An exploration of condom use by street-based female sex workers in Heidelberg Road, Ekurhuleni

By

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Supervisor

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DECLARATION

I, Nokuthula Portia Sikhosana, declare that “An exploration of condom use by street-based female sex workers in Heidelberg Road, Ekurhuleni” is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references. It is being submitted for the degree of Master of Public Health at the Sefako Makgatho Health Sciences University. It has never been submitted before for any degree or any examination at this or any other institution.

_________________________________________________  ______________________________
Nokuthula Portia Sikhosana                                 Date:
Student number: 201609225
DEDICATION

The study is dedicated to my family: my husband Sifiso Brian Sikhosana, my two lovely children Nhlakaniphho Lonwabo Sikhosana and Sinothile Nqobile Sikhosana, my mother Rosemary Malakoane, and my siblings Nhlanhla Makhoba and Tokelo Malakoane, who were supportive, patient and understanding throughout the course of this study.
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I should like to thank the Lord Almighty for giving me courage, strength and guidance to start and complete this dissertation, for if he wasn’t for me I would not have indeed have been able to complete it. “In all things God works for the good for those that love him, who have been called according to his purpose.” Romans 8 verse 28.

Special thanks to my supervisor Professor Mathilda Mpata Mokgatle for all her support, guidance and patience throughout the whole process of completing this dissertation.

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I would like to thank my employer Wits Reproductive Health and HIV Institute (WRHI) for supporting me while I was doing this project.

I would like to thank the Centre for Positive Care (CPC) Germiston branch for granting me permission to conduct the research and support while I conducted the research, as a well as all the informants for participating in the study and sharing their personal experiences and practices with me.
ABSTRACT

Introduction

HIV prevalence remains very high in the country. Sex work is characterised by high rates of multiple sexual partner exchange and a lack of condom use. Female sex workers and their clients are at risk of contracting and transmitting HIV (Human Immunodeficiency Virus) and other STI’s (Sexually Transmitted Infections).

Study purpose

The purpose of the study was to explore the condom use practices of female sex workers, how female sex workers negotiate condom use, and the barriers to condom use between them and their clients or steady partners.

Study design and methodology

Six focus group discussions with a total of 45 participants were conducted among street-based female sex workers in Heidelberg Road. The discussions took place at the Centre for Positive Care offices in Germiston. The participants were recruited using a purposive sampling technique. The data were collected verbatim, translated, transcribed, and analysed using the NVIVO version 10 software.

Findings

At the onset of sex work, most female sex workers lack knowledge of why it is important to use condoms during sexual intercourse and lack information on how to use condoms safely. They reported that they find the female condom very strange, complicated and difficult to use. All the participants reported that they don’t have difficulty in accessing condoms and that there are many organisation responsible for providing them with condoms, such as the National Department of Health, Ekurhuleni mobile clinics, the Centre for Positive Care, and the Wits Reproductive Health and HIV Institute. Being an experienced female sex workers was associated with the ability to refuse clients unprotected sex. Almost all of the female sex workers reported using condoms inconsistently with both clients and steady partners.

The participants reported using four strategies to negotiate condom use with their clients: direct request for the client to use a condom, using health-risk information to...
convince or threaten the client into using a condom, charging more for unprotected sex, and refusing unprotected sex and letting the client go without buying sex.

Various barriers to condom use were reported, such as financial need; a sense of love and belonging; risky, unregulated and unhealthy working environments; an absence of threat related to appearance-based judgment; the excuses given by male clients when refusing condom use; the intentional spread of HIV/STI's; the abuse, harassment and victimisation of sex workers by the police; and the work pressures of being a sex worker.

**Conclusions and recommendations**

Based on these findings it will necessary for the Department of Health to review the female condom design and possibly redesign it to make it user friendly and more suitable for use by female sex workers, especially because they are always in a hurry in their work. Peer education with regards to condom use and condom demonstration for both male and female condoms must be strengthened in hot spots, so that new female sex workers can be educated on the importance of condom use, and also learn how to use condoms effectively. Female sex workers should also be empowered to refuse unprotected sex and should be taught how to convince an unwilling client or steady partner to use condoms. As condom use is dependant not only on sex workers, HIV prevention programme strategies should target both sex workers and their clients or steady partners.

**Key words;** Female sex workers, sex work, HIV/STI, condom use.
# ABREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbr.</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
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<td>CPC</td>
<td>Centre for Positive Care</td>
</tr>
<tr>
<td>FSWs</td>
<td>Female Sex Workers</td>
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<td>NGO</td>
<td>Non–Governmental Organisation</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>SWEAT</td>
<td>Sex Workers Education and Advocacy Taskforce</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WRHI</td>
<td>Wits Reproductive and HIV Institute</td>
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</tbody>
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DEFINITION OF TERMS

**Sex work**: is the consensual provision of sex services for money or goods (Overs, 2002).

**Brothels**: are houses where sex work takes place and are located in specific areas known for their sex work activities (Overs, 2002).

**Female sex workers**: are adults who receive money or goods in exchange for sexual services, this can be done on a regular basis as the only source of income or on part time to supplement another source of income either regularly or part-time (Overs, 2002).

**Condom use**: is the act of using a condom (as a form of protection) during sexual intercourse between female sex workers and their clients and stable partners (Overs, 2002).

**Street-based female sex workers**: are sex workers who solicit their clients from public places, commonly streets (mostly highways and freeways), while waiting at street corners or walking alongside a street, but also in other public places such as parks, etc. (Overs, 2002).

**Peer educators**: are female sex workers who have been trained to teach or share health information, values and behaviour in educating others (other female sex workers) who share similar backgrounds or life experiences (Overs, 2002).

**Sex worker clients**: are people (usually men) who pay with cash or other resources for sexual services either explicitly or within an agreed package that includes other services such as entertainment or domestic service like doing laundry or cooking (Overs, 2002).

**Third parties**: are people who play ancillary roles in commercial sex. These include arranging meetings between sex workers and clients and/or providing resources and services. These roles vary from place to place and in terms of influence and power over commercial sex and sex workers (Overs, 2002).

**Sex workers’ steady partners**: are men who pay for sex with the same female sex worker many times or men who have more emotional involvement with female sex workers and who, in addition to paying for sex, may also provide extra money for basic...
necessities or assistance with living accommodation. After some time in some instances the steady partners no longer pay for sex as they are perceived as partners and not clients (Overs, 2002).
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Content</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declaration</td>
<td>i</td>
</tr>
<tr>
<td>Dedication</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>iii</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>iv</td>
</tr>
<tr>
<td>Abstract</td>
<td>v</td>
</tr>
<tr>
<td>Definition of terms</td>
<td>vi</td>
</tr>
<tr>
<td>Chapter 1: Introduction, Background ad study Rationale.</td>
<td></td>
</tr>
<tr>
<td>1.1 Introduction and background</td>
<td>1</td>
</tr>
<tr>
<td>1.2 The context of sex work on Heidelberg Road in Ekurhuleni</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Research Problem</td>
<td>4</td>
</tr>
<tr>
<td>1.3.1 The source of the research problem</td>
<td>4</td>
</tr>
<tr>
<td>1.3.2 Research Problem statement</td>
<td>4</td>
</tr>
<tr>
<td>1.4 Study purpose and research questions</td>
<td>5</td>
</tr>
<tr>
<td>1.4.1 Research questions</td>
<td>5</td>
</tr>
<tr>
<td>1.5 Research objectives</td>
<td>5</td>
</tr>
<tr>
<td>1.6 Justification of the study</td>
<td>6</td>
</tr>
<tr>
<td>Summary</td>
<td>6</td>
</tr>
<tr>
<td>Chapter 2: Literature Review.</td>
<td></td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>7</td>
</tr>
<tr>
<td>2.2 The prevalence of sex work</td>
<td>7</td>
</tr>
<tr>
<td>2.3 The structure of sex work</td>
<td>9</td>
</tr>
<tr>
<td>2.4 Factors leading into sex work</td>
<td>9</td>
</tr>
<tr>
<td>2.4.1 Financial issues and a lack of education</td>
<td>9</td>
</tr>
<tr>
<td>2.4.2 Family disorganisation</td>
<td>10</td>
</tr>
<tr>
<td>2.4.3 Traditional and cultural issues</td>
<td>10</td>
</tr>
<tr>
<td>2.5 Available types of condoms</td>
<td>10</td>
</tr>
<tr>
<td>2.6 Challenges faced by sex workers</td>
<td>12</td>
</tr>
<tr>
<td>2.6.1 Female sex workers’ condom use and vulnerability to STI's/HIV</td>
<td>12</td>
</tr>
<tr>
<td>2.6.2 Barriers to condom use</td>
<td>13</td>
</tr>
<tr>
<td>2.6.2.1 Lack of information on condom use</td>
<td>14</td>
</tr>
<tr>
<td>2.6.2.2 Lack of education</td>
<td>14</td>
</tr>
</tbody>
</table>

x
2.6.2.3 Personal barriers to condom use.15
2.6.2.4 Condom failure during sex as a challenge.16
2.6.2.5 Sex work and law enforcement.17
2.6.2.6 Violence experienced by female sex workers.18
2.6.2.7 Practices that increases the risk of HIV/STI transmission and acquisition among female sex workers.18

2.7 Clients of female sex workers characteristics and their sexual risk behaviours.19

2.8 The impact of doing sex work.20
2.8.1 The impact on personal romantic relationships.20
2.8.2 The stigma surrounding sex work.21
2.8.3 The experience of violence.21
2.8.4 Poor health.22

2.9 Strategies to mitigate the challenges faced by female sex workers.22
2.9.1 Sex worker-specific health services.22
2.9.2 Adolescent- and gender-focused interventions.23
2.9.3 Rehabilitation services for female sex workers.24
2.9.4 Improve women’s literacy levels.24

2.10 Institutions contributing to STI/HIV prevention among female sex workers.24
2.10.1 The National Department of Health of South Africa.24
2.10.2 Wits Reproductive Health and HIV Institute.25
2.10.3 Sex Worker Advocacy and Task Force.25
2.10.4 Centre for Positive Care.25
2.10.5 North Star Alliance.26

Summary.26

Chapter 3: Research Design and Methodology
3.1 Introduction.28
3.2 Study design.28
3.3 Data collection.29
3.4 Focus Groups.30
3.5 Study setting and population.30
3.6 Sample and sample technique.30
3.7 Inclusion and exclusion criteria.31
3.8 Participant recruitment ................................................................. 32
3.9 Data analysis .................................................................................. 32
3.10 Trustworthiness ............................................................................ 33
3.11 Ethical considerations ................................................................. 35
Summary ............................................................................................ 37

Chapter 4: Presentation of Study Findings.
4.1 Introduction .................................................................................... 38
4.2 Description of the data analysis process and the development of themes ... 38
4.3 Study context .................................................................................. 39
4.4 Socio-demographics ....................................................................... 39
4.4.1 Tables ............................................................................................. 40
4.4.2 Pie charts ....................................................................................... 45
4.4.3 Normality histograms ..................................................................... 47
4.5 Overview of Themes and Subthemes .............................................. 49
4.5.1 Condom use, knowledge and practices ........................................ 51
4.5.1.1 Condom use knowledge and practices at the outset of sex work ... 51
4.5.1.2 Condom use practices over time as a sex worker ....................... 52
4.5.1.3 Use of female condoms as an alternative .................................... 53
4.5.1.4 Female sex workers criticizing the female condom ....................... 55
4.5.1.5 Incorrect use of condoms by female sex workers ....................... 56
4.5.1.6 Knowledge that non condom use is associated with health risks ... 56
4.5.1.7 Accessibility of condoms to female sex workers ....................... 57
4.5.2 Negotiation of condom use by female sex workers ...................... 58
4.5.2.1 Direct request and enforcement of condom use by female sex workers ............................................................................................................. 59
4.5.2.2 The use of health risk information by participants as a condom use negotiation strategy ..................................................................................... 60
4.5.2.3 Charging more for unprotected sex as a condom use negotiation strategy ........................................................................................................... 61
4.5.2.4 Refusal of unprotected sex and letting the client go without buying as a condom use negotiation strategy ........................................................................ 62
4.5.3 Perceived barriers to condom use ............................................... 62
4.5.3.1 Financial need as a barrier to condom use ................................... 63
4.5.3.2 The sense of love and the need to belong .................................... 64
CHAPTER ONE

INTRODUCTION, BACKGROUND AND STUDY RATIONALE

1.1 Introduction and background

Worldwide, Human Immune Deficiency Virus (HIV) epidemics are mostly concentrated in high-risk populations such as sex workers, drug users, and homosexual men. High risk populations have a high burden of HIV/sexually transmitted infections (STI’s) even in countries with HIV epidemics such as those in sub-Saharan Africa. This may be caused by the fact that high risk populations, including sex workers, have been poorly represented in the national health surveillance system. Globally, sex work bears a disproportionately high HIV burden (Coetzee et al., 2017; Okafor et al., 2017). Sex workers also experience high levels of social and health problems such as unwanted pregnancies, STI’s and HIV infections (Moore et al., 2014; Voetan et al., 2002). In countries with HIV epidemics, female sex workers (FSW’s) have a 13.5 greater chance of contracting HIV than the general female population (Chow et al., 2015). Sex workers carry a heavier burden of HIV than the general population. In South Africa there is high prevalence of HIV among sex workers in urban arrears, with the overall odds of HIV infection among sex workers being five times higher than in the general female population (Fobosi et al., 2017).

About 4.3% of woman engage in sex work in sub-Saharan Africa. Their having multiple sex partners and their poor condom negotiation skills predispose them to acquiring and transmitting HIV and other STI’s (SANAC, 2013). Unprotected sex and multiple sexual partners are important risk factors in HIV acquisition and transmission (Okafor et al., 2017). It has been noted that many woman, whether married or single, employed or unemployed, as well as young girls between the ages of 13 and 17 years, enter into sex work (Nkala, 2014). According to Jie et al. (2012) the practice of offering sex in return for money has been reported for centuries, with the majority of FSWs starting to do sex work at a very young age. Entry into sex work, chiefly in cities, is said to be
caused mainly by the lack of employment opportunities that pay descent remuneration packages (McKinnon et al., 2015; Okafor et al., 2017). The literature shows that most FSW's are illiterate and are responsible for financially supporting their families (Bharat et al., 2013).

Due to their having so many sexual partners and their inconsistent condom use, FSW’s are more likely to be infected with HIV than the general female population (Chow et al., 2015; Okafor et al., 2017). HIV and other sexually transmitted infections (STI’s) remain highly prevalent among FSW’s in most settings, with 33-37% prevalence of HIV (Matovu & Ssebadduka, 2013; Okafor et al., 2017). Given the fact that sex work is expanding worldwide, the failure to use of condoms by FSWs is still an important target for STI/HIV prevention (Urada et al., 2012, Okafor et al., 2017). The UNAIDS 2010 global report on HIV/AIDS indicated that more than 90% of FSW’s reported condom use with their last client. Even with this progress, consistent condom use with clients remains very rare in majority of settings (Matovu & Ssebadduka, 2013).

According to Loftie et al. (2012) and Okafor et al. (2017) the correct and continuous use of condoms during sexual relations is one of the most effective strategies for HIV/STI prevention. FSWs are therefore a key target population for HIV prevention and promoting condom use with male clients (Bharat et al., 2013, Okafor et al., 2017). However, FSW’s lack power to negotiate condom use, not only on account of being women but also due to their being in unequal relationships with male clients who are their source of income (Okafor et al., 2017). Condom use with male clients depends on the ability of a FSW to successfully negotiate condom use (Bharat et al., 2013).

According to the National Health Strategic Plan on HIV, STI’s, TB and sex worker health have been identified as priorities by the Health Department of South Africa. This shows the need for assessing condom use practices and barriers to condom use negotiation (Batist et al., 2013). However, Moore et al (2014) state that FSW’s are a priority for HIV intervention globally but have low prevention, treatment and support.

The criminalization of sex work limits the ability of FSW’s to minimize their occupational health hazard. In countries where sex work is illegal, FSW’s are abused
by the law enforcement agencies and as a result resort to not carrying condoms around because they can be used as evidence of their occupations in court, should they be arrested. In addition, police officers would require a bribe or sex in exchange for their freedom, and hence they are at risk of contracting and transmitting HIV and other STIs (Coetzee et al., 2017; Nkala, 2014; SANAC, 2013).

1.2 The context of sex work on Heidelberg Road in Ekurhuleni

Heidelberg is a South African town with coordinates of 26.5° south and 28.35° east. It has about 64,199 inhabitants. It is not far from the OR Tambo international airport. Heidelberg Road is on the border of Gauteng Province. Lots of farming is done in Heidelberg, so trucks frequent the area. The road is also parallel to the toll route N3 to Durban, so some truckers avoid the toll road and use Heidelberg Road instead. According to the Geoview.info, Heidelberg Road is a busy road as it connects to the N3 going to Durban as well as to the route going to Free State Province. The road is also a feeder to Nigel, which happens to be an industrial area, so there is a lot of movement in and around this area. The place is frequented by sex workers from all over the country as well as from outside the country. It is regarded as a Hot Spot since it has a high prevalence of HIV/STI infection among street-based FSW’s. The area has never been studied from this perspective, although it is a “hot spot” with lots of sex workers. Hence, the researcher decided to conduct a study there (geoview.info).

Gauteng province has an estimated 32 000 sex workers, of whom 89% are FSW’s. A proportion of 80% of the sex workers are based in Ekurhuleni, the City of Johannesburg and Tshwane districts (Dunkle et al., 2004). The high number of FSW’s in Ekurhuleni could be due to the fact that the OR Tambo international airport is nearby, it is an industrial area, and a large number of truck drivers pass through on the Heidelberg Road. A map of Heidelberg Road has been pasted below.
1.3 Research Problem

1.3.1 The source of the research problem
The researcher worked for Wits Reproductive Health & HIV Institute (WRHI) sex worker project for one year, where she was responsible for providing Primary Health Care Services including (HIV counselling and testing, ART initiation and management, screening and treatment of Sexually Transmitted Infections) to the sex workers in Johannesburg, Pretoria and Ekurhuleni. The project has a well-established peer education program, which provides health education on condom use, condom demonstration as well as distribution of condoms and lubricants to all sex worker hot spots. The researcher then identified some of the challenges faced by female sex workers such as a high rate of new HIV infections as well as recurrent sexually transmitted infections. This stimulated the researcher to be interested in knowing more about female sex worker condom use.

1.3.2 Research Problem statement

Almost 68% of all people living with HIV world-wide are in Sub-Saharan Africa whereby 59% of them are woman (Bukenya et al., 2013). Meaning that woman account for an increasingly disproportionate number of HIV infections (Shannon et al., 2009).
Annually there is an estimation of about 350 000 new HIV infections, and 20% of them are related to sex work. Approximately 14% of the newly infected are sex worker clients and partners, and an estimated 6% are the sex workers themselves (Batist et al., 2013). Unprotected heterosexual intercourse, including transactional sex, is one of the major drivers of new HIV/STI infections (Nyembe et al., 2014). There is an estimation of 130 000 to 180 000 sex workers in the country with 90% of them being female sex workers and 10% being transgender or males (Nyembe et al., 2014).

Numerous countries including South Africa have adopted intervention programmes for FSWs that focus on increasing condom use as a strategy, because of the effectiveness of consistent condom use for preventing the acquisition and transmission of HIV/STIs (Chow et al., 2015; Okafor et al., 2017). The role of condom use in prevention of HIV/STI has been known for over 25 years and we might expect individuals with multiple sexual partners to consistently use condoms during sex for protection but it’s not always like that (Bukenya et al., 2013). However, the literature shows that FSWs lack condom use negotiation skills with clients (Bharat et al., 2013). As a result FSW remain a core group for HIV transmission in both early and advanced HIV epidemics (Bukenya et al., 2013).

