F I N A L R E P O R T

"I expect to be abused and I have fear": Sex workers' experiences of human rights violations and barriers to accessing healthcare in four African countries

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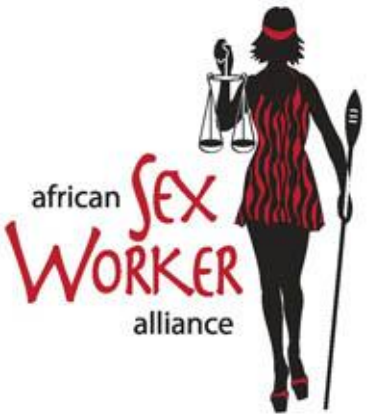
April 2011



Acknowledgements

Funding for this study was received by Oxfam NOVIB and the Ford Foundation in southern Africa. We are grateful to Eka Esu-Williams and Denise Parmentier for their support and input on the project.

The study team would like to thank Sian Maseko, Prince Nare, Kyomya MacLean, Nzioki King'ola, and Peninah Mwangi for valuable assistance in overseeing data collection for the project, on-site. Thanks are also due to Eric Harper, Mickey Meiji, Dianne Massawe and Lee van der Westhuizen at SWEAT for project direction, conceptual input, and broader logistical support, and to Matthew Chersich from the Centre for Health Policy at Wits for input on the study design, assistance with statistical analysis of results and editing the report.

We would also like to thank various organisations for supporting this research and acting as hosts for our researchers in each country. These include: the Sexual Rights Centre in Bulawayo, the Women's Organization Network for Human Rights Advocacy (WONETHA) in Kampala, the International Centre for Reproductive Health (ICRH) and Bar Hostess Empowerment and Support Programme in Kenya, the Thohoyandou Victim Empowerment Project (TVEP) in Limpopo, South Africa, and Sisonke in Hillbrow, South Africa. The Reproductive Health & HIV Unit (RHRU) provided office space for the conducting of interviews in Hillbrow, as did individual sex workers in Musina, Limpopo, who kindly opened their homes to us for this purpose.

Finally, none of this research would have been possible without the participation of sex workers in Kampala, Mombasa, Bulawayo, Johannesburg and Limpopo province, who shared their stories with us – often traumatising to narrate – and trusted us with this information. We salute you all for the courage you display in living and working under frequently brutal conditions, where your rights and dignity are repeatedly violated. May this research, and the advocacy work it will inform, bring us all one step closer to ending these violations.

Dedication

For Itumeleng, a sex worker from Lesotho who was assaulted by a hotel security guard in Hillbrow, Johannesburg, in 2010 and later died of her injuries.

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Abbreviations and Acronyms

AIDS – Acquired Immunodeficiency Syndrome

ASWA – African Sex Worker Alliance

DHS – Demographic and Health Survey

FGD – Focus Group Discussion

HCT – HIV Counselling and Testing

HIV – Human Immunodeficiency Virus

IDI – Individual In-depth Interview

MSM – Men who have sex with men

RHRU – Reproductive Health & HIV Unit

SRH – Sexual and Reproductive Health

STI – Sexually Transmitted Infections

SWEAT – Sex Worker Education and Advocacy Taskforce

UNAIDS – Joint United Nations Programme on HIV/AIDS

UNFPA – United Nations Population Fund

UNGASS – United Nations General Assembly Special Session

WONETHA – Women's Organization Network for Human Rights Advocacy

Executive Summary

This report documents human rights violations experienced by female, male and transgender sex workers in four African countries (Kenya, Uganda, South Africa and Zimbabwe), and describes barriers they face to accessing health services. Through cross-country comparison and documenting sub-regional trends, the study moves beyond previous often-localised descriptions of violations against sex workers in Africa. The study also fills information gaps about violations in male and transgender sex workers in this setting.

Research questions:

1. How are sex workers in the 4 countries commonly targeted by police and with what outcomes? What human rights violations are commonly perpetrated by police, clients, pimps, boyfriends and landlords?
2. What strategies do sex workers use to redress or avoid these violations?
3. How and where do sex workers access healthcare they need? What barriers prevent them from doing so?
4. What violations and healthcare barriers are experienced by migrant or foreign national sex workers? How does high mobility affect these?
5. What is the impact of the current legal and policy framework on sex workers' health and wellbeing?

Methods

A desk review of literature and policies pertaining to sex work in the study settings preceded individual in-depth interviews (n=55) and 12 focus group discussions (n=81) with sex workers above 18 years. Interviews covered the human rights violations SW experienced, strategies to avoid these, barriers to health services and practical suggestions for advocacy to improve these circumstances. Broader health (HIV) impacts were also examined. Salient demographic and sexual behaviour data were collected.

Sex worker peer educators were trained to obtain narrative information through interviews with sex workers (hereafter 'SW'). Convenience sampling was used, aiming to enrol participants across diverse sex-work settings in each site. Interviews took place from December 2010 to February 2011 in Mombasa, Kenya; Hillbrow, Johannesburg, and the towns of Musina and Thohoyandou in Limpopo province, South Africa; Kampala, Uganda; and Bulawayo, Zimbabwe.

Kenyan law penalises the sale of sex but not its purchase, thus rendering sex workers criminals. Under the **South African** Sexual Offences Act, voluntary selling of adult prostitution, buying of voluntary adult sex as well as all prostitution related acts are criminal offences. Authorities tend to rely largely on municipal bylaws to arrest and prosecute sex workers, such as for "loitering".

In **Uganda**, the Penal Code Act makes prostitution, living on the earnings of sex work and keeping a brothel an offence, although procuring sex work services is not illegal. **Zimbabwe** has laws that criminalize both same-sex activity (the Sodomy Act) and sex work (laws criminalising soliciting for the purposes of prostitution).

The interviews with 107 women and 29 men aimed to be non-judgemental and respectful, and to secure participant confidentiality and safety. Once informed of the study aims, procedures, risks and benefits of participation, and that participation was entirely voluntary, individuals gave informed consent. Study activities were approved by the Ethics Committee of the University of the Witwatersrand, South Africa. Interviews adhered to an interview guide, were audio-recorded, translated into English and then transcribed. The study coordinator analysed data thematically, identifying key themes and developing an interpretive framework for analysis of results.

Results

Around 60% of participants in Hillbrow and Limpopo were foreign migrants (mainly from Zimbabwe) and a substantial portion in other sites identified as internal migrants. Most female SW had children. Severe poverty and unemployment spurred many to enter the sex industry, but several cited the appeal of financial independence, and the means to support family members, pay school fees, or obtain finance for other income-earning ventures. Male SW reported a median 6 clients per week, while women's average ranged from 20 per week in Mombasa and Kampala, slightly lower in Hillbrow, to only around 5 in Limpopo

and Zimbabwe. The flexible working hours, ready cash, and a measure of independence gained through sex work highlight the limitations of narrow "exit programs".

Experiences of human rights violations

Sexual violence, perpetrated by **police and related authorities**, was common across all sites. Some SW (both female and male) had experienced this multiple times, often in the form of gang rape by police. Having to **bribe** the police, "all the time", was deeply connected with sexual violence. Police demand money, failing which sex, or vice versa. Women characterised the full loss of night's wages as "robbery" rather than "bribery". Equally common was physical abuse by police, often taking extreme forms, involving beating and repeated assault, as well as humiliation during arrest, such as being forced to carry used condoms on their heads or being stripped of their clothes in public. Older sex workers in Uganda suggested that police violence had actually increased in recent years.

Men who sell sex to women (only found in Zimbabwe) reported less police harassment, but police abuse of other male SW was frequent, often marked by **homophobia**. The few female SW who had ever laid charges against the police, reported being bribed, by as much as R2000, to drop charges. Most participants felt that it was futile to report abuses to the police (particularly if the perpetrators were police), since the response was often abusive in itself. About half had actually being **arrested** by police, most frequently released before arriving at the police station, and therefore not formally charged. For those charged, their "crime" was usually that of "loitering". Being **detained**, generally for a week, but up to six months, seemed commoner in east than southern Africa.

A range of people **on the fringes of the sex industry** take advantage of sex work criminalisation by extorting money or sex. One female SW reported: "my landlord asks me to sleep with him or else he throws me out of his house" and another said "one bouncer told me to sleep with him so that I was allowed to enter that club again. I had no choice". The quarter who worked from brothels had generally exploitative managers, who took large percentages of their earnings (even when clients refused to pay). Boyfriends were another source of abuse, generally treating their partners with disdain on account of their status as SW, inflicting physical, verbal and sexual abuse and at times also abusing their children. Others eschewed relationships with regular partners altogether, while a handful of sex workers reported positive, supportive relationships.

Clients, according to female SW, commonly ignored their wishes or the occurrence of pain. By having paid for sex, clients appeared to feel they had 'ownership' of SW and **objectified** them in various ways: "You can tell the client to stop… he says, 'Didn't I buy you with my money? .... For you don't appear to him like a human being." Another said "When I say 'you are hurting me', he said 'I pay you, so don't tell me shit'." Moreover, clients (of female and male SW alike) across sites often refused to pay for services or tricked SW into accepting smaller payments. Virtually all had experienced physical beatings by clients or threats with firearms. **Gang rape** was common, and usually took the form of a SW agreeing to sex with one client, who has secretly struck a deal with several other men to "take turns" with the SW afterwards. Condoms were apparently seldom used in instances of rape, by gangs or otherwise. Across sites, SW faced violence for refusing unprotected sex, or were offered extra money for unprotected sex. Rather than explicitly demanding unprotected sex, clients often sabotaged safe sex, by reportedly breaking condoms or secretly removing condoms before sex. Notably, not all interactions ended in unprotected sex: "I do get clients who refuse to use condoms but I have a strict policy that 'no condom, no sex'." Even in the face of overwhelming disempowerment, some SW were therefore able to exert a degree of agency.

Once a SW's occupation became known, they were usually despised by **family and community members**, and in some cases chased away from their homes. Many SW described the community as deeply suspicious of them. Street-based SW, in particular, were shouted at by community members, ridiculed, called names, characterised as somehow "not human", accused of "stealing men" or being HIV positive. Such **verbal abuse**, at times even from children, was described as "our everyday bread". The children of female SW also appear to experience similar abuse: "When they see my child they say 'that's a prostitute's child, look at it". Social isolation within SWs' own neighbourhoods was common, and took expression in their exclusion from social events, parties and community-initiatives, such as micro-finance projects. Their occupation was thus usually deliberately concealed and they tended to avoid selling sex in their own neighbourhoods. Male SW were doubly persecuted by community members, particularly in Uganda and Zimbabwe, where homosexuality is illegal and highly stigmatised: one said "I am tortured every day… They [the community] really hate us". Participants alluded to long-term **psychological** consequences of repeated trauma, which they described as a "heaviness".

Many reported being ostracised by **religious institutions** (both Christian and Muslim), at times in extreme forms, particularly in east Africa. Males also faced fierce rejection of their sexuality. One in Mombasa recalled a pastor making him stand before the congregation to tell them he was a sex worker, and was then excommunicated from the congregation: "I can never forget how all those people shouted at me... I was really traumatized after this incident to the extent I tried to commit suicide." Church elders were also said to influence health-provider behaviour, since nurses would attend services, hear "a Reverend cursing sex workers", and subsequently find it difficult "to give you services with her whole heart."

In general, **migrant** SWs' experiences of being singled out and mistreated reveal much about attitudes in South Africa towards foreigners. They reported being denied treatment by health workers, who were often disrespectful and verbally abusive. Migrants also experienced prejudice from local SW. Some gay male SW, however, reported experiencing greater respect for their rights after arriving in South Africa. Perhaps unavoidably, **conflict and jealousy between sex workers** was reported, mostly arising from competition for clients. Many SW did find some relief through building solidarity with fellow SW, however, sharing their experiences.

In rare instances, SW literally physically **fought back** against their abusers. SW also attempted to be discerning, hoping to select clients who did not appear to be violent, although when money was needed, this selectivity could not be afforded. Though many were adamant that they **seeking justice was futile**, a few had successfully sought redress, mostly when supported by local sex worker organisations. "Inaction" stemmed from an acute understanding of how **criminalisation of sex work renders sex workers largely powerless**. Without exception, participants spoke of how the illegality of sex work deprived them of basic rights and impacted directly on their ability to avoid HIV. In Uganda some clients further exploit the illegality of same-sex relations to avoid payment: "the client says, 'You are gay, where can you report me? I'm not paying you'." By distorting power balances between SW and police, criminalisation legitimates bribery, blackmail, humiliation, cruelty and sexual abuse by authorities. This generates deep fear about being exposed as SW, entrenching reluctance to go public with their experiences and claim their rights.

Barriers to accessing healthcare

Various health needs were cited, mostly occupation related. Foremost was diagnosis and treatment for STIs, which were construed as inevitable: "there's no way we can avoid STIs". Female SW also called for improved access to pap smears and female condoms. Unplanned pregnancies were reported by a handful of female SW, usually resulting in abortion – commonly painfully self-induced with alcohol or medication

bought from pharmacies. Several mentioned the need for services for injuries suffered after beatings and rape, but were often denied treatment. SWs' profound vulnerability to HIV was clearly inseparable from the violence accompanying sex work and the broader context of patriarchy and criminality.

SWs described many instances of **poor treatment** once health providers – particularly those in public clinics and hospitals – became aware of their work. They were said to ask invasive and unnecessary questions of SW and frequently breached patient **confidentiality**. For many SW in this study, health providers were plainly described as "abusive" or "hostile": "We are despised in the hospitals. They say, 'We don't have time for prostitutes' and they also say that if one prostitute dies then the number reduces." Sometimes SW had to pay health workers additional money for services, especially for STI treatment, and were almost always turned away if unable to bring their sexual partner to the clinic. Male and transgender SW reported being viewed as a curiosity by some health workers: "When the doctor examined me and find out that I am a she-male he called other doctors and nurses. They left their work to come and see....I just walked from the hospital without being treated." There were exceptions, however: some described their relationship with nurses in public clinics as "good…they treated me very nice".

Given these conditions, SW generally **avoided facilities** where providers were known to be cruel or likely to withhold treatment. Another solution, resources permitting, was accessing **private services**, which were described – almost unanimously – as higher quality and as places where they would be treated with dignity and their confidentiality protected. In Hillbrow, virtually all SW mentioned accessing services at Esselen Street Clinic, run specifically for sex workers by a large, long-established research institute in the area. Their experiences of this clinic were almost universally positive. Also in Zimbabwe, SW reported similar experiences in accessing a newly established **SW-specific clinic**. SW in Limpopo cited numerous difficulties in finding a suitable health facility to access, particularly as the Médicins Sans Frontières clinic serving foreign migrants now appears to have curtailed its services.

Not surprisingly, SW commonly chose **not to disclose** their occupation when interacting with health workers, but acknowledged that non-disclosure was ultimately a poor solution, as it undermined diagnostic accuracy and treatment effectiveness. Isolation following discrimination and "self-stigma" impacted on SWs' willingness to test for **HIV**, while broader stigma against people living with HIV appeared somehow magnified for SW with HIV. Disclosing their HIV status to fellow SW might hurt business, "If you disclose, other people, they close doors for you... clients won't buy you." Sex workers in virtually every site except Hillbrow reported difficulties in accessing **condoms**, resorting to using expired or used condoms, or stopping work while condom shortages lasted. In particular, female condoms were almost impossible to source, though highly desired. In general, SWs' fervent attempts to use condoms challenge depictions of them as active 'spreaders of HIV'. Health workers at public facilities often restricted the number of condoms per person, and one clinic was reported to be selling government-issue condoms, rather than supplying them free, as intended. Few females reported **lubricant** use. Those familiar with lubricant were, however, unequivocal about how much it would benefit them. Men noted the importance of lubricants, but also its expense, and commonly resorted to oil-based lubricants (e.g. Vaseline), which damage latex condoms.

Participants emphasised the importance of local organisations dedicated to supporting sex workers and working alongside to advocate and seek legal redress to violations – including restrictions in accessing health services. Many called for 'sex-worker specific' or -friendly facilities: "…we sex workers should be given our own hospital …… where we can go and disclose and open up to the health workers."

Recommendations for advocacy

Sex work criminalisation hinders efforts to prevent HIV and other STIs, heightens SWs' vulnerability to rights violations, and renders perpetrators effectively immune from censure or prosecution. Many SW in fact consider the risk of violence to be a far greater (and more immediate) threat than HIV. This study highlights yet again the importance of **legislative reform and the application of a rights-based approach to public health interventions** (including HIV) with SW, which will directly address SW disempowerment in the region. Decriminalisation of sex work does not necessarily equal reduced discrimination, however. The latter requires further actions, beginning with coordinated advocacy to change the attitudes of health care workers, law enforcement authorities and community members more broadly. Sex worker-led organisations need to be centre-stage in this response, taking control of advocacy to reduce stigma and to demand access to rights and health services as any other citizen would enjoy.

ASWA could build on signs of incipient resistance shown by individual SW who have developed strategies to avoid, trick or even confront police, in some instances to challenge them directly and assert their rights. The focus should be on increasing SWs' capacity to **leverage support collectively**, rather than confronting authorities as lone individuals. Continued, collective, engagement with the police and related authorities is needed, involving sensitisation and 'values clarification' **training of the police** to raise awareness of SWs' lives, their struggles for financial survival and daily vulnerability to abuse. Pilot projects documenting the success of such an approach are long overdue.

Neighbours, family members, religious institutions and the broader **community** bear substantial responsibility for entrenching perceptions of SW as undeserving of human rights, and must be included in future **advocacy** initiatives to raise public awareness of the effects of abuse suffered by SW. Several mentioned the need for unity among sex workers, although notably, some males felt excluded by projects focusing mainly on women. SW also noted that their high mobility hampers formation of sustainable collectives – all important issues that need to be taken into account by ASWA and its affiliates when planning interventions.

Strong calls by SW for **health facilities established to specifically serve them** should be heeded – but with some caution as such facilities might become stigmatised themselves. Providing health services (especially condom and lubricant distribution) through **outreach** in SW communities is one model that could be tested. Other expressed needs included "an organisation to stand for us" – as advocates, particularly with respect to offering **legal assistance**, additional support and information about how to lay a charge. SW appealed also for English language classes, adult literacy training and broader skills training, to compensate for poor education received when younger. Interestingly, street-based SWs in Limpopo called for "a better place" and "a building" where they could safely live and work – effectively, brothels.

Finally, **human rights training** for SW remains important as a strategy to enhance their overall collective empowerment. Such training needs a stronger focus on clarifying current and planned legislation pertaining to sex work, in order to pre-empt the spread of misinformation and confusion within the SW community and instead empower it with knowledge on legal issues. SW taking steps to assert their rights, will, in almost all instances, require strong support from SW organisations to redress violations.

Chapter 1: Introduction

Sex workers across sub-Saharan Africa are marginalised and face gross human rights violations, discrimination, harassment and numerous barriers to accessing healthcare. Ongoing criminalisation of sex work virtually throughout the continent means that sex workers are exposed to occupational health and safety risks that would never be accepted in any other profession. This includes exposure to injuries, infection with HIV and other sexually transmitted diseases, harassment, violence, rape, musculoskeletal injuries, urino-genital problems, stress, depression, alcohol and drug use, respiratory infections, the removal of children, and death (Rekart, 2005). Having restricted access to legal protection makes them a soft and easy target for criminals, and sex workers around the world continue to be murdered at rates higher than the general population. Across sub-Saharan Africa, sex workers also carry a disproportionate burden of HIV, with prevalence commonly 10–20-fold higher than among the general population (Godin et al., 2008, Riedner et al., 2003).

As in many parts of the world, sex workers in sub-Saharan Africa experience violence and abuse from police as well as from clients, controllers ("pimps"), and members of the larger society. Sex work is highly stigmatised, and discrimination, violence and abuse against sex workers are often publicly condoned and encouraged. Because they are by and large female, sex workers remain particularly vulnerable to all crimes of violence against women, while male and transgender sex workers are often the targets of homophobia and related hate crimes. Men who engage in sex work therefore face dual stigma and discrimination and are disproportionately affected by HIV (Population Council, 2009).

There is an urgent need for systematic research to examine the links between sex work criminalization and stigma on the one hand, and sex workers' sexual and reproductive health (SRH) on the other, including violence against women and hate crimes against men who have sex with men (MSM). A growing body of evidence indicates that criminalization of sex work is harmful to public health efforts to prevent the spread of HIV and other sexually transmitted infections (Richter et al., 2010, Richter and Massawe, 2010, WHO, 2005). South Africa's own HIV & AIDS and STI strategic plan for 2007-2011 calls for decriminalization of sex work, as it recognizes that sex workers face barriers to accessing HIV prevention and treatment services because their activity is unlawful. Yet decriminalisation advocates in this country have seen little evidence of impending change in this situation. Similarly, UNAIDS recognises that where stigmatization prevails and sex work is driven underground, prevention and treatment of HIV and AIDS becomes all but impossible. Consequently, the UNAIDS Guidance Note on HIV and Sex Work unequivocally expects all UNAIDS Cosponsors and the Secretariat to support the empowerment of sex workers and to provide the space for their involvement and engagement in national and community level responses. Closer to home, legislative reform on the criminalisation of sex work is urgently needed in Africa so that organisations and services can work freely with sex workers and begin to advance a rights-based approach to universal access to services.

