and function of the racial positioning of Black peoples across the world—Africans, Afro-descendant, and Black—as non-human Others and fundamentally unfree. In this article our thinking about the structural nature of antiblackness is informed by scholars who remain skeptical of Euromodern conceptual capacities (Oyěwùmí, 2011; Asante, 2008) to articulate how and why the invention of Black positionality is not analogous to other experiences. Scholars engage this challenge through various framings, including Black Feminisms (Spillers, 2003; Bierria, 2014), Afro-Pessimist conceptions of societal dependence on anti-black violence (Fanon, 2007 [1963], Bledsoe and Wright, 2019), and the abiding relationship between blackness and animality (Jackson, 2020). Cohering these claims is the idea that "civil society is inherently antithetical to all manifestations of Black social life, yet requires Blackness for its political, economic, ontological, epistemological, and … spatial coherence" (Bledsoe and Wright, 2019:9). As such, antiblackness differs from racism. Frameworks of racism center liberal logics of Whiteness to evaluate human experience and racialized harms, and propose redress through existing laws, economic policies, and social institutions. In contrast, frameworks of antiblackness force analytical parameters to begin from the fundamental distinction of Black positionality, including the ways it defines what it means to be human, while being excluded from this category (Fanon, 2007 [1963]; Spillers, 2003; Vargas, 2018; Wilderson, 2010). Zakiyyah Iman Jackson notes that "black people are most representative of the abject animalistic dimensions of humanity, or the beast" (2020:3). Antiblackness thus calls into question the very definition of what it means to be human (Jung and Vargas, 2021).

In the aftermath of global slave trades and colonial occupation, we locate conditions of antiblack continuity by describing how spatial, political, and social logics emerging from the Transatlantic trades in African flesh anchor modern global institutions, giving rise to shared global experiences of Blackness. Black physical and social death systematized through colonialism has never been banished to the "past" or confined to particular geographies; rather, the relations of slavery and occupation are constantly reformed and regulated through new sociopolitical configurations (representationalism) and institutions (e.g., laws, police, healthcare systems). An analytic of antiblackness argues that the disparities Black populations experience cannot be addressed by the very institutions and modes of thinking that gave rise to and uphold these global inequities.

Grounding Global Health research in an analytic of antiblackness demands attention to histories of subjection, colonialism, and racialized power relations informing disciplinary training, methodologies, and interventions. Global Health is "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide" (Koplan et al., 2009). While liberally foregrounded as a humanitarian field, its predecessors of Colonial and Tropical Medicine were designed as systems to control and economically exploit colonial populations (Hirsch, 2020, 2021). Birthed from antiblack ideology, Tropical Medicine medicalized and bestialized Blackness by narrativizing extensive data on the social nature and emerging biological challenges within European colonies. Policies built on racist "scientific" bases of biological difference profited from exploiting Africa by enshrining racialized hierarchies derivative of colonial thinking. Global Health as a discipline of health inquiry, public safety, surveillance, and standardized health care practice, is thus rooted in and entangled with antiblack ideologies circulated through colonial world building projects.

As Lioba Hirsch (2020:190) argues, "modern Global Health institutions were designed to work within a system of inequality whose colonial roots were largely overlooked. It has been more comfortable to explain Global Health inequalities largely through biomedicine and culture than colonialism." Over time, colonial administrators have informed the technocratic "experts" of Global Health, who through research and projects with NGOs, have territorialized "the Global South" as training grounds for students and medical professionals and lucrative sites of contract work for professionals (Benton, 2015; Pfeiffer, 2003; Sullivan, 2018). Many of these projects, externally managed by "experts," prioritize short-term, data-driven "results" based in disciplinary narratives and evidence-based analytics (Abimbola, 2021; Crane, 2013). These unequal collaborations operate within liberal "human rights" discourses that seek change *within* current systems of law. Without disciplinary reflexivity, Global Health will remain a colonial discipline and practice rooted in antiblack modes of inquiry which perpetuates, rather than mitigates, systematized violence and health inequities.

2. Antiblack colonial legacies in Kenya

While Africa's history does not begin with its continental subjugation, multiple colonizing efforts by European and Arab states have profoundly shaped its trajectory. Walter Rodney's framework of underdevelopment demonstrates how colonial empire-building projects and the globalization of antiblack capitalism required the systematic exploitation of Africa (2018 [1972]). Throughout occupation, colonial administrators and missionaries implemented social control through spatial and corporeal discipline. Africans improvised their own responses.

