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INVESTIGATIING SOCIAL NETWORK PREFERENCES OF SEX WORKERS IN HILLBROW AND THEIR SEXUAL HEALTH PRACTICES

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A research report submitted in partial fulfillment of the requirements for the degree of Master of Arts by Coursework and Research Report in the field of Psychology in the Faculty of Humanities, University of the Witwatersrand, Johannesburg

DECLARATION

I declare that this research report is my own, unaided work. It is being submitted for the degree of Masters of Arts in Psychology by Coursework and Research Report at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Signed  on this day 10 June 2014.

Jabulile Patricia Sibeko

DEDICATION

To my late father Mr. Thamisanqa Montgomery Sibeko (29 July 1948 - 28 June 2010). Gone but never forgotten. You remain forever in my heart.

My mother Sr. Nester Ntombikayise Sibeko, I did not choose you I was allocated to you by forces beyond my own comprehension, you have been my anchor, my motivator, and no words could ever describe my gratitude-am so thankful to still have you. I love you beyond measure. My father Thamisanqa Montgomery Sibeko (Daddy) whom I lost during this process, I am who I am because of you. You instilled independence, “take no-nonsense approach”, love and kindness in me- qualities I will forever hold dear. You live in my heart and no man will ever measure up to you.

My son Tebogo Qhawelami Nokaneng my hero, my purpose for living I trust that you will live up to be a great man despite all odds you are surrounded by love and trust. In your yearning for a father I pray that you find solace and comfort in the men who are present in your life. It will never replace the love of a real father that you deserve- but God is all the father you need! And you have me forever!

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ABSTRACT

This research investigated harmful vaginal practices of female sex workers (FSW) in Hillbrow including the products they used to dry, tighten and cleanse the vagina. The main objective of the study was to understand the practices they engaged in, as well as to explore their beliefs and motivations for engaging in those practices and what the implications of introducing vaginal microbicides to this population will be and understanding their social networks. This research is crucial in understanding factors that contribute to HIV acquisition. Past research has indicated that the prevalence rates of HIV amongst sex workers tends to be higher than in the general population due to the nature of their work, therefore it is important to understand structural and behavioural factors that lead to increased susceptibility. In this study, purposive sampling was used to obtain a sample of FSW; and a total sample of 10 was reached from a private house in Hillbrow. The participants ages ranged from 21-43; and all women were self- identified sex workers. The study was qualitative in nature, employing in-depth interviews as the main method of data collection. All interviews were conducted in local languages of choice namely: English, Zulu and Sotho. Data were transcribed, translated and analysed thematically using scientific software Atlas Ti, Version 6.0. Key themes were drawn namely, sexual practices, social networks, life histories, and sex work health. Motivations for engaging in vaginal practices included: cleansing the condom content from the vagina, creating more competition, cleansing sperm after condom-breakage, to keep clients returning, to stop bleeding when on periods and to make sex nicer. Practices included washing with traditional and non-traditional products. The study demonstrated that there is still limited information regarding health risks that lead to higher levels of HIV acquisition. To address these it is important to understand a varied number of factors such as culture, behaviour, and psychosocial factors. Further, educational, prevention and empowerment interventions need to be developed incorporating key messages about harmful practices. At a national level, government educational campaigns and policies need to address this issue in relation to the unequal distribution of power between men and women, create equal opportunities and devise socio-economic solutions.

Key Words: *Sex work, Sexual practices, South Africa, Hillbrow, Social network*

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BMGF	Bill and Melinda Gates Foundation
BV	Bacterial Vaginosis
DALSA	Disseminating Avahan Lessons to South Africa
DoH	Department of Health
FHI360	Family Health International 360
FSW	Female Sex Worker
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRMSM	High Risk Men who Have Sex with Men
HSRC	Human Sciences Research Council
HTA	High Transmission Area Program
IEC	Information Education Communication
KP	Key Populations
KZN	KwaZulu Natal
LRMSM	Low Risk Men who have Sex with Men
MARPS	Most At Risk Populations
MMP	Migrant Mobile Populations
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NGO	Non-governmental Organization

NSP	National Strategic plan on HIV, STI and TB (2012-2016)
PWID	People Who Inject Drugs
SA	South Africa
SALAC	South African Law Commission
SANAC	South African National Aids Council
SNT	Social Network Theory
STI	Sexually Transmitted Infections
SWEAT	Sex Work Education and Task Force
UNAIDS	Joint United Nations Programme on HIV/AIDS
WRHI	Wits Reproductive Health and HIV Institute
WHO	World Health Organization

GLOSSARY

The terms defined below are specific to the study at hand and have been defined in terms of how they are used in this study:

Key word	**Definition**
Brothel	A house or other place where men pay to have sex with sex workers.
Private House	A term used in the study to de-stigmatize the word "brothel" but means the same as above.
Sex Work	UNAIDS definition "female, male, transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally and who may or may not consciously define those activities as income-generating" In this study it means women over the age 18 whose primary source of income is sex work. Also this term is preferred over the use of prostitute as it is stigmatizing.
Sexual Practices	In this study the definition includes practices such as external and internal vaginal washing, dry sex, intra-vaginal practices, oral and anal sex, and insertion of products.

Social Networks	This definition may differ according to discipline; however in this study they are defined as one's immediate points of contact they can include other sex workers, friends, family and clients.
Women	This term is used throughout the study to refer to the sex workers as it recognizes them as women first before they are sex workers.

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CHAPTER 1

INTRODUCTION

1.1. Sex Work

Sex work as a term is said to have emerged in the late 1980s and early 1990s as an alternative usage to the word “prostitution” in order to demonstrate a certain acceptance of sex work as work, instead of further stigmatizing those involved in it (Busza, 2006). Since the beginning of the Human Immunodeficiency Virus (HIV) epidemic, sex workers have been identified as the population at greatest risk of acquiring and transmitting HIV and other sexually transmitted infections (STI) due to reported high rates of sexual partner change, (Morison, Weiss, Buve, Caräel, Abega, Kaona, Kanhonou, Chege, & Hayes, 2001) which may overlap in time, as well as their inconsistent use of condoms. Sex workers are often regarded as “core reservoirs of STD and HIV infection” (Pettifor, Beksinka, Rees, 2000 p.36 as cited by Richter, 2008) and further viewed as “vectors or source of disease” in (Dorf, 2006 p.14; Delany & Nielson 2000 p.1 as cited by Richter, 2008). However, in this study herein the focus was on lessening any stigma, judgements and discrimination attached to this population of study and rather viewed sex workers “as part of the solution to halting the HIV epidemic” (Marten, 2005 p. 21).

Sex workers have been defined by the United Nations Programme on HIV/AIDS (UNAIDS) as “female, male, transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally and who may or may not consciously define those activities as income-generating”(Grover, 2010 p. 6). This definition is too broad, it is noted however that no single term may adequately cover the range of transactions worldwide that involve sex work (Grover, 2010) .

Sex workers are considered a homogenous group in terms of their working environment, socio-economic status, health status, knowledge and practices of protective measures they implement (Estébanez, Fitch & Najera, 1993). Their activities vary vastly by typologies which vary by country e.g. street sex work is the most common type, there are those who operate from hotels, bars, truck-stops on national highways, bus stations, massage parlors, brothel-based, call-girls who may operate independently and those employed by private agencies (e.g. escort services) and those who work from home who have a private list of clients and may not self-identify as sex workers (Estébanez, et al., 1993). Often their behaviors remain hidden and therefore cumbersome in attempting to define and when attempting to recruit them for research purposes.

There are a number of challenges that sex workers face on a daily basis which continuously place them at a disadvantage and exposes them to high levels of risk such as poor work and living conditions, multiple partners, inconsistent use of condoms, economic issues, drug and alcohol usage, migration and mobility. Other challenges include limited access to health care services due to stigma and discrimination which may be posed by nurses and other health care providers, low levels of education, and susceptibility to violence (Marten, 2005).

Kessler (2005) defines a sex worker as a woman who chooses to sell sexual services to a man in immediate and direct exchange for money, drugs, food and other forms of subsistence. They are referred to as agents in her thesis because they choose this type of employment due to their desire for money and independence which cannot be fulfilled through other means of employment (Kessler, 2005). Sex work in this case becomes a chosen and viable option where the person makes the choice and takes action under the social and economic constraints that impede their choices (Kessler, 2005). Further in the South African legal framework sex work is defined as the exchange of any financial or other reward, favor, or compensation for the purposes of engaging in a sexual act (Boudin & Richter, 2009). However, in this study sex workers have been defined as consenting, females over the age of 18, who self-identify as sex workers and exchange sex for money as their primary source of income.

Sex workers recruit clients according to where they work e.g. streets, bars, brothels etc. It is suggested that when recruiting them it is important to categorize activities according to place of recruitment of clients (streets, bars, club, home), types of clients recruited (local, foreign), amount charged, registered vs. freelance type (Estébanez, et al., 1993). When recruiting for research purposes Estébanez (1993) identifies that it may be possible to recruit large samples of street-based sex workers if they are approached with an incentive, and that it may be harder to reach brothel based sex workers if management opposes and it may be virtually impossible to recruit those who work privately (Estébanez, et al., 1993).

Researchers often therefore resort to convenience sampling methods whereby they recruit from STI clinics, drug treatment centers, and sex work organizations and through advertising (Estébanez, et al., 1993; Pascorn, Szwarcwald & Junior, 2010). Consequently the challenges of working with this population are that samples may not represent the number and types of sex work activities thus making it impossible to estimate the number of sex workers operating in the industry. Several studies have attempted to estimate the sizes of these populations as well as the HIV prevalence rates among them. These have been discussed in the section about the burden of HIV in the sex work population in the next chapter.

Much of the research that has been published about commercial sex workers focuses on behavioural and prevention interventions, multiple partnerships, decriminalisation of the industry, transactional exchange of sex, migration, access to health services and experiences; but very little research has focused on social networks and how they influence sexual health choices of sex workers, particularly in the South African context. This limitation lead to the coining of this research study with the intention of answering critical questions such as how are these social networks formed, what is the structure of these networks, what role do they play in how health decisions are made, whether or not they influence the recruitment of women into sex work, how they influence the choices made in terms of sex, sexual partners, accessing health services and overall attitudes with regards to health and particularly sexual health practices.

The sex workers in this study were identified through the services of the Wits Reproductive Health and HIV Institute (WRHI) which renders health services in the sex work community. WRHI is an academic Non-Governmental Organization with a focus on conducting health research which ensures that people have sexual health which is enjoyed without the fear of disease. It conducts research in the field of sexual and reproductive health and HIV and supports the public health care system through its partnership with the Department of Health and its head office is located in Hillbrow, Johannesburg (Richter, 2008).

WRHI runs the Sex Worker's Project (Women at Risk) and provides a mobile HIV Counselling and Testing (HCT) service for the brothel-based as well as street based sex workers within the community of Hillbrow. The mobile service has primary health care nurses, peer educators as well as community health workers. The service visits streets, hotels and brothels and renders a minimum package of services which include: HIV testing and Counselling (HCT), pregnancy tests, STI diagnosis and treatment, pap smears, distribution of female and male condoms, family planning, health education and referrals. By using the services of WRHI to recruit from the brothel, the researcher was aware that this would provide a limitation to the study as the sex workers who use the service may be more aware of their health; however, it has been shown in a number of studies that availability to care may not necessarily equal access.

On allocated days the nurses and community health workers go into the brothels during the day to provide the services stated above. It is acknowledged that men, transgender individuals do form part of the sex work industry; however, for purposes of this research only the female population was of focus. The inclusion criteria for the research included women who identified themselves as sex workers, who were at the consenting legal age of 18 and above, who were able to give written consent to be in the study. Participation was voluntary, and participants were available for an in depth (IDI) semi-structured interview which lasted between 45-60 minutes, in some instances longer. Their participation was limited to one IDI.

1.2. Brief Overview of HIV in South Africa

South Africa has the highest number of people living with the Human Immunodeficiency Virus (HIV) /Acquired Immuno Deficiency Syndrome (AIDS) in the world with 6.4 million people infected with the virus by 2012 (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios & Onaya, 2014). The South African HIV epidemic is generalized, and has stabilised over the past four years according to the national antenatal prevalence of around 30% (NSP, 2012-2016). South Africa currently ranks the third highest in the world in terms of the TB burden, with an incidence that has increased by 400% over the past 15 years (NSP, 2012-2016). There is a wide variation in HIV and TB prevalence by age, race, gender, socio-economic status and geographical location (UNAIDS, 2012).

Due to the high levels of HIV infection in the country, South Africa's HIV epidemic is now said to be a *hyper*endemic epidemic (SANAC, 2011). This means that there are a significant number of people living with HIV 16.9% of adults aged 15-49 according to the national health survey conducted in 2008 carrying the highest burden (Fraser-Hurt, Zuma, Njuho, Chikwava, Slaymaker, Hosegood & Gorgens, 2011). Given the many HIV interventions and numerous HIV epidemic drivers it is generally accepted that no single HIV prevention intervention works on its own therefore it is suggested in the Know Your Epidemic (KYE), Know Your Response (KYR) summary report that well-chosen combination interventions need to be developed (Fraser-Hurt, et al., 2011).

According to the South Africa HIV Epidemic, Response and Policy Synthesis Report (2011) the HIV incidence differs according to sub-populations, a summary of sub-populations at greatest risk include: youth between the ages 15-24, African (black) people, those who reside in urban informal areas, those sexually active but neither married nor cohabiting, the widowed, people with low education attainment, pregnant women, people reporting more than one sexual partner over a period of a year, sex workers and their clients (SANAC, 2011). The sex workers in the study fall between these risk categories identified above.

Even though South Africa has a generalised HIV epidemic, with some of the highest rates of TB infection and disease burden in the world, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations (KP)/ most at risk populations (MARPS). The Human Sciences Research Council (HSRC) defines MARPS as those groups that have higher than average HIV prevalence when compared to the general population (UNGASS, 2012).

According to the National Strategic Plan 2012-2016, which is a strategic guide for the national response to HIV, STI and TB for the next 5years, key populations include those who lack access to services, and for whom the risk of HIV and TB infection is also driven by inadequate protection of human rights, and by prejudice, more frequent exposure to the virus, involvement in risky behaviors, potentially weak family and social support systems, marginalization, lack of resources, and inadequate access to health-care services (NSP, 2012-2016).

Globally, men who have sex with men (MSM), transgender people (TG), sex workers (SW), injecting drug users (IDU), prisoners, and migrant populations are shown to be at disproportionate risk for HIV infection because they are often marginalized by society and greatly affected by discrimination and stigma.(UNAIDS, 2010).

Past research has indicated that the prevalence rates of HIV amongst sex workers tends to be higher than in the general population due to the nature of their work, therefore it is crucial to understand structural, and behavioural risk factors that lead to increased HIV susceptibility in order for effective interventions to be developed.

Currently HIV prevalence rates amongst female sex workers in South Africa is thought to be as high as 40-69% compared to 13.3% amongst women in the general population (SANAC, 2013). This calls for urgent research to understand factors that lead to increased susceptibility to HIV acquisition. It is estimated that there are 153, 000 sex workers operating in South Africa 4,427 of those are located in Hillbrow, Johannesburg area (SANAC, 2013). According to the Key Populations, Key solutions policy brief, “national

efforts to reach the set goals for zero new infections, zero stigma and zero aids related deaths will only be achieved through explicit commitment to addressing HIV epidemics among key populations as part of the overall response to HIV" (Policy Brief, 2011 p.1).

In June 2011 South Africa signed a commitment with the United Nations called the Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS this declaration explicitly outlines the commitment of all UN member states to address the inadequacies of HIV prevention strategies which focus on key populations such as men who have sex with men (MSM), people who inject drugs (PWID) and sex workers (SW). The goal is to further improve access to HIV prevention, treatment, and care and support services for migrant populations (Scheibe, Brown, Duby, Bekker, 2011).

It is in light of this that this research investigated behavioural aspects such as harmful vaginal practices that female sex workers engaged in as well as the products they used to tighten, dry, warm and cleanse the vagina as behaviours which contribute or exacerbate HIV and STI susceptibility.

1.3. Social networks

Social networks have been studied since the 1970s and have been used to advance research in social and behavioural sciences (Levy & Pescosolido, 2002). Understanding the role of personal and organizational connections gives a solid foundation in understanding how the social world affects and is affected by health and medical phenomena (Levy & Pescosolido, 2002). Social networks have grown in popularity because they enable researchers to study not only the social actors (nodes); but also the social relationships (links) among those actors (Wassermann & Galaskeiwicz, 1994). They have also been used in tracing the epidemiology of illness, distress, disease, disability and in understanding how people identify and respond to crises (Levy & Pescosolido, 2002). In the aforementioned study this approach was used as an approach to answering some important questions with regards to health and sex work.

The social network perspective offers a dynamic approach, insisting that people be understood in terms of what happens in their lives, their risk of illness both in the short and long term and how they confront such problems. Its purpose is to understand human behaviour through social relationships or social ties that they form (Levy & Pescosolido, 2002). According to the theory of Durkheim (1951), social networks may bring care and concern (integration) but they can also bring oversight (regulation) meaning that the social interactions may be positive or negative, helpful and harmful. They can integrate the individual into the community and equally place them in stringent isolation (Levy & Pescosolido, 2002). Over the years research on social networks has tended to focus on the positive aspects of social networks. The limited research that has explored the negative ties in people's lives have found them to have powerful effects on health (Levy & Pescosolido, 2002). Thus it is this power, and/or lack thereof, of these networks that were explored in the current study.

1.4. Sex Work Debates

Sex work is a social and economic issue which has gained much attention and generated debates in academia, politics and other spaces. The two main leads in these debates are the "antiprostitution" as well as "pro-sex-worker" feminist arguments (Mgbako & Smith, 2011). The antiprostitution feminist camp views "prostitution as an exploitative institution of patriarchy" a form of sexual slavery and containing the violation of the rights of women (Mgbako, et al., 2011 p.1178). It further characterizes prostitution as violence against women and embraces an abolitionist stand point (Mgbako, et al., 2011). The pro-sex-worker camp promotes human rights to advocate for the protection of sex workers and to be able to recognize sex work as a legitimate profession and a viable economic channel to empower sex workers to take care of their health and give consideration to the aspect of human rights (Mgbako, et al., 2011). It is identified that the antiprostitution feminists have dominated prostitution discourse since the twentieth century. Its roots stemming from the United States and Western Europe. According to abolitionist's prostitution is a result of poverty, coercion and unequal gender relations and patriarchy rooted in the sexual exploitation of women thus enforcing gender stereotypes (Mgbako, et al., 2011). They aim

to abolish prostitution. They state violent crimes such as human trafficking, public health crises and high rates of substance abuse as reasons for society to encourage the eradication of sex work (Mgbako, et al., 2011). This platform rejects sex work as a legitimate viable means of economic survival and argues that voluntary prostitution cannot occur because the exchange of sex for money leads to sexual exploitation (Mgbako, et al., 2011). Following all these reasons many of these antiprostitution feminists have endorsed "rescue" operations which seek to "save" sex workers from the industry. It is argued that these rescue projects forced sex workers to leave sex work without the provision of an alternative which addresses issues of poverty, unemployment, violence and female subordination (Mgbako, et al., 2011).

Despite this traditional dominance; the pro-sex-work movement emerged to call for the recognition of sex work rights. This alternative movement was a result of shared beliefs by advocates and sex workers suggesting that the initial debate failed to reflect the diverse experiences of sex workers; and the aim was to shift from morality to an issue of work and human rights (Mgbako, et al., 2011). In this model the ills of the industry are a result of stigma and discrimination that affect sex workers. It is suggested in Mgbako (2011) that "only after the prostitution debate moves from a moral paradigm to a framework of human rights will sex workers be able to negotiate the rights and protections that they deserve as laborers struggling to secure a livelihood" (Mgbako, et al., 2011 p. 1192). It is further recognized that because sex work is not considered work; society fails to view women in prostitution as women. Sex workers occupy various roles, they are mothers, daughters, sisters, wives etc. and should not be solely viewed based on their livelihood (Mgbako, et al., 2011). This research takes the pro-sex-work movement approach and further discusses policy and legal options that South Africa should follow under the section Sex Work and Law in Chapter 2. In sum African states should reform their legal positions and policies towards sex work and consider the option to remove all laws associated with the industry in order for sex workers' human rights to be recognized and eradicate all forms of abuse they are faced by. The current state of criminalization of the industry has been proven ineffective.

1.5. RESEARCH AIMS

1.5.1. Primary Aim

The main objective of the study was to understand the sexual practices that the sex workers engaged in, within that to explore their beliefs and motivations for engaging in those practices as well as explore the role played by their social networks in making such decisions. Further it was to explore the implications of these behaviours when introducing prevention interventions such as vaginal microbicides to this population.

1.5.2. Secondary Objectives

- The narrative approach was the overarching approach used to gather information on life histories which included: how sex workers ended up choosing sex work as work, how they were recruited in to sex work and understanding their life stories.
- Through the social network theory it was feasible to understand the types of support provided by the network, namely: social, economic, practical, information-sharing types of support and how these translate into decision making with regards to sexual practices.
- Through Bronfenbrenner's bio-ecological theory; a better understanding of the different systems that impact the life of an individual at the microsystem level was obtained and lead to the identification of key people (egos) who belong in one's network.
- In the discussion the feasibility of conducting social network research with the sex worker population was addressed.

1.5. RATIONALE

Social network theory, Bronfenbrenner's bio-ecological theory (1970) and the narrative approach were applied to the research study at hand because it has been identified that prevention programs can be improved by understanding how social structures influence an individual's sexual behaviour. This understanding further fuels the development of strategies for positive change (Bond, Valente & Kendall, 1999). Furthermore research

suggests that social ties and relationships play a critical role in determining the health status of an individual (House, Landis & Umberson, 1988) therefore we need to understand the depth and the extent of how these relationships determine the health status of the individual in order to develop appropriate and useful interventions which can be sustained in the long term.

These chosen approaches are useful because not only has it been identified that "populations which have been viewed as networks of social acquaintances are vulnerable to disease epidemics such as HIV" (Stanley & Havlin, 2003, p.174) but we need to understand how these conclusions have been reached so appropriate interventions can be developed. In addition social network theory has not been utilized extensively amongst sex workers, this theory has been applied mainly with the Men who have sex with men (MSM) populations in the United States (U.S), and in adolescents who are at schools in learning about their sexual and social networks, other studies have looked at the support provided through the networks when individuals are faced with a disease and as a copying strategy. Through the gap identified in the literature, it is important that the networks of the sex worker population be studied because this is a segmented population, which has a high prevalence of HIV, and prevention methods can be put in place to alleviate the burden amongst sex workers by understanding their behaviours.

Research needs to be invested in this population because they face all the aforementioned challenges which distinguish them from other populations, through this research useful information can be gained in terms of the feasibility of conducting microbicides clinical research by understanding sexual health practises of this population and assisting them with care. These practices may affect adherence and efficacy of the products. Therefore it is essential to understand what the practices are, and what their beliefs and motivations are for engaging in those practices.

In the great efforts taken to develop interventions that encourage the prevention of STI and HIV infection among sex workers as well as the general population; little attention has been geared towards education around unsafe sexual practices. Previous emphasis has been

placed on safer practices such as the use of condoms, medical male circumcision, HIV Counseling and Testing, prevention of mother to child (PMTCT) strategies, Post Exposure Prophylaxis and other social methods as tool kits for HIV prevention.

Currently more research is being conducted in finding rectal and vaginal microbicides, vaccines and the use of Pre-Exposure Prophylaxis, but none of these methods speak to educating people about sexual practices which lead to high HIV susceptibility (Yuoule & Wainberg, 2003). In order to implement these modalities it is crucial to understand sexual practices, sexual health and behavior of the population under study. Therefore the ultimate purpose of this study is to fill that gap and strategize around the best ways information on sexual practices can be delivered possibly through social networks.

1.7. Chapter Outline

Chapter 2 provides an overview of the theoretical framework and empirical research conducted to support the study. The theoretical framework explains behavior according to the Social Network Theory, Bronfenbrenner's bio-ecological theory (1970) and Narrative Approaches to identity. These theories are important as they allow greater understanding of life histories through time and the understanding of social network formations and the role played by different systems in human and social development. The chapter further gives an empirical description of the literature that was relevant and reviewed for the study.
Chapter 3 presents the qualitative research design methodology that was employed in sampling, collecting, thematically analyzing of the data, the ethical considerations and reflexivity issues. Individual semi-structured interviews were adopted and are discussed in the chapter and the chapter further included a focus on the methodological benefits of such an approach to data collection.
Chapter 4 discusses results and interpretations of the findings. Through the analysis four main themes were drawn to answer the research question: life histories, social networks, sexual health practices, and sex work health. These analytic themes are discussed within the framework of social network theory, bio-ecological theory and narrative approaches to identity.