Although Shannon et al. (2009) maintain that research has identified individual level factors that predict consistent condom use, there remains a paucity of data in South Africa on condom use among sex workers. Condom use with a male client depends on the ability of a FSW to effectively negotiate condom use (Bharat et al., 2013). Interventions which promote condom use by FSW’s must empower them with condom use negotiation skills; but this will be possible only when there are adequate data on FSWs’ condom use practices (Okafor et al., 2017). According to Lotfi et al. (2012), some FSW’s who are also drug users have low self-esteem. They feel that because they have chosen to be in this profession they are therefore deprived of their right of choice regarding condom use (Moore et al., 2014).
1.4 Study purpose and research questions

The aim of this study was to explore FSW’s condom use practices and condom use negotiation skills, and the barriers to their condom use.

1.4.1 Research Questions

The research questions asked in this study are as follows:

- What are the condom use practices of FSW’s on Heidelberg Road, Ekurhuleni?
- How do FSW’s negotiate condom use on Heidelberg Road, Ekurhuleni?
- What are the barriers to condom use among FSW’s on Heidelberg Road, Ekurhuleni?

1.5 Research Objectives

The objectives of this study were:

- To describe condom use practices among FSW’s and their clients;
- To describe and understand how FSW’s negotiate condom use; and
- To describe FSW’s barriers to condom use.

1.6 Justification of the study

The prevalence of HIV among FSW’s is 60% and this notion indicates that condom use is minimal amongst these group of participants (WHO, 2011). Since heterosexual sex is one of the ways in which HIV is transmitted, it is of importance to understand the dynamics of condom use by FSW’s. Condom use would contribute to the reduction of HIV prevalence and incidence among FSW’s. Sex workers have many sexual partners, a fact which increases the risk of infection, and the spread of HIV and other STI’s to the general population. It is evident that most studies that focus on FSW’s sexual behaviors and condom use have been conducted outside of sub-Saharan Africa and most are largely quantitative in nature. Most studies focus on quantitative assessment of the practices, negotiation of condom use and barriers to condom use among FSW’s and their clients. Hence, condom use by FSW’s has not been fully explored, especially in sub-Saharan countries, as they have conservative cultures and
backgrounds. Therefore, the information obtained in this study will be useful in influencing health promotion strategies aimed at improving condom use promotion programmes by FSW's and their clients.

**Summary**

This has chapter focused on the orientation of the study. Some studies on sex work have identified a high rate of HIV/STI transmission amongst sex workers and their clients (Batist *et al.*, 2013; Coetzee *et al.*, 2017; Chow *et al.*, 2015; Fobosi *et al.*, 2017; Moore *et al.*, 2014; Okafor *et al.*, 2017; WHO, 2011). Limited research has been performed in SA on female sex workers and their condom use. Hence the need for the researcher to focus on the topic. The researcher realized that there was a need to explore and better understand the experiences of sex workers as regards the use of condoms, condom use negotiation and barriers to condom use.

The next chapter presents a literature review on female sex worker condom use
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The previous chapter focused on the orientation to the study. This chapter will focus on the literature review and will cover the prevalence of sex work, the structure of sex work, factors leading to sex work, the impact of sex work, challenges faced by female sex workers, and factors mitigating sex work.

2.2 The prevalence of sex work

Sex work is defined as the exchange of money for sexual services. Sex work pertains to adult consensual sex (UNAIDS, 2011). Sex workers include female, male and transgender adults who are sex traders, and it is different from human trafficking as well as the commercial sexual trafficking of children, which are abuses of human rights (SANAC, 2013). For the purpose of this study a female sex worker is defined as a woman who is above the age of 18 years, who receives money, food, shelter, materials or goods in exchange for sexual activities, and who consciously defines those activities as income generating, even if she does not consider sex work as her occupation (Harcourt & Donovan, 2005).

Female sex work is the most prominent type of sex work in South Africa. Sex work is an important feature of the transmission dynamics of HIV within early, advanced and regressing epidemics in sub-Saharan Africa (SANAC, 2013). The prevalence of FSW's in sub-Saharan Africa ranges from 0.7% to 4.3% of the total female adult population in capitals, and 0.4 % to 4.3% in other urban areas, with an estimate of 132 000 FSW's in South Africa in 2009 (SANAC, 2013). After three decades of the HIV pandemic, understanding of its impact on sex workers remains limited (Bharat et al., 2012). Sex workers are 10 times more at risk of HIV than the adult population as a whole (UNAIDS, 2016). In low and middle-income countries, the HIV prevalence among sex workers is estimated to be 12% (Bharat et al., 2012). Sex workers are at risk of HIV
due to their increased likelihood of being economically vulnerable, unable to negotiate consistent condom use, and experiencing violence, criminalization and marginalization.

In four countries in sub-Saharan Africa the HIV prevalence among FSW’s is 50 times higher than in the general population. One study of 16 countries in sub-Saharan Africa found an average HIV prevalence of 37% among sex workers (UNAIDS, 2014). In Nigeria and Ghana, the HIV prevalence among sex workers is 8 times higher than among the rest of the population (The World Bank, 2013). Although sex workers are among one of the groups most affected by HIV, they are also one of the groups most likely to respond well to HIV prevention programmes. Proof of this can be seen in countries such as Cambodia, the Dominican Republic, India and Thailand, where a reduction in national HIV prevalence have been helped by initiatives targeting sex workers and their clients.

As HIV epidemics appear to be decreasing in some countries in sub-Saharan Africa in the general population, as in parts of the East Africa, the relative importance of key populations such as sex workers increases. An important public health principle applicable to many diseases, including HIV, is that different populations have an unequal risk of acquiring diseases, and that those groups at higher risk require specific services. These services, by necessity, must differ in type from services that target groups at lower risk (UNAIDS, 2011).

In sub-Saharan Africa there are no country-level programmes that specifically target HIV prevention among sex workers on an adequate scale. Currently, about one in three sex workers receives adequate HIV prevention services in sub-Saharan Africa, with even fewer having access to HIV treatment, care and support (UNAIDS, 2009). A few non-governmental organizations and research groups, however, have developed and implemented effective programmes for sex workers and their clients. Most of these programmes are small in scale and project-based, do not sufficiently involve sex workers in the planning and evaluation, and operate with insufficient resources and support from national governments and international agencies (WHO, 2011). To date, research and programmatic activities on sex work in sub-Saharan Africa have focused
almost exclusively on female sex workers and their male clients. To respond to the heavy burden of HIV/STI among sex workers, the national Department of Health published the South African sex workers HIV plan (NSWP), which aims to reach 70,000 sex workers over the next five years. The programme aims to offer sex workers comprehensive health care and ensure that the 90-90-90 global targets have been met. The targets are aimed at ensuring that at least 90% of sex workers have tested for HIV and know their HIV status, that 90% of those who tested HIV-positive have been started on antiretroviral treatment, and that 90% of sex workers on ART are virally suppressed (SANAC, 2016).

2.3 The structure of sex work

The structure of sex work varies substantially around the world, due to the fact that FSW’s may work with or without a third party who is a facilitator or controller, for example a pimp, a boss or a manager (Round, 2015; Coetzee et al., 2017; Okafor et al., 2017). Sex work is illegal in most countries and FSW’s lack access to legalized indoor settings. Hence, they practice sex work in any place possible, such as in public places such as parks, streets, highways or in bars, hotels, brothels, private houses and in some instances in any place of the client’s choice, such as in the client’s car (Baral et al., 2012; Okafor et al., 2017; Overs, 2002). Sex work can be done part-time with or without another type of employment, or as a full-time job, where it is done on regular basis (World Health Organization, 2011).

2.4 Factors leading into sex work

The literature presents the factors leading to sex work as being financial or economic issues, a lack of education, family disorganization, and traditional and cultural issues.

2.4.1 Financial issues and a lack of education

Entry into sex work may be precipitated by high rates of unemployment, low socio-economic status and limited education, as most sex workers are responsible for supporting their children and extended family members (Coetzee et al., 2017). Although some are pushed into the profession, most enter it out of economic necessity
and the lack of skills to earn a living otherwise (Bharat et al., 2013). A country’s dysfunctional socio-economic and political system may predispose women into entering sex work. Poverty and an inability to afford education are some of the factors that push them into this type of work (Nkala, 2014). Women may be doing other jobs in addition to sex work, and sex work may be done to augment the insufficient income. Some may be doing it full time, and therefore it is difficult to get an idea of how any FSW’s there are, and even harder to provide any type of healthcare intervention for the many different categories, because most of them are in hiding and some of them don’t self-identify themselves as sex workers (Mbonye et al., 2013). Coetzee et al. (2017) also found that lower levels of education, gender inequity, violence, migration and poverty are all structural drivers to entering sex work, and they are also drivers of the heterosexual HIV epidemic.

2.4.2 Family disorganization

All forms of abuse, which include physical, emotional, sexual and psychological abuse, have negative impacts on young women and girls at home. Child neglect and incest can perpetuate the cycle of sex work, leading them to contract HIV/AIDS. This may lead to young women running away from home and practicing sex work as a survival strategy in the streets (Nkala, 2014). In some instances, in child headed-families a girl child can resort to practicing sex work to support herself and her siblings. In most families children are raised by single women, perhaps because of a divorce or parents separating, the death of the father and/or the mother. Then the woman is left alone with the responsibility to finically support herself and her children. The shortage of employment opportunities results in these woman entering sex work to meet their financial needs (Beattie et al., 2015).

2.4.3 Traditional and cultural issues

Some women enter into sex work because they want to avoid the traditional domestic gender roles. They seek independence and the flexibility offered by sex work. Given their financial debts and their relationship or family problems, sex work is an important source of income, especially in informal settlements (SANAC, 2013). In most African
countries women are responsible for preparing meals and ensuring that there is food on the table on a daily basis. Therefore, to ensure that the family does not go hungry they may enter into sex work (Beattie et al., 2015; SANAC, 2013) In some cultures parents have different gender expectations and aspirations for their children. Gender discrimination results in girls having lesser education than boys, therefore young women don’t get enough support and motivation to stay in schools. In some instances, young girls are forced to get married at a young age and to have children. Should the relationship break down the young woman has minimal chances of getting a decent paying job and could resort to sex work for its financial benefits (Beattie et al., 2015). Some traditional practices force women to get married at a very young age without their consent, whereby they are sold by their parents or family members to men at an agreed price (Beattie et al., 2015). Although it is illegal, in rural arrears of South Africa this act is practised as a tradition. It is called ukuthwalwa in Isizulu, which means “abduction”. Therefore some young girls run away from home and from these husbands and find themselves resorting to sex work in the cities.

2.5. Available types of condoms - Male female and dental dam condoms

Condoms are described as thin rubber or plastic membranes or barriers used during sexual activity to prevent the phallus from coming into contact with vaginal, seminal fluid or blood during sex. Condoms are an effective, safe and easy to use method of preventing unwanted pregnancy as well as STI’s and HIV (Van Dyk, 2010). There are three types of condoms: the male condom, the female condom and the dental dam. They are presented in a variety of ways. They may be flavoured, coloured, spotted, or ribbed condoms. There are also finger projected condoms, and they may be lubricated or dry (Van Dyk, 2010). The male condom is the most preferred (Peters et al., 2014). There is low uptake of the female condom, which may be due to the limited promotion or marketing of the device, and it is therefore inaccessible for most woman. In addition, the low acceptance rate and infrequent use may be associated with a lack of knowledge of how to insert it and use it safely (Peters et al., 2014).
2.6. Challenges faced by sex workers

Literature states that the following are the challenges of being a sex worker; female sex workers condom use and vulnerability to STI/HIV, barriers to condom use and lack of education.

2.6.1 Female sex workers’ condom use and vulnerability to STI’s/HIV

Sex work is characterized by increased rates of commercial sex partner exchange and low rates of condom use with clients and regular partners (Ghimire et al., 2011; Overs, 2002; Okafor et al., 2017). The literature shows that consistent condom use between FSW’s and their clients is hard to find, and even lower between FSW’s and their regular partners or non-paying clients (Jie et al., 2012; Okafor et al., 2017; Overs, 2002). Tamene et al. (2015) found that FSWs lacked condom use with all of their sexual partners, regardless of whether they were partners, boyfriends, husbands or clients.

FSWs make a psychological distinction between their private sexual lives and their work, as they develop feelings of trust and intimacy with their steady partners, boyfriends or husbands, and the use of a condom is solely dependent on the male partner and the fear that suggesting condom use would be used as evidence of doing sex work (Ulibarri et al., 2012). The lack of condom use with steady partners is a great concern, given that their partners may contribute more to FSW’s STI/HIV risks than clients do (Overs, 2002; Okafor et al., 2017). For example, a study which was done in Cotonou, Benin, showed that HIV prevalence among FSWs’ steady partners was twice as high as the HIV prevalence among their clients (16.1% versus 8.4%). This was an issue especially because some of these partners were people that they had met when they were already sex workers (Ulibarri et al., 2012).

The point of contact was also found to be influential in regard to condom use, because FSW’s that were street-based reported less condom use than those working in well-structured environments like hotels and massage parlours (Bui et al., 2013). Round
(2015) found that HIV and syphilis were higher among street-based FSW’s than among establishment-based FSWs. The street-based FSWs had lower education levels, charged less for sex, and had been sex workers for a longer period of time than those who were establishment-based. As a result, the vulnerability of street-based FSW’s to HIV/STI’s is much higher than that of the establishment-based FSW’s. Street-based FSW’s are also more likely to abuse drugs and make inconsistent use of condoms, and their clients are often drug users (Barat et al., 2012).

Urada et al. (2012) found that FSW’s who were coerced or trafficked into sex work are twelve times less likely to negotiate condom use than those who entered sex work willingly. Barath et al. (2012), in a study that assessed the burden of HIV among FSW’s, found that HIV and syphilis were also highly prevalent among separated (widowed/divorced) FSW’s. In the context of commercial sex, women who were divorced or widowed and who had lower educational status may have more financial pressure and need to support their family, especially children, as well as themselves, which will predispose them into not using condoms to make more money (Bharat et al., 2013).

Women who grew up in resource-poor settings usually lacked opportunities to acquire education or skills. Without job-related skills, these women may lack the opportunities to find alternative jobs and may therefore engage in sex work to make money (Chow et al., 2015). In a study assessing the prevalence of HIV/STI’s among FSW’s, comparing it to the findings of the same study done in 2007 (prior to the implementation of the sex worker intervention programmes) he found that HIV infection was still widespread among FSW’s, and condom use was reported to be lower than the highest standard of quality which was expected, given the interventions that had been made (Vandenhoudt et al., 2013).

2.6.2 Barriers to condom use

The literature presents the following factors as barriers to condom use: a lack of information on condom use, and a lack of education,
2.6.2.1 Lack of information on condom use

Bui et al. (2013) found that the FSW’s did not have strategies to negotiate condom use with clients. Most mentioned the use of risk information as a negotiation strategy, and if that failed they did not know how to further negotiate condom use. It was also reported they were not able to negotiate condom use due to language barriers (Tamene et al., 2015; Okafor et al., 2017).

2.6.2.2 Lack of education

They further reported that being more educated with regard to methods of HIV/STI transmission and prevention resulted in an increase in condom use by FSW’s. Studies conducted by Coetzee et al. (2017), Overs (2002), and Okafor et al. (2017). It was also found that FSW’s who lacked knowledge regarding STI/HIV transmission were more likely not to use condoms consistently than those who had knowledge. It was found in a cohort study that HIV prevalence was high at baseline (30%), suggesting that many FSW’s had already been infected prior to exposure to a HIV-prevention programme (Overs 2002; McKinnon et al., 2015). Other barriers to consistent condom use which were reported by FSW’s were client objections, a need for sexual satisfaction, being under the influence of substances, and trusting that the sex partner does not have a disease (Tamene et al., 2015).

Occupational characteristics, trusting the stable partner, wanting to demonstrate trust towards their partners, boyfriends and clients, the venue where the sexual act takes place, and a lack of social support as the important determinants to unsafe sex. In addition to the factors that influence non-condom use, this includes being new in the sex work trade, and charging more for unprotected sex (Mbonye et al., 2013). Being a FSW was associated with high rates of physical and sexual intimate partner violence, which also increases the risk of contracting HIV/STI’s (Coetzee et al., 2017).

McKinnon et al. (2015) found that there was high HIV prevalence among sex workers who charged more for sex, suggesting that they could have been charging more for unprotected sex. The cost of sex work varies among sex workers. The price is negotiated between a client and a sex worker and it is determined by the client’s requests, the duration of time spent together, and if a condom will be used or not
Alcohol and drugs were found to be barriers to condom use. The literature has shown that there are personal factors associated with FSW's failures to use condoms. An earlier study conducted by Wee et al. (2004) found that alcoholism, poor knowledge of STI/HIV, less positive social norms, and lower self-efficacy were related to inconsistent condom use, as these factors impaired their decision-making abilities, while Jie et al. (2012) found that being young and having a lower level of education was associated with inconsistent condom use. FSW's that had recently tested for HIV were more likely to use condoms than those that had not, and this could be related to knowing one's HIV status and the effectiveness of the counselling provided before and after testing (Tamene et al., 2015).

### 2.6.2.3 Personal barriers to condom use

According to Lofti et al. (2012), personal barriers to FSW's using condoms are that they don't perceive any threat in their actions, they are not motivated to protect themselves and others, they know little regarding the risk of infection, they believe that they are not in control and that as a result they cannot make a decision regarding condom use, they want to experience sexual pleasure, they have negative attitudes towards using condoms, and alcohol and drug abuse minimizes their ability to judge safety behaviour (Bukenya et al., 2013). FSWs are therefore susceptible to risk due to the decisions they make when engaging in risky sexual behaviours (Bukenya et al., 2013). The following factors are suggested as being associated with the inconsistent use of condoms: debut at an age of less than 14 years; being unmarried; having fewer clients; and alcohol consumption (compared with those who don't drink). Being pregnant was also associated with inconsistent condom use, as the women were no longer worried about conceiving (Mbonye et al., 201). The reasons for the refusal of condom use given by clients, as reported by FSW's, were that they thought there would be less pleasure in the act, and that when the client and the worker were well acquainted they did not need protection against STI's/HIV.

Some of the FSW's beliefs are that a good-looking male client cannot spread HIV/STI, and some take antibiotics before sex as a preventative measure against STI's. Others reported that their pimps are not supportive of condom use and consider it a threat to
business. Condom unacceptability is the main reason for not using condoms for both FSW’s and their clients (Basuki et al., 2002). Although free condom distribution has increased over the years, some FSW’s reported a lack of accessibility to free condoms as a reason for not using condoms. Client brutality, client refusal, a fear of negotiating condom use, receiving extra payment as well as being instructed by their pimps or the owners of the working environment, are some of the reasons for not using condoms (WHO, 2011). The refusal of the male partner to use a condom, the belief that a condom kills the mood for sex, as well as alcohol and drug use before sex are the key barriers to consistent condom use (Mbonye et al., 2013).

According to Bellhouse et al. (2015), poverty interpreted as ones inability to take care of one’s basic needs was noted as the driving force for FSW’s not to use condoms even in situations where they knew that there is a risk of STI and HIV infection (McKinnon et al., 2015). The need to make money overrides the normative expectation that a woman who is on her menses should not have sex at this period. One of the excuses given by males when refusing to use condoms was a failure to maintain an erection (Wojcicki & Malala, 2001). Matovu and Ssebadduka (2013) and Okafor et al. (2017) state that although programmes for HIV prevention among FSW’s have achieved major progress in increasing condom use and reducing the associated HIV infections, consistent condom use remains low in most settings. As a result the prevalence of STI’s and HIV remains very high.