In Kenya, economic sexual exchange, or "prostitution," emerged in the late nineteenth century in what Anne McClintock (1991) calls a "collision of natural catastrophe and empire" (93). Disease epidemics and climatic events devastated livestock and disrupted pre-colonial marriage exchange practices as the British conquested land and enslaved native populations through physical threats and taxation to build the infrastructure of the colonial order. In Nairobi and other urbanizing centers, migrating men converged to work in segregated urban spaces while living separately from their families, and women found ways to challenge their economic subordination. As Luise White's (1990) seminal work documents, sex was often part of an array of domestic services women offered these men, and prostitution became a critical mode of accumulation, tactic of survival, and mode of resistance to gendered colonialist oppression. As in other settings, the real threat to the colonial project was women's agency in contesting White male power (McClintock, 1991). Societies demonize these women because they acquire money for services that men expect for free; concerns are less about prostitution per se, but women's ability to accumulate money and property (McClintock, 1992).

During colonization, prostitution became associated with Black and colonized populations who were racially denigrated and had to be controlled (McClintock, 1992). In most colonial contexts, disease was a central metaphor and logic for the containment of dangerous

populations. In Kenya, disease was also folded into broader discourses of control over social and sexual relations and legitimated segregated urban development policies to keep non-Africans from the "contamination" of African sex workers (White, 1990). These internalizing colonial notions of "the unsanitary" wed surveillance, religious conformity, containment, and germ theory with Blackness, non-normativity (e.g., sex work), and moral and spiritual cleanliness (Ombongi, 2011).

Many of these ideas became codified when British common law conjoined with indigenous court systems as the contemporary basis for police, prisons, courts, and penal codes (Kercher, 1981; Pfingst and Kimari, 2021), illustrating how colonialism and antiblack technologies are co-constituted phenomena (Bledsoe and Wright, 2019). Kenyan penal codes originating in the 1930s expanded state power to micromanage women's bodies. Prostitution was criminalized through codes prohibiting individuals from soliciting clients, using their residence to do so, earning a living from sexual exchange, or even being perceived as a "common prostitute behaving in a disorderly or indecent manner in any public place" (Kenya Penal Codes, 1930). The codes also established rape as a capital offense to assuage settler anxieties about the "threat Black (Kenyan) men posed to White women," yet acts of sexual violence against Kenyans were not considered serious offenses (Anderson and Weis, 2018).

Post-independence, state strategies enacting gendered control were powerfully reworked and intensified through capitalistic models of political and economic organization with internal "patriarchal alliances … through policing women and, more broadly, enforcing gender and sexual normativity" (Macharia, 2019:99). By law, women remained dispossessed of rights to independently own land, required marital partners for decisions regarding reproductive health, and were positioned with financial and social pressures to support their families without adequate access to education, healthcare, and legal rights. As Achille Mbembe (1992) notes, colonial logics become reconstituted through state projects and internalized in people's consciousness as commonsense, even as entire groups of people - in this example, women - continue to be marginalized.

Despite historical efforts to contain women, forms of sexual exchange continue to be practiced across Kenya. Globally, sexual exchange practices are diverse, including formal venue-based work in hotels and bars, and street-based and other informal arrangements that may include exchange for money, food, support for children, material items, or other arrangements (Kempadoo and Doezema, 1998; Stoebenau et al., 2016). In their review of the literature on "transactional sex" in sub-Saharan Africa, Stoebenau et al. (2016) documented three major paradigms, including sex for basic needs, sex for social status, and sex and material expressions of love, all of which exist on a continuum of "deprivation, agency, and instrumentality" but speak to the diversity of motivations and practices that operate across the continent. The Global Health community has created definitional boundaries around "prostitution," "sex work," and "commercial" sex that attempt to suspend judgement while focusing on the behavior itself, usually in the interest of "risk" assessment. However, the language remains conceptually challenging. While we also wish to avoid imposing judgment, the remainder of this paper adopts the admittedly Western term "sex work" because it acknowledges sexual exchange as a form of labor, which is consistent with colonial histories of sexual exchange in Kenya and how the particular women with whom we worked understood their practice.

Even as sex work often offers women economic and social mobility, experiences of violence, assault from police and clients, unsafe working conditions, and social stigma stemming from criminalization maintain unfreedom (Mgbako, 2016; Shannon et al., 2015). In African contexts in the late 1990s, sex worker unions emerged as responses to ongoing criminalization, with Kenyan sex workers among the first on the continent to organize (Mgbako, 2016). Many current campaigns are supported by Global Health donors and focus on "human rights" discourses advocating legal reforms, mirroring Global Health literature on the structural determinants of sex worker health (Shannon et al., 2015). The Kenya Sex Workers Alliance (KESWA) has drawn attention to how Kenya's 2010 revised Constitution centering "human rights" could provide expanded protections for sex workers, but note that thus far, change is negligible (Kantindi & Company, nd).

The women we learned from engaged in informal sex work driven by financial need and were largely not part of organized social movements. We conceptualize this form of sex work as a way of surviving the perdurance of colonial thinking and antiblack structures made possible through punitive legal structures and sustained social stigmas about gender and sexuality. By centering how the antiblack project of erasure has grounded the development of Kenya and Global Health enterprises, we recognize that the conditions driving sex work are the consequences of overlapping techniques of subjugation. From these interconnected histories, the evolving interlocking strategies of power and control sustaining antiblack relations must be analyzed to understand what must change.