Chapter 5 presents a summary of the research with a consideration of issues of researcher reflexivity, limitations and key recommendations for future research and concludes the study.

1.8. Conclusion

This chapter gave background information in terms of the current state of HIV/AIDS in South Africa, it gave an overview of topics that are addressed in the study in terms of briefly describing sex work, social networks, current debates and an overview of process that were followed in conducting the study at hand. The next chapter, chapter 2 explains the theoretical framework that was followed and discusses literature reviewed pertaining to sex work in detail.

CHAPTER 2

LITERATURE REVIEW

2.1. Introduction

This chapter provides a theoretical background to the research topic. The researcher draws primarily from the Social Network Theory, Narrative Approaches to identity and Urie Bronfenbrenner (1970)'s bio-ecological theory in order to discuss the experiences of the population under study in terms of how they relate their life stories, experiences and perceptions of sexual behaviours. All these theories acknowledge the importance of the role played by the environment in shaping how an individual perceives and relates their life stories and sequence of events in relation to time and in all the theories the person remains the centre of analysis. The researcher provides a critical review and commentary about each of the theories. Thereafter the chapter gives an overview of empirical literature critical to the sex work industry, given particular concerns around the vulnerabilities of sex workers i.e. the global health burden of Sex Work and HIV, HIV prevention interventions for sex workers, sex work and the law and sexual health practices.

2.1.1. Social Network Theory

Social network analysis of personal communities looks at how a person at the centre of the network deals with members of their egocentric universe (Wellman, 1992). At the relational level researchers often study social characteristics of the network (e.g. gender, intimacy, kinship and frequency of contact) of the network members and respondents who are the focal persons at the centre of the network (Wellman, 1992). In studying social support at both the relational and network analysis levels the common aim is to identify the kinds of support that are provided to the individual (Wellman, 1992). Networks are defined by Kadushin (2004) "as a set of relationships containing a set of objects and mapping or descriptions of relations between two objects or nodes" (Kadushin, 2004 p.3). In Halgin (2012) networks are said to consist of a set of nodes (sometimes called actors)

along with a set of ties of specified type e.g. friendship that link them (Halglin, 2012). In social network analysis literature nodes are often individuals or groups of individuals e.g. families, organizations, the nation (Halgin, 2012). Social scientists have investigated three kinds of networks: ego-centric, socio-centric and open-system networks. These have been defined in Kadushin (2004) as: ego-centric-networks connected by a single node or individual e.g. friends, and information must be available about how they are connected. The socio-centric network which involves personal communications e.g. connecting children in the classroom, executives in an organization and these systems are closed systems (Kadushin, 2004). An open system network has no boundaries e.g. adoptions of new practices, a chain of influencers of a particular decision (Kadushin, 2004).

There is an implicit theory of the flow or distribution of information within networks and researchers refer to these as flow/pipe models carrying the basic assumption that the longer the path of connectedness the longer it takes for information to flow unlike when networks are centrally positioned (Halgin, 2012).

The conceptual model of how social networks impact health is said to begin with a causal process which begins with macro to social to psychobiological processes which link together to form how social integration affects health. It is argued in (Berkman, Glass, Brissette, Seeman, 2000) that networks operate at the behavioural level through four primary ways namely: *provision of social support, social influence, social engagement and attachment (person to person contact) and access to resources and material goods* (Berkman, et al., 2000). Social support acknowledges that not all ties are supportive and that there is a variation in the type, frequency, intensity and type of support provided. Social support is divided into subtypes which include *emotional, instrumental, appraisal and information support* (Berkman, et al., 2000). Social influence is when people compare their attitudes with those of a reference group of similar others, example in a group of sex workers who may have shared norms around health behaviours etc. Social engagement is said to be more difficult to define because networks influence health by promoting social participation and through engagement for instance getting together with friends, attending social functions, occupational or social roles. Thus through opportunities of engagement, social networks define meaningful social roles (Berkman, et al., 2000).

Of particular importance particularly to this proposed research, is person-to-person contact because it is a behavioural pathway that can restrict and promote exposure to infectious disease agents (Berkman, et al., 2000). A network that has characteristics that are health-promoting can at the same time be health-damaging if they serve as vectors for the spread of infectious diseases. This aids in better understanding of the fact that diseases are not spread randomly throughout a population but rather that it is based on geographical location, the flow of information, whether social ties are concentrated or far removed. The social ties amongst e.g. sex workers that are street-based versus those in more established settings such as brothels, socio-demographic factors such (as age, gender, race), socioeconomic position, occupation and sexual orientation (Berkman, et al., 2000) all influence the decisions one makes. Social network analysis focuses on the characteristics of the network rather than the individual, and strives to uncover the ego-centred networks that promote the spread of a disease.

2.1.2 Urie Bronfenbrenner's Ecological Theory of Human Development

A number of psychologists have contributed to the field of human development like Sigmund Freud (1923), Alfred Bowlby (1951), Lawrence Kohlberg (1969), Eric Erikson (1968), Jean Piaget (1971) and Lev Vygotsky (1920). Unlike most of these theorists Bronfenbrenner's work did not focus on specific domains such as social relations or cognition, or biological development, instead his work focused on emphasizing interrelationships of different processes and contextual variations (Darling, 2007). The importance of Bronfenbrenner's work has been summarized in two ways firstly, he has been cited for bringing attention to context variations in human development and helping move "the science of strange behaviour of children in strange situations with strange adults for the briefest period of time" to a more "ecologically valid" study of development of individuals in their natural environment (Bronfenbrenner, 1970; cited in Darling, 2007). Secondly it is often summarized with a diagram which shows the individual being at the

centre of the circle representing the micro, meso-, exo- and macro-systems to development with arrows that link context within the systems (Darling, 2007). This has been illustrated below in Fig.1. Moreover his theory presents interrelatedness and that knowledge is bounded by context, culture and history (Darling, 2007).

Urie Bronfenbrenner (1970) was an American development psychologist who theorized the Ecological Systems Theory of child development. His theory was said to be key in changing the perspective of developmental psychology. He argued that "in order to understand human development, one must consider the entire ecological system in which growth occurs" (Bronfenbrenner, 1994). He identified that the ecological system is essentially comprised of five socially organized subsystems that help support and guide human growth with the individual being at the centre (Bronfenbrenner, 1994). These range from the micro-, meso-, exos-, macro-and chrono-systems which operate as systems both within themselves and in relation to each other. This is illustrated in Fig 1 below:

Illustration revised from: Genevieve Marie Johnson adapted from: http://www.cjlt.ca/index.php/cjlt/article/view/172/169

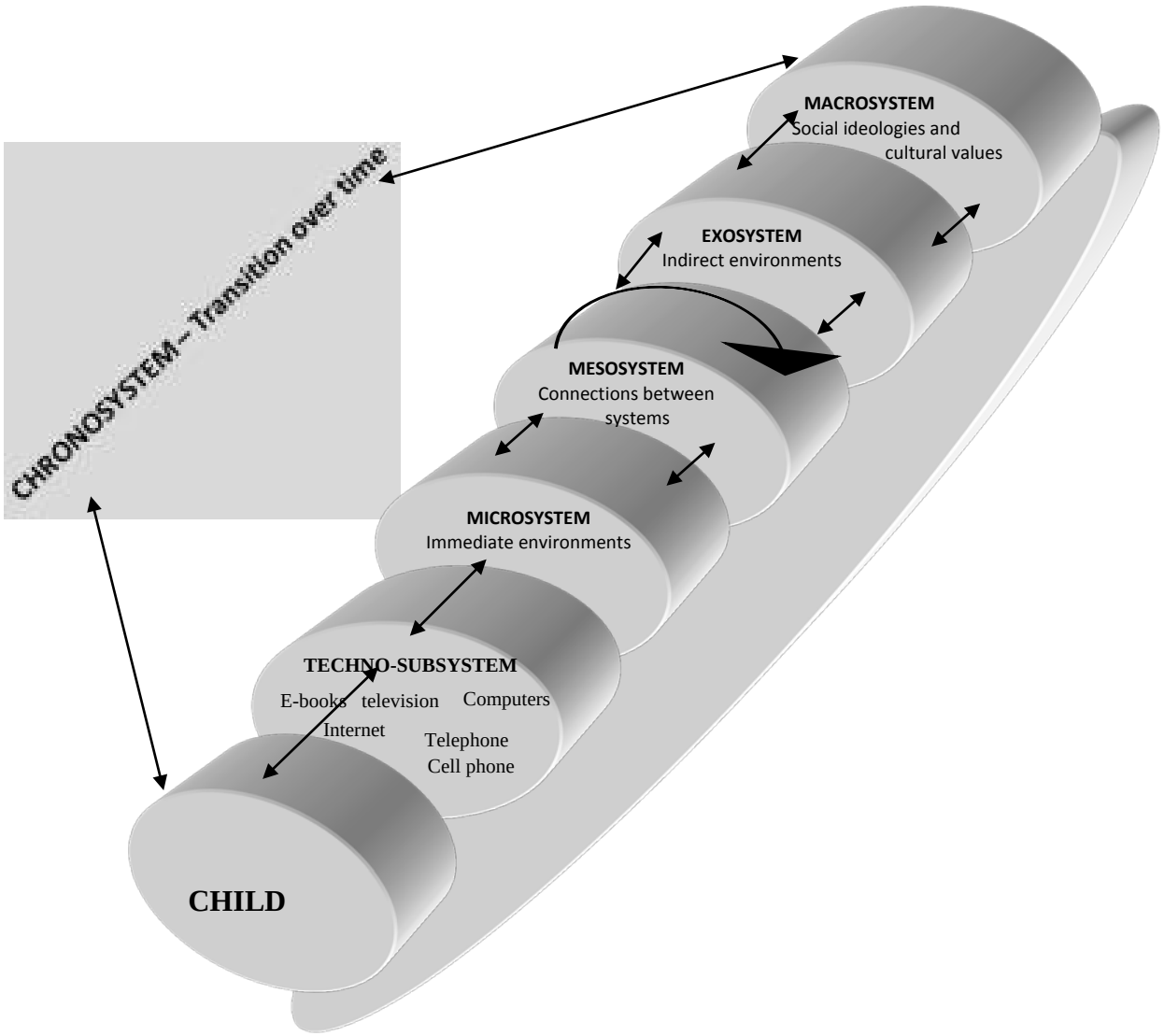


Fig 2.4: Ecological system of human development

In this section the systems are briefly reviewed as well as how they support the development of the individual. This model is among the most widely cited and frequently taught theories of human development (Weiner, 2008). In the ecological environment they are perceived as a set of nested structures with one system inside another (Bronfenbrenner, 1994):

a) *Microsystem*s are defined as the immediate environment in which a person lives which includes family members, peers, religious communities, neighbourhoods and others whom the individual has interactions with and those they encounter the most in their social interactions (Bronfenbrenner, 1994). The person is said to not only be an observer; but an active participant in helping to create and construct experiences.

b) *Mesosystems* are defined as interactions of the microsystems they form linkages between settings e.g. includes experiences at home in relation to school, from school to the workplace to church. They help create the experience people have.

c) *Exosystems* are defined as linkages between two or more settings where the one setting does not contain the developing person. The events that occur indirectly influence processes within the immediate setting where the developing individual resides. There are 3 systems that are said to influence the individual, the family, school, and peer groups.

d) *Macrosystems* are a combination of all the systems. This system includes an individual's belief system, culture, customs and lifestyle.

e) *Chronosystem* is identified as cumulative experiences of a person over time and over chronological age. It includes the changes or consistencies of the individual over time. They can be major transitions in life e.g. divorce, the birth of a baby, marriage etc. These changes or consistencies lay not only in the character of the person but also in the environment in which they live. These changes may be in the family structure, socioeconomic status of the individual, employment status, place of residence, and the degree of hecticness of their lifestyle (Bronfenbrenner, 1994).

Bronfenbrenner (1970) draws his work from Kurt Lewin (1935) who was a social psychologist renowned for his "field theory". He proposed that human behaviour is the function of both the person and the environment (Lethwaite, 2011). In his field theory he defined field "as the totality of co-existing factors which are conceived of as mutually independent" (Lewin, 1935 cited in Lethwaite, 2011, p.9). He further asserted that individuals behave and develop differently according to the way in which tensions between

perceptions of self and the environment are worked through (Lethwaite, 2011). It is this work of Lewin which informed the foundation of Uri Bronfenbrenner's work.

In Bronfenbrenner's work he suggests that the most proximal and significant sphere or setting is the individual's microsystem i.e. the patterns of activities, roles, and interpersonal relationships developed in a face-face setting. The three other systems are more removed from the individual. Of importance to note, is the acknowledgement of "engines" that support the process of development (Lethwaite, 2011). The engines include context, time and processes that influence the systems. Thus in understanding the individual one needs to take into account the individual's personal attributes, the context in which development takes place and the time in which development processes occur (Lethwaite, 2011).

Most recently, there has been an extension of the ecological paradigm and it is said to involve "a reconceptualization of the role of genetics in human development" (Bronfenbrenner, 1994 p.41) which is called the bio-ecological model. It explains the mechanism of how genotypes are transformed into phenotypes and proposes that heritability can be shown to vary substantially as a direct function of the magnitude of proximal processes and the quality of the environment in which they occur (Bronfenbrenner, 1994).

The bio-ecological system is considered to be an evolutionary system for the scientific study of human development over time (Bronfenbrenner & Morris, 2007). Development in this model is defined as "the phenomenon of continuity and change in the bio-psychosocial characteristics of human beings both as individuals and groups" (Bronfenbrenner, et al., 2007 p.793). Further the phenomenon extends over the course of life, across generations and through time relating to the past and the future (Bronfenbrenner, et al., 2007).

The bio-ecological model is said to address two closely related but fundamentally different developmental processes that take place over time. Firstly it defines the phenomenon under investigation, continuity and change in the bio-psychological characteristics of human beings, and secondly it is concerned with the development of tools (research, models, and designs) that aim to assess continuity and change (Bronfenbrenner, et al., 2007).

It is highlighted in Bronfenbrenner (2007) that to place the theory of human development into a larger context it is important to take into consideration other perspectives which have helped shape the theory (Bronfenbrenner, et al., 2007). With regards to other views he identifies the prominent example with Robert Cairns who has played a major role in the evolution of the four defining properties of the bio-ecological model over the last three decades along with (Bronfenbrenner & Crouter, 1983; cited in Bronfenbrenner, 1995). Firstly he talks about the social address model which they say has received much criticism as it does not consider how the environment affects the course of development and doesn't consider how people are living, what they are alike and the activities that influence the development of the child. Then model shifted to Process-Context model which looked at the impact of the external environment on particular processes. Then much later the Person-Process-Context and Time model was developed (Bronfenbrenner, 1986; Tudge, Mokrova, Hatfield & Karnik, 2009).

Process, Person, Context and Time (PPCT) model (Bronfenbrenner, et al., 2007) explained: Process is said to be the core of the model encompassing particular forms of interaction between the organism and the environment called proximal processes operating over time and functioning as primary mechanisms producing human development. The person involves the developing person in the immediate Context or remote in Time periods where proximal processes occur (Bronfenbrenner, et al., 2007).

The Person characteristics are viewed as most influential in shaping future development through the capacity to direct and affect power. Three characteristics have been identified in the process: disposition, resource and demand which have all been incorporated in the definition of microsystem (Bronfenbrenner, et al., 2007). Time was identified as occurring at three successive levels of the micro-, meso-, and macro-levels. They were identified as micro-time which refers to continuity vs. discontinuity, meso-time which looks at episodes across broader time intervals and macro-time which changes expectations and events in larger society (Bronfenbrenner, et al., 2007). The most critical element in the definition of the bio-ecological model is experience; meaning human development not only includes objective properties but includes subjective experiences of the person living in that environment (Bronfenbrenner, et al., 2007).

Bronfenbrenner's theory has not come under much critique as other theories have; instead a number of authors have applied his theory particularly in the field of education which is concerned with the development of children. Of those who did criticize the theory the criticism was based on that it gave little attention to biological and cognitive factors that occur when a child develops and that his theory does not address the step by step developmental changes which were the focus of Piaget and Erickson's theories (Social Context and development).

The researcher acknowledges the importance of a model of this nature which looks at the individual in relation to the environment and not as a separate entity. However as Bronfenbrenner's work currently stands; the microsystem seems to involve the notion of the "perfect nuclear family" represented by a mother and father and how they influence development of the child at the microsystem level. However in the current state of the world and in South Africa where immediate families may exclude the presence of a father or mother and become a single-parent headed household/orphaned household; the development of that child is not considered in his theory. It is only much later in his work with Croute that he acknowledged the variation and called it "new demography" where he acknowledges the role of single-parents, day care, and mothers in the labour force, issues of remarriage and fathers as principal care givers and even race by incorporating black children (Bronfenbrenner, 1986). His definition still excludes a number of contextual factors and his theory still excludes various backgrounds.

When viewing the microsystem definition it seems to end at adolescence and does not cater for when an individual e.g. has migrated to a different country and the friends within that context becoming part of ones microsystem as is the case in the current study with sex workers. Although the system is not shaping the individual at the child level (because they are already into adulthood) the network is comprised of other sex workers who become part of their microsystem and are influenced by it.

Also at this day in age of the HIV/AIDS era where a number of families are headed by grandmothers or even children themselves have been excluded in his analysis of how the child would develop in that context. South Africa has also refined its laws and accepted homosexual marriages and his theory did not consider how being raised in a same-sex

marriage environment would impact the child's development. Perhaps the issue should not be who is there raising the child; perhaps the focus should be on "how" the child is raised and the types of values instilled in the developing child that will determine the future of the child into adulthood. Also the theory excludes the recognition of love and creating sense of belonging as important factors in raising the child. It may be acknowledge that his theory was based within the American context and in the ideal situation of what a family should represent. This theory would need to be reviewed within the South African context and many others in order for his theory to be truly representative. It is beyond doubt that the immediate environment plays a critical role in the development of the child however much still needs to be considered.

Further Bronfenbrenner's theory seems to focus on children from the middle social class life in terms of socio-economic standards of living and neglected to look at children from poverty stricken backgrounds. Although is some environments the cycle of poverty continues and becomes a generational issue whereby people cannot think and believe themselves out of poverty; however there are distinct circumstances where people from the poorest households have applied themselves and have become wealthy and success individuals. When comparing children from those backgrounds Bronfenbrenner's theory would probably argue that the child who develops in the middle class family will be a "better adult" than the one from poverty. In terms of the microsystem one wonders what the children would be taught under both circumstances. The child from the middle class would likely have the latest toys and technology which the other is deprived off and when going to school who would presumably get better grades? Bronfenbrenner's theory would most probably assume the child from the better background would achieve better grades.

Would the child from a poverty stricken background work harder as a result of being aware of where they come from? And would the child with "everything" work any less hard upon realizing all is available to him? In a context like South Africa where we were politically faced with the apartheid regime and as a result black people would work low-income jobs such as domestic work, gardeners etc. and the children who came from that made a success of themselves. What could we attribute this to when considering Bronfenbrenner's theory? There are many other examples which could be put forth here that the theory did not

consider; however the value of Bronfenbrenner's work is unquestionably useful even today, the recommendations would be to expand what has been initially started.

2.1.3. Narrative Theories

Narrative approach put simply studies how stories help people make sense of the world, whilst also studying how people make sense of those stories (Mitchell & Egudo, 2004; Owens, 2007). The limitation of this theory is it does not define the thought-processes used to make sense of the stories i.e. do they use logic, emotion, experience or the combination and how do people differ in how they reason stories out. The narrative paradigm is said to have been proposed in 1984 by Walter Fischer and it was criticized for its attempt to establish hierarchy where narrative is more highly valued than traditional rationality (Owens, 2007). The traditional rationality paradigm received much critique as a narrative paradigm. Owens (2007) argued it specifically in that it omits the role played by myths in creating narratives and further proposed the shift to a mythic paradigm (Owens, 2007). This paradigm challenges the notion that any narrative act cannot be examined in isolation. In order to understand narrative Owens suggests that "the narrative must be examined within a larger framework of the overall myth in which it is situated" (Owens, 2007 p.2).

Narrative theory makes a significant contribution in understanding how people make sense of life. According to Schiff, (2012) narrative is best thought of as a verb and the primary function of narrating being to bring forth life experiences and interpretations of life in a particular time and space (Schiff, 2012). In his paper he considers narrative as crucial in understanding experience and interpretation of life. This definition is related to that of Tamboukou (2002) who says narratives in human sciences are defined as "discourses with a clear sequential order that connects events in a meaningful way for a definite audience and offers insight about the world and other people's experience of it" (Elliot, 2005,cited by Tamboukou, 2002). It has been defined by Squire (2012) as "chains of signs with particular social, cultural, historical meanings which involve sign sets that move temporally, causally in other socio-culturally recognizable ways, and that because they operate with particularity rather than generality, they are not reducible to theories" (Squire, 2012 p.1).

Bamberg (2010) suggests that there are different connotations connected to the narrative term such as narrative research, narrative inquiry, and narrative analysis but he acknowledges that what is central are the aspects of human memory or experiences and defined it as "positioning characters in space and time and giving order to make sense of what happened and what is imagined to have happened" (Bamberg, 2010, p. 3). Therefore narrative according to Bamberg (2010) attempts to explain "why things are the way they are or have become the way they are" (Bamberg, 2010 p.3). This definition may be limited in that it excludes the operational "how" things have become the way they have. In thinking about how people relate their current circumstances in their narratives they include the why and how things have led to the point they are at in life as demonstrated in the study at hand.

Schiff further sees his work as contributing to the field of social sciences as he considers narrative as a powerful metaphor in understanding life (Schiff, 2012) and essential in understanding psychological processes and social reality. The function of narrative according to (Schiff, 2012) is not only concerned with structure but interaction because of the meanings people are able to express and articulate through narrating.

Mark Freeman (2009) in Schiff (2012) introduces the concept of "making present" whereby "the past that we make present and the timing of when we make it present rewrites the meaning of our lives and our identities" (Schiff, 2012 p.40). Tamboukou (2002) agrees with this and stipulates that past, present and future co-exists in the now of narratives and further suggests that these events should be taken as moments which express ones being (Tamboukou, 2002).

Freeman (2009) recognized 3 ways to conceptualize "making present" which when viewed together enable one to view narration as a whole: *declarative* making present gives presence to subjective experience e.g. "I know this, I have experienced it and these are my thoughts" forms of narration, the *temporal* where making present gives meaning to the past, present and future and *spatial* whereby making present co-creates shared and divergent understandings of the world (Schiff, 2012). Somers (1994) proposed that in order for narrative identity to avoid rigidity in time and space the concept of relationality should be introduced (Somers, 1994).

Narrating is viewed as establishing subjective factors of life experience by communicating how one feels and telling this experience in order to make known what one has lived through memory, autobiographies etc. Schiff (2012) further acknowledges that there is a gap between what we know, experience and what we tell (Schiff, 2012). He says the gap is attributed to the inability of words to truly capture and represent events and sentiments and the inability to speak or write as fast as we think and feel (Schiff, 2012). It is further acknowledged that there is a difference in experience and in telling. Narrating is closely tied with lived experience and our reflections of life; it is also the closest we will get to experience or understanding experience (Schiff, 2012).

It is also acknowledged that the ability to tell stories is acquired in childhood whereby a child participates in story telling activities with others who are experts (co-narratives). Schiff posits that through repeated interactions with others we come to know stories of our communities and the speakers take up certain roles/positions where story telling produces negotiated accounts. He says even in an interview situation, the process involves balance, mutuality, and negotiation between participants. In turn, this results in achieving joint understanding of self, others, the world and the past (Schiff, 2012).

Schiff stipulates that the function of narrating is to establish close bonds, organize past events, give colour and pathos to our lives, to bring about cause and agency to our experiences, and to establish social identity (Schiff, 2012).

Ultimately what is key in narrative studies is to understand the relationship between narrative and time. Schiff stipulates that we position ourselves in relation to what is being said to others present and to the larger identity discourse (Schiff, 2012) and that whether something is considered narrative depends upon whether or not we understand it narratively. He says narrative research should be about how do persons in time and space make sense of life experience and suggests that scholars focus on meaning making and on what narrative does and how it accomplishes this. Further when this type of research is conducted it could help answer questions that would advance psychology and the field of social sciences (Schiff, 2012).

