SEXUAL PRACTICES AND HEALTH SEEKING BEHAVIOUR ABOUT SEXUALLY TRANSMITTED INFECTIONS AMONG THE FEMALE SEX WORKERS

BY

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DECLARATION

I Raesetja, Agnes Wechoemang, hereby declare that the work on which this dissertation is based, is original (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or shall be submitted for another degree at this or any other university, institution for tertiary education or examining body.

_____________________________  _______________________
Raesetja Agnes Wechoemang            Date

16/11/2018
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ABSTRACT

Background: Female Sex Workers (FSWs) are a group of key population that are marginalized, stigmatized and discriminated by the communities, Health Care Workers and the Police because of the type of work that they are doing. Sex work put them at risk of contracting sexual transmitted infections (STIs) that include HIV, because the majority of their clients don’t want to use condoms and those that try to negotiate condom use become violent. This is problematic for the Sex Workers as they are not able to report the abuse due to the fact that sex work is still criminalized in South Africa. Those who have contracted STIs are afraid to use the Health Facilities because of the attitudes of the Health Care Workers.

Methodology: Qualitative, cross sectional study in which exploratory approach was used. The researcher used focus group discussion and in-depth interviews (IDI) to interview the participants aged 18-49 years who have been working as Sex Workers for a year to explore their sexual practice and health seeking behaviour in the Ekurhuleni North sub district.

Results: FSWs expressed that they joined the sex work industry for different reasons. Some participants expressed that since they joined the industry they can provide for their families and meet their personal needs. Majority of the participants reported that they are not using condoms due to the conditions they are working under, such as clients offer to pay them more for having sex without a condom and their subsequent life situation avail them to consider offering their services without a condom, some of their clients don’t give them an option of practising safe sex but will turn violent and force them to have sex with them without a condom and some rape them and putting them at risk of contracting STIs that include HIV. The majority of the FSWs reported that they use Clinics that are near to their work and where they stay when they are sick though they have challenges with the
attitudes of the Health Care Workers. Attitudes and long waiting times in the Health Care Facilities are their barriers to accessing Health Care Services.

**Conclusion:** Decriminalization of sex work will benefit the FSWs as their working conditions and access to Health Care Services will improve. As a bill has been passed in South Africa, processes need to be in place such as clear policies on how to implement decriminalization of sex work.

**Keywords:** Female Sex Workers, Condom use, Sexually transmitted infections, Health seeking behaviour
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DEFINITIONS OF CONCEPTS

Health seeking behavior: Is defined as when professional help is sought from health care services and/or health care providers (El Kahi et al, 2012)

Research data: Is defined as, the pieces of information that is obtained during a study (Polit and Beck, 2008).

Sexually transmitted infections: Sexually transmitted infections (STIs) are a group of communicable diseases that are mainly transmitted by sexual contact and continue to present major health, social, and economic problems in the developing world and leading to considerable morbidity, mortality and stigma (Patel et al., 2014).

Sex work: Sex work is any agreement between two or more people with the main aim that is exclusively limited to the sexual act and ends with that, and which involves preliminary negotiations for a price (Ritcher, 2013).

Sexual practice: Refers to a behavior that is created that can either be safe to practice or unsafe to practice e.g. by consistent condom use or unsafe sexual practices that predispose one to a risk of acquiring STIs, for example unprotected sex with a partner whose HIV status is unknown and multiple unprotected sexual partnerships (Ritcher, 2013).
### ABBREVIATIONS & ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
</tr>
<tr>
<td>CPC</td>
<td>Centre for Positive Care</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Care Worker</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IDI</td>
<td>In – Depth Interview</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan For AIDS Relief</td>
</tr>
<tr>
<td>PDR</td>
<td>People’s Democratic Republic.</td>
</tr>
<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>SWEAT</td>
<td>South Africa Worker Education and Advocacy Task Force</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations AIDS organization</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1: INTRODUCTION, BACKGROUND AND STUDY RATIONALE

1.1 Introduction and background

Sex workers are described or classified as adults who get involved in consensual sex in exchange for money or any kind of payment (Girish et al., 2014). Sex work has been and still is perceived as a challenge in the world (Ladipo et al; 2011). According to a South Africa Worker Education and Advocacy Task Force (SWEAT) and Impact Consulting (2013) report, there are 167 000 FSWs recorded in South Africa. According to research done in South Africa, it has been indicated that; there is a great number of HIV/AIDS and other STIs among sex workers and that is confirmed by a HIV/AIDS and STI prevalence rates report of 59% amongst FSWs as compared to the 13.3% prevalence rate among the women in the general population (Baral et al., 2012). It is reported that; the number of young females who engage in activities related to sex work is increasing by day especially in the sub-Saharan African countries. This is believed to be attributed to the problems associated with development and scratch of poverty, food and political insecurity; and civil unrest (Lawan et al., 2012). FSWs are perceived to be highly vulnerable in contracting HIV/AIDS and other STIs because of several reasons i.e. the multiple partners they offer services, working in an environment that is not safe and is risky, and inability to negotiate regular condom use. They have little or no control on condom usage because of social marginalisation and the restricted legal framework under which they are forced to work (Baral et al., 2012). The WHO (2011) report has noted that; there is a sign of STIs infection decrease amongst FSWs in urban areas in the developing countries.

Sexually transmitted infections (STIs) are a group of communicable diseases that are transmitted by sexual contact and they continue to cause a major burden on health services, on social interaction, and economical distribution. They are also reported to cause huge numbers of ill health, deaths and stigma among communities (Patel et al., 2014). A WHO (2011) report has indicated that; there are 340 million new cases of curable STIs infection among 15-49 adults daily that are categorised among the top five STIs. It
is further noted that; HIV/AIDS and other STIs are prevalent among FSWs in sub-Saharan. HIV/AIDS and other STIs infection are perceived to be unavoidable for FSWs (Sekoni et al., 2012).

According to Ghimire et al., (2011) FSWs are known to be a subgroup that is extremely disregarded and are well-known to be highly prone to genital warts, candidiasis, gonorrhoea and genital ulcers. Due to unprotected sexual encounter, FSWs can transmit these infections to their clients and other sexual partners. Other factors like stigma and discrimination when seeking health assistance has being regarded as a barrier to the use of sexual infection health services and treatment. Ghimire et al., (2011) further indicated that; the knowledge of STIs, safe sex practices, the early diagnosis and timely appropriate treatment thereof are regarded as an indication to reduce the transmission of STIs and to protect against the contraction of HIV/AIDS. The safer sex negotiation by female sex worker can reduce and control the spread of STIs and HIV/AIDS between and among FSWs and their clients. In case the sex workers cannot negotiate safer sex then, they will remain vulnerable in contracting HIV/AIDS and other STIs and transmit it to their clients through unprotected sexual encounter(s).

South Africa is reported to have some of the highest cases of Human Immunodeficiency Virus/Auto Immunodeficiency Disease Syndrome (HIV/AIDS) infection in the world (UNAIDS, 2011). In South Africa, HIV/AIDS infection is more prevalent in women than men. For every 13 women, 10 men are infected with the HIV/AIDS virus and the gap widens with time. Women are most likely to be infected at an early age than men (Statistics South Africa, 2013). It is further noted that; in 2010, an estimated 280 000 South Africans died from the effects of HIV/AIDS. According to World Health Organization (WHO) 2011, HIV and STI prevalence varies among the Female Sex Workers (FSWs) in the Sub-Saharan Africa and in some countries, it is more than 20 time higher than among the general population. The UNAIDS (2011) reported that; Sub-Saharan Africa is the most HIV/AIDS affected region. There were 22.9 million HIV/AIDS cases recorded by 2010 and 1.2 million deaths were recorded. This however suggested that 5% of the adult population were infected with the HIV/AIDS virus (UNAIDS, 2011). In 2008, Tanzania had a 6% HIV/AIDS prevalence among 15-49 years age group (UNAIDS, 2011). It was also noted
that; there is a high prevalence rate of HIV/AIDS among homosexuals, sex workers and intravenous drug users. According to a Centre for Disease Control (2011) report it was estimated that the United States of America had roughly 1.2 million people who were living with HIV/AIDS in 2008. Of the 1.2 million, 20% did not know that they were infected with HIV/AIDS virus. 17 500 fatalities were recorded over a period of 10 years from 1999-2008 (CDC, 2011). HIV/AIDS and other STIs are reported as burden of diseases to the health public services (Tamene et al., 2015).

1.2 Problem Statement

FSWs are the sub-group that is often than not perceived to be the population that is prone to contracting HIV/AIDS and other STIs (Lawan et al., 2012). The literature available on studies done in Sub-Saharan Africa have revealed that; sex workers have little knowledge about STIs and how to prevent them (Sekoni et al., 2012; Baral et al., 2012; Media trice, 2012). The FSWs have a problem accessing the Health Care Services because of the type of work that they do and the clients they service (Ghimire et al., 2011; Lawan et al., 2012 and Media trice, 2012). FSWs are unable to regard themselves as “normal” people because of the stigmatisation, marginalisation and criminalisation imposed by law and the societies in which they live and work in. This is some of the reasons that make it hard for them to access health care and other social services (Lawan et al., 2012). To relieve and heal themselves, some sex workers seek help by buying over the counter medications, consult traditional healers and the faith-based centres. Ignorance, lack of finances, and lack of access to appropriate Health Care Services can be other contributing factors that delay health seeking behaviour. Some FSWs have reported that some STI are asymptomatic hence they do not report to the health facility (Baral et al., 2012; Sekoni et al., 2012 and Hong et al., 2011).

Gauteng Province has 32 000 sex workers and out of that 89% are FSWs. Eighty percent (80%) of the sex workers are believed to be providing their services in Ekurhuleni, City of
Johannesburg and Tshwane districts (SWEAT and Impact Consulting, 2013). Ekurhuleni is perceived to be the one hosting a huge number of FSWs because is closer to Airport services, trucks and high numbers of transport services. The truck drivers are reported to be the FSWs potential clients. The FSWs places of operation are reported to be far from Health Care Services and that delays FSWs to seek a much-needed Health Care Services. For those who can go and seek health care, they are discouraged to use Health Care Facilities by the negative attitudes presented by Health Care Workers (HCWs) when they seek help (SWEAT and Impact Consulting, 2013). The above-mentioned information on FSWs have prompted the researcher to: explore the sexual practices and health seeking behaviour about STIs and subsequently make recommendations on STIs appropriate intervention tailored to prevent the spread of STIs among the FSWs population in Ekurhuleni North.

1.3 Aim of the study

To explore the sexual practices and health seeking behaviour about STIs among the FSWs in Ekurhuleni North.

1.4 Research questions

- What are the sexual practices of the FSWs in Ekurhuleni North?
- What is the health seeking behaviours of the FSWs in Ekurhuleni North?
- What are the perceived barriers to accessing the health services by the FSWs in Ekurhuleni North?

1.5 Study objectives

- To explore the sexual practices of the FSWs in Ekurhuleni North;
To explore the health seeking behaviour of the FSWs in Ekurhuleni North;
To explore barriers to accessing health services as perceived by the FSWs in Ekurhuleni North.

1.6 Study methods and materials

1.6.1 Study design

A qualitative, exploratory study approach was employed. The researcher used focus group discussion (FGD) and in-depth interview (IDI) to interview the participants to explore their sexual practice and health seeking behaviour of the in the Ekurhuleni North sub district.

1.6.2 Study setting and population

The study was conducted in Ekurhuleni Northern Sub-district. The study population were FSWs from the age of 18 to 49 years who have been working as sex workers for a year and above. The sex workers in this study are not necessarily registered or linked to any structure or organization. They are working independently, and their clients accessed them directly.
1.6.3 Sampling and sampling methods

A convenience sampling was used to select participants as the target group are a hard to reach key population. The researcher was recruited the potential participants individually and those who were interested to take part in the research were transported to the identified private room in Centre for Positive Care or Kempton Park business centre office. The researcher introduced the study to the potential individual participant by explaining the purpose of the study and requests them to consider participating. The FSWs who agreed to come with the researcher to the facility were first offered Health Care Services by Pomona North Star Alliance mobile Clinic. Only after the FSWs have completed the Clinical consultation process they were then recruited to participate in the study. The participants gave verbal consent. Participants could refuse to participate or withdraw at any point of the interview without being coerced or without any effect to their access of Health Care Services.

1.6.4 Inclusion and exclusion criteria

FSWs from the age of 18 to 49 years who have been working as sex workers for a year and above in the respective sub district were included in the study. FSWs who are below 18 years and those who have been working as sex workers for less than a year were excluded from the study.

1.6.5 Data collection

The FDGs and IDIs were conducted using an interview guide by the researcher and a trained research assistant. The guide with unstructured questions and the demographic section were developed by the researcher in English and translated to Sepedi and Isizulu as local languages. The researcher conducted the FGDs and IDIs and the research assistant took notes, they have also observed and documented any body language during the interviews. The research assistant also held debriefing sessions with the researcher
after each IDI. The collection of data took place in a private room in the Centre for Positive care office and Kempton Park business centre office to ensure privacy, the room was also quite and ensured that the audio recorder recorded audible interviews. Arrangements were made with the Clinic managers to allow usage of one consulting room or office in the premises to conduct the interviews. Data collection continued until data saturation was reached. According to Walker (2012) data saturation occurs when participants does not provide new information, or no new themes emerge from the interview with the participants. The developed demographic data forms were completed at the end of the interview by the participants. The transport for the FSWs were provided for by the researcher. The researcher used dedicated transport for collection and drop-off of the participants after the interviews. The researcher collected the participants from their workstations and links; those who choose to access the available reproductive health service at the Primary Health Care Clinic and recruited them to volunteer participation in the study. The fieldwork procedure involved collecting the FSWs from their workstations, brings them to the Clinic, and offered them an option of accessing reproductive health care service or any other services since the services in the Primary Health Care settings are integrated. The health care service was not compulsory but were open to any participant who needed them. The FSWs were only recruited to participate in the study after they have completed their consultations with Clinicians. The FSWs were reminded of the right to refuse participation or to withdraw from the study at any point despite them having accessed the Health Care Services. It was emphasized that even though they received the services, they were not forced by the researcher to participate in the study and their refusal will not influence future access to health services negatively. The researcher also provided refreshments after each interview.

1.7 Significance of the Study

Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is a leading disease on the list of the burden of diseases. The interventions to curb this disease are urgently needed as it continues to increase regardless of the availability of the condoms that can reduce or even stop the spread of the disease. FSWs are perceived
to be at risk of being infected with STIs that include HIV and they also can infect their clients who do not prefer to use protection during a sexual encounter. Empowering FSWs to practice safe sex by negotiating safer sex encounters with their clients is recommended so that the STIs infections can be reduced. It is also important to understand the reasons why they are not accessing and utilizing Health Care Services when they have contracted the STIs. With more knowledge about the accessibility of the health services to the FSWs, programs can be created or modified to target them, and to ensure that plans are in place for the FSWs to access the health services and make use of such health services when they need them.

It is important that studies be conducted about health services that the FSWs use and identify the challenges that they face when they are to make use of the health services around them and the plan of action be drawn. This is also particularly important in South Africa where sex work is still marginalized and criminalised and the health care providers are not trained on how to handle the FSWs as they report to the health facilities, instead the FSWs in the country use health facilities that are provided by the non-governmental organizations which are President’s Emergency Plan for AIDS Relief (PEPFAR) funded and which are not available every day but comes to the FSWs spot once a week. Understanding these factors is helpful in identifying reasons for differences in utilisation, consumer satisfaction which is one of the reasons the FSWs choose to use non-governmental organization where they feel satisfied with their treatment. These will also help in formulating policies and programs for the FSWs that will encourage utilisation of the health services available in the areas of their work.

Timely and adequate use of Health Care Services will address prevention of the sexually transmitted infections that include HIV, unwanted pregnancies and the improved quality of life among FSWs.

1.8 Dissertation outline

The outline of the study will be arranged in five Chapters as follows:
Chapter 1: Study introduction and literature review
Chapter 2: Literature review
Chapter 3: Research design and methods
Chapter 4: Research findings
Chapter 5: Conclusion, limitations and recommendations
CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Sex work is defined as, a service with a client in an exchange for any form of payment preferably money (Brown et al., 2013). It is further noted that; most of the Health Care Workers might be familiar with the sort of FSWs that provide their sexual services in exchange for money. FSWs are highly vulnerable to health and social problems, especially; violence, exploitation, unintended pregnancy, discrimination, substance abuse and are at the high risk of contracting STIs. In countries where HIV/AIDS is indiscriminate, the likelihood of FSWs living with HIV/AIDS is 13.5% times more than to other women (Brown et al., 2013). FSWs are unable to regard themselves as “normal” people because of the stigmatization, marginalization, and criminalization imposed by law and the societies in which they live and work. This might be some of the reasons that make it hard for them to access health care and other social services (Lawan et al., 2012).

Women choose to become FSWs for different reasons. The available literature on FSWs has reported that; economic needs are regarded as the first drive for people to get involved in sex work. Lawan et al, (2011) further noted that; in South Africa, there is a high level of unemployment and it affects mostly women and they are sometimes unable to support their family as most of the household are supported and maintained by women. The FSWs have asserted that; sex work has allowed themselves to survive and put food on their table for themselves and their families. There are also other factors that make women to opt for this kind of services i.e. low level of education and being a foreigner in a country without a national citizenship of that country. The study done at Hillbrow, in Johannesburg has indicated that an estimated 60% of FSWs are from other countries and from other cities within South Africa (Brown et al., 2012).
In the study conducted in Nigeria, it is reported that; many of FSWs in that country comes from disadvantaged backgrounds and had low or no formal education hence they have problems securing a job that requires specific skills. Surprising enough without formal education, most of them were aware that unprotected sexual intercourse and multiple sexual partners are the main risk factors for STIs including HIV/AIDS (Lawan et al., 2012). Women are less educated from many households in the world, mostly from poor families (WHO, 2011). Most of the times when parents cannot afford to educate all their children, boys are often prioritized. Furthermore, girls are often kept out of school to take care of domestic duties at home. Lack of education and skills influences women’s and girls' HIV/AIDS risk because of their economic dependency on male partners (WHO, 2011).

2.2 Sex work and HIV/AIDS infection as a problem

Human Immunodeficiency Virus/Acquired Immunodeficiency Disease Syndrome (HIV/AIDS) and other STIs are reported to be generally prevalent amongst FSWs sub-groups (Lawan et al., 2012). A WHO (2011) report has indicated that there is a noticeable increase of STIs among FSWs in developing countries. These might suggest that there is a potential reservoir of STIs among the general population in the developing countries. FSWs are a section of the population that is at high risk of contracting HIV/AIDS and other STIs due to multiple factors, including large numbers of sex partners, unsafe working conditions and barriers to the negotiation of consistent condom use (Baral et al., 2012). Baral et al (2012), further noted that, this is happening especially because the FSWs often have little control over these factors because of social marginalisation and the restricted legal framework under which they are forced to work under. It is estimated that, half to two thirds of FSWs is believed to have a curable STI once in their lifetime. Ten percent (10%) or more had an active genital ulcer and over 30% have reactive syphilis serology (WHO, 2011). High rates of other STIs and unsafe sexual practices further increase the probability of HIV transmission in FSWs (Tamene et al., 2015).
2.3 Characteristics of female sex worker and their vulnerability in doing the sex work.

The reason for entry to this industry and socio-demographic characteristics are generally different. World Health Organization (WHO, 2011) has reported that, in Africa most women are initiated into sex work because of the low socio-economic levels, having high mobility, often moving from rural to urban areas in search of employment and end up turning to sex work when there is no other employment. They are often victimized or abused due to unequal gender relations. The report further noted that most FSWs are in large found in urban areas, cities and on trucking routes. Economic and gender inequities is perceived to be the reason that the risk of HIV/AIDS infection is on the increase, especially among women. The study conducted in the Sub Saharan Africa countries indicated that much of HIV/AIDS risk for the FSWs is due to demonstration of their unusual social and economic vulnerability, and the high levels of stigma and violence attached to sex work (Chersich et al., 2013). The study that was conducted in sub-Saharan has reported that, women and girls are always at risk of HIV because of their limited access to prevention information and tools that they can use to prevent themselves from infections. The study has also discovered that, women work very hard to get basic needs and some engage in risky behaviours, such as becoming commercial FSWs, which can bring basic survival resources for their families (Phrasisombath, 2012). Other factors that expose FSW are the gender-based inequality, insufficient information on STIs including HIV/AIDS. The way they can prevent these infections and perhaps limited access to both health and social services because of stigmatization and marginalization (Lawan et al., 2012). According to the study done by Shukla & Mehrotra, (2015) in Uganda, it has indicated that majority of the FSWs were between 24 and 30 years of age, some were married and semi-literate, lived in unhygienic informal settlements and belonged to low socio-economic status. Most of them did not have children and some had one child. Some FSWs had express the dissatisfaction on social support received from the family on the job they are doing as FSWs and that they only get support when they are extremely ill and cannot go and provide their services. The FSW who had secondary education (grade nine, maximum) were not satisfied with their socio-economic status as well as with their monthly income so they decided to get involved in sex work. The author suggested that;
all the above findings were indicative of the fact that ignorance, illiteracy, poor income prepared a base to become sex worker Shukla & Mehrotra, (2015).