To understand current conditions of sex work, we conceptually suture Black Feminist scholar Alisa Bierria's (2014) concepts of social authoring and insurgent agency to show how Kenyan sex workers' exposure to violence is constructed and upheld through actions and institutions steeped in antiblackness. Social authoring describes an agentic relationship between observer and act developed to detail how and why Black women intentionally act in precarious conditions of violence. Social authoring supplements an intuitive definition of agency, or how one thinks, speaks, moves, feels, and acts in the world, to focus upon how actions may be (mis)interpreted. Social authoring – creating an interpretation of the intentions and actions of others – is filtered through histories, representations, and shared cultural logics, which may be unconsciously taken for granted. According to Bierria (2014:130), "when facilitated by reasoning designed to reinforce and rationalize systems of domination, social authoring relies on and further entrenches an institutionally sanctioned distortion of the intentions of some agents." Put another way, social authoring is a process of labeling, making individuals blameworthy for their structural position, and reinforcing disadvantage and violence by those in positions of power because individuals "deserve" this treatment.

Social authoring illuminates the structure of the mind and informs the scales of violence sex working women traverse among clients, police officers, community members, and intuitions. The interpretation of womens' intentions gets distorted, calling for a heterogeneous framework of agency recognizing how individual positionality informs how intentions are authored. This conceptual move is capable of describing patterns of violence structuring a continuum of survival practices. Here, we apply the concept of insurgent agency, which does not describe acts aimed at transforming structures of oppression, but rather "is employed by subjects who intentionally act in unstable and precarious circumstances that are difficult to escape or alter, and who craft provisional and makeshift practices of opposition that subvert, but still remain defined by, conditions of power" (Bierria, 2014:140). In other words, violence, discipline, and exploitation in domestic and public spaces as a standard of impoverished living prompt improvisation as a survival response to historical antiblackness. Women in Kenya who engage in sex work are socially authored as dangerous threats. But their creative, insurgent acts of survival are not merely theoretical concepts – they are experientially grounded in the violence of an ongoing legacy of antiblackness that Global Health interventions have yet to reckon with.

2.1. Kisumu, Kenya

Our study took place in Kisumu, Kenya, where its population of nearly 400,000 people represents one of the fastest growing cities in East Africa. Located on the shores of Lake Victoria in western Kenya, Kisumu was established as a port town and major railroad station around 1900. Its potential as a hub for transportation linking the ports on the Indian Ocean with interior Africa historically attracted imperial investors and migrants to build the intercontinental railway system. While Kisumu has

experienced periods of prosperity throughout its history, political neglect and economic decline linked to structural adjustment programs in the 1980s preceded the devastating introduction of HIV/AIDS into this region, which has shaped the city's modern course of development. As in other "Global Health" landscapes (Crane, 2013), a constant and expanding influx of foreign researchers and aid workers has catalyzed transformations of Kisumu's public, institutional, and social landscapes. Kisumu has developed an NGO economy and hosts a robust local research scene toward the production of "Global Health" training and scholarship (Geissler, 2013; Prince, 2014). Despite an ever-expanding portfolio of Global Health projects, HIV prevalence remains high and prosperity remains unevenly distributed, leaving precarity as the condition of daily life for socially vulnerable groups, including sex workers.

Historically, the concentration of sex work in Kisumu emerged through women pursuing economic partnerships with working class men engaged in railroad and construction work as part of the colonial empire. As elsewhere in Kenya, some women in Kisumu were successful in saving money to build homes and leave female heirs property while others economically struggled (Ogot, 2016). Others migrated to Nairobi. In the 1940s, a Luo Union (the dominant ethnic group in the region) was formed as an organization to promote "social cohesion," including controlling proper sexual relationships and locating "runaway" women assumed to be engaging in sex work in Nairobi. Colonial administrators opposed these groups for usurping colonial judicial power, while members of the Luo Union enacted their own violent tactics of control, including humiliating women by making them strip in public and physically removing women from their homes and escorting them back to their families (White, 1990).

Nevertheless, sex work has proliferated in Kisumu over time as colonial legacies undergirded by land alienation, environmental conditions and changing agricultural practices, migration, shifts toward a cash economy, and demands for consumer goods have exacerbated conditions of inequality and poverty for women (Mojola, 2014). Though the current magnitude of sex work in Kenya is unknown, researchers estimate 5% of the urban population of women engage in sex work, but in Kisumu, 28% of this population participate in sex work (Odek et al., 2014). Previous estimates counted nearly 1700 female sex workers in Kisumu, among whom the HIV prevalence reached 56.5% (Vandenhoudt et al., 2013). Sex workers in the community told us that sex work was a growing industry, and worried about younger women increasingly entering into it out of necessity (unpublished fieldnotes).