In the literature reviewed what is eminent is the lack of acknowledging within space and time the importance of relations (the whom) the story is being told to and by whom. As individuals we relate to people differently whether due to their socio-economic status (whether better or worse than the individuals), the role they play in the community, parental relationship, social networks in general and the fact that people are selective in what they want to tell. The articles also do not unpack the concept of helping make sense of the world which in the view of the researcher could be concepts such as religion, culture, politics, and globalization issues. In all the literature one assumes these must be the concepts the authors are thinking about. Despite this limitation, the narrative theory remains an important tool for analysis of research is aspects of life stories.

McAdams (2006) looked at the role of narrative within personality psychology which is the scientific study of the whole person (McAdams, 2006). Personality psychology was developed in the 1930s focusing on factors within the individual and on their environment in order to account for why one person thinks, feels, strives and acts differently to another (McAdam, 2006). He considers that the approach is divided into two: namely the nomothemic approach and idiographic approach (McAdams, 2006). The nomothetic approach validates and measures individual differences through qualitative inquiry whereas the idiographic approach puts together many dimensions of human variations. The central debate in personality psychology has been reconciling the different demands of analytical, quantitative, nomothetic studies and synthetic, qualitative idiographic inquiries (McAdams, 2006). He asserts that people do what their immediate situations tell them to do rather than their long standing internal traits prompting on what to do. It is indicated in the paper that 25 years ago psychologists wondered if there was a need for the idea of personality until the 1980s where personality psychologists made a come-back through an entity they called “The Revenge of the trait” whereby the nomothetic (studying the uniqueness of the individual) research concluded six things regarding personality traits (McAdams, 2006).

1. Individual differences are associated with trait consistent behaviour trends
2. Traits being viewed as powerful predictors of important life outcomes (like mental health, success etc.)

3. Individual differences in traits showing longitudinal consistency in adult years
4. That traits are highly heritable and account for the genetic differences in people
5. That traits are linked with brain processes (neurological make-up)
6. Lastly, that trait terms can be classified into five clusters of: extroversion, neuroticism, conscientiousness, agreeableness, and openness to experience.

McAdams agrees that today the field offers strong theories and stronger data to explain human variations in personality. It is stated that in the 20th century theorists did not imagine people as story tellers and human lives as stories worthy to be told (McAdams, 2002).

He postulates that the first narrative theories emerged in the late 1970s and early 1980s when personality psychology was battling with critique. McAdams (1985) came up with the "life story model" of identity which says that people begin in late adolescents and young adulthood to construe their lives as evolving stories that integrate the reconstructed past and imagined future to provide meaning (McAdams, 1985). It is indicated that narrative theories have helped re-contextualize personality psychology to move beyond traits- to examining how values and moral orientations are reflected and shaped by life narratives, family stories, the broader community and myths (McAdams, 2002; Owens, 2012).

It is also gathered that narrative approaches have been used extensively in studies of difficult life events and major life decisions revealing how people make sense of adversity, change and how these sense-making processes influence the development of the personality (McAdams, 2002). This is of prominence in the study here-in.

Narrative methods have assisted researchers to provide rich, qualitative data about individual's lives and given them the tools to examine particularities of single cases (McAdams, 2002).

Kenneth Gergen (1935) wrote extensively on his interests in social constructionism. The term "social constructionism was coined in the sociology of knowledge by Berger and Luckman (1966) in (Aceros, 2012). During the 1970s and 1980s it is indicated that it played an important role in the "linguistic turn" in social sciences. Today it is said that the term is used to describe the work of a variety of authors concerned with "the role of cultural,

historical, socio-linguistic and context-dependent meaning making processes" (Aceros, 2012 p.1002). His career took a turn in 1973 after publishing "Social Psychology as History" where he expressed doubt about experimental research as a neutral reading of social behaviour and presented it as a form of social influence (Aceros, 2012).

Gergen & Gergen, (1983) indicates that "narrating implies that the individual is generally imbued with a structure of self-descriptions (concepts, schemata, prototypes) that remain stabilized until subjected to external influences from the social surroundings" (Gergen & Gergen, 1983 p.255). They suggest that much attention needs to be given to how the individual actively constructs their view of the self. This was identified as a result of looking at previous studies which they felt neglected to consider the individuals capacity in configuring the self. They further suggest that traditional views failed to appreciate the individual's understanding of themselves as a historically emerging being (Gergen, et al., 1983).

Therefore they use the term "self-narrative" to refer to the individual's account of the relationship among self-relevant events across time (Gergen, et al., 1983 p.255). It is identified that developing a self-narrative requires the individual to attempt establishing coherent connections among life events (Cohler, 1979; Kohli, 1981 in Gergen, et al., 1983). It is further elaborated that one's present identity is not a sudden mysterious event, but a sensible result of life history (Gergen, et al., 1983).

The social context of the narratives is divided into two: the temporal forms in self- narrative and the dramatic engagement in narrative form. Within the temporal form we can distinguish between three forms of narrative; *stability, progression, and regression* these narratives have implications for ones future, also they give an indication for a forthcoming future. Stability is said to "include narratives which link incidents, images and concepts in such a way that the individual remains essentially unchanged with respect to evaluative position" (Gergen, et al., 1983 p.258). Progressive is when the individual links together experiences in such a way that either increments characterize movement along the evaluative dimension and Regression being the opposite occurs when decrements characterize movement across time and space (Gergen, et al., 1983 p.258). All these narratives may be intertwined in the life of an individual and can follow different patterns

i.e. starting off as stable, regressing then making progress depending on how the situation was experienced. This process has been illustrated through graphs below from Fig.1-3. These will be applied to demonstrate the position of each woman in the study in the Results chapter depending on how they evaluate their lives through time from the time they joined the sex work industry. One of the themes that emerged in the study was the theme life stories, therefore the narrative theories set the scene for why the theory was relevant and contributes in understanding the importance of life stories. In this section the researcher drew a lot from Gergen& Gergen (1983) to help position the lives of the women. Below is an illustration of the 3 concepts of stability, progression, and regression (intersecting) and how they are viewed and change over time.

In addition Gergen 1983 indicates that narrative forms are in no way construed as objective reflections of one's personal life. They emphasize that the individual should be able to use any form to account for their life story. It is further suggested that the events themselves do not contain inherent evaluational properties but rather such properties are contained within a particular construction one makes of the event (Gergen, et al., 1983).

The dramatic engagement narrative form identifies that coherence is produced through events. It is also the capacity to create feelings of drama or emotion. It is further suggested that it is the relationship among events; not the events themselves that are responsible for sustaining dramatic engagement.

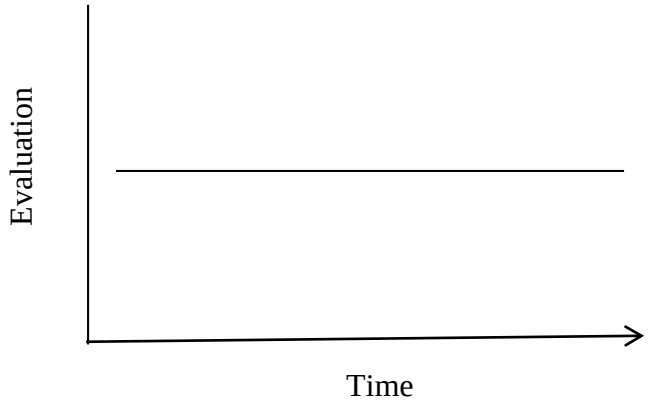


Fig.2.1: Stability

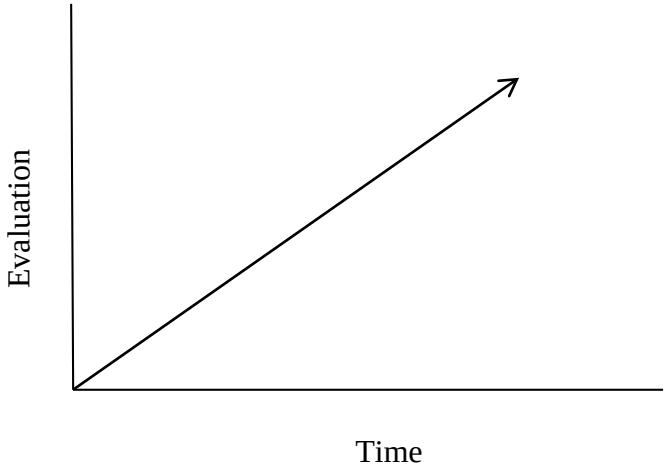


Fig.2.2. Progression

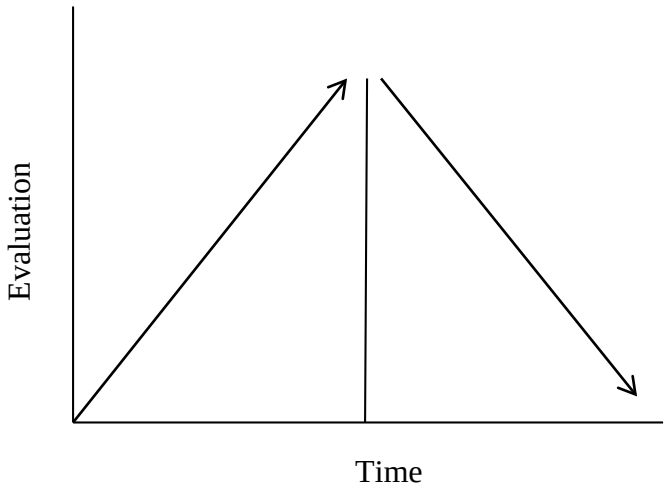


Fig. 2.3 Progression and Regression (intersecting)

Methodologically the critique and limitations of narrative have been elucidated upon in (Riessman, 2012) indicating that the narrative could pose over-personalizing personal

narratives, that the method may not be appropriate for studies of large numbers of nameless and faceless subjects. It is further stated that imagination and strategic interest influence how story tellers choose to connect events and make them meaningful and that the method offers storytellers a way to re-imagine their lives (Riessman, 2012). Other limitations include those identified in Hayward (2003) where he critiqued narrative on the basis of criticism of isolation, deserting the family, language, secretariasm and colonialism and ethical superiority particularly when it comes to therapy (Hayward, 2003). Other limitations are those identified in (Andrews, Squire & Tamboukou, 2013) which include that narrative research has no start or end point, it offers no rules about methods of investigating narrative whether through speech, interviews etc., or the level at which stories should be studied (Andrews, et al., 2013). Although narrative is considered exciting and insightful it has been criticized as "over complex, over simple, too long and too conventional" (Andrews, et al., 2013 p. 3).

Narrative has been applied in numerous papers as a methodology as demonstrated in (Mitchell & Egudo, 2004; Andrews, et al., 2013), it has also been applied in therapy as indicated in (Androutopolou, 2001) in terms of working with reports, novels, plays and film as an alternative or "safer" method to use instead of people relating stories in the first person (Androutoplou, 2002). It has also been applied as rhetoric in looking at narrative beyond the sequence of events to narrative in and of itself as an event (Herman, Phelan, Rabinowitz, Richardson & Warhol, 2012). The rhetoric looks beyond meaning of narrative but also looks at the experience.

Narratives approaches have also been applied in identity development and has been noted that narratives look beyond methodology but more into a construct. It is indicated that it is not the self that is measured by the stories; rather the self is the story (McLean & Pratt, 2006). In examining meaning making McLean and Thorne devised a system to label meaning as a report of lessons or insights (McLean, et al., 2006).

Throughout this report it acknowledged that stories that people tell are dependent on whom they are told to as well as the situation under-which they are told. In this study as later discussed, responses may have been influenced by the fact that the researcher was viewed as a "health specialist" therefore responses needed to be pleasing. This brings about

questions on the validity of the stories being told as they can be imagined, or narrated in the third person or in being selective about what story tellers want to share. Then again this would depend on what the researcher intends to do with the information whether the aim is to generalize their results or whether it is to understand particularities among individuals. In this study the latter was the objective. Qualitative methodology more broadly aims for the same purpose.

According to the researcher the stories or narratives are still the best data collection method and that scientists working in this field need to accept that the notion of "truth" in these stories are subjective and influenced by various factors but to also acknowledge this limitation in their work and not present their studies as absolute truth. The advantage of this method is it gives context and meaning of why people act, think and feel the way they do. Ultimately the outcome of this type of research is not to change how people act, think and feel but to devise mechanisms which could shape how their beliefs may change given the options. Given the previous paradigm shifts that have occurred, those that are in the development process and those yet to come. It is important to note that narrative or story telling remains an essential tool in understanding human behaviour from their own perspective and interpretation of their world.

2.2. Sex Work Vulnerabilities

2.2.1. Global Health burden of Sex work and HIV/AIDS

Since the beginning of the AIDS epidemic sex workers were thought to be the high-risk group for the transmission of HIV because seroprevalence studies indicated high rates of HIV infection in female sex workers in Africa (Estébanez, et. al., 1993). In the United States (US) and Europe it was feared that such women would spread HIV heterosexually and this belief lead to increased stigma, in some places led to restrictive legislation such as mandatory HIV testing and quarantining of infected persons (Estébanez, et al., 1993). Despite this notion, Willis (2013) recognizes that urgent attention and understanding of the

global health burden of sex work, including trafficking and transactional sex is needed in order to direct resources to those large and vulnerable populations (Willis, 2013).

It is acknowledged that although various studies have been conducted around sex work specifically around health problems, HIV and STI, alcohol and drug use, mental health problem, and violence, the global health burden of sex work remains unknown (Willis, 2013). Sex workers are a heterogeneous group in terms of their work environment, socio-economic status, health status, knowledge and practices of protective measures (Estébanez, et. al., 1993) therefore it is not factual to conclude that they are the "core" transmitters of HIV when their behavior is nuanced. However it is important to understand the burden of diseases in this population in order to design better interventions which are human-rights based and address their health care needs. HIV seropravelence rates amongst sex workers differs from country to country and within the same country and from one type of sex work to another, more than the assumption of promiscuity HIV transmission within this population may be associated with other risk factors such as drug injecting behaviors, having a steady partner who may be an injecting drug user (IDU) etc. (Estébanez, et al., 2006).

Cross sectional studies have been conducted to measure the HIV prevalence rates among female sex workers and it has been documented that these studies are challenging to implement due to the fact that the profession is surrounded by a great deal of stigma which leads women to not declare themselves as sex workers and hide their activity from family members and friends (Pascorn, et al., 2010; Estébanez, et al., 1993). Therefore obtaining representative samples of this population remains a challenge in conducting surveillance work because samples may be too small to be significant. Another challenge with this kind of research is sample sizes that are reached are often inadequate to determine estimates (Pascorn, et al., 2010). Also a lot of the women do not live in permanent private homes, they reside in workplaces which may be excluded in recruitment processes when using traditional research methods (Pascorn, et al., 2010). Thus there are no reliable denominators to estimate the total amount of HIV infection among the sex work population in many countries (Estébanez, et al., 1993).

From an epidemiological point of view high risk populations which include Men who have sex with men (MSM), People Who Inject Drugs (PWID) and Sex Workers (SW) are the most affected and infected since early days of the epidemic due to sexual practices such as multiple partner concurrency, and inconsistent condom usage and the presence of STIs which are a co-factor in HIV transmission (Pascorn, et al., 2010). However it is highlighted that it is useful to examine the rates of infection in terms of understanding the general patterns of transmission in different geographical regions (Estébanez, et al., 1993).

In the systematic reviews that were conducted in many countries it was found that female sex workers are at an HIV prevalence rate estimated to be fifteen fold higher than among the general female population (Pascorn, et al., 2010). In studies conducted in Pune, India they found an HIV prevalence rate of 54% among female sex workers by the year 2003 (Brahme, Mehta, Sahay, Joglekar, Ghate, Joshi, Khedar, Risbud, Bollinger & Mehendale, 2006). In China 1% of the female sex work population was HIV positive by 2004 (Wang, Chen, Ding, Ma, Ma, Jiao, Wu, Sharp & Wang, 2009). In Mexico in the Zona Norte red light district the HIV prevalence increased from less than 1 to 6% (Goldenberg, Engstrom, Rolon, Silverman & Strathdee, 2013).

In South Africa the HIV prevalence rates amongst sex workers is estimated at 59.6% compared to the 13.3% females in the general population (SANAC, 2013). In Pakistan, HIV prevalence rates were identified as low amongst transgender sex workers and absent amongst the total of 553 female sex work population who formed part of their cross sectional survey. This was attributed to the fact that the HIV epidemic is still at its early stages amongst people who sell sex for a living but what was further identified was the potential of spread of HIV due to the presence of high STI rates predominantly in the transgender population (Hawkes, Collumben, Platt, Laljil, Rizviz, Andreasen, Chow, Muzaffar, Rehman, Siddiqui, Hasan & Bakhan, 2009). In Cambodia cervical cancer was identified as the leading cancer resulting in death, the cause of this is the STI Genital Human Papillomavirus (HPV) which is the most common STI worldwide and the key agent in cervical cancer (Couture, Page, Stein, Sansothy, Sichan, Kaldor, Evans, Macher &

Palefsky, 2012). In a cross-sectional study they conducted they found an HIV prevalence rate of 15.8 % amongst young (age 15-29) female sex workers and HPV prevalence rates of 34.4% amongst HIV negative FSW and up to 78.8% amongst those who were HIV positive, the general HPV prevalence was at 41.1% indicating an urgent need to develop screening programs (Couture, et al., 2012). Currently routine HPV screening is not available in the country and few treatment options exist for women. An urgent need for cancer screening strategies and the need for immunization programs has been identified (Couture, et al., 2012).

In Israel with the metropolitan area of Tel Aviv which is a gay orientated community, where openly gay people reside, gay-related activities occur and commercial sex occurs the study looked at male sex workers (MSW) and divided the general population of MSM to high risk MSM (HRMSM) and low risk MSM (LRMSM) and risky behaviors were compared. The study found the STI burden among male sex workers to be at 28.3%, 23.5% among HRMSM and 10.3% amongst LRMSM (Mor & Dan, 2012). The HIV burden amongst MSW was 5.6% and 9.2% in HRMSM and 0% in LRMSM (Mor, et al., 2012).

In Nigeria which is the country with the second largest HIV epidemic estimated at 2.9 million after South Africa's 5.5 million in the year 2009, the HIV prevalence amongst sex workers was estimated at 75% amongst the estimated one million sex workers operating in the Niger Delta region (Udoh, Mantell, Sandfort & Eighmy, 2009). This was largely attributed to under-representation in national government i.e. the weak public health sector and poor education systems, the disproportionately smaller share of donor funding and region-specific political conditions which include: migration, poverty, and sex work. (Udoh, et al., 2009).

Marital status, typology, and presence of STIs which included infections such as genital ulcer diseases, genital warts, trichomonas, chlamydial infections, gonorrhea, and syphilis emerged as important factors that determined the probability of being HIV positive within the female sex work population (Brahme, et, al., 2006; Ramesh, Moses, Washington, Isac, Mohapatra, Mahagarohkar, Adhikary, Brahmann, Paranjape, Subramanian, & Blanchard,

2008). A number of HIV prevalence studies conducted screened and diagnosed for the STIs and in addition tested for HIV. In studies conducted in India HIV prevalence was higher among female sex workers who were not married and those who were widowed (Brahme, et al., 2006). This was attributed to the fact that married sex workers reported their husbands as being their regular partners therefore in their network they had restricted number of regular sex partners and limited irregular partners unlike those who are single (Brahme, et al., 2006).

It is eminent from the various studies referenced above that STIs are a co-factor in the transmission of HIV and multiple partnerships and inconsistent condom usage further contribute to the vulnerabilities of sex workers. Therefore interventions that are developed need to consider these issues. A number of interventions have been identified which have been described below which have ensured that the HIV prevalence amongst sex workers and their clients remain stable in some countries when other countries need to scale up existing interventions or share best practices on interventions which have been deemed successful.

In countries such as India (Brahme, et al., 2006) successful prevention interventions have led to increased and consistent reported condom usage amongst sex workers, and decreased STI prevalence rates as also demonstrated in (Paul, Beattie, Ur, Syed, Venukumar, Venugopal, Fathima, Raghavendra, Akram, Manjula, Lakshmi, Isac, Ramesh, Washington, Mahagaonkar, Glynn, Blanchard & Moses, 2008). Although condom usage with clients seemed to have increased due to the interventions introduced; condoms with regular sexual partners did not significantly change indicating that regular partners are possibly viewed as “safe” further indicating that when designing interventions sex workers should be educated to use condoms even with regular partners (Brahme, et al., 2006). Some interventions have led to the empowerment of sex workers enough to refuse sexual contact without a condom suggesting that safe sex interventions have a positive impact on safer sex choices of sex workers. Some interventions have led to stable HIV prevalence rates for long periods of time in countries such as India, Asia, Japan and Thailand e.g. the introduction of “no condom, no sex” programs, and “100% condom usage” programs. The

stability in HIV rates in India have been attributable to sex workers moving out of the community and a function of awareness of HIV education and reporting to the clinic early with suspicion of diseases as opposed to waiting until advanced stages of diseases progression (Brahme, et al., 2006).

It was further noted that in countries such as China, Vietnam, Nigeria where similar programs are not implemented; the HIV prevalence rates there were observed to be on the increase thus indicating that education and awareness amongst sex workers and their clients might help stabilize or reverse HIV transmission and improve HIV prevention techniques, further such interventions need to be socio-culturally acceptable and economically feasible to implement in each country (Brahme, et al., 2006). From the year 2005 UNAIDS emphasized the need to monitor indicators within the sex work population in all countries with concentrated epidemics (Pascorn, et. al., 2010) to help gain a better understanding of the population.

2.2.2. HIV Prevention Interventions for Sex Workers

The purpose of looking at different interventions in different countries is to be able to identify how a South African, sex work-context appropriate intervention can be designed which will include the minimum package of services that need to be included when catering to the needs of sex workers. There are many studies across the globe that have been conducted to design interventions to halter the spread of HIV within the sex work population however for purposes of this section the focus has been on studies where there was a significant drop in HIV prevalence and STI rates in the sex work population, or where the prevalence stabilized. Understanding the models adopted by other countries is crucial in order to learn how best South Africa can replicate the interventions.

In China as in South Africa "prostitution" (as referred to in legal terms) is still criminalized and therefore no specific tailor-made services exist which target sex workers unless they get arrested and detained in re-education centers. As a result the staff at the maternal neo-

natal hospital in Guangzhou, China felt there was a need for STI care for female sex workers outside of detention and started a program within the hospital which recruited sex workers through outreach activities whereby FSW were interviewed, counseled and tested for STI and HIV. Although 1.4% were found to be positive for HIV, STI rates were as high as 14% Syphilis, 32% Chlamydia trachomatis, 8% gonorrhea, and 12.5% trichomoniasis indicating high potential for the spread of HIV and also indicating a greater need for STI care and prevention programs (Van Den Hoek, Yaling, Dukers, Zhineng, Jiangting, Lina & Xiuxing, 2001).

In India substantial efforts have been made to increase awareness about HIV/AIDS amongst the sex work population one of the projects implemented was called Nigeria which was a program stressing "No condom, No sex" which was found to be successful (Brahme, et al., 2006). In other parts of India such as in Mysore, they implemented a community-led intervention program which included key components such as: community mobilization, peer-mediated outreach, increased access to and utilization of sexual health services and enhancing an enabling environment to support program activities. By 2004 the HIV intervention they implemented targeted female, male and transgender sex workers through the India Aids Initiative (Avahan) project of the Bill and Melinda Gates Foundation across 6 states in India namely: Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Naga land, and Manipur. The program took a rights-based approach with 3 key project focus areas: *community mobilization*-which included peer-mediated outreach, condom promotion, and provision, *increased access to and utilization of sexual health services*-expanding condom accessibility through social marketing and increased condom availability in non-traditional outlets and lastly, *creating an enabling environment* which is an environment that will support the program (Paul, et al., 2008; Ramesh, et al., 2008). Within the first phase of the project a participatory mapping activity was conducted to establish where sex workers operate from and to prioritize those areas, then they established a peer-mediated outreach team and simultaneously identified sexual health services providing treatment of STI and promoting positive health image where sexual health screening becomes the norm, having advocacy work done with police, local government officials, drop-in centers and a 24hour crisis response team to assist SW (Paul, et al., 2006).