The research that was conducted in Europe, has recommended that HIV prevention interventions should be inside strategies that address the social welfare of FSWs. The author emphasised the need to target the social determinants of health and inequality, including access to services, experience of violence and migration from the other countries or from the rural areas to the urban area in search for jobs (Platt et al., 2016). In the study done in China all participants had migrated from poor rural areas of western China, and most had come from Sichuan, Hunan, or Hubei (Cai et al., 2010).

2.4 Stigmatization of FSWs

2.4.1 Stigma

Stigma refers to shame or disgrace that is directed toward something regarded as socially unacceptable (Brown et al., 2012). The stigmatisation in most cases causes undesirable effects to the well-being of the FSWs and overall health, and that in a way reduce the impact of HIV/AIDS prevention programming. The literature has also indicated that FSWs can experience stigma within the health care setting and specifically from HCWs themselves (Brown et al., 2012). The study conducted in Davangere city has shown that there is a challenge in combating HIV/AIDS because FSWs are associated with STIs (Girish et al., 2014). FSWs face many forms of violence coming from clients, employers, community members, partners and other FSWs (Tamene et al., 2015).

2.4.2 Discrimination

Scogie et al., (2012) has indicated that social marginalization and a typically criminalized working environment limit the ability of FSWs to moderate the impact of their occupational
hazards which they don’t have control over, such as multiple sexual partners, difficulties in negotiating condom use, poor access to appropriate lubricants and high STI prevalence. Discrimination that the FSWs experience is regarded as a barrier to the use of sexual health services and treatment and are known to be highly vulnerable to genital warts, candidiasis, gonorrhoea and genital ulcers and which will be consequently be transmitted to their clients and their other sexual partners back home (Ghimire et al., 2011).

2.4.2 Marginalization

Female Sex Workers are disregarded by everyone. According to the study in Cape Town, FSWs are a socially marginalized group with poor physical health. They are not taken serious by community members and the police. They are called names such as “marhosha” which means sex worker (Media trice, 2012; Baral et al., 2012). A study conducted in Laos indicated that FSWs were fearful to openly talk about the services that they render to their clients and they were very concerned to be seen by people that they know, even the relatives because that is generally unacceptable. Any women identified as selling sex would be someone who brings shame and embarrassment to parents and family. The community would blame parents for the poor upbringing of the daughter (Phrasisombath, 2012).

2.4.3 The sexual practices among the FSWs

The literature has also indicated that condom usage was inconsistent because of financial incentives, condom breakage, violence, rape and non-payment from clients when FSWs insisting on condom usage. The poor social or economic status of the FSW which is demonstrated by their willingness to practice unsafe sex exposed them to the risk of been infected with STIs and the HIV virus (Media trice, 2012). In South Africa it has been reported that about 8% FSWs get involved in unprotected sex (Media trice, 2012). FSWs in Sand ton, Rustenburg and Cape Town were more likely to engage in unprotected sex
than those in Hillbrow. Generally, FSWs from Kenya and South Africa practiced unprotected sex (Richter, 2013). A study that was done at Durban in South Africa has revealed that condoms were suggestive of dirty disease, infidelity and mistrust, so it was disregarded (Media trice, 2012). Access to HIV/AIDS and STIs prevention and reproductive health supplies such as condoms, lubricant and contraceptives; voluntary HIV counselling and testing; treatment for HIV and other sexually transmitted and opportunistic infections; harm reduction interventions for substance abuse, and a range of social and welfare services are required to ensure a comprehensive HIV/AIDS response among the FSWs (UNAIDS 2012).

A study conducted in Kano, Nigeria has discovered that unsafe sex was practiced even by FSWs who knew that they are HIV positive (Lawan et al., 2012). The unprotected sexual encounter with regular and non-paying partners in Ethiopia put both FSWs and their partners at higher risk of contracting HIV infection (Mooney et al., 2013).

In Pakistan condom use among FSWs is 5.4% in Lahore and 3.1% in Karachi (Saleem et al., 2013). In Ethiopia, the work-related violence was associated with unprotected sex with regular, non-paying partners among FSWs who abused alcohol (Mooney et al., 2013). In Uganda poverty, refusal to use condoms by male partners, alcohol use before sex and beliefs that condoms ‘kill the mood for sex’ were the key barriers to consistent condom use among the FSW (Matovu & Sebadduka, 2013). A study in Kinshasa found that about a quarter of FSWs reported having unprotected sex for extra money, charging up to 3.5 times more for unprotected sex (WHO, 2011). The FSWs wanted to ask their client to use a condom but were too afraid to ask because of the conditions they are working under. Nearly three quarters of FSWs in that study also reported having had sex with a client who had refused their request for condom use. Some of the non-use of condoms was due to instructions from the owner of their working place (WHO, 2011). Evidence suggests that FSWs are poorly organized and have few alternative sources of income; so, they are unlikely to refuse a client who does not want to use a condom. In
Kenya Nairobi, there is a common belief that boyfriends and healthy-looking clients cannot spread STIs. The males who were taking preventive measures like swallowing antibiotics prior to sexual encounter were perceived as people who were not at risk to acquiring STI/HIV infection(s) by the FSWs (Nyamu, 2013).

2.5 Health seeking behavior among FSWs

The studies that were conducted in South Africa have indicated that FSWs are a hard to reach and a hidden population and they often had difficulty in accessing health services that are in a way may result in their poor health outcome and that might encourage rapid and higher HIV/AIDS and STIs transmission rate among their partners from the general population (Desmond Tutu HIV Foundation, 2012). It is also noted that health providers’ attitudes determine the FSW desires and the discouragement of the use of health services. Negative treatment and social exclusion make the women feel that health providers perceive them as unworthy or undeserving of health services. Some preferred seeing a traditional healer to ensure their privacy (Savva, 2013).

There has been a long-standing problem among the FSWs when going to see the doctors when they have STIs symptoms (Phrasisombath et al., 2012). Most of the FSWs prefers to use the Clinic that are operating by Non-Governmental Organisation (NGO) when they are infected with STIs (Phrasisombath et al., 2012). Most FSWs do not seek STIs treatment on time and sometimes they do not seek treatment at all until the STI is severe in nature. A study that was conducted in Lagos, revealed that 53% of the participants who had STIs reported that they received their treatment from the drop-in centre services, 23% used the public hospital, 12% used the private Clinic, 9% used private pharmaceutical services private pharmacy, and lastly 2% used herbalist services (Lawan et al., 2012). According to the research by Baral et al., (2012) it was reported that; sometimes the FSWs as the vulnerable group they would not seek appropriate medical treatment from the public health facilities like Clinic or hospitals. Some of FSWs feel safe and comfortable
to use health providing facilities such as traditional healers, faith-based centres and out-and-out medicine stores. This behaviour is believed to have been encouraged by the fear of the possible discrimination by the Health Care Workers, lack of finances, ignorance and lack of access to appropriate Health Care Services (Baral et al., 2012; Sekoni et al., 2012 and Hong et al., 2011).

Some of the FSWs in Nigeria do seek help in public health facilities. About half of those with sexually transmitted infections sought treatment in a hospital or health centre while 32.5% from a patent medicine vendor (Sekoni et al., 2012). In Kano, Nigeria has reported that because of the unhealthy sexual encounter and lack of health seeking behaviour amongst FSWs, it was recommended that peer education package should target the FSWs and their clients, with focus on reducing risk behaviours associated with STIs and HIV transmission, safer sex; and treatment seeking. FSWs frequently reported that having local health services was not important for them as they preferred to visit Clinics or hospitals in more distant places (Lawan et al., 2012).

According to Ghimire et al. (2011) in Nepal, research conducted revealed that 25% of the FSWs have reported that they had never visited any health facilities especially for sexual health services. Seventy two percent (72%) prefers to use non-governmental Clinics, 50% preferred private Clinics, 27% preferred hospital and 13% preferred health centres (Ghimire et al., 2011).
2.6 Challenges in health services

A study conducted in Cape Town has indicated that most of FSWs do not go for routine like HIV test every three months if they are HIV negative or yearly blood tests if they are HIV positive and are on ART and other medical check-ups such as those for hypertension, diabetes, mental illness etc. Some were not satisfied with health care provision, discrimination tendencies towards them and long waiting times. The illegality of sex work services in South Africa has pushed FSWs to practice their sex work in obscure places and that makes them very vulnerable to their clients (Media trice, 2012). It is documented that, health provider attitudes, and external discrimination by the community and internal discrimination by the Health Care Workers and stigma that is related to their work have influence on access to health services among the FSWs (Savva, 2013). Some FSWs reported that their health needs were not met because of bad services and sometimes outright services refusal based on stigma because they are FSW. More than half of FSWs who reported that they were denied service or given bad treatment were from Rustenburg (Savva, 2013). Some FSWs complained about the lack of privacy and confidentiality in public health facilities. Some reported inaccessible services because of the long waiting times, inefficient staff, and lack of cleanliness in Clinics (Savva, 2013). The available literature on FSWs has reported that even though FSWs knew that they need to use the health facilities, the type of work that they do and type of clients they service, made them unable to practice safe sex and utilize the health services that were around them (Ghimire et al., 2011; Lawan et al., 2012 and Media trice, 2012). It is also reported that main barriers to seeking health care among FSWs infected with STI symptoms were both structural such as social stigma by the Health Care Workers and the community they might meet in the health facilities and individual such as fear of social discrimination by the Health Care Workers (Sihavong et al., 2011). Some FSWs also mentioned that they visit Clinics that were far from where they stay because they are afraid of telling the Health Care Workers about their health status (Ghimire et al., 2011). The perceived quality of care from the Health Care Workers is one of the main reasons for seeking treatment in their other chosen places (Sekoni et al., 2012).
According to Phrasisombath et al., (2012), the participants reported the health facilities are far from them so it is not easy for them access those Health Care Services, those facilities they can reach have got long waiting times, some other times they find themselves wanting as they don’t know where the health facilities are located when they need to use them, and negative attitudes among Health Care Workers and the quality of care that are provided were reported as the reasons FSWs use alternative health services providers. Majority of the respondents who had not sought care for STI symptoms in the previous three months mentioned inconvenient location of the Clinic and they did not know where to get treatment. Long queues in the Clinics, lack of time to wait in those long queues and lack of money to use other Health Care Services like pharmacies and private Health Care Services that will expect them to pay, lack of confidentiality from the Health Care Workers and their attitudes are the main cause the FSWs not to seek medical help when sick (Phrasisombath et al., 2012).

A study conducted in Nepal showed that the FSWs reported that personal, structural and socio-cultural barriers, such as Clinic opening hours that are not suitable to the FSWs, discrimination by both the community and the Health Care Workers, the judgemental attitude of the Health Care Workers, lack of confidentiality, fear of meeting the neighbours, and higher fees for the services are a barrier to their access and utilisation of sexual Health Care Services (Ghimire et al., 2011). A study done in Uganda has reported high costs, shortages of medicines and inadequate transportation to hospitals as some of the challenges the FSWs experiences that is also made worse by stigma and movement due to the kind of work they do. This includes lack of a clear country guidance document on the implementation of HIV/AIDS prevention among the FSWs. There is also lack of indicators that would help tracking FSWs receiving various services at the national level as there are no clear guidelines on management of FSWs (Patel et al., 2014). The different classifications and definitions of female sex worker, poor attitudes of some Health Care Workers toward FSWs and limited community support (Patel et al., 2014). FSWs who were HIVAIDS positive were more likely to experience discrimination than
HIVAIDS negative FSWs in the health care setting. It was also discovered that HIVAIDS related stigma was negatively correlated with getting a recent HIV test. The similar results were found in Russia on HIV-related stigma as a barrier to services both among other populations (King et al., 2013).

2.7 Conclusion

In most countries sex work is illegal, and it is criminalised. Most FSWs suffer stigmatisation, discrimination and they are marginalised among families, communities and in the Health Care Facilities. Due to the type of the services they provide, they are perceived as the sub-group that is vulnerable and are driving the spread of HIVAIDS and STIs. They seldom use health facilities because, they do not know where to get the services, they do not have money for the transport, long waiting times, poor quality of services and the negatives attitudes from the health professionals. The FSWs empowerment on consistent condom use negotiation is recommended. The STIs preventative programmes that will focus on FSWs should be developed and they should be made available at their services station. The methodology about the study will be presented in the next Chapter.
CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Data collection research processes and procedures are outlined and discussed in this chapter. Some of the research design and methods that were briefly described in Chapter 1, are discussed in more details. Qualitative and cross-sectional design was used in the form of focus group discussions and in-depth interviews. The purpose of the study was to explore sexual practices and health seeking behaviour about STIs among the FSWs in Ekurhuleni North. The following research processes and designs were discussed: Research design, study setting, and selection of the sample, data collection methods and procedures, recruitment of study participants, pilot testing, tools, data analysis, trustworthiness and ethical consideration.

3.2 Research design

Qualitative, explorative research designed was used. Qualitative research method is an excellent approach when exploring sexual practices and the health seeking behaviour about STIs among the FSWs (Bowling & Ebrahim, 2006).

The researcher selected this approach to explore the sexual practice and health seeking behaviour of FSWs in Ekurhuleni and focus group discussion (FGD) and in-depth interviews (IDIs) were used. The cross-sectional study was used to allow the researcher room to describe the health of populations that were studied (Bowling & Ebrahim, 2006).

3.3 Study setting

The study was done in Ekurhuleni North sub district. The Ekurhuleni district is now named the City of Ekurhuleni, which was established in the year 2000 from the merging of two regional entities, namely Kyalami Metropolitan and the Eastern Gauteng Services
Council. City of Ekurhuleni is consisted of nine towns, namely Alberton, Benoni, Boksburg, Brakpan, Edenvale, Germiston and Kempton Park, Nigel and Springs. Of these, Kempton Park, Benoni and Springs are the largest. According to the Community Survey that was conducted in 2016, City of Ekurhuleni has an estimated population of 3 379 104, which increased by 200 634 people from 3 178 470 2011 census (Statistics South Africa, 2017). The growth in the Ekurhuleni population is high and the rate in which people migrate into the city to look for jobs, like it is happening in Tshwane and Johannesburg. City of Ekurhuleni had an unemployment rate of 29.7% in 2015, which is higher than Gauteng’s unemployment of 26.3% (Statistics South Africa, 2017).

The City of Ekurhuleni has three regions which are the East, the South and the North. The study was conducted in Ekurhuleni North, in the Kempton Park area. Kempton Park is three km from OR Tambo international airport. It has 27 hotels and petrol filling stations for truck drivers in Pomona. Pomona truck stop is in the heart of distribution hub of OR Tambo International Airport in Kempton Park, so all the trucks that go to different countries stop for petrol filling in Pomona. There is also a Wellness Clinic that renders Primary Health Care Services that include STI, health screenings such as HIV tests for both FSWs and the truck drivers who are sick and those who are on chronic medication. The Clinic renders health services from 11:00 till 19:00, Monday to Friday. The Wellness Clinic renders both services in the Clinic and does outreaches in the lodges and pubs in Kempton Park.

Gauteng Province has 32 000 sex workers and out of that 89% are FSWs. Eighty percent (80%) of the FSWs are believed to be providing their services in Ekurhuleni, City of Johannesburg and Tshwane districts (SWEAT and Impact Consulting, 2013). Ekurhuleni is perceived to be the one hosting a huge number of FSWs because is closer to the Airport services, trucks and high numbers of transport services. The truck drivers are reported to be the FSWs potential clients. The FSWs places of operation are reported to be far from Health Care Services and that delays FSWs to seek a much-needed Health Care Services. For those who can go and seek health care, they are discouraged to use Health Care Facilities by the negative attitudes presented by Health Care Workers when they
seek help. The above-mentioned information on FSWs have prompted the researcher to: explore the sexual practices and health seeking behaviour about STIs and subsequently make recommendations on STIs appropriate intervention tailored to prevent the spread of STIs among the FSWs population in Ekurhuleni North.

<table>
<thead>
<tr>
<th>Area</th>
<th>2005</th>
<th>2010</th>
<th>2015</th>
<th>Average annual growth</th>
</tr>
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<tbody>
<tr>
<td>Eastern</td>
<td>859 00</td>
<td>942 000</td>
<td>1 030 000</td>
<td>1.79%</td>
</tr>
<tr>
<td>Northern</td>
<td>812 000</td>
<td>994 000</td>
<td>1 100 000</td>
<td>3.11%</td>
</tr>
<tr>
<td>Southern</td>
<td>995 000</td>
<td>1 110 000</td>
<td>1 250 000</td>
<td>2.29%</td>
</tr>
<tr>
<td>Ekurhuleni</td>
<td>2 666 000</td>
<td>2 996 000</td>
<td>3 380 000</td>
<td>2.39%</td>
</tr>
</tbody>
</table>

Table 1: Total Population (Ekurhuleni Regions)
Figure 1: Ekurhuleni Northern sub-district Map

3.4 Study population

The study population were FSWs from the age of 18 to 49 years who have been working as FSWs for a year and above. The FSWs in this study were not registered or linked to any structure or organization. They are working independently, and their clients accessed them directly.

3.5 Recruitment of study participants

The researcher recruited the potential participants individually according to the inclusion criteria at their different service points and those who were interested were then
transported to the Centre for Positive Care office in Kempton or Kempton Park office. Upon arrival, they were taken to the consulting room or the office where the purpose of the study was explained in detail and the data collection procedures were explained. The researcher had also indicated that the study was voluntary and that the participants can withdraw from participating from the study at any time without any penalty and that will not impact on their Clinic services negatively.

3.6 Selection of the sample

Convenience sampling was used to select participants as the target group are a hard to reach key population. The researcher recruited the potential participants individually and those who were interested to take part in the research were transported to the identified private room in Centre for Positive Care or Kempton Park Business Centre office. The researcher introduced the study to the potential individual participant by explaining the purpose of the study and requested them to consider participating. The FSWs who agreed to come with the researcher to the facility were first offered Health Care Services by Pomona North Star Alliance mobile Clinic. Only after the FSWs had completed the Clinical consultation process they then participated in the study. The participants gave consent to participate in the research. Participants could refuse to participate or withdraw at any point of the interview without being coerced or without any effect to their access of Health Care Services.

3.7 Data collection methods and procedures

According to Polit and Beck (2008) research data is defined as, the pieces of information that is obtained during a study (Polit and Beck, 2008). Focus group discussions (FGD) and an in-depth Interview (IDI) guide were used by the researcher and a trained research assistant. The guide with semi structured questions and the demographic section were developed by the researcher in English and translated to Sepedi and isiZulu as local languages (APPENDIX 1). The participants gave consent to take part in the research and allowed the researcher to use an audio recorder to record their response. The researcher
conducted interviews and the research assistant took notes and documented body language that were observed during the interviews. The research assistant and the researcher had debriefing sessions after each FGD and IDI. The collection of data took place in a consulting room at Centre for Positive care (CPC) office and Kempton Park Business Centre to ensure privacy. Data collection was continued until data saturation was reached. According to Walker (2012) data saturation occurs when participants does not provide new information, or no new themes emerge from the interview with the participants (Walker, 2012). The developed demographic data forms were completed at the end of the interview by the participants.

3.7.1 Tools

The questionnaire for the study was semi-structured and un-structured, and the researcher used the other FSWs literature to develop a research questionnaire guide.

Five semi-structured, FGDs and five IDIs were conducted and data saturation was obtained. The FGDs were conducted face to face with participants by the researcher and research assistant. Recorded data were transcribed and transcripts in Sepedi and isiZulu were translated into English. All English versions of the transcripts were uploaded onto NVIVO 12 software for analysis by the researcher.

3.7.2 Focus Group Discussions

The FGDs were conducted from the 14th September 2017 to the 28th October 2017. Five FGDs were conducted with the FSWs and it took two hours to complete each focus group discussion. The sample sizes were smaller because the researcher found it difficult to get the FSWs who were willing to participate on the study but managed to get focus group numbers that are required by the focus group formation research policy (Wibeck et al, 2007). The FGDs were used by the researcher to explore the FSWs sexual practices and their health seeking behaviours. In the FGDs, the FSWs had an opportunity to tell their individual stories and the experiences they had about their sex work. The structure of the questions allowed the interviewer to probe as the interview progressed and allowed the
participants to raise other issues that were not have been included in the interview guide. All the interviews were audio recorded as per agreement with the FSWs and later transcribed verbatim and stored on the laptop and a memory stick. Field notes were also written alongside as a complement and were filled and kept safe.