A growing Global Health literature on sex work in Kenya has often focused on sex workers' disproportionate risk of violence as a determinant of HIV infection (Chersich et al., 2007; Okal et al., 2011; Lorway et al., 2018; Wilson et al., 2016). In Kisumu, a focus on HIV/AIDS is justified given the stubbornly high prevalence in the region, but biomedical conceptions of sex work and other sexual exchange relationships can also erase the role of colonial legacies in creating conditions of disease and health risk in the first place. One example is the practice of *jaboya*: as contamination and weed growth in Lake Victoria restricted fish supplies, fishermen had to travel further away from their homes and longer periods of time; lacking portable refrigeration and needing to get their catch to market, men developed sexual relationships with women at different beaches who in turn secured preferential access to fish to sell for cash in local markets (Mojola, 2014). These sexual relationships are not necessarily considered "commercial sex work" because of the social intimacy (and children) that these relationships often produced. However, these arrangements nonetheless represent modern reworkings of the gendered economies of "prostitution" that women developed in response to colonial occupation and economic insecurity (White, 1990). These arrangements continue under neoliberal conditions of austerity and Global Health donor funding that do little to reposition Black women's socioeconomic opportunities in an African context.

At the time of this study, sex workers had access to a suite of NGO-hosted health services, including HIV/STI testing and basic clinical care, while a new center addressing gender-based violence recently opened. Some sex workers engaged in local grassroots organizing to bring attention to the violence experienced by women, including an annual event to commemorate the International Day to End Violence Against Sex Workers. However, economic and social programs were less common, if available at all, which reinforced women's need to engage in sex work. The original intent of our study was to contribute to Global Health programming addressing violence prevention. However, in reflecting on our analysis of women's experiences and our own role in research, we recognized that the intervention had to go deeper to examine the conceptual framing of Global Health itself.

3. Methodologies

Our research in Kenya began in 2013, when U.S. academics and Kenyan researchers from an NGO collaborated on the first study of injection drug use in the region. The NGO provided services to "key populations" in Kisumu, including people who use drugs and sex workers, and the collaboration was designed for academic results and applied knowledge to inform health services and policy. In this preliminary work, we learned that most of the women in our study traded sex, engaged in poly-drug and alcohol use, and had four times the odds of reporting being HIV positive compared to men (Syvertsen et al., 2015). Our research further suggested that drug and alcohol use was a coping mechanism in light of intersecting vulnerabilities, including education barriers, dependent children to care for with limited (if any) male partner support, and few economic options. The majority of these women, including Lilia, reported their daily lives requiring constant maneuvering of sexual abuse, coercion, rape, and other forms of trauma, which often had negative repercussions for their mental, physical, and reproductive health (Yotebieng et al., 2016). During this early work, the second author heard Lilia's story. This led to funding for an additional project focusing on the intersections of violence and substance use among sex workers.

The current paper is based on this subsequent study, drawing on in-depth interviews with 45 female sex workers from August–December 2016. Interviews explored early life experiences, reproductive histories, sex work behaviors, lifetime and recent experiences of violence, and perspectives on sex workers' health programming needs. The PI or a trained Research Assistant conducted interviews in the participant's language of choice (Luo, Swahili, or English). Participants were reimbursed 300 ksh (~US $4), a rate consistent with local research norms. We continued to conduct interviews until we reached saturation (redundancy) of themes. Building on the PI's prior years of ethnographic fieldwork, the entire study team conducted participant observation, including accompanying NGO workers in field outreach, training events hosted by the NGO, community meetings with key populations, and visiting local establishments where sex work occurs to contextualize study interviews.

The PI and assistants typed fieldnotes on a daily basis. Interviews were audio recorded, transcribed, and translated for text analysis by trained trilingual staff. The research team engaged in a collaborative process of analysis, first reading through the same selected interviews and independently generating lists of codes based on emergent themes in the interview text (Ryan and Bernard, 2003). After constructing a codebook, the lead Research Assistant coded the data and PI checked for consistency in the application of codes.

Later, the authors of this paper engaged in an iterative analytical process, as JLS originally designed and conducted the study, and BS as a graduate student was interested in working in Kenya and bringing a lens of antiblackness into Global Health research. In the course of her fieldwork from 2013 to 2019, JLS grew increasingly disillusioned with Global Health research and has sought to strengthen the role of local research assistants and students to implement new frameworks to better address enduring inequities. BS's approach to Global Health stems from navigating health systems in the U.S. and Trinidad where she reflected

on structural similarities rendering Black peoples' experiences of institutional healthcare-as-entrapment.