These components indicating that a successful intervention requires the combination of sexual risk reduction, condom promotion, the improved access to STI treatment and structural components which include policy change and the empowerment of sex workers (Paul, et al. 2008). This program is currently implemented in South Africa as the Disseminating Avahan Lessons in South Africa (DALSA) project through Family Health International (FHI360) with the goals of supporting the South African National Aids Council (SANAC), the National Department of Health (NDoH), Department of Transport (DoT) and KwaZulu Natal provincial department of Health (KZN-DoH) to refine HIV prevention efforts and focus on proven approaches and adapt and coordinate these to make them SA specific. The researcher is currently working for this project by offering technical guidance to the National Department of Health's High Transmission Area (HTA) Program to scale up key population (SW, MSM, PWID/IDU, MMP, and TP) interventions.

Another intervention identified to be successful and sustainable in India was the Sampada Gramin Mahila Sanstha (SANGRAM) and Veshiya Anyay Mukti Parishad (VAMP) which demonstrated how sex workers can create strategies for HIV prevention, care and treatment from a rights-based approach (Pillai, Seshu & Shivdas, 2008). Their work aimed to address HIV in the rural parts of Maharashtra, northern parts of Karnataka and Mumbai and they stated that "in order to effect change among marginalized populations, it is crucial to create a sense of community by developing an awareness of community identity and from that building collective solidarity and secondly people in prostitution and sex work can become agents of social change, who can transform their own communities (Pillai, et al., 2008 p. 314). They show that the SANGRAM and VAMP approach differs from typical interventions because the project is sustainable as it is designed and implemented by the "insiders" who have a vested interest in the health of the overall community, and the approach recognizes sex workers as people first with full human rights and they further suggest shifting from focusing on high-risk groups to preventing risky behavior in the entire community (Pillai, et al., 2008).

Their approach was divided into two firstly *creating a sense of identity* and *collective solidarity* whereby outreach workers spent time with sex workers sharing life stories and gaining deeper understanding of the experiences of the people as women and as sex workers which forged trust and strong ties amongst the women (Pillai, et al., 2008). Through this process solidarity was forged and they used the concept of "responsible sex" throughout the program as opposed to "unsafe sex". The second approach was *recognizing sex workers as agents of change* and seeing them as information agents within their communities. The outcomes of the program were that it became a sustainable project that the women could identify with and lead to the recognition of sex workers as people with human rights (Pillai, et al., 2008).

Through systematic reviews that have been conducted evidence emerges that combining sexual risk reduction, condom promotion and improved access to STI treatment reduces HIV and STI acquisition (Shahmesnesh, Patel, Mabey & Cowan, 2008). It is indicated that in addition structural interventions such as 100% condom usage projects, policy change i.e. refining laws that criminalize sex work and the empowerment of sex workers further reduce susceptibility to HIV infection (Shahmesnesh, et al., 2008).

A program such as the Sonagachi project initiated in Kolkata, India looked beyond the clinical and prevention interventions and aimed to adopt empowerment strategies that can significantly impact the broader range of factors to reduce vulnerabilities to sex workers (Swendeman, Basu, Das, Jana & Rotherman-Borus, 2009). The program looked at community mobilization, rights-based framing, and advocacy and microfinance issues to support effective evidence on HIV/STI prevention (Swendeman, et al., 2009). What distinguishes this program from the others is it intervenes at multiples levels such as the structural environment, community level, social network level and at the individual level (Swendeman, et al., 2009) using core strategies common to women empowerment programs. The program was designed to look at common factors that make up women empowerment programs such as: providing a framework for change, increasing knowledge of risk and protective factors, building cognitive, affective and behavioral skills, reducing

environmental barriers to change, building on-going social support to sustain change over time (Swendema, et al., 2009).

The program has been said to have evolved into becoming a widely diffused model labeled as “the empowerment approach”. In order for the program to achieve its goals it adopted empowerment strategies common across women empowerment programs (Swendeman, et al., 2009). The program is founded upon the following: Education and leadership development, Media use and advocacy, Public education and participation, Organizing associations and unions, Work training and micro-enterprise, Enabling services and assistance and Rights protection and promotion (EMPOWER) (Swendeman, et al., 2009). The program’s success were the fact that the movement included more than 6000 sex workers and has been sustained and expanded to more than 60 communities in India (Swendeman, et al., 2009). The Sonagachi model has been used as a model for the Bill and Melinda Gates Foundation (BMGF) (Avahan) funded scale-up of HIV prevention targeting high risk groups in India (Swendeman, et al., 2009).

Historically interventions have stood on a three legged approach namely: *peer-education* which raised awareness regarding HIV, *condom distribution*/ social marketing which involves the distribution of male and female condoms and *periodic STI screening*, treatment and management (Kerrigan, Fonner, Stromdahl & Kennedy, 2013). Therefore the shift and inclusion of empowerment issues within interventions has added value to most interventions. Empowerment interventions recognize that sex work is work and should be respected as such and that trust should be bestowed upon sex workers in designing interventions as they know best to identify their health priorities and suitable responses therefore the design can be sex work led and enabling sustenance of programs (Kerrigan, et al., 2013). In this context empowerment is understood as a social process which seeks to challenge unequal power structures which inhibit the overall health and well-being of a given group (Kerrigan, et al., 2013). Therefore community empowerment in this case, is considered a structural intervention as it seeks to address the social, political and material conditions surrounding sex work in a given setting (Kerrigan, et al., 2013). Despite the growing number of empowerment interventions done; there is no study that has

systematically examined the evidence of the effects of community empowerment interventions among sex workers and related HIV outcomes (Kerrigan, et al., 2013).

In studies in Asia it was identified that HIV spread rapidly due to conditions of high vulnerability, sex work, injecting drug use, low condom usage, intact foreskin in men, and ulcerative STIs, migration and population mobility (Steen, Zhao, Wi, Puchihewa, Abeyewickreme & Lo, 2013). The estimated proportions of women in sex work ranged between 0.2-2.6 percent; therefore a number of interventions were reviewed in order to develop a national response (Steen, et. al., 2013). They looked at combination interventions that would lead to a decline in HIV/STI and ways to halter or reverse the epidemic. To achieve this process they looked at 10 countries within Asia with low level, concentrated and generalized HIV epidemic such as Bangladesh, Cambodia, China, Indonesia, Mangolia, Myanmar, Nepal, Thailand, Vietnam, West Bengal (Steen, et al., 2013). What was common in these countries was the success of the Sonagachi project as well as the 100% condom use program (100% CUP), both were labeled as structural interventions since they addressed conditions of sex work that influence the vulnerability of sex workers (Steen, et al., 2013). The Sonagachi project has been explained above. The 100% CUP project was first piloted in Rachabrin province in 1989, it was then scaled up nationally between 1991-1992, the program was successful as it saturated coverage in sex work establishments where condoms were made mandatory and establishments which did not comply would be shut down (Steen, et al., 2013).

In Mexico, the country considered to have hundreds and thousands of trafficked persons across international borders it was found that public health interventions that address the vulnerability and sexual exploitation of sex workers was lacking (Goldenberg, et al., 2013). In this country sex work is quasi-legal meaning to avoid persecution sex workers undergo routine HIV/STI testing to maintain health permits which are unavailable to minors (Goldenberg, et al., 2013). In their intervention as part of empowerment they allowed participants (FSW) to make their own recommendations to prevent sexual exploitation and youth sex work. Their recommendations included: *reducing susceptibility to sexual exploitation* by providing social support and peer-based education, mitigate harm by

improving access to HIV prevention resources, psychological support, and reducing gender-based violence (GBV), providing an opportunity to exit the sex industry via vocational support and improved access to effective drug treatment as they are a major contributory factor to FSW entering sex work (Goldenberg, et al., 2013).

In studies in Sub-Saharan Africa, the empowerment intervention conducted in Senegal seemed to stand out as sex work is decriminalized in the country and there are low and stable rates of HIV prevalence due to the decriminalization of the industry (Chersich, Luchters, Ntanganira, Gerbase, Lo, Scorgie & Steen, 2013). Sex workers there are required to register and attend monthly clinic visits and required to screen for STIs, get access to condoms and family planning (Chersich, et al., 2013). However it was found that a portion of the sex work population remained unregistered due to being below the age of 21 which is the legal age of sex work, others lacked identity papers whereas others were not aware of the registration process and believed the system compromised their discretion (Chersich, et al., 2013). These requirements do not seem fitting and prove that legalization may pose further challenges than solutions. In order to cater to the needs of this population; in other Sub-Saharan countries service delivery models included the provision of night clinics and taking STI treatment directly to the sex workers and their clients (Chersich, et al., 2013).

In terms of studies that addressed the empowerment of sex workers in Sub-Saharan Africa there was a trial conducted in Pretoria, South Africa which aimed to empower sex workers by building their skills in negotiating safer sex practices, refusing uncooperative clients, self-protection in violent situations and applying educational and counseling strategies to equip women with violence protection skills such as avoiding alcohol use, exiting violent situations and seeking community resources (Wechsberg, 2006 in Chersich, et al., 2013).

Sex work is considered one of the most dangerous professions as sex workers are exposed to drug use, diseases, violence, discrimination, debt, criminalization, and exploitation (Rekart, 2006). In order for successful harm reduction to take place a number of strategies have been made available e.g. education, empowerment, prevention, care, occupational health and safety, decriminalization and human rights based approaches (Rekart, 2006). It

has also been identified that successful interventions need to include peer-education training in condom negotiation safety, the availability of male and female condoms, prevention-care synergy, occupational health and safety guidelines for brothels, the availability of self-help organizations and community-based child protection networks (Rekart, 2006).

In South Africa progress has made in addressing sex work vulnerabilities through various NGOs that are service-delivery focused namely: Wits Reproductive Health and HIV Institute (WRHI), the National Department of Health's High Transmission Area Program (HTA), Sex Work Education, Advocacy Taskforce (SWEAT), Sisonke Sex Work Movement, LifeLine Durban, North Star Alliance, Trucking Wellness and the Women's Legal Centre Tswaranang legal Advocacy Centre and Networking HIV/AIDS Community of South Africa (NACOSA) (SANAC, 2013). Although rigorous research and data collection on efficacy of interventions is limited in the South African context; the development of prevention intervention policies at national level are still underway. There are several other organizations who work with sex workers; however WRHI is the first that provides a service delivery model with sex work friendly staff. At the national level several policies and training manuals are underway which target key populations under the HIV Prevention Strategies Directorate (NDoH) and SANAC namely the: National Department of Health's Health Sector HIV Prevention Strategy and the Key Populations Operational Manual, the Health Care Provision for MSM, SW and PWID which is an integrated training manual for health care providers to create an enabling environment and the National Sex Work Strategy and many others which will follow to guide the country on minimum package of services that need to be provided to key populations as well as using a "combination approach" to HIV prevention.

The combination approach combines three elements of HIV prevention: behavioural, biomedical and structural interventions (Jones, Cremin,Abdulla, Idoko, Cherutich, Kilonzo, Rees,Hallet, O'Reilly, Koechlin, Schwartlander, de Zalduondo, Kim, Jay, Huh, Piot & Dybul, 2014). Although data has not been collected yet on the efficacy of these interventions but this highlights the progress made nationally towards acknowledging key populations and their vulnerability. Although policies look at the broader definition of key

populations and implementing interventions to the benefit of all the NSP 2012-2016 key populations, it is deemed important to describe the planned interventions as sex workers are included in the definition of key populations.

The *socio-behavioural* component aims to focus on behaviour change communication to promote partner reduction in groups that report multiple partners, increase condom usage, increasing utilization of HCT and other services, using media to clarify values (NDoH, 2014). In addition, this component will be peer-led, whereby peer education and outreach will be conducted, the peer educators will do risk reduction counselling, and sexual health screening. Further they will promote, demonstrate and distribute male and female condoms and condom-compatible lubricants, motivational interviewing, skills building and distribution of IEC material (NDoH, 2012).

The *biomedical* component will focus on providing: HCT services, diagnosis, and treatment of STI, MMC, PMTCT, PEP, TB screening and diagnosis and condom provision and education (NDoH, 2014). Further to include HIV care and treatment (including ART), SRH services such as family planning, emergency contraceptives, cervical cancer screening, and the HPV vaccine (NDOH, 2012). In other studies it has been identified that some of the behavioural interventions such as ARV based microbicides, Pre-exposure Prophylaxis, and treatment as prevention have been viewed as “game-changers” by Michael Sidibé UNAIDS Executive Director and a lot more emphasis is based on biomedical interventions as prevention however less attention is becoming focused on the behavioural interventions (Overs & Loff, 2013). In the South African model the need for a combination approach has been adopted.

The *structural* component will include the sensitization of health care providers, addressing violence, gender inequity, ensuring adequate supply of prevention commodities (NDOH, 2012). In addition to providing appropriate policy legislation, aligning with various stakeholders working with sex workers and providing strong referral linkages (NDOH, 2014).

It is proposed in the National Department of Health's Key Population Operational Manual that additional care should be included such as: psychosocial support, support groups, support to violence and sexual assault survivors, family and social services (NDOH, 2012).

The lessons learned from these interventions are: that it is important to have an intervention which caters to the needs of sex workers meaning they must be involved in the design, implementation and evaluation of the interventions. This will give them a sense of ownership of the program and they will be able to prioritize issues which they deem important and will be able to sustain the program and behavior change because they have identified what works. Interventions need to include a combined approach which looks at structural, behavioral and biomedical aspects of what is needed. It is also evident that issues of empowerment are crucial to add as well as options for exiting sex work. All the factors combined have been proven to reduce HIV/STI vulnerability in many countries and can be scaled to countries such as South Africa where little has been done.

2.2.3 Sex Work and Law

Sex work in South Africa is still criminalized (Manoek, 2011; Criminal law Sexual Offences Bill, 2003). All voluntary selling or buying of adult sex work and all related activities are criminal offences; since it is difficult to prosecute individuals under the Sexual offenses Act authorities rely on municipal bylaws to arrest and prosecute sex work (Scorgie, Nakato, Akoth, Netshivhambe, Chakavinga, Nkomo, Abdalla, Sibanda, & Richter, 2011).

The South African Law Commission (SALC, 2009) aims to develop the best ways to deal with the myriad issues on sexual offences and it aims to do this is through the publication of discussion papers dealing with the various aspects of sexual offences. One of the key issues discussed were on developing solutions for the problems surrounding adult sex work and regulating prostitution (SALC, 2009).

According to the Sexual offences Act 1957, certain aspects of sex work are regulated i.e. sex work in and of itself is penalized, keeping a brothel, procuring women as sex workers,

soliciting sex work and living off the earnings of sex work is prohibited (Manoek, 2011). In the discussion paper developed by Helene Combrinck (2002) of the Community Law Center of the University of the Western Cape, along with research staff and members of the project committee, three options were developed in dealing with adult sex work in (Project 107, 2002). Those are: to *criminalize* all aspects of adult prostitution as criminal offenses, to *legalize* adult prostitution within narrowly circumscribed situations, or to *decriminalize* adult prostitution which involves the removal of all laws that criminalize prostitution (Project 107, 2002). Comments were invited to discuss the legal options provided.

Criminalization as it is the current state of law has not worked. Sex workers do not have the protection of the law and continue to be marginalized, facing violations of their basic human rights; they experience discrimination, harassment, and barriers when accessing health care services (Scorgie, et al, 2011). These issues drive sex workers underground and make them more susceptible to HIV infection (UNAIDS, 2012). This method has not resulted in eradicating sex work nor in reducing the number of people involved in the industry (Fick, 2006) instead it has the opposite effect; therefore better, more workable solutions need to be developed.

Legalization, involves legalizing certain aspects of sex work, further defined in Richter (2009) as sex workers working under specific conditions created by local municipalities and parliament whereby there would be specific “red light disctricts” where sex workers would be able to work, and sex workers would be expected to register with authorities and carry cards that identify them as sex workers and they would be forced to go for regular check-ups. The disadvantage of the legalization option would be that sex workers may bend these rules if the situation does not support the nature of their work for instance if the designated “red light districts” are not conducive for their work, sex workers may be forced to move out of this area to find clients thus posing further challenges of being arrested as they would be working outside of the designated areas (Richter, 2009).

By forcing sex workers to go for regular check- ups and placing them in designated areas of work; legalization compromises the following basic human rights: being entitled to standard care, liberty, privacy, freedom from arbitrary arrests, freedom of choice of employment , just and favorable working conditions, non-discrimination and prohibition of forced labor (UNAIDS, 2010).

Decriminalization of the industry involves the removal of laws that criminalize sex work this means sex work should be regulated by recognizing the industry as work and sex workers should be able to have the benefits of the protection of labor laws and occupational health laws. This method is considered the best option for the South African context because this would mean the industry would share the same regulations as any other industry (Richter, 2009). Human rights and women rights activists have been advocating this method for decades through organizations such as Sex Worker Education Advocacy Task Force (SWEAT) which is a non-profit organization working with sex workers on health matters and human right issues and Sisonke which is an organization run by sex workers for sex workers (Richter, 2009). More researchers and activists within the field of HIV are adopting a rights-based approach in addressing sex work interventions (Scorgie, et al., 2011).

It has been identified in South Africa that much of the vulnerability of sex workers to HIV/STI stems directly from the fact that their work is criminalized and they operate in a patriarchal context (Richter, Chersich, Scorgie, Luchters, Temmerman & Steen, 2010). Criminalization of the industry is not a feasible option as it leads to: *barriers in accessing services* these include access to health and social services and biomedical services, *increases in sexual and gender-based violence* as it prevents sex workers from reporting abuse to the police and seeking legal recourse after sexual assault and rape. These further strengthens the client's power and dominance over the sex workers and leads to other forms of abuse such as unlawful arrests, rape, sexual assault, extortion and bribes (Richter, et al., 2010). Criminalization also leads *to unsafe working conditions* where sex workers can operate from crime-laden areas because sex work is illegal, *difficulty negotiating condom use* as sex workers are afraid the client may respond violently if refused sex without a

condom, some clients hire other sex workers who are willing to engage in sex with no condom and *stigma* whereby discrimination, abuse and violence against sex workers seems to be condoned (Richter, et al., 2010).

In Canada similar reasons were stated to fight for the decriminalization of sex work. The current criminalization state includes: (a) the belief that criminalization fuels and fosters violence against women, men and transgender sex workers, (b) it undermines sex work access to justice, (c) hinders ability to maintain physical and sexual health, (d) it denies sex workers the protection of labor laws, (e) it limits their work options e.g. if they have a criminal record of being sex workers they experience difficulty finding alternative employment, (f) takes away sexual autonomy, (g) marginalizes and isolates sex workers, (h) creates barriers when addressing harm, (i) legitimizes discrimination and (j) criminalizing clients not being a solution (Mensah & Bruckert, 2012).

The relevance of the legal framework is to indicate and concur with (Richter & Chakuvinga, 2012) that for "as long as sex workers, their clients and partners remain criminals, no intervention will be effective" (Richter, et al., 2012 p.66). It is evident in the other studies where sex work was decriminalized or quasi-criminalized that HIV/STI prevalence rates decreased or stabilized and work conditions were regulated, and sex workers could access the justice system.

2.2.4. Sexual Health Practices

In acknowledging the role played by STIs as a co-factor in the transmission of HIV there needs to be a further recognition of certain vaginal practices which have the potential to further fuel the vulnerability and susceptibility of women to STI and HIV infection (Myer, Denny, DeSouza, Burone, Wright & Kuhn, 2004; Hilber, Chersich, van de Wijgert, Rees & Temmerman, 2007; Beksinka, Rees, Kleinschmidr & McIntyre, 1999; Francis, Baisley, Lees, Andrews, Zalwango, Seeley, Vandepitte, Ao, van de Wijgert, Watson-Jones, Kapiga, Grosslarth & Hayes, 2013; Brown & Brown, 2000) however little is known about how biological vulnerability occurs (Hilber, et al.,2010) .

Certain practices have been identified to increase the prevalence of bacterial vaginosis (BV) and lead to the exacerbation of other reproductive-tract infections resulting in increased vaginal discharge which in turn encourages vaginal practices (Hilber, et al., 2007; Turner, Morrison, Munjoma, Moyo, Chipato & van de Wijgert, 2010; Hilber, Hull, Preston-Whyte, Bagnol, Smit, Wacharasin & Widvantoro, 2010). In past decades cross-sectional and longitudinal studies have found adverse reproductive health outcomes such as pelvic inflammatory diseases, ectopic pregnancy, and BV associated with intravaginal practices (Hilber, et al., 2007).

The substances inserted are said to cause disruption of the membranes lining the vaginal and uterine walls leading to abrasive trauma during intercourse thus placing the women at greater risk of acquiring HIV and STI (Morar, Ramjee & Karim, 1998).Some products cause extreme dryness fostering epithelium trauma during intercourse for both men and women (Brown, Ayowa, Brown, 1993). Products that have been mentioned in various studies include: traditional products such as herbs, leaves, bark, fruit, stones, food stuff, soaps, creams, household detergents, antibacterial products like savlon (Hilber, et al., 2010). Commercial products used included snuff (crushed tobacco), tiger balm (which is an anti-itching remedy used for colds, headaches and insect bites), staaldruppels (which is an oral remedy for iron deficiency and stopping bleeding) other general items included whisky, newspapers, silver bullet, and traditional medicines “imithi” (Gafos, Mzimela, Sukazi, Pool, Montgomery & Elford, 2010). Drying the vagina was found mainly in African studies (Beksinka, Rees, Kleinschmidr & McIntyre, 1999) whereby women inserted substances like tissue, cloth and drank preparations to cause a drying effect on the vagina (Beksinka, et al., 1999).

These behaviours contradict HIV prevention methods which promote the use of female and male condoms leading to low/no condom usage in order to experience the full effect of these products (Beksinka, et al., 1999). Studies in KZN described a practice which included incision of the genital area “ukugcaba” to introduce herbal substances as a way to cement relationships and increase sexual pleasure, the incision is done using a razor blade and

herbal treatment to attract men and keep them sexually satisfied (Scorgie, Beksinka, Chersich, Kunene, Hilber & Smit, 2010).

A number of authors hypothesized that these practices deserve greater research attention as some of these behaviours are abrasive and harmful (Hilber, et al., 2007).

Studies have been conducted previously in Africa and abroad focusing on sexual health practices generally in the population, this study focuses specifically on the sex worker population in Hillbrow. To the knowledge of the researcher, and in the literature review conducted no studies have been conducted to understand sexual health practices of sex workers in Hillbrow, however there have been studies conducted in KwaZulu- Natal (KZN) (Morar & Karim, 1998) and Cape Town (Myer, et al., 2004) amongst sex work population and women with high numbers of lifetime sexual partners.

Sexual practices in this study include vaginal practices and "health" practices that women engage in which although considered "healthy" by the women may in actual fact be harmful as demonstrated by evidence. Vaginal practices are defined to include washing, modifying, cleansing, enhancing, drying, tightening, lubricating or loosening the vagina, labia, clitoris and hymen (Hilber, et al., 2010). Including substances that are applied, ingested, inserted or steamed (Hilber, et.al, 2010). Health practices are those considered to heal the vagina through intravaginal cleansing, traditional cutting, and insertion of herbal preparations and application of substances to soothe irritated vaginal tissue (Hilber, et al., 2010).

These practices have been documented worldwide including: the reasons why they are done, frequency as well as products that are used to achieve the desired vaginal state (Hilber, et al., 2010).

In the World Health Organization Multi-Country study on Gender Sexuality and Vaginal Practices (2007) a framework of six distinct types of vaginal practices were identified to assist with categorizing the varied practices conducted worldwide and to enable cross-study

comparisons when conducting research of this nature (Hilber, et al., 2007; Gafos, et al., 2010). The practices were categorized into: *external washing with or without products, external application of products around the vulva, anatomical modifications, intravaginal cleansing with/ without products, intravaginal insertion of products and oral ingestion* (Gafos, et al., 2010). This standardization is believed to offer more detailed measures of vaginal practices and can also improve the quality of research. An illustration has been included in Fig2.5 below adopted from (Gafos, et al., 2010). It labels the practices in the centre, and describes the 6 practices identified as well as their definition.