2.6.2.4 Condom failure during sex as a challenge

Condom failure is explained as the condom’s breaking or slipping during sex, and sex workers report that condom failure may be intentionally or unintentionally caused by the direct action of the client (Masvawure et al., 2017; Okafor et al., 2017). In a study which was done to assess the determinants of condom breakage among FSW’s, factors in play were found to be being new in sex work, being less than 20 years old, not having witnessed a condom demonstration, and inconsistent condom use. Those who reported that they had had anal sex were twice as likely to report having had a condom breakage as those that had not. Condom breaks were even higher in those
that reported that they had been the ones that inserted the condom at the last sexual act where a condom was used and it broke (Bradley et al., 2011; Okafor et al., 2017).

Considering that not all condom users know how to use a condom correctly, the healthcare workers and peer educators of sex workers should be equipped with the necessary knowledge, skills and abilities to train sex workers through condom demonstrations. Illustrations of using condoms can enable the safe and effective use of condoms to curb the spread of HIV/STIs (Bradley et al., 2011; Okafor et al., 2017). Following a condom failure, some sex workers reported that they did nothing in particular. Some reported taking a bath and some replaced the condom, while others took post-exposure prophylaxis for HIV, and some tested for HIV (Masvawure et al., 2017).

2.6.2.5 Sex work and law enforcement

In most countries including South Africa sex work is considered illegal. Therefore sex workers have minimal legal protection and their direct contact with the criminal law is through police officers, as they have a mandate to apprehend criminal offenders. However, there few sex workers are prosecuted under criminal law due to the difficulties associated with establishing evidence of sex-for-reward transactions and the procedural problems related to arresting people involved in these transactions (SANAC, 2013).

The police exercise wide powers over sex workers without following the correct procedure. They use municipal by-laws such as loitering or creating a public disturbance to harass them, and this creates a hostile and violent environment for sex workers. The types of abuse inflicted by police on sex workers include rape, gang rape, physical and verbal abuse, unlawful arrest, demanding bribes for freedom, and refusing to open cases for them if they complain of crimes such as rape (Coetzee et al., 2017; Overs, 2002). The activity of arresting sex workers as a method of abolishing sex work is counterproductive in that when they are released they work harder to make up for the time lost in prison as well as the money lost through having to pay a bribe or bail (SANAC, 2013).
2.6.2.6  Violence experienced by female sex workers

Sex work is illegal in South Africa. As a result it is relegated to hidden environments or areas with little protection, and this predisposes people to engage in all kinds of violence against FSW’s (Fobosi et al., 2017; Okafor et al., 2017; Overs, 2002; Wirtz et al., 2015). Violence is a common experience for them. The perpetrators of the violence may be clients, intimate partners, the police, or individuals not known by the sex workers (Coetzee et al., 2017; Overs, 2002; Okafor et al., 2017). The victimisation of sex workers takes place across multiple settings, including workplaces, their homes, and public spaces. The use of alcohol and drugs by both the sex workers and their clients exacerbates the violence against them. Violence against FSW’s minimises their condom use during sex, as well as the opportunities for successful condom use negotiation (Wirtz et al., 2015; Okafor et al., 2017).

2.6.2.7  Practices that increase the risk of HIV/STI transmission and acquisition among female sex workers

Douching is one of the sex workers’ practices that increases the risk of HIV transmission. Vaginal douching is the action of intra-vaginal cleansing with a liquid solution which may contain water and vinegar, lemon, soap and other agents (Coetzee et al., 2017). Douching is used for personal hygiene or for aesthetic reasons, for the prevention or treatment of sexually transmitted infection, for cleaning the vagina following sexual intercourse, during menstruation and to prevent pregnancy (Masese et al., 2013). Intra-vaginal practices including washing cause mucosal disruption and changes in the vaginal flora, and hence this practice is associated with HIV 1 acquisition (Masese et al., 2013). Coetzee et al. (2017) found that douching and dry sex were bivariably associated with HIV infection, and the increased vaginal cleaning practice was also associated with recurrent vaginal infections in HIV-positive sex workers.

WHO (2011) found that douching was the most common practice among FSW’s with some of them doing it more than once a day, and this was a concern as it is known that douching disrupts the genital vaginal mucosa, causing inflammation and
increasing the risk of HIV transmission in those who practise it, in comparison to those who do not practise douching. During menstruation FSW’s insert objects like a kitchen sponge, a cloth, cotton wool or a tampon into the vaginal canal to prevent menstrual blood from showing during or after sex with a client (Coetzee et al., 2017). In addition to the above mentioned reasons for douching, FSW’s also mentioned that they practice douching “for dry sex,” which enhances a client’s sexual pleasure, to remove semen after unprotected sex, to soothe vaginal soreness following multiple sexual acts with clients, to trick clients into thinking that they are their first clients for the day, as well as to maintain a level of cleanliness which will attract clients (WHO, 2011).

2.7 Clients of female sex workers characteristics and their sexual risk behaviours

The clients of FSW’s are men of all races, with different financial statuses, who may be foreigners in the country, young or old, may be single or married, educated or uneducated. These men pay with money or other resources for sexual services, either explicitly or within an agreed package that includes other services such as domestic services or entertainment (Overs, 2002). A study of clients of FSWs consisting of 64 males who were clients of FSW’s found that more than half of them had had sex with three or more different FSW’s in the past year, with a usual frequency of once or twice per week. These male partners reported that they had one or two steady FSW’s as simultaneous partners, and that the relationship would lasted for anything from a minimum of weeks up to months or several years, with a maximum of less than 5 years. FSW’s become steady partners after three to four sexual encounters, which normally take place within 2 to 4 weeks. The male clients reported that they paid the rent for their steady FSW, gave them amounts of money based on their financial obligations, bought them food or paid them on a regular basis rather separately for each sexual encounter.

Although they were their steady partners, they still distinguished them from their other girlfriends who were not sex workers. For example, they mentioned that their non-commercial partners loved them even if they didn’t have money, unlike the FSW’s. More than 40% of the clients reported not ever or rarely using a condom with a FSW,
and those that used them sometimes mentioned that they used them only on the first encounter and not all the time. Some of the reasons for not using condoms by male clients were that they trusted that the sex worker would be faithful, especially if the partner was financial supporting the FSW, that they trusted that the FSW was disease free, that they felt that after multiple sexual encounters they had got to know each other, and that they believed that they were the only partner with whom the FSW was not using a condoms (Voeten et al., 2002).

2.8 The impact of doing sex work

Literature presents the following factors as among the impacts of engaging in sex work: impacts on personal romantic relationships; stigma; exposure to violence, which is exacerbated by the use of substances such as alcohol and drugs; and poor health.

2.8.1 The impact on personal romantic relationships

Most FSW’s remain single of their own choice, for they feel that it would not be possible for them to be in a relationship because of the nature of their work. They report that romantic partners would not be able understand the nature of their work and this would create problems for them as the partner would always be jealous that they were having sex with other men (Bellhouse et al., 2015). Those who were in relationship reported that they made a distinction between work and private life, like using condoms during sex with a client and not using condoms with romantic partners, as well as not socialising with other sex workers, and this created a symbolic barrier between work and private life (Bellhouse et al., 2015).

2.8.2 The stigma surrounding sex work

Most sex workers experience stigma associated with their work, which may be due to the perceived violation of gendered norms, beliefs, culture and traditions caused by having sex with many man including strangers in exchange for cash (Bellhouse et al., 2015). Stigma can be an internalised sense of shame and guilt or externalised and enacted by the discrimination of others, which may be related to knowing that their
behaviour will not be acceptable to others. Therefore they constantly have to lie about their jobs, and as a result they don’t disclose their sex worker status to boyfriends, family members and friends, as they fear being judged and rejected (Jeal et al., 2017).

Although most woman experience negative impacts from doing sex work, few of them reported that sex work had impacted negatively on their sex lives, as they experience deeper intimacy. It boosts their self-esteem and confidence (Bellhouse et al., 2015; Jeal et al., 2017).

2.8.3 The experience of violence

Almost all sex workers are at risk of and experience some form of sexual and physical violence due to the nature of their work, which may be caused but client’s, partners, law enforcement agents or other people, including other fellow sex workers (Bellhouse et al., 2015; Jeal et al., 2017). Drug and alcohol use is very common amongst FSW’s. Their dependency on substances may have precipitated their entry into sex work, with some of them turning to the use of alcohol and drugs to numb or cope with the challenges they are faced with in sex work. (Dunkle et al., 2004; Lotfi et al., 2012). FSW’s managers or pimps may also increase the risk of sex workers experiencing violence which they may perpetrate themselves to exercise control over the SFW’s or by clients by interfering with condom use negotiation prices. The sex workers may be exposed to violence when clients are thwarted in certain expectations which have been promised by pimps (Strathdee et al., 2015). In most brothels or bars both sex workers and their clients are expected to purchase and consume alcohol. When both the sex workers and their clients are under the influence of alcohol, violence is quite likely to erupt. Then, of course, there are gender power imbalances. Women are naturally weaker than men, and men’s dominance and power predisposes them to violence vis-à-vis the weaker sex (Bellhouse et al., 2015; Jeal et al., 2017; Strathdee et al., 2015).

Due to their bad behaviour when they are under the influence of alcohol and drugs, some sex workers are excluded from brothels or other secure work environments and are displaced to street settings where they’re less safe. As a result they are pressured into practising unsafe sex and are exposed to many forms of violence (Strathdee et
Currently sex work is criminalised in the country, and the perpetrators of violence against sex workers are aware of that. As a result they take advantage of the situation, because they know that the police don’t really follow up on sex workers’ cases, whether they are assaulted, raped or even killed (SANAC, 2016).

2.8.4 Poor health

Female sex work is linked to the abuse of substances such as alcohol and drugs. Most sex workers who are dependent on drugs are street-based, and they experience the greatest risk to their health. When they are under the influence of drugs and when they have withdrawal symptoms and seek money for drugs they engage in increased sexual activity and their ability to negotiate condom use is reduced (Jeal et al., 2017). Sex workers that share injecting equipment during drug use have a high risk of being infected with blood borne disease such as HIV/STI/Hepatitis, as well as abscesses in injection sites, and they have poor adherence to treatment (Bellhouse et al., 2015).

2.9 Strategies to mitigate the challenges faced by female sex workers

The literature reports the following as strategies to mitigate sex worker challenges: sex worker-specific health services; adolescent- and gender-focused interventions; rehabilitation services for sex workers; and improving women’s literacy levels.

2.9.1 Sex worker-specific health services

There are ideal and tailor-made sexual and reproductive health care services designed for presentation to sex workers. Numerous countries have adopted intervention programmes for FSW’s that focus on increasing condom use as a central strategy to curb the spread of HIV, and South Africa is one of those countries (Chow et al., 2015; Okafor et al., 2017; Bharat et al., 2013). Free condom distribution in all healthcare institutions, in public spaces, and in sex worker hot spots, and education via peers and community healthcare workers are making a critical contribution to increasing condom accessibility and use amongst FSW’s and their clients (Chersich et al., 2013; Okafor et al., 2017).
Although sex worker programmes have a limited and narrow scope of services and are poorly coordinated and rely mostly on non-governmental funder contributions, it is through these programme interventions targeting the risk factors linked to sex work that the risks of HIV/STI infection can be substantially reduced. Fobosi et al. (2017) suggest that sex workers also have a need to access all health care services just like the general population, and not services restricted to sexual health only. Several studies suggest that peer mediated condom use promotion is particularly effective in supporting consistent condom use amongst sex workers and their clients. In addition screening and treatment for STI’s, HIV counselling and testing, and enhanced accessibility to ART as well as PrEP will reduce transmission efficiently (Chersich et al., 2013b). In a systematic review, Dhana et al. (2014) found that after the implementation of the 100% condom use programme among female sex workers there was an increase from 14% to 94% in condom use.

The organisation responsible for providing sex work services In South Africa are listed in 2.10 below.

2.9.2 Adolescent- and gender-focused interventions

Evidence of a global review of programmes that aim to promote the school retention of young girls in sub-Saharan Africa show that keeping girls in schools for longer delays their sexual debut, and they get married when they are older (Beattie et al., 2015). Keeping young girls in schools for longer reduces their financial vulnerability to sex work caused by their poverty. Advising young woman to postpone their sexual debut is sometimes productive. Unwanted teenage pregnancy may lead young women into sex work in order to support their children (Beattie et al., 2015).

2.9.3 Rehabilitation services for female sex workers

Empowering sex workers with skills which will enable them to have other methods of making money, such as doing arts and crafts which they can sell, or cosmetology skills where they can be nail artists and work in beauty salons, may also be productive.
2.9.4 Improve women's literacy levels

Keeping girls at school longer, providing health education on the prevention of pregnancy, as well as making contraceptives available to those who are sexually active are also useful, and education fits women for better employment opportunities (Beattie et al., 2015; Strathdee et al., 2015).

2.10 Institutions contributing to STI/HIV prevention among female sex workers

The following are some of the organizations which are responsible for providing healthcare services to sex workers: the National Department of Health of South Africa (NDoH), Wits Reproductive and HIV Health Institute (WRHI), the Sex Worker Education and Advocacy Task Force (SWEAT), the Centre for Positive Care (CPC), and North Star Alliance.

2.10.1 The National Department of Health of South Africa

The Department of Health of South Africa, working together with the Society for Family Health, the South African Business Coalition on HIV/AIDS and South African Breweries distributes millions of both male and female condoms to South Africans each year, mostly in areas where “high risk” sexual behaviour is prevalent, which are sex worker hot spots, long distance truck stops, taverns, and shebeens, where alcohol consumption may reduce sexual inhibitions. They ensure that condoms are accessible without fuss or embarrassment to those requiring them.

2.10.2 Wits Reproductive Health and HIV Institute

The Wits Reproductive Health Institute (WRHI) established a sex worker programme in 2003, where they work with key populations in the Johannesburg inner city. The Women at Risk Programme provides clinical and outreach services to brothel- and street-based sex workers and their clients in the inner city. In 2014 WRHI expanded this programme to include sex workers in both Pretoria and Ekurhuleni and increased
its focus on helping foreign sex workers. In collaboration with its partners, the programme also expanded its services to sex workers and truckers in trucking hot spots throughout South Africa.

2.10.3 Sex Worker Education and Advocacy Task Force

SWEAT is at the cutting edge of human rights defence and mobilisation in South Africa. This organisation has been running for over 20 years and it has established its visibility as a force struggling for a legal and safe adult sex work industry, where sex work is acknowledged as work, and where sex workers have a strong voice which informs and influences wider social debates. SWEAT has campaigned for the inclusion of sex workers as respected and valued members of society. Sex workers strongly inform the work done by SWEAT, as they are integrated as staff members on their board and as service users. SWEAT’s core objective is to provide sex workers with health and rights services while advocating for sex work to be decriminalised in South Africa. They do this through their programme areas: Sex Workers Empowerment and Enabling Environment (SWEEP); Advocacy and Law Reform; and the Sisonke movement.

2.10.4 Centre for Positive Care

The Centre for Positive Care (CPC) is a national NGO which is based in Limpopo and operates in three provinces, namely Limpopo, Gauteng and North West. With the vision that all sex workers should receive high-quality treatment, care and support to improving their quality of life, it supports the National Strategic Plan of South Africa to reduce HIV, STI and TB, ensuring the greater participation and involvement of targeted beneficiaries in community systems, strengthening and reproductive health and rights services.

2.10.5 North Star Alliance

This is a non-governmental organisation in partnership with the public and private sectors, investing in sustainable practice. It is responsible for providing primary healthcare services to mobile populations - mainly truck drivers and sex workers. The
high burden of HIV/STI among truck drivers means that they are at risk of spreading the diseases to other people as they move between countries and cities. Due to the nature of their work, mobile populations can’t go to healthcare services, so the services have to be brought to them. They have multiple roadside wellness centres next to truck stops in Southern Africa, West Africa and East Africa. They provide comprehensive primary healthcare services including sexual reproductive healthcare services (HIV counselling and testing, ART initiation and management, and the treatment of STI’s).

**Summary**

This chapter has provided a comprehensive overview of the already available literature on the dynamics of condom use by female sex workers in the world. It is evident that sex work is common in most countries, and South Africa is one of the African countries that has a high prevalence of sex workers. There is little evidence of research on this topic done in South Africa, and therefore more research is needed. This chapter has focused on the prevalence of sex work, the structure of sex work, factors leading people to become sex workers, the impact of sex work, challenges faced by sex workers, and the factors mitigating sex work. The next chapter presents the research design, research method and materials.
CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 Introduction

The previous chapter focused on previous research findings on condom use by FSW’s across the globe. This chapter outlines the research methods and materials used in this study. This includes the study setting and population, the sample size and sampling technique, and the inclusion and exclusion criteria for the participants in the study. The recruitment methods, the data collection tool and the method of analysing the data are also explained, and there is a discussion of the trustworthiness of the research and the ethical considerations.

3.2 Study design

Polit and Beck (2017) say that a research design is the overall plan for addressing research question, including specifications for enhancing the study’s integrity. This study was designed as qualitative research, which is conducive to investigation of a phenomenon, typically in an in-depth and holistic fashion, through the collection of rich narrative materials (Polit & Beck, 2017).

Polit and Beck (2012) observe that qualitative research often involves merging together various data strategies, tends to be holistic and strives for an understanding of a whole, requires researchers to become the research instrument, involves ongoing analysis of the data to formulate subsequent strategies and to determine when data collection is done, and is sufficiently flexible to be capable of adjusting to new information during the course of data collection. A qualitative researcher may choose to explore the dimensions of a phenomenon or develop and refine a hypothesis about the relationship between phenomena (Polit & Beck 2017). This kind of approach seemed eminently suited to an attempt to explore FSW’s practices and experiences on condom use between them and their clients and steady partners.
3.3 Data collection

Prior to data collection, the researcher built a positive and healthy rapport with the participants. The importance of the research, its objectives, the length of the interviews and research ethics were discussed. Consent forms were signed before the interviews were conducted, and permission for audio recording was also sought from the participants. The interviews/discussions lasted for about 60-75 minutes each. After the interviews the participants were reimbursed with a transport allowance.

Polit and Beck (2012) assert that data collection refers to the process of gathering information to address a research problem, Mouton (1996) maintains that data collection involves applying the measuring instruments to the sample or cases selected for the investigation, whilst Burns and Groves (2011) say that is a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of the study. For the purpose of this study, the researcher was the main data collector.

The researcher used an interview guide as a tool consisting of both open-ended and closed-ended questions for data collection purposes (Annexure1st). This guide was used to conduct the focus group discussions on the exploration of condom use by street-based FSW’s on Heidelberg Road, Ekurhuleni. The interview guide was developed in English and translated into both IsiZulu and Sesotho, as these are the commonly spoken languages in that area. The data was collected by the researcher with the help of a research assistant, following data collection training to ensure integrity in the process and the collection of data that was rich in quality. In addition to the data collection training, the researcher and the research assistant were able to take notes of non-verbal cues since they could not be communicated by the participants. All the data recorded were filed, and this included the responses to the demographic questionnaires, the field notes and the consent forms.
3.4 Focus groups

According to Polit & Beck (2017), focus group sessions are carefully planned group discussions that take advantage of group dynamics for accessing rich information in an economic manner. To promote a comfortable group dynamic, a fairly homogenous group of participants is selected to participate in the discussion (Polit & Beck, 2017). When participants share a similar background with other group members they usually feel more at ease when expressing their views (Polit & Beck, 2017). Furthermore the advantage of using a focus group was that, it allowed the researcher to interview a number of participants simultaneously and systematically (Babbie, 2016). Focus group discussion are able to bring out aspects of the topic that would not have emerged in individual interviews (Babbie, 2016). Information was therefore collected through focus group discussions.