1.1. Rationale for the study

Over the last two decades, as the HIV epidemic has taken root in many parts of Africa, there has been increased focus on sex workers – but, until very recently, much of this focus has dwelt on the potential for sex workers to infect others, rather than on sex workers' *own* need for prevention, treatment and care (Wolffers and van Beelen, 2003). The reality is that sex workers are themselves at much higher risk of HIV

acquisition than members of the general population, and their needs for treatment, care and support are frequently not met. The fact that many sex workers consider the risk of violence to be a far greater (and more immediate) threat than HIV, further indicates something of the often extreme dangers associated with sex work and the conditions under which it takes place (Nairne, 2000).

For long, research on sex workers tended to focus either on human rights violations *or* on HIV and other health issues, thus seldom exploring the links between the two in any systematic way. Fortunately, this is beginning to change. One consequence of the heightened focus on sex workers and HIV is that the vulnerability of sex workers has been highlighted in new ways and it has become increasingly evident that HIV prevention interventions involving sex workers are often hindered precisely because sex work is criminalised (Aral and Mann, 1998, Arnott and Crago, 2009, Richter et al., 2010, Ray et al., 2001). More researchers and activists in the health and HIV fields are now beginning to argue for a *rights-based* approach to sex worker interventions that address work-related health risks by foregrounding sex workers' human rights (Wolffers and van Beelen, 2003, Rekart, 2005, Richter and Massawe, 2010).

Much existing documentation of human rights violations against sex workers in Africa tends to be restricted to project-specific, and often country-specific inquiries (Federation of Women Lawyers (FIDA) Kenya, 2008), or form part of broader inquiries into violations experienced by women in general (Amnesty International, 2010). Existing evidence also tends to reflect current sex worker demographics, with the vast majority of research focusing on the experiences of *female* sex workers alone. Data on male and transgender sex workers in Africa is extremely limited, although this is beginning to change (Geibel et al., 2007, Kellerman et al., 2009).

Overall, we need a more careful detailing of the diverse forms and conditions of sex work, the circumstances of sex workers' lives, and the kinds of human rights violations experienced by sex workers across Africa. Regional and sub-regional trends in human rights violations experienced by sex workers over time also need to be systematically documented. Finally, for coordinated efforts by health and human rights groups across the region, there is an urgent need for research of this nature to build a credible body of knowledge that can inform advocacy and policy-making decisions. There remains insufficient recognition by public health authorities, policy makers and politicians that sex work is an important social and public health challenge demanding urgent attention. Rigorous and sound research on local sex work situations may go a long way towards convincing authorities in sub-Saharan Africa to prioritise legal and policy reform and implement scaled-up public health interventions to improve the lives of sex workers.

This study was commissioned by the African Sex Worker Alliance (ASWA) and its parent body, the Sex Worker Education and Advocacy Taskforce (SWEAT) in Cape Town, South Africa, as part of a broader initiative to promote access to health care and legal redress when health and human rights violations against sex workers occur. Through stakeholder mapping, skills-building and sex worker collectivism, ASWA aims to build a capacitated, coherent sex-worker led movement defending the rights of sex workers across the African continent.[1] As a contribution to the evidence base and to building a basis for coordinated advocacy activities in the region, this study therefore focuses on human rights violations and barriers to health care for sex workers in selected countries in east and southern Africa. With few exceptions (Arnott and Crago, 2009, Amnesty International, 2010), little research of this nature presently exists. Results of the study will be shared with sex worker organisations, local and international NGOs, and advocacy groups working with sex workers in each country for advocacy purposes, as well as with sympathetic representatives of health and social services in each country.

[1] See http://www.africansexworkeralliance.org/ for more.

1.2. Study aims and objectives

The project set out to provide comparative data across four African countries (Kenya, Uganda, South Africa and Zimbabwe) on sex workers' experiences of human rights violations, including unlawful arrests and detention, violence and extortion, as well as their experiences of barriers to accessing healthcare.[2] The study aimed not only to document these violations and barriers, but also to ask what their effects are in terms of the broader health (and HIV) impact on sex workers. Ultimately, evidence generated from this study is intended to inform dialogue on legal and policy reform related to sex work in the four study countries and beyond.

Study Questions:

1. In what ways are sex workers in the six countries commonly targeted by police and with what outcomes? What are the most common human rights violations perpetrated by police, clients, pimps/controllers, regular partners/boyfriends and landlords?
2. What strategies do sex workers use to redress or avoid these violations?
3. How and where do sex workers access the healthcare they need? What barriers prevent them from doing so?
4. What specific violations and healthcare barriers are experienced by sex workers who are migrants and/or foreign nationals? How does migration and high mobility affect sex workers' access to health and their vulnerability to abuse?
5. What is the impact of the current legal and policy framework on sex workers' health and wellbeing?

1.3. Definitions

The study uses a definition of "sex work" first proposed by UNAIDS in 2000: "any agreement between two or more persons in which the objective is exclusively limited to the sexual act and ends with that and which involves preliminary negotiations for a price" (UNAIDS, 2000). The term "sex worker" therefore refers to an adult who engages in sexual commerce as described in this definition.

"Transgender" denotes a person whose "inner gender identity differs from the physical characteristics of his or her body at birth" (Open Society Institute, 2006), and includes transsexual persons (i.e. people who have undergone alterations of the body to change their sex, either through surgery and/or hormonal therapy).

"Human rights violations" is a broad term encompassing a range of abuses and infringements that, to some extent, may be considered to be culturally defined and context-specific. This study follows the definition of "human rights" set out in the Universal Declaration of Human Rights. In the context of sex work, the rights that are likely to be most commonly violated include:

- the right to freedom, equality and dignity
- the right to life, liberty and security of person
- the right not to be subjected to torture, cruel, inhuman or degrading treatment

[2] Nigeria and Mozambique were originally included in the study but were subsequently omitted owing to logistical difficulties, communication challenges and poor coordination on the ground by ASWA coordinators (Nigeria) and to timing challenges around seeking ethics approval (Mozambique).

- the right not to be subjected to arbitrary arrest or detention
- the right to equality and recognition before the law, and to a fair trial
- the right to freedom of movement
- the right to work and to have rest and leisure, including reasonable limitation of working hours
- the right not to be arbitrarily deprived of one's property

Chapter 2: An overview of the legal status of sex work and health issues facing sex workers

Sex work is criminalised virtually throughout Africa, but since it is often difficult for authorities to prosecute sex workers under anti-prostitution laws, police tend to invoke municipal by-laws or other non-criminal laws to arrest sex workers on charges of "loitering", "importuning" or "indecent exposure". Following arrest, sex workers are vulnerable to assault, rape, unlawful detention, demands for sexual favours or bribes from police. In Zambia, a group of sex workers sought legal action in 2002 against police officers for repeatedly arresting them and abusing them sexually, although the case has since been closed for lack of investigation (Human Rights Watch, 2003). Reports have emerged of a group of sex workers being rounded up, fined, forcibly tested for HIV by police in Malawi and their test results revealed in the media (Hlema, 2009). Sex workers in Uganda are often threatened with arrest for loitering, their earnings seized and premises raided. They know that reporting such attacks to the police is futile since this will trigger further harassment and arrests (Amnesty International, 2010). It is also common for sex workers in parts of Africa to be arrested by the authorities if they are found carrying condoms, which is taken as "evidence" of their involvement in sex work. In short, where sex work is criminalised and stigmatised, sex workers are highly vulnerable to human rights violations and their health and wellbeing are severely compromised, yet they are often powerless to challenge perpetrators or seek justice and legal compensation. Migrant or refugee women who are sex workers usually face even greater risks and less protection from the law.

Preventing violence is not only a human rights priority but also a global public health concern, as violence exacerbates the risk of sexually transmitted infections, including HIV. Sex workers often have poor access to contraception and HIV prevention commodities since they are excluded from public campaigns for safer sex and their access to health services in general is impeded by discrimination and prejudice. Historically, sex workers have been viewed as "reservoirs of sexually transmitted disease", and are consequently blamed for Africa's ongoing HIV crisis, with sex work being seen as "the cause of disease rather than the consequence of economic marginalization" (Elmore-Meegan et al., 2004). While many sex workers are fully aware of how to prevent the spread of sexually-transmitted infections, they often have little power to enact this knowledge: many clients will force sex workers to have sex without a condom or offer a higher price for unprotected sex (Adu-Oppong et al., 2007). Free condoms and HIV programs rarely target the places where sex workers meet their clients. Appropriate health services that meet the specific needs of sex workers are rare, and where offered, such services are usually small in scale and coverage, and of questionable sustainability. Reports of health providers refusing to treat or attend to sex workers are common (UNAIDS, 2009, Stadler and Delany, 2006).

Below, we summarise key features of sex work in each study site from a legal and health point of view. The information in this section was obtained through a desk review of grey literature, reports by NGOs and research institutions, published literature, and policy documents dealing with sex work in the study sites.

Kenya

Sex work in Kenya is illegal and highly stigmatised. The law penalises the sale of sex but not the purchasing of it, thus rendering sex workers criminals and consequently highly vulnerable to harassment and violation by law enforcement agencies (UNFPA, n.d.-a). The number of sex workers in Kenya is unknown, but is

estimated to be well over 100,000, with 60,000 in Nairobi alone (Kenya National AIDS Control Council, 2010). These figures should be read with caution, however, as they include young women and girls engaging in transactional sex (an estimated 16% of girls aged 15-19, according to the 2003 Kenya DHS study). One study of 475 female sex workers in four rural towns and three Nairobi townships found that most (88%) of the women worked from bars, hotels, bus depots and discos. Levels of interpersonal violence were high: 17% reported experiences of assault and 35% had been raped by clients in the previous month. Unwanted pregnancy was common, with 86% having had at least one abortion (Elmore-Meegan et al., 2004).

Together with truck drivers, sex workers were initially identified as core groups for HIV infection and as a 'bridge' for transmission to the general population. While Kenya now has a generalised epidemic, sex workers and their partners remain important contributors to the epidemic and key population at risk of HIV infection (Ferguson and Morris, 2007, UNAIDS and Kenya National AIDS Control Council, 2009). In 2000, HIV prevalence among urban sex workers in Kenya was estimated to be 27% (compared to 6.1% prevalence among people in the general population aged 15-49)(UNFPA, n.d.-a), although a 2001 study among 543 sex workers in Nairobi found an HIV prevalence of 30% (Fonck et al., 2001). Rates of sexually transmitted infections other than HIV are also high (Cohen et al., 2007).

While Kenya's recently enacted HIV/AIDS Prevention and Control Act legislates on the rights of people living with HIV, it makes no specific reference to protection for vulnerable populations. Only 17% of the country's sex workers are estimated to be currently reached by prevention programmes (UNFPA, n.d.-a). These programmes are mostly run by NGOs or research groups and are therefore small in scale and largely unconnected to the broader government effort to address the epidemic.

South Africa

Under South African legislation (specifically, the Sexual Offences Act), voluntary selling of adult prostitution, buying of voluntary adult sex as well as all prostitution related acts are criminal offences (South African Law Reform Commission, 2009). Since it is difficult to successfully prosecute under the Sexual Offences Act, authorities tend to rely largely on municipal bylaws to arrest and prosecute sex workers. "Loitering" is an offence that sex workers are commonly detained for, and often without trial. Police raid brothels and arrest sex workers and often extort bribes from them or demand sex in exchange for their release from prison. Sex workers in general – even those working in indoor venues – have no recourse to labour rights and very limited recourse to any protection under the law (Open Society Institute, 2006).

Sex workers' access to state-provided health services is hindered by health provider attitudes which tend to reflect the stigma attached to sex work that remains persistent in the broader society, despite a relatively progressive Constitution. Currently only isolated, small-scale interventions run by NGOs and research institutions – such as SWEAT and RHRU – exist to address their needs. Some innovative models of healthcare provision for sex workers have been tested recently in settings in Johannesburg. These include mobile health units and peer educators regularly visiting hotels in Hillbrow to take STI treatment kits, condoms and other health services directly to sex workers (Richter and Yarrow, 2008, Stadler and Delany, 2006).

South Africa has a generalised HIV epidemic, with prevalence extremely high in young women compared to men. In the 25-29 year age group, one in three women (32.7%) were HIV positive in 2008, more than twice as high as that of men in the same age group. HIV prevalence among older men (30-34 years) is higher, though, peaking at 25.8% (HSRC, 2008). It is thought that – despite the generalised nature of South Africa's

HIV epidemic – sex work and sex between men continue to play a role in new infections, although this is often not sufficiently recognised (UNAIDS, 2008). Research on most-at-risk-populations in the country, including commercial sex workers, has consequently tended to be neglected. The last recorded HIV prevalence rates among sex workers in the country were between 45 and 69% (Richter and Massawe, 2010, Rees et al., 2000); these data were collected in the late 1990s and – to our knowledge – no further prevalence data on sex workers has been collected since then.

Uganda

Sex work is illegal, although reportedly common and highly stigmatised (UNFPA, n.d.-b). One study has estimated that there are 8000 female sex workers on the trans-Africa highway between Mombasa and Kampala (Morris and Ferguson, 2006). Recently, the possible legalisation of adult prostitution has been raised in parliamentary discussions, triggering widespread public debate on the issue, which has become increasingly polarised (South African Law Reform Commission, 2009). The current Penal Code Act makes prostitution, living on the earnings of sex work and keeping a brothel an offence, although procuring the services of sex work is not illegal (Amnesty International, 2010). Sex workers are commonly threatened with arrest for loitering, their premises raided and their earnings seized. When reporting offences, sex workers are often told that "a prostitute can't be raped" or that since they are selling sex, they "are asking for it" (Amnesty International, 2010). Entrenched gender roles and conservative attitudes towards young women and girls accessing SRH services, including accessing condoms, together with high rates of domestic violence and lack of economic opportunities for females deepens women's overall vulnerability to HIV (UNFPA, n.d.-b). Ugandan society is also characterised by pervasive homophobia and restrictive laws against homosexuality, implying that male and transgender sex workers are likely to be at even greater risk of violence and stigmatisation.

Uganda has a generalised HIV epidemic, with an estimated prevalence of around 6.5% in antenatal clinics – down from a peak of 18% in 1992, although the much-vaunted decline in prevalence since then appears to have stabilised. Commercial sex workers, their clients and partners of clients are thought to contribute 10% of new infections, and there remains a perception in official circles that sex workers are essentially 'vectors of infection' (Government of Uganda, 2010).

Zimbabwe

While discrimination against people living with HIV and AIDS is prohibited by law in Zimbabwe, sub-populations – such as commercial sex workers and men who have sex with men (MSM) – are not recognised by Zimbabwean law and therefore have no protection against discrimination, harassment and assault. Despite the claim made in the latest UNGASS Progress Report that commercial sex workers and MSM "have not been denied access to health services as a result of a specific law or policy", the country has draconian laws in place that criminalize both same sex activity (the Sodomy Act) and sex work (laws criminalising soliciting for the purposes of prostitution) (Government of Zimbabwe, 2009). This legal and policy framework creates obstacles to effective HIV prevention, treatment, care and support for sex workers and MSM. Overall, the UNGASS report clearly distances itself from sex workers and MSM sub-populations, often describing them in terms suggestive of fear, stigma and ignorance.

Sex workers in Zimbabwe remain largely concealed because they fear prosecution. The practice of police arresting sex workers and subjecting them to humiliating acts, mistreatment and rape is reportedly widespread. Accessing health care is also extremely challenging for sex workers, with reports of nurses

publicly deriding them and providing them medical attention only after seeing to all other clients (Pswarayi, 2010). The state appears to have no targeted programme addressing the HIV prevention and treatment needs of sex workers; more than 75% of HIV programmes for sex workers are estimated to be provided by civil society. A key provider in this respect is a prevention programme run by the International Organization for Migration (IOM), which has reached a sizeable number of sex workers and migrant populations with HIV testing and counselling services. Médecins Sans Frontières (MSF) also have support groups for sex workers and provide training and information around HIV/AIDS prevention and care.

In the interests of providing some contextual background on characteristics of sex worker environments in Africa, particularly from a health and HIV point of view, below we have summarized key HIV-related risk behaviours reported in the literature for sex workers in the four study sites. It needs to be stressed, however, that this summary in no way seeks to entrench the view that sex workers in Africa are 'vectors of disease' or responsible for spreading the virus in the general population. Rather, this information highlights the extent to which social factors and the occupational contexts in which sex workers operate deepen their vulnerability to HIV and remind us of how urgently prevention and treatment services for sex workers are needed.

Table 1. Sexual behaviour and related HIV risk factors among female sex workers in Kenya, South Africa and Zimbabwe*

Country; city/province, year of study (reference)	Age began sex work (years)	Years of sex work	Condom use: casual and regular clients	Condom use with emotional partners	Number of clients	Use of alcohol or other substance	Anal or oral sex	HIV prevalence
Region: East Africa								
Kenya; Nairobi, 2000 (Cohen et al., 2007)	-	Mean 3.9	≥75% of sex acts with client: 41%	Used in ≥75% sex acts with regular partner: 15%	Mean 11.7/week	Ever drink 72%	Anal sex: 13%	30%
Kenya; Nairobi (Kibera slum), 2000 (Chege et al., 2002)	-	Mean 6	-	-	-	Use of alcohol and cannabis 36%	-	-
Kenya; Mombasa, 2000 (Luchters et al., 2008, Hawken et al., 2002)	-	Mean 9.2	Always with client: 29%	Always with boyfriend/ husband: 20%	≥4 sexual partners in past week: 29%	-	-	31%
Kenya; Nairobi outskirts, Rural towns (Bondo, Kiisi, Migori, Siaya) 2000-2001 (Elmore-Meegan et al., 2004)	-	-	-	-	Median per week: 9 (urban); 4 (rural)	-	Oral sex "rare"	-
Kenya; Nairobi, 2003-2005 (Odek et al., 2009)	Mean 23.1	-	100% in past week: casual client 94%; regular client 79%	-	Casual 1.4 past week; regular 2.0 past week	-	-	-
Kenya; Mombasa, 2004 (Gallo et al., 2007, Thomsen et al., 2006)	-	-	Consistently in past week: all partners: 60%; regular clients: 94%; casual clients: 99%	Consistent in past week: 45.6%	Mean in past week: 5 casual clients; 2 regular clients	-	-	-
Kenya; Mombasa, 2005 (Luchters et al., 2008, Chersich et al., 2007)	-	Mean 5.6	Always with client: 70%	Always with boyfriend/ husband: 20%	≥4 sexual partners in past week: 48%	≥5 drinks on ≥1 occasion in past month: 33%	Anal sex: 4%	33%
Kenya; Meru, year not stated (Schwandt et al., 2006)	-	Median 3	Consistent use: one time client: 60%; regular clients: 55.8%	-	Mean 6.4 and median 5 partners in week preceding survey	-	Ever anal sex: 41%. Of these, 50% ≥1/month. Most charged more for anal than vaginal sex	-
Kenya; Uganda; Trans-Africa highway from Mombasa to Kampala, year not stated (Morris and Ferguson, 2006, Morris et al., 2009)	-	-	Consistent in past month: 26.8% (Kenya); 18.9% (Uganda)	-	Median per month: 12 (Kenya); 12 (Uganda)	-	-	-
Kenya; Mombasa, 2008 (van der Elst et al., 2009)	-	-	100% in past week: regular client 46%, casual client 56%	-	Median in past week: regular 2; casual 3	Felt drunk: daily 25.2%; alcohol before sex 14%	Anal sex past 3 months 39.6%	29.5%
Region: Southern Africa								
South Africa; Johannesburg	-	Mean 2.1	50-75% of time: 50%		Mean 4.1/day and		Anal sex: ever 6%	46%

Country; city/province, year of study (reference)	Age began sex work (years)	Years of sex work	Condom use: casual and regular clients	Condom use with emotional partners	Number of clients	Use of alcohol or other substance	Anal or oral sex	HIV prevalence
1996-1998 (Dunkle et al., 2005, Rees et al., 2000)			>75% of time: 35%		25.1/week		Oral sex: ever: 24% regular: 20% (mean 7/week)	
South Africa; KwaZulu-Natal, 1998 (Ramjee et al., 2005, Van Damme et al., 2002)	-	Mean 2.5	Always: 11%; never: 41%. 17% with >50% of sex acts	-	Mean 20/week	-	Ever anal sex: 40%	50%
South Africa; Carletonville, 1998, 2000 (Williams et al., 2003)	-	-	Ever: 69.7% (1998); 77.2% (2000). Always, casual partner: 54.3% (1998); 41.9% (2000)	-	-	Drink alcohol: 59.2% (1998); 83.9% (2000)	-	68.6% (1998)
South Africa; KwaZulu-Natal, Durban, year not stated (Varga, 2001)	33% younger than 20	-	Always: 22% Sometimes: 76%	Never with personal partners: 98%	Mean just under 3/day	-	-	-
South Africa; Pretoria, 2000 (Wechsberg et al., 2006)	Mean 16	-	Always with client: 93% Condom break in past week: 42%	Use with boyfriend: last sex: 41%; never: 41%	-	Daily cocaine: 72% Daily alcohol: 18% Current substance problem: 77%	-	-
South Africa; KwaZulu-Natal, 2004-2005 (van Loggerenberg et al., 2008)	Median 26	Median 3	Last sex: 59% Never able to insist on condom use with casual partner: 14%	Never able to insist on condom use with regular partner: 34.3%	Median 2 in past week	-	Ever anal sex: 34.6% Ever oral sex: 25.4%	59.6%
South Africa; Pretoria, 2004-2007 (Wechsberg et al., 2009)	-	-	-	-	-	Past year: alcohol or drug disorder: 84%. Lifetime: alcohol abuse/ dependence: 86%; drug abuse/ dependence: 52%	-	-
Zimbabwe; Harare, year not stated (Ray et al., 2001)	-	Median 2 ≤5: 80%	Last sex with client: 77%	Last sex with boyfriend: 26%	Per week: 0-4: 22%; 5-9: 34%; 10-14: 13%; 15-19: 13%; ≥20: 17%	-	-	86%
Zimbabwe; rural Mashonaland, 2001 (Cowan et al., 2005, Cowan et al., 2006, Cowan et al., 2008)	-	≤2: 28.7%; 2-3: 30.1%; 4-7: 23.8%; ≥8: 17.4%	-	-	Per week: ≤2: 39.4% 2-4: 51.2% ≥5: 9.4%	-	-	55.7%

*No studies summarizing these variables for Uganda could be found, with the exception of Morris and Ferguson (2006) and Morris et al (2009), listed under Kenya.