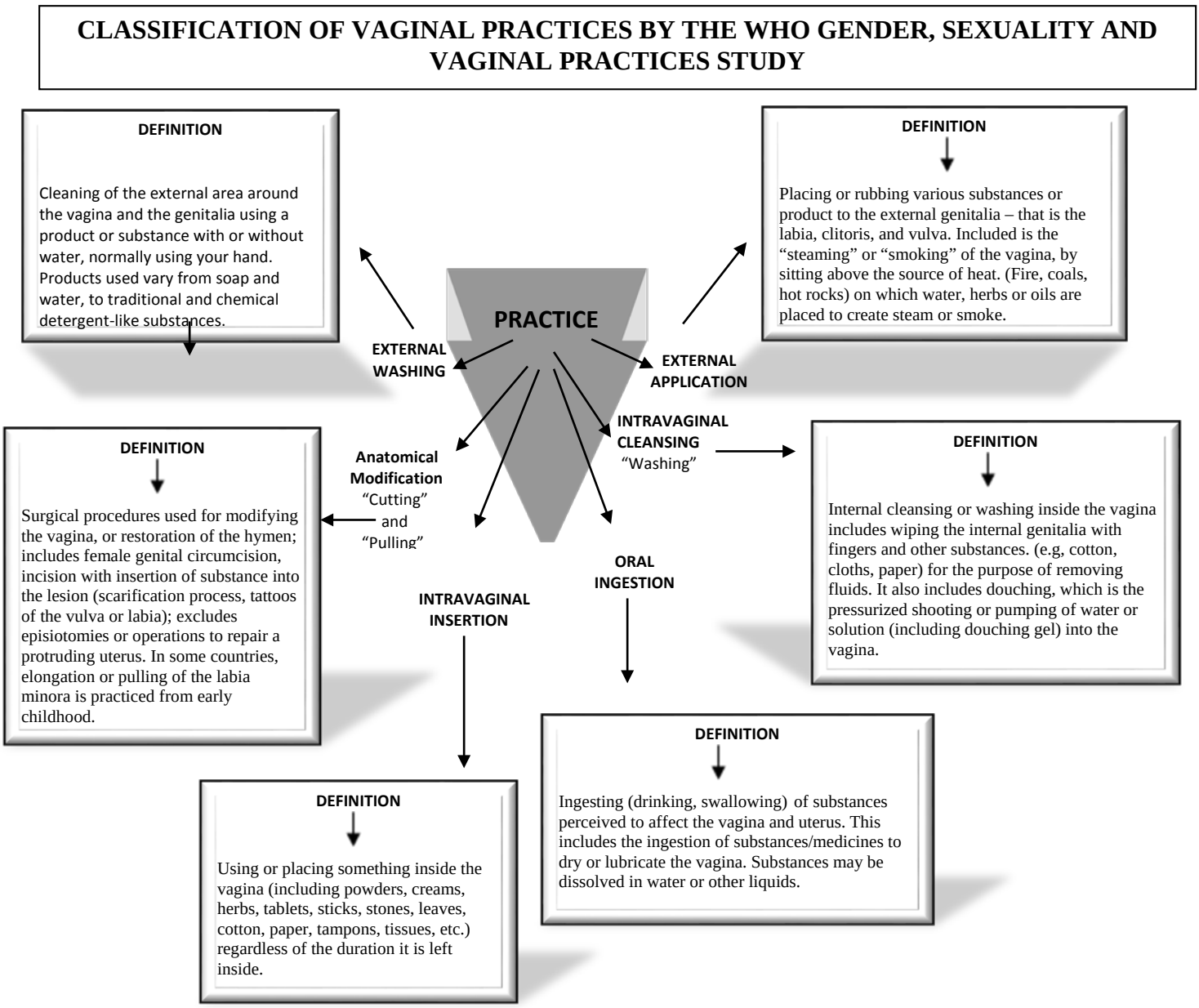


Fig. 2.5. WHO Classification of Vaginal Practices

The reasons stated by women for engaging in these practices varied across countries generally the reasons stated were related to hygiene, genital health, well-being/sexuality

and a tool they used to create balance in their relationships and bodies in most cases it was an attempt used to overcome undesirable discharge and odour (Hilber, 2010). in other studies they stated treating STI, preventing pregnancy, inducing abortion, enhancing sexual pleasure for the male partner, or used as a "love potion" to attract and retain sexual partners, maintain fidelity, to treat vaginal itching, and cleansing the presence of seminal fluid following sex (Gafos, et al., 2010; Schwandt, Morris, Ferguson, Ngugi & Moses, 2006; Morar & Karim, 1998; Turner, et al., 2010).

The relevance of these behaviors is two-fold in that they demonstrate the unequal power distribution between men and women in terms of their willingness to engage in behaviors that could further pose a danger to their life and the role played by these methods when implementing HIV prevention modalities. The role of gender is a significant influence limiting the power of women to negotiate their own sexual lives and added concerns of intimate partner violence are documented as determinants of poor sexual and reproductive health outcomes (Hilber, et al., 2010). Most clearly vaginal practices and their motivations reveal much about the gendered nature of the HIV epidemic and its underlying drivers (Hilber, et al., 2007). In resource constrained settings where sex may be the primary means of achieving economic security either directly through sex work or through maintaining economically essential relations with sexual partners/husbands optimizing pleasure for men becomes prime importance to women (Hilber, et al., 2007).

Women may spend considerable proportion of their limited resources on such products hoping to obtain a return from their investment by achieving the vaginal state desired by men (Hilber, et al., 2007). In settings with unequal gender power and economic disparities women continue to have limited ability to negotiate protected sex and continue adopting practices which explicitly aim to satisfy men's sexual desires (Hilber, et al., 2007). It was evident in Morar & Karim (1998) that women were willing to undergo pain and suffering in order to enhance sexual pleasure for their partner (Morar & Karim, 1998).

Researchers have also been concerned with how these practices may affect condom usage and microbicides which are key elements to HIV prevention efforts (Hilber, et al., 2010). Microbicides are defined "as experimental products that are currently evaluated to find out

if they reduce HIV infection for women during sexual intercourse" (Gafos, et al., 2010 p.929). All HIV prevention microbicides tested to date have been vaginally applied, lubricant-based gels that women insert vaginally prior to sex (Gafos, et al., 2010). Microbicide trials were also concerned about women who remove vaginal lubrication or cleanse the vagina around the time of sex as they may unintentionally remove or dilute the microbicides product (Hilber, et al., 2007). Of more concern was that substances inserted in the vagina may interact with the microbicides with potentially harmful by-products of such reactions and identified that chemical reactions may occur (Hilber, et al., 2007). Evidence in sub-Saharan Africa demonstrated a high acceptability of the gel; however scientists questioned whether these gels will be acceptable among women who engage in vaginal practices to achieve dry sex (Gafos, et al., 2010). This study by (Gafos, et al., 2010) was the first to investigate acceptability of microbicides to populations that preferred dry sex. The study found that using the gel was acceptable and recommended that when developing a marketing strategy for the use of the gel; local perceptions of communities, sexual practices, preferences and expectations should be considered (Gafos, et al., 2010).

2.2.5. Conclusion

This chapter described the theoretical framework and gave empirical evidence supporting vulnerabilities of sex workers. The chapter discussed the legal framework that continues to infringe on basic human rights of sex workers, it also discussed factors that lead to increased susceptibility to HIV as well as best practices from other countries that need to be considered when developing behavioral interventions. The chapter also discussed the power inequalities women have in relation to making decisions about sex, and vaginal practices and linked this to interventions that intend to introduce microbicides as a biomedical intervention. The next chapter describes the methodology that was employed in conducting the study.

CHAPTER 3

Research Design and Methodology

3.1. Introduction

This chapter discusses the methods employed in this study. Firstly, it outlines the qualitative research design which describes how the research was conducted; it describes the participants who formed part of the study, the inclusion and exclusion criterion as well as the research setting. It describes how access was gained to the private house, how the population was sampled and procedures that were followed. Thereafter, it explains the data collection methods that were incorporated and describes how the study was piloted before conducting the research. A summary of the field notes that were taken during the data collection process have been included as well as a description of how data was analysed. This chapter concludes by discussing ethical issues that needed to be considered when implementing a study of this nature and reflexivity of the researcher's position as it emerged in the study.

3.2. Research Design

This study utilised the qualitative-interpretative approach; in that emphasis was placed on understanding the social world through examining the interpretation of that world by its participants (Bryman, 2008). This nature of research allowed for the exploration of human actions and interactions as they occurred within their natural settings (Bless, Higson-Smith & Kagee, 2006) and therefore this method was considered ideal for the current study.

The qualitative approach to social research is further described as a holistic approach stemming from an antipositivistic interpretative approach (de Vos, Strydom & Delport, 2002). It produces descriptive data in the participant's own written and unspoken words and involves identifying a participant's beliefs, and values that underlie the phenomenon. The approach is considered as a phenomenology strategy of qualitative research. Its aims

to understand and interpret the meanings subjects give to their everyday life and the researcher should be able to enter the participant's life world and setting (de Vos, et al., 2002). It emphasizes the importance of personal perspective and interpretation. This method is said to be powerful in understanding subjective experiences, gaining insights into people's motivations and actions (Lester, 1999).

The strength of this type of research is that it provides the "human" side of an issue; it also presents the contradictory behaviours, beliefs and opinions as well as emotions on relationships of individuals. Additionally, it seeks to understand a given research problem or area from the perspectives of the local population that is studies (Mack, Woodsong, MacQueen, Guest & Namey, 2005). Its methods are flexible therefore allowing greater spontaneity and adaptation of the interaction between the researcher and participants. Its methods mainly ask "open-ended" questions allowing participants to respond in their own words and in greater detail (Mack, et al., 2005). It is for these reasons that the researcher chose this approach as best to understanding sex work within this particular context.

3.3. Participants

The women in this study all self-identified as sex workers, their age group ranged from 21-43 years old, and represented different cultural groups namely Zulu, Sotho, Siswati, Ndebele and Shona. All the women in the study were black and of African origin, this in no way is indicative of the fact that other races do not make up part of the sex work population; however what it does indicate is the fact that the private house selected only had black female sex workers. Further, the women were from provinces within South Africa such as KwaZulu-Natal and Mpumalanga and some were from surrounding countries such as Zimbabwe and Swaziland.

Their levels of education varied from completing tertiary qualification, completing high school, dropping out of high school and/or completing basic education. All sex workers in the study were single. The number of years they had been in sex work ranged from 2 months to 13 years. All the women in the study were recruited from the private house. A breakdown of their demographics has been given in Table 3.1 below:

Participant	***Age***	***Highest Education Level***	***Country/Province***	***Number of Children***
**[1] Joy*	*22*	*Grade 9*	*Zimbabwe*	*0*
Loveness	*22*	*Grade 9*	*Zimbabwe*	*1*
Lerato	*22*	*Completed high school*	*Johannesburg-Randfontein*	*1*
Sibongile	*28*	*Completed high school*	*Swaziland*	*1*
Sunshine	*32*	*Tertiary qualification*	*Zimbabwe*	*2*
Linda	*30*	*Primary Education*	*Zimbabwe*	*1*
Carol	*21*	*Completed high school*	*Zimbabwe*	*1*
Brightness	*29*	*Completed high school*	*Zimbabwe*	*0*
Sponono	*43*	*Completed high school*	*Nelspruit*	*2*
Zodidi	*34*	*Grade 9*	*KZN-KwaMashu*	*0*

Table 3.1: Demographics of sex workers

[1]The asterisks indicate pseudonyms have been used

3.4. Inclusion and Exclusion Criteria

Women under the consenting legal age of 18 were not included in the study, in order to avoid ethical issues around child sex work. Although child sex work and human trafficking remain prevalent issues of exploitation in a number of countries including South Africa (Adepoju, 2005) it was not the focus of the study at hand.

The inclusion criterion for this study were: women aged 18 and above, self-identifying as sex workers, their primary source of income is sex work, residing in the Hillbrow area, and able to give written and verbal consent to be in the study.

3.5. Research Setting

This study took place at a private house within the Hillbrow community. The private house is a brothel however for purposes of this study the term private house was chosen as a less stigmatizing description of the setting. Hillbrow is described as a densely populated suburb located in the inner city of Johannesburg, South Africa. In 2006, it was estimated that over 50 000 people lived in approximately 200 high rise apartment buildings and hotels (Stadler & Delany, 2006). It is estimated that at least 90% of Hillbrow's population live in blocks of flats; the remainder live in hotels, streets, in domestic quarters on the roofs of blocks of flats or in negligible residential homes that are still standing (Morris, 1999.) The number of people living in this area has since increased over the years. In 2006, it was estimated that 19,143 people lived within the Inner-city of Johannesburg (Rust, 2006). Currently, population estimates are at 74, 131 according to the 2011 Census, and 49.44% of the population being female and 50.56% being male (Stats SA, 2012).

Initially this suburb was designed as low-cost accommodation for young families and immigrants and is said to be one of the suburbs in Johannesburg to retain a mixed race profile throughout the implementation of the apartheid policies (Morris, 1999; Stadler, et al., 2006). Currently, it accommodates a large migrant population from countries north of

South Africa and it is notorious for inner city crime, drug dealing and sex work (Stadler, 2006, p.452). The researcher chose this setting as the ideal area as previous research indicates that sex work is common within this community (Pettifor, Beksinka, Rees, 2000; Rees, Beksinka, Dickson-Tetteh, Ballard & Htun, 2000) and the community is highly mobile, and popularly known for its history of sex work.

Sex workers were estimated to be between five to ten thousand in the year 2000 (Pettifor, et al., 2000; Rees, et al., 2000) however it is challenging to keep track of these numbers as this is a highly mobile and hidden population. Recent population size estimates indicate that there are 153, 000 sex workers operating in South Africa of these, 4,427 are located in the Hillbrow Johannesburg area (SANAC, 2013).

3.6. Accessing House 222

The researcher viewed a number of houses, streets and hotels within the Hillbrow community as potential areas where the research would be conducted. Some of these places visited included Diplomat, Summit, Royale and the private houses. The researcher eventually settled on the private house called *House 222 due to availability of sex workers in terms of time and practicalities of space. The house number has been changed to further protect the venue. The first places seen did not provide space, other hotels were busy on a daily basis and were not practical to allow sex workers to spend time talking to a researcher.

The researcher therefore settled on House 222. This is a private house which accommodates on average 30 sex workers, they have individual rooms (at times have a roommate) separate and surrounding the main house which has the bar area. This is where they recruit clients. The house has a pool and lapa area where clients are entertained. Their busiest days were from Wednesday to Sundays which made data collection less difficult as the researcher collected data on Monday and Tuesday mornings. The sex workers reported that they had never participated in any research studies. During the first visit they showed a keen interest in talking about their lives. Permission was obtained telephonically from the House Manager as he only goes to the private house on selected days and specifically at night to welcome clients. The house has a security guard at the entrance to limit access of guests visiting the house and to provide security to the women who live there.

3.7. Sample

The sampling method employed in the study was purposive sampling. The goal of this method is to sample participants in a strategic way such that those sampled are relevant to the research question (Bryman, 2008; Green, Thorogood, 2004). The case that is chosen is chosen because it illustrates some feature or process that is of interest for a particular study (de Vos, et al., 2002). The researcher samples and ensures that there is variety within the sample and that participants may differ in terms of key characteristics (Bryman, 2008).

In total 20 sex workers within the selected private house were approached but only a sample of 10 was obtained and interviewed. Some participants had indicated they were not interested in the study, others refused the recording of the interview and others gave their contact details but could not be reached after 3 attempts.

3.8. Procedure

The target sample was approached by using the social network theory's egocentric approach as designed in (Doherty, Padian, Marlow & Aral, 2005) whereby the ego is identified and it later identifies the alters. In the egocentric approach the index subject is identified (ego), and asked to give names of people who are closest to the ego, (alters), they are requested to state the duration of their relationship, how often they see each other and other demographic details of each individual (alter) (Doherty, et al., 2005). The alters in turn play the role of the ego and identify more alters, which is a technique similar to snowballing and respondent driven sampling (Heckathorn, 1997). These methods rely on individuals or participants to recruit a limited number of their peers, who in turn recruit a number of their peers continuing along the recruitment chain until the sampling goal has been reached (Heckathorn, 1997).

The researcher teamed up with the Community Programs team that works on the Sex Work Project within the Wits Reproductive Health and HIV Institute (WRHI), the project coordinator of the study would send a monthly roster of the scheduled hotels, and street outreach work that needed to be conducted for each month, on the day that House 222 was

scheduled; the researcher would go out with the team to collect data, this also depended on the day of the week and the less busy days were selected.

The researcher supplied the sex workers with information sheets (see Appendix C) as they waited for their clinic visits and informally told them about the planned study. The first ego was identified as a sex worker who had lived at the private house for the longest period of time, she seemed to be the confidant of some of the girls who lived there, had never participated in research previously and was available during the first visit.

Once participants agreed to be in the study, based on the information provided in the information sheet; a time was scheduled for the interview to avoid their busiest days. Prior to each individual interview, a venue was arranged in the room of the willing participant or a friend as space was limited. The participant was then given a copy of the consent form (see Appendix A) as well as a copy of the recording form (Appendix B) to complete. The interview guide (Appendix D) was used to guide the flow of the interview, but the researcher did not limit the discussion to what was in the guide only, there was room to explore further upon issues that were raised by the participants but were not in the guide.

During the interviews the researcher took down notes including observations of the environment, interruptions that occurred during the interviews, non-verbal cues as well as other behaviours that participants engaged in such as smoking Marijuana, fights and the like. All interviews were recorded using the Olympus Digital Voice Recorder DM-450. All interviews lasted between 30 to over 60 minutes and were conducted in the local language of choice that the participants were most comfortable with namely; English, isiZulu and in one case SeSotho.

3.9 Data Collection Methods

Individual in depth interviews (IDI) were the primary method of data collection. Data was collected from May to September 2011. IDIs were selected because they are optimal for collecting data on personal histories, perspectives and experiences particularly when exploring sensitive issues (Mack, et al, 2005). The interviews were semi-structured in that

the researcher had an interview guide which comprised of a list of questions to be covered (see Appendix D). The researcher allowed a great deal of leeway in how the participants replied (Bryman, 2008). In this type of interview, questions may not necessarily follow the exact way as outlined in the guide because the researcher explores more on what the participants said at the time. However, all the questions were asked and in some cases were worded differently to suit the situation at hand. The researcher probed where necessary or asked for clarifications where there were misunderstandings. The advantage of this method is that it is flexible and the emphasis is on how the participant frames and understands issues, events, patterns and forms of behaviour (Bryman, 2008). Participants were advised of this method during the first visit and they indicated an interest in talking about their lives.

The experience of conducting the actual research was facilitated by working closely with the Sex Work Project (SWP) Team. Working with this team eliminated all concerns around safety, as the researcher was never alone on site. Participants were interviewed by the researcher and the skills the researcher had acquired over the years made it easier to build rapport and to probe where necessary.

The logistics of data collection were as follows: the SWP nurse usually conducted clinic visits in one of the rooms that belonged to any volunteering sex worker; they usually were understanding and offered their rooms, but the researcher's interviews required a separate room, which meant two sex workers (if they had no roommate) had to give up their rooms for several hours and not conduct business on that particular morning. This at times meant conducting three interviews on the day as women snowballed one another. This exercise became exhausting but the life histories of these women provided the researcher with ongoing motivation.

Some women during the interviews reported being victims of rape and expressed feelings of trauma and difficulty in reporting cases due to the invasive nature of questions asked by the same police who arrest, bribe and deport them back to their countries. These women often felt there was no way out. These rape incidences were reported during the interview as retrospective accounts of what had happened, when counseling was offered at the time

of the interview- most women rejected the referral for counseling and explained that therapy would mean talking and reliving incidences which they desperately wanted to put behind them in order to move on with their lives.

The overall research experience was informative and at times one that was frustrating especially when the researcher felt helpless regarding the circumstances of some of the women. For instance when women would relate how they were raped (often by more than one person) and robbed of their money. Others felt they did not want to report the rape because they saw no point to it as they were already HIV positive at the time of the incident therefore Post-Exposure Prophylaxis (PEP) would not have helped them in any way. Post Exposure prophylaxis is often offered to rape victims and it is supposed to be taken within 72 hours after the incident to prevent HIV sero-conversion (WHO, 2007). These findings are further discussed in Chapter 4 in the results chapter. These points just demonstrate the challenges the researcher experienced when collecting data.

3.10. Piloting the study

A pilot is referred to as a feasibility or small experiment designed to test logistics and gather information in order to improve quality and efficiency of a study. It is further defined as experimental, exploratory, test, preliminary trial or try out investigation in the paper by (Thabane, Ma, Chu. Chena, Ismalia, Rios, Robinson, Thabane & Giangregono, 2010). This method is often used in clinical trials however; in this study it was used to test the feasibility of the tools and methods on a small scale. The pilot is often informal and a few respondents who possess the same characteristics as those in the main investigation are selected to determine whether the relevant data can be obtained from the respondents (de Vos, et al., 2002).

Pilot studies are said to play an important role in health research in terms of providing information for planning and justifying randomized control trials (Lancaster, Dodd, & Williamson, 2002). They may often lead to study design changes as was the case in this study whereby the social mapping exercise was dropped. It is further noted in (Lancaster,

et al., 2002) that the major reason for conducting a pilot is to test data collection tools as this will ensure that the tool/form is comprehensive and ensure appropriateness that questions are well defined and clearly understood and presented in a consistent manner (Lancaster, et al 2002). It is for this reason that the tool and documentation were tested. It was also to test the feasibility of the social mapping exercise activity and to estimate the duration of the interview taking into cognisance that there was no reimbursement in being in the study therefore not intentionally taking up too much time that participants were willing to give.

The researcher piloted the information sheet, consent form and recording form with two participants who were sex workers and had become sex work peer educators a week before beginning data collection at the private house. These interviews were conducted at the researcher's office in Hillbrow. The information that participants shared during the pilot was included in the analysis. Therefore this process was not considered separate as useful information came from this activity.

3.11. Field Notes

The researcher took down some observation notes during the process of data collection. Participant observation is a qualitative method, in the observation of the participants the emphasis is on both one's own and the participation of others (de Vos, et al, 2002). The researcher observes both the human activities and the physical settings in which activities take place (de Vos, et al, 2002).

The researcher took notes on non-verbal cues, the activities that occurred on site, what the participants looked like and sounded like. Overall in this study participants felt the interview was an opportunity to talk and share their experiences with someone who was willing to listen and learn. When conducting research in the natural environment of where sex work occurs one has to keep an open mind. Sex workers often smoked marijuana and interrupted the interview process by wanting to see what was going on during the interview. They wanted to know who the sex workers were talking to and why. They had pornographic material on their walls which other people may find offensive. Some participants seemed disinterested during their interview, some were shy and some were open and vocal about

issues that affected their lives. The researcher also noted some moments during the interview whereby participants became emotional or when they showed no emotion.

The interviews usually took place in the morning and in the participant's rooms the researcher would find their beds not made and the women still wearing their night wear. The researcher would also take notes on what the participants looked like if they had distinct features.

The researcher would take notes of how the women would respond to questions and whether they kept eye contact, laughed and where issues had to be probed further. Most interruptions occurred if the participants had to go and see the nurse; the interview had to be paused to allow them to seek their services. At times this would lead to a loss in train of thought but the researcher would summarize what was discussed before proceeding with the interview.

Some of the interviews revealed the women's levels of resilience some related painful stories but also related stories of overcoming. Most of the participants made reference to God indicating their faith in spite of their challenges.

3.13 Data Analysis

Data was analysed utilizing the thematic content analysis method. According to the article by Braun and Clarke (2006) thematic content analysis "is defined as a method used for identifying, analysing and reporting patterns (themes) within data and organizing and describing data in rich detail" (Braun & Clarke, 2006 p.79). In the paper it is further described as a foundational method of analysis that researchers should learn as it provides core skills that are useful when conducting other analysis (Braun & Clarke, 2006).

Thematic analysis is said to be divided into 3 phases namely the *essentialist/ realist method* which reports on experiences, meanings and the reality of the participants. The *constructionist method*, which examines the ways in which events, realities, meanings and experiences of people are the effects of a range of discourses operating within society. Lastly the *contextualist method* which sits within the two previously identified posts and

acknowledges that individuals make meaning of their experiences and in turn are influenced by their broader social context (Braun & Clarke, 2006).

It is the latter approach which was chosen to guide the analysis of this data based on its definition that although the individual makes meaning of their own experiences, they are also influenced by their society. An example of this in this study is the case of female sex workers giving meaningful accounts of why they engage in certain sexual practices and how their behaviours are often influenced by their social context through the discussions they engage in with other sex workers and the nature of the highly competitiveness of the industry and desires to keep up with the industry.

The audio files from the interviews were downloaded onto a password protected computer and the files were simultaneously transcribed and translated verbatim. The 6 phases of thematic analysis were followed in conducting the analysis as suggested in Braun and Clarke, 2006 of: a) becoming familiar with the data, b) generating initial codes, c) searching for themes d) reviewing themes e) defining and naming themes and f) producing the report (Braun & Clarke, 2006).