3.5 Study setting and population

The setting of a study is the physical location in which data collection takes place (Polit & Beck, 2017). For the purpose of this study, data collection was conducted at the Centre for Positive Care (CPC), a non-governmental organisation in Germiston, Gauteng Province. The participants were fetched from their place of work in Heidelberg Road by a taxi in the morning of the days when discussions were due to take place and taken to CPC offices. The population for the study consisted of all the street-based female sex workers working in Heidelberg Road. The sample consisted of those who met the inclusion criteria.

3.6 Sample and sample technique

- **Sample**

A sample is a subset of a population, comprising those selected by the researcher for the purpose of data collection. The envisaged sample size for the study was 46 individuals, who would be divided into 6 focus groups for convenience’s sake.
Sample technique

This refers to the process of selecting a portion of a population to represent the entire population (Polit & Beck, 2012). The researcher employed the non-probability sampling technique. In non-probability sampling, elements are selected by random methods. (Polit & Beck, 2012).

Purposive sampling uses the researcher’s knowledge of a population to select sample members (Polit & Beck, 2017). It is regarded as a useful sampling technique because through this method the researcher can gather information from participants “typical” of the study population (Strydom & Delport, 2005; Walliman, 2009).

A purposive sampling technique was chosen for the recruitment of participants in the study. Members of the population were selected because they had the necessary features that would bring about an understanding of the questions the researcher aimed to study (Ritchie et al., 2014). They had to have direct experience of the phenomenon under investigation.

3.7 Inclusion and exclusion criteria

The researcher observed the following inclusion and exclusion criteria for the study:

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adult females aged 18 years and</td>
<td>• Female below the age of 18 years</td>
</tr>
<tr>
<td>above</td>
<td></td>
</tr>
<tr>
<td>• Street-based sex workers for 6</td>
<td>• Non-street based sex workers</td>
</tr>
<tr>
<td>months and more</td>
<td></td>
</tr>
<tr>
<td>• Must not be under the influence</td>
<td>• Being under the influence of alcohol and drugs</td>
</tr>
<tr>
<td>of alcohol or drugs during the</td>
<td></td>
</tr>
<tr>
<td>interview discussions</td>
<td></td>
</tr>
</tbody>
</table>

31
<table>
<thead>
<tr>
<th>Willing to share own personal and sexual experiences in a group</th>
<th>Unwilling to share own personal and sexual experiences in a group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing to sign a consent form</td>
<td>Not willing to sign a consent form</td>
</tr>
<tr>
<td>Willing to be audio-recorded during the interviews</td>
<td>Not willing to be audio-recorded during the interviews</td>
</tr>
</tbody>
</table>

### 3.8 Participant recruitment

The researcher engaged the research site coordinator (the CPC coordinator) regarding the research. All relevant research documents were provided, including ethical clearance and the proposal. Permission was granted to conduct the study and collect data from the participants. The researcher was invited to the creative space site meeting for further discussion of the research study. In this meeting, the participants were invited and informed about the purpose of the study. The organisation provided the researcher with peer educators to assist with the recruitment of sex workers. The researcher then went to Heidelberg Road, where the FSW’s work, for further recruitment. The purpose of the research was shared with them and they were requested to come to the CPC offices for the focus group discussions. On the day of the focus group discussions the participants met in Heidelberg, and reported to the research site for the focus group discussions.

### 3.9 Data analysis

Content Analysis refers to the study of recorded human communications such as books, websites, and paintings (Babbie, 2016). Thematic content analysis was used to identify key themes using the NVIVO10 software. The audio files were listened to over and over again to immerse the researcher in the data and transcribed verbatim. During the translation of the transcripts from isiZulu to English the researcher ensured that no meaning was lost.
In order to ensure that the analysis was thorough the researcher read and re-read the transcripts and rechecked the interview documents several times. A code list was developed for coding the data into themes (Annexure2nd) and the process of data analysis was facilitated. The researcher identified and examined the data for emerging themes and sub-themes, which were grouped into similar concepts and contexts for interpretation. The results in the form of coded themes and sub-themes as identified by the researcher were then discussed with the supervisor and interpreted. The final write-up consisted of summaries, interpretations and quotations which represented common themes. The organization of the themes depended on the frequency of the occurrence of the themes. Quotes were supplied to support the descriptions of the themes and subthemes.

3.10 Trustworthiness

According to Polit and Beck (2012), trustworthiness is the degree of confidence qualitative researchers maintain in their reporting. Trustworthiness is assessed using the criteria of credibility, transferability, dependability, confirmability (objectivity) and authenticity. For trustworthiness to be recognized and accepted, the research findings have to reflect as closely as possible the meanings as described by the research participants, ensuring that the findings represent the reality of the situations and persons who are being studied (Douglas, 2003). Trustworthiness was assessed using the criteria of credibility, transferability, dependability and conformability.

- Credibility

Credibility refers to confidence in the truth of the data and their interpretation (Polit & Beck, 2012). This was ensured by means of transcribing the data collected in a verbatim format. Thereafter the audio tapes were made available to the supervisor, who verified the data. In addition, the supervisor acted as an independent coder following the verification of the tapes.
• Transferability

Streubert and Carpenter (2003) and Polit and Beck (2012) are of the opinion that transferability refers to the ability to generalize or to extrapolate meaning from data to the extent to which the findings from the data can be transferred to other settings or groups. Sufficient descriptive data had to be provided by the researcher so that readers could judge the applicability of the findings to other contexts.

• Dependability

Dependability has to do with evaluating integrity over time and is analogous to reliability in research (Polit & Beck, 2012). In this study, detailed field notes were obtained and an audit trail was prepared to provide a thorough and detailed explanation of how the data were collected and analyzed. A good quality digital recorder was used to record the interviews, transcriptions were done verbatim, and NVivo 10 software was used to assist in data management and the application of the codes.

• Confirmability

This refers to the potential for congruence between two or more independent people about the data accuracy, relevance, or meaning (Polit & Beck, 2012). All study participants were interviewed and audio-recorded, and the data were transcribed verbatim. The Nvivo 10 statistical analysis package was used for data analysis and recording the findings. Lastly, the supervisor was involved in the development of the codebook and then did independent coding of a sample of transcripts to ensure confirmability.
3.11 Ethical considerations

Research ethics is a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal, and societal obligations (Polit & Beck, 2017). The researcher observed the common practices of research ethics to ensure that the study complied with the generally accepted ethical principles.

- Ethical approval

Both the Research Ethics Committee of the Sefako Makgatho Health Sciences University (SMUREC) in Annexure 3rd and the research site (Center for Positive Care, a non-governmental organization) in Annexure 5th reviewed the researcher’s proposal and provided permission for the researcher to conduct the study. This enabled the researcher to access the study site so that the data could be collected from the participants.

- Informed consent form

A consent form is a written agreement signed by a study participant and a researcher concerning the terms and conditions of the subject’s voluntary participation in a study. All study participants who took part in the study were informed about the need to give their informed consent, and the issue was discussed in depth. The participants were informed that participation was fully voluntarily and anyone was free and welcome to withdraw from the study at any stage. They were requested to accept that they would be audio-recorded during the interviews to ensure accurate data collection, and told that the data would be made available to the supervisor. They were told that their rights would be fully respected throughout the research study.

- Anonymity

According to Polit and Beck (2017), anonymity refers to the protection of participant’s confidentiality so that even the researcher cannot link individuals with the data they
provided. Prior to data collection, the researcher assured the participants that their details would not be made available to anyone. This was confirmed during the interviews. The participants were given pseudonyms and their details were also changed when recorded.

- **The right to privacy and confidentiality**

Research with human beings involves intrusion into people’s personal lives, and the participants’ privacy must be maintained, (Polit & Beck 2017). The participants’ right to privacy was observed throughout the research process. The data collected were not publicly shared with anyone, and the participants were assured that it would be kept confidential. The data were recorded anonymously and are being kept in a safe place.

- **The right to disclosure**

Polit and Beck (2017) stipulate that in order to honour people’s right to make informed decision they must be allowed to take voluntary decisions about their participation in the study, which requires full disclosure. This refers to the researcher’s having to fully describe the study, the person’s right to refuse participation, the researcher’s responsibilities, and the likely risks and benefits. For the purpose of this study, the researcher disclosed all the information pertaining to the study as per the informed consent. Clarity was provided to ensure that the subjects understood that their participation would be free and voluntary.

- **Protecting the participants from harm or Injury**

The principle of beneficence imposes a duty on researchers to minimize harm and maximize benefits (Polit and Beck, 2017). Due to the sensitivity of the research topic, all participants were necessarily treated with especial respect and dignity throughout the study. Clarification was provided to ensure that all of them understood what their involvement entailed and so that they would be able to express themselves without
any fear or intimidation. The researcher provided reassurance, emotional and psychosocial support from time to time, to ensure that the participants felt at home and were able to share their experiences. Some participants were emotional. They were referred to the social worker on site for further intervention and management. Those who were not sure if they wanted to consult with the social worker were requested to think about it and were assisted with scheduling an appointment with the social worker (Polit & Beck, 2017; Babbie, 2016).

- **Reimbursement**

The study participants were provided with R50.00 for transport purposes.

- **Protecting the right of the institution/organisation**

The researcher used a pseudonym to identify the research institution for the purpose of the research.

- **Publication of results**

The study participants were informed that their data would not be shared with anyone but would be used only for the purposes of the study. The actual participants’ names would not appear in any report.

**Summary**

This chapter has discussed the research design and methods including the population, sampling methods, inclusion and exclusion criteria, and methods of data collection and data analysis. The research ethics was also discussed. The following chapter will present the results of the research and discuss the findings.
CHAPTER FOUR

PRESENTATION OF STUDY FINDINGS

4.1 Introduction

This chapter presents the results derived from the data collected from the six focus group discussions. The focus groups consisted of a total of 45 participants who were recruited at their place of work on Heidelberg Road. The study sought to explore the condom use practices of street-based FSW’s with their clients and stable partners, how they negotiated condom, and the barriers to their using condoms. This chapter describes process of analysing the data and developing themes, the participants’ demographics, and the themes and sub-themes that emerged from the data, with quotation to elaborate upon them.

4.2 Description of the data analysis process and the development of the themes

Six focus group discussions were conducted, through which data saturation was obtained. The focus group discussions were conducted face-to-face, the participants including the subjects, the researcher and a researcher assistant. Audio-taped recorded data was transcribed verbatim in isiZulu and were then translated into English. All six focus group discussion transcripts were uploaded onto NVIVO 10 software for analysis by the researcher.

Excerpts from the interview transcripts were coded into themes and sub-themes during the analysis of the data, and these themes and sub-themes were developed through repetitive reading of the transcripts and obtaining the meaning of what was said by the participants in the excerpts. The context and meaning of what was said in the excerpts were then coded into the relevant themes and sub-themes, and the details of the results were finally discussed and analysed by the researcher. Themes were developed to ensure that proper analysis of the collected data occurred. Several themes that emerged from the data represent both the positive and negative practices and
experiences of condom use between female sex workers and their clients and stable partners. The following is a list of themes that came up: condom use knowledge and practices at the outset of sex of sex work; negotiation of condom use by FSW’s, and perceived barriers to condom use.

4.3 Study context

Centre for Positive Care (CPC) is non-governmental organisation responsible for providing health care service, support and condom distribution to Sex Workers in the East-rand including those working in Heidelberg Road. According to the statistic received from the CPC coordinators, it is estimated that more than 60 FSW’s work on Heidelberg Road. Apparently, they come from all over the country.

Not far from the main road (Heidelberg Road) there are two taverns, namely “Bra Peter’s Tavern” and “Lukhele’s Tavern.” Both of them have rooms which are rented by sex workers. They may become permanent residents, or rent on specific days with a daily rent of a minimum R50 per day.

4. 4 Socio-demographics

Though all the participants were sex workers but there was lot diversity on their birth place, level of education, previous source of income, marital status, lest HIV test, HIV status, history of STI, number of children they have and number of abortions they had and this is illustrated in the following tables.
### Table 1: Background characteristics of the respondents

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY (N=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PROVINCE OF BIRTH</strong></td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>1</td>
</tr>
<tr>
<td>Western Cape</td>
<td>1</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>12</td>
</tr>
<tr>
<td>Free State</td>
<td>9</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>14</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1</td>
</tr>
<tr>
<td>Outside the country (Zimbabwe &amp; Lesotho)</td>
<td>8</td>
</tr>
<tr>
<td><strong>LAST STI TREATMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Never tested</td>
<td>5</td>
</tr>
<tr>
<td>3 months</td>
<td>14</td>
</tr>
<tr>
<td>6 months</td>
<td>15</td>
</tr>
<tr>
<td>Last year</td>
<td>10</td>
</tr>
<tr>
<td>2 years ago</td>
<td>2</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>32</td>
</tr>
<tr>
<td>Grade 12</td>
<td>11</td>
</tr>
<tr>
<td>---------------</td>
<td>----</td>
</tr>
<tr>
<td>Tertiary</td>
<td>1</td>
</tr>
<tr>
<td><strong>PREVIOUS INCOME-RELATED ACTIVITIES</strong></td>
<td></td>
</tr>
<tr>
<td>Domestic worker</td>
<td>1</td>
</tr>
<tr>
<td>Hairdresser</td>
<td>1</td>
</tr>
<tr>
<td>Retailer</td>
<td>18</td>
</tr>
<tr>
<td>Salon</td>
<td>1</td>
</tr>
<tr>
<td>Stayed at home</td>
<td>8</td>
</tr>
<tr>
<td>(Unemployed) Student</td>
<td>17</td>
</tr>
<tr>
<td><strong>MARITAL STATUS</strong></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>42</td>
</tr>
<tr>
<td>Married</td>
<td>3</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
</tr>
<tr>
<td><strong>LAST HIV TEST</strong></td>
<td></td>
</tr>
<tr>
<td>3 months</td>
<td>10</td>
</tr>
<tr>
<td>6 months</td>
<td>4</td>
</tr>
<tr>
<td>More than a year</td>
<td>32</td>
</tr>
<tr>
<td><strong>HIV STATUS</strong></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>15</td>
</tr>
<tr>
<td>Positive</td>
<td>31</td>
</tr>
</tbody>
</table>
### NUMBER OF CHILDREN

<table>
<thead>
<tr>
<th>None</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>16</td>
</tr>
<tr>
<td>Two</td>
<td>18</td>
</tr>
<tr>
<td>Three</td>
<td>7</td>
</tr>
</tbody>
</table>

### NUMBER OFabortIONS

<table>
<thead>
<tr>
<th>None</th>
<th>37</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>8</td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
</tr>
</tbody>
</table>

### NUMBER OF DAYS WORKED PER WEEK

<table>
<thead>
<tr>
<th>Two</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three</td>
<td>6</td>
</tr>
<tr>
<td>Four</td>
<td>4</td>
</tr>
<tr>
<td>Five</td>
<td>11</td>
</tr>
<tr>
<td>Six</td>
<td>4</td>
</tr>
<tr>
<td>Seven</td>
<td>19</td>
</tr>
</tbody>
</table>

**Interpretation of the table**

Tables 1 and 2 present the main descriptive characteristics of the sample. Kwazulu-Natal was the most common birth-place, as reported by 14 (30.43%) of the participants. More than two-thirds (29/46) of the participants reported to have been treated for STI’s in the last 3 months with 15 (32.61%) reporting treatment in the past
6 months and 14 (30.43%) in the past 3 months. The majority (42; 91.30%) were single and only 3 were married. Of the three who were married, two reported having a stable partner, two were HIV positive, none consistently used condoms with their partner, and only one had made the partner aware of the sex work. The only married woman who reported not to have a stable partner also did not live her partner, was one of the two who were HIV-positive, and had not made her partner aware of the sex work. 44 participants (95.65%) were educated to at least grade 12, with 12 reaching the grade but not completing it, 32 completing grade 12, and one achieving a tertiary education.

The mean and median age for the sample were 33 and 32.17 respectively, with a standard deviation of 5.17. The women had started sex work at an average age of 23 and had been working for 9 years. Their mean and median daily incomes were R425 and R506.52 respectively, with a large standard deviation of R33.75. While a sample size of 46 could be too small to produce robust measures of central tendency that a bigger sample would, the central limit theorem specifies that a sample size of 30 is large enough to assume normality, even if the sample was derived from a non-normal distribution (Daniel, 2009). This sample of 46 is larger than the recommended 30, and hence the estimates can be produced in line with the theorem.

The researcher also plotted histograms and only the age of the participants and the age of debut simulated an approximately normal distribution. Due to the lack of visible normality of the histograms, the researcher presented both mean and median, standard deviation and Interquartile Ranges (IQR) for measures of central tendency and measures of dispersion respectively. The interquartile range is the difference between the 75th and the 25th percentile, which depicts where the bulk of the values lie.

<table>
<thead>
<tr>
<th>Variable (N=46)</th>
<th>Median</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>IQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>33</td>
<td>32.17</td>
<td>5.71</td>
<td>7</td>
</tr>
<tr>
<td>Age at debut</td>
<td>22</td>
<td>23.00</td>
<td>4.57</td>
<td>7</td>
</tr>
<tr>
<td>Years on the job</td>
<td>7</td>
<td>9.17</td>
<td>5.89</td>
<td>9</td>
</tr>
<tr>
<td>Duration of stay</td>
<td>6</td>
<td>7.67</td>
<td>5.88</td>
<td>8</td>
</tr>
<tr>
<td>Daily income</td>
<td>425</td>
<td>506.52</td>
<td>336.75</td>
<td>300</td>
</tr>
</tbody>
</table>

Table 2:
Table 3 below present the rest of the variables, mostly with binary “Yes/No” responses. One of the notable results was that all 46 women use substances such as alcohol at work. The women also used other drugs such as unspecified drugs (29; 63.04%) and dagga (27; 58.70%). The majority (34) had not told their family members about their sex work and the same number, though not necessarily the same people, did not use condoms consistently with their partners.