3.7.3 In depth Interviews

Five IDIs were held with the FSWs from the 15th November 2017 to the 17th November 2017 for 45 minutes long by the researcher and the trained research assistant. The individual interviews were conducted to explore other issues about their sexual practices and their health seeking behaviour that have not been discussed during FGDs as some participants might have been shying to talk in a group. The structure of the questions also allowed the interviewer to probe as the interview progressed and for the participants to raise other issues that would not have been included in the interview guide. All the interviews were audio recorded as per agreement with the FSWs and later transcribed verbatim and stored on the laptop and a memory stick. Field notes were also written alongside as a complement and filled and put way in a safe place.

3.8 Data analysis

Data that was collected using FGD and IDIs and was transcribed verbatim in English, Sepedi, and isiZulu. Later the Sepedi, and isiZulu discussions were transcribed and translated into English. All transcripts were read and validated for accuracy by listening and re-listening to audio-recordings to come up with themes and sub themes. The researcher conducted first data analysis using manual coding to identify the initial code that came up. The second level coding of data analysis was done to assess the codes and identify common themes that emerge from the data. The themes and codes were discussed with the supervisor to confirm if they will address the study and a code list was developed. The researcher used NVIVO version 12 qualitative software to manage and analyse data. All the English transcripts and Sepedi and isiZulu transcripts that were
translated to English were in a Microsoft Word format, there after they were then imported into NVIVO 12 and the code list was uploaded. All coding was done in NVIVO 12 and the data analysis outputs in a form of themes and quotations by the participants were used to present the analysis. The transcripts were reviewed as much as possible and coded to identify major themes that arose from the data such as becoming a sex worker, condom use, negotiating condom use with the clients, knowledge about female condom use, HIV prevention, condom bursting, experience on rape, health seeking behaviours, barriers to health service utilization, attitudes of Health Care Workers, disclosure of been sex worker to the partner, family and friends and the special needs of the FSWs as the key population. The participant’s quotations were copied or dragged to the relevant themes so that they will be used as excerpts in the next chapter. To maintain truthfulness of the data that was collected, all participants in the study were requested to respond to the questions as honest as possible.

3.9 Trustworthiness of the study

3.9.1 Trustworthiness

Trustworthiness of this study was assessed by credibility, dependability and transferability (de Vos et al., 2011).

Trustworthiness was established when the findings from the interviews reflect as closely as possible the meanings as described by the participants (Lincoln & Guba, 1985). The IDI guide was pre-tested by interviewing five FSWs around Ekurhuleni North where data collection was done to ensure trustworthiness of the findings.

3.9.2 Credibility

Credibility of the study was ensured by recording the interviews using a digital audio recorder and by transcribing the interviews verbatim to ensure that data represent the experiences of the participants. Data was triangulated to ensure credibility by writing field
notes and collecting demographic information of the participants. Data was collected by the researcher and research assistant was used to take notes. Manual coding started at the beginning of data collection by identifying initial codes when the researcher transcribed the interviews. The researcher read the transcripts repeatedly translating them from Isizulu and Sepedi to English and typing them in Microsoft Word version 2016.

3.9.3 Dependability

Dependability was ensured by involving the supervisor in guiding the researcher during the interviews, whereby the researcher reflected on the findings of the interviews to ensure that the study bring about the same results with studies conducted elsewhere and conformability reflected consistency of findings (Lincoln & Guba, 1985).

3.9.4 Transferability

Transferability was ensured by in-depth discussion of obtained data, data analysis and interpretation of the study findings by the researcher so that the results had same meaning to others with same setting.

3.9.5 Confirmability

Confirmability was ensured by discussing the collected data by the researcher and the supervisor and both parties agreeing on objectivity of data.

3.10 Data analysis plan

Data from FDCs and IDIs were transcribed verbatim in Sepedi and Isizulu and translated into English. All transcripts were read and validated for accuracy by re-listening to audio-recordings. The researcher conducted first level analysis using manual coding to identify the initial codes. The second level coding of data analysis was assessed, and coded and common themes were identified as they emerged from the data. The codes were discussed with the supervisor for confirmation and a code list was developed. NVIVO
version 12 qualitative software was used to manage and analyse data. The transcripts, in a Microsoft Word format was imported into NVIVO 12 and the code list uploaded. All coding was done in NVIVO 12 and the data analysis outputs in a form of themes and quotations were used to present the analysis. A codebook was developed for data analysis. The codebook which had seven themes and three sub themes were discussed with the supervisor and the themes were increased to nine themes and twenty-two sub themes. Demographic data which was quantitative was captured in the Micro Office Excel version 2016 for analysis.

3.11 Ethical consideration

In research, researchers work guided by several laws, regulations, and professional codes of practice, that designed to protect the rights and interests of the participants (Bowling & Ebrahim, 2006). Ethical clearance and approval to conduct the study were obtained from the Student Research Ethics Committee (SREC) and Sefako Makgatho University’s Research Ethics Committee (SMUREC/H/114/2016: PG) (APPENDIX 4). Permission to conduct the study was granted by Ekurhuleni Research Ethics (APPENDIX 5). The participants were treated with care as they are the vulnerable group and their rights were protected (Polit & Beck, 2008). The researcher got permission (informed consent) (APPENDIX 3) from the participants who were interviewed, and the study design and methods were explained to them. The researcher protected the identity of study participants by using pseudo names, and the information that was communicated by the participants remained anonymous (Joubert & Ehrlich, 2009). Privacy was ensured by conducting the interviews in a private place in Kempton Park office and a private space at Centre for Positive Care office.

3.12 Conclusion

This Chapter explained all research methods, processes and procedures as outlined in the introduction of the Chapter. The characteristics of data collection tool of the instrument were also explained and discussed in this Chapter. In the next Chapter, the research results will be outlined and presented in an orderly manner.
CHAPTER 4: STUDY FINDINGS

4.1 Introduction

This Chapter is presenting the results of data collected from the five FGDs and five IDIs of the FSWs who were recruited from North Star Alliance Mobile Clinic and Centre for Positive Care (CPC). The study was aimed at exploring the sexual practices and health seeking behavior among the FSWs in Ekurhuleni North. Data was collected from the FSWs that are working in Kempton Park on the sexual practices and health seeking behavior about STIs among the FSWs in Ekurhuleni North. The Chapter presents the research findings that are derived from the five FGDs and five IDIs hat were done with the FSWs in Ekurhuleni North. This Chapter highlights the description of the data analysis process and development of themes, the participants’ demographics, and the themes including sub-themes that emerged from the collected data with excerpts to elaborate on them.

4.2 Demographic data

In this study five FGDs and five IDIs were conducted, the socio-demographic data included the age, educational background, marital status, and place of originality. This information is presented below.

4.2.1 Age of respondents

From the sample of n=38 FSWs, the minimum age of the respondents was 18 years while the maximum age was found to be 49 years. The study showed that of the 38 participants, 27 of the respondents were between ages 25-35 years, seven were aged between 18-24 years and four were aged between 38-49 years as shown below in Figure 2.
4.2.2 Marital status

In addition to age, of the 38 participants, the respondents were requested to indicate their marital status. Accordingly, 33 of respondents were single and five respondents reported that they were married as shown in Figure 3 below.
4.2.3 Level of Education

A total of 38 respondents participated in the study, of which two (n=2) stated that they had attended primary school education, 31 (n=31) attended high school education and five (n=5) had completed tertiary education as shown below in Figure 4.

Figure 3: Marital Status of participants
4.2.4 Place of origin

In this study, majority of the respondents were from other countries (n= 16), Gauteng (n=8), Limpopo (n= 7), Free State (n= 3), KwaZulu Natal (n= 3) and North West (n= 1) as shown below in Figure 5.
Of the 38 FSWs n=24 had 0 – 1 child, n=12 had 2 – 3 children and n=2 had 4 – 5 children as per Figure 6 below.

![Figure 6: Number of children](image)

Of the 38 FSWs 23 used a contraceptives method and 15 did not use any contraceptive method as per Figure 7 below.
In this study, of the 38 FSWs n=10 had 1 – 2 abortions and n=2 had 3 – 6 abortions as FSWs as indicated in Figure 8 below.
Of the 38 FSWs, n=11 FSWs conceived and had baby from their clients according to Figure 9 below.

**Figure 9:** Had children since working as sex worker

Of the 38 FSWs, n=23 indicated that they have been working as sex worker between 1 – 5 years, n=12 worked as FSWs between 6 – 10 years and n=3 worked as FSWs between 11 – 20 years as indicated in Figure 10 below.
In this study n=14 FSWs had 2 – 5 clients per day, n=17 had 6 – 10 clients per day and n=7 had 16 – 25 clients per day in their sex work as indicated in Figure 11 below.

**Figure 10:** Number of years working as sex worker

**Figure 11:** Number of clients per day
In this study, n=31 FSWs indicated that they earn between R 150 and R 1000 per day, n=3 indicated that they earn between R 1100 and R 2500 per day and n=4 indicated that they earned between R 2600 and R 4500 per day as in Figure 12 below.

![Figure 12: Earnings per day](image)

Of the 38 FSWs, n=1 respondent reported that she works between 1-2 days in a week, n=15 reported that they work between 3-5 days in a week and n=22 works between 6-7 days in a week as indicated in Figure 13 below.

![Figure 13: Number of days working](image)
4.3 Development of themes

The excerpts from the interview transcripts were coded into themes and sub-themes during the analysis of the data. The researcher read the transcript repetitively to get the meaning of what was said by the participants in the excerpts to be able to develop the themes and sub-themes. The context and meaning of what were said in the excerpts by the participants was then coded into the relevant themes and sub-themes, and the researcher discussed and analyzed the details of the results. Themes were developed to ensure proper analysis of the data that was collected. Several themes that emerged from the data represent the sexual practices and the health seeking behavior of the FSWs aged between 18-49 years.

Table 2: Data themes and sub-themes

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### 4.3.1 Becoming sex worker

Data shows that FSWs joined the sex work industry for different reasons. Some participants expressed that since they joined the industry they can provide for their
families and meet their personal needs. The following are some of the excerpts that were raised by the participants about how they became FSWs.

“Like as for me I was working as a maid in Zimbabwe like I was working and my boss she was able to pay me enough money sometimes say she does not have money so like me I am a breadwinner in my family so I was tired I work hard, my friend told just leave this job and go to South Africa and look for jobs but she told me when you get there you must be a sex worker, I was told from home to come to Joburg and be a sex worker” (Fortue, 24 years, single, Zimbabwe).

“We do it for different reasons some to support families, some for drug reasons and some for are forced into it” (Jay, 32 years, single, Limpopo).

“I am an adult I have five kids of which they need to be maintained so I have been looking for a job for a long time so since it is difficult to get job that is why I just decided to go and do whatever that help to put food on the table for my kids that is whereby I join this job of been sex worker at least there even though it is difficult I can get something for my family” (Mary, 49 years, married, Limpopo).

“I had to support my child it was my first child, so my boyfriend left me when I was pregnant” (Phesy, 28 years, single, Limpopo).

“We came here looking for jobs and we didn’t find jobs and life was very hard for us, we had nowhere to stay.” (Prim, 28 years, single, Zimbabwe).

“There was a girl that I knew she was working here in Joburg, I asked her that I can come and stay with her while I am looking for a job so I didn’t find a job and she was already
working as a sex worker, I asked her one day where she is working and she said may it is going to be difficult for you to work there, but I said that I will try because I have to work for my siblings so I came that is how I started.” (Rose, 27 years, single, Free State).

“I was fighting with my husband and my sister said come to get job in Joburg, so I came to Joburg.” (Thembi, 28 years, married, Limpopo).

“I am doing this job it helps me as I can’t find job I am able to support my child and family when I am sick I am able to go to the Clinic I use the money to go to the Clinic.” (Bitter, 35 years, married, KwaZulu Natal).

“We all came here because of different challenges for instance we as Zimbabweans at home it is very hard to survive we have got no job and you can’t bring money every day, so we try by all means we try in fact by all means to do something else something decent to get something that will give us money to look for our families back home and we end up doing this job, for example. I came here looking for a job, that was in 2012, a cousin of mine called me and I came here and it was like this is boring my sister you have to sell what you have to get what you want so that is how I got myself into this job, every one of us has a different story, we have a story behind what we are doing, no one does this job because we like it or because it is nice this job is very hard as we face different challenges every day.” (Candice, 27 years, single, Zimbabwe).

“Because of the situation in Zim because things are difficult like myself when my Mom and Dad passed on and I have my child and I was staying with my Granny and my Grandfather so the way my Grandfather was treating me I was wash my child nappies with leave from the bush, so there is another girl who stayed in Beitbridge she told me come and work for me and whilst the girl was a sex worker I got to her house working as a house girl someday myself I was sitting during the night around six, seven she went out
and come back in the morning with too much money and working for her washing her panty, cleaning for her she said you see this money this small money which I am giving you, you can't even afford to send money for your child, and those days things were difficult for me, they were hard, the situation of washing someone panty you see then from she started bringing a message to say I want to find a boyfriend for you and me to go out and me was a church goer then from there that when it started bring men for me and when I was felt she was the one who taking the money me I sleep with someone and she is the one who is going with the money. And I said what is happening then I said ok, until I knew that she is doing this business” (Mbali, 29 years, single, Zimbabwe).

“This life is not easy, sometime you find it hard like maybe you say “Eish” I don’t have anything to send home I have to take the risk and you ask to do it without protection it’s hard, sometimes you can’t make that money and he is offering you big amount and you cannot say no sometimes you can say “Eish” I am risking my life but you don’t have choice but at least if we get jobs, sometimes even if we go and look for a job when you get job they promise to pay you 2 500, 2 800, 3000 and at the end of the month they will say you break this, you stole this, you did this and you end up saying that let me go back to the street” (Sherai, 39 years, single, Zimbabwe).

4.3.2. Experiences of been a sex worker

Female Sex Workers experienced different things in their work. Some of the participants indicated that it is difficult to be a sex worker as they experience difficult and challenging situations. The participants expressed that they meet different clients that treat them in different ways such as beating them, doing business with them and not pay them, they say they have met rapists, thieves and murderers hence some of them are on drugs and using alcohol, just to numb the pain they are going through. When they have encountered those challenging situations and when reporting the rape, the Police instead of helping them, also rape them and when they go to the Health Care Facilities when they are ill or reporting a bursting condom they are been judged by the Health Care Workers.
“I was beaten once in by client I was working in the street, after doing business with that guy, he was my regular after doing business with him he said today you are not nice give back my money, I was like no I can’t give back your money why we did it already there is no need to refund you, the client he went out, he was a Congo and he came back with friends, they beat me up I have stiches, that is one of the challenges we face. Some of them are thieves, some murders some of them even carry weapon, sometimes they are searched at the door, but they can’t find knives and can’t find drugs, we are at high risk because we are dealing with very dangerous thieves, people that are dangerous” (Candice, 27 years, single, Zimbabwe).

“Been a sex worker is not nice, we meet bad things, horrible things, bad men that abuse us, they degrade us as women, sometimes you don’t get clients and no business no money” (Cindy, 25 years, single, KwaZulu Natal).

“Some clients are mean and abusive and that is why some of us are on drugs and we drink alcohol” (Clara, 27 years, single, Ekurhuleni).

“Some of these men have raped me and some wanted to take my life before some will just rape and you in a place you don’t know like the bushes and leave you there and you just get very bad treatment from them” (Edith, 25 years, single, Zimbabwe).

“Yes, I have experienced rape, it happened once but after that I tried to, I wanted to go to the police but some lady told me that whenever you to the police and tell them that you were raped and you tell them that you are sex worker, they don’t follow procedures, they just leave your case just like that so I washed it off and went back to work and I never went to the Clinic” (Edith, 25 years, single, Zimbabwe).
“Challenges that we come across as FSWs is that these men they beat us, and they become violent with us because as you know some of them are thieves and murders” (Felicity, 30 years, single, Zimbabwe).

“Some are killed, I am able to voice out my opinions about there are dead into ditches right now and their family don’t know where they are there are people that are forced into drugs they are spite you forced into drugs and you smoke drugs, some into prostitutions, some are even held at gun point” (Jay, 32 years, single, Limpopo).

“Police also when you go report rape will double rape you when you report rape to them, they will tell you the way to get off they will leave you at the high way because you refused to sell to them for free and even leave you there, even the Nurses will go rude, they will say this small child is selling her vagina who are you to judge me” (Jay, 32 years, single, Limpopo).

“Like it’s not a pleasant job it is a dangerous many people do it for different reasons when you are out there someone can get killed it’s not easy, when you are there somebody can just kill you. Another challenge is crooks you do business pay you they come in suit and driving nice car and when you get where you are going tables turn they become something” (Kyra, 20 years, single, Congo).

“My challenges are when we have rape and go to report we are taken serious, rape is rape when you go to police station tell them you have been raped they laugh at you and they say you “magosha”, we are used to that stand rape is rape we get hurt we were not born like this, client will stab you, hurt, we were not born like this, client beat us your life is in the hand of somebody, you can die, the reasons we don’t go to the Clinic is that people are judgmental, Nurses are judgmental” (Kyra, 20 years, single, Congo).
“Hey this job of been sex worker is truly very difficult because you just go there because you don’t go there because you like to do that but because of life challenges for example like me you can see that I am an adult I have five kids of which they need to be maintained so I have been looking for a job for a long time so since it is difficult to get job that is why I just decided to go and do whatever that help to put food on the table for my kids that is whereby I to join this job of been sex worker at least there even though it is difficult I can get something for my family so though is risky because anytime you can get some STIs sometimes some other clients don’t want to give you something anytime you need to know that even if you get there, it’s just a risk anything you need to prepare to accept and admit it” (Mary, 49 years, married, Limpopo).

“This job is difficult for us, the way we doing this job we meet murderers, we meet thieves, sometimes someone will get you in the street and get and have sex with you for free and go and drop you may be you are staying Kempton Park but they go and drop you somewhere, it’s a difficult job, it’s only the Almighty God who is taking care of us, this job is risky, too much, too much” (Mbali, 29 years, single, Zimbabwe).

“The client just had sex with me and dropped me far by the bush by Pomona in the river he took my clothes and I was naked he left me there and said I am full of nonsense (Pinky, 26 years, single, Ekurhuleni).

“It is hard because normally we sleep with man we don’t have feelings for them, it’s very hard and some are very rough the way they have sex with us” (Prim, 28 years, single, Zimbabwe).

“I was new in the industry they were three clients who took me to the bush and park the car under the tree the first client had sex with me I ask for the money he said the money
will come with my other brother the next one come do business when I ask for money he said my next brother will give and when we finish he said lets go and check for my brother they were all gone he said maybe they went to buy drink lets go and check them and they never came back and my heart was sore” (Sexygirl, 31 years, single, Lesotho).

“These men they will pay you, give you what you are asking for, after sex they will demand and say pay back my money sometime holding a knife or at gun point you never know if it is toy gun or having bullet or call his friend or brother and they will do you again and take your money” (Sherai, 39 years, single, Zimbabwe).

“It’s hard because you can meet a client who want to have sex with you without a condom and the person wants to fight with you in this business, so it’s hard” (Zanele, 30 years, single, Zimbabwe).

“To be FSWs is not easy, it’s like weather sometimes bad luck sometimes you get beaten and they will leave you there and some after work they will not pay you the money you agreed on” (Edith, 25 years, single, Zimbabwe).

“We meet different clients they are dangerous men, we put our lives at risk because we cannot find suitable job to be able to fail these bullies, we drink alcohol” (Harriet, 29 years, single, Zimbabwe).

“Well to be a sex worker is risky, the clients that we meet kidnap us, beat us and have sex with us and not pay us” (Kgadi, 20 years, single, Limpopo).
“Challenges that we have are sometimes there are not clients, sometimes when still with the client the cops come and threaten to arrest you and that client and end up having sex with you even take the money the client paid you” (Kgadi, 20 years, single, Limpopo).

“The challenges are that when we sleep with different men, they don’t have feelings for us they just want money” (Prime, 35 years, single, Free State).

“I support what she says that is very true, it sorts of an abuse because when he gives you the money and later say give back the money you don’t have choice but to give back for you own life and use you and you are trying to work for your own family” (Victoria, 30 years, single, Zimbabwe).

“It’s hard to sleep with different men every day, it is not nice and being away from your family, I don’t like it” (Promise, 25 years, single, Limpopo).

4.3.3 Condom use

Data revealed that the FSWs were not consistently using condoms. Some of the participants reported that they did not use condoms as they had pressure from most of their clients who did not want to use condoms and the difficult situations at home whereby they had to put food on the table for their families and pay for the place they stay in. Most of them indicated that they would agree to have sex without condom when they don’t have anything in the house or when the client offers to pay more money.

“Yes, lots of clients who say if offer you R 1000 and you have sex with me without a condom” (Candice, 27 years, single, Zimbabwe).
“Some people are greedy and want to have sex without condom” (Jay, 32 years, single, Limpopo).