Starting from the coded data, we regularly met to share and discuss notes about emerging themes and connections to theory. We began by reading through segments of coded text related to violence while assessing its systematic relation to women's life histories. A critical reading of the transcripts proceeded through consultation with local Kenyan news, literature on regional history, global academic discourses on sex work, and theoretical literatures reframing global development as processes requiring antiblackness. Below, we describe sex workers' experiences in terms of the contexts of violence they navigate, and the antiblackness of their social and institutional relations.

4. The women in our study

Among 45 women, the median age was 28 (range: 18–42). Nearly half were born in Kisumu (n = 21, 46%), but nearly all (n = 41, 91%) had lived outside of Kisumu, attesting to the considerable mobility of this population. Most women had a steady partner (n = 33, 73%). All but four women had children. Self-reported HIV prevalence reached 31% (n = 14). Based on our observations and interviews, we thread our theoretical concepts through an analysis organized around four major themes: 1) entry into sex work as an insurgent practice, 2) interpersonal violence by clients, 3) subjugation by police, and 4) lack of institutional recourse for victimization as another form of violence.

4.1. Sex work as insurgent agency

Women described their lives as part of working poor families. Many of their parents were farmers and they often grieved the loss of their parents at a young age. Most shared how this devastating loss eroded physical and financial support. Pregnancy and child care created additional financial burdens. Women discussed the impetus to provide a better life for their children amidst their economic constraints and limited options. Women typically reported that engaging in sex work was borne out of economic need:

> You need money to buy food, pay rent, pay school fees … sometimes the children are sent home because of school fees because you cannot afford to pay it. – Nissa, 33

> I am a school dropout and without proper education there is nothing that one can do apart from sex work. – Carol, 27

Despite these challenges, the women were socially authored as morally deficient for their "failure" to engage in acceptable work and gender roles in civil society. Mercy, 37, called the forms of violence they experienced in the context of sex work "just the normal" in their daily lives. "You people don't know what prostitutes go through," Cybil, 26, told us, foreshadowing the interlocking forms of oppression and violence from clients and police that saturated women's narratives about their work. Other women agreed, relaying the difficulty of sex work:

> Life is difficult, if only I could get a place and get employed or get someone to give me five hundred thousand shillings, I would look for a business to do. Prostitution is very tiring, right now my chest is aching, we get beaten, the police beat us on the streets when waiting for clients. Sometimes it rains and you have no fare back home, so you must have sex with the Bodaboda guys (people who ride motorcycles as public transport) for them to take you home … we decide to do sex work because there is nothing else we can do. – Aluna, 27

> Sex work is not a good work. We also wish that we'd get a better job to do, because when walking at night everyday one can meet different people; one day you meet a killer … someone wants to have sex with you free, sometimes you meet someone who has a knife and he wants to sleep with you free. You will have to do what? Just sleep with him. – Zaida, 21

After hearing descriptions of lifelong experiences of poverty, abuse, and violence, women explained that sex work could be empowering because it offered recourse through flexible hours, self-employment, and financial opportunity. The women's narratives suggest that they want basic economic opportunities that have remained out of reach. The imperative of survival shifts what individuals are willing to do to provide for themselves and loved ones given a lack of viable choices. While insurgent agency does not transform structures of oppression, it reframes sex work as a method of surviving the longue durée of exploitation. We thus interpret sex work as a simultaneously constrained choice and subversive act of resistance within conditions of precarity. Women's entry into sex work also reflects how Global Health interventions have yet to undo the gendered consequences of sustained underdevelopment of Kenya.

4.2. Interpersonal violence as entitlement

Women often worked in bars and hotels that were active hubs for sex work or "hot spots" in NGO speak. Many of these areas have rough reputations and become busy at night as patrons congregate to drink. The drinking establishments are often attached to or adjacent to inexpensive hotel rooms. As many clients in these spaces were unknown, women operated in a constant state of alert. Some clandestinely used drugs to muster "strength" and "courage" to negotiate for better prices for "shots," or an agreed-upon sexual exchange. Our ethnographic observations also suggest that alcohol-fueled arguments were normalized in these contexts even apart from sex work.

Client-perpetrated violence was gratuitous and common. Often it started as verbal insults and arguing, but sometimes escalated to physical assault. Most commonly, violence erupted over clients agreeing on predetermined prices for sexual acts, but refusing to pay or refusing to use a condom. Interlocking forms of violence spilled over from sex work negotiations to physical acts of violence:

> We go through a lot, sometimes we get clients who force us into unprotected sex. Sometimes they do not pay. They would take away your phone and beat you up … It is hard but we just endure … Some clients are rough. Some say that they have paid for it so they make thorough use of it. They do it ruthlessly. –Violet, 28

> You can meet a bad person, they can take you and most likely kill you. He can take you someplace and you don't know this guy and people don't know you're there … he can kill you or he can give you a group of people to have sex with force and they can hurt you. – Wamuiru, 27