Table 3:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Yes</th>
<th>no</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any family member aware of work</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (26.09)</td>
<td>2 (73.91)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Baby on the job</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>3 (28.26)</td>
<td>3 (71.74)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Abortion</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>9 (19.57)</td>
<td>7 (80.43)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Knew anyone</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>9 (84.78)</td>
<td>3 (15.22)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Money on arrival</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (23.91)</td>
<td>2 (76.09)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Staying with partner</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (26.09)</td>
<td>3 (76.09)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>0ther income</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (23.91)</td>
<td>4 (76.09)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Children</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (89.13)</td>
<td>3 (10.87)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Stable partner</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>4 (73.91)</td>
<td>2 (26.09)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Partner aware of sex work</td>
<td>(%</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>8 (60.87)</td>
<td>2 (39.13)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Consistent condom use with</td>
<td>(%)</td>
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<td>n/a</td>
</tr>
<tr>
<td>partner</td>
<td>0 (21.74)</td>
<td>1 (78.26)</td>
<td>0 (0.00)</td>
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<tr>
<td>Consistent condom use at all</td>
<td>(%)</td>
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<td>n/a</td>
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<tr>
<td>times</td>
<td>2 (52.17)</td>
<td>1 (47.83)</td>
<td>0 (0.00)</td>
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<tr>
<td>Thoughts of leaving sex work</td>
<td>(%)</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>9 (84.78)</td>
<td>3 (15.22)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Ever tested</td>
<td>(%)</td>
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<td>n/a</td>
</tr>
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<td></td>
<td>6 (100.00)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
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<tr>
<td>Positive on ART</td>
<td>(%)</td>
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<td>n/a</td>
</tr>
<tr>
<td></td>
<td>8 (60.87)</td>
<td>2 (39.13)</td>
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<tr>
<td>History of STI</td>
<td>(%)</td>
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<td>n/a</td>
</tr>
<tr>
<td></td>
<td>1 (89.13)</td>
<td>3 (10.87)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Contraceptive use</td>
<td>(%)</td>
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<td>n/a</td>
</tr>
<tr>
<td></td>
<td>2 (26.09)</td>
<td>4 (73.91)</td>
<td>0 (0.00)</td>
</tr>
<tr>
<td>Substance use to ease work</td>
<td>(%)</td>
<td>n</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>6 (100.00)</td>
<td>0 (0.00)</td>
<td>0 (0.00)</td>
</tr>
</tbody>
</table>
### 4.4.2 Pie charts

**Birth place**

![PROVINCE OF BIRTH](image)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>(%)</th>
<th>n</th>
<th>(%)</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit hospital or clinic last month</td>
<td>4</td>
<td>(100.00)</td>
<td>3</td>
<td>(76.09)</td>
<td>1</td>
<td>(23.91)</td>
</tr>
<tr>
<td>Alcohol</td>
<td>6</td>
<td>(100.00)</td>
<td>0</td>
<td>(0.00)</td>
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<td>(0.00)</td>
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<tr>
<td>Drugs</td>
<td>9</td>
<td>(63.04)</td>
<td>7</td>
<td>(36.96)</td>
<td>0</td>
<td>(0.00)</td>
</tr>
<tr>
<td>Cigarettes</td>
<td>4</td>
<td>(73.91)</td>
<td>2</td>
<td>(26.09)</td>
<td>0</td>
<td>(0.00)</td>
</tr>
<tr>
<td>Dagga</td>
<td>7</td>
<td>(58.70)</td>
<td>9</td>
<td>(41.30)</td>
<td>0</td>
<td>(0.00)</td>
</tr>
</tbody>
</table>
Education

Marital status
4.4.3 Normality histograms

Age

Age at debut
Daily income

Number of days per week
4.5 Overview of themes and sub themes

Analysis of the focus group discussions showed several themes and subthemes as summarised in Table 4.
<table>
<thead>
<tr>
<th>Table 4: Theme</th>
<th>Sub Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sex workers condom use and practices</td>
<td>Condom use knowledge and practices at the onset of sex work</td>
</tr>
<tr>
<td></td>
<td>Condom use practices over time as a sex worker</td>
</tr>
<tr>
<td></td>
<td>Use of female condoms as an alternative</td>
</tr>
<tr>
<td></td>
<td>Female sex workers criticizing the female condom</td>
</tr>
<tr>
<td></td>
<td>Incorrect use of condoms by female sex workers</td>
</tr>
<tr>
<td></td>
<td>Knowledge that non condom use is associated with health risks</td>
</tr>
<tr>
<td></td>
<td>Accessibility of condoms to female sex workers</td>
</tr>
<tr>
<td>Negotiation of condom use by female sex workers</td>
<td>Direct request and enforcement of condom use by female sex workers</td>
</tr>
<tr>
<td></td>
<td>The use of health risk information by participants as a condom use negotiation strategy</td>
</tr>
<tr>
<td></td>
<td>Charging more for unprotected sex as a condom use negotiation strategy</td>
</tr>
<tr>
<td></td>
<td>Refusal of unprotected sex and letting the client go without buying as a condom use negotiation strategy</td>
</tr>
<tr>
<td>Perceived barriers to condom use</td>
<td>Financial need as a barrier to condom use</td>
</tr>
<tr>
<td></td>
<td>The sense of love and the need to belong</td>
</tr>
<tr>
<td></td>
<td>The risky, unregulated and unhealthy working environment</td>
</tr>
<tr>
<td></td>
<td>The use of alcohol and drugs as a barrier to condom use</td>
</tr>
<tr>
<td></td>
<td>The absence of threat related to appearance-based judgement</td>
</tr>
<tr>
<td></td>
<td>Reasons given by clients when requesting unprotected sex</td>
</tr>
</tbody>
</table>
4.5.1 Female sex workers’ condom use knowledge and practices

The sub themes that emerged under this theme were: condom use knowledge and practices at the outset of sex work; condom use practices over time by FSW’s; using the female condom as an alternative; FSW’s criticizing the female condom; the incorrect use of condoms whereby FSW’s use two condoms instead of one; FSW’s reporting that they know that non condom use during sex is associated with the risk of contracting or spreading HIV/STI’s; and the accessibility of condoms by FSW’s.

4.5.1.1 Condom use knowledge and practices at the onset of sex work

The sex workers reported that they knew nothing about condoms [what they looked like, why it is important to use them during sex] at their outset of sex work, and this is illustrated in the following excerpts from the data:

To be honest when I first started as a sex worker I didn’t even know what is a condom, I didn’t know how to use it, what I wanted was to make money, my clients when I started were white men only, when a client wanted a blow job I would do it and later wash my hands, but currently I use a condom except if it’s a hand job because he ejaculates quickly (34, secondary, HIV+, 15 years’ experience of sex work).
When I first started in this job, it was twenty rand per client but most clients gave me fifty rand because they did not want to use a condom, (41, secondary, HIV+, 18 years’ experience of sex work).

When I first started as a sex worker I would agree if a client refuses to use condoms (27, secondary, HIV+, 2 years’ experience in sex work).

I never thought of it before [the condom], when a client come and show me three hundred Rands I took it without any worry (40, secondary, HIV+, 16 years’ experience).

I also did not use a condom previously, clients loved me because I didn’t use a condom and I made more money, when I get inside a client’s car a client would complain and say “I can’t resist this.” I used to make a lot of money then (23, secondary, HIV+, 5 years’ experience).

4.5.1.2 Condom use practices over time as a sex worker

Over time as they practised sex work and interacted with their friends, and through exposure to peer education, they reported that they learned about condoms and started using them. This is illustrated in the following excerpts:

I always carry a condom where-ever I go, even now in my bag I have them for in case I can get a client anywhere it can happen that as I walk out of Pick ‘n Pay then I meet a client so I must always have them in my bag so if the client says they don’t have a condom I tell them to relax because I have them (33, grade 12, HIV-, 8 years’ experience of sex work).

I prefer to put in on myself because when they finish they usually say “Take out this rubbish of yours” (26, secondary, HIV+, 6 years’ experience of sex work).

If you force a client to use a condom he will end up cheating and taking it out without you noticing it. That is why we don’t want to negotiate when it comes to condom use (27, secondary, HIV-, 2 years’ experience of sex work).
When I first started as a sex worker I would agree if a client refuses to use a condom but now if a client doesn't want to use a condom I ask him to take his money and leave (27, secondary, HIV+, 6 years’ experience of sex work).

We use both male and female condoms. Now there’s the third one which I always carry with me, it’s called sheet condom [the dental dam]. If a client wants a blow job then I use a sheet condom, so I always carry three condoms (40, secondary, HIV+, 16 years’ experience of sex work).

Condom use is a challenge because some clients will tell you that they don’t use a condom and you force them to use a condom, the client will tell you that his penis can’t get an erection, with some clients if you put on a condom the penis doesn’t get an erection, when that happens I tell the client to take his money and leave (30, secondary, HIV+, 5 years’ experience of sex work).

Most of the clients they use condoms, what the clients do is that they 1st test you what would you say if the client says he does not want to use a condom, if you are weak you are going to agree but if you are strong you’re going to say no, but most of the clients are using condoms (34, secondary, HIV-, 7 years’ experience of sex work).

So I learned then that it is wrong not to use a condom but clients don’t want a condom, it is your responsibility to persuade him or show him the importance of condom use (41, secondary, HIV+, 18 years’ experience of sex work).

4.5.1.3 Use of female condoms as an alternative

The few clients that reported that they use the female condom reported that they use it only as an alternative when they can’t use the male condom, as it is not their number one option. This is illustrated in the following excerpts:

Some clients say when they put on a male condom they don’t get an erection, so the client will ask you to use the female condom (39, secondary, HIV+, 21 years’ experience of sex work).
There are clients who are drunk, when they want sex without a condom I agree and then I insert a female condom, the client won't notice, I make sure I put his penis inside the female condom, he won't feel a anything, he will think we did not use a condom but we did (40, secondary, HIV+, 16 years’ experience).

I use a female condom, I don’t usually get clients who don't want to use a condom most of my clients they prefer a condom, when a client says he does not want to use a condom I insert the female condom with the sponge, you will hear a client saying “you are so nice, you sound like a virgin” but in most cases we use condoms (35, secondary, HIV+, 16 years’ experience of sex work).

It once happened to me, I had a client who didn't want a condom and it was a rich man, it was during the day, I then put on the female condom, the client was drunk, when we went inside the room I tried by all means that the client must not notice, later the client said to me “I am aware that you have put on a female condom” but he gave me the agreed amount of money, If a client says he does not want a condom he does not want it, so it is up to you as a sex worker whether you agree with the client’s terms or not (35, secondary, HIV+, 5 years’ experience of sex work).

Most of the time I use male condoms. I use female condoms if I come across a client who complains that a condoms hurts him and he doesn’t have the money to add, and I will say to the client, because this one is hurting you I am going to put on this female condom, and you don’t have to do anything (24, secondary, HIV+, 2 years’ experience of sex work).

I use male condoms. Female condoms, I use them when I am menstruating (37, secondary, HIV+, 7 years’ experience of sex work).

I use both male and female condoms when “uma ama robots avalile” [during menstruation] (40, secondary, HIV+, 19 years’ experience of sex work).
4.5.1.4 Female sex workers criticizing the female condom

When they were asked about their preferences for different types of condoms, the FSW’s criticised the female condom. Only two participants reported that they knew the dental dam (sheath) condom. This is illustrated by the next few excerpts:

*The male condom is easy to use whereas the female condom has an around ring that will hurt me inside unlike the male condom (19, secondary, HIV-, 1 years’ experience of sex work).*

*I use a male condom because the female condom it needs preparation unlike the male condom, we are in a hurry in this business, so the female condom is not ideal (23, primary, HIV+, 7 years’ experience of sex work).*

*A female condom is not comfortable during sex (30, secondary, HIV+, 4 years’ experience of sex work)*

*I am using a male condom. I have never used a female condom because you have to wait for 3 hours before you can have sex with a female condom, a male condom you use it immediately (30, secondary, HIV+, 5 years’ experience of sex work).*

*I am using male condoms because I don’t know how to use the female condom (29, secondary, HIV-, 3 years’ experience of sex work).*

*If a client does not want to condom you can’t force him, a female condom is not comfortable during sex, If a client wants to use a condom I use male condom, clients have a choice, if a client does not want to use a condom I insert a sponge, If you can put on a female condom the client is going to notice it and he will feel it (30, secondary, HIV+, 4 years’ experience of sex work)*
4.5.1.5 Incorrect use of condoms by female sex workers

During our discussions the participants reported that sometimes they use two male condoms at once, so that if the one breaks then the other one is still intact. They perceive this act as protective. This is illustrated by the following excerpts:

*It depends on what you want. If there’s something that has disturbed you, you can use one condom, but most of the time I use two condoms, the number of condoms you are going to use depends on the type of a client you are with at that moment, there’s a client that is drunk, when you get inside with him you have to be calm so that you can be safe after sex (37, secondary, HIV+, 8 years’ experience).*

*If the client is drunk he becomes rough, so you make sure that if it happens that the condom burst I’m safe because the other one would have protected me (40, secondary, HIV+, 19 years’ experience of sex work).*

4.5.1.6 Knowledge that non condom use is associated with health risks

When asked if there were any health risks that were linked to unprotected sex with clients, participants reported that there were risks of contracting and spreading HIV/STI’s. This is illustrated in the following excerpts:

*It does happen to me that I have sex with a client without a condom. After that has happened I wake up in the morning and go to the clinic to ask for antibiotics, that is why I don’t get the bad odour, I avoid having an illness or bad odour, others they have sex without a condom and they don’t go to the clinic, that is what causes bad odour and clients don’t want to have sex with you (35, secondary, HIV+, 5 years’ experience of sex work).*

*We use a condom a lot because it prevents diseases like STI, HIV and that is what is needed (23, secondary, HIV+, 7 years’ experience of sex work)*

*We have to insist on condom use because you cannot sleep with more than twenty men without a condom. That would be a serious problem (30, secondary, HIV-, 2 years’ experience of sex work).*
If you didn’t use a condom with a client you get infected. There’s a client that I had sex with without the condom, I had problems passing urine, I had a burning sensation every time I wanted to urinate, my womb was hot (23, secondary, HIV+, 6 years’ experience of sex work).

But then I realised that not using a condom is risky because there are many diseases out there, I will die young and at home they don’t know that I’m doing sex work. I will end up contracting STIs, HIV and all other diseases (23, secondary, HIV+, 5 years’ experience)

if you don’t use condoms, yes there is a STI called Syphilis, the reality about it is that you get two shots of injections every Monday four times. Syphilis is very dangerous. If you’re infected you must know that you no longer going to have children. On top of that we have cysts on our vaginas that are there forever and when it’s hot the cysts grow larger, and some of us can’t go and work because of the infection in the vaginal area. It is not right but we take that risk [of not using condoms] (35, secondary, HIV+, 5 years’ experience of sex work).

4.5.1.7 Accessibility of condoms to female sex workers

Participants were asked if they had any challenges accessing health care services and condoms, and they reported that, there are several organisations (Wits Reproductive Health & HIV Institute, SISONKE, and Centre for Positive care) that bring health care services as well condoms to their place of work but also they go to nearby provincial and municipal clinics for their health care needs. This is illustrated in the following excerpts:

There’s a white truck (WRHI mobile truck) that bring condoms for us (37, secondary, HIV+, 5 years’ experience of sex work)

Yes, they made it easy for us (CPC and SISONKE) because they deliver them (condoms) in brothels, we love the fee condoms especially the purple and the strawberry flavor, they rock (34, secondary, HIV+, 15 years’ experience of sex work)
These cars from Ekurhuleni and Sisonke bring us condoms (23, secondary, HIV+, 7 years’ experience of sex work)

Mobile clinics also provide us with ARVs (40, secondary, HIV+, 19 years’ experience)

Like today they are in Heidelberg (WRHI mobile truck staff), they bring ARVs to people that they have appointments with and bring treatment, also PrEP, that’s what they will be doing today (33, secondary, HIV+, 5 years’ experience of sex work)
I go to J Dumane clinic (it’s a nearby provincial clinic) for my treatment and if I am sick (30, secondary, HIV+, 30 years of experience of sex work)

CPC people (Centre for Positive Care staff) If you want to test they do that, if you need treatment they also assist, whatever problems you are having you can talk to them and they are able to assist, also if you come across challenges here in this business they are able to give advice (30, secondary, HIV-, 2 years’ experience of sex work)

There is also a (WRHI) mobile clinic that’s provides us with HIV treatment and treatment for sexual infections (30, secondary, HIV+, 4 years’ experience of sex work)

4.5.2 Negotiation of condom use by female sex workers

In this study the following subthemes emerged, and we found at least four types of condom use negotiating strategies which were used by the female sex workers on their clients.

The most commonly used condom use negotiation strategy was a “direct request and enforcing condom use,” whereby female sex workers took out a condom and showed it or gave it to a client. The second most commonly used strategy was using the
“health-risk information” to threaten or motivate clients to use condoms. The third most popularly used strategy was charging more for unprotected sex, and the fourth and least mentioned strategy used was refusing unprotected sex and telling a client to go to another sex worker who would be willing to have sex without a condom.

4.5.2.1 Direct request and enforcement of condom use by female sex workers

When participants were asked what they say or do when negotiating condom use, they reported that they make a direct request and an insist on condom use, which is demonstrated by the FSW’s taking out a condom, asking the number of preferred condoms, and asking if the client has his own condom that he would like to use. This is illustrated in the following excerpts;

*I tell the client that the first thing we do is, he gives me the money, we use a condom, I don't operate until I receive money on my hands. The money stays inside my breast. There are those clients who will say “I will pay you let's have sex first.” What is the client after having sex with you he tells you that he does not have money, so my principle is, condom first and money after (35, secondary, HIV+, 16 years’ experience of sex work).*

*I ask for money first and on the other hand I'm carrying a condom (40, secondary, HIV+, 20 years’ experience of sex work).*

*When we enter the room, I say to a client “do you have a condom?” because sometimes clients when you offer him a condom they will tell you that “don't worry I have my own condom.” Some clients are very silly, if you let them put a condom themselves they tear it up without you noticing, you will realise during sex that something is not right, and when you ask the client what happened the client usually says “I didn't notice that the condom has burst” so you must throw it away and put another one (34, secondary, HIV+, 10 years’ experience of sex work).*

*In most cases when you are with the client, he gives you the money and ask you whether do you have condoms and you ask the client whether he wants one or two*
condoms, you don’t ask if the client wants to use a condom or not, already you ask if the client wants to use one or two condoms (37, secondary, HIV+, 8 years’ experience of sex work).

4.5.2.2 The use of health risk information by participants as a condom use negotiation strategy

The second most commonly used condom use negotiation strategy was the use of health-risk information as a motivation to use a condom. FSW’s would say “I am a sex worker and sleep with many men and you don’t know if I have an STI or not or I don’t want to be infected with your STI’s.” This is illustrated in the following excerpts;

Indeed you do tell a person that you are seeing me for the first time and you already want to have sex with me without a condom, whilst I’m doing this type of work that is a high risk, when they talk about high risk people when it comes to illnesses we are topping the list, we are the ones that are killing people, why don’t you take care of yourself? I value my life, I don’t want to have a relationship with you because I don’t want to see myself sick and die, so please listen to me and let’s use condoms. You know that when you get home you will have sex without a condom (37, secondary, HIV+, 8 years’ experience of sex work).

I say to the client “this is how this thing is.” Firstly I tell him about STI’s. “You don’t even know whether I was on my periods yesterday or this morning my periods stopped and I took a bath and came here, I might still have some few blood clots from my menstruation and that is too risky, you will have sex with me without seeing anything, after some few days you will go and have sex with your wife, when you have sex with her you will be infecting her with what you took from me, and you will say us sex workers are the ones that are infecting you with diseases, only to find that it’s not us, you didn’t resist and have self-respect, so you rather take your fifty Rands and leave” (33, secondary, HIV+, 4 years’ experience of sex work).

What I say to a client is that “If you don’t want to use a condom you’ll end up getting something else from me, I had cauliflower on my vagina, abscesses that are
infectious, so continue by not using a condom and you will die. I’m not HIV-positive I have AIDS. Maybe you are HIV positive and you want to kill yourself.” And the client will say “I am scared now.” He will end up putting two condoms (35, secondary, HIV+, 3 years’ experience).

It’s the truth ma’am, we try and scare clients by telling them that you are HIV positive and the client will say “Does it mean that if you are HIV positive you will die in one day?” Some they leave without buying sex and say “I will get someone who will give me sex without a condom if you don’t want me to have sex with you without a condom” (34, secondary, HIV+, 11 years’ experience of sex work).