Note: "-" indicates that data for this variable were not reported.

Chapter 3: Research methods

3.1. Study Design

A qualitative study design was chosen in order to collect narrative information directly from sex workers. A combination of semi-structured, individual, in-depth interviews (IDI) and focus group discussions (FGD) was conducted, along with limited quantitative data gathered from all participants in the form of a brief, one-page questionnaire on sex worker socio-demographics and current sex work activities. Data collection was standardised across all four countries in the study, to allow for reliable comparison of results between these settings. This meant that a single set of data collection tools was used, with limited modifications where necessary to accommodate country-specific realities.

Information gathered directly from sex workers provides the most accurate and reliable account of the daily realities of their lives (Arnott and Crago, 2009), and when gathered by way of a qualitative approach, allows one to capture rich and nuanced detail. Given the history of much previous research on sex work and prostitution, which has tended to frame sex workers as "disease carriers" or to objectify them as engaging in morally objectionable behaviour, our approach was to place sex workers' accounts of their own experiences at the centre of the research and to treat these as narratives with validity and meaning in their own right. Although challenging in the context of research on human rights violations, we tried to avoid approaching the interviews (and interpreting them) in ways that entrench the "enduring associations between sex work and victimization" (Shaver, 2005).

3.1.1. Study population, sampling and recruitment

A convenience, or 'snowball' sampling method was used to find participants for the study. By default, 'snowball' sampling strategies tend to recruit sex workers that are more visible, cooperative, and interested in participating in research, rather than capturing a truly representative sample that reflects the diversity and heterogeneity of sex workers in a given setting (Shaver, 2005). The sampling method used in this study also limits the extent to which the findings can be generalised to all sex workers in the study sites. In a context where many sex workers are stigmatised, hidden and hard-to-reach, and given the resource constraints in this study, it was not possible to use any other sampling method, such as random sampling.

Even within the framework of a qualitative study, with relatively small numbers of participants in each study site, however, it is possible to capture a relatively heterogeneous sample. We know that in sub-Saharan Africa, sex work commonly takes place in informal venues such as bars, clubs and hotels or on the streets and at roadside truck-stops. Escort agencies and massage parlours are at times locations for sex work, particularly in southern Africa (Gould, 2008), while in parts of west and east Africa, sex work is also brothel-based (Oyefara, 2007, Godin et al., 2008, Elmore-Meegan et al., 2004, Gomes do Espirito Santo and Etheredge, 2004). A substantial portion of sex workers are also commonly migrants from other countries or regions (Steen et al., 2000, Ghys et al., 2002, Alary et al., 2002). Interviewers were therefore instructed to recruit participants from diverse groups of sex workers, including local and migrant sex workers, as well as those working in a variety of settings (bar, brothel, street, etc.) in order to reflect the full range of experiences germane to sex work in each country.

During the training of interviewers (discussed below), the geographical boundaries of each study area were defined, and interviewers worked together in country teams to develop a brief synopsis of the sex worker community in the area based on existing knowledge (i.e. from their own outreach and peer education work

experience). This synopsis was then used to guide the recruitment process and ensure that – as far as possible – individuals matching the area profile were recruited. With this in mind, sex workers were recruited for participation in the study initially through existing peer networks of the interviewers, largely drawing on advocacy work they had done in the broader sex work community in each country. Participants interviewed early in the study were then asked to recommend other sex workers in their own networks who could be approached to take part in the study.

Several inclusion criteria were set for the study: (1) Only sex workers who had had at least one client in the week preceding the interview (in order to capture current as opposed to former sex workers); (2) Only sex workers older than 18 years of age; and (3) Only sex workers not under the influence of drugs or alcohol at the time of recruitment.

3.1.2. Study sites

Data collection took place in Nairobi[3] & Mombasa, Kenya; Hillbrow, Johannesburg, and the towns of Musina and Thohoyandou in Limpopo province, South Africa; Kampala, Uganda; and Bulawayo, Zimbabwe. These sites were chosen as they are locations where ASWA already operates, and where the network intends to consolidate and extend its advocacy activities.

3.1.3. Data Collection

In total, 136 female, male and transgender sex workers were interviewed for this study. Fifty five participants were interviewed individually, while 81 were interviewed in a total of 12 focus group discussions, with between 5 and 8 participants per group. Table 2 (below) summarises the number of participants interviewed in each study site.

Table 2. Breakdown of participant numbers in each study site

Study Site	Participants interviewed individually	Participants interviewed in FGDs	
Kampala, Uganda	13	17	
Mombasa, Kenya	8	15	
Nairobi, Kenya	-	-	
Hillbrow, South Africa	12	13	
Limpopo, South Africa*	6	24	
Bulawayo, Zimbabwe	16	12	
Total number of participants	**55**	**81**	**136**

*Includes the towns of Thohoyandou and Musina

All interviews were conducted by Country Coordinators employed by ASWA, who were already familiar with the lives of sex workers by virtue of their experience of advocacy work with this group. Their longstanding links to sex worker communities facilitated ease of access to individual sex workers as participants, and helped to ensure that the interviews were carried out in a non-judgemental and

[3] Data from the Nairobi portion of the study were not available at the time of compiling this report and have therefore been excluded from analysis.

respectful context. All the Coordinators (hereafter referred to as 'interviewers') underwent training in basic research skills and research ethics prior to data collection. Given their familiarity with the local languages used in each country, interviewers translated the data collection tools, where relevant, to ensure that the terms and expressions used closely approximated those used by sex workers themselves. Following data collection, they also translated and transcribed the recorded interviews.

Both individual interviews and focus group discussions were semi-structured, using an interview guide containing mainly open-ended questions and some prompts for the interviewers to keep the discussion on-topic. The individual interviews focused on sex workers' personal experiences of human rights violations, while the focus group discussions focused mainly on issues of health needs and access and, to a lesser degree, human rights violations and strategies for redress. Most of the interviews were audio-recorded (6 participants declined to be recorded, in which case hand-written notes were taken).

Data collection took place at slightly different times in each of the study sites. Interviews were conducted in Kampala in December 2010, in Bulawayo, Hillbrow, Mombasa and Nairobi in January 2011, and in Limpopo in February 2011.

Once the recorded interviews were translated into English and transcribed, these were sent to the study coordinator in Johannesburg and analysed thematically, through a process of identifying key themes and developing an interpretive framework for overall analysis of results. Questionnaire data (on socio-demographic details and sex work contexts) were entered into an excel spread-sheet and analysed using the statistical package, STATA Version 10.0 (College Station, Texas).

3.2. Ethical considerations

Doing research among highly stigmatised groups that are hard to reach, in contexts where their work is criminalised, raises a number of ethical challenges. First and foremost, researchers working with sex workers have a responsibility to ensure that respect for human dignity, as well as respect for vulnerable persons and the protection of their safety, is built into the study design.

3.2.1. Informed consent

Individuals approached during the recruitment process and who indicated an interest in taking part in the study were asked to offer informed consent to participate. They were assured that information gathered during the research would not be used in a way that would cause them foreseeable harm. Interviewers read out an informed consent form clearly describing the aims and purpose of the study, the procedures to be followed and the risks and benefits of participation (see Appendix 1). The form also explained that participation was entirely voluntary, that the information shared during the course of the research would be kept confidential, and that the participant's desire for privacy and anonymity would be respected throughout. Interviewers further explained that non-participation in the study would not affect the individual's ongoing interaction with NGOs affiliated to ASWA, nor would it influence their accessing of health and social services, and that withdrawal from the study at any time was possible. Finally, participants were informed of their right to refuse to answer any of the questions that made them feel uncomfortable. Following this explanation, participants were given a chance to ask their own questions about the study.

3.2.2. Confidentiality

As with any research involving participants who are vulnerable to arrest or police harassment, there is a risk that through participation in the research, individuals may be exposed or become known to the authorities.

This risk is magnified in contexts where sex work is illegal, which is true of all the sites chosen for this study. Participants from highly stigmatised communities may also become known to family members and friends who are not aware of their involvement in the sex industry. We sought to minimise these risks through observance of confidentiality and through use of various anonymity measures.

All interviews with sex workers were conducted in locations that were selected to maximise the confidentiality and safety of participants.[4] They were conducted in venues that offered privacy, such as the participant's own home, the interviewer's home/lodgings or a private room in the offices of the NGO to which the interviewer was affiliated. The collection of real names was restricted to the signing of informed consent forms and not used at any other point. The identity of all participants was confidential and unique identifying numbers (e.g. 001, 002, 003, etc.) were used on the questionnaires and interview transcripts. Audio-recordings of interviews will be safely stored for a minimum of 2 years after publication of the study's results or 6 years in the absence of publication. Thereafter they will be destroyed.

3.2.3. Additional risks and benefits

In a project of this nature, we anticipated that participants would need to talk about experiences of extreme violation, abuse and harassment. The research team as a whole was responsible for ensuring that adequate support was provided to participants experiencing emotional distress as a result of remembering and talking about past (and present) traumas. Arrangements were made in each study site to refer participants to local counselling, health and legal organisations if the need arose during interviews. In addition, most of the interviewers directly offered support, empathy and understanding to distressed participants, by virtue of having experienced similar traumas themselves. It is hoped that participants benefited on an individual level from taking part in the study and from giving voice to their experiences in a context that validated, respected and de-stigmatised sex workers.

In line with previous research in the region among sex workers, all participants in this study received a small reimbursement for refreshments on the day of the interview, in the form of a cash payment of ZAR30 (or equivalent in local currency).

3.2.4. Institutional Ethical Approval

Ethical approval for the study was granted by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg, South Africa.

3.3. Research challenges

3.3.1. Challenges emerging from the context of sex work

The illegality of sex work in all the countries where this research was undertaken – not to mention the frequency of police harassment of sex workers – meant that recruitment of participants was risky to some extent and posed certain dangers for both the interviewers and the participants themselves. Several incidents illustrated this risk all too well. In November 2010, a conference on sex workers' health, rights and economic empowerment in Kampala, organised by local NGO, Akina Mama wa Afrika, was abruptly stopped by the Ugandan State Minister for Ethics and Integrity, who claimed the conference would be "abetting

[4] There were unfortunate exceptions to this, however. Data collection in Limpopo province, originally conducted in November 2010, had to be repeated as interviews were held in a public space (despite instructions against this), with very little privacy for participants and with patrolling police officers close by. These data have been excluded from the analysis on the grounds that they were obtained in an unethical manner. The second round of data collection was more strictly monitored; interviews took place in the privacy of a local sex worker's own home.

illegality in Uganda". Sex workers attending the conference were evicted from the hotel venue and the event received substantial – and somewhat sensationalist – media attention, potentially endangering the safety of sex workers across the country. The incident took place just as the Ugandan interviews for this research were about to begin.

A second incident occurred in Limpopo province earlier in 2011, around the time that data collection in that site was drawing to a close. After a larger confrontation between 16 police officers and soldiers and a small group of sex workers, a female sex worker was followed by a police officer who proceeded to beat her with a sjambok (rubber whip). She sustained serious injuries, and several days later attempted to lodge a charge of assault against the police officer. The police officers on duty at the charge office at the time refused to assist her, declined to open a charge of assault, and reprimanded her for being Zimbabwean. A week later, the sex worker received a visit from several police officers at her home, who picked her up and took her back to the police station. There, she was questioned by 5 police officers and asked if she intended to continue with her charge of assault against the offending police officer. In what appears to have been a clear case of intimidation, the sex worker subsequently withdrew the charges and indicated she had no interest in pursuing the matter further.[5]

Both incidents brought home to the study team the kinds of contexts we were working in and how important it was to protect the safety of all parties involved. Our priority was to ensure that accurate documentation of human rights violations was recorded without further endangering the wellbeing of sex workers as a whole. It is possible, of course, that this context of ever-present danger and risk of exposure to the authorities may have restricted the openness with which participants shared information with the researchers. Indeed, some of the interviews are marked by troubling silences, with participants appearing to have either concealed information or stopping short of providing too much detail on particular incidents and experiences.

3.3.2. Methodological challenges

Perhaps the greatest challenge methodologically stemmed from the fact that data were collected from four different countries but the process was coordinated from only one site. The study coordinator resided in South Africa and – owing to budgetary constraints – could not travel to the sites to oversee any of the study activities. This attempt to supervise data collection at a distance proved to be less successful than initially hoped. Communication between the individual interviewers in each country and the study coordinator therefore took place via telephone, email and skype. During these interactions, interviewers were encouraged to raise and discuss challenges in the field, seek clarity on procedures and check whether they were remaining on-track in terms of data collection targets and overall study objectives. While some interviewers remained engaged throughout the process and took advantage of these communication opportunities, for others it was more difficult and breaks in communication and consequent misunderstandings arose. Added to this was the fact that the short, 3-day training workshop at the start of the project could only convey a limited amount of information about the research process as a whole. With most of the interviewers having had little or no previous research experience, as the study progressed, the limitations of this training exercise became apparent. The quality of the data was inevitably affected by these challenges.

On the positive side, however, by placing full responsibility for data collection in the hands of the Country Coordinators, they were afforded an opportunity to learn valuable research and documentation skills and broaden their understanding of the experiences of sex workers in their cities and towns. They built new

[5] Thanks to Kyomya Maclean of WONETHA, Uganda, and Stacey-Leigh Manoek of the Women's Legal Centre in Cape Town, South Africa, for details of these two cases.

relationships with sex workers who had not previously been involved in ASWA activities and in this way, laid the foundation for future collaboration and capacity building with this community.

Finally, a multi-country study of this nature required additional staff to support coordination and logistical activities, but this was not possible, again owing to financial constraints. The consequence of this was that much of the intended focus on the research content itself was diverted to resolving logistical, budgetary and time management issues.

Chapter 4: Research findings

4.1. Context

4.1.1. Socio-demographic features of the sample

A total of 107 women participated in in-depth interviews or focus group discussions (Table 3). Twenty-nine male sex workers participated, eleven in South Africa, seven each in both Kenya and Zimbabwe, and four in Uganda (Table 4). Across the sites, female sex workers interviewed for this study were on average between the ages of 26 and 36 years old, with a higher proportion of the sample in Limpopo province being younger than 25 (nearly 50%), compared to other sites. The male participants were an average 26.0 years, with 62% aged 18-25.

Overall, for the female and the male sex workers, around two thirds had completed secondary school, although in the two South African sites, this proportion was higher in females (93% in Hillbrow and 83% in Limpopo). By contrast, most of the Ugandan (60%) and Zimbabwean (48%) women participants had completed only primary school. Only a handful of participants in total reported having a tertiary-level qualification, though 14% of the men reported this.

Table 3. Socio-demographic characteristics of female study participants in Kenya, Uganda, South Africa and Zimbabwe

Variable	Total (n=107)	Kenya, Mombasa (n=16)	Uganda, Kampala (n=26)	South Africa		Zimbabwe, Bulawayo (n=21)
				Hillbrow, Gauteng Province (n=15)	Limpopo Province (n=29)	
Age mean years (sd)	29.8 (6.7)	29 .0 (3.3)	28.4 (7.0)	30.7 (5.6)	26.7 (4.8)	35.9 (7.5)
Age groups years: % (n)						
18-25	27 (29)	19 (3)	31 (8)	13 (2)	48 (14)	13 (2)
26-35	54 (58)	75 (12)	62 (16)	60 (9)	45 (13)	60 (9)
36+	19 (20)	6 (1)	8 (2)	27 (4)	7 (2)	27 (4)
Migration history % (n)						
Born outside the city	85 (89)	69 (11)	100 (26)	100 (15)	96 (27)	100 (15)
Born outside the country	25 (26)	0 (0)	0 (0)	60 (9)	61 (17)	0 (0)
Highest education level % (n)						
Primary school	32 (34)	19 (3)	60 (15)	7 (1)	17 (5)	48 (10)
Secondary school	63 (67)	63 (10)	40 (10)	93 (14)	83 (24)	43 (9)
Tertiary	5 (5)	19 (3)	0 (0)	0 (0)	0 (0)	10 (2)
Number of children median (IQR)	1.6 (1.3)	2.0 (1.1)	2.5 (1.3)	1.5 (0.9)	1.3 (0.9)	2.4 (1.4)
Number of children						
0	6 (6)	6 91)	0 (0)	13 (2)	10 (3)	0 (0)
1-2	71 (76)	75 (12)	65 (17)	73 (11)	79 (23)	62 (13)
3+	23 (25)	19 (3)	35 (9)	13 (2)	10 (3)	38 (8)
Other income sources % (n)	61 (65)	6 (1)	19 (5)	33 (5)	69 (20)	52 (11)

In terms of migration patterns of female sex workers, we recorded both the town and country of birth, and found that all participants interviewed in Kenya, Uganda and Zimbabwe had been born in their home country. By contrast, around 60% of participants in both the Hillbrow and Limpopo province sites were

foreign migrants who had been born outside of South Africa. The pattern in Mombasa, Kampala and Bulawayo was that a substantial portion of participants (in some cases, all of them) had been born outside of these cities but moved there later in life – often to take up sex work. A quarter of male sex workers had been born outside the country, while 57% were living away from their birth place. High levels of mobility were also reported in the interviews. With some exceptions, sex workers said they generally do not work where they live. They travel elsewhere to their working area or neighbourhood and also move to other places beyond that, periodically.

In keeping with findings from elsewhere in sub-Saharan Africa, most female participants had children: three quarters had between one and two children, while almost a quarter had three or more. By contrast 83% of men reported having no children. Just over 60% of the female sex workers said they had an income source aside from sex work (i.e. could be classified as "part-time sex workers"), although in many cases these sources were quite erratic. In Limpopo and Bulawayo, more than half of the female sex workers interviewed had alternative sources of income. Only a quarter of men reported other forms of employment.

Table 4. Socio-demographic characteristics and sex work characteristics of male and transgender[#] participants in Kenya, Uganda, South Africa and Zimbabwe (n=29)

Variable	Category	Men
Age (years)	mean (sd) 18-25 % (n) 26-35 36+	26.0 (4.7) 62 (18) 34 (10) 3 (1)
Migration history % (n)	Born outside city Born outside country	57 (16) 25 (7)
Highest education level % (n)	Primary school Secondary school Tertiary	21 (6) 66 (19) 14 (4)
Number of children % (n)	0 1-2	83 (20) 17 (7)
Other sources of income	% (n)	24 (7)
Age began sex work (years)	mean (sd) 12-17 % (n) 18-25	19.0 (3.3) 34 (10) 66 (19)
Number of years of sex work	mean (sd) 0-2 % (n) 3-5 6-10 11+	7.0 (5.6) 34 (10) 17 (5) 21 (6) 28 (8)
Number of areas work % (n)	1 2-3 4+	35 (10) 48 (14) 17 (5)
Sex work setting* % (n)	Bar/club Hotel Brothel Escort agency Street Home	66 (19) 45 (13) 14 (4) 14 (4) 66 (19) 48 (14)
Has a regular partner	% (n)	41 (12)
Number of clients median (IQR)	Last working day Last week	2 (1-3) 6 (5-10)

[#]Five participants in Mombasa were identified by the interviewer as "transgender", although upon closer inspection most of these participants actually self-identified in their interviews as "gay" or "MSM". Given this uncertainty, the complexity of sexual identity itself, and the small numbers involved, we have merged the sub-category of "transgender" with "male" sex workers. *Multiple-response question.

Overall, female sex workers began sex work at a mean of 22.9 years (Table 5), while men started younger, on average at 19.0 years. The average age of sex work debut in Mombasa, Kenya was 17.6, with almost two thirds beginning sex work before the age of 18. Of note, 21% in Limpopo province (largely migrant Zimbabwean women) and 38% in Bulawayo had taken up sex work older than 28 years, some even when above 40 years. The duration of sex work varied considerably between settings, as high as 20 years or more in some women. The majority of female participants in Hillbrow, Limpopo and Zimbabwe worked from only one location (e.g. a brothel or bar). More than half the women in Uganda solicited clients from four or more venues, while 48% of men overall worked at two to three sites and only 17% from four or more.