Women's descriptions of clients not only conveyed a sense of the unknown, but gesture to men's pervasive sense of entitlement to sex that could culminate in violence. This was evident in multiple reports of gang rapes. Some men arranged and paid for sex, only to invite others to take advantage. Aza told a story of promising to buy her children kuku and chips (chicken and French fries) for a treat. When she finally secured a client, they engaged in an agreed upon interaction. After he excused himself to the restroom, he returned with four other men:

> These men, all of them slept with me. But they didn't even give me a single cent. They raped me. I was trying to scream … I tried even to cry but they were there. Then they told me to leave at 4 am. So I left. I was crying on the way, just asking God, "Why? Why is this happening to me when I promised my kids that they will eat kuku and chips?" I just went to my house with no money, no kuku and no chips for my kids. – Aza, 30

Samira told a similar story:

> They had sex with me until I almost died because they were taking turns and the knife placed at my neck. I prayed please God protect me, take care of me, I may not die this time … I was crying and nobody could help me. After they finished, I told them please help me, I am just a human being like you people, I am just like your sister. Remember if someone is doing this to your sister how will you feel? – Samira, 36

These narratives not only reflect the brutal violence experienced by women, but pose broader questions about the socialized ease in harming people. These forms of violence are part of larger processes of devaluing women because they engaged in sex work. The clients in these narratives socially authored sex workers as deserving of violence because of their job, and their pervasive sense of entitlement reflects a continuation of gendered ideas about discipline and control over women's bodies.

4.3. Subjection by police officers

Not only was interpersonal violence pervasive in women's lives, it was sanctioned and reproduced through state institutions, most notably the police. Nearly all women reported police surveillance was a constant presence that shaped perceived and actual safety. From experiences of police harassment including being verbally harassed, beaten, stalked, arrested without aggravation, fined, jailed, and coerced into sex for condition of release, women collectively expressed fear and distrust of police. Even if women were not committing illegal acts, police officers socially authored women as promiscuous, which led to harassment and distrust. These negative interactions eroded women's safety because they did not want to report violence by police officers. As Eve, 28, put it, women shared the conviction that "here in Kenya, the police are always above the law."

> The police are troublesome every day. They hate females who wear short skirts, when they get you in a short skirt, they will beat you up or they will arrest you …. They say that even if you are looking for money, you should dress decently so that you do not show off your whole body. – Jina, 23

In the most egregious cases, sex workers were arrested – sometimes in groups – and given the "choice" to pay a bribe, have forced sex, or face jail time. For women unable to pay, police tried to coerce them into sex or outright raped them, often without using a condom:

> We were told to go and pay with our bodies. We had to do it. They booked a room and we did it with them but weren't paid. They left us. That is what they do to girls. If they arrest you and you don't have money, you will have to pay with your body. – Lela, 28

Of the women in our sample who were arrested, the majority felt they had no choice but to have sex in exchange for their freedom, nor did they have any voice in reporting it:

> They then drove us to some quiet place and asked for sex in exchange for our freedom. I told them that since I had condoms but with no money then we should do it for us to be free. I lied down in the vehicle we had sex, then I was released. For those who declined the officer's offer were taken to court. They were taken to court, fined and jailed for two months.
>
> Interviewer: Did you take any action against the officers?
>
> No, I was afraid. This is someone who asked for sex for your freedom, what if you press charges and he meets next time out there? He might arrest and falsely charge you with something more serious. – Carol, 27

Because officers' extensive authority as agents of state power is amplified through cultural values of patriarchal reverence, their actions are sanctioned and institutionally protected through mechanisms that render it virtually impossible for women to get justice by reporting their experiences. Women also reported that police did not want to "see" sex work happening in the community. Officers stigmatized the women and blamed them for spreading HIV:

> Interviewer: You have said that you cannot go to the police [to report violence] because they have been chasing you around. Why are they doing that?
>
> They do it because they don't want to see us.
>
> Interviewer: Why?
>
> … because we are spreading the virus. There was a policeman who chased me. He was claiming that we have been infecting people. This is someone who had slept with me earlier. I think he was doing it because he was jealous or because he was broke and didn't have money. In fact, the day when I had sex with him, he didn't pay me as agreed. He gave me a little money and said that I should know he is a police officer. "I can even arrest you right now," he said. I remembered that I have children and decided not to do anything about it. – Rose, 32

Women's narratives reveal the multilayered complexities underlying the violence experienced by sex workers. We read the widespread acts of police impunity as grounded in antiblackness. These agents of the state socially author sex workers as morally questionable women who spread disease, reproducing narratives which rationalize criminalizing and disciplining sex working women. This gratuitous violence against women becomes acceptable and even expected, thus repositioning women who trade sex as an "Other" to be dispossessed and removed because of the threat to societal order. These attitudes trace back to colonial subjugation and disciplining of women. The social hierarchy of police versus "Others" reproduces the state by bonding stigma and the criminalization of survival strategies among marginalized women through abusive policing. As a global system steeped in antiblackness, policing with impunity exacerbated women's subjection to abuses for which there was little recourse.