4.5.2.3 Charging more for unprotected sex as a condom use negotiation strategy

During the discussion participants reported that they have different prices for sex with a condom and for sex without a condom, and sometimes clients offer the amount of money they are willing to pay for non-condom use. This illustrated in the following excerpts;

I don’t want to lie. Me and my clients we have an understanding. If a client doesn’t want to use a condom and does not have money to pay me I tell him to either go and withdraw the money or go and try elsewhere (24, secondary, HIV+, 2 years’ experience of sex work).

The other cause of this money, the client will offer me two thousand Rands for not using a condom, wouldn’t you take it? You don’t have a choice, you will succumb to the clients demands (34, secondary, HIV+, 8 years’ experience of sex work).

I am still not using a condom to certain clients if they offer me five hundred Rands, (40, secondary, HIV+, 16 years’ experience).

Most of the time when we count money, mine is always more with more fifty Rands notes or sometimes there are two twenty Rands notes. My cousin would say “There is something I don’t understand, Zanele’s money is always more when we count, I
don’t know what is happening maybe she’s not using a condom (41, secondary, HIV+, 18 years’ experience of sex work).

If clients do not want to use a condom then they pay more, isn’t that we love money? (30, secondary, HIV+, 4 years’ experience of sex work).

it’s up to you as a person whether you want to use it or not but most of the clients don’t like a condom they rather pay any amount you asking for not using a condom but some will come carrying their own condoms (33, secondary, HIV+, 8 years’ experience).

4.5.2.4 Refusal of unprotected sex and letting the client go without buying as a condom use negotiation strategy

Participants reported that sometimes they refuse unprotected sex and are not concerned about losing the money or clients, and that they are not will to put themselves at risk of contracting HIV/STI’s:

If the client doesn't want a male condom I tell the client to go to another sex worker who will agree to his demands (40, secondary, HIV+, 20 years’ experience of sex work).

If he refuses to use it [the condom] I tell him straight “It's your loss” because I use condoms (33, secondary, HIV- , 8 years’ experience in sex work).

I don’t care how much he’s willing to give me, I have children that I have to take care of. The five hundred he’s offering me it won’t make a difference (27, secondary, HIV+, 6 years’ experience of sex work).

Even now I insist on using it [the condom] with my clients. If a client does not want to use a condom I tell him to leave (23, secondary, HIV+, 5 years’ experience in sex work).
4.5.3 Perceived barriers to condom use

The women were asked to tell us about the barriers to condom use between them and their clients, and the following subthemes emerged: financial need; the need for a sense of love and belonging; risky unregulated and unhealthy working environments; the use of substances like alcohol and drugs; the lack of a threat related to appearance-based judgements; excuses or reasons given by clients when requesting unprotected sex; the intentional spread of HIV/STI's; the harassment and victimisation of sex workers by police; and the pressure of being a sex worker.

4.5.3.1 Financial need as a barrier to condom use

Participants reported that they have monthly financial targets they set for themselves, and they have the responsibility to support themselves, their children and their extended family members. In those instances they don’t use condoms when offered more for unprotected sex

_Sometimes it’s because of desperation. If I need the money I take the risk. When I get home I drink pills to flush the sperms out [the morning-after pill]. The thing is I need the money because I don’t have it, I have children to feed, bills to pay and other things, so there are many challenges (40, secondary, HIV+, 20 years’ experience of sex work)._ 

_But at times when the client comes you are in a bad situation and you really need the money. The client says here is one thousand Rands and you have bills and burial insurance to pay, also to buy food for the children. You do take that risk and tell yourself that after this I will take treatment (37, secondary, HIV+, 8 years’ experience of sex work)._ 

_Some sex workers they have a target of two or three thousand per week. Even if your target is five hundred, she will do whatever it takes in order for her to reach the target, because at home they are expecting something (37, secondary, HIV+, 15 years’ experience of sex work)._
A client comes and offer you a lot of money to have sex with him without a condom, and at that time I have financial problems, I will end up do it and I will deal with the after-effects later (35, secondary, HIV+, 5 years’ experience of sex work).

The sex workers who do not use condoms with clients is because of competition amongst ourselves. If a client can offer me one hundred Rands to have sex without a condom I will take it because in my mind I’m thinking if I don’t take it another sex worker will be making more money than me, and by so doing we are getting ourselves in trouble. This is what is happening in most cases within the sex industry (32, secondary, HIV+, 11 years’ experience of sex work).

4.5.3.2 The sense of love and the need to belong

The sense of love and the need to belong were found to be factors that led to female sex workers disregarding condom use. Some sex workers reported that they have a need for affection, intimacy and lustful desires such as sexual pleasure, and hence they did not use condoms with clients and steady partners.

One thing that make us to end up not using a condom is, and I know it usually happens to us as sex workers, as sex workers the boyfriends and the community we live with they don’t love us so we always miss being loved. We long for boyfriends who love us whole heartedly, so when a client comes first day and the second day he tells me that he loves, I will be excited and stop using a condom with him because he said he loves me and now I have myself a boyfriend. That is the problem we have (40, secondary, HIV+, 16 years’ experience of sex work).

As I mentioned before that they would approach you as their girlfriend. He will propose you and tell you he loves you… It’s obvious you will be girlfriend and boyfriend and after two months he will ask you not to use the condom anymore. He will say he wants to marry you then you will fall for that charm and stop using a condom (33, secondary, HIV+, 4 years’ of sex work).
There are two things that a client is up to. He doesn’t want to use a condom and also doesn’t want to pay. When you are in a relationship he promises to give you money when he gets paid and when he gets paid he doesn’t give you a cent. What you console yourself with is that this man is good in bed (41, secondary, HIV+, 18 years’ experience of sex work).

It’s all up to you how you deal with that situation. There are clients who can come to you and charm you to an extent you fall for them and end up wanting a relationship with him but it is all up to you. If you are that type who agrees to everything then it’s your choice (33, secondary, HIV-, 8 years’ experience of sex work).

It is true that you get such client. They charm you even when you have sex with them you enjoy so much to an extent you ask yourself a question, what if he takes out the condom, maybe it would be more enjoyable… You know it happen. You get a client who wants the whole night with you, then as you spend the night you feel him, you have a strong connection with that person and he is very good in bed. When he does a second round you end up forgetting to tell him to use a condom. It depends on how he satisfies you in bed (34, secondary, HIV+, 15 years’ experience of sex work).

4.5.3.3 The risky, unregulated and unhealthy working environment

The sex workers reported that another barrier to condom uses is the fact the they don’t have control of their clients’ behaviour, because the sex act is sometimes performed in the bushes, in the clients car, in the clients place and sometimes in place rented by clients or even in the sex workers’ rooms. It is just the two of them in the room, so most of them are vulnerable to and experience all forms of abuse from their clients. This also minimises the chances of condom use, as is illustrated in the following excerpts:

Sometimes you get a client who is kind to you and take you to the bushes, when you get there he points a gun at you and tell you that you’re going to have sex without the
condom and you are going to give in to his demands (23, secondary, HIV+, 6 years’ experience of sex work).

A client will book you for the whole night and take you to his place. He then point a gun at you and say “I will shoot you, I am going to have sex with you without a condom,” and you end up saying it’s better not to have sex without a condom instead of dying (30, secondary, HIV-, 2 years’ experience of sex work).

Some clients they remove the condom by force. Some client after removing the condom he doesn’t pay you, he leaves without paying. Some clients are harassing us (27, secondary, HIV+, 6 years’ experience of sex work).

One client will buy you and ask you to go with him to his place, only to find that he has already sent messages to some of his friends telling them that he’s bringing a prostitute with. When you get there all of them would want to have sex with you and the others are not going to pay, you’re only going to receive one payment from the one that you came with, and after they had sex with you without a condom some of them will beat you up and chase you away, at times you might find that the place where the client has taken you to is very far and you have to walk back, you’ll be lucky if you get a lift (34, secondary, HIV+, 8 years’ experience of sex work).

4.5.3.4 The use of alcohol and drugs as a barrier to condom use.

During the week I can manage to work without using any substance but weekends I can’t. Most of our clients when they come here during the weekend they are drunk and stubborn, another client would want to hug me and because I’m sober the smell of alcohol will be bad to me, and another client will be dirty and you start judging the client. On weekends clients are problematic, so if you are at their level you’ll be able to handle them and be able to work and make money (30, secondary, HIV-, 2 years’ experience of sex work).
I can’t face clients. That is why I smoke, drink alcohol, I sometimes use drugs. When I’m sober I’m shy but when I’m high I’m able to approach a client (35, secondary, HIV+, 16 years’ experience) of sex work.

I can’t work without smoking drugs, I’m short tempered. There are some clients with bad odour, when I come across such a client I vomit, when I’ve smoked I don’t mind (28, secondary, HIV-, 4 years’ experience of sex work).

I also can’t do sex work without smoking (drugs) and drinking. If I’m sober I have a serious face and clients can’t approach me because they think I’m angry, but if I’m drunk I’m able to approach them and have patience but if I’m sober I don’t have patience (35, secondary, HIV+, 5 years’ experience of sex work).

I drink alcohol. When I’m drunk I’m non-judgemental (32, secondary, HIV+, 11 years’ experience of sex work).

We are not the same. A client will use money to convince you, and another client will check if you are too drunk, because if we are drunk we are too loose (26, secondary, HIV+, 6 years’ experience of sex work).

Most of us we become too drunk. You come across a client on top of a sex worker, and like at the hostel if you find a client on top of a drunk sex worker if you try to check whether the client has used a condom or not the client will threaten you and there’s nothing you can do (23, secondary, HIV-, 2 years’ experience of sex work).

4.5.3.5 The absence of threat related to appearance-based judgement

The sex workers reported that if a client requests unprotected sex they do an observational assessment and judge the client by the way he looks. If he looks clean, smells nice, drives an expensive care and has money, then they agree to unprotected sex. They say that that type of client deserves to get unprotected sex. This is illustrated in the following excerpts:
I first look at what type of a person is he, whether he’s clean or not. I do self-assessment. I check if he’s circumcised or not (37, secondary, HIV-, 7 years’ experience of sex work).

Before you can do anything with a client you must first assess him. You can’t take money from a client that is sick because you are desperate for money, after assessment and then you sell him sex (31, secondary, HIV+, 12 years’ experience of sex work).

When you look at the client he is very clean, driving a nice car, you tell yourself that this man is clean (23, secondary, HIV+, 6 years’ experience of sex work).

4.5.3.6 Reasons given by clients when requesting unprotected sex.

During the discussion the participants reported that clients make excuses such as that they react to a condom, they are not used to using a condom, or they are diabetic, and in addition they offer to pay more for unprotected sex. This is illustrated in the following excerpts:

The main excuse the client will give for not using a condom is promising you a lot of money, and that’s it (39, secondary, HIV+, 21 years’ experience of sex work).

Sometimes a client will say I can’t ejaculate and we have been doing this for an hour, and the client has only paid fifty Rands, and I end up saying rather take this condom out because I can see that you can’t cum. When I get home I drink pills. There’s a pill that they give us from the clinic, it is used in rape cases, that pill helps a lot, but at the pharmacies it’s been sold (35, secondary, HIV+, 3 years’ experience of sex work).

Some clients are not used to using a condom because at home he does not use a condom. As we have already mentioned that most of our clients are married men. A client will tell you that he is not used to a condom because at home they don’t use it (30, secondary, HIV+, 9 years’ experience of sex work).
Another difficult thing is, when you ask a client to use a condom, the client will claim that the condom causes rash or blisters… Another client if he does not want to use a condom the reason he gives is that, every month at his workplace they are being tested for HIV, and he says to you “Do you see how fresh I look?” At that time he’s showing you his private parts, there’s no way that you can say “no” (23, secondary, HIV+, 6 years’ experience of sex work).

When it comes to condom use black people are very problematic even now. They give excuses about the “Max” condom. A client will mention a name of a condom knowing which they know you don’t have it. They will say “Can’t we just put it in and when I ejaculate I will take it out,” then that becomes a problem (41, secondary, HIV+, 18 years’ experience of sex work).

Another client will tell you that he is diabetic or he knows his status and he is HIV negative, and you end up believing the client (23, secondary, HIV+, 6 years’ experience of sex work).

Most of the time we insist on using a condom, but I want to be honest, there are clients that bribe us. Please don’t judge me. Usually a client will say “The condom hurts me. Usually if I put on a condom I don’t get an erection. I will give you four hundred Rands at least and I will take you out for shopping” and then I will agree to his demands. At the end the client didn’t use a condom (24, secondary, HIV+, 2 years’ experience of sex work).

4.5.3.7 The intentional spread of HIV/STI’s

During the discussion one of the barriers to condom use that emerged was the intentional spread of HIV, whereby the participants reported that some people don’t
use condoms because they want to infect others. This was reported be done by both sex workers and their clients. It is illustrated in the following excerpts:

There's nothing because a Zulu client tell himself that “I'm going to have sex with a sex worker because after that I'm going to use muthi [traditional medicine] to cleanse myself.” Another one will say “This AIDS that I'm having I don't know where I got it from, so let me give it to this sex worker and she will infect others” (44, secondary, HIV+, 25 years’ experience of sex work).

I used to have a friend but now she has passed away. She never liked to use a condom, and I ask her why don't you like using a condom? and she said “I'm HIV positive and I'm not going to die alone”, and I said to her she’s having sex with a lot of people, on average she gets four clients a day, and she said “I’m no longer using a condom. Every client I’m having sex with, I’m doing it without a condom, I can’t die alone, I don’t know who infected me” (34, secondary, HIV+, 11 years’ experience of sex work).

4.5.3.8 The abuse, harassment and victimisation of sex workers by the police

Sex work is illegal in the country. As a result sex workers are constantly finding themselves on the other side of the law. The police have a mandate to apprehend criminals, and they use their power over sex workers by using regulations to harass them without following the required procedures. As a result, sex workers are scared of carrying condoms around as this maybe be used as evidence of their work, should they be arrested. This is illustrated in the following excerpts:

He beat me up and as I was running away from him a truck came and hit me on my thighs. That's how I got injured, and the reason for my injury was because I was running away from the police (27,secondary, HIV+, 2 years’ experience of sex work).

It does happen that we run out of condoms. The police they do come and burn our condoms from where we have hid them (40, secondary, HIV+, 20 years’ experience of sex work).
The police are harassing us. At times when they find you with a client they will charge you and the client and they have sex with you for free. They are really harassing us (35, secondary, HIV+, 5 years’ experience of sex work).

Also police, when you go to the police station to open a case of rape, a police officer will say “How is this a rape case, because you and that man had an agreement that he is going to give you money and you offer him sex in exchange.” The police are refusing to take our cases, our cases when we report them they don’t go anywhere and we are being murdered each and every day (33, secondary, HIV+, 4 years’ experience of sex work.)

They took me with one of the sex workers to Rondebult police station. When we got there they told us to get out of the vehicle and we were naked… There’s this police officer who is always on my case, I don’t know whether he hates me or not, he will make me to walk from the bridge in Tsakane up until here. He will follow me with his car, when I sit down he stops the car, when I start walking he follows me, he doesn’t want me to hike and after that he dumps me in the bushes (23, secondary, HIV+, 7 years’ experience of sex work).

My challenge is also the police. They chase us away at night especially us who are doing business on the streets. We try to work next to a safe place and clients at times ask us to go to a secluded place because they are afraid of the police and when you get there the client attacks you. In December I was attacked by a client because at the spot where we operate from there were police. The client that I went with he attacked me and I was admitted at hospital (27, secondary, HIV+, 7 years’ experience of sex work).

Another challenge that we come across is the police. They spray us with pepper spray, they arrest us without having committed any crime, we don’t know how to resolve this matter (24, secondary, HIV+, 2 years’ experience).
4.5.4 Work pressures

Performing sex work as an income generating activity implies that the FSWs often experience downtimes due to illness, menstruation, pregnancy and any other family business that takes them away from their work. During the downtime they improvise other ways of carrying on their business, such as inserting material in their vaginas and doing sex work during menstruation.

4.5.4.1 Inserting material in the vagina to prevent the loss of the work day

They use various materials which they insert inside the vagina before unprotected sex (a sponge or cotton wool or a stocking) as a strategy to prevent the semen from coming into contact with the cervix, which is perceived by them to be protective against STI's. This is illustrated in the following excerpts:

We insert sponge as well... If a client does not want to use a condom you can’t force him (30, secondary, HIV+, 4 years’ experience of sex work).

On the streets there are clients who refuse using condoms. The female condom has a sponge inside. Most of us use that sponge. When you insert it inside the vagina it is already wet. When the client asks to urinate (before sex) you insert the sponge and he gives you the one thousand Rands that he has promised you. After he finishes you say it’s OK you can go. Then you take out the sponge (33, secondary, HIV+, 5 years’ experience in sex work).

But If you did not agree (to use a male or female condom) with the client then you use a sponge or cotton wool (30, secondary, HIV+, 4 years’ experience of sex work).

If a client wants to use a condom I use male condom. Clients have a choice. If a client does not want to use a condom I insert a sponge (30, secondary, HIV+, 4 years’ experience of sex work).
4.5.4.22 Doing sex work whilst menstruating

Participants reported that even during their menstruation they have to work in order to earn a living and support themselves and their children, therefore they use sponge which they insert into their vaginas to block the menstrual fluids from coming out, and they go on with selling sex as usual. This is illustrated in the following excerpts:

*If it’s towards month end and I have to have money to pay rent and buy food, and I’m menstruating, I take these new female condoms which has a sponge. I’ll take out that round sponge and put it inside my vagina, then after three clients I take it out, wash it then put it back. After two more clients I wash it again and put it back inside my vagina. I will do that until I knock off (40, secondary, HIV+, 16 years’ experience of sex work).*

*I use a stockings, the one that women wear… I use it for the whole day without taking it out. After I knock off I go and take a bath and take it out (33, secondary, HIV-, 8 years’ experience of sex work).*

*In order for the client not to notice that I’m menstruating, I usually use [red in colour] strawberry flavoured condoms because the condom is also red (34, secondary, HIV+, 15 years’ experience of sex work).*

*At first when I realised that I’m menstruating I took Disprin and inserted it inside my vagina and within thirty minutes the blood stops, until a friend of mine who is a nurse told me it is wrong to stop the blood because it must come out of the body. Then if I’m on periods I’m using the sponge, but the disadvantage about it is, if it’s a Friday, you are drunk and you forget it, it smells very bad when I take it out, especially if I left it the whole day, because remember I’m doing two jobs, one is to make sure that I take out the sponge and rinse it and take it back in. If you forget to take it out it goes up until the womb (41, secondary, HIV+, 18 years’ experience of sex work).*

*It’s a sex worker’s secret. The female condom has a sponge inside (26, secondary, HIV-, 9 years’ experience of sex work).*
I drink Disprin and Grandpa and the menstruation stops immediately. I take it in the morning and later the menstruation starts again. If I want to do sex work in the morning I drink it again (37, secondary, HIV+, 15 years’ experience of sex work).

You insert a sponge or use the condom called “red umbrella” so that the client cannot notice. When you take it out you hide yourself… Apart from the female condom, we also use the sponge that it’s commonly used for washing dishes. You must not use a used one. It must be a brand new sponge. You cut it and insert it inside your vagina (27, secondary, HIV+, 6 years’ experience of sex work).

That’s the one, and after sex I don’t use toilet paper. I have a towel, I’m using a towel so that the client can’t see if there’s blood because the colour of the condom is also red. There’s no way I won’t take the money because I’m on my periods… It’s not like you are injured… Some sex workers they wait for three days, others they insert sponges. These are some of the taboos we are experiencing. These flavoured condoms have come to our aid. Before we were aided by “Red umbrella.” I’m still saddened by its discontinuity because there was no need to use a toilet paper, you take it out first so that the client can’t see (35, secondary, HIV+, 3 years’ experience of sex work).