“No, they don’t want to use condom” (Joy, 18 years, single, City of Johannesburg).

“If a person say I want private business I will do it without a condom” (Kyra, 20 years, single, Congo).

“To tell you the truth most of the men do not like condom” (Mbali, 29 years, single, Zimbabwe).

“Even the married one they don’t want to use condom” (Monica, 33 years, single, Sedibeng).

“Most of my clients don’t like condoms so I always give them what they want because they come with money and they meet my needs” (Prime, 35 years, single, Free State).

“This lady was doing dog style, I saw the man was not having condom and I said hei you where are the condom this lady said where is the condom you see, and I realized that this guy was not using the condom’ (Rose, 27 years, single, Free State).

“Men don’t want to use condoms, they don’t like” (Talent, 33 years, single, Zimbabwe).
“Like we said before I think it’s because of the amount or someone can come, and I can offer you 1000 and you don’t have anything in the house and you don’t have choice by then you must that time most of the men don’t like condom” (Victoria, 30 years, single, Zimbabwe).

4.3.3.1 Experiences about condom use with difficult clients

Data show that FSWs met some clients who were not cooperative. Some participants indicated that they had difficult clients that did not want to practice safe sex and that when they tried to negotiate condom use, they were beaten.

“Well I’ve had quite a few, because these clients they don’t want to use condoms and if you insist of using condoms they beat you” (Felicity, 30 years, single, Zimbabwe).

“I realized this man who don’t want condom they are angry because they have people who infected them, so they don’t want to die alone so then there is nothing you can do” (Kyra, 20 years, single, Congo).

“They don’t want to use condom, sometimes they beat us” (Mahlatsi, 23 years, single, Ekurhuleni).

“Sometimes even those who are not drunk, those who are not drunk they want to have sex with you with no condom” (Pam, 33 years, single, Zimbabwe).

“Like the ones who do not want to use protection, they are the difficult, you don’t know if they are sick or why does he say or is it because he knows I sleep with different man how
he says he want to have unprotected sex with may be is a date, I don’t know (Pam, 33 years, single, Zimbabwe).

“It’s hard because you can meet a client who want to have sex with you without a condom and the person wants to fight with you in this business, so it’s hard” (Zanele, 30 years, single, Zimbabwe).

“The client can notice that there is no business they turn to be rude and make stupid demands and ask you to have sex in the street right there or telling you stupid things or ask you to do business with you for 30 or 40” (Jay, 32 years, single, Limpopo).

“This client that we come across some of them are very violent like we gamble with our lives basically because this people they treat us in a certain way just so that they can feel dominant and they also want to have sex with us without condoms which is very risky and in exchange they even promise you to give extra cash which they don’t at the end of the day” (Sharon, 21 years, single, Maputo).

4.3.3.2 Negotiating for condom use

Data show that some of the FSWs do try to negotiate condom use and some are not able to negotiate condom use as illustrated in the experts below:

“I always try to negotiate with my clients on condom use” (Jay, 32 years, single, Limpopo).

“I will always negotiate with them, even though it is not easy” (Kgadi, 20 years, single, Limpopo).
“I always try to talk to my clients to use condoms and if I win then we use the condom but if I lose then we go without it” (Prime, 35 years, single, Free State).

“I try but you know at the end of the day I just find myself giving in” (Sharon, 21 years, single, Maputo).

“We try, we do try to negotiate with them to use condom, you get those aggressive one, because as FSWs you don’t get that respect that is supposed to be given to a human being, they become forceful and say I am paying you, so I should be the one that decide whether to use condom or not” (Lettie, 29 years, single, Free State).

“I cannot negotiate because to my understanding what if I am sick and I can’t offer them what they want so I let them do what they want without a condom” (Cindy, 25 years, single, KwaZulu Natal).

“I try to explain to my clients why we should use condom, but others will not buy that, and others will agree to use condom” (Harriet, 29 years, single, Zimbabwe).

“I will always negotiate with them but is it is difficult if they promise extra cash though I will try to explain why we should use condom” (Kgadi, 20 years, single, Limpopo).

“It is a big challenge like sometimes like what we said before that you want money and you can negotiate for condom they can say I don’t feel it I will give you another 100 so you end up doing it because you need that money” (Pam, 33 years, single, Zimbabwe).
“It’s like if you have someone you going to tell please use condom, they don’t want, so people are different, I don’t know how to negotiate” (Talent, 33 years, single, Zimbabwe).

4.3.3.3 Knowledge on how to use a female condom

Data reveals that not all FSWs are able to/know how to use the female condoms. Some FSWs indicated that they tried to read the pamphlets on how to use the female condoms but fail to understand how it is used. Some of them reported that demonstrations were done to explain to them how to use it but that they still did not understand how to use it.

“I don’t know how to use a female condom” (Fortue, 24 years, single, Zimbabwe).

“I don’t know how to use a female condom.” (Marry, 29 years, single, Tshwane).

“No not really, I don’t know how to use a female condom.” (Pamela, 38 years, single, Zimbabwe).

“No, I don’t know how to use the female condom.” (Promise, 25 years, single, Limpopo).

“I didn’t use it because some other people say it will disappear inside you.” (Pam, 33 years, single, Zimbabwe).

“No, I have not used the female condom.” (Talent, 33 years, single, Zimbabwe).
“No, it seems complicated, like what Kgadi said client come in big number and you don’t get time to use them” (Sharon, 21 years, single, Maputo).

“Yes, some of the client will tell you I don’t want condoms you become clever and use the female one you can go to the toilet and put the female condom” (Rose, 27-years, single, Free State).

4.3.4. Risk of contracting HIV as FSWs

Data revealed that the FSWs are at risk of contracting HIV. The participants gave different reasons that expressed the risk of contracting HIV. From the experts below, the reasons included bursting condoms, rape, working when they have STIs, inconsistent condom usage and inability to negotiate condom use.

“Yes, we are at risk as we sleep with people we don’t know if they are positive or negative.” (Marry, 29 years, single, Tshwane).

“I had experienced burst condom.” (Kyra, 20 years, single, Congo).

“Yes, we are at risk.” (Kgadi, 20 years, single, Limpopo).

“To tell you the truth most of the men do not like condom.” (Mbali, 29 years, Zimbabwe).

“Sometime, but sometimes we don’t use them.” (Ndivhu, 27 years, married, Limpopo).
“We are at risk of contracting HIV because some time when you are sleeping, and the client is having sex with you without condom.” (Phesy, 28 years, single, Limpopo).

“Yes, I’d say that every sex worker is at risk of contracting HIV because the clients come in numbers and they are different every day, so we don’t know whether they’ve been to other places with other FSWs who have the sickness and then they come to us, they don’t use condom.” (Sharon, 21 years, single, Maputo).

“Most of our clients in most cases they don’t like to use condom because they say they can’t eat sweet which is covered.” (Mary, 49 years, married, Limpopo).

“Our lives are always at risk because we meet different people of which some of them they are HIV positive and they don’t use condom.” (Mary, 49 years, married, Limpopo).

Majority of my clients don’t like condoms, so I always give them what they want because they come with money and they meet my needs.” (Prime, 35 years, single, Free State).

“Yes sister, too much, we are at risk like when you fight with client and there is too much blood and you touch blood when you have a cut, like when you fight with client and you have a cut.” (Rose, 27 years, single, Free State).

4.3.4.1 Bursting condoms

Data shows that the FSWs had experiences with bursting condoms of clients, which put them at risk of contracting HIV and STIs. Some participants indicated that they had experiences with bursting condoms as some clients were rough when having sex.
“I had experienced burst condom, I felt tension, I was stressed.” (Kyra, 20 years, single, Congo).

“These condoms that break, they burst.” (Promise, 25 years, single, Limpopo).

“A number of times, a number of times. They do burst.” (Lettie, 29 years, single, Free State).

“Sometimes you have a bursting condom in this work.” (Pam, 33 years, single, Zimbabwe).

“Sometimes you have a bursting condom, we do.” (Sherai, 39 years, single, Zimbabwe).

“The condom bursts and he didn’t tell me about his status then I am at risk.” (Cindy, 25 years, single, Kwazulu Natal).

“Yes, I experienced a bursting condom when I was using the blue condom.” (Fortue, 24 years, single, Zimbabwe).

“Yes, I had a bursting condom once and I went to Clinic for treatment.” (Mbali, 29 years, Zimbabwe).

“Yes, I have always experienced that because the clients are rough and after experiencing the bursting condom I went to the Clinic.” (Prime, 35 years, single and from Free State)
4.3.4.2 Inability to negotiate condom use

Data shows that the FSWs are not able to negotiate condom use for different reasons. Some of the FSWs expressed that they are not able to negotiate condom use as some of their clients will beat them when they try to negotiate; some forget to negotiate as they are forever under drug or alcohol influence - which they use to numb pain of what they experience in the work while some participants fail to negotiate condom use as the clients will offer to pay them more money.

“I cannot negotiate because to my understanding what if I am sick and I can’t offer them what they want so I let them do what they want without a condom.” (Cindy, 25 years, single, KwaZulu Natal).

“I try to explain to them more why we should use condom, but others will not buy that.” (Harriet, 29 years, single, Zimbabwe).

“It is difficult to negotiate condom use with our clients in our work.” (Marry, 29 years, single, Tshwane).

“No, I can’t negotiate condom use because the clients pay more money and that is what we need.” (Reya, 29 years, single, Tshwane).

“Experienced when I was working in Zambia, they give us female condom and they say put it for four hours and it take your body temperature so if a man say I want unprotected sex you don’t have to wait you said ok because you are already having the female condom, but now here it’s one man after the other so that thing won’t work.” (Sherai, 39 years, single, Zimbabwe).

“I don’t know how to negotiate.” (Talent, 33 years, single, Zimbabwe).
“Majority of my clients don't like condoms, so I always give them what they want because they come with money and they meet my needs.” (Prime, 35 years, single, Free State).

“It is a big challenge like sometimes like what we said before that you want money and you can negotiate for condom they can say I don't feel it I will give you another 100 so you end up doing it because you need that money.” (Pam, 33 years, single, Zimbabwe).

“These clients promise us extra cash just so that they don't use condom especially if you have financial problems you just end up giving in just to make that extra money.” (Sharon, 21 years, single, Maputo).

“No, I don't know how to negotiate condom use as clients never listen, never.” (Tebogo, 22 years, single, Ekurhuleni).

“We try, we do try to negotiate with them to use condom, you get those aggressive one, because as FSWs you don't get that respect that is supposed to be given to a human being, they become forceful and say I am paying you, so I should be the one that decide whether to use condom or not” (Lettie, 29 years, single, Free State).

4.3.4.3 Inconsistent condom use

Data shows inconsistent condom use among the FSWs. Some of the participants indicated that they would prefer to consistently practice safe sex but the different kind of clients that they meet, make it difficult to use condoms consistently as some literally don't agree to use condoms. Even when they try to negotiate condom use and they will do as their clients wants, e.g. to have sex without a condom as they are afraid of losing money. Some expressed that when they are high on drugs and that they forget to use condoms.

“Sometime, but sometimes we don't use them.” (Pam, 33 years, single, Zimbabwe).
“Our lives are always at risk because we meet different people of which some of them they are HIV positive and they don’t use condom.” (Mary, 49 years, married, Limpopo).

“The other want to use condoms and others do not want to use condoms, so that is the problem.” (Pamela, 38 years, single, Zimbabwe).

“We don’t always use condoms, when I am drunk or high on drugs I forget to use it.” (Clara, 27 years, single, Ekurhuleni).

“You will be lucky if they sleep with your condom and be unfortunate sleep with you without condoms.” (Jay, 32 years, single, Limpopo).

“Well it depends, we would like to use condoms all the time but sometimes you find a client who does not want to use a condom and by saying no I lose money, sometimes we do and sometimes we don’t.” (Lettie, 29 years, single, Free State).

“Yes, it depends with the customer if they want to use it or not.” (Marry, 29 years, single, Tshwane).

“Well, most of my clients do not agree to use condom although I try to convince them to use condom so that we might not catch the disease, but they still disagree in most cases.” (Edith, 25 years, single, Zimbabwe).

“Sometimes we use condom but if the client offers to pay extra cash we do business without condom.” (Kgadi, 20 years, single, Limpopo).
“Majority of my clients don’t like condoms, so I always give them what they want because they come with money and they meet my needs.” (Prime, 35 years, single, Free State).

4.3.4.4 Experiences on rape

Data revealed that there are FSWs who experienced rape in their line of duty. Some of the participants indicated that they experienced rape from their clients and one had a child from the rape.

“I also got raped.” (Sherai, 39 years, single, Zimbabwe).

“Yes, twice first I have a child from, but the child does not know anything even if you get it from the client, the blessing sometimes you just keep the baby.” (Pam, 33 years, single, Zimbabwe).

“Yes, I have encountered rape in this job.” (Felicity, 30 years, single, Zimbabwe).

“Yes, I was raped at work, but I washed off.” (Harriet, 29 years, single, Zimbabwe).

“Yes, I had experienced rape.” (Jay, 32 years, single, Limpopo).

“I have been raped several times by my clients.” (Kyra, 20 years, single, Congo).

“Yes, I did experience rape and I went to the Clinic after to get treatment.” (Clara, 27 years, single, Ekurhuleni).

“Yes, I have experienced rape, it happened once but after that I tried to, I wanted to go to the police but some lady told me that whenever you to the police and tell them that you were raped and you tell them that you are sex worker, they don’t follow procedures, they just leave your case just like that so I washed it off and went back to work and I never
went to the Clinic” (Edith, 25 years, single, Zimbabwe).

4.3.4.5 Working when having STIs

Data shows that some of the participants work even when they are having STIs, because they need money to survive.

“Sometimes we do our work may be because we don’t have money that time when we have the signs of STI.” (Candice, 27 years, single, Zimbabwe).

“Sometimes we work when we have STIs because of circumstances that we find ourselves facing.” (Cindy, 25 years, single, KwaZulu Natal).

“Yes, we do work. You snooze you lose money.” (Kgadi, 20 years, single, Limpopo).

“Yes, I do work as we need money.” (Kyra, 20 years, single, Congo).

“Yes, because we need money, if we don’t go to work then how will we not survive?” (Mary, 49 years, married, Limpopo).

“Yes, we come because we need to survive.” (Pam, 33 years, single, Zimbabwe).

“I work every day even if I have STIs.” (Pamela, 38 years, single, Zimbabwe).

“Yes, because if don’t go to work I have kid to survive and if I don’t go to work they must go to school.” (Sherai, 39 years, single, Zimbabwe).
“Every day if I have tablet to drink I take them and continue doing my work.” (Talent, 33 years, single, Zimbabwe).

“Yes, I must work otherwise who will pay my bills, I need that money.” (Victoria, 30 years, single, Zimbabwe).

4.3.4.6 Reported sex work and episodes of STIs, menstruation and pregnancy

Data revealed that FSWs continue working even if they have STIs, when they menstruate and when they are pregnant as for them it is the only way to earn for a living.

“I come like when it is month end money is going even when menstruating.” (Candice, 27 years, single, Zimbabwe).

“Sometimes we work when menstruating.” (Cindy, 25 years, single, KwaZulu Natal).

“Every day when I have sexually transmitted infection and if I have tablet to drink I take them.” (Talent, 33 years, single, Zimbabwe).

“Yes, I must even if I have sexually transmitted infection.” (Victoria, 30 years, single, Zimbabwe).

“No, I do work even when menstruating.” (Harriet, 29 years, single, Zimbabwe).
“Yes, I work when menstruating because if there is no money there is no food for my kids and yes, I have been pregnant and that added one person to my family.” (Kgadi, 20 years, single, Limpopo).

“Yes, I work when having sexually transmitted infections because if don’t go to work I have kid to survive and if I don’t go to work they must go to school.” (Sherai, 39 years, single, Zimbabwe).

4.3.5. Disclosure about sex work to the significant others
In the discussions below, disclosure to significant others will be discussed.

4.3.5.1 Disclosure to partner about your sex work

Data showed that FSWs had difficulty in disclosing the type of work they are doing. Some of the participants indicated that their partners, family members and friends know about their sex work. Some of them expressed how their significant others feel about their sex work, e.g. reactions such as some are not talking to them or that they are undergoing divorce. Some indicated that they met their partners at work as FSWs.

“He knows as we met here he started as a client.” (Candice, 27 years, single, Zimbabwe).

“My partner knows that I am sex worker, it was not easy to tell him right now we are in the procedure of divorce and my aunt found out that I am a sex worker and we not talking to each other right now because she was disgusted she doesn’t like people who are FSWs so she kept it to herself and the rest of my family don’t know.” (Kgadi, 20 years, single, Limpopo).
“Me yes he knows he found me there, we even now we stay together, when I come he say I will find you there and my sister know, I told her you see I am your baby this as I am a work I am a sex worker and that I buy Nike and everything, she say no problem even if anything happen to me she will know what happened to me, even if I become sick.” (Phesy, 28 years, single, Limpopo).

4.3.5.2 Disclosure to family and friends about your sex work

Participants reported that it is hard for them to disclose to their family and friends as they will judge them.

“My one sister knows, even if they know I don’t mind, my sister knows even if she tells them I don’t mind.” (Prim, 28 years, single, Zimbabwe).

“Yes, they know, and they just encourage me to make money and send them at home as we are suffering back at home.” (Reya, 29 years, single, Tshwane).

“My family are Christian and my ex-boyfriend told them that I am a sex worker in South Africa, so he go home and told my brother and them know that I am a teacher so my boyfriend he took my pictures in my shorts, so they are suspecting, so me I said it was a party and they say party in the bar, I say yes it was a baby shower for my friend, for me to tell my family is difficult.” (Mbali, 29 years, single, Zimbabwe).

“Well one of my friends knows that I am a sex worker and as for the rest of the family they just know me as a woman who has nice job in Johannesburg.” (Edith, 25 years, single, Zimbabwe).
4.3.6 Health seeking behavior

Data revealed that the FSWs make use of the Health Care Facilities when they are ill. Some even mentioned that they use Health Care Facilities when they want to be checked if they have not contracted any diseases.

“I had a bladder infection, so I had to go check it out at Spartan Clinic.” (Cindy, 25 years, single, KwaZulu Natal).

“I go to the Clinic to check if I haven’t contracted any of the disease.” (Edith, 25 years, single, Zimbabwe).

“I go to the Clinic to check for my health.” (Mbali, 29 years, single, Zimbabwe).

“I go to the Clinic when I feel abdominal pains when I am having sex.” (Pinky, 26 years, single, Ekurhuleni).

4.3.6.1 Reasons for choosing the health facility

Data shows that FSWs make use of the Health Care Services when they are ill. Some of the participants expressed the reasons why they chose those Health Care Facilities that they used when ill or when they need a health checkup.

“I choose the South Rand hospital because they don’t judge us.” (Jay, 32 years, single, Limpopo).

“I prefer to use the chemist because they don’t judge us.” (Kyra, 20 years, single, Congo).
“I use the Clinic because it is free.” (Lettie, 29 years, single, Free State).

“I use Kempton Park Civic because even if they know of your work they treat us nicely.” (Phesy, 28 years, single, Limpopo).

“I use the mobile service that come to the Centre for Positive Care and Pomona Clinic as they are very good to use, the Nurses who work there understand us.” (Mbali, 29 years, single, Zimbabwe).

4.3.6.2 When having STI do you feel comfortable to tell the Health Care Worker?

Data shows that the FSWs were not comfortable to tell the Health Care Workers that they have STIs. Some indicated that it was difficult as they were afraid about how the Health Care Workers will react and some of them experienced negative attitudes such as rudeness and being judgmental towards them. Some indicated that they would change their story instead of telling them that they have STIs they will say they have headache.

“There are these people that are very rude they will say such a small child, especially Yeoville and Rossetenville and its their men who make us sick maybe their wife are having those STIs.” (Jay, 32 years, single, Limpopo).

“Eish! Sometimes it is not easy to tell the Health Worker that you have STI.” (Kgadi, 20 years, single, Limpopo).
“In the Clinic, there are people that will make you to change what you want to tell them, like when you have a discharge.” (Kyra, 20 years, single, Congo).

“No, it is not easy to tell Health Workers that you have STIs.” (Marry, 29 years, single, Tshwane).

“Sometimes it is difficult to tell them knowing that you are a sex worker, because they will judge you.” (Ndichu, 27 years, married, Limpopo).

“No, we are not free because it is difficult when you do this type of job because it’s like they don’t treat us like others.” (Pam, 33 years, single, Zimbabwe).

“We are not free because those people are different, sometimes you find that this person is free you are free and the other one is not you are also not free and end up saying the headache when I know it is not the headache I am afraid to say I am not feeling well.” (Pamela, 38 years, single, Zimbabwe).

“Especially if you are taking ARVs they will say this is the last time I attend to you if you come again with the same problem I will not attend to you.” (Sherai, 39 years, single, Zimbabwe).