4.4. Lack of recourse as further violence

Women almost never reported sex work-related violence from the officers, clients, or others who violated them. While technically able to file a report, barriers prompted women to instead draw on a repertoire of insurgent practices to defend themselves, including informal vigilante justice where male bouncers and front desk workers sometimes "beat up" clients who tried to leave without paying. In other cases, groups of sex workers ganged up on clients to force payment. However, situations of violence with weapons and late-night dates often left women without protection.

Most women asserted that government recourse was not invested in interrupting the harm they experienced, nor in providing alternative housing, income, or trauma-informed care. Legislative, judicial, and medical spaces use criteria to evaluate which individuals are "deserving" of institutional provision:

> I knew that if I reported him, he would tell them that I was a sex worker and was just doing it for pleasure. – Jawana, 25
>
> Because you are a prostitute and no one wants to listen to a prostitute. Sex workers have no rights here in Kenya. – Eve, 28

Among the handful of women who tried to report incidents of violence, most did not get any results, which discouraged any further reporting. Ruth said a client stole her phone and money. She told a sex worker friend who accompanied her to the police station, but they were sent away:

> We went to report at the police station, but the police chased us away instead of helping us…I did not find that to be good because the police are supposed to help us. We are also human beings. – Ruth, 25

Ruth's statement also speaks to the underlying sentiment that sex workers are not valued as "human beings" and thus "undeserving" of protection or care. Despite also wanting medical attention for the violence they experienced, women often found their occupation as sex workers were disqualifiers, as they were socially authored as engaging in sex work for reasons apart from their survival. Many refrained from accessing care because they required extra money to file a medical report form detailing personal (traceable) identification in addition to transportation and hospital fees. As described by Mercy, seeking medical care involved multiple costs:

> Taking action means money (stressing the word). Taking action means money, you have to pay for the form at the hospital. Then you have to bribe the doctors too. – Mercy, 37

The extent to which these women felt dehumanized and dismissed was exacerbated by their daily interactions with police and medical professionals who enacted further forms of violence and erasure. In general, women did not feel that their cases were taken seriously, nor could they trust the authorities to help them. They did not view the available state paradigm for justice, accountability, and healthcare as assisting them or preventing everyday conditions of violence. The antiblackness of these state intuitions and actors only upheld the disciplinary function of the state by enacting further violence against sex workers.

5. Discussion: reimagining global health

In this article, we have foregrounded an analytic of antiblackness to examine a globally pressing and persistent problem for Global Health: violence against sex workers. We return to our original question as to why women - like Lilia in the opening vignette and all of those whose narratives appear herein - continue to endure violence despite Global Health intervention. Our interest here is in revealing the broader consequences of antiblackness in Global Health research and practice, including considering if engaging in disciplinary reflexivity can actually change harmful conditions.

While colonialism through Transatlantic trades and occupation circulated antiblack logics as the basis of all racialized relationships, its manifestation in the Kenyan context inflects the U.S. and Caribbean perspectives we have woven. We admit that theorizing antiblackness in the African context is challenging, as much of the current scholarship has been developed throughout, about, and from regions of the Black diaspora, yet the retelling of colonial devastation in Africa by African writers has not always been named as specifically antiblack. However, we know there is a shared global experience of antiblackness (Jung and Vargas, 2021; Sithole, 2020; Walcott, 2021; Rocha, 2012). In the region which became Kenya– an outcome of centuries of migration and trade– legalized possession of land for administrators' trade and occupation were the focus of European and Arab powers. As we speak of the afterlives of slavery and colonialism, we are attempting to reckon with the contemporary manifestations of centuries of compounded violations, erasures, and methods of exploitation.

The violence inscribed within the lived experiences of Kenyan women who trade sex is made possible by the persistence of colonial infrastructures of social order undergirded by a global antiblackness structuring relations, including Global Health (Hirsch, 2020). These antagonistic conditions maintain antiblack dynamics among relationships to self, environment, community, and region that unfold at different temporalities as interlocking conditions for daily life. In Kenya, part of how marginalized genders– including women– experience the afterlives of colonialism are through legalized gendered dispossession and restricted bodily autonomy enforced through an expanding set of social and structural predatory techniques, such as the violent policing and disregard for women's humanity that are described in our analysis.

Sex workers in Kenya have always known the co-occurring agency and violence of their work long before Global Health research made it legible to international audiences as an object of intervention. Our analysis perceives trading sex as an insurgent practice of survival, but others (community, police, clients, healthcare providers) socially author these women to be immoral agents whose poor "choices" render them unworthy of respect and care. Reading through theories of antiblackness with Black Feminist epistemologies and practice can transform our approaches to Global Health. Without critical attention to antiblackness, scholars risk enacting our own forms of social authoring that normalize the violence and health disparities that sex workers (and others) experience while justifying outside-led intervention. Social authoring reinforces antiblack logics that shape women's opportunities and responses to their living conditions (Bierria, 2014). Our analysis urges a disruption of the taken-for-granted inevitability of violence against sex workers to recognize its rootedness in global antiblackness that requires new methods of redress.