I once tried to use a sponge. I just started recently to see my menstruation. Before I was not seeing my menstruation because I was pregnant. I once tried to use a sponge. A sponge tear up a condom because it is dry. My advice is that when you are on your periods stay at home. It doesn't take the whole month it’s only a few days (24, secondary, HIV+, 2 years’ experience of sex work).

I’m using cotton wool with the red condom. Before a client insert his penis I smear it with a gel. There’s no way a condom can burst if I used a gel (34, secondary, HIV-, 7 years’ experience of sex work).

When I first came to this industry I was inserting a cotton wool with baby oil. The cotton wool will hold the blood (33, secondary, HIV+, 4 years’ experience of sex work).
Summary

The narrative of this chapter has been finalized based on the exploration of the practices and experiences of female sex workers pertaining to condom use, how they negotiate condom use, as well as the barriers to condom use between them and their clients or steady partners. These experiences are detailed through categories and themes.
CHAPTER FIVE
DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the discussion, conclusion and recommendation made by the researcher. The discussion is centered on the research questions and objectives of the study. The aim of this study was to assess the condom use practices, negotiation strategies and associated perceived barriers to condom use among FSW’s and their clients. The findings of the study are compared with those of the literature reviewed.

Discussion

5.2 Condom use knowledge and practice

The data show that at onset of sex work the FSW’s lack basic health information on what condoms are and the importance of condom use during sex, and even when they have access to condoms, they still do not know how to insert or use them. These findings support the findings of a systematic review of studies done in sub-Saharan Africa by Chersich et al. (2013). Our research findings demonstrate that condom use skills are learned on the job through interacting with other sex workers as well as through peer educators at condom use demonstration. These findings support those of a study done in Africa by Dhana et al. (2014).

In the study conducted by the researcher, FSW’s were educated on the available types of condoms (male, female and sometimes dental dam, if available) by peer educators, and they were also knowledgeable about the importance of condom use (health-risk information) as well as how to insert or use a condom. These findings support the findings of a study conducted in sub-Saharan Africa by Chersich et al. (2013b). In this study a male condom was identified as the preferred type of condom by all sex workers. Although some of them knew how to use the female condom, it was still not
their preferred type of a condom. Peters et al. (2014) also reported that policy makers often argue that the female condom is not acceptable to its users.

The female condom was described by the FSW’s as something which they used optionally when a male condoms could not be used, and it was criticized for its large size, the complicated insertion procedure, the noise it makes during sex, and the inconvenience of having to wait for hours after insertion before you can have sex. These findings are similar to those found in a study which was conducted in sub-Saharan Africa by Peters et al. (2014). The above mentioned findings raise concern, since they downplay the empowerment that could be derived from using a condom without the need to negotiate its use, which is possible only with the use of a female condom. This suggests that there is a need to rigorously promote and market female condom use among FSWs. These study findings support those of a literature review done in sub-Saharan Africa which found female condom acceptability varying from 2% to 98 % and concluding that the participants accepted the use of female condom only if they had access to and were provided with the necessary counselling and training on how to use the female condom (Peters et al. 2014).

The findings of this study suggest that condom use health education programmes need to be strengthened, because the participants didn’t know how to use condoms safely and effectively, as they reported that they use two condoms instead of one as a form of added protection. This behaviour increases the chances of the condom’s bursting. These findings support the findings of a study done in Kenya whereby 61 of 75 participants reported having had a condom breakage or slippage during commercial sex related to incorrect use of condoms (Masvawure et al. 2017).

Some of the sex workers were quite confident in their condom use and stood their ground in the face of their clients by refusing to have unprotected sex with them, meaning that the interventions promoting no sex without a condom seem to be empowering the sex workers to refuse unprotected sex with clients. But this does not empower them with the skills to effectively negotiate condom use. These findings are similar to those of a systematic review conducted in Africa which found that sex work programmes in Africa have limited coverage and a narrow scope of services which are
poorly coordinated. (Dhana et al. (2014). Therefore, going forward, the interventions should not only empower them to refuse unprotected sex but should also build their skills in convincing or persuading unwilling clients to use condoms.

The perceived risk of contracting or spreading HIV/STI was found to be an important factor that facilitated condom use negotiation by FSWs. The participants demonstrated that they have knowledge that non-condom use during sexual intercourse is associated with an increased risk of contracting or spreading HIV/STI’s, and these findings are similar to those of a study conducted in China. In on Barriers to condom use among female sex workers he found that 17 of 24 participants believed that they were at high risk of acquiring HIV/STI if they did not use condoms with clients (Jie et al. (2012). So we realise from this study that at least this sample of a key population has access to condoms at all times, and that peer education interventions are effective and very crucial to combatting the spread of HIV/STI’s. This is in agreement with the findings of other studies (Moore et al., 2014; Chersich et al., 2013; Dhana et al., 2014).

5.3 Condom use negotiation

We identified four condom use negotiation strategies used by the participants in this study. The FSW’s employed direct request for condom use by their clients, they used health-risk information, they charged more for unprotected sex, and would sometimes refuse to engage in unprotected sex by letting the client go without buying sex. These are some of the strategies found to be used by other sex workers in other studies (Bui et al., 2013; Batist et al., 2013; Bharat et al., 2013; Tamene et al., 2015).

From the use of the above mentioned strategies we have learned that FSWs have self-efficacy, which demonstrates that health promotion has taken place and there has been behaviour change. This can be confirmed by reports of direct requests for and the enforcement of condom use, and the use of health information as both a motivator and a threat. This suggests that FSWs are empowered and want to protect themselves and others (their clients and other sexual partners, like their clients’ wives and girlfriends at home). These findings support the findings of studies conducted on
programmes which have been tailor-made for sex workers (Loftie et al., 2012; Batist et al., 2013; Bukenya et al., 2013; Vandenhoudt et al., 2013).

The refusal of unprotected sex also means that the sex workers have been empowered and they are taking their lives seriously, as they are able avoid exposing themselves to health-risks problem for the sake of making more money. These findings confirm those found in a study done in Uganda by Mbonye et al., (2013). However, charging more for unprotected sex is a risky behaviour that still occurs, since some FSW’s succumb to non-condom use in order to earn more money. This finding is similar to that of a study conducted in Uganda by Bukenya et al., (2013). The data show that even experienced female sex workers who know about the health risks involved in non-condom use still lack condom use negotiation skills with their clients. They reported using only the four above mentioned strategies, and they did not have anything else to say to convince an unwilling client. This was also found in other studies (Bharat et al., 2013; Bui et al., 2013; Tamene et al. 2015; Vandenhoudt et al., 2013).

5.4 Perceived barriers to condom use

Almost all the participants reported that the reason for their non-condom use during sex with clients was that they could charge more for unprotected sex, which was useful to them as they had financial problems. This finding similar to those found in other studies (Bui et al., 2013; Bukenya et al., 2013; Bharat et al., 2013; Matovu & Ssebaduka, 2013; Nkala, 2014). Having dependants such as children as well as having to care for extended family members was another reason for non-condom use, especially because the sex workers’ occupations had not been disclosed to the family members. These finding are similar to those found in other studies (Mbonye et al., 2013; Nkala, 2014). There is competition among FSW’s to get more clients and make more money. If they think that they are not making enough, then they adopt various strategies like choosing clients that pay more for unprotected sex, and this contributes to non-condom use. These findings are similar to those in a study done in Uganda by Mbonye et al. (2013).
The findings in this study inform us that the issue of trust, love and belonging, as well as the FSW's need for sexual satisfaction with their steady partners has an impact on condom use. Sex workers are financially dependent on their steady partners and therefore find it difficult to suggest condom use to them. This vulnerability has brought about gender inequity and the fear of the loss of relationships as well as the loss of financial support, as reported in other studies (Bukenya et al., 2013; Tamene et al., 2015; Okafor et al., 2017). The participants reported that they work in risky and unregulated environments where they are exposed to all kinds of violence, and this minimizes their chances of successfully negotiating for condom use. These findings are similar to those found in studies done by Fobosi et al. (2017) and Coetzee et al. (2017).

All of the participants reported that they consumed alcohol, and the excessive consumption of alcohol and drug use were found to be compromising factors when it came to condom negotiation and use, as they are associated with high risk behaviour. These findings are similar to those found in other studies (Mbonye et al., 2013; McKinnon et al., 2015).

We can tell from this study that most female sex workers know about the health risks of not using condoms with clients and partners, but the decision is made between two people who are behind closed doors. Male clients therefore also contribute to non-condom use, as has been found in other studies (Basuki et al., 2002; Coetzee et al., 2017; Jie et al., 2012; Masvawure et al., 2017). Female sex workers use condoms inconsistently with both clients and partners, partly for fear of clients and intimate partner violence. This finding is confirmed by other studies (Coetzee et al., 2017; Masvawure et al., 2017; Matovu & Ssebaduka, 2013; WHO, 2011). Clients also offer to pay more for unprotected sex and come up with all sorts of excuses for not using condoms, such as saying they have medical conditions like diabetes or claiming they react to condoms. There is evidence that there is a big problem when clients request unprotected sex from sex workers, and this needs further investigation and
recommendation on how it can be curbed. This supports the findings of studies done in Ethiopia by Tamene et al. (2015) and Wirtz et al. (2015).

The deliberate refusal of condom use by both sex workers and clients raises suspicion of the intentional spread of HIV/STI's, and this requires further investigation. Some of the participants laboured under the misconception that circumcised male clients could not spread HIV/STI's, therefore this information has to be clarified in health interventions, because according to WHO, 2011 circumcision only reduces the risk of HIV acquisition by 62% and therefore it cannot be used as a reason for having unprotected sex. In this study we noted that male clients are also responsible for the spread of HIV/STI's. The participants complained of all kinds of violence, including rape, perpetrated by clients, stable partners, pimps and the police, as well as unknown people. These findings are similar to those found in a study done in the USA (Strathdee et al., 2015).

The FSW's also reported that they experience all kinds of abuse and violence in the hands of the police, and if they report try to report a case at the police station the police officers refuse to open their cases and don’t investigate and follow up on the crimes experienced by sex workers. They also reported that the police harass them and sometimes arrest them and demand a bribe for their freedom. These findings support those of studies done in Africa by Nkala (2014) and SANAC (2013).

5.5 Work pressure

Sex workers experience work pressures due to their wanting to earn a great deal of money and their having to pay for renting the rooms where they are staying. As a result, the FSW's reported using a sponge or a wad of cotton wool during their periods. They insert this inside the vagina until it reaches the cervix. They say the sponge absorbs and blocks the menstrual fluids from descending, and then it is business as usual for them. This can constitute a gynaecological hazard for them. These findings are similar to those found in another study done in the South Africa by Coetzee et al. (2017).
5.6 Limitations of the study

The aim of this study was to explore FSW’s condom use practices, condom use negotiation skills, and barriers to condom use. The findings reported are based on self-reporting by FSW’s on Heidelberg Road. The study was conducted in an urban area rather than a rural area. The participants were not easily recruited as they were inconvenienced by having to leave their workplace and come to the research setting for the group discussions. Due to the sensitivity of the topic, the participants were not comfortable to speak in groups initially, but as the interviews progressed they became more relaxed and were able to share their personal and sexual experiences with regards to their condom use practices and experiences. During the discussions the researcher attempted to be sensitive and provided some supportive and psychosocial counselling services. Participants who were emotional were referred to the site’s social worker for further intervention and management.

The sex workers had to be recruited as groups to come to the venue on different days, and they preferred to come with friends, as there are things that are too personal to share with strangers. There may therefore be some bias in the findings. The researcher noticed that in some groups the participants preferred to tell us about what other sex workers are doing and not about what they themselves are doing. For example, they would say “some sex workers say they use condoms but they have a bad vaginal smell.”

Due to the sensitivity of the topic the participants were not comfortable to speak in groups initially, but as the interviews progressed they were more relaxed and were able to share their personal and sexual experiences with regards to their condom use practices and experiences with their clients and partners. During the discussions the researcher attempted to be sensitive and provided some supportive and psychosocial services. Participants who were emotional were referred to the site social worker for further intervention and management.
5.7 Conclusion

Limited research has been performed on condom use practices, condom use negotiation and the barriers to condom use among FSW’s in sub-Saharan Africa. Poverty is the most common factor that led these women into sex work. Having dependants was seen as a factor that predisposed them not to use condoms, and also having fewer clients in a day led to them abandoning condom use as they wanted to meet their financial targets. Condom use negotiation skills are learned through health intervention programmes. The FSW’s know the health risks associated with non-condom use. Condom use is dependent on both the sex worker and the client or stable partner. There is inconsistent condom use in the FSW industry due to economic factors and the nature of the relationships formed, including the threat of intimate partner violence. The findings in this study could help in the development of more effective health interventions for sex workers.

5.8 Implications for further studies

It is evident that female sex work continues to increase in many countries, including South Africa. There is limited research on the topic in South Africa. Most of the research has been done in other countries. Studies have noted different challenges facing female sex workers in different countries. The researcher’s findings support the claim that many challenges are faced by female sex workers e.g. the incorrect use of condoms, or the use of a foreign objects such as sponges, wads of cotton wool or stockings to block the flow of menstrual fluid or as a protective measures during unprotected sex.

Interventions are needed to scale up the services provided to female sex workers. Health care practitioners do further investigations and discuss how this can be managed and how these practices can be prevented from migrating to other countries, as they have own negative effects on the health of both the sex workers and the
clients, especially when the objects are not changed in between one client and the next, and are kept inside the vagina for the whole night or weekend.

5.9 Recommendations
Based on the study findings the following recommendations have been made; health education and promotion, condom use negotiation strategies and empowerment of healthcare workers and the police

5.9.1 Health education and promotion
- Health interventions should focus not only on the sex workers but must include their clients as well.
- Peer education should be strengthened by training more peer educators and ensuring that there is at least one peer educator per 15 sex workers in all sex worker hot spots. They should be reimbursed fairly and according to the number of sex workers with whom they did condom use demonstrations and health talks.
- The promotion of condom use should target both FSW’s and their clients or steady partners, because condom use is dependant not only on FSW’s but also on their clients or steady partners. The facts that clients refuse to use condoms, are willing to pay extra for unprotected sex, and make excuses for not wearing condoms means that condom use is not considered important, which is a sign of the lack of knowledge within the general population.
- The excessive use of alcohol and drugs among sex workers strongly argues for the need to address alcohol- and drug-related abuse among this population, as it exacerbates non condom use.
- The misconception that healthy-looking clients and circumcised males are not health risks needs to be addressed through peer education.
5.9.2 Condom use negotiation strategies

- Interventions should not only empower FSW’s to refuse unprotected sex, because we already know that this strategy might not be effective because the clients can offer money which a sex worker might not be able to resist. Therefore it should be imperative that sex workers are empowered with other condom use negotiation skills or strategies which will help them to be able to persuade their clients to use condoms. For example, in addition to making direct requests and talking about health risks, such as the chance that the client might take an infection home to his wife, they should be able to present a choice of different condom brands or different flavoured MAX condoms and allow the client to choose his favourite, or suggest a novel way of putting on a condom, and offer to help with putting it on during foreplay (Ghose et al., 2008).

5.9.3 Empowerment of healthcare workers and the police

- The sensitisation of healthcare workers and law enforcement agencies to the care and appropriate management of key populations (sex workers, drug users, and men having sex with men) should be emphasized and strengthened, with priority being given to areas with lots of hot spots. For example, the FSW’s said that the police burn their condoms and sometimes drive them to unfamiliar environments and leave them to walk home alone. This increases their vulnerability to crime and reduces the already limited chances of condom use. Healthcare workers should also provide healthcare services with respect and without a judgemental attitude, to ensure and promote accessibility to healthcare services for all.
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Annexure 1: ENGLISH DATA COLLECTION TOOLS

**Title:** An exploration of condom use by street based female sex workers in Heidelberg road, Ekurhuleni

<table>
<thead>
<tr>
<th>In-depth interview Guide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thank you for agreeing to participate in this in-depth interview, my name is Nokuthula, from the School of Public Health in Sefako Makgatho Health Science University. Our interview will be with the female sex workers (FSW), I would like to understand your knowledge and practices regarding condom use, negotiation and barriers to condom use. The participants will be assured that all the information gathered in this room will be kept confidential and their personal identity will be protected at all times. The participants will not be required to provide their identity at any time. The participants will be asked to feel free to tell me when they are not comfortable about any of the questions, but that it would appreciated if they could answer as many of the question as possible.</td>
</tr>
</tbody>
</table>

**Section 1: Discussion Guide**

1. How did you get into doing sex work?
   **Probe:** What were the reasons that lead you to doing sex work?

2. Who are your clients?
   - Where are these man coming from?

3. What are your practices with regards to condom use with clients?
   **Probe:** Do you think that condom use is doable in the sex work industry?

4. Where do you get condoms?
   **Probe:** Is that the only place where you get condoms from?

5. Which type of condoms do you use?
   **Probe:** Do you use male or female condom

6. How do you negotiate condom use with your clients?
   **Probes:** What do you say to a client when asking him to use a condom with you?
   - If that doesn’t work, what else do you say?

7. How do you convince a non-willing client to use a condom?
**Probes:** When a client initially refused to use a condom, but ended agreeing how did you make him change his mind

8. What are some of the factors that make it difficult to negotiate condom use?

**Probes:** What are the things that make it difficult to negotiate use of condoms with clients?

What are the clients excuses to not using condoms?

9. In which circumstances would you abandon condom use?

**Probes:** What can be the reasons that would make give up condom use with a client?

What is that can make you agree not using a condom with a client or partner?

10. What would you say are factors that would encourage condoms use between you and your partner or clients?

**Probe:** What do you think can be done to promote condom use between clients and sex workers

11. Are there any health risks that you are exposed to when not using condoms

**Probe:** Can you name them please?

12. What happens when you're are on your periods
   - Do continue with working?

13. Are you on contraceptives?

**Probe:** Which one, If not, why not and what do you when you're pregnant

14. Have you had any signs of STI in the past 6 months (burning on passing urine, discolored offensive vaginal discharge, vaginal itch and or lower abdominal pain?

15. Did you consult at any health facility for the above signs?

**Probe:** Was it a public or private facility?

16. What were your experiencing with accessing public health care services?

**Probes:** Were you satisfied with the service you received
   - Any recommendations of o you would like to be treated

17. Are there any organizations that bring health care services to you place of work?
   - If any, What are the services are they providing you with
18. Does your partner know that you are doing sex work
   **Probe**: If not what are your reasons for not telling him

19. What are other challenges that you’re exposed to as a sex worker?

20. Is this the only job you do?
   **Probe**: Do you have another source of income?

21. Do you think you will ever leave this job?
   - If yes, what should happen for you to leave this job
   - If no why?

22. Is there anything else that you would like to add on the topic?

---

Thank you for participating in the study.
In – depth interview

Siyabonga ngokuba uvume ukubamba iqhaza kulenhlokhono, igam ngingu Nokuthula, obuya esikoleni i School of Public Health ese Sefako Makgatho Health Science University. Inhlolokhono yethu namuhla iyobe ibuza abadayisi ngomzimba, sizobe sifuna ukwazi nokuqonda ukuthi niyaye nenzenjain ngokusetshenziswa kwamakhondomu, sazi ukuthi niyaye ninoxisa kanjani nabathengi nokuthi yoizipho izinto ezivimbel ukuba ningaxosisani kah;e nabathengi maela nokusetshenziswa kwama khondomu. Ababame iqhaza bazokwaziswa ukuthi yonke imininingwane yolwazi ethola kale lakhe izoba yimfihlo futhi namagam abo awazukudalulwa. Ababambe iqhaza abasoze bacele ukuba basho amagam abo, bazocela ukuba bakhululeke kuthi lokho abangafuni ukukuphendula bangakusho kodwa singakuthokozela kakhulu um bengaphendula yonke imubuzo.

1. Wangena kanjani kulomsebenzi wokudayisa ngokoncansi?

Probes
- Yiziphi izizathu ezenza ukuba ungene kulomsebenzi
- Ungasho ukuthi kukhona owenza ukuthize ukuba ungcine usuwenza lomsebenzi?

2. Ingabe wobani amakhaisimende enu

- Incazelo mayelana nabathengi, youkuthi laba besilisa banjani, baqhamukaphi, baqhamukaphi, baqhamukaphi, banemiyaka emingaki

3. Ingabe wenzanjani mayelana nokusetshenziswa kwe khondomu kanye nabathengi bakho

Probes
- Ucabanga ukuthi ukusetshenziswa kwekhondomu into enegenziwa kalula noma kungabanzima phakathi kwabadaiyisi kanye nabathengi?
4. Ingabe niwatholakuphi amakhondomu
   - Ungasibalele izinkampani ezininikza amakhondomu

5. Ingabe yiyiphi inhlobo yamakhondomu oyisebenzisayo
   - Awabesifazane noma awabesilisa

6. Uyaye uxoxisane kanjani nabathengi mayelana nokusetshenziswa kwe khondomu?
   **Probes**
   - Ngicela ungitshela uyaye ukusho uma ucela ukuba nisebenzise ikhondomu nomthengi
   - Uma lokho kungasebenzi uyaye uthini

7. Uwushintsha kanjani umqondo womthengi ongafuni ukuebenzisa ikhondomu?
   **Probes**
   - Umthengi owayengafunin ukusebenzisa ikhondomu, wawushintsha kanjaini umqondo wakhe?
   - Izinto ozishoya ukuze owesila ongafuni ukusenbezisa ikhondomu agcine eyisebenzisile

8. Yiziphi izinkinga oyaye uhlabangezano nazo uma uxoxisana nabathengi ngokusetshenziswa kwekhondomu?
   **Probes**
   - Yini eyaye yenze ukuba kubenzima ukuxoxisana ngokusetshenziswa kwe khondomu kanye nabathengi?
   - Baye babekebe maphi amaphuzu abathengi uma bengafuni ukusetshenzisaw kwekhondomu?

9. Yiziphi izikhathi noma izimo ezingenza ukuba ulahle phansi ukusetshenziswa kwe khondomu
   **Probes**
   - Yiziphi izizathu ezingenza ukuba kungasetshenziswa ikhondomu phakathi kwakho nabathengi?
10. yini egenza ukuthi kubelula ukusebenzisa amakhondomu pahakathi kwabathengi kanye nabadayisisi

**Probe**

- yiziphi izinto ocabanga ukuthi zingenza ukuba kubelula ukusebenzisa amakhondomu phakathi kwabadayisi nabathengi

11. Kukhona yini izifo ongahle uzithole uma ungawasebenzisi amkahondu uma uya ocansini

- Ungisichazela kabanzi, ngokuthi zibonakala kanjani uma usunazo.

12. Sichazele ukuthi ingabe usebenza kanjani uma esesikhathini, phecelezi in menstruation?

13. Ingabe uyawuhlela yini umndeni

- Usebenzisa ini, ukuvikela ukukhulelwana?
- Uma ungahleli ingabe yini isizthu?


15. Uma ukewabazoo izifo ezithathelini ngokocansi, ukewaya yini emtholampilo ukuyothola usizo

- Ubuye emtholampilo kahulumeni noma emtholampilo wabazimele nje ngdokotela bangase

16. Kulabo abaye emtholampilo kahulumeni, bangasichazela ukuthi baphatheke kanjani?

- Banelisekile yini ngosizo abalitholile?
- Kukhona yini indlela abangathanda ukuba batheke ngayo uma besemitholampilo kahulumeni?

17. Yiziphi izinkampane eziletha imitholampilo la nisebenzela khona?

- Ingabe yiluphi usizo enilitholayo phecelezi nisizwa ngaziphi izinkinga zezempilo
18. Ingabe othandana naye uyazi yini ukuthi wenza lomsebenzi wokudayis ngokocansi?
   - Uma engazi ingabe yiziphi izizathu ezenza ukuba ungamazisi?

19. Yizihi izinkinga enibhekana nazo kulokhakah lomsebnezi wenu wokudayis ngokocansi
   - Ningasichazela kabanzi

20. Ingabe ukhona yini umunye umsebenzi owenzayo ngaphandle kwalona wokudyisa ngokocansi?
   - Ingabe ikhona yhi ni enye endlela okwzi ukwenz ngayo imali ngaphandle kwalena?

21. Ingabe ngokucabanga kwakho ungawuyekela yini lomsebenzi?
   - Uma yebo, ingabe yini engenza ukuba ukwazi ukuwuyekela?

22. Kukhona yini okunye ongathanda ukusho mayelana nesihloko sanamhlange?
SECTION 2: Demographic Data Tool

Title: An exploration of condom use by street based female sex workers in Heidelberg road, Ekurhuleni

<p>| Participant’s ID |  |  |
|------------------|-------------------------|
| 1.               | How old are you?        |  |
| 2.               | Where you born here in Ekurhuleni? | Yes | No |
| 3.               | If no, what is your place of birth? |  |
| 4.               | How long have you been staying here in Ekurhuleni? |  |
| 5.               | What is your highest level of education? | Primary school | Secondary school | Grade 12 | Tertiary |
| 6.               | What did you do for a living before you became a sex worker | Student | Hairdresser | Waitress | Retail worker | Other | Specify |
| 7.               | Do you have any other way of making money beside being a sex worker | Yes | No | Do not know | No response |
| 8.               | Do you have children | Yes | No |
| 9.               | If yes, how many children do you have? |  |
| 10.              | Marital status | Married | Divorced | Widowed | Single |</p>
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td>Do you have any other way of making money beside being a sex worker</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not know</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No response</td>
</tr>
<tr>
<td>12.</td>
<td>Did you have any children when you were already doing this job</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>13.</td>
<td>If yes, how many children do you have?</td>
<td></td>
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<tr>
<td>14.</td>
<td>Have you ever had an abortion since you have been a sex worker?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>15.</td>
<td>If yes, how many abortions have you had?</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Did you have a baby since you became a sex worker?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>17.</td>
<td>How old were you when you started sex work?</td>
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<tr>
<td>18.</td>
<td>How long have you been working as a sex worker?</td>
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<tr>
<td>19.</td>
<td>How many days a week do you work?</td>
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<tr>
<td>20.</td>
<td>How much do you make per day?</td>
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<tr>
<td>21.</td>
<td>How many clients you see per day?</td>
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<tr>
<td>22.</td>
<td>Do any of your family members know about your sex work?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>23.</td>
<td>Do you have a steady partner?</td>
<td>Yes</td>
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<td></td>
<td></td>
<td>No</td>
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<td>24.</td>
<td>If yes, how long are you in this relationship?</td>
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<tr>
<td>25.</td>
<td>Do you live with your partner?</td>
<td>Yes</td>
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<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>26.</td>
<td>Does your partner know about your sex work?</td>
<td>Yes</td>
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<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>27.</td>
<td>Do you ever think about leaving this work?</td>
<td>Yes</td>
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<td></td>
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<td>No</td>
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</table>
### Demographic tool: translated into isiZulu

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<tbody>
<tr>
<td>1. Uneminyaka emingaki</td>
<td></td>
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<tr>
<td>2. Wazalelwawa la Ekurhuleni na?</td>
<td>Yebo</td>
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<td></td>
<td>Cha</td>
</tr>
<tr>
<td>3. Uma cha, wazalela kuphi?</td>
<td></td>
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<tr>
<td>4. Unesikhathi esingakananin uhlala</td>
<td></td>
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<tr>
<td>Ekurhuleni?</td>
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<tr>
<td>5. Esikoleni ugcine kwabani?</td>
<td>Ongayile</td>
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<td>esikoleni</td>
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<td>Ibanga 8 -11</td>
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<td>Imfudo</td>
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<td>ephakeme</td>
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<td>6. Ukhona umsebezi owake wawenza</td>
<td>Umfund</td>
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<td>ngaphambili ngaphandle kwalona?</td>
<td>weninwele</td>
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<td>Weta</td>
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<td></td>
<td>Osebenza</td>
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<td></td>
<td>esitolo</td>
</tr>
<tr>
<td>7. Unayo yini enye indlela yokwenza</td>
<td>Yebo</td>
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<tr>
<td>imali ngaphandle kwalena yokudayisa</td>
<td>Cha</td>
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<tr>
<td>ngokocansi</td>
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<tr>
<td>8. Unazo yini izingane</td>
<td>Yebo</td>
</tr>
<tr>
<td></td>
<td>Cha</td>
</tr>
<tr>
<td>9. Uma unazo izingane zingaki</td>
<td></td>
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<td>10. Isimo sokushada</td>
<td>Oshadile</td>
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<td>Ohlukanisile</td>
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<tr>
<td></td>
<td>Question</td>
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<td>---</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11.</td>
<td>Unayo yini anye inlela yokwenz imali ngphandle kwale yokudayisa ngokocansi</td>
</tr>
<tr>
<td>12.</td>
<td>Unazo yini izingane ozithole usukulomsebenzi</td>
</tr>
<tr>
<td>13.</td>
<td>Uma unazo zinginkaki izingane?</td>
</tr>
<tr>
<td>14.</td>
<td>Wake wasikhipha yini isisu seloku waqala lomsebenzi</td>
</tr>
<tr>
<td>15.</td>
<td>Uma yebo zingaki isisu okewazikhipha</td>
</tr>
<tr>
<td>16.</td>
<td>Ikhona yini ingane oyizale ususebenza lomsebenzi</td>
</tr>
<tr>
<td>17.</td>
<td>Wawuneminyaka emingaki uma uqala ukwenza lomsebenzi?</td>
</tr>
<tr>
<td>18.</td>
<td>Isimingaki manje iminyaka wenza lomsebenzi?</td>
</tr>
<tr>
<td>19.</td>
<td>Usebenza izinsuku ezingaki nge viki?</td>
</tr>
<tr>
<td>20.</td>
<td>Malilini oynza ngosuku uma usebenzile?</td>
</tr>
<tr>
<td>22.</td>
<td>Ukhona yini owomndeni wakho owaziyo ukuthi wenza lomsebenzi?</td>
</tr>
<tr>
<td>23.</td>
<td>Unaye yini umqondana wakho othandana naye?</td>
</tr>
<tr>
<td>24.</td>
<td>Uma yebo, singakanani isikhathi nithanadana?</td>
</tr>
<tr>
<td>25.</td>
<td>Ingabe othandana naye uhla naye na?</td>
</tr>
<tr>
<td>26.</td>
<td>Does your partner know about your sex work?</td>
</tr>
<tr>
<td>27.</td>
<td>Uke ucabange yini ukuwuyekela lomsebenzi?</td>
</tr>
</tbody>
</table>
## ANNEXURE 2: CODE LIST

**Code book**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Inclusion/exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSWs condom use knowledge and practices</td>
<td>This reference to what participant’s say their condom use practices were at onset and overtime of doing sex work</td>
<td>This includes condom use practices with their clients only.</td>
</tr>
<tr>
<td></td>
<td>• At the onset of sex of sex work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Over time as a sex worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Knowledge of how to insert condom correctly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Preferred type of a condom</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Accessibility to condoms</td>
<td></td>
</tr>
<tr>
<td>Negotiation of condom use by female sex workers</td>
<td>In reference to what the participants say about ensuring condom use during sex with client’s</td>
<td>Includes strategies used by participants to ensure condom use.</td>
</tr>
<tr>
<td></td>
<td>• Direct request and enforcement of condom use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The use of health risk information</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Charging more for unprotected sex</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Refusal of unprotected sex with clients</td>
<td>Excludes participants who don’t use strategies to ensure condom use</td>
</tr>
<tr>
<td>Perceived barriers to condom use</td>
<td>In reference to what participants mentioned as barriers to using condoms with clients</td>
<td>Includes participants who experience barriers to using condoms with clients</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>• Financial need</td>
<td></td>
<td>Includes participants whose condom use decision making is affected by substance and their perceptions</td>
</tr>
<tr>
<td>• The sense of love and belonging need</td>
<td></td>
<td>Excludes participants who have never been harassed and by police.</td>
</tr>
<tr>
<td>• The use of alcohol and drugs</td>
<td></td>
<td>Excludes participants who don’t experience work pressures</td>
</tr>
<tr>
<td>• Absence of threat related to appearance based judgement</td>
<td>Intentional spread of HIV/STI’s t</td>
<td></td>
</tr>
<tr>
<td>• Abuse, harassment and victimisation of sex workers by police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Work pressures of being a sex worker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Statement concerning participation in a Research Project.

Name of research project: An exploration of condom use by street based female sex workers in Heidelberg road, Ekurhuleni

I have read the information and heard 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 audio recordings will be taken from 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 research Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this Project has been approved by the Sefako Makgatho University Research Ethics Committee (SMUREC), Sefako Makgatho Health Sciences University. I am fully aware that the results of this Project 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 research project.

Name of participant ……………………………

Place……………………. Date……………………

Witness………………………………………………………………

Statement by the Researcher

I provided verbal and written information regarding this Project

I agree to answer any future questions concerning the Project as best as I am able.
I will adhere to the approved protocol.

<table>
<thead>
<tr>
<th>Name of Researcher</th>
<th>Signature</th>
<th>Date</th>
<th>Place</th>
</tr>
</thead>
</table>
ISITHASISELO

SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY ISIZULU CONSENT FORM

Isitatimende esimaqondana nokuhlanganyela oHlolweni kuPhrojekthi

Igama lePhrojekthi: ucwaningo ngokusetshenziswa kwe khondomu kubesifazane abadayisa ngomzimba emgwaqeni i Heidelberg, Erkurhuleni………………………………………………………………

Ngilufundile ulwazi, ngizizwile izinhloso nezinjongo zocwaningo oluhlongoziwe futhi nganikezwa nethuba lokubuza imibuzo nganikezwa nesikhathi esanele sokuphinde ngicabange ngodaba. Inhloso nenjongo yocwaningo kucace ngokwanele kimi. Azange ngicindezelwe ukuthi ngihlanganyele nganoma iyiphi indlela.

Ngiyaqonda ukuthi ukuhlanganyela kule Projekthi yoHlolo ngokukuzithandela ngokuphelele nokuthi ningarohoxa kulo noma nini ngaphandle kokunikeza izizathu. Lokhu angeke kube nomthelela ekwelashweni okuvamile kwesimo sami futhi angeke kube nomthelela ekunakekelweni engikuthola kudokotela wami ovamile.

Ngiyazi ukuthi le Projekthi igunyazwe yi-Sefako Makgatho University Research Ethics Committee (SMUREC), Sefako Makgatho Health Sciences University. Nginolwazi olugcwele lokuthi imiphumela yale Projekthi izosetshenziselwa izinhloso zesayensi futhi ingashicilelwa. Ngiyakuvuma lokhu, uma nje ingasese lami liqinisekisiwe Lapha nginikeza imvume yokuhlanganyela kule Projekthi.

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

Igama levolontiya Isignesha yesiguli noma yomgadi.

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

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

Indawo. Usuku. Ufakazi

..............................................................
Isitatimende somCwaningi

Nginikezele ngolwazi ngomlomo kanye/noma olubhaliwe* maqondana nalolu Hlolo/Cwaningo/nale Phrojekthi*. Ngiyavuma ukuphendula nanoma yimiphi imibuzo yesikhathi esizayo maqondana noHlolo/ Cwaningo /ne Phrojekthi* kahle kakhulu kangangoba ngikwazi. Ngizobambelela kusivumelwano senqubo esigunyaziwe

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

Igama loMcwningi Isignesha Usuku Indawo
ANNEXURE 4: ETHICAL CLEARANCE 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 163 Medunsa 0204

APPROVAL NOTICE - NEW APPLICATION

02 February 2017

Mrs N Sihosana
Department of Public Health
P.O Box 215
Medunsa, 0204

MEETING: 01/2017

SMUREC Ethics Reference Number: SMUREC/H1/31/2017: PG

The New Application received on 20 October 2016, was reviewed by members of Sefako Makgatho University Research Ethics Committee on 03 November 2016 and was approved on 02 February 2017.

Title: An exploration of condom use by street-based female sex workers in Heidelberg Road, Ekuhluleni

Researcher: Mrs N Sihosana
Supervisor: Prof MM Makgale
Department: Public Health
School: Health Care Sciences
Degree: MPH

Please note the following information about your approved research protocol

Protocol Approval Period: 02 February 2017 – 02 February 2018

Please remember to use your protocol number (SMUREC/H1/31/2017: 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.


Sincerely

[Signature]

PROF GA OSUNBANO
CHAIRPERSON SMUREC

[Date]
REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I am a registered Master’s student in the Department of Public Health at the Sefako Makgatho Health Science University. My supervisor is Professor Mokgatle. The proposed topic of my research is: **An exploration of condom use by street based female sex workers in Heidelberg road, Ekurhuleni**

The objectives of the study are:

(a) To explore condom use practices among female sex workers and their clients.
(b) To explore and understand how female sex workers negotiate condom use.
(c) To explore condom use negotiation perceived barriers among female sex workers and the clients.

I am hereby seeking your consent to collect data for the fieldwork of this research within your demarcation. To assist you in reaching a decision, I have attached to this letter:

(a) A copy of an ethical clearance certificate issued by the University
(b) A copy the research instruments which I intend using in my research

Should you require any further information, please do not hesitate to contact me or my
supervisor. Our contact details are as follows:

1. **Professor Mokgatle (Supervisor)**  mathildamokgatle@smu.ac.za  
   +2712 521 4177

2. **Nokuthula Sikhosana (Student)**  nokuthulamakhoba3@gmail.com  
   +27846402313

Upon completion of the study, I undertake to provide you with a bound copy of the dissertation.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

-----------------------

Nokuthula Sikhosana
CENTRE FOR POSITIVE CARE (CPC)
Granting Permission to Conduct Research

Research Project Title: An exploration of condom use by street based female sex workers in Heidelberg road, Ekurhuleni

Name of researcher: N P Sikhosana

Division/Institution/ Company: Sefako Health Science University

Decision taken by: Centre for Positive Care East Rand Branch

- This document certifies that the above research project has been fully approved by CPC East Rand branch. The researcher may therefore commence with the intended research project.
- Note that the researcher will be expected to present the research findings to CPC team and participants and provide us with a copy of a dissertation.
- The CPC East Rand branch wishes the researcher the best of success

Name: Tshungam Muka
Signature: 
Designation: Programme Manager
Date: 21/08/2017

Name: NWAFING EDISAN SHARON
Signature:
Designation: Site Coordinator
Date: 02 August 2017
TO WHOM IT MAY CONCERN

2 February 2018

I hereby certify that I have edited the language of a dissertation by Nokuthula Portia Sikhosana titled “An exploration of condom use by street-based female sex workers in Old Heidelberg Road, Ekurhuleni.”

I am Professor Alan Brimer, DLitt (UPE), Professor Emeritus of UKZN.

Yours faithfully,

Alan Brimer