The complete transcripts were then loaded in the Hermeneutic Unit (HU) in Atlas Ti for analysis purposes. A total of 97 codes and sub-codes were developed as a code framework and entered into the code book manager and later applied to analyse text. Data coding took place in a manner that codes were dragged and applied to a particular sum of text relevant to the code as illustrated in Fig. 3.1 below.

In succession to the development of the codes and application of the codes took place, code reports were generated and read through to facilitate the write up of the results. Quotations were extracted from the reports to capture what participants said in their own words, how they interpreted their actions, and how they felt. These were later linked with theory. Careful consideration was given in extracting the quotations as the researcher felt all the data was equally crucial to include in the report; however only a few cases could be presented to enhance the structure of the argument and place emphasis on the findings.

There were four broad themes that were elicited to answer the research question, namely:

- Life Histories
- Social networks
- Sexual Practices
- Sex Work and Health

A theme is described as something important about the data in relation to the research question; it represents some level of patterned responses or meanings within a data set (Braun & Clarke, 2006). The level at which themes were developed followed the latent/interpretative level which is described as moving beyond semantics of the data and moving to a process of identifying underlying ideas, assumptions and conceptualizations that are theorized as shaping or informing the semantic content of the data (Braun & Clarke, 2006). According to Braun & Clarke (2006) there are two types of themes: semantic and latent themes. A semantic theme "is identified within the explicit or surface meanings of the data. It does not look beyond what the participant has said or what has been written" (Braun & Clarke, 2006 p.82). The latent theme goes beyond the semantic it starts identifying the underlying ideas, assumptions and conceptualization and follows a constructionist paradigm. It is the latter method that was used to coin the themes because the development of these themes involves interpretative work and the analysis produced will not just be a description but has been theorized (Braun, et al., 2006)

These themes were comprised of several sub-themes making up the total number of codes. Code descriptions were developed for each code to explain which part of text would be covered by the particular code as demonstrated in Fig.3.4. The code .0 for each theme was developed as a "miscellaneous code" to capture data which did not seem to fit in but was deemed as having potential relevance for later in the analysis phase as suggested in (Braun, et al., 2006).

When coding the data the researcher ensured that the context was retained, the researcher would code the context of the extraction to capture the question and background that was posed as well as the context of the response in order to not loose meaning as suggested in (Braun, et al., 2006). In some instances the text was "double-coded" as demonstrated in Fig. 3.2 below if the content addressed overlapping issues and themes. In other instances text was coded with more than two codes. When generating code reports at the final stage,

this process helped to ensure that the text is covered by each code. Each code was labelled as per the theme, example sub-codes under the theme Life History were labelled as LH 1.0-LH 1.8, sub-codes under Sexual Health Practices were labelled as SHP 1.0-, Social Networks sub-codes were labelled as SN 1.0 codes and sub-themes codes under Sex Work and Health were labelled as SWH 1.0 codes as illustrated in Fig. 3.3 using the example of just the LH codes.

The examples below are an illustration of how coding was conducted:

Data extract	**Code**
I: Ok, to begin the interview I would like to know a little more about you. How old are you? P: I am 30 years old I: Ok and where were you born? P: I was born in Zimbabwe and I decided to come to South Africa in 2005. But when I arrived here I was staying in Berea with my friends then I decided to find my own place. Some other girls told me that this place was advertising rooms that were up to rent then I decided to move here in beginning of last year.	LH 1.1. Life History
P: Usually I am dry, dry, dry sometimes I use baby oil because you often don't feel the person you are just doing it for him to finish and go	SHP 1.3 External Application

Figure 3.1 Coding: Data Extract with code applied

Data Extract	**Code**
I: Ok what made you decide to join the industry? P: It's when you realize there is no way out and you have responsibilities and you have to survive. Then I met the father of my child who promised to take care of me I met him on the job he was a truck driver but he was in a truck accident and his spine was damaged he couldn't walk I think the depression got to him he only lived about 4 months after the incident and passed away. I think that was a hard time for me. I was kicked out by his family because he hadn't finished the lobola payment so they said I am not his wife yet. I thought about lawyers but I think it would have cost me a lot to travel to court to fight for something which I may never win so I gave up. I	LH1.4Reasons for Joining sex work, LH1.1Life history SWH1.5. Experiences of Gender based Violence

decided to take the baby home to Zim then work here and send money. One of his brothers forced to stay at the house after his passing and he raped me many times then I realized for my peace I must leave.	

Fig 3.2 Coding: demonstrating "double-coding"

Code/Main Theme	Sub-Codes
Life Histories	LH 1.0 Miscellaneous code capturing life history information LH 1.1. Age LH1.2 Place of birth LH 1.3. Number of Children LH1.4 Number of people financially supporting LH 1.5. Level of Education LH1.6. Entering into sex work LH1.7. Number of years in sex work LH1.8. First experiences of being in sex work

Fig. 3.3 Code book Manager: An example of codes/main theme and sub-codes entered into the code book manager

Code	Code description
Sexual Health Practices SHP 1.1 External Washing	This code will capture any information mentioned by the participants which demonstrates the use of any products they use externally to cleanse the vagina in addition to "normal cleansing" or methods and means that they may have heard other women doing within their networks

Fig. 3.4 Code Description: Demonstrates and example of the main code, sub code and code description

3.12. Ethical Considerations

Ethical clearance to proceed with the study was obtained internally within the Department at the School of Human and Community Development and Psychology as well as the Wits Human Research Ethics Committee (HREC) (Non-Medical) (Protocol No. H110209). The protocol was considered by the HREC committee on the 11th of February 2011. It was approved unconditionally and valid for two years commencing from the approval date as attached in (Appendix E). The proposal also underwent an internal approval process within

WRHI through the Research Leadership Group (RLG). The RLG is comprised of a group of expertise/academic staff representing various research backgrounds. The meeting takes place monthly and allows a researcher to present their research idea to the committee, critical feedback and inputs are given for the researcher to incorporate and finalize then approval is obtained. These meetings also ensure that the RLG is aware of any research that is being conducted by the organization.

All ethical issues in the study were based on the three fundamental principles of the Belmont Report which was developed by the National Commission For The Protection of Human Subjects of Biomedical and Behavioral Research , namely: *respect of persons, beneficence, and justice* (Rivera & Borasky, 2009). *Respect of persons* according to (Rivera & Borasky, 2009) means allowing people to make choices, respect for the community and local culture and autonomy. The principle of *beneficence* emphasizes the responsibility of the researcher in protecting research participants, and minimizing all risk and ensuring their social well-being. Lastly, it is the principle of *justice* which emphasizes the distribution of risks and benefits and special protection of "vulnerable groups". The vulnerable groups according to the report were classified as pregnant women, children, prisoners, mentally ill, those with limited education, the poor, women in some circumstances, those with difficulty accessing some health services and sex workers (Rivera & Borasky, 2009).

In the study confidentiality was a key issue which needed to be maintained throughout. Women who formed part of this study were expected to disclose information which they ordinarily would not have to. Therefore this was maintained by protecting their identity by using pseudonyms. Access to the data was also limited to the researcher and participants were informed that the supervisor may be the only other person who may have access to the data and that the supervisor is trained in maintaining issues of confidentiality.

The recorded audio files of the interviews were downloaded onto a password protected computer and were archived at the end of the study. The researcher ensured that transcripts were kept in a password protected computer at all times and all the signed copies of the consent form were kept in a lockable cabinet in the researcher's office. Participants were also informed of their right to discontinue the interview at any given time with no

repercussions. They were also informed of the referral services in place if at any point they felt they needed further counseling whether as a result of the research or any other problems that they may be challenged with, as stipulated in (Appendix C).

Participants were also informed of their right to access the study findings by informing them that a summary of the findings will be made available. They were also advised that if and when they needed to contact the researcher; they could do so as contact details were provided in the information sheet for safe-keeping.

3.13. Reflexivity

This step involves a process where the researcher reflects upon their own beliefs, values and principles and how these shape their view of the world. This process is considered essential and potentially aids in facilitating an understanding of both the phenomenon under study and the research process itself (Watt, 2007). This process is included in most studies so that the readers may have the opportunity to see how the researcher went about the process of knowledge construction during a particular study (Watt, 2007).

In this particular research; the researcher is a black South African Zulu female, who has been working in the HIV/AIDS research field formally since 2005. Working in this field has exposed the researcher to clinical trials, behavioral and prevention interventions with various groups of people such as youth, HIV positive individuals and couples. The researcher had special interests with regards to studying the sex work population (more specifically the women) in this industry, as the researcher has special research interests in sexual and reproductive health needs of women. This was also due to the fact that the researcher could relate to the experiences of these women; by this the researcher means she understood the lack of opportunities that these women were presented with, understood the nature of their responsibilities as mothers, sisters, daughters, girlfriends, members of society and breadwinners for their families more importantly in meeting their basic need for survival. Reflexivity in this section has been looked at on three levels *personal, epistemology and methodologically*.

On a *personal* level I believe that sex workers, like all people deserve equal opportunities, and equal human rights and the right to access services which cater to their needs. I learned that if given the opportunity the woman would choose alternative work this was evident in how they communicated plans to "not want to do this forever". I also believe because of my interest in the sexual reproductive health of women, I wanted to know about availability and access to services. I further firmly believe in the empowerment of women and equal economic opportunities and when I realized that women are still far from reaching this goal as they are still attempting to please men and believing their bodies are the only tools to use in order to please men at the compromise of pleasing themselves it made me feel despondent. However I was pleased with women who took positions and felt they were empowered enough to negotiate protected sex.

I believe every woman should enjoy sex with no fear. I think these thoughts and feelings may have shaped my research in that when I was writing this report my sole purpose was to bring out their experiences to highlight their disadvantaged position so that one day if a reader has pre-conceived ideas or "moral judgment" they can begin to see the challenges of these women and feel the need to help instead of judging. I wanted their desperate need for survival to be brought to the fore and wanted to show the reader how much more still needs to be done so that women can have economic opportunities, emotional as well as financial independence. As an independent woman myself; I believe every woman should have that as a choice.

During the interviews I acknowledge that there may have been bias in presenting the research as it was hard to ignore personal feelings when women related stories about rape, police brutality, deportation and the like. I aimed to build a case to demonstrate that there is a need for multi-sectors, government, partner organizations, implementing partners and donors to respond and acknowledge the challenges of the sex industry. I hoped that through this work society will begin looking at sex workers as people first before they are sex workers.

On an *epistemological* view I believe the qualitative method of interviewing I chose was an appropriate method as it allowed the women to speak more broadly, to share their beliefs and motivations by not being restricted to yes-no answers. The theories I chose e.g. the narrative approach helped understand who the women are, what their personal journeys are and understanding whom they consider important in their social networks through the principles of the social network theory. Further it helped to understand not only who the important network are, but also the types of support they receive from the networks in order to understand the sex industry ties. The bio-ecological systems helped to understand the women more as a migrant population and the people they are responsible for back at home and how events at all the levels of the system impact the choices one makes through time.

Methodologically, after it was proposed by a pilot participant that I should ask about the women's experiences of "whole-night" which although was not the main analysis. I wanted those experiences brought to the fore as these stories form part of whom the women are and what they experience. Women sometimes experience violence, rape, and being abandoned in the middle of the night with no protection from the police. Therefore it is possible that I influenced the discussion by asking leading questions in some instances.

Overall the women were open to share their stories some needed to have taken some substance before actually opening up about issues. I did not exclude them because I was not looking for anything beyond their stories e.g. collection of blood samples etc. I wanted to know and understand and fulfill a deep desire to learn what it took for women to decide that sex work is the only option available and which behaviors contribute to their susceptibility for diseases. I believes that when faced with limited options mankind will do anything to survive. These women were no different; they are disadvantaged by virtue of families they were born into, the political stand of the countries they belong to as well as socioeconomic difficulties. I speak solely from a standpoint of women who are in the industry due to limited opportunities and in this study those were the women I spoke with. I also acknowledges that some women may enter the industry because they purely wanted to.

The women also viewed me as part of the Sex Work Project team member as they often referred to the team as “your colleagues”. When I proposed the study I was aware that doing field work with the assistance of the Sex Work Project team would pose bias in the responses of the women. They could give socially desirable responses and may be more knowledgeable about sexual health because of the sex work friendly service they received as well as the peer education they received.

Overall, this research provided me a good learning opportunity about the phenomenon of interest and provided better understanding of the sex industry and challenges faced by these women.

3.14 Conclusion

This chapter highlighted the methodological approach of how this research was designed and conducted. Further to that, ethical considerations and implications were also discussed. The researcher also took into account issues of reflexivity; as this was highlighted with a discussion of the researcher’s reflections of the process of conducting a study of this nature. It is important to note however that some of these methods may differ depending on the context as well as the objectives of the study at hand. The next chapter discusses the results and interprets the findings of this study.

CHAPTER 4

RESULTS

4.1. INTRODUCTION

This chapter discusses the findings obtained from the in depth interviews. The data was analysed thematically using analysis software Atlas Ti as per the detailed process described in Chapter 3. Four main themes were drawn to answer the research question namely: Life Histories, Social Networks, Sexual Health Practices and Sex Work Health. The chapter is structured in a way that it presents the common finding of a particular theme, then identifies extracts to support the general findings and then links the findings with the theoretical frameworks in discussing life histories and social networks as identified and discussed in chapter 2. The sexual health practices and sex work health codes have been compared with other empirical work conducted in studies of a similar nature. The extracts that have been selected to support findings have been labelled with pseudonyms to ensure anonymity of the participants and have been extracted verbatim.

4.4.1. Demographics

Majority of the women in the study (N=60%) were from Zimbabwe, (N=10%) Swaziland and (N=30%) South Africa. Their mean age was (N=28) years, and on average had (N= 1) child. Their levels of education varied from (N=10 %) had a tertiary qualification, (N=60%) completed high school and (N=20%) dropped out of high school and (N=10%) completed basic education. All sex workers in the study were single. The number of years in sex work ranged from 2 months to 13 years.

4.4.2. Life Histories

> *"P: The sex industry? Ya it's a good one, ya its ok, fast money, big money (cliques fingers) like if you are not educated there's nowhere else where you can get the kind of money we are getting here"-Sibongile*

This theme aimed to give context about the women who formed part of this study. In order to better understand where a person is in life; it is best to know where they come from as the events are not separate as indicated in (Gergen, et al., 1983). Life histories are said to be "particular narratives used to reconstruct and interpret whole lives to obtain a comprehensive, overtime view of people's experiences" (Wicks & Whiteford, 2006 p.8). They are further proposed as an important approach in understanding personal, social, economic, historical and geographical influences that shape experiences (Wicks, et al., 2006). Although this theme was not the focus of the study; it emerged during the analysis; this is in agreement with what grounded theory researchers (Lincoln & Guba, 1995) argue that the development of theory emerges from a thorough analysis of contextual data (Egan, 2002).

This code captured some background information about age, where the women were born, number of children they have, how long they have been in sex work, levels of education, the number of people they support financially, how and why they got into sex work and what their first experience of sex work was like. These narratives are further looked into in terms of the stability, progression, regression analysis as provided by Gergen (1983) to demonstrate how all women have narrated their experiences of joining sex work in relation to the three concepts.

Narratives are said to be stories that people tell which are important because we get to understand how stories help people make sense of the world, whilst also studying how people make sense of those stories (Mitchel & Egudo, 2004; Owens, 2007). According to Schiff, (2012) narrative is best thought of as a verb and the primary function of narrating being to bring forth life experiences and interpretations of life in a particular time and space (Schiff, 2012). They provide a clear sequential order that connects events in a meaningful way for a definite audience and offers insight about the world and other people's experience of it" (Elliot, 2005,cited by Tamboukou, 2002). It also helps one to know how one feels and telling this experience in order to make known what one has lived through memory (Schiff, 2012). That was the purpose of including this theme in the analysis, it provided useful narratives of the women's current situation and decisions made as a result of past

and their sense of resilience despite certain choices they have made. Key findings of the theme have been discussed below.

The women in the study all had families they support financially and sex work was their main and only source of income. Women indicated that their families were not aware that they are in the sex work industry some indicated telling a close friend back home for in the event that something happens they should know where to trace them, this is in line with the social network theory of kinship by identifying a person who is trustworthy and who can serve as the next of kin..

When exploring accounts of why women joined the sex industry, it was indicated mainly that it was an issue of survival; many of them had families to support financially as well as support themselves. Some had previously worked in other jobs but due to increased responsibilities and retrenchment issues had to find alternative ways of making money.

Some women wanted a better work environment and migrated as a result of sex work and in other instances sex work was used as a strategy to raise money in order to complete tertiary education. Some women explained the loss of a breadwinner due to separation and death. Many of the women who were in South Africa illegally experienced limited work opportunities even though presenting education qualifications they were rejected and not registered to teach in SA. Registering with the education board would not have been feasible as the woman is in the country illegally.

These reasons stated above are somewhat in line with findings from other studies whereby women have been identified to resort to sex work as a result of: unemployment, financial struggles, the need to support families, migration patterns whereby male migrants are away from home and female migrants need an income leading them to engage in sex work voluntarily or intermittently as identified by (Stachowick, et al., 2005 in Weine, Golobof, Bahroma, Kashuba, Jonbekov & Loue, 2012). According to the UNAIDS report poverty, gender inequality, indebtness, low levels of education, lack of employment opportunities, family breakdown and abuse, drug dependence, humanitarian emergencies and post conflict situations further contribute to women opting for sex work as a solution (UNAIDS, 2012). In another study it was identified that women chose this type of employment due to

their desire for money and independence which cannot be fulfilled through other means of employment (Kessler, 2005). All these reasons are equally important and further important to consider if policy makers, researchers etc. are to plan to curb the numbers of women who join the industry.

The following extract for example illustrates the importance of survival as motivation for joining the sex industry:

> "I: Ok what made you decide to join the industry?
>
> P: It's when you realize there is no way out and you have responsibilities and you have to survive. Then I met the father of my child who promised to take care of me I met him on the job he was a truck driver but he was in a truck accident and his spine was damaged he couldn't walk I think the depression got to him he only lived about 4 months after the incident and passed away. I think that was a hard time for me. I was kicked out by his family because he hadn't finished the "lobola" payment so they said I am not his wife yet. I thought about lawyers but I think it would have cost me a lot to travel to court to fight for something which I may never win so I gave up. I decided to take the baby home to Zimbabwe then work here and send money. One of his brothers forced to stay at the house after his passing and he raped me many times then I realized for my peace I must leave."*-Linda, 30*

This extract demonstrates the need for survival and limited choice that the woman was presented with. Bronfenbrenner's Ecological System thus can be applied in understanding that the microsystem of this woman which included her husband to be and child. The truck accident that occurred demonstrates the exosystem whereby the individual even though not present within the context in which it occurred; its results affected her because the breadwinner could no longer work and later died leaving her to make survival decisions.

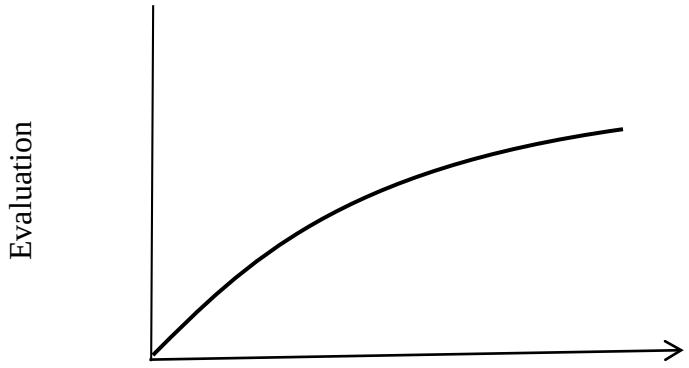
The macrosystem is also intricate here as demonstrated through the family's belief that culturally the participant is not a wife yet to the man because the "lobola" processes were never completed. Traditionally a couple is considered married once the lobola negotiations and payment have been complete and sealed by the traditional wedding ceremony. In this case this was not done yet. The mesosystem is demonstrated by how she resolves to take her child home to Zimbabwe and find work in order to support her family. The chronosystem is further demonstrated through the major life changes the participant had to

make i.e. moving away from the place they lived in to finding alternative accommodation, dealing with her loss of her partner, having a baby and having to start working again.

The social network theory can also be applied as it demonstrates her immediate social ties which include her husband, child, the man's family and her own family who is raising her child in her physical absence. Further, the participant says:

> "I: Mh thank you for sharing something so deep, do you still want to continue?
>
> P: Yes, I think those experiences build a person. I have faith in God he is the healer and knows why certain things happen. I mean I can't say I am completely happy but things are better now. I have good friends and good support from my aunts at home".
>
> -*Linda, 30*

This statement is indicative of her macrosystem when she talks about her belief in God and him knowing why things have turned out this way to comfort herself. This statement also reveals Gergen & Gergen's (1983) narrative theory (1983) i.e. progressive thinking in that the participant although she cannot say she is completely happy, but things have become better and has continued support from the people who make up her mesosystem which include her aunt and microsystem of good friends. This could be illustrated as follows:



Progression and Stability

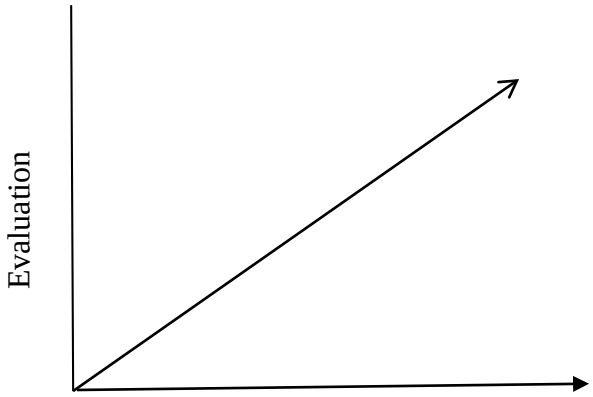
This illustration depicts her life from being unemployed to joining the sex industry. The beginning represents the rape, being chased away from home, having to find work and life stabilizing after finding work as a sex worker. She is optimistic and shows an appreciation

of relationships and seems more in control of her life this is similar to other studies whereby it was found that preconditions for psychological well-being and health include: control, emotional nourishment, empathy and optimism (Marie, 2009). It has been demonstrated previously that people with a high subjective well-being are optimistic, have control over many aspects of their lives, have fulfilling relationships and find meaning in what they do (Marie, 2009).

In the next excerpts the women highlight that they attempted alternative work; however money was not enough in other jobs, and had to decide to join the sex industry to make ends meet:

> "I: Ok, what made you join the industry?
>
> P: I think its realizing that my mom is struggling and needs support, it's not like I didn't try to find other jobs. I started off cleaning at one of the local shops back at home but the money was just not enough. I tried doing domestic work where I stayed with a white family and cooked, cleaned and looked after their babies but still the money was not enough. Then I met one friend of mine who had been working in jozi and she always had money and would take us out to buy drinks, weed and cigarettes, basically everything we needed even borrow us some of her clothes and tell us to keep some. So I wanted to move to jozi as well, I needed to know what she was doing to get all the money and latest fashion. She told me to come with her one day and I did. "
>
> *Zodidi, 34*

Zodidi's life can also be depicted this way:



Progression

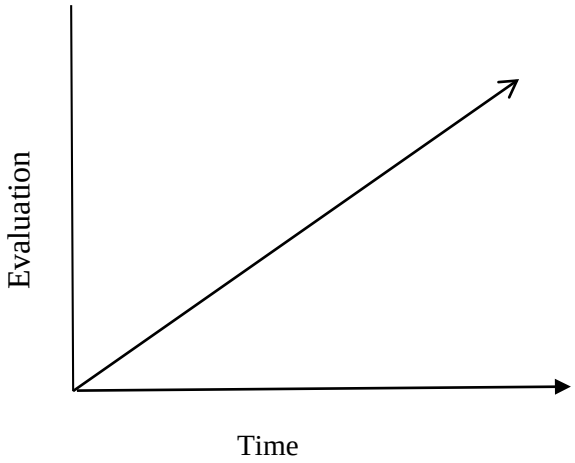
She starts off by explaining the challenges of trying to find work in the beginning at the shops and in domestic work and none of these forms of employment could fulfil her financial responsibilities. Then she entered sex work and her life begins to improve.

The illustration below depicts the life of Sponono who also tried alternative ways of making a living but related that work would end sometimes due to retrenchment:

"I: And then when did you start?