Women mentioned a variety of sex work settings, from having their own room which is rented, to working on streets or in hotels. Most female sex workers in Mombasa and Hillbrow worked in bars and clubs while most of those in Kampala, Limpopo and Bulawayo were street-based. Once a client had been secured, they reported having sex in the 'bush', in a nearby lodge, hotel, the client's home, or at their home. To a large extent, women said that the type of sex work settings in which they worked had a major impact on their safety and on their ability to avoid police harassment. A sex worker in Bulawayo explained:

> "Well I don't have much problem with [the police] because I don't work from the streets. It's safer inside the bars, because loitering is an offence so they always arrest those who work from the streets" [Female SW, Bulawayo FGD1][6]

Others pointed out that when accompanying a client to his home (as opposed to having sex in a 'neutral' space, such as a room in a lodge or in the sex worker's own space) this increases their vulnerability to abuse. A male sex worker in Kampala explained:

> "Someone will take you when you have agreed 50,000UGX, you reach his home he locks [the door] and he says 'I'm fucking you and I'm not paying you, what are you going to do to me?' It's common; people do that to us. Some of us [sex workers] decided that we either go to hotels or our houses but not to a client's house to avoid that. One will have power in his home [but] it's hard to do sex against my wish in a hotel or in my home." [Male SW, Kampala IDI14]

Another sex worker who operates from a massage parlour in Bulawayo explained how this setting impacts on her safety:

> "I'm in an environment where my clients would not be abusive because it's not everyone who comes for a massage. It's a certain type of clientele that comes for a massage and they are not likely to be brutal or violent so when they do come over they come for what they came for and they go." [Female SW, Bulawayo IDI4]

About two thirds of males workers in bars or on the street, and around half said they solicited clients at hotels (respondents reported all the venues they worked at, thus total percentages are great than 100). Male sex workers reported a median 6 clients in the past week. For female sex workers the median number of clients per week ranged from 20 in Mombasa and Kampala, a slightly lower number in Hillbrow, to only around 5 in Limpopo and Zimbabwe.

[6] Throughout this document, quotes by participants are identified in terms of their gender, the study site where they were recruited from, and whether they were interviewed individually or in FGDs. The number at the end corresponds with a particular transcript. All quotes are verbatim, but where grammar obscures meaning, this has been corrected.

Table 5. Sex work characteristics of female study participants in Kenya, Uganda, South Africa and Zimbabwe

Variable	Total (n=107)	Kenya, Mombasa (n=16)	Uganda, Kampala (n=26)	South Africa		Zimbabwe, Bulawayo (n=21)
				Hillbrow, Gauteng Province (n=15)	Limpopo Province (n=29)	
Age began sex work						
Mean years (sd)	22.9 (5.7)	17.6 (3.6)	21.2 (4.4)	25.8 (6.8)	23.1 (4.6)	26.6 (5.0)
12-17	18 (19)	63 (10)	19 (5)	1 (7)	10 (3)	0 (0)
18-27	63 (67)	38 (6)	73 (19)	60 (9)	69 (20)	62 (13)
28-40	20 (21)	0 (0)	8 (2)	33 (5)	21 (6)	38 (8)
Number of years of sex work						
Mean (sd)	6.9 (5.3)	11.3 (5.1)	7.3 (4.9)	4.8 (2.9)	3.5 (3.1)	9.0 (6.1)
0-2	16 (17)	0 (0)	4 (1)	27 (4)	41 (12)	0 (0)
3-5	38 (42)	25 (4)	42 (11)	40 (6)	41 (12)	43 (9)
6-10	25 (27)	25 (4)	35 (9)	27 (4)	14 (4)	29 (6)
11+	20 (21)	50 (8)	19 (5)	7 (1)	3 (1)	29 (6)
Number of areas work						
1	45 (48)	19 (3)	0 (0)	87 (13)	72 (21)	55 (11)
2-3	37 (39)	63 (10)	46 (12)	13 (2)	28 (8)	35 (7)
4+	18 (19)	19 (3)	54 (14)	0 (0)	0 (0)	10 (2)
Sex work setting*						
Bar/club	57 (61)	88 (14)	73 (19)	60 (9)	24 (7)	57 (12)
Hotel	28 (30)	56 (9)	35 (9)	20 (3)	14 (4)	24 (5)
Brothel	27 (29)	50 (8)	50 (13)	47 (7)	3 (1)	0 (0)
Escort agency	5 (5)	19 (3)	0 (0)	0 (0)	7 (2)	0 (0)
Street	67 (72)	44 (7)	96 (25)	20 (3)	83 (24)	62 (13)
Home	25 (27)	50 (8)	19 (5)	0 (0)	21 (6)	38 (8)
Has a regular partner	37 (38)	27 (4)	20 (5)	80 (12)	46 (130	21 (4)
Number of clients last working day						
median (IQR)	3 (2-4)	3 (2-4)	4 (3-10)	3 (2-8)	1 (1-3)	2 (1-3)
0-1	25 (26)	6 (1)	8 (2)	13 (2)	52 (15)	30 (6)
2-4	53 (56)	75 (12)	46 (12)	40 (6)	48 (14)	60 (12)
5+	23 (24)	19 (3)	46 (12)	47 (7)	0 (0)	10 (2)
Number of clients last week						
median (IQR)	10 (5-21)	20.5 (13-27)	20.5 (15-40)	17.5 (10-37)	6 (4-10)	4 (3-8)
0-5	25 (26)	13 (2)	4 (1)	14 (2)	38 (11)	59 (10)
6-14	33 (34)	19 (3)	15 (4)	29 (4)	59 (17)	35 (6)
15-24	19 (19)	38 (6)	35 (9)	14 (2)	3 (1)	6 (1)
25+	23 (23)	31 (5)	46 (12)	43 (6)	0 (0)	0 (0)

*multiple-response question

4.1.2. Benefits to entering the sex industry

Factors motivating individuals to sell sex are complex, no matter where they are located in the world. While many sex workers we interviewed had clearly entered the sex industry for economic survival, and often in the face of severe poverty and unemployment, it is important to acknowledge that several found that the work gave them financial independence and the ability to improve their lives quite dramatically. One participant saw it as an advantage that money from sex work "comes right there and then unlike other jobs where the money will come late." [Male SW, Bulawayo IDI6] Another stated: "I manage my own business – my money is not taxed." [Female SW, Hillbrow IDI9]

Many sex workers – especially women – use their income to support family members and pay school fees for their children. A few have used the money from sex work to create alternative income earning ventures, such as buying sewing machines, additional land for rental purposes, or bars:

> "I joined this work when I was renting a room of 10,000UGX and suffering. Now I built a house in Natete. I worked for a period of one year after building my main house – I also built some rooms for rent – they are about eight rooms. I got this money only in sex work, nowhere else." [Female SW, Kampala IDI3]

But money – whether for basic economic survival or for growing business opportunities – was not seen as the only advantage of sex work. One male participant, whose clients are largely female, noted that he engaged in sex work part-time as it helped to pay for his studies, and that:

> "…it's kinda something I do out of passion. It's just something that I do because I appreciate women and I really love sex. It's also partly because I find it an easy way to make money….and get to meet a lot of different women and I love that." [Male SW, Bulawayo IDI25]

On a similar note, a Kenyan participant working at brothels and truck-stops explained some of the positive aspects of sex work:

> "First, I love sex. Second, it gives me money. Third, I like travelling here and there and my work allows me [to do that]." [Female SW, Mombasa IDI20]

While not providing a comprehensive analysis of sex workers' motivations for entering the industry, what this brief snapshot shows is that sex work is not necessarily something that can be "exited" that easily, since there are real advantages to engaging in this work – from having flexible working hours and ready cash, to being able to assert a measure of independence in one's working environment. These perspectives are important to bear in mind as we turn now to examine some of the more negative aspects of sex work in this region.

4.2. Sex workers' experiences of human rights violations

4.2.1. Violations perpetrated by police

One of the most common forms of abuse perpetrated by the police and related authorities was sexual violence, reported across all country sites and in forms that were remarkably similar.

> "Recently the military police raped sex workers in Kisenyi and they had unprotected sex but the sex workers refused to go to the police. They asked themselves 'how are we going to report this case, that this time around we have been raped by the military police?' [Female SW, Kampala IDI3]

> "I was escorting my client to his car after his massage and there were plain-clothes policemen…three of them. Just as he drove off they came and I thought they were thieves trying to take money so I tried to explain to them no I am not carrying anything. Only to discover that they were policemen. There's a car park next to the flat and they took me there and they took turns." [Female SW, Bulawayo IDI4]

> "…one time I was with a client and after having sex with a client the police man also came in and forced himself on me" [Female SW, Kampala IDI3]

When asked how often she had experienced this kind of violation, the last participant responded "this has happened many times".

Gang rape by police was also commonly experienced by male sex workers:

> "One time they [the police] took us – we were two – and drove. We reached in a dark corner and they raped us." [Male SW, Kampala IDI14]

> "There was this time when I was arrested by six policemen. They afterwards demanded sex from me. One of them threatened to stab me if I refused. I ended up having sex with all of them and the experience was so painful." [Male SW, Mombasa IDI17]

Closely linked with these experiences of sexual violence was that of having to bribe the police, in the form of either money or sex.[7] Bribery is so common, when asked "in the past year, have you been forced to pay bribes to the police or anyone else?" many participants simply answered that they pay bribes "all the time", explaining that there were too many instances to recount individually. Some characterised this as "theft" or "robbery" rather than "bribery":

> "The police are a huge problem. One night you can work and then all your money is just taken by the police. Police are really making big money from robbing sex workers…" [Female SW, Bulawayo IDI12]

> "With the police we bribe them every day even if we don't want. If they see you outside the club they call it loitering, but you don't get to the station they just say 'give us some money' before you get there…it's all about money." [Female SW, Bulawayo IDI7]

> "Police… usually stand outside night clubs, they arrest you and tell you that you are loitering, so when I don't have money to bribe, they demand sex." [Female SW, Bulawayo IDI9]

Money paid to police was at times construed as 'fines' but – as this account from a sex worker in Limpopo indicates – these payments are in fact little more than bribes:

> "I pay a fine of R300….they didn't give us papers, we just pay outside [the police station], coming out from the van" [Female SW, Musina IDI10]

Police also occasionally steal from the sex workers' clients:

> "…the police are a problem, all the money I work for sometimes is taken by the police, they sometimes demand money even from our clients, especially when they find you having a short-time in the bush" [Female SW, Bulawayo IDI28]

Paying a bribe is usually necessary to avoid arrest. Sex workers end up meeting police demands because they need to avoid arrest in order to continue working.

> "So because I would be looking for money, I end up bribing them so I can go back to my work and look for more money." [Female SW, Bulawayo IDI8]

[7] This form of 'bribery' is probably better described as blackmail or extortion, since it is usually accompanied by threats and/or negative consequences for sex workers if they do not give to police demands. Throughout the document, the terms 'bribe' and 'bribery' will be used, however, as these are the terms more commonly used by sex workers themselves.

In Hillbrow, sex workers spoke of the common practice of police deliberately arresting sex workers on Fridays so that they would have to spend the weekend in prison, only being released on a Monday.

A male sex worker reported that the police demanded that they pay them in order to investigate a case of physical assault against him:

> "I meet men and they beat me and I went to police. When I reached the police station they asked me to pay money in order to report and they said, 'This one is a prostitute and a homosexual – give us money and report your case.' I did not have the money so I gave up." [Male SW, Kampala IDI12]

Equally common was physical abuse by police, often taking extreme forms. Virtually all sex workers interviewed shared experiences of having been beaten and assaulted repeatedly by police.

> "They hit us asking why we are selling our bodies, why do we do this, they always hit us." [Female SW, Hillbrow IDI5]

> "I remember when the riot police once picked us up, we were severely beaten, insulted and mocked by the police, I won't forget that day. I was badly injured. My child asked what had happened to me and I had to lie and say I was attacked by robbers." [Female SW, Bulawayo IDI28]

> "We were in a club and we were just getting in the car and an officer came and said, 'can you come to us?' We were like 'no, why?' Then he klapped [hit] me twice…I just went away, even if I wanted to [report him] I didn't get his force number or recognise him since it was dark and I was drunk." [Female SW, Bulawayo IDI7]

> "…when someone wants to get money out of you and he calls the police and then the police comes and orders all of us to lie down on our backs and they beat us and take our money without taking us to the police station They beat us from there and scare us and take the money…" [Female SW, Kampala IDI2]

> "The police are very abusive and they treat us like animals" [Female SW, Bulawayo FGD1]

Another form of physical abuse mentioned by participants include being beaten on the soles of the feet with a metal pipe [Female SW, Musina IDI10]. When it came to male or transgender sex workers, abuse from the police was often marked by homophobia, as revealed by the following transgender sex worker in Uganda:

> "I was coming from work they [the police] arrested me and undressed me and asked me whether I was a woman or man. They beat me and detained me in prison." [Transgender SW, Kampala IDI11]

During the period of data collection in Limpopo, our research team recorded an incident that spoke volumes about the levels of violence experienced by sex workers stationed near the border, and the impunity with which security authorities appear to act while administering this violence. A Zimbabwean woman working in Musina as a sex worker was attacked one night by a security guard who occasionally works as a police reservist. This man is well known among sex workers in the area for his frequent harassment of sex workers, often involving attacks with an electric shocking device. On the night in question, she was caught by him, put in his vehicle and driven 10km out of town. There, he hauled her out of the car and pushed her onto a barbed-wire fence, injuring her severely in the process. She was left there bleeding and unable to walk. A friend rescued her and took her to a hospital to receive 15 stitches on her leg.

Some of the older sex workers interviewed in Uganda suggested that such high levels of violence inflicted by the police in their country were relatively new from a historical point of view:

> "In the 80s we used to walk freely and enter a hotel without anyone asking you or stopping you. But now days, as you walk the police patrol follows you… the police we had before used not to arrest sex workers. People could go and do their work as they wished and move freely because then the police could not arrest sex workers." [Female SW, Kampala FGD13]

If charges are ever laid against the police – and in most cases of abuse, sex workers declined to do this – there were usually attempts to bribe the sex worker to drop the charges, as in the following example from Hillbrow. After being confronted by a violent, armed client – who turned out to be a policeman – this sex worker attempted to lay a charge, with the assistance of neighbours who had overheard the confrontation:

> "…we go to police station then open a docket but other police tell him to talk to me to cancel the docket because he was going to lose his job. But that money l refuse. Then after 4 days phoning me, telling me that he is going to pay me money for that, that's when l cancel the docket and he pays me R2000." [Female SW, Hillbrow IDI4]

Experiences of actually being arrested by police were described by about half the participants, but frequently they were either released before arriving at the police station or were taken there but not formally charged or detained. In Hillbrow, as in Zimbabwe, when sex workers *are* arrested, the charge is usually "loitering", since it is difficult to 'prove' that someone has been engaging in sex work.

Experiences of being arrested and detained for fairly long periods of time seemed to be more common in the two east African countries than in Zimbabwe and South Africa. In Uganda and Kenya, reports of detention periods variously lasting one week, two months, and six months were reported. A sex worker from Mombasa described her experience of being arrested while visiting Uganda:

> "In Kampala I was arrested and detained for one month with no one to visit me or even enough food for me. I was a prostitute in a foreign country so you can imagine the treatment and discrimination. Some friends from Kampala heard of my story and came to settle the fine for my freedom." [Female SW, Mombasa IDI20]

> "One day I went out as usual and before I even started [working] I got arrested… I had nothing with me to give the police and that day I was never interested to give free sex to the police. So they took me to a police station, I slept there and was taken to court the next day and I was jailed for six months or pay three thousand Kenya shillings. I decided to be jailed for six months because I never had money to pay the fine." [Male SW, Mombasa IDI17]

One of the few respondents who reported having had no experiences of police harassment or abuse was a male sex worker from Zimbabwe who noted that the police probably did not target him as he was not gay, nor could he be easily identified as a sex worker:

> "With matters regarding sex work I have not had any problems with the police. The reason for this is probably that I'm not gay and the police don't know much about male sex workers who are straight so whenever I bump into a police officer while looking for clients, they don't even give me problems because they would be thinking that I am doing other kinds of business not sex work. It's really a good thing that the police are ignorant about this kind of job." [Male SW, Bulawayo IDI26]

Another male sex worker, also from Zimbabwe, noted that he did not have much trouble with the police as "they don't know male sex workers exist, they think there are only female sex workers". [Male SW, Bulawayo IDI1]

4.2.2. Treatment by clients

A number of female sex workers reported that clients commonly ignored them when they expressed their wishes or indicated they were in pain. A pattern emerged in these accounts, in which it was clear that by paying for sex, these clients felt they had 'ownership' over the sex worker herself and could therefore do whatever they wanted with her:

> "You can tell the client to stop and he says, 'Didn't I buy you with my money? I have to complete my money first'. For you don't appear to him like a human being. Even if when you tell him you are tired he says, 'After all, you want money'. So he mistreats you…when he leaves he may hit you on your face and it gets swollen. We really get big problems with them." [Female SW, Kampala IDI2]

> "A man came to me and approached me as a client, then we go to the bush and he sleep with me in a hard way. When I say 'you are hurting me', he said 'I pay you so don't tell me shit'." [Female SW, Thohoyandou IDI10]

> "If he pays you, he fucks you rough, harshly, because 'I paid my money'." [Female SW, Hillbrow IDI3]

> "Some men are very rough. They say they prefer dog style, then in the process you feel that they are actually wanting anal sex. If you refuse then they beat you because you are a woman, they then refuse to pay you." [Female SW, Bulawayo FGD1]

Exacerbating this situation was the finding that – across all study sites – clients often refused to pay for services or tricked the sex worker into accepting a smaller payment:

> "We meet clients who are so rough. Sometimes some pretend they want a short-time so when you are done, they refuse to pay." [Female SW, Bulawayo IDI12]

> "One day I go out with my client, he said we are going to …. accommodation and he is going to give me R150 per round. Then when we come back he gave me R70 and said 'I won't give you the rest because I sleep with you for a few seconds only so it's OK'." [Female SW, Thohoyandou IDI10]

> "[S]ometimes I meet clients who are rough and some who don't even want to use a condom. So some of them say 'you don't exist so I won't pay' so it's really difficult for me." [Male SW, Bulawayo IDI6]

Some clients in Uganda were said to take advantage of the illegal nature of same-sex relationships in that country to get out of paying for sexual services:

> "Sometimes a man will take you and after fucking he says, 'You are gay, where can you report me? I'm not paying you and you have nothing to do.' So it's also hectic." [Male SW, Kampala IDI14]

In some cases, clients were said to even demand payment to *them* for sexual services:

> "I get clients who, after we have sex, they demand me to pay them. This is a major challenge because I do this for a living, but you get people who after having sex with them they demand that you pay them." [Female SW, Bulawayo IDI3]

Theft by clients was reported by several sex workers. Either the client pays upfront for services and then afterwards demands the money back (or steals it when the sex worker has turned her back or gone into another room), and then beats or threatens to beat the sex worker when she refuses to give it back. There were a few reports also of clients stealing cell phones and other valuables belonging to the sex worker.

Experiences of having been physically beaten by clients or threatened with firearms were reported by virtually all sex workers interviewed.

> "I once met a man who asked to take me to his lodge. I agreed but when we got there in his room he strangled me. I nearly died, I even went for treatment of the neck and eyes." [Female SW, Bulawayo FGD1]

> "I was taken by a client to go to his place and I didn't know that this client is a police. So when we get to his place he gave me my money then we do business, but then during the time having sex with this police he take almost one hour fucking me, he don't want to finish. So I talk to him in a nice way but he refuse to stop. There was a bottle next to his bed then I take it and beat him on his head, that's when he stop fucking me. He go into another room and come back holding a gun. I closed the door and start screaming. The people heard me screaming for help, they called the police…" [Female SW, Hillbrow IDI4]

A number of participants described experiences where they had come to an agreement to have sex with a client, but upon arriving at the venue, discovering several other men waiting to join in and have sex with them as well. These instances of gang rape were distressingly common.

> "Last year April I was raped. I go to the police, they said, 'We can't help you, you are a sex worker.' I was taken by one man. I didn't' know that there were three other men at home so all of them they rape me… after they finish sex they beat me." [Female SW, Musina IDI10]

> "I was taken by a client to his place. When the car started another guy jumped in the car. So they [had already agreed] before that they are going to sleep with me, both of them. They told me, 'No one knows this place, we can do whatever we want, we can even kill you'. They ask me do I have condoms then I say 'yes'. They tell me if I say 'no' they were going to sleep with me without condom anyway. Both of them sleep with me changing the whole night, having 7 rounds. In the morning they didn't give me chance to bath and that night they promised me that they will take me back to the hotel but they didn't. They take me to the robot, they stop there. I told them I don't have money for taxis. They throw coins at me and say, 'Next time you must have your own money for transport'." [Female SW, Hillbrow IDI24]

> "I found a man at Jambo village and he told me accompany him to his place. On arrival at his house, some other four men came and entered the room. They all wanted to sleep with me. When I refused, they beat me up calling me all sorts of names. I cried for help but nobody came to my rescue. They tore my clothes therefore I had to walk home naked. They even stole my money. God one day will punish them for me." [Female SW, Mombasa IDI19]

> "The men who take us they treat us badly. A man can come and tell you that, 'I want to spend a night with you.' …So the man tells you that he stays alone; sometimes he even shows you the house keys and you go with him. When you reach there he opens the door and you enter or even you sleep with him and then he pretends as if he is going out to bath and there comes in others, like four of them and they all have sex with you." [Female SW, Kampala IDI1]

Following this incident, the last participant asked one of the men "why do you do things like that?