“Sometimes you end up scared to talk your problem because they say you have problem you have so many diseases like disease because you don’t use condoms and at the same time it is a condom that burst you end up saying this end up like shouting you end up saying let me say anything.” (Victoria, 30 years, single, Zimbabwe).
4.3.6.3 Lack of access to the Health Care Services

Data shows lack of access to Health Care Services to the FSWs. A participant indicated that when they arrive late or in the afternoon in the Health Care Facilities they are turned back and asked to come early.

“As we mostly work during the night, they want us to come early to the Clinic and the morning we are still sleeping or resting so when we arrive late to the Clinic they turn us away.” (Mahlatsi, 23 years, single, Ekurhuleni).

4.3.6.4 Lack of access to the Health Care Services due to long queues in the Health Care Facilities

Data show that FSWs find it difficult to access Health Care Services. Some of the participants indicated that queues in the Health Care Facilities discourage them using the Health Care Facilities as according to them they will lose clients waiting in the long queues.

“The queue makes me not to use, as we don’t have time to wait.” (Kyra, 20 years, single, Congo).

“The queue is too much, and we can’t wait.” (Sexygirl, 312 years, single, Lesotho).

4.3.6.5 How can Health Care Services be of help to you?

Some participants expressed that the Health Care Services can be of help to them if only the Health Care Workers can understand them as FSWs; treat them well like other general population; not judge them; stop being rude and treat them with respect. Some
even suggested that there be peer educators in Health Care Facilities who will make them feel accepted and understand them.

“They should start respecting us and treat equally like other people because this job we are doing is part of making a living it’s not because we like them.” (Cindy, 25 years, single, KwaZulu Natal).

“I’d say that we totally deserve all the respect that they give to everyone else.” (Edith, 25 years, single, Zimbabwe).

“I would suggest that they get CPC educators to be part of the staff as you know many of them understand us.” (Felicity, 30 years, single, Zimbabwe).

“I think first and foremost not to judge us because you don’t understand the reasons why we do what we do and if you judge it makes the whole thing harder because if I had choice I would not be doing this job, but because I don’t have a choice, it would be better if health practitioners are supportive and not judgmental.” (Lettie, 29 years, single; Free State).

“They should be understanding at all times.” (Prime, 35 years, single, Free State).

“The Clinics can be of help to us if they can give us respect and treat us like other people.” (Harriet, 29 years, single, Zimbabwe).

“The Health Care Workers need to have patience, let them not do their job for the money but for the love of their job.” (Jay, 32 years, single, Limpopo).
“They must give us respect and treat us like decent people not because we are FSWs but because we are all humans, so we must work with each other.” (Kgadi, 20 years, single, Limpopo).

“The problem with Health Workers is that they judge us, so they should not judge us, instead of judging let them sit me down and talk to me as I know the result of what I am doing are not good.” (Kyra, 20 years, single, Congo).

“If they put themselves in our position and understand that we are doing this for fun, we are doing this because we must put food on the table, we have children at home, we do this to sustain our lives and they can start treating us equally like other people that come to their Clinics and not judging us and try to understand why we are doing what we are doing.” (Lettie, 29 years, single, Free State).

“They need to give us the good attitude and respect and when we do things wrong they mustn’t be afraid to guide us because truly speaking this job is risky and at the end of the day it affects our lives so, as the Health Workers in our Clinics I’d like to encourage them to give us more advises, they mustn’t be afraid to give us advice and think we going to fight them, they must do the right thing and be able to help us save our lives.” (Mary, 49 years, married, Limpopo).

“They must accept us the way we are, we expect respect from them, they must give us those services wholeheartedly without judging us and anything we discuss with them should be kept a secret because some of their attitudes makes not to trust them and we end up not even telling them because of lack of confidentiality. We are all humans so, we should be respected.” (Mary, 49 years, married, Limpopo).
“What I’d like you to tell them is that, you know as humans we shouldn’t judge each other and judge the decisions that we make because only we know why we do what we do and they don’t have the right to say, “You do this and that…” because at the end of the day we are all humans and we make mistakes.” (Sharon, 21 years, single, Maputo).

4.3.7 Barriers to accessing Health Care Services

Data revealed that the FSWs are not able to access Health Care Services for different reasons as observed from the Health Care Workers. Some of the participants expressed bad treatment from the Health Care Workers e.g. taking the liberty of them to access the Health Care Facilities freely. Attitudes such as rudeness, judgment, lack of respect, discrimination, stigmatization, criticisms and lack of patience by the Health Care Workers were observed.

“They ill-treat us, and they don’t show respect.” (Cindy, 25 years, single, KwaZulu Natal).

“The bad treatment that they give to us.” (Edith, 25 years, single, Zimbabwe).

“I wouldn’t go there because they don’t give us respect.” (Harriet, 29 years, single, Zimbabwe).

“The only reason why I would not go to the Clinic is because they discriminate us just because we don’t have decent jobs like them, they look at us with disgust, they don’t respect us.” (Kgadi, 20 years, single, Limpopo).

“The reasons we don’t go to the Clinic is that people are judgmental.” (Kyra, 20 years, single, Congo).
“Some of them they treat us like we just go because you are sick, so it is bad, very bad.” (Victoria, 30 years, single, Zimbabwe).

“If they have a negative attitude towards us, I don’t think I’ll go there anymore, I’d rather go look for a new facility, if they don’t treat me with respect.” (Zain, 34 years, married, Tshwane).

4.3.7.1 Attitudes of Health Care Workers

Data revealed that FSWs experienced different kinds attitudes from the HCWs.

4.3.7.1.1 Rudeness of the HCWs

Data show that there are Health Care Workers who are rude to the FSWs. Some participants indicated that the Nurses are rude to them when they hear that they are the FSWs.

“Even the Nurses will go rude to us.” (Jay, 32 years, single, Limpopo).

“Nurses are rude to the patients.” (Ndivhu, 27 years, single, Free State).

“I wouldn’t go there if they are judgmental and rude.” (Prime, 35 years, single, Free State).

4.3.7.1.2 Impatience of the HCWs

Some participants indicated that Health Care Workers were impatient to them.
“Impatience by the Health Care Workers towards their patients.” (Jay, 32 years, single, Limpopo).

“Patience, the Nurses are not patient with us.” (Sexygirl, 31 years, single, Lesotho).

4.3.7.1.3 Lack of respect by HCWs

Data shows that Health Care Workers did not treat FSWs with respect as expected from the Constitution and ethics. Some participants indicated that the Health Care Workers did not treat them with respect.

“They don’t show respect at all on us.” (Cindy, 25 years, single, Kwazulu Natal).

“They don’t give us respect, as we deserve to be respected.” (Harriet, 29 years, single, Zimbabwe).

“They don’t respect us like they do to other people that come to the Clinics and hospital.” (Kgadi, 20 years, single, Limpopo).

“They don’t show us respect to us like they do to the others.” (Mary, 49 years, married, Limpopo).
4.3.7.1.4 Stigmatization by the HCWs

Data shows that the Health Care Workers stigmatize the FSWs. Some participants indicated that the Health Care Workers will call you names that make you feel shameful and disgraced.

“When a Nurse will call you in front of other people, because you will find Nurses who are like that who will say of others that are sex worker and you come with illnesses.” (Lettie, 29 years, single, Free State).

“They don’t treat us like human being they treat us, it’s like dirty thing.” (Pam, 33 years single, Zimbabwe).

“They don’t treat us equally like other people because of this job that we are doing.” (Cindy, 25 years, single, KwaZulu Natal).

“They don’t treat equally like other people because of this job we are doing.” (Kgadi, 20 years, single, Limpopo).

“They become cold, you know suddenly just switch, but there will one who when you say you are a sex worker they will give you encouraging words, most of the people just switch and become mean people and not willing to help out unlike when they did not know that I am a sex worker.” (Lettie, 29 years, single, Free State).
“They are not looking well at us, you can see when then stand, you feel they are discussing you.” (Mahlatsi, 23 years, single, Ekurhuleni).

“Their attitude is sometimes negative, their facial expressions; they nod their head, shoulders, so they undermine us, they are disgusted by the work we are doing.” (Mary, 49 years, married, Limpopo).

“Eish! as I have said that they judge us when I think of going there and that those women are going to gossip hei!” (Reya, 29 years, single, Tshwane).

“Their look, you’ll find them looking you with the corner of their eyes.” (Sharon, 21 years, single, Maputo).

4.3.7.1.5 Judgmental by the HCWs

Data shows that Health Care Workers judges the FSWs when they come to the Health Care Facilities. Some participants indicated that they were judged by the Health Care Workers and that made them feel that they cannot freely to access the Health Care Services.

“They judge us when they hear that we are FSWs.” (Clara, 27 years, single, Ekurhuleni).

“Nurses are judgmental, even they don’t know why we are doing this job,” (Kyra, 20 years, single, Congo).
“They will judge you because you are a sex worker.” (Ndivhu, 27 years, married, Limpopo).

“I wouldn’t go there if they are judgmental and rude.” (Prime, 35 years, single, Free State).

“They judge us even they don’t know us.” (Reya, 29 years, single, Tshwane).

“They look at us with disgust, they put that disgusted face.” (Kgadi, 20 years, single, Limpopo).

“Tell them that when they started studying for Nursing they were doing that out of love, but now they have changed, they know that their work is to help people, so they should not judge people now.” (Mahlatsi, 23 years, single, Ekurhuleni).

“We don’t feel comfortable because it’s like they are judging us.” (Pam, 33 years, single, Zimbabwe).

4.3.7.1.6 Criticism by the HCWs

Data shows that FSWs are been criticized by the Health Care Workers. Some participants indicated that the Health Care Workers criticize them because of the kind of work they do.

“They will criticize you because you are a sex worker.” (Marry, 29 years, single, Tshwane).
“When they criticize us, it becomes a problem because we did not just choose to be FSWs, but the circumstances have made us to find ourselves there.” (Mary, 49 years, married, Limpopo).

4.3.7.1.7 Discrimination by the HCWs

Data reveals that FSWs are still experiencing discrimination from the Health Care Workers. Some participants indicated that they are not treated like the other general population that visit the Health Care Facilities.

“The Health Care Workers discriminate us.” (Kgadi, 20 years, single, Limpopo).

“We have a problem when they discriminate us, when they don’t treat us like other people.” (Mary, 49 years, married, Limpopo).

“The Health Care Workers don’t treat us like human being they treat us, it’s like dirty thing, they don’t treat us like others.” (Pam, 33 years, single, Zimbabwe).

“Health Care Workers don’t treat us equally like other people because of this job we are doing.” (Cindy, 25 years, single, KwaZulu Natal).

4.3.8 Challenges about HIV prevention among the FSWs

Data revealed that FSWs have problems related to HIV prevention. Some of the participants indicated that they are not yet on ARVs and some who were on ARVs from their place of origin have not continued with treatment when they arrived in Ekurhuleni.
Some have indicated that they have trouble with (consistent) condom use as their clients do not want to use condoms. Few participants that tested HIV negative are on Prep.

“Positive and I am not yet on ARVs.” (Cindy, 25 years, single, KwaZulu Natal).

“I try most of the time sometimes I have to lose a client as some don’t want to use a condom, as FSWs we know of the guy who don’t want to use condoms and we know that it is a risk to sleep with certain people, I try to beg a client to use a condom.” (Lettie, 29 years, single, Free State).

“From Zimbabwe, I want to start here.” (Pamela, 38 years, single, Zimbabwe).

“Well, I wouldn’t say I am using a specific pill, but I try to keep healthy.” (Sharon, 21 years, single, Maputo).

“I haven’t started.” (Victoria, 30 years, single, Zimbabwe).

“I use condom.” (Marry, 29 years, single, Tshwane).

“I make sure that I use condom.” (Ndivhu, 27 years, married, Limpopo).

“I’m using female condom.” (Prime, 35 years, single, Free State).
4.3.9 Special needs of the FSWs as the vulnerable community

Data revealed that the FSWs have certain needs that need assistance from the multidisciplinary team like Health Care Workers, Social Workers, Psychologists, Police and other Rehabilitation teams.

Some of the participants indicated that when they need help from the Police like when they are raped, the Police will mistreat them by either raping them again, laugh at them and not follow the policy on how they are to handle rape cases.

Some also indicated that Health Care Workers are judgmental to them instead of been open so that they can express their feelings about their kind of work and to refer them to the relevant stakeholders such as Social workers, Psychologists etc., so that they can get the help that they need.

Some indicated that if they raise funds from their work they will go back to school and finish their studies to be able to get better jobs.

Some indicated that they need rehabilitation services as they are now drug addicts, some are too young to be in this kind of industry and that clients will take advantage of them and force them to do use alcohol and drugs, not using condoms which can lead to STIs and HIV.

“I’m still studying, I want to go back to school so I can get a better job.” (Cindy, 25 years, single, KwaZulu Natal).
“Yes, I have experienced rape, it happened once but after that I tried to, I wanted to go to the police but some lady told me that whenever you to the police and tell them that you were raped and you tell them that you are sex worker, they don’t follow procedures, they just leave your case just like that so I washed it off and went back to work and I never went to the Clinic” (Edith, 25 years, single, Zimbabwe).

“Police also when you go report rape will double rape you when you report rape to them, they will tell you the way to get off they will leave you at the high way because you refused to sell to them for free and even leave you there, even the Nurses will go rude, they will say this small child is selling her vagina who are you to judge me, don’t tell me you have been raped maybe your child is raped in your house.” (Jay, 32 years, single, Limpopo).

“The NGOs as government people need to help, they need to have programs that will assist to earn money that we earn here.” (Jay, 32 years, single, Limpopo).

“My dream was to be business woman, but I use to like boys and men at a very young age that got me pregnant and I couldn’t finish school and now I had no choice but to be a sex worker.” (Kgadi, 20 years, single, Limpopo).

“We need help.” (Kyra, 20 years, single, Congo).

“I have realized I don’t have qualifications most of the places they want people with qualification, so it is difficult to get the right job.” (Mahlatsi, 23 years, single, Ekurhuleni).

“Next year is the last year for me by December I will be finished with my house and I will be saving for opening shebeen.” (Sexygirl, 39 years, single, Zimbabwe).
“The NGOs as government people need to help, they need to have programs that will assist to earn money that we earn here.” (Jay, 32 years, single, Limpopo).

“I don’t want to leave because I am making money unless I try to do something like I am building house and when I a rich.” (Fortue, 24 years, single, Zimbabwe).

“She is too shy, you can see, she is a small girl, she is not supposed to be here, that are also the challenges that need the government should be intervening to help young girls like her help her for her to go to back to school maybe to a rehabilitation center, help her to connect to her family may be she is even scared to go back home maybe she left home going to buy bread till today she is scared maybe if someone can talk to her to go home ask her personally so help her and don’t judge give her time give her love she need motherly love may be the Social Workers can be also of help you can see that there is a lot written from her face but she cannot mouth it.” (Jay, 32 years, single, Limpopo).

“My challenges are when we have rape and go to report we are taken serious, rape is rape when you go to police station tell them you have been raped they laugh at you and they say you “makgosha”, we are used to that stand rape is rape we get hurt we were not born like this, client will stab you, hurt, we were not born like this, client beat us your life is in the hand of somebody, you can die, the reasons we don’t go to the Clinic is that people are judgmental, Nurses are judgmental.” (Kyra, 20 years, single, Congo).

4.10 Conclusions

In this Chapter the participant’s demography, level of education, their place where they operate, and their place of origin are provided and discussed. The information on the challenges they are facing with the kind of services have been indicated, e.g. being forced not to use condoms by clients; being raped and not being paid by clients. The FSWs lack
support from their families, communities and South African Police services. The stigma, discrimination make them to suffer under Heath Care Service Providers when they seek STI related health care. They have also expressed their powerlessness when they negotiate condom use with clients.

In this study, the FSW finds themselves practicing unsafe sex due to pressure and treatment they have from their clients as some will offer to pay them more whilst not using condoms; some clients would rape them and sometimes they would have bursting condoms to deal with alone. All these will result in FSWs contracting STIs including HIV. The attitudes of the Health Care Workers and operating times of the Health Care Services cause the FSWs not to freely access the Health Care Services. The FSWs find it difficult to disclose the nature of their work to the Health Care Workers and to their significant others like their partners, families and friends.
CHAPTER 5: INTERPRETATION AND DISCUSSION OF THE RESULTS

5.1 Introduction

The aim of this study is to explore the sexual practices and health seeking behavior about STIs among the FSWs, with the intentions to explore the sexual practices of the FSWs, their health seeking behavior and discovers barriers to accessing health services as perceived by the FSWs. In this Chapter, the above-mentioned objective results are discussed in detail and subsequently compare and refer to other similar studies done on FSWs in different areas of the world. The limitation of the study, the recommendations and the conclusions are also discussed.

5.2 Discussion

This chapter focus on interpreting the findings of the study using themes that were identified in chapter 4.

5.2.1 Becoming a sex worker

In this study it became evident that FSWs joined the sex work industry because they could not find a job and like any other people have the need to provide for their families.

A study that was conducted in Hill brow, Johannesburg, indicated that an estimated 60% of FSWs are from other countries and migrate from rural areas and other cities within South Africa (Brown et al., 2012).

In line with this study, a study conducted in Nepal, FSWs’ low socio-economic and education status are the contributing factors for those women to join the sex work industry so that they can provide for their families. This was very important, as breadwinners, to them (Ghimire et al., 2011).
Similar studies that were done have reported that most of the women that participate in sex work have a low level of education and are foreigners in a country and without a national citizenship. In line with this study, a study conducted in Nigeria reported that many of FSWs in that country comes from disadvantaged backgrounds and had low or no formal education hence they have problems such as securing their jobs that required specific skills (Lawan et al., 2012).

Generally, women are considered as people who are less educated from many households in the world, especially from poor families (WHO, 2011). When parents cannot afford to take all their children to school, boys are the once who are encouraged to continue with their studies while girls are prevented from furthering their studies. Girls are often kept out of school to take care of domestic duties at home. Lack of education and skills influences women's and girls’ HIV/AIDS risk because of their economic dependency on male partners (WHO, 2011).

Many of these FSWs come from disadvantaged family backgrounds and are poorly educated hence they cannot get proper employment (Lawan et al., 2012). A study in sub-Saharan Africa found that FSWs work hard to meet basic needs of life and get themselves involved in risky behaviors, such as becoming commercial FSWs, all but to provide for their families' needs (Phrasisombath, 2012). A study that was conducted in China also confirmed that unemployment from the African, Uganda women played a role in these women becoming FSWs for their survival (Davis et al., 2016).

According to a study conducted by Media trice, sex work is the primary source of income for the FSWs because their parent’s inability to not able to provide for their basic needs (Media trice, 2012).

In a study that was conducted in Mumbai and China women joined the sex work industry to pay their debt, school fees for sibling and support family (Sharma et al., 2016).
5.2.2 Experiences of been a sex worker

The FSWs in this study have experienced different kinds of violence and abuse by their clients such as been raped, beaten and some of their clients and police taking their money that they have worked for.

In line to this study the FSWs in Nepal face stigma and discrimination, and a high level of violence at work from their clients who will force them to practice unsafe sex. It has also been reported that violence and stigma are higher in FSWs, compared to women in the general population (Ghimire et al., 2011).

The FSWs from Andhra Pradesh reported that they experienced violence in their work such as been beaten or physically forced by their clients to have sexual intercourse against their will (Ramesh et al., 2012).

FSWs from Kenya and South Africa also experienced sexual and/or physical violence by an emotional partner who will physically force them to have sex out of their will (Ritcher M, 2013).

In Argentina the FSWs have experienced a high frequency of different violent experiences. Violent situations force the FSWs to prioritize their security over attempts to negotiate condom use with their clients (Pando et al., 2013).

According that was conducted by Goldenberg et al, (2014) the FSWs in this study reported high levels of workplace violence and barriers to condom negotiation (Goldenberg et al, 2014).
According to the studies that were conducted in India, Kenya, Mozambique and South Africa FSWs have reported violence which includes sexual violence by their clients (Lafort et al., 2017).

5.2.3 Condom usage among the FSWs

Female sex worker finds themselves practicing unsafe sex due to pressure and treatment they receive from their clients. Some will offer to pay them more money and not use condoms; some clients would rape them and sometimes they would have to deal with bursting condoms resulting in FSWs contracting STIs including HIV/AIDS. The participants expressed that they meet different clients that treat them in different ways such as beating them, doing business with them and not paying them, unknowingly meeting up with rapists, thieves and murderers. This is because some of them are on drugs and alcohol, to numb the pain they are going through. When they have such encounters and report the rape, Police rather rape them instead of assisting them.

FSWs from Nepal still find themselves practicing unsafe sex with clients that demand condom less sex as the clients believe condom usage reduce their sexual pleasure. Some are also forced to inconsistent condom use as they are offered more money for not using a condom. Some of the FSWs want to use condoms but their inability to negotiate condom use with regular and irregular clients and partners exposes them to STIs that include HIV (Ghimire et al., 2011).