P: I started when I lost my job it was 1998 when I started and I was doing fashion dressing at the shops and working at the till at the shops and in the restaurants so sometimes the job ends because that kind of job does not have a guarantee like working for government you see that kind of thing with time the job ends all jobs have their own problems and sometimes you end up leaving the job so that's just the way it is. But I started in 1998 and a friend of mine said because I don't have a job, and I have children and debit orders, and at the time I was in debt and they put me under what do they call it…you know those people that say you must pay and that if you don't pay they will get you arrested or blacklisted"

Sponono



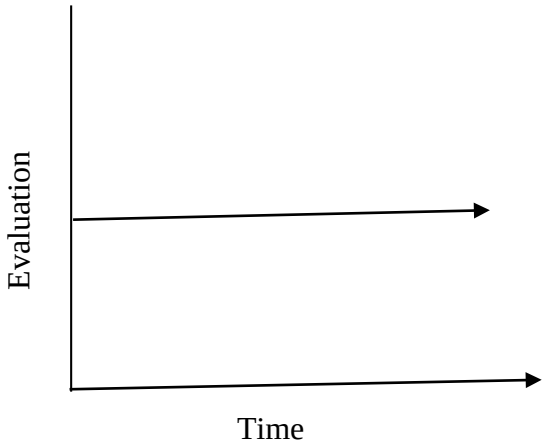
Progression

Sponono also relates a poor beginning of how she started off doing other work but due to retrenchment and not being educated she could not find work. She further related that she was in debt, and was faced with responsibilities of her children. She faced being blacklisted and sex work seemed a viable option to make money. Since being in sex work she is able to take care of herself and her children.

Being able to make money and gaining financial independence offers sex workers pride, self-confidence and a high self-esteem as it offers them financial security, the ability to buy food, clothes, support their families, pay rent makes them feel good and raises their sense of self-worth as also demonstrated in other studies (Fischer, 2003).

In the excerpt below is an illustration of Brightness who was a sex worker and migrated as a result of sex work to seek better financial opportunities:

> I: Ok and is sex work your first job or were you doing other jobs before joining sex work?
>
> P: No I have always been in sex work even back home but I moved here because I was told there is better money.
>
> *Brightness*

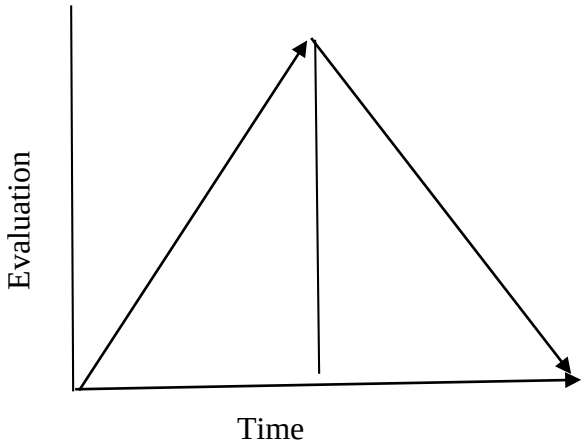


Stability

Brightness's life depicts stability because in her home country she was doing sex work and migrated as a result of desiring more money.

Sunshine's life as demonstrated below depicts a story of a woman who was hopeful about the future but due to factors beyond her, had to resort to sex work.

> "I: and then when you came to Jo'burg how did you get into sex work?
> P: You know when I left my place I thought maybe since I have this ordinary level certificate you know when you hear stories back home people say it's easy in South Africa, there are a lot of jobs and stuff like that so I brought my certificates with me when I came here, thinking that maybe I will just get a job or something or a place in college or something like that but then it was not like that…"*Sunshine*



Intersecting

Sunshine's life depicts an intersecting way of how she joined the industry. She came to South Africa with her qualifications hopeful of opportunities she had been promised by friends who lived in South Africa only to find that she would not be allowed to teach in the country and had to make ends meet by engaging in sex work and survive in a foreign country.

Generally women gave accounts of their first experiences of sex work the majority of the women narrated it as uncomfortable, and were fearful. They experienced difficulty in approaching clients for the first time and some mentioned having feelings of guilt and regret.

The illustration below is an example of participants feeling guilty and fearful:

"I: and then how was your first experience of it

P: Wow it was hectic hey it was very, very hectic it was painful let me say because for me I felt very bad about myself for exchanging money for sex …"

Joy

"I: And how was that for you on the first time?

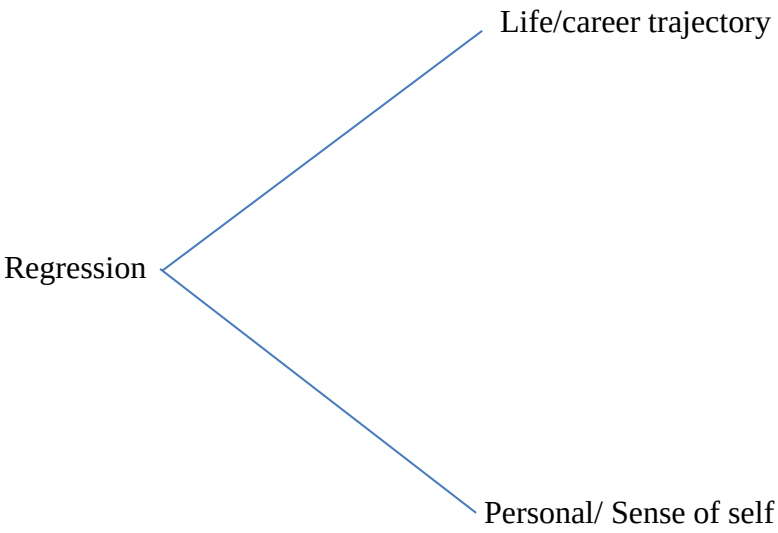
P: I was scared like when I got there I still remember the day I arrived there when it was a strip show and I ran away out the door actually

I: (both laugh) running away from what?

P: Like I didn't know how it worked and in my family they had warned me about this and I used to see it a lot in the movies you see, so I was scared and saw myself as a disappointment to my family but the following day I sat down and really gave it some thought and decided to go back"

Carol

Both participants share feelings of guilt and disappointment in themselves and in the career life they have chosen; these could be linked with Gergen's theory of regression. In many ways, all of the participants narrate stories of regression and may be stability in terms of their life/career trajectories by virtue of being in the sex industry. This means that there are two different trajectories present here the sense of self and career choices made:



Participants narrated feelings of guilt in themselves demonstrating that they were not proud of choosing sex work as work. Some of the women expressed not wanting to work as sex workers for the rest of their lives. Although the choice of being in sex work was clouded by guilt at times it seemed the only viable alternative for survival for the women.

This is in line with the model of well-being (Ryff, 1989) where it was identified that there are *six components* of positive psychological functioning including: positive evaluation of one's self and one's past life (Self-Acceptance), although in this research self-acceptance took some time as women were disappointed in themselves and in their life choice. Further

components are (Personal Growth) which is a sense of continued growth and development as a person, (Purpose in life) which is the belief that one's life has purpose and meaning and the possession of quality relations with others (Positive relations with others), the capacity to manage one's life and surroundings (Environmental Mastery) and a sense of determination (Autonomy) (Ryff & Keyes, 1995). Therefore the discussions above can be placed in the aforementioned discussions and discuss sex workers psychological state of mind according to the model of well-being. Through being in the sex industry women find meaning in life and in their work contributing to their psychological well-being as they feel needed and feel their work goes beyond sexual satisfaction (Marie, 2009). They see themselves as counsellors, therapists, sexual health educators etc. They are also in control of their work situation and in control of their lives enhancing their well-being and decreasing stress (Marie, 2009). Having autonomy also increases job satisfaction and well-being through working in supportive environments where good peer relations could be established (Marie, 2009).

4.4.3. Social Networks

This theme captured information on the role played by social networks. This theme was important in answering who the social network preferences of the sex workers were as posed in the coining this study. There were 8 sub-themes under the social network theme which included: friendships, duration of friendships, country specific friendships, and recruitment into sex work, main partners and clients as part of network, places of recruiting clients, and types of support provided by the network. The information captured in this theme draws a lot from the Social Network Theory and Bronfenbrenner's Ecology of human development as it explains the networks of the women from the micro through to the chronosystems as well as the importance of social ties and types of support provided by their networks.

It is mentioned in (Hunt, 2011) that in order to understand the social support in health we must first define social support and identify its key features. According to Hunt (2011) "social support is defined as a transactional communicative process, including verbal and

non-verbal communication that aims to improve an individual's feeling of coping, competence, belonging and or esteem" (Hunt, 2011 p.184).

Social networks are often broad and complex and can be characterized by a number of people like family, friends and colleagues, and so forth, and through the years science has developed innovative ways of staying in touch with people who form part of one's network. Women in this study identified their colleagues as their networks. These networks played a role in how women entered sex work; they also related experiences of recruiting other people such as siblings and friends into sex work.

The women formed friendships according to where they were from; these provided a strong support structure as they were speaking the same language, and felt they could relate easily with one another. However there was ambivalence in terms of how they felt about friendships in sex work generally. Some women felt they could not form new friendships amongst the sex work network as the industry is highly competitive, others felt there are no friends because women are desperate and betray one other when it comes to money. They mentioned that forming new friendships with people who are not in the industry remains a challenge as the industry is still stigmatized and judged.

Often when sex workers speak amongst each other, their conversations were mainly around sex work and day-to-day experiences of it therefore they felt it would be difficult to talk to people who are not within the same industry as they would judge them.

Of those who reported strong social networks, they mentioned that networks provided practical support i.e. they bailed them out if they have been arrested, offering emotional support if one is diagnosed HIV positive, offering advice with regards to sex, health and financial support at times. These types of support are further identified as *emotional, esteem, network, information and tangibl*e forms of support (Hunt, 2011). Emotional support meets an individual's emotional and affective needs, esteem support is communication which bolsters ones' self-esteem and beliefs in their ability to handle problems or perform a needed task, network support refers to communication which affirms an individual's belonging to a network and reminds them they are not alone no matter what the situation and information support is communication which provides needed

or useful information and needed in order to make decisions. Tangible support is any physical assistance provided by others (Hunt, 2011). Social support does not only make individuals happy or cope better; they also play a role in leading to improved health psychologically and physically and improve overall health (Hunt, 2011).

In terms of maintaining friendships the women often lost touch with people who introduced them to sex work because they are a highly mobile population and some friends die over time. Friendships in general also seemed to be a challenge to retain due to mobility and sometimes death.

Family members also formed part of their identified close knit networks. Although they considered family members as close; they often did not disclose to family members that they are in sex work; the common job they chose to say they were doing was waitressing as it is a "socially acceptable" profession in comparison to sex work. However the women mentioned that they identified one person in their home country whom they did inform that they are in sex work in case anything could happen to them. Clients and partner(s) although do form part of their social networks, none of the women mentioned them directly as being part of their networks.

The except below illustrates a participant indicating that new friendships cannot be formed because sex workers are willing to do anything for money:

> "I: And here in Johannesburg, have you formed new friends?
>
> P: Ya (hesitant) there are others from here but its not a close friendship but its just friendship but in this place there are no friends anyway
>
> I: Why do you say that?
>
> P: There is no friendship here because they can do anything for money at the end of the day making new friends it's not something you can do. "
>
> *Loveness, 22*

Another participant illustrates that one cannot rely on friends in the sex industry:

> I: And then in business would you say there are friends you can rely on
>
> P: No, no ways
>
> I: why?

P: eish, I am just me, I chat with them because obviously we are in the same industry but as I said in this industry you observe a lot of things, ok, I wouldn't rely on friends when I think of the fact that I came alone from home you see that kind of thing, I would rely on the person who brought me here you understand. I would leave here and go stay somewhere else when I am tired of this place you see so I cant rely on anyone I just do what satisfies me.
Sponono

I: Ok and can you tell me people whom you are close to.

P: where? Here?

I: It can be here and back home, maybe I can say people that you trust and support you.

P: Well here you cant trust too many people its easy for them to stab you in the back. But home is great everyone is always excited to see me and they don't know what I do so they welcome me and I forget about my life here.- Linda

The excerpt below demonstrates a sex workers preference of people who are in the same industry and who form part of their network. She indicates that friendships come from the same work as they do:

"P: …And I personally prefer having a friend who is doing the same business as me, I can't have a friend who is not doing business because I just ask myself like where I stay there are a lot of girls who think I am stuck up but there is nothing I can talk about with them. What will I talk with them because I am doing business and they will gossip about that so. I am very difficult to people who are not doing business I just don't want them close to me because what am I going to talk with them, at least with my friends I can talk about how it was at work, how much I got for the day the kinds of problems I encountered and blah…blah…blah…"
Sbongile, 28

The microsystem of the individual changes when they move from place of origin, the friends made at the brothel become their microsystem as they are their immediate points of contact and the most influential people by virtue of being in the same environment. These networks become close sources of support and influence how the individual makes decisions.

Family members as a result of migration tend to become part of the mesosystem which although the women are not there physically, their decisions impact the people back in their home countries and vice versa. A number of women in the study expressed that they did

not want their families to know what kind of work they do indicating feelings of shame and regression in the sense of self and career decisions:

"I: Ok, and does your family know that you are in sex work?

P: No because I am trying to protect them

I: protect them from what and how?

P: I am trying to protect them from the truth because I am the sole bread winner for my mom and my son. She tried her best to send me to school but now she doesn't have enough money to get me through university and these days with no varsity degree you can only get as far as being a waiter and that hurts me. So I can't rely on her all the time. I am a grown woman now I have to hussle to make a better life for myself, my mom and my little boy. Sometimes I dream that one day I will be able to pay (you know) like have the life I want and give support to other girls in my situation its life jo (local slang). Not everyone in life has a mom and dad who can afford so I have to think…think about where life is going…how I will get food…who I have to sleep with…(you know) if you don't do it yourself no one else will." *Lerato*

This afore extract represents the exosystem where the participant is the breadwinner for her mom and son. Bronfenbrenner has argued for the significance of the exosystem in understanding the interpersonal and social decisions individuals make in their daily life experiences. The significant networks in this exosystem influence the myriad experiences and interpretations that we make relative to social events and occurrences. The extract for example highlights the significance and role of familial figures in influencing the participant's decision to remain in the sex work industry, it similarly demonstrates the role of the exosystem in influencing how individuals choose sex work as a viable economic option. The extract however argues for the importance of understanding sex workers' different exosystems in the decision to remain. Her anticipation for the future sense of self are presented in a positive light whereby the participant plans on completing her studies indicating a sense of progressive thinking as demonstrated in (Gergen et al, 1983).

The illustration below demonstrates religion as a barrier to informing family members that the participant is in the sex industry and hopes one day she may be able to leave the industry without ever having to tell:

I: Does your family know you are in the industry?

P: No, I don't want them to know I was raised by my grandmother and she is a strong Christian I think she would die if she learned that I am in sex work so I think its best she doesn't know. I think when the time is right and she needs to know I will inform her.

I: What do you mean by when the time is right?

P: I think if I get sick then I might want to tell her like if I need help and cannot do things for them any longer I don't know I guess that is a hard question but I hope one day I will stop doing sex work and maybe I never need to tell her.

Brightness

This illustration indicates the strong influence of the macrosystem which encompasses ones belief system. The belief system she was raised under still influences the decisions she makes in her current life. Out of respect of the belief system she does not want to disclose her career choice. The participant also acknowledges that if she were to fall sick she would need this exosystem to provide social support which may be esteem, network and tangible forms of support to help her through. However she hopes through the significance of the chronosystem that life-changing events could occur which may make her leave sex work leaving her with the decision to never have to tell her grandmother.

One participant indicated someone back at home knowing that they are in sex work in case something happens to them:

A participant narrating that her sister knows she is in sex work:

"I: So do they know back home what you are doing here?

P: My sister knows

I: How did you tell her?

P: She is a sister, she is like a friend, we grew up together so I decided to tell her for incase maybe there can be something bad which may happen to me I can be in a car accident here she will know where I am staying if they can't see me for a while and I gave her my manager's number just to keep in touch."

Carol, 21

This extraction illustrates the microsystem because she refers to her sister as a close network but since they live apart it demonstrates the exosystem. Her thinking of the

possibility of anything happening and providing contact details is indicative of progressive and planned thinking and the demonstration of kinship in the social network theory.

Social network preferences of sex workers included other women whom came from the same country as they were indicating that friendships are easier formed that way as they come from similar backgrounds, speak the same language and willing to protect each other. Usually women in the study kept their friendship networks really small stating two or three close friends.

An illustration of participants indicating that friendships are country specific and that one has to associate with the "right" networks to ensure clients become interested:

> "P: ya we are close especially with the girls I come from the same country with wherever you go if you go to a brothel if you understand that this person is from Swaziland definitely you will have to introduce yourself to them and if she has a problem she can come to you can help her."
>
> *Sibongile*

> I: ok, and now I want to know more about the friendships that you have like friends that you have within the industry or here how are the friendships?
>
> P: Oh, here people make friends according to where you are from like if you are from the same country you can get along and if in these kind of places sometimes there are other ladies who don't know how to take care of themselves and there are those who take care of themselves so they group themselves because at the end of the day clients judge from the way you look like. They can say these girls are dirty, these ones are clean these ones are like this so if you mix yourself with the group of girls which are bad you risk chances of having clients because they don't like those kind or that group of people.
>
> Joy

> I: Ok and how would you say you choose your friends?
>
> P: I don't know I guess I don't. There are just people you clique with and there are those you don't. But it helps to have people from the same country as friends because you speak a similar language, you look out for one another. Like if I see a girl from Zim getting beat up I won't even ask I will go in there and fight too because we are sisters like that. And girls from other countries also do the same.-Linda

Generally women indicated that their social networks provided practical, emotional and financial support. The illustrations below are indicative of the different support mechanisms they receive from their networks:

I: Ok what kind of support do they give you?

P: All kinds I think they are the people I talk to when I need to be bailed out of jail, they are the people I tell when I have a "whole night" and I am not sure where I am going, they are also the people whom if they are going home I give them money to take to my family and Christmas clothes for the kids if I am not going on that weekend. I know I can depend on them, they won't spend the money. Brightness

I: Oh ok, how would you describe your friendship with all of them?

P: I think I love them all I mean we all come from Emadadeni even though I met the others here in jozi we are home girls and we take care of each other. Like if I am going through a hard time financially I know they will save me, or if I have boyfriend or client problems they comfort me and tell me what to do. They influence my life in a big way. Zodidi

Overall through the analysis it was evident that sex workers' social networks are comprised of a close set of friends, whom they identify with by virtue of coming from the same country and doing similar work. Other social networks include their families back in their home countries. It was evident that retaining friendships was a challenge due to mobility, competition levels and death. The role of the social network remains an important one offering all kinds of support and offering advice about health in general.

4.4.4. Sexual Practices

This theme contained the most number of subthemes amounting to 12 as was the main focus of the study. The sexual practice codes were divided into: external washing, external application, anatomical modification, intra-vaginal insertion, and oral ingestion as per WHO classification of vaginal practices (Gafos, et al., 2010) further sub-themes included: frequency, discussions about the practices, discussions around sex, motivations for engaging in practices, dry sex, engaging in sex when on periods, and condom breakage experiences.

What was evident in the study was that a small number of women reported engaging in vaginal practices by using methods to tighten and dry the vagina in comparison to larger studies such as (Hilber, Hull,Preston-Whyte, Bagnol, Smit, Wacharasin & Widvantoro

2010;Gafos, et al., 2010; Schwandt, et al., 2006; Myer, et al., 2004; Hilber, et al., 2007; Beksinka, et al., 1999; Morar, et al., 1998; Green, et al., 2001; Brown, et al., 1993; Turner, et al., 2010; Francis, et al., 2013 & Brown, et al., 2000). Most participants mainly knew about traditional and non-traditional methods used but had never experienced or practiced them first-hand. They mentioned hearing about other sex workers using snuff, newspapers, water and savlon which are products similar to those found in other studies such as (Hilber, et al., 2010) which further highlighted other products such as leaves, bark, fruits, stones, food stuff, soaps, creams, household detergents, antibacterial agents and toothpastes etc. (Hilber, et al., 2010).

Many of those products were not listed in the current study. Of those women who engaged in vaginal practices in the study, they mentioned using self- medication pills, enema, “vacuuming”, Chinese medicines, sticks, and sponges as products. None of the women in this study related stories of incisions as demonstrated in (Scorgie, et al., 2010) this study referred to a practice called “ukugcaba” which is an incision made to the genital area with a razor blade to introduce herbal medicines to enhance sexual desirability to men (Scorgie, et al., 2010). In another study conducted in the midlands in KZN reflected that sex workers engage in post-coital douching with antiseptics and detergents such as savlon, Dettol, jik to prevent conception and STI (Morar, et al., 1998). These findings were similar to the current study whereby sex workers described a situation where a condom bursts resulting in vaginal discharge then using savlon to offer relief; and later suggestions to seek pharmacy care if the cleansing method is unsuccessful.

Their major reasons for engaging in these behaviours in this current study included: cleansing the condom content from the vagina, creating more competition, after the condom breaks-to cleanse sperm, to keep clients returning, to stop bleeding when on periods, and to make sex nicer. Of those reporting that they did not engage in such behaviours mentioned it was due to fear of damaging their health, and the lack of belief in the efficacy of products. In other studies women engaged in these practices to create balance in their relationships and bodies, to improve hygiene, well-being and sexuality (Hilber, et al., 2010). In studies conducted in KZN the reasons included the desire to increase men’s sexual pleasure and maintain fidelity in relationships, for the treatment of

STI/ vaginal discharge, prevention of pregnancy, inducing abortion, and retaining partners (Gafos, et al., 2010).

The lack of reporting of engaging in vaginal practices may be attributed to the fact that the women's responses were self-reported and possibly they were not open enough to discuss the issue. Further this study only contained a small number of the population of sex workers (N=10) therefore in the general population of sex workers the results could be different and may represent a larger number of women who engage in these practices. However because it is a qualitative study design the aim was not show any statistical significance. The purpose was to understand what was happening and what the motivations were for engaging in those practices if at all they occurred.

The small percentage of women reporting these behaviours can be further attributed to the fact that the population sampled was specific to the sex work population and did not assess these practices in the general population of women. The implications of introducing microbicides to this population are that it is feasible as demonstrated by (Gafos, et al., 2010) and further suggested that it is important to consider local perception and experiences as these behaviours could affect the efficacy, and adherence of the gel (Gafos, et al., 2010). It is recommended that such studies assess if such practices occur locally when designing clinical trials specific to communities.

Even though a small percentage of sex workers referred to having engaged in these practices it does not indicate that these practices are not happening. As a result, interventions need to be developed if we are to address HIV prevention issues.

Women further indicated being failed by a condom and this being largely attributed to the fact that they are often not aroused when meeting a client. Sex is a psychological process when the women meet a client for the first time, he is a stranger and opportunities of arousal are limited particularly in instances where the client is ready, also due to high number of partner change arousal may be reduced further. The breakage also was reported to be due to repeated friction where clients take too long to reach orgasms. As a result the women find means to cleanse the sperm out of panic because often times they knew their HIV status and it was negative. Indicating that dry sex in this study was not necessarily a practice

but resulted from friction, and not being stimulated enough etc. Contradictory to studies conducted in South Africa which indicated that dry sex was a common practice whereby women insert powders, stones and leaves and drink preparations believed to cause a drying effect on the vagina (Beksinka, et al., 1999). The study reported dry practices as high as 60% in men and 46% in women and differed by age group and educational level, whereby in the age group 16-25 87% of the respondents whose educational levels exceeded standard 5 (beyond basic education) reported dry sex (Beksinka, et al., 1999).

Women in this study voiced dry sex as a concern leading to condom breakage and pain during sex resulting in the need to lubricate with products such as Johnson and Johnson's baby oil as the only available option since KY Jel and other water-based lubricants are expensive. Many reported using baby oil as lubricant due to the fact that lubricant was expensive and was never distributed as part of the Department of Health's strategy to prevent HIV. However plans are underway now to include the distribution of condoms and condom-compatible lubricant as the HIV prevention strategy.

The extract below indicates application and insertion method that the sex worker uses:

> I: Can you elaborate on the statement?
>
> P: Yes so, our job is very competitive so I have to consult to learn how I can keep my clients and gain new ones. So the healer gives me "muthi yokuqinisa" (muthi to stegthen myself)
>
> I: What kinds of medicine?
>
> P: Herbs that I apply on my skin after I bath it makes me more attractive to men and sticks to put in my vagina over-night so that my vagina stays appealing.
>
> I: So how do you put the sticks?
>
> P: Well it's just the top part then I sleep with no panty because in the morning I must pull it out. It's a long stick and it has strong herbs. LINDA

The extract below is a participant indicating the motivation for why she engages in vaginal practices as well as cleansing material she uses and explaining descriptively how she thinks the medicines help:

> I: Ok have you heard about cleaning of the vagina?
>
> P: You mean with things like Muthi?