> "The boy said that, 'We collect money amongst ourselves. So then one comes and negotiates with a woman and he takes you. After he finishes you he calls the rest of the others'." [Female SW, Kampala IDI1]

This pattern closely echoes that of clients' sense of "ownership" and objectification of sex workers, as described above, where payment for services is seen by clients to offer them 'carte blanche' to do with them as they wish.

Finally, participants' descriptions of rape by clients – whether gang rape or otherwise – was almost always accompanied by mention of the fact that in these instances, condoms were not used. This could suggest that the issue of condom-use by clients may be closely tied up with sex workers' understanding of sexual "consent", and consequently "rape". This finding requires closer examination and possibly further research.

4.2.3. Condom use with clients

A strong theme across all sites was that sex workers were commonly faced with violence for refusing unprotected sex, and that when extra money was offered for unprotected sex, they would usually accept this because they needed money. Not all interactions with clients ended with the sex worker giving in to sex without a condom, however. Zimbabwean sex workers expressed the strongest views on this matter:

> "I know a lot of men like that [unprotected sex] but if you are principled, you stick to the principle of no condom, no sex." [Female SW, Bulawayo IDI8]

> "I do get clients who refuse to use condoms but I have a strict policy that no condom no sex" [Female SW, Bulawayo IDI5]

Others indicated the degree of agency/choice they have in the matter; that even in the face of quite overwhelming disempowerment, there is still room for negotiation:

> "I have always seen many of my friends insist on condoms. As a woman I have a choice of the female condom. Many of my clients prefer using the female condom; they complain that the male condom is too tight for them." [Female SW, Bulawayo IDI9]

This sex worker went on to explain her thinking on dealing with clients who insist on unprotected sex:

> "…I'm a single parent , I don't want to die living my children young , so I would rather go back home without any money than to get sexually transmitted infections or HIV from unprotected sex." [Female SW, Bulawayo IDI9]

At times, clients did not explicitly demand unprotected sex; instead they found ways to surreptitiously sabotage sex workers' efforts at safe sex. Sex workers in Uganda reported that some clients deliberately broke condoms before use [Female SW, Kampala IDI2], while a male sex worker in Zimbabwe noted that one of his clients had secretly removed the condom before sex [Male SW, Bulawayo IDI3].

Such experiences bring home the point that sex workers are often keen to practice safe sex but that they are usually thwarted by unscrupulous or violent clients (and others). On a related note, there was a strong sense among some participants that sex workers were *more* likely than non-sex workers to be aware of the need for condom use and to enforce this with their sexual partners in practice.

> "Sex workers are the most conscious in regards to protective sex because for me when I was in marriage, I did not know anything about condom use. The man could come with all the infections and infect me – but now I know that when I use a condom I prevent myself from getting infections." [Female SW, Kampala IDI9]

4.2.4. Violations perpetrated by pimps, regular partners, landlords and others

From the accounts provided by our participants, it would seem that there is a whole range of people – including landlords, hotel and bar staff, security guards and pimps, among others – who are either centrally involved in the sex trade or operating on its fringes, who take advantage of sex workers' vulnerable position and the illegality of sex work to extort either money or forced sex from sex workers.

> "…the security where l work, he chased me away so l ended up paying him some money for me to work." [Female SW, Hillbrow IDI9]

> "…one bouncer [at a club] told me to sleep with him so that I was allowed to enter that club again. I had no choice but to do so." [Female SW, Mombasa IDI19]

> "One day I was harassed by a client and when I told the bar manager he demanded sex so that he can help me. My landlord also demanded sex because I could not afford rent." [Female SW, Mombasa IDI18]

Indeed, landlords demanding sex in exchange for accommodation or basic services was a common experience for sex workers across all study sites.

> "At home my landlord asks me to sleep with him or else he throws me out of his house" [Female SW, Mombasa IDI20]

> "Landlords at our work places are not good. However much we pay them they don't value us – yet we pay them a lot of money daily. We are not allowed to rest or attend to any problems at home like [going to a] burial because the moment you come back they ask you to pay a fine of money for not being around." [Female SW, Kampala IDI3]

One male sex worker noted how landlords in Uganda do not want to rent out accommodation to him as they see him as morally corrupt:

> "Most landlords chase us out of their houses... that we might spoil their children." [Male SW, Kampala IDI12]

In Mombasa there were reports of having to even bribe bar maids with money:

> "I have to give half of my money to them so that they treat me well and allow me into their bars" [Mombasa IDI20]

Just over a quarter (27%) of sex workers interviewed for this study reported working from brothels and therefore having to negotiate terms with a brothel manager. This relationship was generally exploitative:

> "When you go with a client the brothel manager takes 50% of your money. Since am the one who toils for this money I thought the manager would be taking a smaller percentage…Even when a client goes without paying me I still have to pay the manager." [Female SW, Kampala IDI9]

All but one [Bulawayo IDI1] of the male and transgender sex workers in the study reported working without pimps.

Regular sexual partners and "boyfriends" were another source of abuse. Recall that 41% of male participants and 37% of female participants in the study reported having a regular partner. For most of these participants, experiences of being verbally abused, beaten or rejected by their partners on account of their sex worker status – even if initially this had seemed not to be a contentious issue – were common.

> "When you get a boyfriend who knows that you are a sex worker he can love and give you money, but with time he starts complaining. Each time you go somewhere he tells you, 'you are [coming] from selling sex – after all, you're a sex worker'. Even if you have been somewhere else. This happened to me, I got a man but all the time he could keep on telling me the same thing: 'you are a prostitute'." [Female SW, Kampala IDI3]

> "My boyfriend harasses me because I am a sex worker and he demands sex….and if I refuse he rapes me. There was a time when he raped my child when I was at work. And I cannot chase him because if I try to chase him away he says that he will try his best to expose me." [Female SW, Mombasa IDI18]

Others had made deliberate decisions to eschew relationships with regular partners altogether, on account of this abuse:

> "I do not have a permanent boyfriend because some of them beat me up while others attempt to sodomise my son." [Female SW, Mombasa IDI20]

Only a handful of sex workers interviewed reported positive, supportive relationships with their regular partners, such as this participant from Hillbrow:

> "I met my boyfriend in this business. He understands me a lot because no one chooses to be a sex worker, but it's the situation that makes you to be a sex worker." [Female SW, Hillbrow IDI24]

4.2.5. Violations perpetrated by family and community members

In general, the attitude of family and community members was one of overt stigmatisation of sex workers, who were often unambiguously despised. Many participants expressed a fear of gossip by neighbours and other community members. A Limpopo-based participant pointed to the deep suspicion of sex workers felt by neighbours – particularly women – on account of their fear that sex workers would sleep with their husbands: "Married women, they are a big problem. They hate us." [Female SW, Musina FGD1]. A Kenyan participant recalled an incident where these suspicions were acted out in a particularly humiliating form of abuse:

> "One day I was at a club when a neighbour's husband joined the table [where] I was seated. Someone saw us chatting and called his wife. The wife took some other few neighbours and protested at the club. They beat me up and took me to the toilet. There, they pushed my head inside a dirty sink to drink the sewer. It was horrible. The husband ran instead of telling them that there wasn't anything bad we were doing but just talking. Back at home the landlord told me that I could no longer reside in his house as all women were furious with me and that I could steal their husbands." [Female SW, Mombasa IDI19]

Largely because of this abuse meted out by neighbours and other community members, a Ugandan sex worker said that the sex workers she knew had made a deliberate decision not to sell sex to men in their neighbourhoods, "unless they come to our workplace and find us there". [Female SW, Kampala IDI3]

Sex workers in all study sites reported various experiences of social isolation by neighbours, family and community members more broadly, once their occupation as sex workers became known. Some recounted how when someone in the community is throwing a party or organising a traditional ceremony,

> "…the neighbour will give everyone around an invitation card but will exclude you because people will say that 'even a prostitute came on this occasion'. So you are never invited however much you may be friends…a sex worker is never welcome…when it comes to parties you will never be invited because you might bring disgrace." [Female SW, Kampala IDI2]

Discrimination and exclusion was also reported to occur in other community-based initiatives, such as projects to support orphaned children whose parents had died of AIDS:

> "We also have children whose fathers died, but we cannot go to those organisations for support. They say they cannot deal with sex workers, they want decent people." [Female SW, Kampala FGD13]

A common theme in Uganda was the exclusion of sex workers from money-lending projects – even those dedicated to "developing women". One explained:

> "…when a sex worker goes to them to ask for a loan so that she may start up a business which she will manage during day time and at night go to do sex work so that she may pay back their money, they refuse because she is a sex worker." [Female SW, Kampala FGD16]

Similar sentiments were expressed in relation to burial schemes:

> "…there are groups which contribute money when someone has died, but when a sex worker dies no one contributes yet when their people die they come to us for contribution and we contribute." [Female SW, Kampala FGD16]

In other words, the stigma associated with sex work was so great, it could even serve to negate the social and financial contributions made by individual sex workers to their families and communities. In the following exchange, a Ugandan sex worker expresses her frustration with this situation and is given encouragement by the interviewer:

> Participant: I still have a challenge with the people in the community. People we live with, they don't want to associate with us. If you give them all you can they only keep on saying 'you are a prostitute', no matter what good things you do for them.
>
> Interviewer: Then stop giving them good things; just keep your money.
>
> Participant: But then it is my duty to help. Like my whole family depends on me alone, even when a person in my family dies I have to encounter all the expenses. Yet people still go on calling me a prostitute.
>
> Interviewer: Then you should be proud of your job because this shows that you are above them, no matter what they call you, you still support them. [Female SW, Kampala IDI3]

Other sex workers reported being "looked down upon in the family" or of concealing the true nature of their work from family members. Several participants had experienced being chased away from their homes by parents and other family members, on account of their involvement in sex work.

> "… [my family] don't know. I have always lied to my children, I tell them story after story. I can't tell them I am working somewhere because they will want to come, so it's difficult for me to speak to my children so I have to hide it from them." [Female SW, Bulawayo IDI8]

> "At home, my own father asked my mother not to give me food for even one day because if I could sell pussy, therefore I was able to feed myself. My sister doesn't like sharing her things with me with fears of being infected by diseases." [Female SW, Mombasa IDI20]

> "My family is a threat to me [...] because they know what I do and they can chase me out of the clan…. One time I was chased from home after they realised what I was doing, being a sex worker and a male and I got lost for some time. I used to be real scared of moving out because my friends could laugh at me and say, 'Check out that homosexual who sells his ass'." [Male SW, Kampala IDI15]

As this last participant indicates, for male sex workers there is a double stigma attached to being involved in sex work and being identified as a gay man, particularly in countries like Uganda where homosexuality is illegal.

> "[A]s a male sex worker, I am tortured every day… They [the community] really hate us. So now I have one boda [bike] which I use every day for transport because if I use other bodas or other means of transport people beat me and say, 'This is a prostitute and homosexual' - so I find myself not having peace" [Male SW, Kampala IDI12]

Similar experiences of stigmatisation and being ostracised by the community were reported by a transgender sex worker in Mombasa:

> "Muslim elders and the community at large… they threatened to stone me to death if I go back there [home]. Now I have kept a distance from my village and my people." [Transgender SW, Mombasa IDI17]

Being reprimanded or chased away by traditional authorities was reported by sex workers in Limpopo and in Kenya:

> "One day, a village elder called me to a meeting telling me that I should look for another place to go and live. When I asked why they said that they fear their daughters to copy my behaviour and be like me. I thought it was a joke but it wasn't." [Female SW, Mombasa IDI19]

Instances of bribery/blackmail are also not restricted to the police. One sex worker in Limpopo described how members of the community used similar tactics to extort money:

> "Other people came to me; they were four and they abuse me verbally. They said 'you are promoting child sex work. We are taking you to the police station or else give us money'." [Female SW, Thohoyandou IDI10]

Many participants had personally experienced being ostracised by religious institutions, at times in quite extreme forms, particularly in east Africa:

> "…in Migyera where I come from, we are seriously discriminated [against] and hated, even in churches. I was chased out of the Mosque when I had gone for prayers and they told me 'Get out of this place. What you are doing is abominable'." [Female SW, Kampala FGD16]

> "[The church] put a lot of emphasis in abolishing us, they even suggest that we should be taken to an island and be shot to death, others say we should be killed; the others say we should hang them. Things of that kind…." [Male SW, Kampala IDI15]

> Sometimes I think it [the church] even promotes these people who come and buy us and they are like, 'Let me just fuck him and I don't pay him – after all, even the church is against them; the Reverend was preaching about them and it's evil'." [Male SW, Kampala IDI14]

Other examples illustrated more subtle discrimination but no less stigmatising:

> "…as you get to the entrance of the church the preacher switches from the topic of the day and begins preaching against sex work and you become the topic. They speak ill about sex workers – that's why we are so scared to go to church." [Female SW, Kampala FGD16]

Again, for male sex workers, the fierce rejection of their sexuality by religious institutions often took expression in appalling forms of abuse. A male sex worker from Mombasa recalled:

> "Religious leaders have neglected me and do not want to be associated with me. This has left me very lonely .They have always pointed fingers at me. The pastor even made me stand before the congregation and after telling them that I was a sex worker, he excommunicated me from the congregation. I can never forget how all those people shouted at me calling me all sorts of names. They were precisely glad that I was no longer part of the church. I was really traumatized after this incident to the extent I tried to commit suicide." [Male SW, Mombasa IDI17]

One participant explained how the power of the church could influence health (and other service) providers in their approach to sex workers:

> "The fact is that the church is against us and most people really believe in church. So, when a Reverend comes and says, 'You don't need to do this', it really becomes hard for a nurse who has been in church and has heard a Reverend cursing sex workers, for that nurse to give you services with her whole heart. She will be going with what the Reverend has said." [Male SW, Kampala IDI14]

Only one sex worker mentioned positive experiences with his church (the Universal Church), which apparently tells them "about their rights". [Male SW, Hillbrow IDI25]

4.2.6. Violations experienced by sex workers who are foreign nationals

A substantial portion of the sample of sex workers interviewed in Hillbrow and Limpopo (in the border town of Musina, especially) were migrants from Zimbabwe. Although we did not set out to explore the relationship between migration and sex work, was the data did suggest is that cross-border migrants may travel to South Africa without necessarily intending to enter the sex industry. One participant noted that he had entered sex work as he did not have the necessary documentation to obtain formal employment in South Africa:

> "Mostly people from Zimbabwe. It's not easy having papers so I can't get a job. I decided to be sex worker." [Male SW, Hillbrow FGD23]

In general, foreign migrants' experiences of being singled out, verbally abused and mistreated, reveal much about attitudes in South African society towards migrants from other parts of Africa in general. Prejudice and discrimination against migrant sex workers came from several sources, including community members, clients, police and even local sex workers.

> "We are foreigners so clients threaten us and accuse us of coming here to spread HIV, that's why in South Africa the rate of AIDS is high. Because of us… They insult you with words telling you 'I can kill you because you are a foreigner, you don't have rights in this country'." [Female SW, Hillbrow IDI24]

> "There are other guys who always come there; they say we come here to spoil their country." [Female SW, Hillbrow IDI9]

> "They [women in the community] always say, 'Zimbabweans, you sell your body and you come to take our husbands." [Female SW, Musina FGD11]

> "Police are always complaining that we are not supposed to come here and do this business. They call us names – 'makwerekwere' [a derogatory term for foreigner]…They arrested us and sprayed us with pepper spray inside 'gumbagumba', that big van. People were vomiting and coughing. Me, they sprayed me into my eyes saying insulting words and 'go back to your country'." [Female SW, Hillbrow IDI24]

> "…other sex workers they tell us 'you are not supposed to work here, you are foreigners, you are here taking our jobs'." [Female SW, Hillbrow IDI9]

> "Where l work the guys force me to buy beer for them. If you don't have money they klap [hit] you and tell you not to come back because we are foreigners." [Female SW, Hillbrow IDI3]

This woman also described having to pay frequent bribes to these "thugs in the bar" in order to continue working there. When seeking emergency health services, one Zimbabwean participant working in Limpopo was denied treatment partly on account of her nationality:

> "When l was l raped l just go to the [private] doctor because [at the public hospital] they say, 'We can't help a sex worker, you don't have document from Zimbabwe and you are not working.' It pains me because l go there for help but they never done anything for me." [Female SW, Musina IDI10]

Other migrant sex workers in the town had had similar experiences when attending local clinics:

> "At the clinic they are rough and say, 'You are from Zimbabwe, you want tablets too much, you are not sick'." [Female SW, Musina FGD11]

> "At Netsfield [public clinic] if they recognize or identify you that you are a Zimbabwean they don't treat you and they shout at you." [Female SW, Musina FGD11]

Not all experiences of migration were negative, however. A male sex worker in Hillbrow noted that he came to South Africa as he thought he would experience less discrimination:

> "In my country - l am from Zimbabwe - its illegal, that's why l come here in SA because we are free to do our things. l have rights being gay." [Male SW, Hillbrow IDI25]

4.2.7. Name-calling, verbal abuse and humiliation

Sex workers – particularly those working on the streets – described frequent experiences of being shouted at by community members, "laughed at", being called names, accused of "stealing men" and of being HIV positive [Female SW, Thohoyandou IDI10]. One participant summed up the frequency of verbal abuse, saying it was "our everyday bread" [Female SW, Bulawayo IDI7].

Some described how hurtful it was when "even children insult me" [Female SW, Kampala IDI3]. In Limpopo, a sex worker recalled how she was taunted by children:

> "It happens to me waiting for a taxi to go to town: small kids 10 years old asking me to have sex, saying 'I have 10 rand'. So I refuse and they start to shout at me that, 'You sleep with our fathers at night!'" [Female SW, Musina FGD1]

Others reported experiences where the verbal abuse meted out by community members extended to their own children:

> "My neighbours, as they know I am sex worker, they brand me with bad names, treating me badly; even they tell my children that they are children of a prostitute. I feel irritated and also discriminated." [Male SW, Mombasa IDI22]

Comparisons with or allusions to dogs were common in Uganda:

> "…where I stay they insult me a lot even when my kids are around even when my mother came to visit me people will never stop calling me a prostitute they go on and say "you even sell sex to dogs" but really is there any dog that can have sex with a human being?" [Female SW, Kampala IDI3]

> "[They say] 'You're just a prostitute and prostitutes are like dogs'." [Female SW, Kampala IDI4]

Common terms of abuse in some of the sites included the following: 'prostitute', 'street-dog' (Uganda), 'bitch', 'whore' (Zimbabwe), 'AIDS-man', 'chifere' (for male sex workers in Zimbabwe), and 'mahure', 'magosha' (Limpopo). The last name – which translates in English as "whore" – was vehemently rejected by one participant, who had been called it many times:

> "It pains to be called this name because I am a human being." [Male SW, Musina IDI9]

Indeed, the notion that sex workers were not perceived to be "human beings" emerged strongly across all study sites but particularly in east Africa.

> "…when we go to the hospitals and find people who are not sex workers we get fear because they don't treat us like human beings." [Female SW, Kampala FGD16]

> "Most of these health workers at public hospitals, they discriminate [against] me. They don't take me as a patient…they mistreat us like we are not human beings." [Female SW, Mombasa IDI18]

> "…insults that they throw at you, they take you to be less human" [Male SW, Kampala IDI14]

> "[People in the community say] I'm not a human being because I can't even advise a married person. I am just useless, spoiled and that's the end of me. They can't allow me to spoil others. When they see my child they say 'that's a prostitute's child, look at it, child of a prostitute, let her

go away'. And what are you going to say? After all, your child is also going to sell herself. Those are the kinds of things that they are always saying." [Female SW, Kampala IDI2]

Various experiences of deliberate humiliation were reported by participants, often designed to highlight the supposedly shameful nature of their work.

> "Police arrested me with other sex workers and we were asked to carry used condoms on our heads. When we reached at the police station they asked for money…" [Female SW, Kampala IDI3]

In another account, a sex worker recalled an incident where she was gang raped by a group of men in one room while a fellow sex worker was experiencing the same violation in the next room and "was forced to eat each condom after sex…each condom they would use they would tell her to chew it with the sperms" [Female SW, Kampala IDI1]

Further examples of humiliation attached to outright violence include instances where sex workers were stripped of their clothes in public.

> "I was arrested and ordered to remove my panties at gun point and I had to give in to sex with [the police] and then I was left free." [Female SW, Mombasa IDI18]

Although the study did not set out to capture the long-term psychological consequences of experiencing such high levels of ongoing abuse and deliberate public humiliation, our participants made reference to them in their narratives.

> "…whenever somebody degrades you, you always feel ashamed and become sad" [Female SW, Hillbrow IDI9]

> "it [experiences of violence and abuse] has caused me a lot of fear because each client I go with I think maybe he will treat me like other bad ones" [Female SW, Kampala IDI2]

In the following exchange, after reeling off a list of violations that are commonly experienced in her work, a Ugandan sex worker could go no further, overwhelmed as she was by the 'heaviness' of these memories. Her words provide insight into the deep levels of traumatisation that are likely experienced by many sex workers in this region.

> "Participant: There is a lot of torture and harassment and there is nowhere you can report to…clients beat us, mistreat us, they refuse to use condoms, they use us and refuse to pay our money. Sometimes you spend a night with a man and he refuse to pay you the following day. You go back home without money, when children have nothing to eat – yet you slept with a man the whole night.
>
> Interviewer: Do you still have more bad things that you want to tell me?
>
> Participant: The bad things are really many and I cannot tell you all of them.
>
> Interviewer: Tell me those which you can remember.
>
> Participant: All the ones that I remember are very heavy." [Female SW, Kampala IDI9]

She later explained that one of the ways of coping with these "bad things" is to build friendships and solidarity with fellow sex workers, which enables her to share these experiences and find some relief.

4.2.8. Relations among sex workers themselves

It is perhaps an unavoidable feature of sex work that conflict and jealousy arises between sex workers owing to the fierce competition for clients in certain areas. This was reported by around a quarter of our participants:

> "Yes, we do fight [over clients], especially new clients who drive cars, always you get someone claiming that it's their client, yet they will just be lying." [Female SW, Bulawayo IDI08]

> "This business is competition, survival of life. So some sex workers, they call the guy to come and take your money and go. He can do as if he wants to do business with you then when you are inside he will threaten you with a knife or gun, then you give him all the money you worked for the whole day and your phone." [Female SW, Hillbrow IDI24]

Some sex workers were suspected of being "whistle blowers" for the police [Female SW, Bulawayo FGD1], and in general, the theme of jealousy among sex workers was a common one.

Some of the male sex workers in Kampala and Hillbrow noted that their female counterparts saw them as competition for clients:

> "Sometimes we face it from the women [sex workers]. They say, 'We don't want gay men.' These days men no longer want to buy women, they want to fuck asses. It's a challenge that MSM are facing. We are getting a strong opposition from our fellow sex workers – the women – because they are like, we are over-taking their market." [Male SW, Kampala IDI14]

But for others, conflict was minimised or absent precisely because of the range of experiences and challenges that are shared by sex workers:

> "The sex workers I work with, we cooperate because we all face the same challenges and we are all mature people." [Female SW, Kampala IDI3]

Other male sex workers noted that female sex workers were their "true sisters" and that

> "…they even help us get clients because some clients go to them and say they are looking for a male to take with them, so our sisters come then and link us with the client" [Male SW, Bulawayo, IDI2].

4.2.9. Strategies used by sex workers to avoid or redress human rights violations

Our research uncovered some rare examples of sex workers literally fighting back against their abusers. A female sex worker in Bulawayo recalled how she responded when assaulted by a police officer:

> "Unfortunately one of the police men who had arrested me… got angry because I had refused to bribe them. He then took me to another room where he started slapping me. Later he took his stick and started beating me up, I don't know what got into me that moment but I shot up at him and beat him nearly to death. When I came back to my senses his arm was broken, he no longer had his shirt on and the room was upside down. I still can't believe they let me go after that." [Female SW, Bulawayo FGD2]

Others attempted to run away from the police (with varying degrees of success), or to 'trick' them. For example, when military police in Uganda rounded up a group of sex workers and raped them,

> "…the only one who survived played a trick and started vomiting saying that she was very sick and no military office could rape a person who was vomiting." [Female SW, Kampala IDI3]

Another strategy for avoiding abuse involves an attempt to be discerning in their selection of clients, hoping that by scrutinising them carefully, they will choose only clients who are not violent.

> "…some people will be looking strange so I don't pick those who look strange" [Female SW, Bulawayo IDI9]

But there are other reasons for such care in selecting clients:

> "Sometimes I have to be careful because there are plain clothes police who pretend to be clients yet their intention is to arrest you" [Female SW, Bulawayo IDI5]

Of course, this strategy is far from fool-proof and in many cases, sex workers cannot afford to be selective about their clients because they need money.

In instances where sex workers actually report violations to the police, the response is usually a negative one.

> "…another time I was beaten by a client so I went to report it to the police. They chased me away [and said] 'you are a bitch'." [Female SW, Hillbrow IDI4]

> "The day I was raped I went to report to the police but the harassment I got there almost made me faint. The police wanted me to explain every detail from the rape to the screams that I made. Another officer asked how a prostitute like me could be raped as I was used to all sizes. He told me in fact that man really spared me. He could have tested my ass too. He ended asking me if my ass is already opened. Never will I again go to report a case. I'd rather die." [Female SW, Mombasa IDI19]

Indeed, in most cases, participants were adamant that they would not seek redress and expressed a sense of futility about the outcome. Consequently, there were very few instances where sex workers actively sought redress in this form for violations they had experienced.

> "I have always had nothing to do about it but just to endure the hardships" [Female SW, Kampala IDI2]

> "Well, I do nothing [when police demand free sex]. I can't even go and report them to the other police, they don't listen to us because they think sex workers make up stories." [Female SW, Bulawayo IDI28]

> "For me, I decided to keep quiet… my keeping quiet has saved me because if I decide to respond or react to these instances I might get in trouble with the police because when the police comes in I'll be the one to blame." [Female SW, Kampala IDI3]

> "Sometimes I don't bother [reporting cases of abuse to the police] because of the poor response from the authorities. For example, on two occasions I have reported rape cases against me but I was given poor treatment and they were also asking me questions that I could not understand." [Female SW, Mombasa IDI20]

Often this sense of futility about whether reporting abuses to the authorities would yield any positive outcome was borne out of an acute understanding of the link between the criminalisation of sex work and the powerlessness of individual sex workers:

> "When a man rapes you, beats you or uses you, you cannot go and report him because you are a sex worker, though other people who are not sex workers can go and report. I just keep quiet and die with my pain… When you go to report you will be asked, 'What were you doing?' and you will be charged for prostitution so the laws do not favour us and we cannot report cases." [Female SW, Kampala IDI9]

Importantly, not all sex workers who had been violated accepted that they had no recourse to the law. This female sex worker from Thohoyandou, Limpopo, showed us that standing up for one's rights could have a positive outcome:

> "One day a client wanted to go with me for the whole night. I told him that its R500, then he agreed. We went to a room and he bought romantic stuff and food. I asked him to give me my money and he said he will give me in the morning and we slept. In the morning I woke and took a bath and asked for my money and he refused and said that I also enjoyed and thus I should not be paid. Then I told him that, 'I will get you arrested'. I took his car keys and went to the police, I told the police that I had an agreement with someone who promised to give me R500 but he did not. So the police said I must wait until he comes to the police station. Within 20 minutes he arrived, then he told the police we agreed on R200 and now I want more. Then the police asked me if he used a condom and I said no. Then the police said he must give me my money in full and I must give him the car keys." [Female SW, Thohoyandou IDI1]

After giving the participant the agreed-upon R500, he unfortunately followed her home and threatened to shoot her. The drama was ended without further harm to the sex worker, however, when her "mother called the police and he was arrested."

Other participants sought redress by utilising the services offered by sex worker organisations and other NGOs:

> "[when experiencing abuse] I call the Sisonke member to ask them what I am supposed to do, because some of us we don't know our rights." [Female SW, Hillbrow IDI5]

The importance of being empowered by knowledge of one's rights cannot be over-estimated. Revealing a potentially useful strategy for dealing with the police, a sex worker from Hillbrow claimed that he tells them in no uncertain terms of his rights and that they therefore avoid harassing him:

> "Most of the cops they always say I am crazy. Then they just drive off. If they arrest they don't come around me because I always tell them about my rights." [Male SW, Hillbrow IDI19]

4.2.10. Impact of the current legal and policy framework on sex workers' health and wellbeing

Without exception, our participants were aware of the illegality of sex work in all four countries, and spoke of the various ways in which this context deprived them of basic human rights.

> "…because people know that sex work is criminalised, that is why even my finger was broken. I just passed by the boda boda [bike] riders at their stage, they beat me up and stole my bag and money, saying 'she is a prostitute, she is [coming] from making money'. Yet there was no sign indicating

that I was selling sex from there. Even the police when you go to report a case that a man has beaten you he cannot attend to you, he just calls you a prostitute." [Female SW, Kampala IDI3]

As mentioned above, the situation is perhaps even worse for male sex workers:

> "I am criminalised twice: One, homosexuality is illegal. Two, a male sex worker is also illegal. So, the laws do not allow me to do my work freely. [Male SW, Kampala IDI11]

Criminalisation of sex work also legitimates bribery, blackmail and sexual abuse by authorities. The following example mentioned by a sex worker in Thohoyandou is typical:

> "Police take me and force me to sleep with them. If I refuse they said they are taking me to jail because I'm selling [sex] and I know that sex work is a crime. So I sleep with them." [Female SW, Thohoyandou IDI10]

A participant in Kampala shared with us her sense that the criminalisation of sex work was also impacting directly on sex workers' ability to protect themselves from HIV:

> "…the government says that this work is not recognised and they don't give us condoms because they think that when they give us condoms we will promote sex work. So this suppresses me because even if I'm a sex worker I'm entitled to protect myself." [Female SW, Kampala IDI9]

Clearly, for many people the illegality of sex work lends legitimacy to ongoing abuse, humiliation and cruelty towards individual sex workers. The 'criminality' of sex work is used to excuse just about any kind of treatment of sex workers, and there appears to be is widespread acceptance in the general public that such treatment is acceptable. This understandably creates fear among sex workers about being exposed, and entrenches a deep reluctance to be public about their experiences and to claim their rights.

In the section that follows, we turn to examine sex workers' experiences of interacting with the healthcare system in their country, and how the broader contexts of criminalisation, discrimination and exclusion described above play themselves out in the realm of healthcare access.

4.3. Sex workers' access to healthcare

4.3.1. Most prominent health needs

Sex workers in this study listed various health needs, a number of which could be considered to be occupational health problems arising from sex work itself. Foremost among these is the need for proper STI diagnosis, treatment and follow-up, which appears to be a major challenge for sex workers in all sites. Contracting STIs was largely accepted as "inevitable"; as one participant put it, "there's no way we can avoid STIs" [Female SW, Kampala FGD13]. A number of participants reported experiencing "lower abdominal pain", which could be a sign of untreated STIs or a range of reproductive health problems. One sex worker in Thohoyandou, Limpopo, narrated the following experience:

> "I found a client, and he was bigger than me, as you can see I'm thin. He slept with me in bad way. Then when we finish I try to stand up I feel pain inside me. And by that time I could not stand up. He took me to a hospital. The nurse told me that I have injured inside my womb then they told me that they are going to take out my womb because they can't operate it, now I'm living without a womb." [Female SW, Thohoyandou IDI1]

Female sex workers also called for improved access to pap smears and female condoms. A further health need arises from unplanned pregnancies, particularly common as contraceptive use among sex workers in general is quite erratic. A sex worker from Mombasa explained how she deals with this:

> "The only thing that forces me to go to hospital is abortion. Whenever I forget to use a condom I get pregnant but I don't like hospitals. I buy medicines from pharmacies and terminate my pregnancy. I use alcohol to remove pain." [Female SW, Mombasa IDI20]

The profound vulnerability to HIV infection that sex workers across Africa face emerged in many of our participants' interviews. Much of this vulnerability is linked to the violence that accompanies sex work and the broader twin contexts of patriarchy and criminality that undermine sex workers' ability to protect themselves.

> "One time I went with a client – I don't know whether he was a police man or not because he had a pistol. He forced me and removed the condom and had unprotected sex with me. After some time, when I went for HIV testing I was positive yet earlier I had tested negative before having unprotected sex with him. So he infected me with the virus." [Female SW, Kampala IDI5]

Finally, several participants mentioned the need to seek medical attention for physical injuries suffered after beatings and rape – but, as the following section illustrates – such treatment was often denied to sex workers.

4.3.2. Sex workers' experiences of accessing healthcare

General challenges with the health system (particularly in public facilities) were noted – e.g. too many patients, not enough nurses to attend to them, long waiting times, medicine shortages, no transport to hospitals, etc. [Female SW, Kampala FGD16] Presumably these kinds of challenges would be faced by all patients, not only those who are sex workers. Of concern, the lack of money for transport and services and the shortage of medication in public facilities meant that even when sex workers tested positive for STIs, they could not be treated. [Female SW, Kampala FGD16]

In addition to these challenges, participants described many instances of poor treatment by healthcare providers who knew they were sex workers:

> "It's tough, especially when you suffer from an STI, they treat you like you just got what you deserve, and we end up using some traditional herbs because the traditional healers don't ask too many questions." [Female SW, Bulawayo IDI9]

> "…when you reach in the hospital in our place the health workers ignore you and if they decide to help you and attend to you they don't give you medicine, they prescribe the medicine for you and you buy it from the pharmacy." [Female SW, Kampala FGD16]

> "When I fell sick and went to a health centre and they realised that I was a sex worker, they did not treat me like a human being. When the health worker came to attend to me she said that I should go to the other health worker and when I reached the other health worker, I was told that he had no time for me so I left without getting treatment." [Female SW, Kampala FGD16]

This kind of selective treatment even at times applies to family members brought into the facility by a sex worker – as one recounted, she was pushed to the end of the queue when bringing her child in for treatment and attended to only after all other patients had been seen. Another participant recalled:

> "My child was sick and one of the health workers who knew me asked me 'How can your child suffer to this extent? The only thing you know is to sell yourself to get money, so get money and take your child to the hospital.' They really treated me in a way that was not good." [Female SW, Kampala FGD13]

Accounts of having to pay health workers additional money for treatment (effectively, a bribe) emerged in Uganda and Zimbabwe, where sex workers often had to pay extra for STI treatment.

Participants reported that when attending public facilities, the health providers generally ask what work they do, and – upon hearing that they are engaged in sex work – will interrogate them unnecessarily, asking questions that violate the sex worker's privacy. A Ugandan participant provided the following example:

> "One time I went to the hospital where they knew me and the health worker started saying, 'Imagine, a beautiful girl like you selling yourself. Why can't you get a man and get married?' Imagine, I was sick but that is what he had to say. I answered him, 'Do you think I'm very happy doing this kind of work? I have many problems and that's why I'm doing this work. Do you want me to come here and you give me a job of injecting people when I did not study it?' There was a way he was looking down upon me and I feared to go deep into what I was suffering from. He was asking me how much money I make in a day…" [Female SW, Kampala FGD13]

> "…you know STDs are very common in women, not only sex workers. But us sex workers, when you go to the hospital and you explain to the doctor that 'my genitals are itching' the first thing that the doctor asks in any hospital is 'what do you do for a living? How many men have you had sex with?' He does not look at what condition you are in." [Female SW, Kampala IDI2]

In another instance, a doctor – who had also previously been a client of the sex worker – revealed her occupation in front of her father who was seeking treatment at the facility. He told her:

> "You are a prostitute and I know you, you operate from Bwaise so you should take your father to a private hospital. Stop coming for free services because you have money. Men don't use you for free, they pay you." [Female SW, Kampala FDG13]

As this example illustrates, in many cases, health providers at public hospitals and clinics were simply described as "abusive" or "hostile". Another participant in the same focus group discussion said,

> "We are despised in the hospitals. They say, 'We don't have time for prostitutes' and they also say that if one prostitute dies then the number reduces." [Female SW, Kampala FGD13]

Gay male sex workers are often seen as a curiosity by some health care workers, which has led to violations of trust and confidentiality between patient and doctor:

> "One time I had a problem and went to Norvik clinic and I explained to the doctor and the doctor was like, 'Let me come back' and after five minutes I saw all the nurses coming and peeping in the room looking at me and going back. So when the doctor came back I asked him, 'Have you said anything to these people? So I don't have a right to confidentiality between me and you?'" [Male SW, Kampala IDI14]

This experience of humiliation was echoed by a sex worker in Hillbrow who identifies as a "she-male". The respondent recounted the following experience:

> "They raped me the whole night and not to pay me money. I go to report to the police they told me to go to the hospital and I was still wearing my jeans, wig and with my breast. When the doctor examined me and find out that I am a she-male he called other doctors and nurses. They left their work to come and see that a man got raped. I was like a mockery… The doctor told me I was not raped but I was sodomised because I am a man. The way I was dressing they said 'what kind of a woman?' I just walked from the hospital without being treated. It was not fair because I was raped the whole night." [Transgender SW, Hillbrow IDI9]

There were a few exceptions to this general picture, however: some described their relationship with nurses in public clinics as "good" [Female SW, Thohoyandou IDI10]. Others had had positive experiences while seeking treatment in public hospitals: "I had a cyst…I went to the hospital and they treated me very nice" [Female SW, Bulawayo IDI7]. A Ugandan sex worker who sought treatment for an STI at a government hospital reported having "a good reception" from the health workers, and being treated "like a general patient" [Female SW, Kampala IDI4]. It is likely that in many of these instances, however, the health workers were unaware that the women were sex workers.

In Hillbrow, virtually all sex workers mentioned using Esselen Street Clinic when they needed medical attention, HIV testing or treatment, contraceptives and other services. This is a clinic specifically for sex workers, which is run by RHRU, a large, established research institution located in the area. Health workers here were said to treat them well and have a "good attitude".

> "They treat you nicely. They do understand whom they are work with and dealing with…everything it's okay at Esselen." [Female SW, Hillbrow IDI5]

The only exception to this pattern was the experience of a male sex worker who had felt "badly treated" at Esselen, and had opted instead to see a traditional healer [Male SW, Hillbrow FGD23].

Similar sentiments were expressed by sex workers in Bulawayo reflecting on a new clinic providing dedicated services for sex workers[8]:

> "Lately, things have changed because of the new clinic that has opened for sex workers. They are friendly and they treat us in a respectful manner." [Female SW, Bulawayo IDI28]

> "It's generally safer for us to go to the sex workers clinic than to the public clinic where you will get people judging you or laughing at you because you are a sex worker or because you have an STI." [Female SW, Bulawayo FGD2]

Sex workers in Musina, Limpopo province, spoke of previously receiving services from a Médicins Sans Frontières clinic, where they were treated well and with dignity. Unfortunately, it would appear that this clinic has moved to more temporary premises (a tent in a field) and now allegedly treats only refugees newly arrived in the country. Sex workers in the town now need to turn to alternative health facilities, and there are few options where decent treatment can be obtained.

As indicated by aforementioned quotes, in some sites, sex workers sidestepped clinics and hospitals altogether and resorted to self-treatment or accessed the services of traditional healers instead. Others tried to be selective, avoiding particular facilities where providers are known to be cruel and stigmatising,

[8] The clinic is an initiative of ZAPP+ (Zimbabwe Association of People living Positively) and funded by UNFPA and UNAIDS, who are piloting sex worker clinics all over Zimbabwe. Sex workers have been trained as peer educators to encourage women to attend the clinic, which was opened in October 2010 in Bulawayo.

or likely to withhold treatment and ask too many questions. But a common solution to the poor services provided by public facilities – providing there was enough money available – was to access private health care instead. Almost unanimously, participants described these services as being of higher quality than public health services. They were also described as places where they were treated with dignity and respect, and where their confidentiality was protected.

> "They [the public clinic] made me sit for the whole day and they did not attend to me. The following day I went back and they still did not work on me so I decided to look for my own money and went to a private clinic." [Male SW, Kampala IDI12]

Private doctors were also reported not to inquire too closely about the work done by sex workers or ask other invasive questions – as their counterparts in public facilities do.

In many cases, health workers seemed also to be insensitive to the particular occupational circumstances of sex workers (or they were simply unaware that their patients were sex workers?), and would apply general rules relating to monogamous heterosexual couples, turning clients away if they could not comply with these expectations. In Zimbabwe, two respondents noted that the clinic did not want to treat them for an STI without bringing their partners along. One reported that his partner refused to come with him and when he went back to the clinic, he had to bribe the sister in charge to treat him [Male SW, Bulawayo IDI26]. These experiences were shared by others:

> "You see being a sex worker I can't really remember the faces of my clients but when I go to the clinic or hospital the nurses demand to see the last sexual partner I had, let's say I want to be treated for an STI so it makes difficult for me to start thinking the last person I had sex with. I end up seeking treatment from private hospital or go to traditional healers." [Female SW, Bulawayo IDI5]

> "When you go to the hospital the health workers say, 'We will not treat you unless you come with your husband'. We don't have husbands so we go to drug shops and buy some drugs to relieve us from the pain." [Female SW, Kampala FGD13]

In some instances, sex workers are blamed for their own illness:

> "My friend went to the hospital she was very sick and she found many people there and she was seriously insulted. They told her that she is the one who looked for her sickness because she went into sex work and they did not attend to her. She came back saying that she will never go back to the hospital according to the way she was mistreated." [Female SW, Kampala FGD16]

Not surprisingly, a common strategy in the face of such mistreatment was to simply not disclose to health professionals the nature of the work they were doing, since such disclosure was often met with the same response: "they despise us" [Female SW, Kampala FGD16]. Even when the reception from health workers is initially good, there is a fear that revealing one's status as a sex worker will have negative consequences.

> "…[the health workers] welcome me well, but the problem I have is that I cannot tell any of them that I do this kind of work, even when I have a chest pain I don't tell them the history of the pain even when I know that it's because of sleeping with men...When a health worker who doesn't know that you are a sex worker gets to know, it feels bad." [Female SW, Kampala IDI3]

> "I cannot go and tell a health worker that I have a genital problem when she doesn't know about my work. I expect to be abused and I have fear." [Female SW, Kampala FGD16]

A sex worker from Zimbabwe mentioned that he sometimes misrepresented his health problems in order to sidestep difficult questions about their origins:

> "There are some major STIs and there are some illnesses which we will be like when we have them and when we go to the clinic we will be scared to tell the nurse because they will start asking you, 'Where did you get it? How did you get it?' So it will be really painful for me to say I got it like this or I was doing this so I will end up lying which will make me not to get the right medication." [Male SW, Bulawayo IDI6]

Others recognised that non-disclosure was ultimately not a solution, and called instead for a facility dedicated to providing services for sex workers alone, so that discrimination would be eliminated from the picture altogether. Non-disclosure of sex worker status was recognised by some as having implications for the accuracy and effectiveness of treatment itself:

> "…because they cannot treat the real sickness. I also hide the reality and tell them other sicknesses but if there was a possibility of disclosing to them, I could tell them the truth and then they would give me proper treatment. But when you tell the health worker the truth that 'I had many clients last night and one of them broke my leg', he/she will throw you out of the hospital." [Female SW, Kampala IDI3]

These barriers also impact on sex workers' willingness to get tested for HIV. While it was claimed that some apparently refrain from testing due to "not knowing" that testing is needed, not knowing where to go or not having transport to get to a testing facility or money to pay for services, the discrimination, stigma and consequent isolation experienced by sex workers more generally clearly plays a significant role:

> "…many sex workers have tried to know their status whether they are positive or negative but what I know is that the majority are positive and the problem is that they have no one to comfort them or counsel them." [Female SW, Kampala FGD16]

Others described a form of "self stigma" leading to avoidance of testing, largely through fear.

> "They fear that if tested positive they will be mistreated [when seeking treatment]. Unless someone is strong they can go for testing but not all of us have strong hearts." [Female SW, Kampala FGD13]

Beyond this, however, lay more complex reasons relating to broader stigma against people living with HIV, which appears to be magnified for sex workers with HIV, even within the sex worker community itself. One participant in Uganda narrated a painful story illustrating this theme:

> "I had a friend who has just died a month back. She feared discrimination, not from the hospital alone but also among sex workers. When sex workers get to know that you are HIV positive, when they see you with a client they tell the client not to take you, that you are sick and you are on treatment. You may go with your friend for testing. Now when your friend gets to know that you are HIV positive you will fear to go to the hospital for treatment till you are ill because you wouldn't want your friend to notice you going for treatment. Like this friend of mine who has just died, she fell sick and you could tell by looking at her. I told her, 'Let us go to the hospital' and she just said she was suffering from malaria. Her mother realised that she was HIV positive when she was left with one week to die. And after that she died. But she feared to be discriminated against from all the people because discrimination is common... they begin gossiping, 'look at her, she is sick'." [Female SW, Kampala FGD13]

One participant in a FGD of male sex workers in Hillbrow noted that sex workers do not disclose their HIV-Status to colleagues as it might hurt their business:

> "We normally don't talk about this HIV thing. If you disclose, other people they close doors for you... clients won't buy you." [Male SW, Hillbrow FGD23]

There was no mention of sex workers ever being tested or coerced into testing for HIV or STIs against their will, except for three cases: in Uganda, Hillbrow, and Limpopo:

> "When my kid was sick I went to the clinic to get treatment. The nurse forced me to have an HIV test first before I could get treatment. I was very annoyed and I went back home without my son getting treatment. Then I ask my mother to take him back to clinic… I was afraid of being tested." [Female SW, Thohoyandou FGD1]

4.3.3. Accessing condoms and lubricant

Sex workers in virtually every site except Hillbrow reported difficulties in accessing condoms. In Kampala, sources include: the Red Cross, WONETHA, MARPI (Most at Risk Populations Initiatives)[9], hospitals and retailers (for bought condoms), but sex workers living in rural areas outside Kampala have severe difficulties accessing condoms. In situations where no condoms could be found or bought, sex workers even reported using expired or used condoms, or stopping work for a period of time:

> "…in Migyera we searched for condoms and failed to get them and we gave the job a break till we were [helped] by someone who came to town and brought for us some condoms…it took us four days without condoms and not working." [Female SW, Kampala FGD16]

In Zimbabwe, sex workers reported accessing condoms from the Sexual Rights Centre or from HIV clinics. Alternatively, condoms are bought from vendors selling them outside bars. Sex workers in Limpopo (in Musina, in particular) spoke at length about the challenges they faced in getting enough condoms – in particular, female condoms, which were almost impossible to source, although highly desired. Even male condoms were hard to come by, however, since health workers at public facilities usually restricted the number of condoms per person: "they give you one packet and say, 'Share that packet'." [Female SW, Musina FGD11]. One clinic in Musina was even reported to be selling government-issue condoms, rather than distributing them free of charge (as they should be). Also in Musina, a FSW reported an experience where these condoms were used as a bargaining tool by male health workers to secure sex:

> "There is one male worker [at the clinic] who bring condoms for me and ask me to have sex with him because he bring me something so I must have sex with him…. [it means] it's not for free, you have to exchange it with something." [Female SW, Musina FGD1]

Other places for obtaining condoms in Thohoyandou, Limpopo, included spaza shops [small independent trading stores] and petrol stations (for purchase), as well as local NGOs and even a police station (without charge), but these sources were unreliable at best.

Few participants reported having had direct experience of using lubricant, and in many cases, had never seen lubricant, nor did they understand its purpose. In Uganda, however, sex workers said they had been able to access lubricant from WONETHA in the past, and made a strong plea for improved and regular access.

[9] See: http://marpi.org/aboutus.php

> "My first time I saw it from WONETHA but the way it helped us we really liked it and we request for support that we get more lubricant because it made us happy." [Female SW, Kampala FGD10]

When asked how lubricant had helped them, their responses revealed just how important – from a health and wellbeing point of view – this commodity is to sex workers, and what a difference it would make to them if readily available.

> "No matter how big the man is he can still enter you… even if you go with ten clients in one night even twenty everything moves on smoothly…when you get lubricant you can even have sex with thirty clients because you don't get tired or feel anything you just feel fit." [Various female SW, Kampala FGD10]

> "You see that thing surprised many people, clients said that, 'We did not know that beautiful women existed in this place.' This lubricant makes you smooth and soft. When a client is entering you…this also prevents the condom from breaking." [Female SW, Kampala FGD10]

Male sex workers in Hillbrow also noted that lubricant is very important and that they use it all the time, although it has to be bought from pharmacies and is expensive. One respondent noted that "you can't buy it every day so we normally use lotion and Vaseline". [Male SW, Hillbrow FGD23] This is of concern as Vaseline and some lotions are oil-based lubricants and can destroy the integrity of latex condoms, thus increasing the risk of contracting STIs.

4.4. The future: sex workers articulate their needs and identify strategies for change

Participants emphasised the importance of local organisations dedicated to supporting sex workers and working together with them to advocate and seek legal redress when violations occurred. These organisations were recognised as playing a significant role in assisting and supporting sex workers in various ways, from supplying bail to release arrested sex workers to offering training and skills building.

> "…at the present moment we are being assisted by the Sexual Rights Centre, they hold workshops for us and it is through them that I have come to know my rights." [Female SW, Bulawayo IDI8]

> "We have a group of sex workers in WONETHA whom we are working with and they have helped us in forming our own group. We hope that in future we will get the ability to fight on because we can gather now. Another thing – we have been able to gather in a group which has attracted politicians who come to us seeking for votes, which implies that they see us as people who have value." [Female SW, Kampala FGD16]

> "I work with another sex worker who is involved in Sisonke and SWEAT. They work together, so she is the one who told me about my rights as a sex worker. That's why police is always telling me that I have a big mouth. She has a lot of knowledge." [Male SW, Hillbrow IDI19]

Some sex workers in Uganda reported having started up saving groups among themselves, where each member contributes money on a weekly basis, which is then distributed in a lump sum to individual members on a rotating basis (known as 'stokvels' in South Africa). While essentially a positive initiative, in that it encourages disciplined saving among sex workers, there were challenges in the timely payment of contributions and, in some cases, challenges in "the treasurer eating the money and promising to pay when her client comes" [Female SW, Kampala FGD13].

Several participants mentioned the need for unity among sex workers and the importance of self-initiated projects:

> "…if we are united we can do whatever is possible to ensure that people don't despise us…sex workers should get united we should also get a representative in parliament such that we can have a voice as sex workers. [Female SW, Kampala IDI12]"

> "…we should mobilise ourselves as sex workers and initiate projects because nobody will come from outside to help sex workers…we as sex workers should lobby for our own health facility which is well equipped and furnished with drugs. This will improve our health and welfare such that people look at us as people who are well off. Together we can." [Female SW, Kampala FGD16]

Male sex workers in Hillbrow noted the need for sex worker organisations to be more inclusive:

> "To open projects for sex workers they must include us gays because we want to learn more. They must not leave us, they must include us for the projects..." [Male SW, Hillbrow FGD23]

Aside from the political importance of initiatives to bring sex workers together and build unity among them, they were also described as important for psychological reasons:

> "…when we sex workers meet together, we discuss many issues and advise one another. We comfort ourselves and come with good ideas, which can help us and this makes us feel like we are also human beings and relieves us from stress." [Female SW, Kampala FGD16]

However, it is important to note that the inherent high mobility of sex workers may hamper the efforts of sex workers to form sustainable groups or collectives such as these. Several participants pointed out that while they would like such groups to form in their areas, it was unlikely to be successful because fellow sex workers moved around a lot (seeking out new client bases, mainly) and this would undermine the continuity and longevity of such groups. Additional challenges were posed by the threat – or reality – of police harassment:

> "It is difficult for us to have groups in my place because when police find out that there is a group of sex workers they can beat us and arrest us." [Female SW, Kampala FGD16]

The notion of sex workers being proactive and participating more fully and more visibly in broader community work – despite efforts to exclude them – came up in some focus group discussions. As one participant put it,

> "We should be part of community work and …and make sure you are not silent. Contribute and give advice – you as a sex worker, [so that] even when a person knows that you are a sex worker they will say, 'Ohh these people understand'." [Female SW, Kampala FGD13]

The theme of advising other sex workers to change their own behaviour – in particular, their way of dressing and their use of alcohol in public – and become more "disciplined" also emerged, however, particularly in the Kampala and Limpopo sites.

> "I call upon my fellow sex workers to change their behaviours in public especially with regard to immodest dressing and alcoholism because it portrays a negative image. In addition we should participate in village meetings perhaps this could touch people's hearts to change their attitude towards sex workers." [Female SW, Kampala FGD16]

> "Sometimes our dressing makes people suspect that we are sex workers. So let us try to put a cloth on top of our miniskirts not to advertise to our neighbours… we must dress better so that people will respect [us]." [Female SW, Musina FGD1]

Another advised that sex workers could earn the respect of the community by changing the way they talk, particularly in public:

> "We should learn how to speak well. The words that come out of us are not good so people have to discriminate against us because of the words we use. But if we want to associate with people we need to use good words which are fruitful." [Female SW, Kampala FGD13]

While this approach may have some short-term benefits, in the long-term it is problematic as it arguably lays the burden of responsibility for reducing the abuse inflicted by others at the feet of sex workers themselves.

A Limpopo-based sex worker regarded "self-respect" as the key to ending discrimination and abuse:

> "First you must respect yourself then respect your neighbours then do your work far from where you stay." [Female SW, Musina FGD11]

On a similar theme, one participant from Thohoyandou used an innovative approach to confronting abusive clients, which ultimately involved taking control of the situation and demanding respect – an approach that yielded results.

> "On the 31st of December l called some of my clients for a party at my house and l explained to them the bad things that they do to me and give me stress. I asked them how they would feel if they call me and l don't accept their calls….Some are now more than my clients, they are now like my friends or cousins. One day l met one of them at the shopping centre then he just greeted me and gave me R20 to buy drinks." [Female SW, Thohoyandou IDI1]

In terms of articulating explicit future needs, several participants made appeals that were directed at organisations currently working with sex workers.

> "Well, I have always wondered why the Sexual Rights Centre does not rescue us by paying school fees for our children..." [Female SW, Bulawayo IDI8]

Many participants called for training for sex workers to improve their skills and enable them to "do our work well" – Female SW, Kampala FGD16], but also training for police so that they

> "…know how to work with us, if they find us they should know that what we do is not bad and has no harm on anyone" [Female SW, Kampala FGD16]

Related to this was a call for sensitisation training with both police and health workers, to make them aware of how traumatic and hurtful their actions are for sex workers:

> "We are hurt but we are also human beings like them. We can report them if they keep on treating us like that. So this will help them understand that we have been silent not because we can't speak." [Female SW, Kampala FGD13]

There was also an appeal for English language classes, adult literacy training and broader skills training for sex workers themselves, "because most sex workers, we did not get good education" [Female SW,

Mombasa IDI21]. Others called for "support so that we can get connected with the local leaders and the police so that the give us peace and they stop harassing us" [Female SW, Kampala FGD16]

Sex workers in Limpopo spoke about needing "an organisation to stand for us" – as advocates, particularly with respect to offering legal assistance. There was a clear need for additional support and information about how to lay a charge etc.

> "I go to police station one day…I was telling them about the police that raped me. They asked me the name of the police, the rank and registration of the car. But I was not knowing any of these things." [Female SW, Thohoyandou IDI10]

> "We want to know more about our rights as a sex worker because police they always want to take us back to Zimbabwe when they arrest you." [Female SW, Musina FGD11]

Sex workers in Limpopo – but also elsewhere – called for organisations to assist in setting up microfinance schemes that would specifically loan money to sex workers so that they could start their own businesses. Interestingly, they also made a strong call for "a better place" and "a building" where sex workers (currently working from the streets) could live and work from in safety – effectively, a brothel:

> "[We want] to have a better place where there is security for a good safety, because clients will not treat us bad when we have rooms to use there – rather than to go to the bush with a client, it's very dangerous." [Female SW, Musina FGD11]

> "…a place like a motel where we can be based as that's a safe and secure place" [Female SW, Thohoyandou FGD1]

> "I support this of having a building because we are not safe, police beat us in the street…and when men come from drinking at night they also harass us in the street" [Female SW, Thohoyandou FGD1]

In terms of strategies to address barriers to accessing healthcare, there were many calls for 'sex-worker specific' facilities and services:

> "…we sex workers should be given our own hospital where we can disclose our status and what we are suffering from…a hospital where we can go and disclose and open up to the health workers." [Female SW, Kampala FGD16]

> "…there comes a time when you cannot even say what you are suffering from in the hospital because of discrimination, so what I am requesting also is that they get us a sex worker friendly hospital where we know that we will find our fellow sex workers and be able to disclose and open up." [Female SW, Kampala FGD16]

The need for information about health was strongly emphasised in Limpopo:

> "Bring an expert of health who can teach us about healthy issues so that we feel free to ask some of things we want to know." [Female SW, Musina FGD1]

One sex worker emphasised the need for the church to learn more about the context of sex work and to re-evaluate their approach to sex work:

> "…the church doesn't know much about me but the religious groups of course most of them – especially the born again Christians – they come and console you, pray for you, you have to change, you know that is a sin. But some of us have been open, that 'I don't need your prayers because I don't want to change. Maybe you could just pray for me not to change but to have a better environment for me to do sex work'." [Male SW, Kampala IDI14]

Importantly, several sex workers queried what this research would do to help them and emphasised the need for the results to be communicated to those in power.

> "Now that you have done this research and there is a lot we want our government to know, will the people who have spear-headed this research take our voices to the government?" [Female SW, Kampala FGD13]

> "For me, it's a recommendation with you people. So many people have done research with us and they just sit on this research. I could only recommend that if you come up with a report take it to relevant people, to the members of parliament, to whoever needs to know." [Male SW, Kampala IDI14]

Lastly, we would like to end with some of the messages voiced by sex workers in the study that were directed at the authorities, including strong calls for the decriminalisation of sex work:

> "I can say to the police they must stop stealing from us, they must let us work and make money and look after our families…I also want the government to leave sex workers alone, they must know we are trying to earn a living" [Female SW, Bulawayo IDI8]

> "I would like to say the government must legalize sex work because we are earning a living through it they must respect us and the police and must stop making us pay bribes." [Female SW, Bulawayo IDI9]

> "Firstly I would like them – whoever is in charge – must make this job to be legalized. We must be treated fairly. They must take sex work as a normal job... We must find more and more people to talk for us." [Female SW, Hillbrow IDI5]

> "If sex work is allowed you would be working freely just like other jobs and you cannot be stigmatized by the community and police." [Female SW, Hillbrow IDI24]

The final word must go to a sex worker from Kampala, who made an impassioned plea at the close of her interview:

> "If we could have a big voice and tell the government that we are also women, we are voters, parents and we are your women. When we can speak for ourselves and come out and challenge some of the laws and we say: if you are discriminating against us in your hospitals, we are going to have our own hospital and if you are discriminating against us in your churches, we are going to have our own churches. But the best thing would be working together because we are from one country, same blood. Because when you discriminate against someone this brings a lot of pain in someone's heart and this can lead to death. Everyone needs to be loved." [Female SW, Kampala IDI9]

Chapter 5: Conclusions and recommendations for advocacy

Across all four study sites, sexual violence, physical beatings, arbitrary arrest and extortion/bribery are among the most common violations inflicted on sex workers by police. Many sex workers have had repeated experiences of such violations and have come to expect them as par for the course in their work. Importantly, however, wherever possible they have also developed strategies to avoid, trick or even confront the police, in some instances challenging them directly and asserting their rights not to be violated. These examples, although few, are encouraging signs that sex workers in the four countries studied here may be drawing courage from the growing movement in the region to advocate for sex workers' rights. ASWA clearly needs to build on these signs of incipient resistance and continue to work with sex workers in each country, increasing their capacity to leverage collective forms of support – rather than attempting to confront authorities as lone individuals.

This study further found evidence of a wide range of people on the fringes of the sex industry (and beyond it) who commonly take advantage of fact that sex work is criminalised and that individual sex workers are deeply vulnerable to extortion and exploitation. Perhaps because sex workers sell sex for a living, sex itself has come to be seen as a 'currency' of exchange for other favours. When it is clear to landlords, bar staff, security guards, pimps, club bouncers, and others that sex workers *need* assistance (a room to live, a few days' grace in paying their rent, protection from a violent client, the ability to enter or recruit clients in a bar/club/hotel without being harassed by staff, etc.), the response is often to demand sex or money from these sex workers, in exchange for assistance.

This pattern is not unrelated to the thinking surrounding sex workers and rape, where the assumed frequency of sex workers' sexual interactions with clients – and the fact that they receive money for these services – is somehow assumed to negate sex workers' very right to assert their own wishes or refuse consent. This logic also somehow renders it 'legitimate' for them to be abused: the oft-heard refrain that "sex workers *cannot* be raped" is one that emerged in this research in various iterations. Such attitudes are perfectly encapsulated in the kinds of verbal abuse and name-calling experienced by many sex workers in this study – particularly those that characterise sex workers as somehow "less than human". After all, a person who is perceived to be "not human" cannot demand that their basic human rights are respected. Neighbours, family members, religious institutions and the broader community bear substantial responsibility for entrenching these perceptions of sex workers as undeserving of human rights, and must be included in future endeavours to raise public awareness of the effects of abuse suffered by sex workers.

Sex workers' attempts to practice safe sex are successful only to a point. They are frequently thwarted by unscrupulous and violent clients and regular partners, who either force or trick sex workers into sex without a condom. In this respect, their experiences seriously challenge the notion – still prevalent in the public domain, particularly in east Africa – of sex workers as 'vectors of disease' or 'spreaders of HIV'. Evidence shows that they try their level best not to be so. Alarmingly, sex workers in Uganda mentioned the impending introduction of a new law that specifically criminalises sex workers found to be HIV positive. Whether this law is indeed imminent or merely the product of rumour is unclear, but it flags the continued peddling of disturbing attitudes towards sex workers in the public sphere that need to be urgently addressed by activists working in tandem with the sex work community itself.

In terms of access to health services, this study found that stigma and discrimination against sex workers was widespread, particularly in public health or government services, where it was common for sex workers (once their occupational status became known) to be ignored, denied treatment, shouted at, insulted, chased away, or – particularly in the case of male and transgender sex workers – treated as a curiosity for other health providers to gawp at. There were important exceptions, however, with a handful of participants reporting receipt of respectful and satisfactory treatment by health workers (mainly from those in the private not-for-profit sector). Strong calls by sex workers for health facilities established to specifically serve only members of the sex worker community should be heeded – but with some caution. There remains the potential for such dedicated facilities to become stigmatised in themselves if attitudes in the broader society remain unchanged.

This study highlights yet again the importance of a rights-based approach to public health interventions with sex workers, and indeed with HIV more broadly, which directly addresses the disempowerment of sex workers in the region. The health sector needs to embrace the human rights approach to sex work and HIV, rather than being content with an outdated disease control model, which is strongly linked to a moralistic approach to sex work. Sex workers and sex worker-led organisations and collectives need to be at centre-stage in this response, as full and active participants, taking control of advocacy to reduce stigma and to demand access to health services as any other citizen would enjoy.

5.1. Recommendations relating to research methods

- Supervision of research 'at a distance' works best when there is good **local support from host organisations** at the site where data are being collected. In the absence of such support, individual researchers are forced to work alone – very difficult for any researcher, but in particular for inexperienced researchers.

- The model of using sex worker **peer educators** as researchers/interviewers on the ground also works best when these individuals have **high intrinsic motivation** to learn from the research process and to complete the task within agreed-upon timelines. Such individuals would benefit from future research exposure and would likely be able to take on more responsibility and independence in the process. The converse also holds true (i.e. for peer educators with low motivation or interest in doing research).

- **Training of peer educators** to prepare them to carry out research should ideally be structured to (1) allow for a thorough familiarisation with the research methods to be used, (2) clearly convey the procedures and logistics of the study itself, and (3) include a practical exercise to enable peer educators to apply newly-learned research skills under close supervision. These components are likely to require no less than 5 days of continuous training.

- Decisions relating to application for institutional **ethical approval** need to be made early on in the planning stages of the project, as these processes can often markedly delay the carrying out of data collection.

5.2. Recommendations for future advocacy initiatives

Human Rights Violations

- Continued, and increasingly collective, engagement with the police and related authorities remains important, with an urgent need for **sensitisation and 'values clarification' training of the police**. This aims to raise awareness of sex workers' lives, their struggles for financial survival and their daily vulnerability to various forms of abuse. Sex workers themselves should be integrally involved in these training exercises, thereby reminding police of **sex workers' agency** and also serving to 'personalise' the industry and help to break down stereotypes of sex workers as fundamentally 'immoral'. Pilot projects documenting the success of such an approach are long overdue.

- Areas with large populations of sex workers who are **foreign migrants** require additional support from sex work organisations to tackle the specific heightened challenges faced by these sex workers and to implement targeted interventions with local police to reduce xenophobia.

- There is enormous value in **human rights training for sex workers**, enhancing their overall collective empowerment, as illustrated by the more confident, assertive approach of individual participants towards seeking redress for violations and claiming their rights in study sites where such training has been ongoing for some time (e.g. Hillbrow and Kampala).

- Such human rights training needs a stronger focus on **clarifying current and planned legislation pertaining to sex work**, in order to pre-empt the spread of misinformation and confusion within the sex work community and instead empower it with up-to-date knowledge on legal issues. Sex workers taking steps to assert their rights, will, in almost all instances, require strong support from sex worker organisations to redress violations.

- Special efforts are needed in Uganda and Kenya to further document and address the apparent pattern of **long-term detention** of sex workers in prison, often without trial.

- Broad social **stigma** against sex workers can be countered, to some extent, by initiatives to engage with **journalists** and discourage their continued use of negative stereotypes of sex workers in the media, which ultimately fosters a climate for ongoing abuse. Initiatives that pair up individual journalists with sex workers wishing to develop their writing and documentation skills would be one way to achieve this.

- **Collective activism** – in the form of sex worker led groups – remain important strategies for building sex workers' resilience and solidarity with one another and creating a stronger platform from which to effectively challenge human rights violations. These groups are potentially undermined by **jealousy** and competition between sex workers, and by the high **mobility** that characterises sex work in Africa. ASWA (and its affiliates) needs to pay special attention to these challenges and pre-empt them, wherever possible, through early outreach activities prior to the establishing of new sex worker groups.

- Deliberate efforts are needed to include **male and transgender sex workers** in collectives to organise and capacitate sex workers to claim their rights. Whether or not mixed gender collectives are appropriate will depend on the context and setting; outreach and **mapping** activities involving local sex worker communities will help to answer this question.

- Decriminalisation of sex work does not necessarily mean de-stigmatisation. What is needed in addition to this is coordinated **advocacy** and information to change the attitudes of health care workers and law enforcement authorities but also the **broader community/general public**.

- Advocacy efforts need to specifically target **religious institutions** and build alliances with those sympathetic religious institutions which *do* exist, in particular those that recognise and offer support to other marginalised groups in society. This may offer a basis for dialogue about sex workers as similarly marginalised and in need of protection and support, not persecution.

- Organisations already engaged with the sex worker community could explore the possibility of extending their **skills building** efforts to include **micro-finance** schemes, as well as **literacy** and **English language** training for sex workers. This recommendation is not intended to promote 'exit strategies' for individuals to leave the sex industry, but rather to encourage a basis for empowerment more broadly, building confidence and capacity, and minimising the dependence on earnings from sex work alone.

- Future research on human rights violations against sex workers needs to address the question of how "**consent**" in the context of **rape** is defined and understood by sex workers in different settings. Activists should be sensitive to the possibility that these understandings are not necessarily aligned with their own approaches to this issue.

- ASWA could consider forging strong links with equivalent entities in **Asia** (Thailand and India in particular), and share experiences and approaches to engaging with authorities and winning their support for sex workers' rights. There is much to be learned from the considerable successes (and longevity) of these organisations, and knowledge exchange would doubtless be bi-directional.

Health Access

- **Training** is required for **health workers** to sensitise them to the specific health needs of sex workers and the inappropriateness of interrogating sex workers about what they do, when they should be treated like any other patient. Wherever possible, sex workers themselves should be involved in – and even lead – these training initiatives.

- Training of health providers alone is not sufficient for changing the current situation in the long term, however. There is a need for further engagement higher up, at a more '**structural'** level – through initiating **dialogue** with the relevant **Ministries of Health** in each country. In particular, sex worker organisations and their allies could (1) share the results of this study with health authorities in the Ministry, and (2) lobby them to review – and improve – current policy and practice relating to the provision of health services for sex workers.

- Among the possible focal areas for **lobbying** of health authorities is the need for strengthening and updating of current approaches to **STI diagnosis and treatment for sex workers**, which appear to be inadequate at present. A case could be made for implementing 'periodic presumptive treatment' [PPT], an approach likely to be recommended by the World Health Organisation in its forthcoming Guidelines on Interventions among Sex Workers.

- A second area for lobbying could be the urgent need to address **sex workers' fears** of and reluctance to access **HIV Counselling and Testing** (HCT) services. A rights-based approach is needed

to inform any initiatives to increase uptake of these services, with special attention paid to ensuring that sex workers receive sensitive counselling, emotional support, and high-quality treatment and care for those testing positive.

- **Dedicated sex worker clinics** appear to be most successful in the settings studied (where they exist), and many more additional clinics are required – at least in the interim, until attitudes in health facilities for the general population can be adequately shifted. These dedicated clinics need to be as **inclusive** as possible, providing high quality services for female, male and transgender sex workers (the needs of the latter two groups tend to be overlooked).

- **Health outreach** is needed to reach sex workers who have lost trust in the health system and who, quite rightly, perceive health workers as hostile and abusive. Ideally, these programmes need to target **clients** as well as sex workers.

- Concerted efforts are needed to ensure that sex work settings have a reliable stock of **condoms**, especially entertainment establishments such as bars, clubs, hotels, and taverns. Health outreach, mentioned above, could be one strategy to improve condom access for sex workers, and to win the support of owners and staff members at these venues. A clearly neglected issue, which is likely feasible to address in many settings, is the distribution of **lubricants** and the **female condom**.

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Appendices

Appendix 1: Informed Consent Forms

Consent to participate in an interview

Title of Study: Sex workers' experiences of human rights violations and barriers to accessing healthcare in six African countries

Principal Investigator: Fiona Scorgie, University of the Witwatersrand, South Africa
Phone number: 082 533 9645 or 011 704 6325
Email address: fscorgie@gmail.com
Sponsors: Ford Foundation; African Sex Worker Alliance (ASWA); Sex Worker Education and Advocacy Task-team (SWEAT)

City: **Date:**

Hello, my name is _____(filled in by Interviewer) and I'm a peer educator conducting research for the African Sex Workers Alliance (ASWA), together with the Sex Worker Education and Advocacy Task Team (SWEAT). This research is being conducted to learn more about the experiences of sex workers in Africa who have suffered human rights violations and to document obstacles or barriers sex workers experience to accessing healthcare. The information gathered by this research will help organisations working with sex workers to monitor trends and improve the services they offer. It will also serve as a basis for an advocacy campaign to mobilise support for sex workers' health and human rights.

You are being invited to take part in this research. Participation is entirely voluntary. I will now explain the aims and procedures of the study and answer any questions you might have about it. You will be given a copy of this information form to keep, and can ask me questions about the study at any time.

What does the study involve?

The study does not involve any treatment, tests, collecting of blood samples or counselling; it only collects information in order to improve our understanding of the experiences of sex workers. The research is being carried out simultaneously in South Africa, Zimbabwe, Mozambique, Uganda, Kenya and Nigeria.

The study will collect information from between 20 and 25 male, female and transgender sex workers in each country who agree to be part of the research. Each sex worker will be interviewed once only. These interviews will involve discussion of their experiences of work, of health services that are accessed, and of personal experiences of human rights violations.

If you agree to participate in the study, you will be interviewed by me, either alone (an individual in-depth interview) or in a group (a focus group discussion). At the end of the interview, you will be asked to fill in a brief, one-page questionnaire that includes basic demographic questions about you and your work. This questionnaire will take approximately 10 minutes to complete.

I will then continue with the interview (either individual or in a group), which will take between 40 minutes and an hour and a half. The conversation will be tape-recorded but if you feel uncomfortable with this, you can request that the conversation is recorded by way of hand-written notes only. In the interview, I will ask you what you think about different subjects. There are no right or wrong answers; we want to learn more about your experiences, thoughts and opinions. You have the right to refuse to answer any questions that make you feel uncomfortable. If at some point

during the interview you wish to stop for any reason, please tell me and I will respect your wishes and privacy. If you wish, the partially completed interview can be immediately destroyed and will not be used in the study.

Participation in the study is entirely voluntary.

You may refuse to join, or you may withdraw from the study at any time, for any reason, without any consequences (for example, any health or social service that you are currently accessing will not be affected).

Risks and benefits

I will be asking you some personal questions about your life and your work. You may experience some embarrassment or discomfort in discussing these and other sensitive topics in the interview. Some of the questions in the interview are about experiences of violence and abuse that may be emotionally difficult or painful to talk about. If you feel that you would like to speak to a counsellor about some of the information discussed in the study, please let me know and I will arrange this support for you, as a free service.

While absolute confidentiality cannot be guaranteed, every effort will be made to keep personal information confidential. If required by law, the research team will have a legal obligation to disclose information from this study to the authorities, but the likelihood of this happening is extremely small.

Research studies are designed to obtain new knowledge. It is hoped that information obtained in this study may help the broader sex worker community in the future. As an individual, you might not receive any direct benefit from being in the study, but your contribution may help to improve legal and health services offered to sex workers in your country. As a reimbursement for the cost of refreshments during or after the interview, you will be offered a R30 voucher redeemable at a supermarket where you live.

How will your privacy be protected?

I will not ask where you live, although questions about where you work will be asked to improve our understanding of how mobile sex workers are. No photography or video-recording will be used in this study.

All the information that you provide on the questionnaire and in the interview will be given anonymously: your name is not recorded anywhere else except on this informed consent form. When your comments are used in reports and other publications resulting from this research, your name will not be used. Instead, your comments will be attributed only to a fake name, which you may choose yourself if you wish. Information collected in this study will be sent to the principal investigator (who is based in South Africa), for analysis. She will keep all the information safe and will respect the rights of participants to remain anonymous.

To indicate that you have understood the nature of this research and that you voluntarily agree to participate, we will request that you sign an 'Informed Consent' form, using your full real name. To protect your confidentiality, this signed form will be kept separate from the questionnaire that you fill in, and from all other information collected in the interview. In this way, nobody (aside from me) can link what you say to your name and other personal information.

If you take part in a focus group discussion, you will be interviewed together with other sex workers who have agreed to be part of the study. This means that what you say during the focus group discussion will be heard by others. All participants in the focus group discussion will be asked to respect the confidentiality of other participants, but there is no guarantee that this will happen once the discussion is over.

How will the information be used?

The information gathered from this survey may be published or disseminated in the media. It will be used as the basis for a report and publication that will be available to the general public, donors, non-governmental organizations and government agencies. Research results will also be published in academic journals.

When the research is completed, you can find out more about its conclusions by giving the researcher a postal address or email to which they can send a written copy of the final report. The report will also be available on-line on the ASWA and SWEAT websites from March 2011: http://africansexworkeralliance.org/ and http://www.sweat.org.za/

Do you have any questions about the study?

If you agree to participate in this research, please say the following sentence out loud and sign below: **"Yes, I fully understand the information provided to me about this study and I voluntarily give my consent to participate in it."**

_____	_____	_____
Participant Signature	Participant Name	Date

For researcher to complete: I confirm that the consent information was accurately explained and that the participant apparently understood the information, and freely gave her/his consent to participate in the study.

_____	_____	_____
Researcher Signature	Researcher Name	Date

If you have questions about your rights as a research participant, or concerns or complaints about this study, please contact the following people who are part of the independent Ethics Review board that has reviewed this study:

- *Prof. Peter Cleaton-Jones* - Chairperson of the Human Research Ethics Committee (HREC), University of the Witwatersrand (Tel: +27 11 717-1234) Email: Anisa.Keshav@wits.ac.za
- *Anisa Keshav* - Research Ethics Committee Administrator (Tel: +27 11 717-1234) Email: Anisa.Keshav@wits.ac.za

If you have further questions about the study itself, please contact the following people who are directly responsible for its implementation:

- *Fiona Scorgie* - Consultant supervising the research (Tel: +27 82 533 9645) Email: fscorgie@gmail.com
- *Eric Harper* - Director of SWEAT (Tel: +27 12 448-7875) Email: eric.harper@sweat.org.za

Consent to have interview audio-recorded

Title of Study: Sex workers' experiences of human rights violations and barriers to accessing healthcare in six African countries

Principal Investigator: Fiona Scorgie, University of the Witwatersrand, South Africa
Phone number: 082 533 9645 or 011 704 6325 **Email address:** fscorgie@gmail.com

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City: **Date:**

Note: This form is to be read out to the participant after s/he has consented to participate in the research.

Why do researchers wish to record the interviews they conduct?

Researchers often audio-record interviews in order to have a reliable and accurate record of what was said by the research participant. It is very difficult, if not impossible, for researchers to remember everything that was said during an interview, but having a recording of the conversation means that they can go back to the tape and replay the conversation to check it. After the interview is over, audio-recordings are usually transcribed. This is a process where someone listens to the tape very carefully and types up every word that was said by both the research participant and the researcher, which is then used for analysis.

Use of audio-recording in this study

All interviews, both individual and group discussions, will be recorded in this study, providing research participants provide their consent for it. The recordings of all the interviews will then be transcribed by someone other than the researcher who has been hired for this purpose. The transcriber will not have access to your name or to your filled-in questionnaire, and will have had prior training in maintaining confidentiality of research data. To further protect your confidentiality, this signed form will be kept separate from the interview transcript and from the audio-recording itself. If the interview is not audio-recorded, I will need to write notes while you speak. These notes will be treated in the same way as an interview that has been recorded and transcribed. Audio-recordings of interviews will be safely stored for a minimum of 2 years after publication of the study's results or 6 years in the absence of publication. Thereafter they will be destroyed.

As a participant **you have the right to refuse to have the interview recorded**, for whatever reason. If you would prefer not to have it recorded, please tell me and I will respect your wishes.

Do you have any questions about the process of recording your interview?

If you agree to have your interview audio-recorded, please say the following sentence out loud and sign below: **"Yes, I fully understand the information provided to me about this study and I voluntarily give my consent to have the interview audio-recorded."**

_____	_____	_____
Participant Signature	Participant Name	Date

For researcher to complete: I confirm that the consent information was accurately explained and that the participant apparently understood the information, and freely gave her/his consent to record the interview.

_____	_____	_____
Researcher Signature	Researcher Name	Date

Appendix 2: Brief self-administered questionnaire on socio-demographic details

Date _____ Participant No. | | | |

This questionnaire forms part of a study being done by the African Sex Worker Alliance (ASWA and the Sex Workers' Education and Advocacy Taskforce (SWEAT) on sex workers' experiences of human rights violations and barriers to accessing healthcare in Africa. The research will help these organisations to monitor trends and ensure appropriate follow-up when assisting individuals who have requested their help. Your confidentiality will be protected. You do not have to provide your name or details of where you work if you are not comfortable doing so. When the study is published, no names or identifying information will be used.

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1. Age: _____ **2. Number of children:** | | |

3. Gender (tick one box):

Female		Male		Transgender	

4. City/village and country where you were born _____

5. What is the highest level of education that you have <u>completed</u>? (tick one box)

Primary School	
Secondary School	
Post-secondary school diploma	
University (degree)	

6. Which parts of the city (or outside of the city) do you mostly work in? _____
_____
_____

7. Which of the following settings do you mostly work in? (tick as many as applicable):

Bar/club	
Escort/ massage agency	
Street	
Brothel	
Hotel/flat	
Home	
Other	

→ Please specify: _____

8. Do you currently have a regular partner, boyfriend/girlfriend or husband/wife?

Yes		No	

9. How many clients did you have:

In the last day you worked	
In the last 7 days	

10. How long have you been working as a sex worker?

Months		Years	

11. At what age did you first start this work? _____ years OR date: _____

12. Do you have a source of income aside from sex work?

Yes		No		Sometimes	

Appendix 3: Interview guides for semi-structured individual interviews and focus group discussions

INDIVIDUAL IN-DEPTH INTERVIEWS: INTERVIEW GUIDE

Working environment & healthcare context

1. Can you tell us how you work and where you do business? Is sex work a full-time occupation for you? Do you only do it when you need extra money?
2. What are the good things about working this way? And the bad things?
3. In the last 3 months, what have your most urgent health needs been? (**probe** for common illnesses, STIs, trauma injuries, HIV-related illnesses, reproductive health, etc.)
4. Where did you go to have these needs met? (**probe**: private, public, clinic, hospital, etc.)
5. What was the outcome? How were you received by the service provider? What was the attitude of the service provider?

Legal & policy context

1. What do the laws in your country say about sex work?
2. Can you tell me how the laws have been used against you as a sex worker or other sex workers that you know?
3. Can you give us examples of how you personally have experienced different people using the law against you? (**Probe** for the following)
    - By the people you work for/ bar managers/ nightclub owners?
    - By the police
    - By clients
    - By the community
    - By boyfriends/regular partners
4. Are there any laws and policies directly related to HIV and AIDS that you know of that affect you in your work?

Human rights

1. Have you ever experienced being discriminated against, abused or treated differently because people know you are a sex worker? If so, can you tell us about these experiences?
2. Do any groups of people threaten your safety? If so, who?
3. What are the ways they threaten your safety the most often?
4. Have you been forced to pay off police or anyone else in the past year? If so, who?
5. Have you ever been arrested or fined for sex work?
6. Have you ever been detained or kept in police cells or prison for sex work? If so, for how long?
7. Have the police ever threatened you with violence? If so, please explain.
8. Have the police ever been physically violent to you or forced you to have sex against your will in the past year? How often?
9. Has anyone else been physically violent or verbally abusive to you in the past year? Who were they? (Again, **probe** for the following)
    - The people you work for/ bar managers/ nightclub owners
    - The police
    - Clients
    - Service providers
    - Landlords
    - Club management
    - Other sex workers
    - Members of the community
    - Boyfriends/regular partners

10. Has anyone else forced you to have sex against your will in the past year? Who were they?
11. Have you experienced any abuse in your workplace (Probe for: fining, excessively long working hours, agencies taking large cut of earnings, physical or verbal abuse)
12. What course of action have you taken in any of these instances, if at all? And with what effect/outcome?
13. As a sex worker, how have you been treated by the Church/church community/religious groups? What impact has the Church's viewpoint had on your ability to access your rights?

FOCUS GROUP DISCUSSIONS: INTERVIEW GUIDE

Accessing healthcare

1. Where do most sex workers access the health care they need? What kinds of services can you get there?
2. Have you ever experienced problems in accessing health services for yourself or your children when the people you approach know you are a sex worker? If yes, please tell us more.
3. Do you generally disclose the nature of your work to healthcare providers?
4. Do most sex workers that you know, know their HIV status? If not, why not?
5. Do most sex workers you know get tested for STIs? If not, why not?
6. Have you ever been tested for HIV or STIs against your will? Please tell us more.
7. Have you or other sex workers you know been able to access medical treatment for STIs or HIV if and when needed? If not, please tell us more.
8. Are you or other sex workers you know able to get as many male and female condoms as you need? If not, why not? Where do you usually access condoms from?
9. Have you ever faced the problem of condom shortages? If so, for how long and what did you do?
10. Is there lubricant available in your country? Are you able to get as much water-based lubricant as you need for work?
11. Are there any projects or programmes that you know of that are against sex work? If so, how do they affect you?

Strategies to improve rights and sexual health

1. What do you think sex workers themselves can do to end discrimination and violence against sex workers and improve health and safety in sex work?
2. Would it be easier or more difficult to achieve changes if sex workers cooperated together as a group? Please explain.
3. If you are already working with other sex workers can you tell us what you have achieve, what the difficulties are, and what your future plans are?
4. Who do you see as allies of the sex worker community (individuals or organisations)?
5. What kinds of support and resources do you think you need to organize as sex workers? **Probe** for:
    - Resources (people, money, organisations, infrastructure)
    - Information
    - Skills
    - Partnerships