Disciplinary reflexivity is urgently needed. Part of creating better conditions requires understanding how colonial reformations of antiblackness operate in the Kenyan context to perpetuate health inequities and using the insights from social theory to guide our work. However, critical theory is often lacking in Global Health training curricula and theoretical contributions are undervalued compared to results-driven practice (Pigg, 2013). We meditate on the limits of Global Health and build on colonialist and neoliberal critiques (Abimbola, 2021; Adams et al., 2014; Crane, 2013; Pfeiffer, 2003) to highlight the role of antiblackness in enduring health inequities. This also requires decolonial and anticolonial approaches to epistemic interrogation (Allen and Jobson, 2016; Jobson, 2019, Harrison, 1991). We call for other scholars to engage in these debates in classrooms and fieldsites so that new forms of intervention can be generated.

Our efforts articulate with other scholars who have raised questions about research, intervention, and the substantiation of Global Health evidence. Seye Abimbola (2019) critiques the Global Health "gaze," lamenting the disproportionate focus on interventions that "unduly emphasizes discrete, short-term and episodic efforts, often initiated or led from outside" (Abimbola, 2019:3). We also find interventions "as usual" without attention to historical conditions of antiblack colonialism and oppression to be a form of Black erasure. Global Health interventions often prioritize risk assessment and individual behavior rather than historical structural conditions of systemic racialized and gendered violence. These interventions can erase historical connections to entrench antiblackness in the afterlives of colonialism, thereby continuing to underdevelop and relegate "local populations" to new forms of surveillance and domination.

As Lioba Hirsch (2021) has written, it is time for Global Health – enterprises of research, funding, publishing, and career-making - to acknowledge its foundation in colonial antiblack power structures and give up its power to enact meaningful change. Redistributing resources to empower individuals is needed to materialize change, including genuine participation from those whose very lives are at stake. The women in our study wanted opportunities for alternative livelihoods. However, without changing the broader conditions in which Global Health operates, any intervention will sustain violence. But how do we create conditions wherein practices of insurgent agency are not needed for basic survival?

The revolutionary imperative of engaging antiblackness – and its fundamental difference from racism – is that we *cannot* deploy existing systems to "fix" things because all interlocked systems are built upon the subjugation of Black people as non-human (Vargas, 2018). Currently, conditions of unfreedom are sustained by human rights discourses that require rights be granted through laws and policies subtended by antiblack notions of the world. However, if globally all Black people are considered as non-human, then we should learn from the limitations of existing "human rights" discourses and throw away the rest to re-imagine how we understand humanity and relate to each other. After all, "human rights" discourses emerged in Europe during continued colonial occupation of Africa (Ekine and Abbas, 2013). There must be an

alternative.

What happens when institutionally privileged researchers choose non-hierarchical, politically engaged, collaborative work committed to interrupting global antiblackness in service of local needs? Moreover, if Global Health requires the systematization of antiblack violence to sustain its conceptual, political, and material salience, what are the stakes of committing to stabilize Global Health "as usual"? Our future work aspires toward anti-oppressive methodologies (Strega and Brown, 2015). We are interested in disrupting what we call the methodological violence of positivist research approaches and adaptation of "evidence-based interventions" imposing western development narratives and ways of knowing without consideration of alternative forms of evidence. For us, this means participatory approaches that center community voices through public discussions, the arts, storytelling, theater, activism, and other creative, collaborative forms of knowledge production, but this could take on many other forms. At its core, anti-oppressive methods are about relationship-building and challenging authoritative regimes of knowledge that erase possibilities for change. Thus, disciplinary reflexivity *can* change current conditions if we are willing to radically engage in new theoretical frameworks and share power.

As a final note, we turn the critique inward to our own work, including its well-intentioned effort to document the violence experienced by women as a way to materialize these concerns, but also for its failure to substantively improve these women's lives. The ethically fraught nature of our data requires care not to enact further violence. Though our period of data collection focused on women's entry into sex work and occupational experiences, it is important to emphasize that Kenyan women also create and live with joy and community. We recognize that depictions of gratuitous violence against Black people are superfluous and we do not wish to erase sex workers' dignity. However, sharing stories can also jar us into action, informing emancipatory approaches to research to build solidarity across space and time (Mgbako, 2016). Because violence against sex workers persists, we share enough of what we have been given to honor our participants' stories of survival as we work towards changing global conditions of antiblackness.

Credit author statement

Both authors equally contributed to the conceptualization, writing, and revisions. JLS originally designed and conducted the study and analyzed the data, and BS helped analyze the data.

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