The findings of this study indicate that the FSWs put their health at risk by contracting STIs including HIV via engaging into sexual intercourse with multiple sexual partners – the majority of these do not want to use condoms and offer to pay more money for sex without a condom. Some of the FSWs reported their inconsistent condom use explaining that their lives depend on their clients who make them be able to purchase food for their families; save money for their future studies and to build their own houses.
The low socioeconomic status of the FSWs has made them willing to offer their services to a client by not using a condom, even if they know that are putting their lives at risk of contracting STIs including HIV. Some FSWs reported that bursting condoms, inconsistent condom use, inability to negotiate condom use, working when menstruating, rape, working when having STIs and when being pregnant expose them to the risk of contracting STIs including HIV.

In line with this study, a study that was conducted in Cape Town, reported they had inconsistent condom usage (due to financial incentives), condom breakage, violence, rape and non-payment from clients when insisting on condom usage. Some respondents reported that no condoms were used at all (Media trice, 2012). In South Africa about 8% of FSWs had unprotected sex. FSWs in the Sandton, Rustenburg and Cape Town sites had unprotected sex while those in Hillbrow had protected sex (Richter, 2013). In Durban, South Africa, a similar study revealed that financial problems among the FSWs caused them to engage in high risk sexual relations by not using condoms to survive and that their acts of unsafe sex practices were a strategy to improve their socioeconomic wellbeing. In a study conducted in Kenya and South Africa it was reported that the FSWs also practiced unprotected sex (Richter, 2013).

A study conducted by Nyamu (2013) in Nairobi and a study conducted in Kenya showed that other reasons for not using condoms was that they had misconceptions of them believing that their boyfriends and healthy-looking clients do not have STIs and so cannot spread STIs and HIV. Another study carried out in Nairobi, investigating the associations of sexual risk taking among Kenyan FSWs after enrollment in an HIV-1 prevention trial, revealed that FSWs lack the skill to be able to negotiate safer sex and are at a higher risk for HIV-1 infection and STIs (Nyamu, 2013).

According to a study that was conducted in Burkina Faso FSWs practiced unsafe sex practices that increased the likelihood of HIV transmission. Some of the FSWs reported condom breakages during sexual intercourse and history of previous pregnancies were
associated with the risk of contracting HIV infection among FSWs (Ouedraogo et al., 2017).

In a study conducted in Nigeria it was found that most of the FSWs are aware that unprotected sexual intercourse and multiple sexual partners are the main risk factors that contribute to STIs including HIV. Low social or economic status of FSWs has been shown by their willingness to practice unsafe sex exposing them to the risk of STIs and HIV. The gender-based violence and inequality, lack of information about STIs including HIV, how to prevent these infections and limited access to both health and social services due of stigmatization and marginalization, play a role in the lives of the FSWs (Lawan et al., 2012). In a study conducted in Kano, Nigeria it was also discovered that FSWs who knew that they are HIV positive practiced unsafe sex, just to be able to meet their physical needs (Lawan et al., 2012).

In a study that was conducted in Ethiopia unprotected sex with regular, non-paying partners put both the FSWs and their partners at higher risk of HIV infection (Mooney et al., 2013). In a study that was conducted in Davangere City, inconsistent condom usage was practiced with both paying and non-paying clients (Girish et al., 2014).

Condom use among FSWs in Pakistan was very low and the same findings were noted in the National STI study, 5.4% in Lahore and 3.1% in Karachi (Saleem et al., 2013). Work-related violence was associated with unprotected sex with regular and non-paying partners among the FSWs who abused alcohol (Mooney et al., 2013). Eighty percent of the FSWs in Ahmedabad city had consistently used condoms in the past year but still half of them suffered from STIs (Patel et al., 2014).

In Uganda, inconsistent condom use among FSWs was caused by economic and relationship factors. The other findings show that inconsistent condom use was due to poverty, refusal to use condoms by male partners, alcohol use before sex and beliefs that condoms ‘kill the mood for sex’. Some FSWs reported that the client that refuses to use a condom will often become violent and that that is one of the main reasons for not using
condoms (Matovu & Ssebadduka, 2013). A study in Kinshasa found that about a quarter of FSWs reported of having unprotected sex for extra money, charged up to 3.5 times more for unprotected sex. While FSWs may want to use condoms for protection against STIs and HIV, their wish if often changed by the client’s refusal to use condoms (WHO, 2011). In a study conducted in Nigeria it has shown that about 60.7% of the FSWs with the STI symptoms continued to have unprotected sex. Above that, 29.6% of the FSWs who knew that they were HIV positive continued with unprotected sexual intercourse with clients even if they knew of STIs/HIV prevention. The majority had knowledge that unprotected sexual intercourse (96.0%) is the risk factor that will make them acquire STIs and HIV. Twenty-five-point eight percent (25.8%) still did not believe that there is anything that can be used to protect them against STIs and HIV (Lawan et al., 2012). Another study indicated that risk factors for STI and HIV transmission among FSWs include risky sexual behavior that include the following: a high number of sexual partners and inconsistent condom use, together with limited access to Health Care Services and prevention strategies for STIs. Furthermore, FSWs who inject drugs are at an even higher risk of acquiring HIV as they will forget to use a condom. Although the global incidence of HIV infection has decreased worldwide, in low-income countries the rates of STI and HIV infections continue to increase among FSWs and their clients (Savva, 2013).

A study done in Lao by Andrew et al., reported inconsistent condom usage especially with regular partners because they did not want to use condoms (Andrews et al., 2015). A study conducted in New Guinea has shown that the FSWs are aware of the risks of HIV and know about the transmission and prevention methods but still do not use condoms. Most reported using condoms ‘sometimes’, almost one-sixth ‘never’ used condoms, only a fraction used condoms ‘always’ with clients, and none used condoms ‘always’ with regular sexual partners. Among these FSWs, having knowledge about the risks, transmission, and prevention of HIV did not make them practice safe sex (Bruce et al., 2011).

The study conducted in Northwest Ethiopia revealed that less than half (47.7%) of the FSWs used a condom with any type of client. Having less numbers of clients in a month
affected condom use, condom usage was low with any type of client whether non-regular, regular, boyfriend or husband, which places not only FSW but also the general population at high risk of contracting STIs and HIV and (Tamene et al., 2015).

Six studies that were conducted by Platt et al., (2013) in Europe reported that HIV among the FSWs was associated with risk behaviors that included: unprotected sex with clients; high numbers of clients; non-paying partner and sex with clients living with HIV (Platt et al., 2013).

The prevalence of STIs among FSWs is high, as many of them do not practices safe sex against STI. Client refusal to use condoms is the most commonly mentioned by the FSWs (Sekoni et al., 2012).

About 19% of FSWs in Antananarivo, Madagascar reported that they had wanted to negotiate use of a condom but were afraid to ask. Three quarters of FSWs in that study also reported having had sex with a client who had refused their request for condom use (WHO, 2011). Another study found that 7% of non-use of condoms was due to instructions from the brothel owner (WHO, 2011). The majority of FSWs practiced unsafe sex when they clients offer more money for sex without a condom. A study in Kinshasa, Democratic Republic of Congo, found that about a quarter of FSWs reported that they had unprotected sex for extra money, charging up to 3.5 times more for unprotected sex (WHO, 2011).

FSWs did not use condoms consistently because of factors, including economics, partner type like those who offer to pay them more money and regular client, and violent clients contribute to this behavior. For example, FSWs may receive more money for unprotected than protected vaginal and anal sex. Further, FSWs report lower condom use with steady partners than with new or casual partners (CDC, 2013).

According to Brown et al., FSWs are willing to using condoms with clients, their adherence depend on cooperation by clients or what their clients want; so, it is not always something
easy for them to achieve. Sometimes clients offer more money for sex without a condom or threaten to go to other FSWs who will agree to have sex without a condom and as they have needs to meet they will compromise and have sex without a condom. Clients also might pay more for riskier sexual practices, such as anal sex, without a condom. Inconsistent condom usage with clients put the FSWs boyfriends and husbands at risk of STIs including HIV, in which they might not use condoms when having sex with them at home (Brown et al., 2012).

In this study, the FSWs reported that they experienced different challenges in their work such as clients that are violent, beating them when they negotiate condom use and some will take them to places they do not where they will rape them. The FSWs reported that their work is dangerous as they deal with murderers and the thieves hence they end up getting involved in drug abuse, drinking alcohol just to numb the pain of what they are going through.

A study conducted in the Sub Saharan Africa countries indicated that much of HIV risk for the FSWs is a manifestation of their extraordinary social and economic vulnerability, and the high levels of stigma and violence attached to sex work (Chersich et al., 2013). According to the study conducted by Goldenberg et, al (2014) the FSWs reported high levels of workplace violence and barriers to condom negotiation (Goldenberg et al, 2014). In a study that was conducted in Lao the People’s Democratic Republic (PDR) FSWs reported inconsistent condom use with their regular partners been related to the partners not wanting to use condoms as they feel that condoms reduce their sexual pleasure (Andrew et al., 2015).

In the study that was conducted in Canada the FSWs reported that they often face higher number of violence and barriers to safer sex practices such as been rushed to condom negotiation and insufficient time to screen their clients (Sou et al, 2015)

The FSWs in Papua New Guinea have reported that they practice unsafe sexual practices as some of their clients will offer them extra money and the other barrier to condom use that came out was the inability of the FSWs to negotiate condom use (Bruce et al., 2011). According to a study that was conducted in Tete and Mozambique FSWs chose the Public
Health Facilities because they were near to where they stay and work and some reported that they are using public Health Care Facilities because Health Care Workers reasons lack of privacy and confidentiality (Lafort et al., 2016).

5.2.4 Risk of contracting HIV as FSWs

Some of the FSWs have indicated that they engage in sexual activities when having STIs related infections. That is encouraged by the reason that sex work is their work, so they must work even when they are sick with STIs.

The above reported information is confirmed by other studies. A study conducted in Kano, Nigeria reported that unsafe sex was practiced by FSWs who knew that they are HIV positive (Lawan et al., 2012). This sub-group are known to be highly vulnerable to genital warts, candidiasis, gonorrhea and genital ulcers and which will be consequently transmitted to their clients and other sexual partners (Ghimire et al., 2011).

Surprising enough without formal education, most of them were aware that unprotected sexual intercourse and multiple sexual partners are the main risk factors for STI including HIV (Lawan et al., 2012).

According to a study that was conducted in Sierra Leone FSWs are at risk of acquiring HIV acquisition and/or transmitting HIV from the combination of behavioral, biological and structural factors, such as unprotected sexual intercourse; a high number of sexual partners; having sex while having STIs, limited access to prevention and treatment services; social stigma and discriminatory legal or regulatory policies (Djomanda et al., 2014).

According to a study that was conducted in Nigeria FSWs reported that they had experienced condom breakage when engaged in sex work with their clients (Adeneye et al., 2016).
5.2.4 The FSWs health seeking behavior

In this study, the FSW had good knowledge about STIs, though they still practiced unsafe sex and knew that when they are sick with diseases like STIs, they need to go to the Health Care Facilities of which the majority went to Clinics and few to the Public Hospital and the Chemist. Of those who chose Public Clinics they also used Pomona North Star Alliance Wellness Clinic which is a non-governmental organization (NGO) Clinic that provide Prep treatment and condoms to the FSWs who test HIV negative, and those that are HIV positive are started on ARVs and encouraged to use both male and female condoms. The FSWs reported that they make use of Kempton Park Clinic, Spartan Clinic and Birch Leigh North Clinic as Public Clinics. The reasons that they gave for choosing Spartan Clinic, Kempton Park Civic Center, Birch Leigh North were that they are near to where they stay and where they work and that the Health Care Services are free. Those who chose the Wellness Clinic reported that the staff in the Clinic understood them. Those FSWs that preferred the pharmacist reported that the Health Care Workers in the Clinics judge them. Some of the FSWs used the Health Care Facilities that are far from they work and stay like South Rand Hospital, Rossetenville Clinic, Yeoville Clinic which are in the City of Johannesburg.

According to a study that was conducted in Nepal FSWs have experienced long waiting times which is one of the contributing factors for the FSWs not to report to the Health Care Facilities or delay to report any health problems that they encounter in their work situation (Ghimire et al., 2011).

Health care provider attitudes, positive and negative, affected the use of health services. Several FSWs reported negative treatment and social exclusion, with the women feeling that Health Providers thought they were unworthy or undeserving of the services (Savva, 2013).

According to a study that was conducted by Tamene et al. (2015), FSWs are one of the vulnerable groups that are at risk of HIV infection due to multiple sexual partners. High
rates of STIs and unsafe sexual practices put them at risk of HIV transmission (Tamene et al., 2015). FSWs knew that they need to use the Health Care Facilities when have diseases like STIs as the type of work that they do and some types of clients they service make them unable to practice safe sex (Ghimire et al., 2011; Lawan et al., 2012 and Matrice, 2012). The health seeking behavior of this vulnerable group would sometimes not seek appropriate medical treatment from the Health Care Facilities like the Clinics but rather choose to use a Chemist as they are too afraid to report STIs to the Health Care Workers (Lawan et al., 2012). This poor treatment seeking behavior might be due to fear of discrimination by the Health Care Workers, ignorance hoping that they will get well without treatment, lack of finances and lack of access to Health Care Services (Baral et al., 2012; Sekoni et al., 2012 and Hong et al., 2011).

According to Lawan et al. (2012) in Kano, Nigeria FSWs knew about STIs/HIV/AIDS prevention, but they still demonstrated unhealthy sex behavior and treatment seeking. In Nigeria, FSW with STIs used Health Care Facilities to seek medical help. According to Sekoni et al., about half of FSWs with STIs sought treatment in a hospital or Health Care Center while 32.5% from a patent medicine vendor (Sekoni et al., 2012).

A study conducted in Nepal showed that a quarter (25%) of FSWs who reported STIs never visited any Health Care Facilities especially for sexual health services. Those who used Health Care Facilities were as follows; those who used non-governmental Clinics (72%), private Clinics (50%), Hospital (27%) and Health Care facilities (13%) (Ghimire et al., 2011). This is also similar in Uganda where FSWs reported that they have challenges in accessing treatment, care and prevention services compared to the general population (Patel et al., 2014).

According to Phrasisombath et al., most of the FSWs reported that they prefer to make use of NGO run Clinics for seeking treatment when they have STIs. Eighty-six percent (88%) of the respondents in Laos reported STI signs in the last three months but only two thirds of those with symptoms went for treatment. Source of treatment for the last STI
episode was the drop-in center (53%) followed by a Public Hospital (23%), Private Clinic (12%), Private Pharmacy (9%), and Herbalist (2%) (Phrasisombath et al., 2012).

In a study that was conducted in Nigeria, the 53.8% of respondents mentioned that quality of care as the main reason for choosing their own health facilities that they feel will offer them better and quality health care (Sekoni et al., 2012). In this study, the FSWs have reported that have challenges in preventing HIV in their work as some of their clients don’t want to use condoms, they must deal with bursting condoms and when they try to negotiate condom use they get offered more money. The need for money makes them put money before their needs to protect themselves from contracting a STI including HIV. The majority of FSWs knew their HIV status and those who are HIV positive are not consistently using condom and not on Prep nor have access to lubricants to protect them from STIs that include HIV. Those FSWs who are HIV positive are only on ARVs and not using dual method of ARVs and condoms.

According to the study that was conducted in Tete and Mozambique the FSWs chose the Public Health Facilities because they were near to where they stay and work and some reported that they are not using public Health Care Facilities because Health Care Workers reasons lack of privacy and confidentiality (Lafort et al., 2016).

5.2.5 The barriers to access health services as perceived by the FSWs

Some of the FSWs have reported that they are not respected like any other persons who are entitled to use Health Care Services. They are called names and perceived as dirty people. Their services are mostly provided in the evening and the Nurses want them to come and queue for Health Care Services in the morning and during that time they are still sleeping. They are denied services when they come to the Clinic during the day or in the afternoon. Most of the participants expressed that they were not comfortable to tell the Health Care Workers that they have STIs, they indicated that it was difficult as they were afraid about how the Health Care Workers will react and some of them experienced negative attitudes such as rudeness and being judgmental. Some indicated that they
would change their story instead of telling them that they have STIs they will say they have a headache.

The studies conducted in South Africa have indicated that FSWs are a hard to reach and a hidden population and they often had difficulty in accessing health services that in a way may result in their poor health outcome and that might encourage rapid and higher STIs and HIV/AIDS transmission rates compared to the general population (Desmond Tutu HIV Foundation, 2012). The study conducted in Davangere city has shown that there is a challenge combating HIV/AIDS because FSWs are associated with STIs (Girish et al., 2014).

Available literature on FSWs has reported that even though FSWs knew that they need to use the Health Care Facilities, the type of work that they do and type of clients they service, made them unable to practice safe sex and utilize the health services that were around them (Ghimire et al., 2011; Lawan et al., 2012 and Media trice, 2012). Other FSWs reported not receiving quality of care as the main reason for seeking treatment in other chosen places (Sekoni et al., 2012).

According to the study that was conducted in India the FSWs have also reported that they are facing a judgmental or disapproving attitude at all levels of healthcare. Another factor which prevented them from using health care facilities was the fear of recognition by their clients (Paul et al, 2017).

5.2.5.1 Long queues

The other factor that contributes to FSWs not using Health Care Facilities is the waiting time. There are FSWs who have regular customers and who might contact them when they are waiting for the Health Care Services. This might lead to loss of income as the client might look elsewhere for sex. The long Clinic queues discourage FSWs to use Health Care Facilities.
Other studies reported that; the long waiting time, inconvenient location of the Clinic, not knowing where to get the services needed, and negative attitudes among Health Care Providers and the quality of care was reported as the reasons FSWs use alternative Health Services Providers (Phrasisombath et al., 2012). The majority of FSWs who had not sought care for STI symptoms in the previous three months mentioned that the location of the Clinics was not convenient to them and they did not know where to get treatment. Long waiting times at the Clinic, lack of time and money, lack of confidentiality and judgmental attitudes of Health Care Workers.

A study done in Cape Town indicated that most of FSWs do not go for routine and other medical check-ups. Some were not satisfied with health care provision discrimination tendencies towards them and long waiting times (Media trice, 2012).

Criminalization of sex work services in South Africa has pushed FSWs to practice their work in obscured places and that makes them very vulnerable to bad treatment by their clients (Media trice, 2012). According to Wanyenze et al., (2017) some of the FSWs reported that there are delays and unfavorable working time that are not suitable to the FSWs at the Health Care Facilities. Most of the time the FSWs work during the night and when they have health problems they are expected to go to the Health Care Facilities between 08:00 and 16:30 which are the normal Clinic hours. The FSWs in this study expressed dissatisfaction with the pace at which the Health Care Workers served them in public facilities (Wanyenze et al., 2017).

5.2.5.2 Discriminations and Stigmatization of the FSWs

Some FSWs have cited bad treatment from the Health Care Providers as some of the reasons they stay away from mainstream Health Care Services. The FSWs do not like it when they are criticized and discriminated because of the type of the job they do.

Stigma is defined as shame or disgrace that is directed toward something regarded as socially unacceptable (Brown et al., 2012). In a study that was conducted in Cape Town
most of the FSWs did not go for routine and other medical checks. Some FSWs were not satisfied with Health Care provision due to discrimination by providers and long waiting times. The illegality of sex work in South Africa pushes FSWs to practice the trade in obscure places making them very vulnerable (Media trice, 2012). In the study that was conducted in South Africa the health provider attitudes, and external and internal discrimination and stigma have influence on access to health services (Savva, 2013). Fifty-eight (58) participants reported health needs that were not met due to bad service or outright refusal of service based on stigma because they were FSW. More than half of FSWs who reported that they were denied service or given bad treatment was from Rustenburg Clinic. FSWs from Rustenburg have shown concern on quality of Health Care Service and Health Care Worker attitudes particularly in public health facilities. Several FSWs complained about the lack of privacy or confidentiality in public health facilities. Several FSWs reported inaccessible services as a long waiting times, inefficient staff, and lack of cleanliness in Clinics (Savva, 2013).

According to a study that was conducted in Cape Town, FSWs are a socially marginalized group with poor physical health. In this majority of respondents reported stigmatization and discrimination by community members and the police. They were called names such as “marhosha” which means sex worker. Male community members teased them by asking them to give them sex in exchange for money. Respondents also reported that community members accused them as being people that are responsible for the spreading of HIV/AIDS in the communities (Media trice, 2012; Baral et al., 2012). Some FSWs reported that their health needs were not met because of bad services and sometimes outright services refusal based on stigma because they are FSW. More than half of FSWs who reported that they were denied service or given bad treatment was from Rustenburg. Some FSWs complained about the lack of privacy and confidentiality in public health facilities. Some reported inaccessible services as a long waiting times, inefficient staff, and lack of cleanliness in Clinics (Savva, 2013). It is documented that, Health Provider attitudes, and external and internal discrimination and stigma have influence on access to health services (Savva, 2013).
The studies done on the issues related to Health Care Services access has noted the following challenges: FSWs experience stigma within the Health Care setting and specifically from Health Care Workers themselves (Brown et al., 2012).

A study conducted in Nepal revealed that FSWs perceived that personal, structural and socio-cultural barriers, such as Clinic opening hours that are not suitable to the them; discrimination; the judgmental attitude of the service providers; lack of confidentiality; fear of public exposure; and higher fees for the services as barriers to their access and utilization of sexual health services (Ghimire et al., 2011). A study done in Uganda has reported high costs; shortages of medicines and inadequate transport to hospitals as some of the challenges the FSWs experiences that is also made worse by stigma and movement due to the kind of work they do. This includes lack of a country guidance document on the implementation of HIV/AIDS prevention. There are gaps and challenges that are faced by FSWs which are further made worse by the stigma that is attached to their work. These occur because there is lack of clear country’s policy guidance on the implementation of HIV prevention and care services for FSWs (Patel et al., 2014). FSWs who were HIV/AIDS positive were more likely to experience discrimination than HIV/AIDS negative FSWs in the Health Care setting. It was also discovered that HIV/AIDS related stigma was negatively correlated with getting a recent HIV test. The similar results were found in Russia on HIV-related stigma as a barrier to services both among other populations (King et al., 2013).

It is also reported that main barriers to seeking health care among FSWs that are infected with STI symptoms were both structural such as social stigma by the Health Care Workers and their neighbors they might meet in the health facilities and individual such as fear of social discrimination by the Health Care Workers (Sihavong et al., 2011). Some FSWs also mentioned that they visit Clinics that were far from their community because of fear of exposure of her status to the doctor (Ghimire et al., 2011). Widespread stigma and discrimination towards FSWs by the Health Care Workers discourage the FSWs from accessing the Health Care Services (WHO, 2011).
5.2.5.3 Attitudes of the Health Care Workers

In this study, most of the participants expressed that they were not comfortable to tell the Health Care Workers that they have STIs, they indicated that it was difficult as they were afraid about how the Health Care Workers will react and some of them experienced negative attitudes such as rudeness and judgmental from the Health Care Workers. Some of the barriers that have been reported by FSWs from Nepal are inappropriate Clinic opening hours, discrimination, the judgmental attitude and lack of confidentiality towards the Health Care Providers (Ghimire et al., 2011).

According to Media trice the behavior of the Health Care Providers and long waiting times are mainly the barriers to FSWs usage of Health Care Services even when they needed them (Media trice, 2012).

According to a study that was conducted by Savva the attitudes of the HCWs discourage the FSWs from using the Health Care Services around them. Negative treatment and social exclusion, it makes the FSWs feel that health providers take them as people that are unworthy or who do not deserve Health Care Services (Savva, 2013).

Patel et al., (2014), reported that the poor attitudes of some Health Care Workers toward FSWs and limited community support also contribute to FSWs not been free to access the Health Care Services (Patel et al., 2014). The FSWs in Zimbabwe are having the challenge of stigma by the Health Care Workers when accessing the Health Care Facilities for HIV treatment. Health Care Workers have negative attitudes such as hostility, disrespectfulness and discriminatory towards the FSWs (Hunt et al., 2016).

The FSWs experience unwelcoming behaviors such as rudeness, discrimination and abuse from the Health Care Workers, when they seek HIV services at some health facilities (Wanyenze et al., 2017).
In the study that was conducted in India, the FSWs also reported facing a judgmental or disapproving attitude in all levels of healthcare facilities. They are also prevented from going to the health care facilities near to them because of fear of been recognized by their clients (Paul et al, 2017).

### 5.2.6 Challenges about HIV prevention among the FSWs

The FSWs need to access the HIV prevention and Health Care Services to reduce the spread of HIV (Wahed et al., 2017). An effective treatment of STIs among the FSWs can reduce STIs and HIV transmission to the general population by clients who have multiple sexual partners such as FSWs (Phrasisombath, 2012).

The FSWs face violence, rape and non-payment from clients when insisting on non-condom use to protect themselves from contracting STIs including HIV (Media trice, 2012).

The FSWs need to have access to HIV prevention and reproductive health commodities such as condoms, lubricant and contraceptives; HIV testing services; treatment for HIV and other ST and opportunistic infections which is a challenge to some of them because the Health Care Services are not accessible to them (Sheibe et al., 2012).

### 5.2.7 Special needs of the FSWs as the vulnerable community

The FSWs need protection from their abusive and violent clients and they are unable to get help from Police in situations where they are victims of such violence and abuse (Shukla & Mehrotra, 2015). Police harassment is one of the constraints for the FSWs to carry condoms with them when they get to their work as they fear to be arrested and robbed of their money. Most FSWs, when asked if they were carrying condoms said no because they feared that the Police would search their bags and find the condoms (Ghimire et al., 2011). FSWs have reported high level of violence by their clients including being raped and beaten if they did not agree to unprotected sex (Wanyenze et al., 2017). The FSWs need protection from the violent and abusive clients, and the protection need to be provided by the Police and the policy of the country.
FSWs are being stigmatized for the work that they do, and this contribute to women’s risk of developing depressive symptoms. Findings from the study that was conducted by Carlson et al, (2017) suggest that women in sex work internalize this stigma in the form of depression. Stigma attached to sex work cause some of the women not to disclose to their families that they are FSWs, so they lack social support from their family members and end up being depressed. So, the women in sex work need support and mental health interventions to avoid pitfalls because of their work, hence we find some of them using alcohol and drugs (Carlson et al., 2017).

To reduce the spread of HIV the FSW need to access to both HIV prevention such as condoms and ARVs and care services next to where they work and at the right times suitable to them (Wahed et al., 2017). FSWs face social barriers because of disclosure of HIV positive status, lack of family support if found to be a sex worker and HIV positive, unmet basic needs to support their families, social level stigma and discrimination (Maphosa, 2013).

5.2.8 Limitations

Qualitative methodology was used in all the processes and procedures that applied to this study. The challenge the researcher had to face was to secure the required number of participants to conduct FGDs (6-10) and in that case the researcher conducted IDIs with participants who did not meet the required number to conduct a focus group. That has taken a lot of time and depleted funds. More time was spent on transcription and translation. The study was emotional in nature, so some information may have been left out or forgotten by the participants during interviews or maybe they decided not to talk about it because the researcher might judge them as the Health Care Providers have done. Some participants might also have left out some information that they thought was of little significance to the study and that information might have been of help to the researcher.
5.3 Conclusion

It is reported in this study that, it is women in their prime age that are mostly involved in sex work services. These women are not that well educated and are South Africans and others are from the neighboring countries. They are working under risky environments such as serving clients who do not want to use condoms and when they try to negotiate condom use are abused physically. Some of the FSWs will provide services to their clients knowing that they are infected with STIs, are pregnant and even when they are menstruating as they need to provide for their families and become financially secured.

The FSWs work with a variety of people e.g. clients that are thieves (who will rob them of the money they have made for the day); murderers and abusers (who will beat them, rape them) when they don’t want to use condoms knowing that they will not report them and make them end up being drug addicts and alcoholics all to try and numb the pain of what they experience at work. The FSWs do not like to use Health Care Facilities because of the long waiting times; attitudes of the Health Care Workers that are perceived as being judgmental, having lack of respect, stigmatization attached to their work, discrimination, rudeness, criticism and impatience of the Health Care Workers.

Criminalization of sex work in South Africa further contribute to the marginalization and stigmatization of the FSWs. Criminalization of sex work expose the FSWs to more abuse, violence by the clients knowing that they will not be reported anywhere as they are not covered by law to do their job. Criminalization of sex work expose them - clients who take advantage of them and cause them to be mistreated by the community, families, partners, Health Care Workers and the Police. The Police who are also supposed to offer public safety to every citizen of the country, also fail to do their duty of treating them like every citizen that need to be protected from any sort of abuse and violence.
5.4 Recommendations

In South Africa, there is a suggested bill on decriminalization of sex work and it would be good if the Policy Makers will come up with a clear policy that to how FSWs as a vulnerable population, need to be treated in the country. The Department of Health also needs to start planning and set aside funds for Mobile Clinics and staff that will provide Health Care Services to the FSWs at their service points and at the time that is suitable to them because their place of client recruitments is visible it is only the place of services that are concealed. The Health Care Workers need to be trained on how to treat vulnerable groups such as FSWs with emphasis on the counselling skills. The training needs to cover how the Health Care Workers need to treat key population that come to the Health Care Facilities with STIs to address the issue of stigma and discrimination among FSWs. Peer Educators who are FSWs are to be allocated in each Health Care Facilities where the FSWs will be accessing Health Care Services as requested by the FSWs and that they will feel comfortable to meet someone they know and are able to open to them when they face any challenge.

The Police needs to treat the FSWs who report rape, violence and abuse like that how they treat the general population and following the same policies.

The FSWs need to be empowered with skills on how to negotiate condom use and how to use both male and female condoms.

Communities to be empowered with information about sex work to be able to accept the FSWs in their communities and support them and not criticize them.
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APPENDICES

APPENDIX 1: CONSENT FORMS

ENGLISH CONSENT FORM

Name of Study: Sexual practices and health seeking behaviour regarding STIs amongst FSWs in Ekurhuleni Northern Sub District.

I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name is not revealed.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. This will have no influence on the regular treatment that holds for my condition neither will it influence the care that I receive from my regular doctor.

I know that this Study has been approved by the Sefako Makgatho University Research Ethics Committee (SMUREC). I am fully aware that the results of these results of this Study will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study.

............................................................ ....................................................
Name of volunteer.

.......................................................... ............................................................

Place  Date  Witness

Statement by the Researcher

I provided verbal and/or written* information regarding this Study

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

Agnes Wechoemang..... .......................................................... ............................................................

Name of Researcher  Signature  Date  Place

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APPENDIX 2: SEPEDI CONSENT FORM

Leina la Dinyakišišo: Tsa thobalano le go nyaka go tseba gore basadi ba somang ka go gweba ka mmele ba ka humana kae tsa maphelo ge ba na le malwetsi a thobalano.

Ke badile e bile ke kwele ka ga tshedimošo mabapi le maikemišetšo le morero wa dinyakišišo tšeo di šišintšwego gomme ke ile ka fiwa monyetla wa go botšiša dipotšišo gomme ka fiwa nako yeo e lekanego gore ke naganišiše ka ga taba ye. Ke tloga ke kwešiša maikemišetšo le morero wa dinyakišišo tše gabotse. Ga se ka gapeletšwa go kgatha tema ka tsela efe goba efe.

Ke a kwešiša gore go kgatha tema Dinyakišišong tše tša Teko ya Klinikhale ke ga boithaopo gomme nka tlogela go kgatha tema nakong efe goba efe ntle le gore ke fe mabaka. Se ka se be le khuetšo efe goba efe go kalafo yaka ya ka mehla ya maemo a ka gape e ka se huetše le ge e ka ba tlhokomelo yeo ke e humanago go ngaka yaka ya ka mehla.

Ke a tseba gore Protšeke di dumeletšwe ke Sefako Makgatho University Research Ethics Committee (SMUREC). Ke tseba gabotse gore dipoelo tša Dinyakišišo di tla dirišetšwa merero ya saense gomme di ka phatlalatšwa. Ke dumelelana le se, ge fela bosephiri bja ka bo ka tišetšwa.

Mo ke fa tumelelo ya go kgatha tema Dinyakišišong.

............................................................

Leina la moithaopi Mosaeno wa molwetši goba mohlokomedi.

............................................................

Lefelo.                             Letšatši - kgwedи                                  Tlhatse

______________________________________________________________________
Setatamente ka Monyakišiši

Ke fana ka tshedimošo ka molomo le ka yeo e ngwadilwe go mabapi le Dinyakišišo

Ke dumela go araba dipotšišo dife goba dife tša ka moso mabapi le Dinyakišišo ka bokgoni ka moo nka kgonago ka gona.

Ke tla latela melao yeo e dumeletšwego.

Agnes Wechoemang.............................. .................................... ...............……

Leina la Monyakišiši                      Mosaeno               Letšatšikgwedi                      Lefelo
APPENDIX 3: ISIZULU CONSENT FORM

Isitamende esiphathelene nokuhlanganyela kuCwaningo lweMitholampilo.

Igama Lokufunda: Imikhuba yezocansi kanye nemphilo efuna ukuziphatha ngokupathelene nezifo zocansi phakathi kwama FSW e-Ekurhuleni Northern Sub District.

Ngïfundlelwe ngezhingisolo ngezhingisolo zezisifundo esihlongozwayo futhi nginikezwa ithuba lokubuza imibuzo futhi nginikezwa isikhathi esanele sokucubungula le nkinga. Inhloso ngezhingisolo zezisifundo zicacile kimi. Angizange ngicindezelwe ukuba ngihlanganye yezishongwe futhi nginikezwa kimi.


Ngiyaqonda ukuthi ukubamba iqhaza kulesi Sifundo kuthanda ngokuzithandela nokuthi ngingase ngikhopho kuswazi izikhathi nangaphandle kokunikeza izizathu. Lokhu ngeke kube nomthelela ekwelapheni okuvamile okugcina isimo sami futhi ngeke kuthonye ukunakekelwa engikuthola kudokotela wami ovamile.


Nginika imvume yokuhlanganyela kulolu Sifundo

......................................................................................................................................................................
Igama lovolontiya.

.......................................................... ................................................

Indawo. Usuku. UFAkazi

..................................................................................................

Isitatimende somcwaningi

Nginikeze ngolwazi lomlomo nolwebhaliwe mayelana nalesi Sifundo

Ngiyavuma ukuphendula noma yikuphi esizayo mayelana nokuFundisisa
njengoba nginamandla kakhulu.

Ngizobambelela ku-protocol evunyelwe.

Agnes Wechoemang........................................... ........................................... ..............................

Name of Researcher Signature Date Place
APPENDIX 4: ENGLISH DATA COLLECTION TOOL

DATA COLLECTION TOOLS

Title: Sexual practice and health seeking behaviour of sexually transmitted infections among the Female Sex Workers.

In-depth interview

Thank you for agreeing to participate in this focus group interview, my name is Agnes, from the School of Public Health in Sefako Makgatho Health Science University. Our talk will be with the Female Sex Workers (FSWs), we would like to understand their knowledge, sexual practices and their health seeking behavior when you have sexually transmitted infection. You are assured that all the information gathered in this room will be kept confidential and your personal identity will be protected. You will not be required to provide your identity at any time. Feel free to answer the questions as the information will be used for the research purpose.

1. How did you get into sex work?
   **Probe:**
   - What were your reasons that led you get involved in sex work?
   - Would you say that someone influenced by you to get into sex work?

2. What have you experienced as a sex worker?
   **Probe:**
   - What is it like to be in the sex work business?

3. What are some of the challenges of being a sex worker?

4. What are some of your experiences of using condoms in your work?
   **Probes:**
   - How do you handle a client who does not want to use a condom?
- Seeing that you have experienced challenges with some clients who do not want to use condoms, have you ever used the female condoms?
- Do you know how to use them?
- Where and how do you get condoms?

5. Have you ever experienced a burst condom?

 Probe:
- How did you deal with a burst condom?

6. What are your experiences about difficult clients?

 Probes:
- How have you handled such clients?
- When do you say a client is difficult?
- How often do you meet such clients?

7. What are some of the reasons that would make you to go to a Clinic?

 Probes:
- Which health facility do you use when you are sick?
- Why do you choose that Clinic?
- When you had a STIs, did you feel comfortable to tell Health Care Workers about that?
- If not, why were you not comfortable?

8. What are your perceptions about the services that you received from the Clinic?

 Probes:
- What are the reasons that would make you not use the Public Health Care Services?
- Are there times when you are expected to disclose to the Nurses that you are a sex worker and what were their attitudes toward that?
- How best can our public health facilities be of help to you?
- What must I tell them for them to understand you?
9. What are the risks of contracting HIV in your work?

**Probes:**
- Have you ever tested for HIV?
- What is your HIV status?
- If negative, how do you prevent yourself from getting HIV positive?
- What are the challenges that you have experienced since started on Prep?
- If HIV positive, have you started on ARVs?

10. Have you ever had burning on micturition, vaginal discharge that yellow/green and smelling, lower abdominal pains, pain during sex, painful or painless sore on the genitalia, sore throat after oral sex, rectal pain or discharge after anal sex?

**Probe:**
- How does having STIs affect your work?

11. In your business do you work when menstruating or when pregnant?

**Probe:**
- If you have a child from being a sex worker, how do you feel about the child who was conceived in your work?

12. Have you ever experienced being raped by your clients?

**Probe:**
- How have you handled the rape instance(s)?
- How did you feel after the rape(s)?

13. Does your life partner know about your sex work?

**Probes:**
- If your partner does not know about your work, what are the reasons for not telling him?
- If your partner knows, how does he react to your work?

14. Is there someone in your family or friends who know about your sex work?

**Probes:**
- How easy or difficult is it to tell family and friends about your work?

15. Do you ever think of leaving this job?
16. Besides the actual sex work, what are some of the other challenges that you are faced with?

Probes:
- Place where you conduct the sex work?
- The place where you stay?
- The police harassment and Health Care Worker’s attitudes?
APPENDIX 5: DIPOTSISO TSA SEPEDI

Translated tool- Sepedi.

Title: Sexual practice and health seeking behaviour of sexually transmitted infections among the FSWs. Focus group interview

Dipoledišano tša sehlopha

Ke rata go le leboga ge le tšea karolo mo poledišanong ya rena, lebitso la ka ke Agnes go tšwa Sefako Makgatho Health Science University. Re tlo bolela ka mošomo wa go gweba ka mmele, ke rata go humana tsebo ye le nang le yona ka malwetši a thobalano, tsela ye le šomang ka yona mo mošomong wa lena wa thobalano le gore ga le na le bolwetši ba thobalano ke mafelo a ma fe a le a šomišago go humana kalafi. Ke rata go le tshephiša gore ditaba ka moka tše di tlago go bolelwa mo di tla ba magareng ga rena le lena le go re mabitso a lena a tshireletšegile ka di nako ka moka. Ke kgopela le mpotše ge le sa lokologe go ka araba ye ngwe ya dipotšišo tšeo di tlago go botšišwa, eupya ke tla thabela ge le ka fetola bontšhi ba dipotšišo.

1. Ke eng se dirileng le ikhwetše le šoma ka go gweba ka mmele?

Probe:
- Ke mabaka a mafe a dirileng gore le gweba ka mmele?
- A go na le motho ya le go getšeng mo mošomong wo?

2. Ke eng dilo tše le kopaneng le tšona mo mošomong wa lena?

Probe:
- Le ikwa bjang ge le dira mošomo wo?

3. Ke mathata a ma fe a le kopaneng le wona mo mošomong wa lena?
4. Ke mathata a mafe a le kopaneng le ona ge le šomiša dikhondomo?

**Probes:**
- Le dira eng ge le kopana le modirelwa yo a sa nyakego go šomiša khondomo?
- Ka ge le na le mathata o go somisa khondomo, a le kile la somisa khondomo ya basadi?
- A le tseba go somisa khondomo?
- Le humana dikhondomo kae e bile bjang?

5. A le kile la ba le khondomo ya go thunya?

**Probes:**
- O dirile bjang morago ga khondomo ya go thunya?

6. Le dira eng ge le kopana le ba direlwa ba se nago tšhomišano?

**Probes:**
- Le dirile eng ka modirelwa wa go se somisane botse le lena?
- Le re modirelwa ga a na tšhomišano ge a dira eng?
- Ke ga kaе le kopana le badirelwa ba mohuta woo?

7. Ke mabaka a mafe a dirang gore le šomiše kliniki?

**Probes:**
- Le ya go tirelo kalafi ye efe ge le lwala?
- Le gona ke ka lebaka la eng le kgetha kliniki yeo?
- Ge le na le bolwetsi ba thobalano le a lokologa go botsa ba tsa maphelo?
- Ga le sa lokologe ke ka mabaka a ma fe?

8. A le bona bjang mafelo a rena a tsa maphelo?

**Probes:**
- Ke mabaka a ma fe a dirago gore o se ke wa somisa lefelо la rena la tsa maphelo?
- A gона le nako yео o tshwanela ke go botša ba tšа maphelo gore o šoma mosomo o mofe?
- Ba tšа maphelo ba be jwang morago ga go kwa gore lešoma kae?
- Mafelo a rena a tsa maphelo some ka le thušа bjang?
<table>
<thead>
<tr>
<th>9. Ke kotsi ye efe ye le nang le yona ya go ka fetela ke bolwetši ba thobalano?</th>
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<tbody>
<tr>
<td><strong>Probes:</strong></td>
</tr>
<tr>
<td>• Le kile la thlola gore ga le bolwetši ba HIV?</td>
</tr>
<tr>
<td>• Direng di poelo morago ga go thlola HIV?</td>
</tr>
<tr>
<td>• Ge le se na bolwetsi ba HIV le I tšhireletša bjang gore le se ke la ba le HIV?</td>
</tr>
<tr>
<td>• Ga le šomiša pilisi ya šireletša go re le se ke la ba le HIV, e le tshwere bjang?</td>
</tr>
<tr>
<td>• Ge le na le blowetsi ba HIV a le thomile go nwa pilisi ya HIV?</td>
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<tr>
<th>10. A le kile la ba le bolwetši ba thobalano?</th>
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<tr>
<td><strong>Probe:</strong></td>
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<tr>
<td>• A le tla mošomong ge le na le bolwetši ba thobalano?</td>
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<tr>
<th>11. Le tla mošomong gale le mokgweding go ba le imile?</th>
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<tr>
<td><strong>Probe:</strong></td>
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<tr>
<td>• Ga le na le ngwana wo le mo imileng le mo mošomong wa le na le ikwa jwnag ka seo?</td>
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<tr>
<th>12. A le kile la betelelwa mo mošomong wa lena?</th>
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<tr>
<td><strong>Probes:</strong></td>
</tr>
<tr>
<td>• Le dirile eng morago ga petelelelo?</td>
</tr>
<tr>
<td>• Le ile la ikwa bjang morago ga petelelelo?</td>
</tr>
</tbody>
</table>

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<tr>
<th>13. A balekane ba lena ba a tseba gore le gweba ka mmele?</th>
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<tbody>
<tr>
<td><strong>Probes:</strong></td>
</tr>
<tr>
<td>• Ge balekane ba sa tsebe gore le gweba ka mmele ke go baneng le sa ba botše?</td>
</tr>
<tr>
<td>• Ge balekane ba tseba, ba reng ka seo?</td>
</tr>
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</table>

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<tr>
<th>14. A gona le o mongwe waba le lapa yo o tsebago gore le gweba ka mmele?</th>
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<tr>
<td><strong>Probe:</strong></td>
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<td>Question</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>15. A lena le go nagana go tlogela go dira mošomo wo?</td>
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<tr>
<td>16. Ka ntle ga go gweba ka mmele ke mathata a ma fe a le nago le ona?</td>
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APPENDIX 6: ITHULUZI LOKUQOQA IDATA

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<thead>
<tr>
<th>Isihloko: Imikhuba yezocansi nempilo efuna ukuziphatha ngezifo ezithathelwana ngocansi phakathi kwabasebenzi besifazane besifazane</th>
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</thead>
</table>

Izingxoxo

Siyabonga ngokuvuma ukubamba iqhaza kule ngxoxo, igama lami ngu-Agnes Wechoemang, esikoleni sezempilo yomphakathi, uSefako Makgatho Health Science University. Inkulumo yethu izoba nabasebenzi besifazane besifazane, singathanda ukuqonda izenzo zakho zobulili nokuziphatha kwezempilo uma unesifo socansi. Uqinisekiswa ukuthi lonke ulwazi oluqoqwe kuleli gumbi lizogcinwa liyimfihlo futhi ubunikazi bakho buzovikelwa ngaso sonke isikhathi. Ngeke udingeke ukuthi unikeze ubunikazi bakho nganoma yisiphi isikhathi. uzizwe ukhululekile ukuphendula imibuzo njengoba ulwazi luzosetshenziselwa injongo yocwaningo

1. Wangena kanjani emsebenzini wezocansi?

Iprobes:

- Yiziphi izizathu zakho ezakuholela ekusebenzeni kocansi?
- Ungasho yini ukuthi othile uthonywe ukuba ungene emsebenzini wobulili?

2. Yini oye wabhekana nokuba isisebenzi socansi?

Iprobe:

- Kufana kanjani nokuba ibhizinisi lomsebenzi wezocansi?

3. Yiziphi ezinye zezinselelo zokuba isisebenzi socansi?

4. Yiziphi ezinye zezinto ezenzeka ekusebenziseni ikhondomu namakhasimende emsebenzini wakho?

Iprobes:

- Uphatha kanjani amaklayenti angafuni ukusebenzisa ikhondomu?
- Ukubona ukuthi uhlangabezane nezinselelo namanye amaklayenti angafuni ukusebenzisa amakhondomu, ingabe wake wasebenzisa amakhondomu?
• Uyazi ukuthi ungayisebenzisa kanjani?
• Utholaphi ikhondomu?

5. Uke wabhekana nekhondomu?
**Iprobe:**
• Wenze kanjani ikhondomu eqhuma kakhulu?

6. Yikuphi okuhlangenwe nakho kwakho mayelana namakhasimende anzima?
**Iprobes:**
• Uhlangabezane kanjani namakhasimende anzima?
• Uthi nini iklayenti kunzima?
• Uhlangana namakhasimende anjalo kangaki?

7. Yiziphi ezinye zezizathu ezenza wenze emtholampilo?
**Izinqubo**
• Yisiphi isakhiwo sempilo oyisebenzisayo uma ugula?
• Kungani ukhetha lowo mtholampilo?
• Uma unesifo sofuba, ngaba uязiza ukhululekile ukutshela izisebenzi zezempilo ngelokho?
• Uma kungenjalo, kungani bekungakhululekile?

8. Uyini umbono wakho mayelana nezinsizakalo ozitholile emtholampilo?
**Iprobes:**
• Yiziphi izizathu ezingakwenza ungasebenzisi izakhiwo zezempilo zomphakathi?
• Ingabe zikhona izikhathi lafho kulindeleke ukuthi ukhiphe abahlengikazi ukuthi uyisisebenzi socansi nokuthi yini isimo sabo sengqondo ngalokho?
• Kungcono kangakanani izindawo zethu zempilo zomphakathi zibe usizo kuwe?
• Yini okufanele ngiyitshele yona ukuze bakwazi ukukuqonda?
9. Yiziphi izingozi zokuthola i-HIV emsebenzini wakho?

**Iprobes:**
- Wake wahlola i-HIV?
- Isiphi isimo sakho se-HIV?
- Uma ungenayo i-negative, uzivimbela kanjani ukuba uthole i-HIV?
- Uma ku-Prep, yiziphi izinselelo oye wazibonela kusukela usuqale ukuPhatha?
- Uma unesandulela ngculaza, ingabe uqale ngama-ARV?

10. Wake wahlangabezana nalokhu okulandelayo:
- ukuvutha emakethe,
- Ukukhukhulwa kwamanzi okwesibhakabhaka / okuphuzi / okwesibhakabhaka nokuphunga,
- ubuhlungu obumphansi besisu,
- ubuhlungu ngesikhathi socansi,
- isifo esibuhlungu noma esingenabuhlungu ku-genitalia,
- isisu somzimba esiyithinta emva kocansi lomlomo,
- ubuhlungu obukhipha emzimbeni noma ukuxoshwa emva kwesondo sangase

**Iprobe:**
- Ukuthola ama-STIs kuthinta kanjani umsebenzini wakho?

11. Ibhizinisi lakho uma uqala ukuya esikhathini noma ukhulelwe?

**Iprobe:**
- Uma unomntwana kusukela emsebenzini wobulili, uzizwa kanjani ngomntwana owakhulelwa emsebenzini?

12. Wake wakghona ukudlwengulwa ngamakhasimende wakho?

**Iprobes:**
- Uhambisane kanjani nokudlwengulwa?
- Wazizwa kanjani ngemva kokudlwengula?

13. Ingabe umlingani wakho wokuphila uyazi ngomsebenzi wakho wezocansi?

**Izinqubo**
- Uma umlingani wakho engazi ngomsebenzi wakho, yiziphi izizathu zokungamtsheli?
- Uma umlingani wakho eyazi, uyasabela kanjani emsebenzini wakho?
14. Ukhona yini emndenini wakho noma abangani owaziyo ngomsebenzi wakho wezocansi?

Izinqubo

• Kulula kangakanani noma kunzima ukutshela umndeni nabangane ngomsebenzi wakho?

15. Uke ucabange ngokushiya lo msebenzi?

Izinqubo

• Uma u-yebo, kufanele kwenzekani ukuba ushiye lo msebenzi?
• Uma kungenjalo kungani?
**APPENDIX 7: DEMOGRAPHIC INFORMATION**

Title: Sexual practice and health seeking behaviour of sexually transmitted infections among the Female Sex Workers.

<table>
<thead>
<tr>
<th>Participant’s ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How old are you?</td>
</tr>
<tr>
<td>2. Where you born here in Ekurhuleni? Yes</td>
</tr>
<tr>
<td>3. If no, what is your place of originality?</td>
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<td>4. How long have you been staying here in Ekurhuleni?</td>
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<td>5. Did you know anyone at the time when you came to? Yes</td>
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<td>6. Did you have money when you first came here? Yes</td>
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<td>7. What is your highest level of education? Primary school</td>
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<td>8. What did you do for living before you became a sex worker? Student</td>
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<td>9. Do you have any other way of making money beside being a sex worker? Yes</td>
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</tbody>
</table>
# APPENDIX 8: DIPOTSISO KA SEPEDI

Sexual practice and health seeking behaviour of sexually transmitted infections among the FSWs.

<table>
<thead>
<tr>
<th>Nomoro ya boitsibiso:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Le na le mengwaga e me kae?</td>
</tr>
<tr>
<td>2.</td>
<td>A le belegetšwe mo Ekurhuleni?</td>
</tr>
<tr>
<td></td>
<td>Ee</td>
</tr>
<tr>
<td></td>
<td>Aowa</td>
</tr>
<tr>
<td>3.</td>
<td>Ge le sa belegelwa mo Ekurhuleni, le tšwa le kae gae?</td>
</tr>
<tr>
<td>4.</td>
<td>Ke nako e kae o dula mo Ekurhuleni?</td>
</tr>
<tr>
<td>5.</td>
<td>Ge o tla Ekurhuleni go na le motho yo le bego o mo tseba?</td>
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<tr>
<td></td>
<td>Ee</td>
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<tr>
<td></td>
<td>Aowa</td>
</tr>
<tr>
<td>6.</td>
<td>Ge le thoma go tla mo Ekurhuleni le be le na le tšhelete?</td>
</tr>
<tr>
<td></td>
<td>Ee</td>
</tr>
<tr>
<td></td>
<td>Aowa</td>
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<tr>
<td>7.</td>
<td>Dithuto tše le fihlilego go tšona?</td>
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<tr>
<td></td>
<td>Thuto tša maemo a fase</td>
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<td>Thuto tša magareng</td>
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<td></td>
<td>Marema tlou</td>
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<td></td>
<td>Thuto tša godimo</td>
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<td>8.</td>
<td>Le be le šoma kae pele le thoma go gweba ka mmele?</td>
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<tr>
<td></td>
<td>Moithuti</td>
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<tr>
<td></td>
<td>šoma ka moriri</td>
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<tr>
<td></td>
<td>Waitress</td>
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<tr>
<td></td>
<td>Cashier</td>
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<td></td>
<td>Tše dingwe</td>
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<td></td>
<td>Hlalosa</td>
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<tr>
<td>9.</td>
<td>Go na le tsela engwe ya go tsenya tšhelete ntle le go gweba ka mmele?</td>
</tr>
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<td>Aowa</td>
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<td>10.</td>
<td>A le na le bana?</td>
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<tr>
<td>11.</td>
<td>Ge ba le gona, ke bana ba kae??</td>
</tr>
<tr>
<td>12.</td>
<td>A le kile wa ntšha mpa go tloga nakong ya ge le thoma go gweba ka mmele?</td>
</tr>
<tr>
<td>13.</td>
<td>Ge le kile wa ntšha mpa, le ntšhitše mpa tše kae?</td>
</tr>
<tr>
<td>14.</td>
<td>A le kile laba le ngwana go tloga nakong ya ge le thoma go gweba ka mmele?</td>
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<tr>
<td>15.</td>
<td>Le thomile go šoma ka go gweba ka mmele le na le mengwaga e me kae?</td>
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<tr>
<td>16.</td>
<td>Ke mengwaga e me kae le šoma ka go gweba ka mmele?</td>
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<tr>
<td>17.</td>
<td>Le šoma matšatši a ma kae mo bekeng?</td>
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<tr>
<td>18.</td>
<td>Le di ra bokae ka letšatši mo mošomomg wa lena?</td>
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<td>19.</td>
<td>Le na le batho ba kae ba rekang mo mošomo wa lena?</td>
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<td>20.</td>
<td>Go na le ba le lap aba tsebang gore o šoma ka go gweba ka mmele?</td>
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<td>21.</td>
<td>A le na le molekane?</td>
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<tr>
<td>22.</td>
<td>Ge ale gona ke nako e ka keng le mo setswalleng se?</td>
</tr>
<tr>
<td>23.</td>
<td>Maemo a lenyalo</td>
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<tr>
<td>24.</td>
<td>A le dula le molekane?</td>
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<tr>
<td>No.</td>
<td>Question</td>
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<td>25.</td>
<td>A molekane wa lena o a tseba go re le šoma ka go gweba ka mmele?</td>
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<td>26.</td>
<td>Go na le nako ye le naganang go tlogela mošomo o?</td>
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<td>27.</td>
<td>A le šomiša khondomo go batho bao le ba rekišetšang mmele?</td>
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<td>28.</td>
<td>A le šomiša khondomo ka dinako ka moka ge le gweba ka mmele?</td>
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<tr>
<td>29.</td>
<td>A le kile la itlhola go re ga le na HIV?</td>
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<tr>
<td>30.</td>
<td>Ke neng la bofelo le thlotše bolwetši ba HIV?</td>
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<td>31.</td>
<td>A la kile la humana kalafi ya bolwetši ba thobalano?</td>
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<td>32.</td>
<td>Ke neng la bofelo mo lekigo la humana kalafi ya bolwetši ba thobalano?</td>
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<tr>
<td></td>
<td>Mengwaga e mebedi ye e fetileng</td>
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<td>33.</td>
<td>A le šomiša thibala pelegi?</td>
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<td>Aowa</td>
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<td>34.</td>
<td>Mo kgweding e fetileng le kile wa etela tirelo ya kalafi, ngaka, ngaka ya sesotho ga ba sepetlele?</td>
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<td>Ga ke tsebe</td>
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<td>Go homola</td>
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<td>Tše dingwe</td>
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APPENDIX 9: AMATHULUZI OMPHAKATHI

Isihloko: Ukuziphatha ngokocansi kanye nokuphila okufuna ukuziphatha kwezifo ezithathelwana ngocansi phakathi kwabasebenzi besifazane.

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<th>I-ID yomhlanganyeli</th>
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<td>Code</td>
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<tr>
<td>Becoming a sex worker</td>
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<td>Condom use</td>
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<td>Risk of contracting HIV</td>
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<td>Disclosure about your sex work to the significant others</td>
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<tr>
<td>• Partner or family or friend know about your sex work</td>
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<table>
<thead>
<tr>
<th>Health seeking behavior</th>
<th>About what the participants mentioned about their health seeking behavior</th>
<th>Include participants who do not use health facilities; include participants who are not comfortable to tell</th>
<th>Exclude participants include participants who use health facilities;</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health facilities used when sick</td>
<td>• Reasons for choosing that health facility</td>
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</tbody>
</table>
- When having STIs are you comfortable to tell Health Care Workers?
- How can the Health Care Services be of help to you?
- Long Queues
- Lack of access to the Health Care Facilities

<table>
<thead>
<tr>
<th>Barriers to accessing health services</th>
<th>Health Care Workers about STIs; include what the participants mentioned how the Health Care Services can be of help to them</th>
<th>exclude participants who are comfortable to tell Health Care Workers about STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes of Health Care Workers</td>
<td>About what the participants mentioned about barriers to accessing of the Health Care Services</td>
<td>Experienced bad attitudes of the Health Care Workers; include participants who experienced stigma by the health workers; include participants who felt they are judged by the health workers; include participants who experienced rudeness of health workers; include participants who experienced lack of respect from the health workers; include participants who were criticized by</td>
</tr>
<tr>
<td>1. Stigmatization</td>
<td></td>
<td>Exclude participants who can access the Health Care Services</td>
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<tr>
<td>2. Judgmental</td>
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<td>3. Rudeness</td>
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<td>4. Lack of respect</td>
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<td>5. Criticism</td>
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<td>6. Discrimination</td>
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<td>7. Impatient</td>
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<td></td>
<td>the Health Care Workers; include participants who were discriminated by Health Care Workers</td>
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</tr>
<tr>
<td>Experiences of been a sex worker</td>
<td>About what the participants mentioned about their experiences of been FSWs</td>
<td></td>
</tr>
<tr>
<td>Challenges on HIV prevention among FSWs</td>
<td>About what the participants mentioned about their challenges on HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Special needs of FSWs as vulnerable community</td>
<td>About what the participants mentioned about their special needs as vulnerable community</td>
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</tr>
<tr>
<td></td>
<td>Include the experiences that the participants met in their work</td>
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<td></td>
<td>Include the participants who are not using any HIV prevention method</td>
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<td>Exclude participants on HIV prevention methods</td>
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</tbody>
</table>
APPENDIX 11: ETHICAL CLEARANCE CERTIFICATE
SMUREC APPROVAL LETTER

Sefako Makgatho Health Sciences University
Research & Postgraduate Studies Directorate
Sefako Makgatho University Research Ethics Committee
(SMUREC)
Molotlegi Street, Ga-Rankuwa 0208
Tel: (012) 521 5617/3698 | fax: (012) 521 3749
Email: lorato.phiri@smu.ac.za
P.O. Box 103 Medunsa 0204

APPROVAL NOTICE - NEW APPLICATION

02 June 2016
Mrs RA Welshemang
Department of Public Health
P.O Box 216
Medunsa, 0204

MEETING: 09/2016
SMUREC Ethics Reference Number: SMUREC/1114/2016: PG

The New Application received on 17 May 2016, was reviewed by members of Sefako Makgatho University Research Ethics Committee 02 June 2016 and was approved on 02 June 2016.

Title: Sexual practices and health seeking behavior of sexually transmitted infections among female sex workers in Ekurhuleni Northern suburb

Researcher: Mrs RA Welshemang
Supervisor: Prof M Mookgathe
Department: Public Health
School: Health Care Sciences
Degree: MPH

Please note the following information about your approved research protocol:

Protocol Approval Period: 02 June 2016 – 02 June 2017

Please remember to use your protocol number (SMUREC/1114/2016: PG) on any documents or correspondence with the REC concerning your research protocol.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modification, or monitor the conduct of your research and the consent process.

After Ethical Review: Please note a template of the progress report is obtainable in the Research Office and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit. Translation of the consent document in the language applicable to the study participants should be submitted.

International Organisation: (CRG0006961), Institutional Review Board (IRB101010381) Expiry date: 09 December 2018, Federal Wide Assurance (FWA000023943) Expiry date: 31 August 2017 and NHREC No: REC 210908-003

Sincerely,

PROF GA OGUNIBANJO
CHAIRPERSON SMUREC

SEFAKO MAKGATHO
HEALTH SCIENCES UNIVERSITY
SMU Research Ethics Committee
Chairperson
Date: 02/06/2016

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APPENDIX 12: EKURHULENI CLEARANCE CERTIFICATE

EKURHULENI RESEARCH CLEARANCE CERTIFICATE

Research Project Title: Sexual practices and health seeking behaviour regarding sexually transmitted infections, among female sex workers in Ekurhuleni Northern sub-district.

NHRD NO: GP_2017RP31_637

Research Project Number: 13/04/2017-6

Name of Researcher(s): Ms A Wechoemang

Division/Institution/Company: Sefako Makgatho Health Sciences University

DECISION TAKEN BY THE EKURHULENI HEALTH DISTRICT RESEARCH COMMITTEE (EHDRC)

- THIS DOCUMENT CERTIFIES THAT THE ABOVE RESEARCH PROJECT HAS BEEN FULLY APPROVED BY THE EHDRC. THE RESEARCHER(S) MAY THEREFORE COMMENCE WITH THE INTENDED RESEARCH PROJECT.

- NOTE THAT THE RESEARCHER WILL BE EXPECTED TO PRESENT THE RESEARCH FINDINGS OF THE PROPOSED RESEARCH PROJECT AT THE ANNUAL EKURHULENI RESEARCH CONFERENCE.

- THE RESEARCH COMMITTEE WISHES THE RESEARCHER(S) THE BEST OF SUCCESS.

Dr. Joseph Seputa

DEPUTY CHAIRPERSON: EKURHULENI METROPOLITAN MUNICIPALITY
Dated: 25/4/2017

Dr. V. Kekana

CHAIRPERSON: GAUTENG DEPARTMENT OF HEALTH (EKURHULENI REGION)
Dated: 25/04/2017