I: Yes

P: I do it sometimes I mean you have to stay relevant

I: What do you mean you have to stay relevant?

P: Ya so the industry is like any other industry in your job you have to study like you are now and get high qualifications, in my job I have to make sure I am most wanted and that means using certain things that will make me more desirable to clients.

I: What kind of stuff do you use?

P: I believe in Chinese stuff there is stuff to cleanse, to make it tight and to make my vagina muscles stronger so I can grab onto a client's penis and squeeze and let loose I think that is what keeps them returning. So you need to know how to use the pussy. ZODIDI

Motivations for why women engaged in certain practices demonstrated their belief that condoms contained oils; which after having sex with a number of partners the oils may slip through to the womb:

I: So things like cleansing the vagina (interruption one of the sex workers looking for a cigarette) ya so which are the methods that you have heard about? Or things you have done after sex?

P: No, I haven't heard of any the thing that I know is that sometimes when I feel pain or when I feel the oil from condoms or sometimes you find that other condoms have powder and oil, it blocks the tubes so I get pills to clean the womb so that I don't feel that pain and so that I can stay active. They also make my body stay active so those kinds of pills I buy from the chemist and I use them.

I: Ok, and what do they call those pills?

P: I just have them for cleaning like Flagyl that I just drink because a lot of the time its difficult here you must always have something, even when the clinic people arrive I just ask them for pills. SPONONO

I:And often times what kind of advice do you get let's say somebody has a discharge
P: they (sex workers) will tell you to put savlon or just go to the pharmacy and use savlon to clean your thing your vagina and then if it doesn't stop then go to the pharmacy
I: ok and if the condom bursts?
P: they believe that you have to take antibiotics ya in brothels that's what goes on there if you have a condom burst that's what you have to take
I: what kind of antibiotics?
P; I don't know where they get them but you just go and get a way of getting antibiotics sometimes these tablets are green and yellow we normally use them for cleaning
I: For cleaning? Cleaning what?
P: cleaning the condom whatever thingy or you are cleaning the sperms and all that, that's the belief of the girls

I: what is their belief?
P; that the condom makes the vagina dirty
I: How? What do they mean?
P: Like the oil if its too much so you have to reduce and take it out sometimes they use a spaid (enema) like they will put savlon in it or magazines. SIBONGILE

An illustration about dry sex; women in this study indicating they were dry as a lack of stimulation and not as a preferred method to please a man:

P: No sometimes I can feel that I am dry

I: and do you have sex anyway or are there things you use to moisten up?

P: Ya

I: Like what?

P: Sometimes I use baby oil I buy sometimes things that make me wet when I am dry

I: Oh so that's the stuff that you use

P: ya

I: Ok, you said baby oil and what else?

P; I don't remember the other ones but it's a product from Johnson and Johnson

CAROL

I: Have you ever heard about dry sex? Where if you still dry you still have sex because some guys say they prefer dry sex or when the vagina is tight

P: Oh ya, sometimes when its very busy your vagina tends to become very very dry because there's more friction and there is no lubrication it becomes even more dry and you are worried that the condom will burst but this client says he is enjoying it because of they friction they enjoy more. SUNSHINE

I: Has a client or your partner ever asked you for dry sex?

P: No I mean a vagina must be moist so penetration can be easy but I would say sometimes a client doesn't give you enough time to get moist sometimes and you justhave sex dry and sometimes the condom breaks because of that. I mean you can imagine its hard when you are having sex with someone you don't love its hard to even be moist or if on that day you are tired and he is client number 5 you only get a bit moist when he is about to finish anyway. But ordinarily I refuseto do things that can put me at risk expecially now that I know I am negative. I don't know how I survived I think God is good. BRIGHTNESS

An illustration of inserting a sponge when she is on her periods:

P: You might never know, we meet a lot of people and a condom is not 100% safe and usually I cannot lie and say I have never had a condom failure always…sometimes it happens and honestly sometimes we do business even though we are on our periods but you put something inside and the condom is soft and all that and sometimes it can burst anything can happen so things happen.
I: So what do you insert when you have sex whilst on your period?
P: A sponge
I: Any sponge?
P: No, like me I usually use the dishwashing one
I: the dishwashing one?
P: Mh!
I: And does it absorb all the blood? LOVENESS

An illustration about motivations for engaging in these practices:

P: I heard that it makes sex nicer and makes clients keep coming back. Sometimes women only do it when they go see their boyfriends especially if the boyfriend doesn't know that she is in sex work. I think someof these things work because you hear rumours that so and so did 1,2,3,4,5 and now the client only wants to see her because her vagina is tight you see. LERATO

It was evident there was a lack of information about the effects of most vaginal practices. Even though the extreme behaviours demonstrated by other studies were not found in the current study. Information is still needed about condoms not having any side effects and there is a need for education about harmful vaginal practices.

4.4.5. Sex Work and Health

This theme aimed to capture general information under the following eight sub-themes: HIV testing, STI, Condoms, contraceptives, oral and anal sex, challenges accessing health care, mental health, gender-based violence. Sex workers in this study knew their HIV status it is a free and regular service provided by WRHI. The women spoke highly of the sex work friendly nurse and staff and quality of service received. This service unquestionably is the first of its kind in Johannesburg and in the country and should be scaled up with appropriate funding and stakeholder relationships.

The participants indicated they could approach the nurse if they had STIs because they knew they would never be judged and HIV and STI screening and testing became a norm.

The importance of the role played by health care providers is demonstrated in (Scorgie, Nakato, Harper, Richter, Maseko, Nare, Smit & Chersich, 2013) whereby sex workers expressed unmet health needs which included diagnosis and treatment of STI and insufficient access to condoms and lubrication resulting in them to access care from private facilities where they could be guaranteed quality service, respect for dignity and confidentiality (Scorgie, et al., 2013) Indicating that the attitude of the health care providers plays an important role in sex workers seeking care.

Programs such as the Sex Work Project (Women at Risk) need to be expanded to all sex work populations. Poor health seeking behaviours were a result of fear and discrimination posed by health care providers which further fuelled the vulnerability of sex workers to acquire HIV and remain untreated for STIs as also seen in (Stadler & Delany, 2006). Indicating that if a clinic is accessible in terms of quality, accessibility and efficacy it can positively influence health seeking behaviours, create health awareness and promote condom use (Stadler, et al., 2006). Additionally through family planning services, women felt empowered to plan better for their families and avoid unplanned children. Abortions were identified as expensive procedures resulting in back-street abortions and in some cases death of the woman who could not afford the medical procedure. Oral and anal sex were also considered risky sexual behaviours, in this study one case reported engaging in these behaviours in comparison to studies such as the one conducted in Kenya whereby 40.8% of FSW reported engaging in anal intercourse (Schwandt, et al., 2006) in this study the male client often negotiated this practice, by negotiating more money for it (Schwandt, et al., 2006). In the current study the woman felt it was a method of distinguishing the sex she has with her primary partner from her clients.

What was also evident in this study was that women felt empowered enough to negotiate for condoms in comparison to other studies such as (Wojcicki & Malala, 2001; Bharat, Mahapatra, Roy, Saggurti, 2013; Jie, Xiaolan, Ciyong, Moyer, Hui, Lingyao & Lieqing, 2012) where women were disempowered. Women in this study specifically indicated that even if the client negotiated to raise the money they would not agree to sex without a condom.

An illustration of participant testing for HIV and the reasons why:

I: and have you ever tested for HIV?

P: Ya

I: and what were your results?

P; Negative, I have just tested now in actual fact every three months when the clinic comes I test

I: What makes you test every 3 moths?

P: because these clients you can sleep with them using a condom and the condom bursts you can't trust that person you know and you must know your health ya,. CAROL

The illustration below demonstrates sex workers experiences with clinics in general

I: I would like to know if other women talk about their experiences at the clinic?

P: yes they do I know I used to hear rumours that they don't even talk about sex work and if infected twice with an STI they don't go to the same clinic because the card will say what you were there for the last time or they use false names and create new cards but sometime people remember faces so its better to change. Others get to a point where they just go to a traditional healers. LINDA

I: Ok, Do your friends talk about their experiences in accessing clinics?

P: Yes we do I mean I went to one clinic Emadadeni with an STI it was bad over December last year and the nurse was shouting at me saying why did I wait so long to get it treated and somehow during her shouting I felt forced to tell her I am a sex worker and I didn't have time to come to the clinic and that I have tried cleaning myself with other stuff but it didn't work so that's why I was there. At that point she seemed shocked and started calling other nurses to listen to what she was hearing from me. I felt so embarrassed I left, I didn't get pills I just wanted to go home. That's why I prefer the clinic that you guys bring here I know that even if I have the worst STI I will never be judged and only will get treated well. ZODIDI

The illustration below highlights participants indicating they are able to negotiate condom usage, and because she is already HIV positive does not wish to re-infect herself:

I: Ok and do you feel you are able to talk about condoms with clients?

P: Yes I mean I always insist on it especially now as I said I wish the one who had infected me told me he was positive I would have decided to have sex or not. But in my case my vagina and body

are my business so I like to tell them in advance about condoms and sometimes to set the mood I have porn dvds where they use condoms to show him we can have fun and be wearing condoms so its easier done that way. LINDA

I: Ok do you feel that you are able freely negotiate the use of condoms?

P: Yes I do I think we all know the state of HIV in this country but I wish I could have made better choices and not taken for granted that just because a client looks healthy means they don't have HIV. But I have no problems asking them to use condoms I mean this is my business and I won't stop but I have to be careful and also not to re-infect myself. ZODIDI

Sex work health also looked at alcohol and drug use as well as violence as a result of police and clients. It has been noted in a number of studies that violence further puts women at risk. In one study it was noted that a few studies in Africa provide detailed descriptions of sex workers to sexual and physical violence thus impacting HIV risk (Okal, Chersich, Tsui, Sutherland, Temmerman & Luchters, 2011). In India high rates of violence were documented indicating 76% of FSW experiencing violence from clients, sexual coercion which includes verbal threats were as high as 77%, physical force by intimate partners reported at 87% and forced/unwanted sexual acts from clients reached 73% (Panchanadeswaran, Johnson, Sivaram, Skikrishnan, Zelaya, Solom, Go & Celantano, 2010). This needs to be well understood in South Africa and more documentation needed.

Women used alcohol and drugs as coping mechanism and suppressing feelings of guilt and as in some instances mentioned them as sources of energy if they want to be active all night. These behaviors play a role in women being unable to make correct decision making if intoxicated further placing them at great risk. Although in other studies injecting drug use was common amongst sex workers (Xu, Smith, Dina, Chu, Wang, Li, Chana, Wang, Shana, Jiang & Wang, 2012); it was not the case in this study. Women in this study shared many cases of being taken for a "whole night" which is when a client takes the sex worker all night in most cases to his place. Women have related stories of being raped and gang raped in these instances and left abandoned to find their way home. Women also alluded to police unlawful arrests and abuse physically and sexually and deportation experiences in sex workers who were in the country illegally.

4.4.6. CONCLUSION

This chapter discussed the main findings and interpretation of the study. The key findings identified in this chapter have been highlighted in the next chapter which concludes the study and identifies limitations and further provides recommendations at the short and long term.

CHAPTER 5

CONCLUSION LIMITATIONS AND RECCOMENDATIONS

5.1. CONCLUSION

Several studies across the globe have conducted research around sexual practices, products used to cleanse, warm and dry the vagina and motivations for the behaviors. Only a few studies have looked at these practices in relation to sex workers and non-have focused on sex workers in the Johannesburg area. This study contributes to the existing scientific body of knowledge by addressing the aforementioned gap.

The study at hand, further sort to understand the feasibility of conducting social network research within the sex work population. Methodologically in the beginning phases of the research a social mapping activity was included as a method to give participants an opportunity to draw and openly discuss where they see themselves in the network, and how the network operates in their view. Participants would have also been asked for permission to take photos of their diagrams at the end of the interview. However during the pilot phase this method had to be left out due to time constraints of doing the in depth interview first then the drawing activity, women also expressed being uncomfortable in drawing sketches of their networks. The relevance of this methodology is it would have given descriptive information about the structures of the networks. The researcher also felt the methodology required extra resources such as camera, photo development and analysis which ultimately would not have added significant changes to the structures of the social networks that they already narrated in their in depth interviews. This activity also meant downloading scientific software UCINET which was cumbersome as the trial was only available for 30 days thereafter the software needed to be purchased and the researcher did not have the capacity to do that nor be trained in the use of the program. However this can be considered as a future recommendation for future funded studies.

5.2. Summary of Key Findings

A summary of key findings has been provided below:

- Sex workers remain the population at greatest risk of acquiring and or transmitting HIV/STIs due to the nature of their work.
- Sexual/vaginal practices contribute significantly to HIV and STI acquisition and transmission and exacerbating existing STI infections.
- Although not mainly reported in the study; vaginal practices remain an on-going health problem.
- Vaginal practices also demonstrate the unequal distribution of power whereby women have the need to fulfil men's sexual desires to the detriment of their health.
- There is a lack of information targeting sex workers regarding behaviours that put them at great risk.
- Dry sex in this population of study was not by choice or a preferred method of sex; but by virtue of circumstance where the sex worker expressed that they may not be sexually interested in a client and will perform sexual activity unaroused or there may be friction during sex where a client takes too long to reach orgasm thus fuelling dry sex.
- Sex workers in this study reported high rates and understanding of being moist during sexual intercourse to facilitate penetration. They resorted to using baby oil to create moisture which may pose further health challenges.
- The implications for conducting microbicides trials with this population may be feasible as they are open to having additional moisture in a form a gel. However studies needs to consider cultural, behavioural and local perceptions of the population to be studied.
- Social networks according to the preference of sex workers remained as friendships from their country/province of origin. They further indicated that friendships change as a result of migration, death etc. Overall sex workers do not retain friendships due to their work being highly competitive.
- Networks provided crucial practical, financial and emotional forms of support.
- It was also found that programs which are service-delivery focused on providing minim package of services should be provided by sensitized health care providers

as it has been proven that health care provider attitudes act as a barrier in accessing care.

- Once health care providers have been sensitized this will ensure an increased utilization of services such as HIV and STI screening and diagnosis and treatment will be the norm.
- Programs also need to be peer-led because peer educators share the same characteristics as sex workers and it will make it easy to relate to their experiences.
- Lastly, interventions designed for these populations need to be human-right focused and include the participation of sex workers to ensure there is a sense of ownership and in order for programs to be sustainable.

5.3. Limitations

The study limitations identified:

- Sex workers at the site of study received health care services regularly and may have been more aware of their health and have better access to information through peer education and may be better equipped to negotiate responsible sex and be aware of harmful practices.
- The researcher was viewed by the participants as part of the Sex Work Project team and not as an independent researcher thus creating a situation whereby women may have given socially desirable responses. However, the researcher felt this possibility was limited as women were honest about sharing their personal experiences and therefore feels they openly shared about their vaginal practices and the lack thereof without fear or shame. They often narrated their experiences with emotion and sincerity; this lead the researcher to believe in their experiences.

5.4. Recommendations

Based on the study findings there is a gap in how interventions are developed and implemented. Currently HIV/AIDS IEC material does not target the sex work population and it further does not include key messaging around harmful sexual practices and the link

with STI infections. As a short term goal these aforementioned recommendations could be implemented. It is further recommended that future studies could have larger and more varied samples to conduct the research in order to generalize the results. Further the sample size in the current study was only based on black, female sex worker's experiences; it is recommended that if the sample included other ethnic groups the results may have been varied. All the participants in the study were unmarried, in studies where sex workers were married sexual practices were different and for different motivations. The sample chosen in this study were brothel-based sex workers suggesting that their environment is more protected in comparison to street-based sex workers; future research could ensure that the sample is inclusive of the street-based sex workers. Lastly, future research on microbicides as per the recommendation of (Gafos, et al., 2010) should consider local perceptions of communities, sexual practices, preferences and expectations (Gafos, et al., 2010) when designing the use of the microbicide gels.

South Africa needs to learn best practice models from other countries that have been deemed sustainable and successful in the reduction of HIV/STI rates amongst sex workers and adopt these and make them South African specific as is currently done with the DALSA model pioneered by FHI360 through SANAC and NDoH and provincial DoH in KZN.

In the longer term the South African Government needs to refine policies and remove all laws that compound sex work behaviour in order for this population to be better reached with HIV prevention and harmful sexual practice information. As has been proven by evidence the current criminalization of sex work option has not worked. In refining the current laws this will enable researchers in Non-governmental (NGO) institutions to better understand the size and varied behaviours that sex workers engage in and gain better population size estimates in order to ensure that the needs of the sex workers are catered for, that there is an availability of services and increased utilization of services by the sex workers and allowing them to screen and receive early diagnosis and treatment of diseases and receive condoms as well as condom-compatible lubricant to minimize condom brakeage and abrasions during intercourse. The NGOs should work with partner

organizations as well the National Department of Health in ensuring capacity building of health care providers to provide health services that are free of stigma and discrimination. Peer educators have been found to play a critical role in interventions that have been successful on sex work; therefore these agents could be used in the development and distribution of IEC material in addition to other responsibilities such as risk reduction counselling, HIV/AIDS awareness and education, the distribution of condoms and provide referrals etc. At the national government level peer education standards need to be developed which will include information about responsibilities of peers. Lastly when designing interventions to ensure that sex workers are included in the development and in the sustenance of those programs.

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Appendix A: Informed Consent for in depth interviews

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 8333 Fax: (011) 717 4559

Study Enrollment Informed Consent Form

I, _____hereby agree to participate in the research to be undertaken by Jabu Sibeko for her study on the Investigation of Social Network/ (groups) Preferences of Sex Workers in Hillbrow, and their Sexual Health Practices with the full understanding that :

- Participation in this study is voluntary.
- Refusal to participate will involve no penalty.
- I have the right to refuse to answer any questions that I prefer not to answer.
- I may withdraw from the study at any time without giving reasons why.
- **The information I provide will not be traced back to me and my identity will not be disclosed in any report, presentation, or other forms of dissemination.**
- **I understand that fake names will be used to protect my identity and a fake name of the brothel will be used to further protect my identity**.
- No information that may identify me will be used in the research report. While direct speech from my interview may be included in the researcher's research report, the researcher will keep all responses as nameless as possible.

Date: _____

Participant Signature: _____

Appendix B: Consent Form for Recording

Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 8333 Fax: (011) 717 4559

I, _____, hereby give consent for the in depth interview (described in the Information Sheet attached) by Jabu Sibeko to be audio recorded, with the full understanding that:

- The tapes will be heard by no other person other than the researcher and her supervisor.
- All tapes and transcripts will be destroyed after the completion of the research and the qualification has been obtained.
- No identifying information will be used in the transcripts or the research report.
- Pseudonyms/false names will be used to identify different participants to maintain privacy.
- I further give consent to the researcher, Jabu Sibeko, to use direct speech that will not have any identifying information.

Date: _____

Participant signature: _____

Appendix C: Information Sheet

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 8333 Fax: (011) 717 4559

INFORMATION SHEET

Good Morning/Afternoon

My name is Jabu Sibeko, I am a student from the University of the Witwatersrand and I am conducting a study on social groups of sex workers and how these groups influence the choices made by sex workers in terms of health and their work. This research is being conducted for my degree in Psychology. I would like to invite you to participate in this research study.

Participation in this study will involve a once off one-on-one interview with me where I will be asking you questions about the people who are part of your social group, the kind of support they give you, how long you have known them, what role they play in your life, who you go to when you need advice with regards to health, as well as other questions about your sexual health. I will ask you during this time to draw a "map" or a picture of how you are linked with all the people in your group. I will then ask you for the contact details of the people you mention in order for me to invite them to be in the research as well. By participating in this research, you will be helping us to understand how social groups are formed and how they influence the choices people make about their health and sexual well-being.

Since what you have to say to me is really important, I am asking for permission to use a tape recorder to assist me in remembering all the information and to ensure that I have understood all that you have to say. No one will know who I am speaking to except for me, I may write about some of the things in my final report but no names will be used. I will only use "fake" names where necessary and all the recordings will be kept in a locked office in a computer which is protected with a password until all information has been analyzed by me, then all recordings will be destroyed once my report is finalized.

The interview should take between 45-60 minutes but may take longer. This interview may cause you some discomfort by taking you away from your normal daily activities. The interview may also ask you to reveal private information about your sexual health. You do not have to participate if you do not want to; you have the right to withdraw from the interview at any point if you choose so and you have the right to not answer any question that may make you feel uncomfortable. You will not lose access to treatment from the mobile clinic or anywhere else as a result of choosing to or not to participate in the research. Your participation in this research is voluntary and you have the right to withdraw without necessarily giving reasons. All this information will be treated as confidential. The study offers referrals to specialist counseling services which are free of charge should you wish to make use of any, the contact details are as follows: 011 358-5500 for the social worker at Wits Reproductive Health and HIV Institute (WRHI). Other services can also be used as referrals depending on the nature of the problem a person has.

People who participated in the research will be contacted at the end of the study and will be given a summary of all the findings and I will be available telephonically if any further questions or concerns are raised. I can be reached telephonically on 011 358 5416 or via email to people who have access to the internet at jsibeko@rhru.co.za.

Your participation in this study would be greatly appreciated and if there are any queries please contact me on the details above or alternatively you can contact my supervisor on the contact details below.

Yours sincerely,
Jabu Sibeko

Research Supervisor: Prof. Brendon Barnes (011) 717-8333
Brendon.Barnes@wits.ac.za

Appendix D: Interview Schedule for in depth Interviews

Interviewer script: Thank you once again for your willingness to participate in this research study. To start our discussion, I would like to know:

Life History: Can we talk a bit about your history?

- How old are you?
- Where were you born? (probe about decisions about being in Hillbrow)
- What is the highest grade in school that you completed?
- How long have you been in sex work?
- What made you decide to be in this industry?
- Were you recruited by someone to join sex work?
- Have you recruited others?
- In what location/areas do you work?
- Where do you live?
- How long have you lived in this area?
-

Now I want to know about the social network(s) you belong to:

- Can you give me names of the three people closest to you whom you work with?
- How did you meet them?
- What kind of support do they give to you? (emotional, instrumental, appraisal, information)
- Who has the most decision-making influence in your life
- Can you give me their contact numbers so I can interview them too?
- How long have you known these people?
- How often do you see them?
- How did you become acquainted with them?
- Do you talk about sex with them? (probe sexual partners)
- How do you select your friends and sexual partners? (probe if friends have an influence on this)
- What role do you play in your friendships?
- Do you go the clinic when you are sick or do you use alternatives such as traditional doctors etc.?
- Do people in your group talk about experiences at the clinic and other health care services?
- Does the group you belong to influence your decision to access care?
- Do you influence other people?
- How do you feel about services that provide HIV testing?
- Do you think It is important to test for HIV and why? What do people in your group say about testing?
- What is the general attitude about health and sexual health in your group?

Sexual health practices

- Do you cleanse the vagina (if so what methods are used, what are the reasons, how often does this method occur, does it happen after sexual coitus or before)

- Are you on contraceptives? (probe about their decision to take them or not and the reasons why)
- Do you go for pap smears? Test for STIs and HIV? (Probe about how frequent, why they think It is important, how often they go
- If you have not done any vaginal cleansing or other practices, then do you know of other people who do it when and why?
- Have you ever slept with a client that you know has HIV just to get money?
- What are your experiences of dry sex? Probe whether or not they have engaged in it, are they aware of the biological effects of this practice, how often do they engage in it. Probe also about use of lubricants?
- Do you insert any objects in the vagina, and were they influenced by anyone within their network of friends?
- Have you ever had sex with someone whilst abusing alcohol and or drugs and have they had clients who were using alcohol or drugs
- Use of condoms (probe about frequency, reasons for using and not using them etc.)

Thank you for your participation.

Appendix E: Ethics Approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Sibeko

CLEARANCE CERTIFICATE **PROTOCOL NUMBER H1 10209**

PROJECT Investigating social network preferences of sex workers in Hillbrow and th
sexual health practice

INVESTIGATORS	Ms J Sibeko
DEPARTMENT	Psychology
DATE CONSIDERED	11.02.2011
DECISION OF THE COMMITTEE*	Approved unconditionally

NOTE:

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 08.03.2011 **CHAIRPERSON** .....
(Professor R Thornton)

cc: Supervisor : Prof B Barnes

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure a approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES