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# Sexual and reproductive healthcare services for female street-and hotel-based sex workers operating from Johannesburg City Deep, South Africa.

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# Sexual and reproductive healthcare services for female street-and hotel-based sex workers operating from Johannesburg City Deep, South Africa

FINAL

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Masters in Research Psychology by Coursework and Research Report

*This research report is submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Arts in Research Psychology by Dissertation and Coursework.*

## Declaration

I declare that this research report is my own unaided work, and that acknowledgements have been made to all sources used throughout the report. This report is submitted to the Faculty of Humanities at the University of the Witwatersrand in partial fulfilment of the requirements for a Degree of Masters of Arts (Research Psychology). It has not been previously submitted for any other degree or examination at any university.



_____

Jenny Coetzee

15 May 2013

# Dedication

*To the woman in the towel:*

*I feel blessed both to have met you and for the hard lessons you brought me.*

*Thank you.*

*My darlings Phoebe and Ethan,*

*I wish to one day leave you with a kinder world.*

*I will try my hardest!*

*For I, M, D, W, C, MM, B, K, C, T, P,*

*and all the other men and women I met in town.*

*Thank you!*

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- First and foremost, thank you to all of the women whom I met and spoke with over the course of this project. I hope that this gives voice to your concerns – that it highlights the oppression you face as a result of an inefficient healthcare and policing system, unjust laws and a legacy of gender disparity. You are incredibly brave and amazing women. May your calls for reform not fall on deaf ears.
- To my supervisor, Prof. Brett Bowman, your insights and guidance have been fundamental throughout this project. You have offered me a depth of perspective which I would have lacked otherwise. For the final time – I truly appreciate your council, advice and sense of humour, Brett. Thank you, thank you, thank you!
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# Abstract

Sex work is a crime in South Africa. With the prevalence and deleterious social and economic effects of HIV, in health literature sex work has often been understood in relation to the way that it intersects with the transmission of the epidemic. This positioning of sex work then inadvertently stigmatises sex workers who are often cast outside the rights-based discourses that characterise South Africa's post-apartheid democracy. In order to address this problem, this study explored the perceived barriers and facilitators to sex workers' accessing sexual and reproductive healthcare (SRHC), gaps in the current service offerings relating to sex worker's sexual and reproductive health (SRH) and the general experiences of SRHC amongst 11 female sex workers in Johannesburg, South Africa. Semi-structured in-depth interviews were conducted with these sex workers, who were based in Johannesburg City Deep. The resultant data were transcribed and subjected to a thematic analysis. The study shows that various structural and individual level barriers are perceived to prevent access to SRH. In particular, the analysis suggests that the disease-specific focus on sex worker-specific projects poses a barrier to sex workers' accessing a complete range of SRHC services. Violence enacted by healthcare professionals, police and clients fuelled a lack of trust in the healthcare sector and displaced the participants from their basic human rights. It is also worrying that religion posed a threat to effective SRHC because some religious discourses label sex workers as sinners who are perceived to be excluded from forgiveness and healing. Finally, motherhood proved to be a point at which the participants actively managed their health and engaged with and in broad-based SRHC. Participants frequently only sought SRHC at the point at which an ailment affected their livelihood and ability to provide for a family. Taken together, these findings seem to show a range of formidable challenges to sex workers' understanding of themselves in a human rights discourse. This study's findings are of particular importance to rethinking the legislation that criminalises sex work, as well as healthcare initiatives geared both towards sex workers and women in general.

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# Chapter One:
# Introduction

> "*Credible research is required into sex work and human rights...that will inform our own responses as well as contribute to the larger sex worker human rights agenda...*[in particular]*... into the gaps and barriers to accessing health services in the region*"(African Sex Worker Alliance, 2010, p. 1).

## 1.1. Introduction

In South Africa, under the *Sexual Offences Act, No. 23 of 1957* (Republic of South Africa, 1957) and the *Sexual Offences Amendment Act*, *No. 32 of 2007* (Republic of South Africa, 2007), sex work is criminalised. In the last few decades, given the prevalence and deleterious social and economic effects of HIV, sex work in health literature has often been understood in relation to the way that it intersects with the transmission of the epidemic. Consequently, sex worker healthcare is predominantly studied as a component of the issues surrounding HIV and STI prevention. This positioning of sex work thus inadvertently stigmatises sex workers (Wojcicki & Malala, 2001), who are often marginalised and cast outside the rights-based discourses that are claimed to characterise South Africa's post-apartheid democracy.

The right to health is crucial to sex workers, who, in South Africa, are faced with the legacies of colonialism, gender inequality, violence and the current economic climate. Given the nature of their work, enabling them to access Sexual and Reproductive Healthcare (SRHC) is critical. While rhetorical debates indicate that urgent action is required in the area of sex worker healthcare, political will seems to be lacking (Pisani, 2008; Richter, 2008a).

Since its first fully democratic elections in 1994, South Africa has instituted one of the most progressive constitutions in the world. This document, the *Constitution of the Republic of South Africa, Act 108 of 1996* (Republic of South Africa, 1996), underpins all legal processes in the country and is grounded in human rights discourses. It aspires to the provision of equality, freedom of expression and association, access to information, education and healthcare (Republic of South Africa, 1996). The inconsistencies in the treatment of a

vulnerable group such as sex workers are thus incongruous against the backdrop of South Africa's human-rights-based constitution and thus highlight that this population should become the beneficiaries of human rights intervention on their behalf. The current study contributes towards an evidence base for such an intervention.

Epidemiological studies have provided the incidence and prevalence figures on HIV amongst sex workers, but the relationship between the host, the agent and the environment is often oversimplified. For example, varying contextual dynamics, such as migrancy status or literacy levels, are regularly overlooked as important factors that can constrain people's ability and willingness to access health services (Cwikel, Lazer, Press, & Lazer, 2008). The combination of discriminatory gender-based attitudes, increased exposure to violence, migrant status, challenges regarding prevention technologies, Multiple Concurrent Partnerships and the ongoing criminalisation of sex work all function to create a complex interplay of causal mechanisms that constrain the accessing of healthcare. Simultaneously, these mechanisms increase sex workers' sexual and reproductive health (SRH) risks (Richter, 2008a; UNAIDS, 2009b; World Health Organisation, 2010).

This research report describes a project geared towards building an evidence-based human rights approach to sex workers' access to SRHC in an interpretivist framework. It is aimed at qualitatively understanding sex workers' accounts of their encounters with SRHC and exploring the perceived structural and psychosocial factors involved in enabling and constraining access to SRHC, while understanding their experiences of the healthcare system. The design of the study and the focus on sex workers' experiences of real structural challenges reflect a deliberate attempt to counter the potential reductionism inherent in many studies on sex workers as vectors of disease.

## 1.2. Rationale

The deep-rooted stigma attached to the sale of sexual services, the on-going criminalisation of the profession and squalid living and working conditions ensure that little information is available about sex workers' health and wellbeing (Richter, 2008b). Access to SRHC is a fundamental human right, and such services are clearly highlighted not only in South Africa's *Constitution,* but also in international mediations on human rights. It is a key to the achievement of the global Millennium Development Goals (MDGs) for 2015 (UNAIDS,

2010b) and have been identified as an area to be addressed in South Africa's National Strategic Plan (UNAIDS, 2010a).

Much of the impetus to address the current lack of service delivery in this sector appears to stem directly from the urgency of addressing the debilitating economic and social aspects of HIV/AIDS, rather than from a desire to address the discriminatory laws and practices that hinder some people's access to basic human rights (Chacham, Diniz, Maia, Galati, & Mirim, 2007), in particular that of sex workers. Consequently, the overall SRH needs of a hidden and vulnerable population are constructed in, and as part of, the global HIV/AIDS agenda in providing medical care presumed to be appropriate to this population. Sex worker healthcare in relation to the specific needs or rights of this population consequently remains unaddressed. The use of such presumptive medical care may inadvertently serve to hinder sex workers' access to a full range of SRHC services.

Research in the health sector is located largely in a biomedical framework, drawing on a positivist paradigm. This approach largely ignores the interplay between micro- and macro-level factors and therefore fails to understand the various inequalities inherent in a complex social world (Bergin, Wells, & Owen, 2008; Connelly, 2001). In order to overcome this failure, the current study was conceptualised in an interpretivist paradigm, allowing for a holistic understanding of the tensions between sex workers and the various mechanisms functioning to create inequalities in the healthcare system (Connelly, 2001). Such social inequity is evident in healthcare hierarchies between public-private healthcare systems, and in public systems which may privilege one population group over another.

A number of studies have considered sex work in the light of a number of structural and individual level factors as presented in Chapter 2. However, despite the current influx of international migrants, research participants in many such studies have remained predominantly South African (see Chapter 2). If such approaches are adopted (intentionally or by default), the complexities in accessing SRHC for migrant populations may be overlooked in designing public health interventions. There are, however, some reports which have included a broader range of factors when considering the health of sex workers For example, Campbell (2000) addressed condom negotiation and safer sexual practices incorporating both structural and psychosocial factors, as did Wojcicki and Malala (2001). In addition, Stadler and Delany (2006) undertook a needs-based assessment of the

effectiveness of a Hillbrow hotel-based clinic service. However, all these studies inadvertently continue to frame sex workers in the biomedical discourse of HIV and STIs. Insufficient attention has been paid to the complex interplay between the strata of factors in a human rights discourse. Consequently, as already indicated above, sex workers are presented as vectors of disease, and not as individual women functioning in a complex system which has created inequalities, rendering them unable to access their basic human rights.

The health rights of sex workers and the broader social determinants of sex worker health have been flagged as a priority health issue that requires further research (African Sex Worker Alliance, 2010). This project serves to address these needs by increasing knowledge about the barriers to and enablers of access to healthcare services amongst sex workers in South Africa. In particular, the project aims to explore perceptions of SRHC alongside perceived gaps between available and required services for sex workers as a human rights-related health issue. Guided by the aims and objectives outlined below, this report endeavours to consider in detail the role of various micro- to macro-level factors implicated in the use of SRHC.

### 1.3. Aims and Objectives

The study aimed to explore perceived access to SRHC facilities and services for female hotel- and street-based sex workers operating from Johannesburg City Deep, South Africa. The objectives of the study were to explore the barriers and facilitators of access to SRHC, while assessing gaps in the current service offerings for female street- and hotel-based sex workers in Johannesburg City Deep, South Africa. In addition, the project aimed to explore sex workers' experiences of SRHC.

Embedded in an interpretivist framework, the study used semi-structured interviews to collect data and analysed the data using thematic analysis. Sex workers were recruited for participation in the project using a convenience sampling technique. The interviews were transcribed, and analysed using thematic analysis as suggested by Braun and Clarke (2006).

## 1.4. Chapter Outline

The rationale, aims and objectives of the study have been introduced in this opening chapter of the report.

Chapter Two presents an overview of the available literature. This chapter encompasses a review of sex worker vulnerability, of risks/threats and protective factors to sex worker health, as well as an overview of SRHC in South Africa.

Following this, Chapter Three discusses the qualitative methodology employed in the study. The theoretical paradigm in which the project was framed is detailed in this chapter, as are the selection criteria, method of recruitment, data collection and analysis, and all the ethical considerations taken into account in the study.

Chapter Four presents and discusses the findings of the research. The findings reported focus on the themes that emerged relating to the interface between human rights and healthcare: the incongruency of the system these sex workers are supposed to access, displacement through violence, motherhood, and religious morality. Each of these major themes is underpinned by a number of auxiliary themes which are discussed in the chapter.

Finally, Chapter Five concludes the report with a detailed discussion of the implications of the findings in relation to legislation criminalising the profession, policing mechanisms employed in managing sex workers and in the creation of healthcare services which are geared to the overall needs of the population.

# Chapter Two:
# Literature Review

## 2.1 Introduction

As has already been indicated in Chapter 1, much of the literature surrounding sex work is located in a biomedical framework which frames sex workers as vectors of both the HIV pandemic and other STIs. What this literature appears to ignore or downplay is the broader SRH needs of the sex worker population as women who may be in search of satisfying sexual relationships, or as mothers in need of antenatal care.

This study offers evidence on the generalised SRH needs of sex workers and the potential that meeting these needs offers as an enabling factor in sex workers' access to "prioritised" HIV-related SRHC. In this way, the project aims to contribute to a better understanding of the overall needs of sex workers outside a biomedical discourse, in line with the South African *Constitution* and international charters on human rights.

The nature of sex work exposes sex workers to a multitude of risk factors, including violence and discrimination. When these factors are combined, they render this population particularly vulnerable to SRH complications. The criminalisation of sex work, offers of free healthcare and police services are claimed to be designed to reduce the risks associated with sex workers' profession and to protect sex workers from harm. In reality, however, these structural factors force women into further levels of subjugation, discriminating against them and serving rather as additional risk factors in terms of their successful accessing of SRHC. This situation is compounded by additional structural, psychosocial and behavioural factors which increase sex workers' vulnerability, simultaneously preventing them from accessing SRHC effectively.

In reviewing the existing evidence base it becomes apparent that sex workers are frequently positioned in a biomedical discourse. While the focus of many interventions are organised in this framework, the current report challenges existing notions through its commitment to an evidence-based human rights approach, advocating a more inclusive approach to sex workers' SRHC. Below is a discussion of some of the factors identified in the available literature on sex workers' vulnerability, the risk and protective factors which either facilitate

or constrain their accessing of SRHC, and the medical services themselves, which are plagued by social inequalities.

## 2.2 Sex Worker Vulnerability

Sex work has been defined in a number of ways. The United Nations defines it as including female adults "who receive money or goods in exchange for sexual services either regularly or occasionally"(UNAIDS, 2009b, p. 3). Other definitions of sex work have emphasised the commercial aspect of the profession. These refer to the degree to which it is formalised or organised and to which it is distinct from other social and sexual relationships and types of sexual-economic exchange (Open Society Institute, 2006, cited in Richter, 2008b). Sex work differs from sex trafficking, in that individual agency is the key to the consensual nature of sex work. In contrast to sex work, trafficking by definition involves forced sex work under the threat of violence and for no reward. It is seen as an exacerbating factor in the accessing of public services and is a serious breach of basic human rights (Richter, 2008a; Skinner, 2008).

Sex work takes place in a multitude of settings, from brothels and hotels to truck stops and parking lots. Sex workers cater to local communities, and the environment lends itself to an ever changing populace. Hence, both migrant and local populations of clients and sex workers converge at the point of trading sex. (Baral, Beyrer, & Sherman, 2009; Richter, 2008a; Stadler & Delaney, 2006; UNAIDS, 2009b)

While some of the literature defines sex workers in terms of a specific location (hotel-based or street-based), other sources are more dynamic in their parameters. Money is often a deciding factor in determining whether sex workers work indoors (for example, in an hotel or a brothel) or outdoors (for example, on the street); for instance, a limited population of indoor clients may lead sex workers onto the streets in search of work (Stadler & Delaney, 2006).

Irrespective of how they are defined, sex workers constitute a marginalised population in South Africa, making them particularly vulnerable to discriminatory gender-based attitudes, violence and sexual exploitation, disease and discrimination (Stadler & Delaney, 2006; Richter, 2008a; Baral et al., 2009; UNAIDS, 2009b). In South Africa, all these factors constrain sex workers' access to basic services and deny them their human rights. This

increased vulnerability puts them at risk for a number of health threats, as described in the sections that follow. The literature highlights violence, STIs and HIV as amongst the most prevalent and formidable health threats to sex workers.

### 2.2.1 Violence

South Africa is seeking increasing opportunities and rights for women. While some drives and initiatives exist which are geared towards protecting women from violence, this is not the case for sex workers. They are frequently victimized by violence, and violence in turn is often associated with unprotected sex (UNAIDS, 2009b). Whether enacted or threatened, violence has far-reaching economic, social and health consequences. It is an important contributor to ill-health in women, especially with regard to SRH (Glasier, Gülmezoglu, Moreno, Schmid, & van Look, 2006; Bowman, Matzopoulos, Butchart, & Mercy, 2008).

A recent study showed that as many as one third of the sex workers interviewed reported having been raped within the six months prior to the research (RHRU, 2002, cited in Richter, 2008b). This is a serious aggravating factor in SRH complications (Glasier et al., 2006). Childhood abuse, forced first intercourse and adult sexual assault by non-partners are all correlated to an increase in risky sexual behaviour and entry into the profession (Dunkle et al, 2004; Baral et al, 2009)

Exposure to high levels of crime and violence increase levels of stress and mood disorders in people, while leaving a low sense of self-efficacy (Bandura, 1996; Campbell, 2000; Wojcicki & Malala, 2001).The resultant psychosocial factors serve to hinder access to SRHC through increased levels of depression, psychological distress, low self-efficacy and self-esteem (Wojcicki & Malala, 2001; Rekart, 2005). Whether directly or indirectly, violence is a breach of human-rights and can prevent access to healthcare, including SRHC.

Male violence against female sex workers is a common occurrence. Both physical and sexual violence is frequently perpetrated by clients, law-enforcement or establishment owners and controllers. This is compounded by the generally higher crime rates in the communities in which sex work is undertaken (Leggett, 1999; Campbell, 2000; Wojcicki & Malala, 2001; Karandikar & Prospero, 2010; UNAIDS, 2009b). While violence can occur both during and after termination of sex worker services (Campbell, 2000; Wojcicki & Malala, 2001; Stadler & Delaney, 2006)), it occurs predominantly at the hands of partners (Stadler &

Delaney, 2006). It can be triggered by a number of factors and typically takes the form of robbery, rape, beatings and sometimes murder (Campbell, 2000; Wojcicki & Malala, 2001; Stadler & Delaney, 2006).

The location for soliciting sex is considered an important determinant of violence. Some studies have found that outdoor sex workers are more prone to high levels of physical violence, while indoor sex workers experience less frequent but more severe incidents of violence (Stadler & Delaney, 2006; Karandikar & Prospero, 2010). Street-based sex workers face an increased level of police and community harassment, leading them to work in poorly lit areas, thereby increasing their vulnerability to violence (Leggett, 1999).

Such experiences of violence are indicative of the needs of the sex worker population, who frequently require post-exposure care. The frequent victimisation, intensely negative focus upon this population and resultant discrimination in both legislative frameworks and healthcare initiatives alienates and displaces sex workers from much-needed SRHC. The inability of sex workers to access basic services during times of immense need, such as after a rape, further estranges this population from basic human rights. This intense disconnection is then indiscriminately applied to all aspects of sex worker access, reinforcing their misalignment to a human rights-based framework. This report positions the need for broader SRHC for sex workers as paramount to their overall wellbeing and to the uptake of specialised services through repositioning the women as deserving of the full range of human rights.

Human rights abuses perpetrated by police compound problems associated with SRHC. Police are in a position to exert power over sex workers, and harassment frequently leads to bribery, violence and sexual demands being made of sex workers. Fear of and unsympathetic treatment by the police ensure that few abuses get reported (SWEAT, 2010; Wojcicki & Malala, 2001). Where incidents of rape are reported, sex workers are often left feeling further traumatised and humiliated by degrading and humiliating police treatment. Such police action has led to discomfort in reporting any form of violence to the police (Wojcicki & Malala, 2001).

Exposure to such violence results in not only humiliation and shame, but also in emotional scarring, psychological stress, depression and low self-esteem (Wojcicki & Malala, 2001;

Rekart, 2005). It also increases the possibility of serious health complications (Wojcicki & Malala, 2001), such as unwanted pregnancies, genital injury, STIs, HIV and emotional trauma. It is thus vital that sex workers have access to services which address the full scope of their SRH needs as women, over and above their needs as sex workers.

### 2.2.2 Sexually transmitted infections

The prevalence of STIs in South Africa is one of the highest in the world (Boily, Baggaley, Wang, Masse et al., 2009). In South Africa, STIs account for 35.6% of years of life lost (YLLs) and 31.5% of disability adjusted life years (DALYs). Of particular importance is the gender disparity, with women accounting for 12.3% and 9.4% more YLLs and DALYs respectively than men (Johnson, Bradshaw, Dorrington, & The South African Risk Assessment Collaborating Group, 2007). Nevertheless, little is known about whether sex workers "are able to access healthcare services and whether HIV treatment and prevention services are reaching them"(Richter, 2008a, p. 12)

It should be acknowledged that considering the health implications of sex work is important in concentrating understandings of its causes and consequences, but the focus in a biomedical framework repositions marginalised and at-risk populations such as sex workers in a vector discourse. If this is done, combating HIV is given clear precedence over the humanity of the individuals concerned. This misalignment of priorities negates the overall needs of such a marginalized group in ensuring access to a singular aspect of SRHC, while simultaneously disregarding the complexities of access and of SRH needs in general. Such a reductionist approach needs to be carefully reconsidered in the implementation of services, because such reductionism poses a potential threat to the uptake of such services.

This is not to deny the importance of HIV and STI interventions. STI infections pose a serious threat in terms of secondary infections, such as HIV transmission, pelvic inflammatory disease, cervical cancer, and adverse fertility and pregnancy outcomes (Johnson et al., 2007; Rekart, 2005; World Health Organisation, 2003). Recent studies have shown that the treatment of Reproductive Tract Infections (RTIs) and STIs reduce the risk of HIV infection by 27%, with early detection and intervention yielding an even greater reduction (Askew & Berer, 2003). Appropriate treatment of STIs at the first contact between patient and healthcare provider is therefore an important public health measure (World Health

Organisation, 2003b). In the South African context, the government has admitted that there are currently no available measures to address this (South African Government, 2009).

This study provides evidence that access to SRHC is a complex functioning between multi-level factors. These need to be considered in unison when developing interventions to increase the uptake of services. The disease-specific focus of many HIV/STI services means that comprehensive SRHC is not offered in these programmes. Thus the partial service offerings in sex worker SRHC may be found to further obscure and complicate access to the STI and HIV services they are geared to provide. The current project therefore offers evidence as to the mechanisms through which such focused service offerings simultaneously encourage certain treatments while hindering access to others.

Accessing SRHC is imperative for sex workers, who are increasingly exposed to STIs (Steen & Dallabetta, 2003; Rekart, 2005; UNAIDS, 2009b). The combination of frequent intercourse and the risk of violence leads to genital trauma. This, coupled with practices such as douching and/or using drying or astringent substances to remove lubricating vaginal fluids to induce a sense of tightness in the vagina or "dry sex" increases the risk of disease. Compounding this is the inability to access effective SRHC services as a result of discriminatory laws and the enactment of stigma by clinicians and nurses alike (Wojcicki & Malala, 2001). An understanding of sex worker practices is important in gearing programmes towards their specific needs; however, caution should be exercised to overcome the potential to fall back into a reductionist approach to SRHC which understands sex work only as a means of transmission of STIs and sex workers as their source. Sex workers cannot be reduced to what they do; they intersect a number of different roles.

The reduction of sex workers to vectors of disease is a pivotal barrier to their accessing broad-based SRHC in line with South Africa's human rights-based *Constitution* and the international drive to address HIV. Due to the potential for transmission dynamics in sex work, high STI prevalence can be sustained in wider sexual networks (Steen & Dallabetta, 2003). There are strong correlations between the spread of STIs and HIV (Lewis & Maruma, 2009). Both ulcerative and non-ulcerative STIs increase the risk of HIV (World Health Organisation, 2003b; Rekart, 2005). Sex workers are viewed as a core transmitter group for HIV, and they are framed as a bridging group to other populations (Askew & Berer, 2003).

Yet, the framing of the population in this way has become detrimental to their accessing of overall SRHC through the often discriminatory and dehumanising treatment they receive.

Motloung (2010) found that among 200 Hillbrow-based sex workers, there was no significant association between abnormal pap-smears and HIV. Yet, intensive STI and HIV services have been set-up within the suburb in targeting apparent sex worker needs. There was, however, a significant association between abnormal pap-smears and street-based sex workers. This serves as a clear indication that where STI management has been valued predominantly as a means to reduce HIV transmission, such a reductionist approach has failed to consider the overarching need for SRHC outside of the HIV framework. Women require a broad range of services in addressing their overall SRH needs. The creation of sex worker-specific services geared to addressing the HIV pandemic perpetuates the positioning of this population as vectors for transmission, displacing them from the "normal" female populace. Concomitantly, it hinders access to services through either gaps in the service offering or through engaging in a discourse which disallows sex workers their basic human rights.

### 2.2.3 HIV/AIDS

Of South Africa's population of 50 million people, an estimated 10.6% were living with HIV/AIDS in 2009 (UNAIDS/WHO, 2010). It is thought that 1.8 million people have died in the country since the epidemic began. Women face a far greater risk than men, accounting for 90% of new infections. In sub-Saharan Africa, heterosexual intercourse remains the driving force of the HIV/AIDS pandemic (World Health Organisation, 2011). In recent years, this has placed sex work under the spotlight as playing a central role in the spread of the pandemic (UNAIDS & WHO, 2009). This has resulted in an oversight of the tensions between basic health care service delivery and basic human rights, focusing on HIV/AIDS as the driver to accessibility to healthcare services (Wojcicki & Malala, 2001). To this end much of the literature focuses on service delivery for sex workers only in relation to HIV prevention and management. However, access to basic SRHC services should not be considered in isolation, neglecting an all-encompassing approach to SRHC service offerings.

The dominance of HIV as a means to attain funding and address issues of access has led the United Nations to identify key issues to be addressed in terms of healthcare for sex workers. These include access to and utilisation of

- HIV prevention, treatment and care, and support services;
- Voluntary testing and counselling (VTC) services;
- Reliable and affordable access to commodities such as condoms, water-based lubricants and contraceptives;
- Access to high quality primary healthcare, including tuberculosis (TB) management, and SRH services;
- The removal of punitive laws, policies, practices, stigma and discrimination which block an effective response to AIDS (UNAIDS, 2009b; United Nations, 2009).

This listing gives clear evidence of the prominence of HIV interventions for sex workers.

In South Africa it is unclear whether SRHC as stipulated by the United Nations is available to sex workers. Nor is the impact of such a biomedical approach to SRHC on access to available services known. Clearly these are key variables in understanding the need for specialised services with the complexities of sex work and the women for whom these services are designed.

HIV infection among sex workers is highlighted as important in transmission in sub-Saharan Africa. Median prevalence reports of HIV for the region are 19% (UNAIDS, 2009a). In South Africa, the national average percentage of HIV-positive women attending antenatal clinics grew from 0.7% in 1990 to 27.9% by 2002 (Medical Research Council, 2003). While such new infection rates are considered high in the normal population, the rate amongst sex workers increased exponentially over a ten-year period. A study conducted between 1996 and 1998 indicated HIV rates for commercial sex workers in Hillbrow to be 45% (Rees, Beksinska, Dickson-Tetteh, Ballard & Ye Htun, 2000, cited in Stadler & Delaney, 2006), a massive increase from the single sex worker found to be HIV-positive in 1986 amongst a study population of 251 (Stadler & Delaney, 2006). More recent data indicates infection rates of between 50.8 and 80% amongst female sex workers in KwaZulu Natal and

Carletonville respectively (Stadler & Delaney, 2006; Baral et al., 2009). Such high rates of HIV infection suggest that despite the implementation of sex worker- and/or HIV-specific interventions, the uptake of HIV prevention and treatment is less than optimal, and sex workers remain high at risk of contracting HIV. Sex workers are vulnerable to HIV, but they are unable to access SRHC services effectively to address prevention and treatment of the disease. Additionally, their vulnerability to violence and the criminalisation of the population often precludes access to SRHC, compounding their vulnerability to both HIV and other SRH concerns.

A recent meta-analysis of transmission rates indicated that the rate of infection could be reduced from 5.6 per 100 person years to 0.5 per 100 person years through consistent anti-retroviral therapy. This would result in a significant reduction in the new infection rate (UNAIDS, 2009a). Consistent access to anti-retrovirals would protect sex workers from HIV-related complications. However, global data estimate that as few as 16% of sex workers have access to basic HIV services.

Claims that between 10% and 18.9% of new infections are directly attributable to "paid for sex" (UNAIDS, 2009b; Department of Health, 2012) have been consistently queried amongst sex worker organisations and advocacy groups (Richter, 2011). Overall population transmission rates are alleged to increase by approximately 5.3 times on exposure to a commercial sex worker population (Boily et al., 2009). Such an increase in transmission rates is ambiguous at best in a country where sex work is illegal, making population estimates vary dramatically, concurrently impacting transmission estimates.

Few studies have addressed the clientele of sex workers. The increase in transmission rates may also be due to client factors such as the increased proclivity to violence. In that case, transmission rates would speak to sex worker vulnerability as an alternative to their vectorship. The intensity of HIV focalisation on sex work encourages a vectorship discourse while neglecting the role of the client (Jewkes, 2011) and that of the "normal" heterosexual couple (Venter, 2011). This again dehumanizes and displaces sex workers from the full scope of human rights. Such displacement serves to render them unable to access SRHC and an evidence base is required to understand the complexities of this as an underlying mechanism to SRHC access.

It is not only the biomedicalisation of sex work that constrains sex worker access to the full range of SRHC. The criminalisation of the profession and resulting discriminatory practices, influx of international migrants and other compounding factors render the accessing of SRHC a complex issue. Directly addressing the structural drivers of this vulnerability should be the target of primary prevention strategies, but access to adequate healthcare services represents a short-term ideal in more tertiary level prevention projects.

Having outlined the key factors that characterise sex workers as a vulnerable population to violence, STIs and HIV, the next section addresses further risk and protective factors in sex worker health. These include the criminalisation of sex work, discrimination and marginalisation, as well as migrancy and socio-economic factors. The impact of risky sexual practices, as well as psychosocial factors are also explored for their potential role in access to SRHC.

## 2.3 Risk and Protective Factors for Compromised Health in Sex Work

While inner city projects and activist organisations are championing better access to services, it is not clear what percentage of the commercial sex worker population is regularly and successfully accessing these programmes. It is likewise not entirely clear what is constraining or enabling this access. What is clear is that STI/HIV management is a priority intervention, and has as such received appropriate and intensive implementation (UNAIDS, 2010a). While an effective HIV campaign is imperative, this should not be to the detriment of any of the various populations in need of pregnancy and childbirth care, sexual relationship advice or post traumatic care. The vectorisation of sex workers through health initiatives and legislative frameworks is having an impact on their access to SRHC. A comprehensive understanding of the complex interplay between the causal mechanisms underlying sex worker access to SRHC would better inform policy and public level interventions. This would improve overall SRHC access in line with the MDGs while increasing sex workers' uptake of HIV initiatives, re-positioning a sex worker as a woman in need of SRHC rather than reducing her to an intervention object. The present lag in SRHC and the fact that sex work is criminalised seriously constrains access to the provision of such services.

### 2.3.1 The criminalisation of sex work

South Africa is frequently lauded for having one of the most progressive constitutions in the world. Human rights are given clear prominence, with the Preamble to the *Constitution* stating the country's intention to "establish a society based on democratic values, social justice and fundamental human rights" (Republic of South Africa, 1996, p. 3). The *Act* goes on to state that it is based upon the values of "human dignity, the achievement of equality and the advancement of human rights and freedoms" (p. 3). A variety of provisions are made in the *Constitution* to provide for the security of human rights, and the protection of individuals against discrimination. Specific provision is made for vulnerable populations, including prison inmates, migrant populations and women.

However, a number of laws and regulations remain in place which create obstacles to certain vulnerable populations' ability to attain certain services and which further promote stigmatisation of and discrimination against them. This perpetuates barriers to the accessing of services, including SRHC. The criminalisation of sex work is one such law (UNAIDS, 2010a). The law initially intended to reduce the prevalence of sex work, but now it serves to render sex workers increasingly vulnerable to violence and exploitation. It forces them to become a hidden population, rendering them more vulnerable to SRH issues, while hindering their access of health and legal services. This perpetuates the stigma associated with their work, at the same time increasing client dominance and power over them (Campbell, 2000; Baral et al., 2009; Richter, Chersich, Scorgie, Lüchters et al., 2009; UNAIDS, 2009b; Fick & SWEAT, 2006). Such attitudes and actions are further maintained through South Africa's patriarchal society, which supports the often violent subjugation of women in general, and sex workers in particular (Brewis & Linsead, 2000).

Since 1994, there have been government-level indications of debates surrounding a reform to the laws governing sex work; however political will is lacking (Wojcicki & Malala, 2001; Richter, 2008b). Some challenges have been brought against such laws, but they have been constitutionally upheld, although they are noted as being discriminatory in the *South African National Strategic Plan 2007-2009* (Richter, 2008a; UNAIDS, 2010a).

Research shows that where the sex work industry is regulated, there are far better health outcomes and there is a reduction in the regular abuse of women (Baral et al., 2009). In

South Africa, the illegal status of sex work means that when a woman openly seeks public healthcare, she may be exposed as a criminal. Decriminalisation of the industry would see sex workers protected by both labour and occupational health laws (Richter, 2008b). This would improve both their health and access status.

Although South African law clearly states that sex work is illegal, due to difficulties in providing evidence, offenders are seldom charged under the *Sexual Offences Act* (Richter, 2008a). Nevertheless, the police wield considerable power through the threat of arrest. Abuse of this power is not uncommon, with demands for bribes and rape being common practice (Leggett, 1999; Wojcicki & Malala, 2001).

The criminalisation of sex work thus renders sex workers vulnerable to violence. This is achieved through a legislative framework which promotes the exploitation of sex workers by policing and other officials (Richter et al, 2009). It also inhibits the reporting of crime by sex workers as this may lead to their vocation being discovered, resulting in their prosecution or further harassment (Fick, 2006). Violence in turn increases the risk of SRH problems. Hence, criminalisation hinders their ability to access health, social, police, legal and financial services, which form the foundation of the legal statute of this country. Simultaneously, it forces them to endure unfair, unsafe and poor working conditions while perpetuating stigma and discrimination, and adversely affects the use of safer sexual practices (Richter, 2008a).

Such marginalisation of a population displaces sex workers from a human rights-based discourse, negating their needs as women in favour of managing their "deviance" from normalised forms of sexuality. The very policies and practices put in place to safeguard human rights serve here to undermine the basis of the *Constitution* by preventing access to human rights. Criminalisation has turned regulation and policing into a set of risk factors rather than protective factors for sex workers.

### 2.3.2 Discrimination and marginalisation

While South Africa's *Constitution* (Republic of South Africa, 1996) is based on principles of human rights, it is clear from the available literature that sex workers are discriminated against on multiple levels. A decade ago, the then National Minister of Health, Manto Tshabalala-Msimang (2001, cited in Richter 2008b, p. 326) was quoted as stating that

"because of stereotypes about their profession, they [sex workers] are poorly treated by mainstream service providers and other institutions". Yet, despite such principled stances, very little has been done, and sex workers continue to fear the withholding of services, as well as public humiliation by healthcare workers (Stadler & Delaney, 2006).

Discrimination based upon their work is rife. Discrimination against sex workers is frequently enacted through more subtle modes such as stigma. The internalisation of stigma acts to constrain the utilization of available services (Scambler & Paoli, 2008). This may account for the poor uptake of available services by sex workers, particularly in areas which have introduced sex worker programmes. Accounts of nurses singling out suspected sex workers and addressing them as "*magosha"* (prostitute or loose woman) are common (Stadler & Delaney, 2006). Such discrimination and the resulting stigma and blame are pivotal to the success or failure of health initiatives (Scambler & Paoli, 2008).

Furthermore, police brutality against women suspected of being sex workers and the regularity thereof is a manifestation of discrimination. Sex workers describe being thrown into police vans and hunted down like animals (Fick & SWEAT, 2006). Beatings are common, and money or sex bribes are frequently elicited by police (Richter, 2008b).

Compounding this is community violence rooted in the stigmatisation of this population (UNAIDS, 2009b). Through such interactions sex workers are rendered increasingly helpless to seek either medical or legal assistance. Few studies have addressed discrimination as one amongst multiple causal mechanisms that have an impact on sex workers' access to SRHC.

### 2.3.3 Migrancy

South Africa's economic and socio-political history has established an internal and external migrant work force (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). The resulting disruption to familial relationships and the disempowerment of women has increased their vulnerability to health concerns (Johnson et al., 2007; Coovadia et al., 2009). Intertwined with the present day lack of education (Campbell, 2000; Wojcicki & Malala, 2001), the high rate of unemployment, and an ineffective healthcare system, migrancy increases the vulnerability of disadvantaged people to disease.

Today, economic migrants come from all corners of South Africa, converging in Johannesburg as a city with the potential to improve their lives (Campbell, 2000; Wojcicki & Malala, 2001; Richter, 2008a). For many migrant women, this represents an attempt to seek autonomy through independently earning money and a departure from the traditional roles into which they have been born. For low-income and marginalised populations, sex work may become the economic cornerstone of their survival, so the healthcare issues they are most vulnerable to are sexual and reproductive in nature (Campbell, 2000; Wojcicki & Malala, 2001).

In addition to these internal migrants, political turmoil in sub-Saharan Africa has led to an increase in cross-border migrations. Many international migrants settle in the greater Johannesburg area. They are vulnerable to xenophobic attacks by local residents. Linguistic difficulties, a lack of social capital, as well as food and housing insecurity have been identified as creating particularly harsh barriers to accessing services such as healthcare (Richter, 2008a; Matzopoulos, Corrigall, & Bowman, 2009; UNAIDS, 2009b)

With the convergence of both local and international migrant populations in Hillbrow, the suburb has become an epicentre for the study of sex workers in South Africa. The current population for the area is approximately 100 000 people. As many as 27% of women living in its hotels self-identify themselves as sex workers. Unconfirmed reports put the total sex worker population between 5 000 and 10 000, predominantly women and children (Stadler& Delaney, 2006; Morris, 1999, cited in Richter, 2008b). While there are no statistics available on the overall number of female migrant sex workers in Hillbrow (Richter, 2008b), research estimates suggest that the number ranges upward of 11% (RHRU, 2002, cited in Richter, 2008a).

In Hillbrow, sex worker vulnerability is to some degree being addressed, with healthcare facilities increasingly being geared towards this population. A collective effort to remedy the lack of service delivery has seen the creation of mobile clinic services and the Esselen Street Clinic. These are part of the Hillbrow Health Precinct and Sex Worker Programme. Such initiatives were introduced into Hillbrow from 1997. They are geared towards providing basic SRHC. In the first year, the mobile clinic screened and treated 1 243 sex workers; with half of them presenting with STI symptoms (Delany et al., 2003, cited in Stadler & Delaney, 2006). Additionally, initiatives such as Sisonke (see Addendum A) are

geared to address issues of empowerment, education and the upliftment of sex workers (SWEAT, 2006). However, the disease-specific nature of Hillbrow's sex worker SRH initiatives still fails to consider the further displacement of this population through their highly focalised approaches, and their inadvertent role in further displacing sex workers from discourses of human rights and sexual wellbeing.

### 2.3.4 Socioeconomic status

Socioeconomic status is an important determinant for health outcomes (Blakely, Hales, Kieft, Wilson, & Woodward, n.d.). It is frequently calculated according to the Gini coefficient (Myer, Ehrlich, & Susser, 2004; World Bank, 2011); however, alternative measures such as education, income or occupation are used individually as a proxy for economic and social status.

The relationship between economics and sex indicate that women in Sub-Saharan Africa are a particularly vulnerable population (Mann, Tarantola & Netter, 1992). For example, a meta-analysis of heterosexual HIV-1 transmission rates indicated that in low-income countries, women are 9.4 times more likely per sex act (oral, anal or vaginal) to contract the disease versus women in high-income countries (Boily et al., 2009). Much of this risk can be attributed to the gender inequalities pervasive in low-income countries and these in turn have an immense socio-cultural influence on health (Bergin et al., 2008).

Attempts have been made to address these gender disparities. However, with unequal access to education and employment, increasing numbers of female-headed households, limited economics and financial insecurity means that gender inequalities remain pervasive and African women remain the poorest and most disadvantaged in South Africa. In this context, sex has become a currency for survival and the majority of sex workers are female (Campbell, 2000; Wojcicki & Malala, 2001; Cwikel et al., 2008; Baral et al., 2009; UNAIDS, 2009b). While education is a vital component of access to healthcare, gender inequality serves as a barrier to attaining both.

Education levels amongst sex worker populations appear to range from no education at all to Grade 12 (Leggett, 1999; Campbell, 2000; Wojcicki & Malala, 2001). While a strong negative correlation exists between literacy level and risk of disease, a positive correlation exists between literacy and access to healthcare (Cwikel et al., 2008; Adamczyk & Greif,

2011). Thus, poorly educated women are at greater risk for SRH complications, while at the same time they are also less likely to access effective treatment.

Education is an area earmarked for attention by the MDGs for 2015 (UNAIDS, 2010b). It can foster economic independence and open avenues for life opportunities beyond sex work. Education is vital in diminishing stigma and discrimination and reducing poverty while eliminating gender inequalities and reducing risky behaviours (UNAIDS, 2009b; Kristof & Wudunn, 2010; Adamczyk & Greif, 2011). Hence, it is an important factor for consideration when implementing any healthcare initiative. The complexity of its interaction with other factors necessitates attention in ensuring that adequate and appropriate steps are taken to remedy the impact a lack of education on effective access to SRHC. This investigation offers an explanation of how low levels of education are affecting sex workers' access to SRHC in complex and often indirect ways. It also offers suggestions on how educational components can be accommodated in the design of SRHC services to both encourage access and empower the women who do access the services offered.

Yet vulnerability and healthcare access are complex in their functioning, with multiple causal mechanisms underlying their workings. Risky sexual behaviours are a potential compounding factor, serving to increase both sex workers' risk of SRH complications while further impairing access.

### 2.3.5 Risky sexual behaviours

Risky sexual behaviour involves such activities as casual sex, Multiple Concurrent Partnerships (MCP) and sex without a condom. These are typically associated with low levels of education and higher levels of drug and/or alcohol use, as well as violence (Glasier et al., 2006). This combination serves to increase sex workers' susceptibility to SRH complaints (Adamczyk & Greif, 2011). South Africa's legislative framework encourages discriminatory practices and the further marginalisation of this vulnerable population, thereby inhibiting access to appropriate medical services (Wojcicki & Malala, 2001; Richter, 2008b). Lack of access then increases individual risk profiles as part of a complex cycle of increasing health threats to both sex workers and clients. Multiple Concurrent Partnerships are such a health threat.

#### 2.3.5.1 Multiple Concurrent Partnerships

Multiple Concurrent Partnerships are partnerships which overlap in time or continue at the same time, with one beginning before another has ended. These are a common practice in many countries and increase the risk of STI spread (Halperin & Epstein, 2004; Connolly, Makhubele, Ntlabati, & Parker, 2007). Amongst sex workers, many women live with or regularly visit a male lover whom they identify as a boyfriend or husband. They distinguish between clients and partners. Partners are less inclined and infrequently requested to wear a condom (Stadler & Delaney, 2006).

Research findings vary on the total number of sexual partners that sex workers engage with, ranging from one to 42 sexual contacts per week (Leggett, 1999; Campbell, 2000; Richter, 2008a). This is inclusive of clients, long-term partners and casual partners. While some friendships may develop between clients and sex workers, in the majority of cases, sexual encounters involve once-off encounters with strangers (Campbell, 2000). However, as Pembrey (2008) has showed, it is not necessarily the high number of sexual partners, but the gender inequalities at the source of the inability to use condoms consistently and correctly that result in SRH complications.

#### 2.3.5.2 Condom usage

Women across Southern Africa are frequently found to be powerless to negotiate safer sexual practices. Their low economic status and resultant dependence upon men contribute to this dilemma (Wojcicki & Malala, 2001). Amongst a sex worker population in Carletonville, only 10% of sexual encounters involved condom usage. According to Campbell (2000), the focus on the act of sex during client-sex worker interactions offers little opportunity for such negotiations.

Condoms are often regarded as unnecessary in stable relationships or once trust is established between a sex worker and her partner or regular client. Clients are more frequently requested to use condoms, and higher prices are demanded for unprotected sex. However, this does not always translate into safer sex, with reports of men puncturing holes in condoms to ensure a fluid exchange being common (Stadler & Delaney, 2006). Traditional power differentials ensure that whether through violence or the withdrawing of funds, the client dictates the outcome (Campbell, 2000). In the context of South Africa's

patriarchal society, the lack of power to negotiate safer sexual practices places sex workers at increased risk of SRH complications from pregnancy to recurring STIs. This makes the need for a broad range of SRHC services critical in addressing not only their needs, but the gender inequalities pervasive in the country.

In addition, condom usage appears to be affected by the opportunity for financial gain, because, as indicted above, higher prices are demanded for unprotected sex. In a study conducted by the Alcohol and Drug Abuse Research Unit (2006), the use of male or female condoms by drug users and sex workers was found to be only 43% and 2% respectively. While such practices are both associated with risky sexual behaviour and increased violence, the dependence on a financial exchange acts to hinder condom usage. In countries where condom usage is being enforced in brothels, an 80% decline in STI incidents has been recorded (Stadler & Delaney, 2006). In such cases, it is industry regulation which enables safer sexual practices (Baral et al., 2009). Under the present legislative framework in South Africa, however, such regulatory structures do not exist and this, in combination with other factors such as violence, discrimination and low socioeconomic status, may hamper the uptake of condom usage. Evidence is required to identify and elaborate these potential causal pathways.

Wojcicki and Malala (2001) pose an alternate explanation for the lack of condom usage. They suggest that condom negotiation is an exertion of power on the part of the sex worker rather than an indication of complete helplessness. They argue that while condom negotiation accounts for the various inequalities and difficulties sex workers encounter, the sex workers' sense of agency in ensuring a degree of economic sustainability is evoked.

In the case of "unsafe sex", the outcome itself is a contributor to risk factors. STI transmission is a combination of both unprotected sex and one partner's being infected. The infection of one partner is as dependent on the population prevalence as on the risky behaviour itself and individual susceptibility (Johnson et al., 2007). If sex workers are unable to safely negotiate condom usage (Richter, 2008a), their risk is significantly increased. A clearer understanding of the role which condoms play in the accessing of SRHC in relation to the present approach to HIV/STI management may offer new and innovative ways in addressing specific, as well as broader, SRH concerns and access issues.

Where condoms are central to preventing various SRH concerns, drug and alcohol can be a compounding factor (Rekart, 2005).

#### *2.3.5.3 Alcohol and drug use*

Drug abuse, in particular alcohol abuse, is a concern amongst sex workers. When it is associated with poor judgement, unsafe sex, immune suppression, violence and HIV infection (Rekart, 2005), it is likely to increase vulnerability to SRH complications. The use of drugs after violence or sexual assault, combined with a lack of supportive structural networks, acts to hinder access to appropriate health services. The risk of untreated SRH complaints compounded by further drug use and frequent sexual encounters serves to increase exposure of the individual to additional SRH complications (Medical Research Council, 2006). Coupled with a suppressed immune system, exposure to violence and the sexual practices frequently employed, SRH ailments are highly likely.

In addition, clients' use of drugs and alcohol poses a serious risk to sex workers' safety through increasing the risk of both physical and sexual abuse (Jewkes, 2011). The complexity of access to SRHC coupled with a focalised sex worker service offering, sex worker risk factors, client violence and widespread discrimination are simultaneously influenced by a number of psychosocial variables (Bandura, 1996; Campbell, 2000; Scambler & Paoli, 2008). This interplay of underlying mechanisms challenges sex workers' access to appropriate healthcare services. A clearer understanding of these mechanisms may prove vital in effectively addressing sex workers' access to SRHC in the long term.

### 2.3.6 Psychosocial factors

The likelihood that individuals will engage in health-promoting behaviour is influenced by their sense of control over various aspects of their lives and the social networks which support them (Bandura, 1996; Campbell, 2000). There is ongoing debate regarding sex workers and whether they are victims of poverty and a patriarchal society; or whether they are active agents, powerful in setting themselves up as female-headed households (Campbell, 2000; Leggett, 1999; Stadler & Delaney, 2006; Wojcicki & Malala, 2001). While the notion of victimhood would serve to further disenfranchise sex workers, displacing them from available services, a sense of agency is empowering in its ability to enable a sense of

control over one's self. Such a sense of control may afford a sex worker the ability to actively manage her health by assertively seeking out SRHC opportunities.

Both Campbell (2000) and Wojcicki and Malala (2001) argue that despite the hardships of sex work, the act of selling sex serves to help women break away from the restrictions of traditional responsibilities including those of mother, homemaker and wife. According to Campbell (1994, cited in Campbell, 2000), elaborate forms of denial and coping strategies have developed around the shame of sex work in relation to these more traditional roles. Such strategies include not referring to the work the women do as sex work, but rather as "work", ensuring that their family at home do not find out what work they are doing, and refusing HIV testing or not returning for results. According to Campbell (2000), for example, knowing one's status would mean having to take responsibility and leaving sex work altogether. With low education levels and limited employment opportunities, the sex worker would be left to contemplate this loss with feelings of depression augmenting existing pressures (Campbell, 2000; Wojcicki & Malala, 2001). Furthermore, Scambler and Paoli (2008) suggest that such internalised norms of shame and blame inhibit the uptake of available services through fear of discrimination.

These strategies (Wojcicki & Malala, 2001) may serve to mask the inadequacies of shame (Leggett, 1999), feelings of depression and of a valueless self, all of which feed into a broader sense of low self-efficacy, undermining existing efforts at healthcare (Campbell, 2000; Scambler & Paoli, 2008). Research indicates that increased levels of confidence, dignity and self-efficacy result in increased feelings of control in sex workers' lives generally, and assertiveness in sexual practices. Furthermore, the early life experiences of sex workers are often not conducive to the development of self-confidence in their ability to take control of their lives. These experiences serve to militate against successful accessing of health-promoting programmes and assertion of their basic human rights (Campbell, 2000).

In Hillbrow, attempts are being made to improve sex workers' self-confidence and access to basic rights through the creation of effective social capital in the form of initiatives such as Sisonke, the mobile clinics and the Sex Worker Project. So far, there is no clear evidence as to the overall reach and effectiveness of these programmes, especially considering the influx of international migrants across South Africa's porous borders, gender inequalities

with resultant poor education levels and government frameworks which serve to encourage discrimination rather than service delivery and the attainment of human rights.

The success of community-led projects depends largely on the extent to which they mobilise pre-existing resources and community networks in line with their health-promoting goals, creating leverage for further resource and network development (Campbell, 2000). Through initiatives such as Sisonke, the transferral of health-promoting initiatives from outside "experts" to lay community members may well be key in the sex workers' accessing of SRHC. Campbell (2000) mentions the mobilisation of networks such as funeral clubs as having a positive impact on health-seeking behaviours, but limited literature is currently available on the leveraging of social networks as a key to access to SRHC in Hillbrow.

Through the criminalisation of sex work and the resulting discrimination against sex workers, this population is rendered increasingly vulnerable to violence and SRH complications. This has in turn compromised the effective accessing of public health services to address their SRH needs. The viewing of sex workers' health predominantly in the context of the transmission of HIV/AIDS has compounded stigmatisation and has framed them as a deviant population. It is from within this reductionist biomedical approach that many of the existing SRHC programmes have been created. Additional psychosocial and behavioural dynamics increase their risk, while decreasing the likelihood of successfully accessing services. Sex workers low socioeconomic status amplifies the complexity of these tensions. Concurrently, the breach of sex workers' basic human rights is ignored or underplayed in favour of the international, political and economic HIV/AIDS agenda. The aim of this project was therefore rather to explore these complexities through sex workers' accounts of accessing SRHC.

Whether risky or protective in nature, all of the above-mentioned factors work together to create a tension which has an impact on the successful accessing of SRHC by sex workers in South Africa. Amendments to the social inequalities pervasive in the healthcare system are imperative in effecting change. To do so, evidence is required on the extent of the problem and the mechanisms through which it is enacted. While the literature discussed above adds great value to understanding sex worker risk and protective factors, the oversimplification of access to healthcare in itself serves as a barrier to creating effective and sustainable initiatives in communities. Access to SRHC is a complex and layered process, with each

factor affecting and being affected by the next. The explication of such a multifaceted approach to the accessing of SRHC will allow for improvements to the medical system, thereby improving access. This project serves to add to such an evidence base by refining the oversimplifications generated in many of the studies outlined above. Finally, an overview of SRHC in South Africa contextualises our present understanding of the barriers and facilitators, and gaps in the service offering for sex workers.

## 2.4 Social Inequalities and the Nature of Healthcare in South Africa

Various international initiatives have been launched to address political and socio-economically unacceptable health inequalities worldwide (Askew & Berer, 2003; World Health Organisation, 2010), for example, commitment to reaching the MDGs includes positioning health equity as a fundamental issue on the global agenda (World Health Organisation, 2010). In this regard, in South Africa, a target of universal access to reproductive healthcare has been set (Government, 2009).

A Primary Healthcare policy was formally introduced into the country after democratisation. The *White Paper on the Transformation of the Health System* in 1997 (Health, n.d.), coupled with the *National Health Bill* (Department of Health, 2002) provided a framework for the restructuring of the public health works. South Africa's Department of Health is in the process of revising core standards for health facilities (Government, 2009). The country currently has approximately 396 public hospitals, alongside 211 private hospitals. Of these facilities, 32 and 84 respectively are in the Gauteng province. In 2003, overall, 85% of these facilities had STI services; however, only 6.7% stocked STI medication (Medical Research Council, 2003). By the government's own admission, the current gap between overall standards and the actual level of compliance remains undocumented and is a matter of core concern (Government, 2009). The lack of basic service offerings in line with human rights is essential, not only to the fight against HIV/AIDS, but in order to ensure basic health and SRHC (Medical Research Council, 2003). This report documents evidence of sex worker access to SRHC, giving an account of existing gaps in service offerings, as well as the underlying mechanisms which combine to hinder or facilitate sex workers' use of SRHC.

### 2.4.1 Sexual and Reproductive Healthcare

Sexual health and reproductive health overlap, in that they both support normal physiological functioning such as pregnancy and childbirth, while aiming to reduce any harmful outcomes of sexual activity and reproduction. In additional, they are geared to enable people of all ages to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, sexual coercion and exploitation, inequalities in access to health services, restrictive laws and gender-based violence (Glasier et al., 2006). To understand SRHC, it is imperative that a range of factors be considered in line with this definition. This report offers a comprehensive overview of factors implicated in sex workers' access to SRHC, as presented through first-hand accounts of SRHC access and SRH concerns by the sex workers who were interviewed.

In line with the goals laid out by the *WHO Sexual and Reproductive Health Medium-term Strategic Plan for 2010–2015 and Programme Budget for 2010–2011* (World Health Organisation, 2010) as well as MDG goal 5B (UNAIDS, 2010b) and the requirements of South Africa's SRHC services (UNAIDS, 2010a), there are five core components of SRHC: a) the improvement of antenatal, perinatal, postpartum and newborn care; b) the provision of high-quality services for family planning; c) the elimination of unsafe abortions; d) the prevention and treatment of STIs, including HIV, cervical cancer and other gynaecological morbidities; and e) the promotion of a healthy sexuality (Glasier et al., 2006). At present, it is not known to what degree these services are available to sex workers in South Africa; or whether these services are being effectively accessed where they are available. However, it is obvious that the health wealth gradient is an important consideration in South Africa and that impoverished sex workers are likely to be excluded from equitable participation in the health sector. This exclusion perpetuates a negative spiral – it has been estimated that conditions relating to SRH account for up to 12% of the global burden of ill health (Glasier et al., 2006; World Health Organisation, 2010). The fiscal drain placed upon countries through poor family planning, STI and HIV infections, maternal mortalities and the like, intensifies the pressure upon their economies, particularly in the Southern African Development Community region (Glasier et al., 2006; World Health Organisation, 2010). A less focalised approach towards SRHC for sex workers is thus critical in addressing the drain on their

micro-economy, while tackling the financial implications for the broader economy by highlighting the impact of highly focused approaches to healthcare.

Even though South Africa has some of the most progressive reproductive laws in the world, the cumulative effects of increasing patient numbers, a worsening HIV/AIDS pandemic, budget cuts, staff attrition, corruption and other constraints mean that access to public health facilities have become increasingly layered and uneven. Urgent action is required to address the lack of effective SRHC, especially in considering the nature of the sex trade and the structural factors placing the lives of women in this sector at risk (Stadler & Delaney, 2006).

A Hillbrow-based study of sex workers prior to the implementation of the mobile clinics in that area by Stadler and Delaney (2006) found that the inability to effectively provide HIV pre- and post-test counselling, a lack of available treatments, and overcrowding of the facilities were cited as problematic and crucial in the creation of mobile clinics. While studies such as these are valued for their influence in effecting basic change to HIV services, they reflect the continued reductionism of SRHC to HIV and STI interventions. Such an approach in itself reveals a clear disregard for the humanity of sex workers and their overall need for access to a complete SRHC service offering.

## 2.5 Access to Healthcare for Sex Workers: An Important Human-rights Issue

Much of the current research into health fails to understand SRHC inequalities in a complex social world. On the one hand, the literature on health policies and epidemiological traditions has outlined various structural factors which have an impact on access to SRHC. Each of these in isolation accounts for some aspect(s) of sex worker access. However, the disjointed nature of such an explanation negates the complexity of the problems facing both the healthcare system and sex workers. The politicisation of HIV has led to attempts being made to understand sex workers as a vector in relation to the pandemic and consequently, a reductive medical model has informed interventions based on this “vectorship” model.

The oversimplification of underlying mechanisms through a reductionist and often one-sided biomedical framework overshadows much of the present literature. Currently, the public services which should be available to all as a basic human right are unavailable to a population made vulnerable to SRH complications.

Thus, the listening to the voices of sex workers is centrally important in re-humanising the context through which we understand the SRH needs of this vulnerable population in order to ensure that the needs of this marginalised group are met, and re-aligning the provision of SRHC to them and treatment of them as people with the civil rights and liberties that should be afforded every human being. This intention framed the rationale, the overarching objectives and research questions of this study.

# Chapter Three:
# Methodology

## 3.1 Method

As recipients or end users of a public health system, sex workers provide a key vantage point on the dynamics and challenges of their access (Clark & Lissel, 2008) to SRHC. In addressing the issue of access to SRHC for this sub-population, three primary research questions guided this research project:

- What do sex workers perceive to be barriers and facilitators to their accessing of SRHC?
- What do sex workers perceive as gaps in current SRHC service offerings?
- What are participants' experiences of SRHC?

Because they are a marginalised group, sex workers' voices are important in understanding their access to SRHC. Hence, an interpretivist approach was selected as a grounding paradigm for the study.

The focus of interpretivist studies is on understanding reconstructions of human products, behaviours and relationships by those who are engaged in the production, behaviour and relationships concerned (Fay, 1996). The primary concern of interpretivism is understanding social life and describing how social meaning is constructed by individuals (Fossey, Harvey, McDermott, & Davidson, 2002). This approach was selected because it takes the marginalised end user of a public health system as a valuable source of data, forming part or a bigger picture. Accordingly, the participants' voices are privileged as a means to understanding the complexities that influence their accessing of SRHC. Participants' voices are not truth claims, yet, seen in the context of their accounts, their voices represent an important perspective on access to SRHC. The voices recorded here reflect the perceptions and experiences of sex workers who have accessed SRHC in the given context, and the barriers and facilitators to care that these women perceive to exist. In addition, a small component of participant's accounts provided greater informational data, which did not require in-depth interrogation of the interpretivist kind.

According to interpretivism, actions are rule-governed and intentional, directed at achieving a particular purpose. As such, they are the symbolic or expressive dimension of human

behaviour, providing meaning to each deed. Interpreting actions and practices requires an understanding of the role that they hold in a complex system. It requires an understanding of beliefs, desires and intentions, along with knowledge of the vocabulary used to express these beliefs, desires and intentions, alongside the social rules governing these; and finally, the institutional practices which they are part of. In interpreting practices, it is important to show the relational dynamics between social orders as they make up a whole. Thus it was of great importance to this project to ascertain the elements which inform agents' social lives, such as the "constitutive meaning" – presuppositions of activities whose meaning is not necessarily known by the agent using them (Fay, 1996). In this way, participants' accounts can be subjected to a detailed interrogation in order to enhance understanding of the multiple factors affecting their access to and of SRHC.

## 3.2 Participants

Sex workers are a criminalised community, posing serious challenges to the recruitment of participants, as sex workers are reluctant to identify themselves or implicate themselves in criminal activities (Jacques & Wright, 2008). Therefore, the assistance of Sisonke (see Addendum A) was paramount to accessing a population of sex workers. Once organisational support had been secured, recruitment began. The recruiter-researcher relationship proved vital during this process, as it established the researcher as a trusted outsider. Displays of friendship and trust formed the basis of participants' judgements of the researcher and built a foundation for developing a rapport during subsequent one-on-one interviews.

The first two interviewees were sought independently by Sisonke and were interviewed in the HHP. These two interviews acted as a pilot for the instrument. The instrument did not require amendment, and therefore these interviews have been included in the corpus. However, the interview setting posed a number of constraints. Participants seemed acutely aware of their surroundings and of the role which the HHP, Sisonke and the WRHI play in terms of sex worker SRHC. This manifested in their whispering throughout the interviews or in the muted nature of their responses. Frequent interruptions occurred during these interviews, and background noises proved challenging for later transcription. To compound this problem, participants were unwilling to nominate other sex workers for participation as was originally hoped for.

In addressing these concerns, a new strategy was adopted. The recruiter introduced the researcher to groups of sex workers (15 to 30 individuals). The venue selected was familiar to the sex workers, but it was unrelated to any healthcare service provider and it offered a safe, private interview environment. This allowed participants the freedom to speak openly about their experiences of healthcare. As participants proved unwilling to nominate other women for participation, a convenience sampling technique (Patton, 2002) was adopted.

While moving the interview location assisted with increasing the participant pool, establishing the researcher's trustworthiness proved to be a major concern for the sex workers. The combination of Sisonke's introducing the researcher, and being introduced to groups of women, gave the researcher a degree of credibility through association. In addition, the researcher's building rapport with the overall group proved paramount to successful recruitment. Participants from the group would then volunteer to speak further with the researcher. Only once this had occurred could rapport be developed on an individual basis. In addition to this, the initial interview for each evening acted as a catalyst in establishing trust in the community of women and became a gateway for accessing further participants. Due to time constraints, the demand to be interviewed far exceeded the researcher's capacity to accommodate all the women.

The value of interviews for accessing information from vulnerable populations has been repeatedly demonstrated (Campbell, 2000; Leggett, 1999; Pisani, 2008; Richter, 2008a, 2008b; Stadler & Delaney, 2006). Obtaining information from such a population is a multistep process, involving the recruitment and then interviewing of sex workers. Recruitment is a means to accessing data without which this project would have been impossible. Hence, participants were offered a stipend (R40) to cover their costs. The amount was based upon the reimbursement model of payment, which includes travel, telephone calls and working hours lost. This relates directly to their participation (Jacques & Wright, 2008) [1]. Both the Sex Worker Education and Advocacy Taskforce (SWEAT) and Sisonke were consulted on the process of payment, because they have extensive experience working in this sector. In line with what these groups suggested, payment was made after the interview, but it was emphasised that participants were free to leave the interview and

[1] Sceptics may criticise the role of a reimbursement in eliciting information from participants. However, reimbursement was important in the exchange of knowledge which took place and acted as a sign of the value of the participant's time. It was by no means the only motivating factor in knowledge acquisition. As an indication of this the participants frequently articulated either the need for a confidante to express their feelings, experiences and desires to, or thanked the researcher for listening to them.

needed to respond only to questions that they chose to respond to. It was clearly articulated and understood that they would receive payment, even if they left the interview.

The participants had to be female and over the age of 18 years. They needed to self-identify themselves as sex workers and be hotel- and street-based, or only street-based sex workers working from Johannesburg City Deep, South Africa. These criteria allowed for a degree of homogeneity across the group so as to limit the number of factors and underlying mechanisms which needed to be considered. Age was considered an important element in terms of ethical considerations. The chosen age group aligned to the current literature on at-risk populations for HIV (World Health Organisation, 2009, 2011). Women were chosen as a group most at risk of SRH complications, consistent with gender inequality pervasive across the world (Hankivsky, 2012; Moss, 2002; Dunkle, Jewkes, Brown, Gray, McIntryre et al., 2004). The women were required to self-identify as sex workers, because the project focused specifically on this sub-population. In addition, hotel- and street-based, or only street-based sex workers were used in line with the definition provided by Stadler and Delaney (2006).

Participants were predominantly street-based sex workers, but a small portion of them resided in hotels and as such may be classed as either hotel-based, or as street- and hotel-based sex workers. The inclusion of women who work in both environments allows for some flexibility in the recruitment of this hard-to-reach population. Excluding women who worked in brothels and hence may have access to healthcare services through the establishment aligned the study with existing public health services- and Hillbrow-based semi-privatised initiatives.

City Deep was chosen for its proximity to the HHP, because women who access these clinics live there. This choice also drew on a population of women who were surrounded by alternative public healthcare solutions.

Interview data exceeded the initial expectations for the project and consideration needed to be given to the richness of the information obtained. According to Lincoln and Guba (1985, cited in Patton, 2002), sample size is determined by informational considerations. In line with this, the sample size of 11 is considered sufficiently informative.

Participation in the study was completely voluntary. In ensuring voluntary informed consent, all participants read (or were read) the information sheet (see Addendum C) prior to consenting to participate. They were also required to sign a participation form (see Addendum D), a form detailing permission for audio recording and verbatim quotations (see Addendum E) and an "age" consent form (see Addendum F).

## 3.3 Data Collection

In line with the interpretivist framework and the aims and objectives of the study, semi-structured one-on-one interviews were conducted. Interviews are considered an important and appropriate manner for collecting data on health-related issues and health-seeking behaviours (Campbell, Cleland, Collumbien, & Soutwick, 1999). While alternative methods may have allowed for larger samples sizes and greater generalizability, the interviews used conducted in the current study engaged participants who detailed their accounts of SRHC, allowing for an in-depth understanding of factors affecting access to SRHC for sex workers. It also allowed for the identification of disparities between service offerings and participants' needs, providing rich material for exploring the fuller experiences of SRHC from the perspectives of sex workers themselves.

The main advantage of this technique over a more structured one was the ability to provide insights and understandings of the context in which sex workers function and their perceptions of the broader social determinants of their behaviour. It also allowed for greater depth and detailed information surrounding access to SRHC with an opportunity to share and understand the participants' point of view. Such an adaptable and responsive approach led participants to provide details about their SRHC concerns. In addition, the complexities in participants' accounts allowed for an understanding of their language in relation to broader issues, while accommodating unexpected findings, as advocated by Campbell et al. (1999).

Addendum E contains the interview schedule. The schedule was loosely based on the semi-structured guidelines of an instrument used by the World Health Organisation (Cleland, Ingham, & Stone, 2001). Semi-structured frameworks allowed for further probing in understanding participants' accounts of SRHC.

With the permission of the participants (see Addendum D), the interviews were audio recorded and transcribed verbatim. All recordings and transcriptions have been stored in a safe, password-protected location (see Section 3.6).

## 3.4 Data Analysis

All recordings were listened to repeatedly, ensuring their integrity for analysis (Patton, 2002). In most cases, not more than a 24-hour period elapsed between the interview and the initial integrity check. Detailed notes were also taken after each session, in addition to during the transcription and analysis stages. The recordings were transcribed using Jefferson Lite (Jefferson, 2004) to ensure a detailed understanding of participants' accounts, as well as to improve the quality of the data analysis (See Addendum B).

Data was analysed using the thematic analysis method described by Braun and Clarke (2006), involving six phases, which has been extensively used in other healthcare studies ((Scorgie, Nakato, Akoth, Netchivhambe et al., 2011; Campbell, 2000; Campbell, Cleland, Collumbien, & Soutwick, 1999) and is an appropriate technique for use in an interpretivist project. The initial phase involves immersion in the data (including repeated listening and reading of the audio recordings and transcripts respectively, while noting ideas). Following this, a draft outline of each interview was created, briefly describing significant events and noting key concepts for later inclusion into codes. For the next phase, tentative codes were highlighted during this process. In addition, an Excel spread sheet noting various demographics, life experience and health concerns was created as a quick reference guide to aid in the analysis (Addendum G).

Following this, every line of interview text was coded using descriptive terms. Thereafter, coding systems were developed both vertically and horizontally across the data. Each transcript was recoded a minimum of three times by hand, or using Atlas ti. The final phases involved a recursive process of writing, referring back to earlier notes and codes, and re-listening to recordings, the codes were pooled in creating tentative themes. Finally, themes were then reviewed and refined to ensure that they reflect the data accurately while demonstrating the mechanisms underlying access to SRHC, in line with the aims and objectives of the research project.

The key objective of this analysis was to describe patterns in the data in relation to themes. These were defined as capturing an important element in the data in relation to the research questions, while representing the level of patterned response or meaning in the data set. The analysis incorporated elements of both inductive and deductive analyses, as emergent themes surfaced alongside existing frameworks (Patton, 2002).

Lastly, the research report was compiled to reflect a coherent and logical account of SRHC services for female hotel- and street-based sex workers in relation to the research questions asked. Extracts from the data set have been embedded in the analysis as *prima facie* evidence of the arguments presented.

A systematic approach towards the collection of data and analysis of the data was undertaken in order to ensure methodological and interpretative rigour. This was done in line with the work of Fossey et al. (2002). Evaluation criteria were used which were aligned to the interpretivist paradigm, as well as the overall aims of the research. Participants' accounts were privileged and authentically represented through the use of verbatim extracts as a source of understanding of the dynamics affecting their accessing of SRHC. Transparency played a central role in this project, from gaining the trust of participants in eliciting their accounts, through to the presentation of these findings. All due ethical considerations were noted and measured were implemented to ensure voluntary informed consent, and the safety and anonymity of participants.

## 3.5 Reflexivity

This project offered a substantial learning experience, proving challenging on various levels. Firstly, the accessing of this hidden population posed an obstacle which required careful negotiation. In this respect, the relationship with both the NGO and the sex worker groups proved vital to establishing a trusting working relationship before any interviews could be conducted. In addition, the use of financial reimbursement for participants' time was fundamental to securing interviews (see Section 3.2). The reimbursement proved to be an equalising factor in the transaction of knowledge for time.

It must be acknowledged that while non sex workers are not exempt from transaction sex as a common mechanism for economic survival, this project focuses exclusively on self-identifying street and hotel based sex workers as a most marginalized group of women.

While money equalised the nature of the transaction, the power dynamic between researcher and participant cannot be ignored. Participants may have felt compelled to answer questions despite repeated communication and careful interviewing and analysis to ensure otherwise. However, the nature of the data collected appears to dispel some concern about this potential problem as a major factor that affected the findings, and careful consideration was given to this potential problem during each phase of the study, from project conceptualisation to report finalisation.

Interestingly, the interview became a point at which many of the women contemplated their SRH needs. This said, there were times in the earlier interviews where the researcher prompted participants for answers. However, several guidelines for ensuring interpretative rigour were applied, as suggested by the work of (Fossey et al., 2002), to minimise the impact of potentially leading questions. This included ensuring responsiveness to the social context and appropriateness of both the sample and data collection, congruence of the research design and coherence of the findings reported, transparency throughout the research process and authenticity in reporting the participants' voices in ensuring equitable representation of participants' accounts.

Furthermore, the fact that the researcher speaks English and Afrikaans and not any of other ten South African official languages of the researcher proved to be a challenge for the project. There were three fundamental concerns regarding this challenge. Firstly, it limited the sample population, frequently to the exclusion of migrant or younger potential participants who were not fluent in English. Secondly, despite the fact that the questions were formulated for easy comprehension, participants misinterpreted some questions. Addressing this required careful renegotiation and phrasing of probes to clarify any misunderstandings. Finally, some answers were given in participants' mother tongue. Despite the richness which these answers may have yielded to the analysis, they comprised a small proportion of the data set and posed a complication through translation dynamics (Temple & Young, 2010). Hence, they have been omitted from the analysis.

Lastly, this study risks reproducing the biomedical discourse it is at pains to debunk. While every effort has been made to avoid understanding sex workers within this framework, its entrenchment within both public health literature and the participants' constructions of themselves in line with this made moving away from such a discourse very challenging.

## 3.6 Ethical Considerations

Due consideration was given to ethical issues which may have arisen during the research process. This is particularly important because the subjects themselves are considered criminals under the *Sexual Offences Act, No 23 of 1957* (Republic of South Africa, 1957 However, according to the *National Health Act, 61 of 2003* (Republic of South Africa, 2004), social problems relating to vulnerable groups should be both identified and prioritised in research. This research investigated the barriers and facilitators to SRHC for female sex workers. It examined the perceived structural and psychosocial factors which interact to create a complex system which renders sex workers both vulnerable to SRH complications and hinders their accessing of SRHC in accordance with their basic human rights.

Ethical approval was received for this study through the Human Research Ethics Committee (non-medical) at the University of the Witwatersrand. The Ethics Protocol Number is H110606.

Consistent with both the *National Health Act* (Republic of South Africa, 2004) and the requirements of the Human Research Ethics Committee (non-medical) at the University of the Witwatersrand, every potential participant was given a participation information sheet (see Addendum B) to ensure voluntary informed consent. This information sheet detailed the aims and rationale of the study, the researcher's and supervisor's contact details, and the data gathering procedures to be used. In addition, the sheet clearly states that participation is completely voluntary, that participants were free to withdraw from the study at any point, and that they may refuse to answer any questions which they do not wish to answer. The information sheet clearly states that participant confidentiality would be upheld as rigorously as possible throughout all research documentation. All the data have accordingly been reported in such a way that the source remains anonymous.

The majority of participants were read the information and consent forms, despite being encouraged to read the material themselves. This was done due to the poor literacy levels amongst the sample. Time was then devoted to discussing any and all concerns which the participants expressed. The only concerns voiced by participants were of being overheard while speaking, and in one case, a potential participant requested proof of the researcher's

identity to ensure that the researcher was not a member of the media. All concerns were appropriately discussed.

Participants were then given the opportunity to either accept or decline the invitation to participate. Care was taken to ensure that participants understood that their involvement in the study was completely voluntary and that they would receive payment, irrespective of whether they completed the interview or not. Addendum C stipulates informed consent, while signing addendum D indicates consent to being audio recorded and quoted verbatim. Addendum E certifies participants' ages. This is in line with the guidelines of both the *National Health Act* (2004) and the Human Research Ethics Committee (non-medical) of the University of the Witwatersrand.

The data management plan was conveyed to the participants. This plan ensures that the recordings and subsequent transcripts are kept safe on a password-protected computer to ensure their security, as both sets of data are considered integral in analysing their accounts of SRHC. The recordings will be destroyed five years from the date of final report submission. While each participant was offered a reimbursement for their costs associated with their participation, it was clearly noted that there are neither advantages nor disadvantages to participating in the study, and they would in no way directly benefit. There was minimal risk for participants in participating in this study. As is ethically appropriate with studies of this kind, a one-page summary of the findings will be made available to the participants on request.

# Chapter Four:
# Findings

## 4.1 Introduction

The thematic analysis as discussed in Section 3.4 yielded four main themes and eight sub-themes, as well as a number of ancillary themes (see Figure 1: Thematic Map, below).

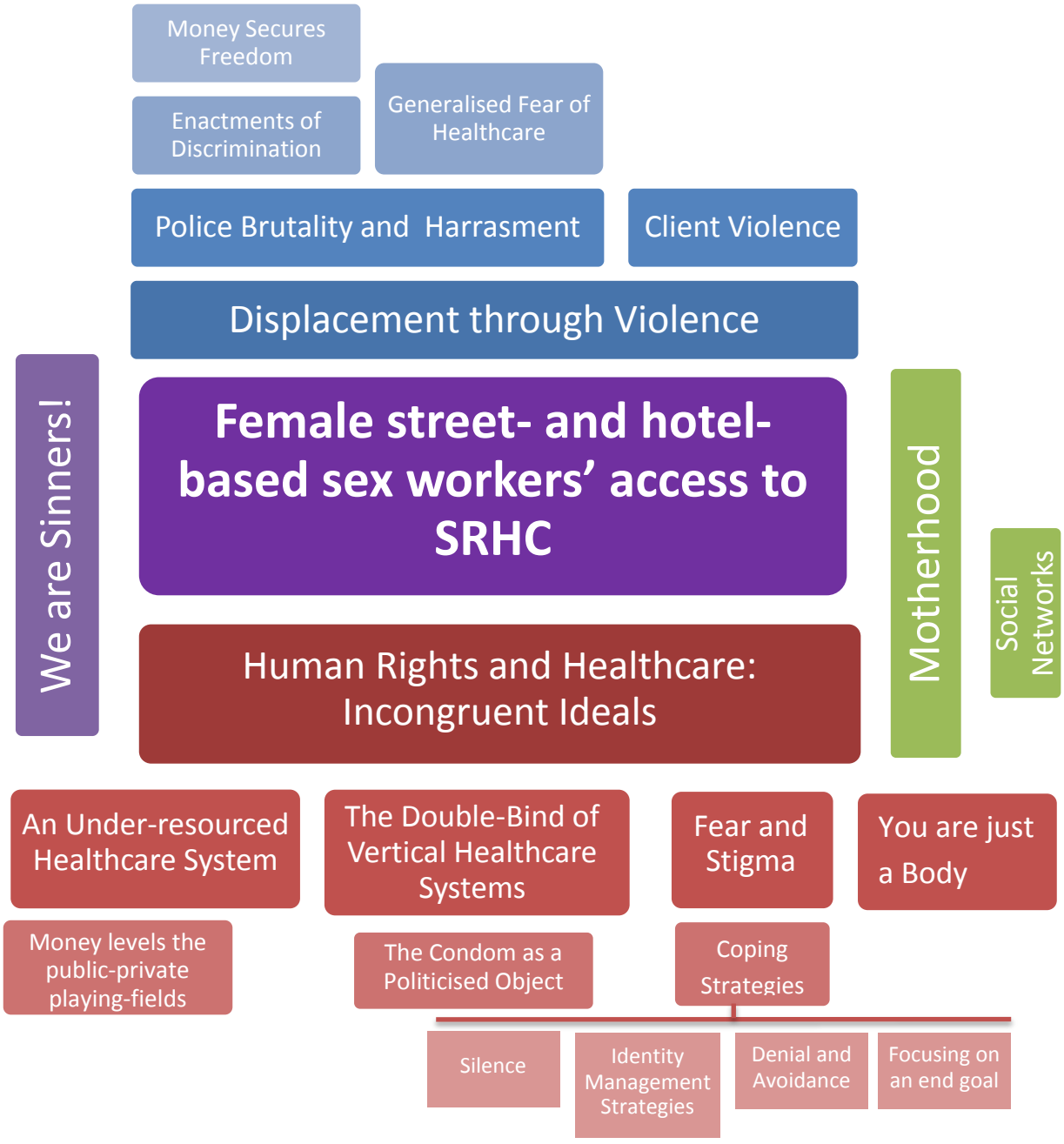


**Figure 1: Thematic Map**

The primary themes that emerged were

- Human Rights and Healthcare: Incongruent Ideals,
- Displacement through Violence,
- Motherhood, and
- We are Sinners.

The *Displacement through Violence* theme was underpinned by a number of sub-themes (*Police Brutality and Harassment* and *Client Violence*) and ancillary themes. *Police Brutality and Harassment* was underpinned by *Police Brutality Causes a Generalised Fear of Healthcare*.

The theme labelled *Human Rights and Healthcare: Incongruent Ideals* was underpinned by four sub-themes *An Under-Resourced Healthcare System, You are Just a Body, The Double-bind of Vertical Healthcare Programmes,* and *Stigma and Fear)*. *Stigma and Fear* was supported by *Coping Strategies*, which in turn addressed *Silence*, *Avoidance and Denial*, *Focus on an End Goal*, and *Identity Management Strategies*. *The Condom as a Politicised Object* was an ancillary theme to the *Double Bind of Vertical Healthcare Programmes*.

The themes are discussed in more detail below, citing comments from the interviews verbatim to illustrate the participants' experiences of the issues concerned.[2] Addendum G provides a demographic overview of participants as a reference point to contextualise participants. This includes the number of children which they support and whether they entered the sex work profession before, during or after they had given birth to these children. In line with the theme on motherhood, children are considered a critical factor in accessing healthcare. Furthermore, education levels have been included as they highlight the range in education levels, from high school drop outs to auxiliary nursing qualifications. Further to this, variables which are discussed within the report were included in providing a more complete snap-shot of participants lives as full or part time sex workers.

[2] Note that some excerpts are presented more than once, to demonstrate different points, as they may highlight more than one aspect simultaneously.

## 4.2 Human Rights and Healthcare: Incongruent Ideals

Healthcare was accessed by participants through a number of avenues, such as integrated public services, vertical SRHC programmes, including semi-privatised initiatives, pharmacies and emergency services. Concerns regarding the healthcare system were expressed by participants through their accounts of the treatment that they received from such organisations or facilities. Their accounts highlighted their experience of the fact that the healthcare system does not meet the clauses of its human-rights based patient charter. These experiences were related to a number of different mechanisms, such as participants' being objectified in the healthcare system, the focalisation of at-risk populations and the under-resourced nature of the present healthcare system in South Africa. Participants also indicated that stigma of their profession and discrimination against them were widespread and that this led to a generalised sense of fear of the healthcare setting. Supporting this overall theme, there are four sub-themes: a) *An Under-resourced Healthcare System*, b) *You Are a Body*, c) *The Double-bind of Verticalized Healthcare Systems*, and c) *Stigma and Fear*.

### 4.2.1 An Under-resourced Healthcare System

South Africa's public medical system is under-resourced. This fact is well-documented, (Askew & Berer, 2003; South African Government, 2009; World Health Organisation, 2010; Nattrass & Seekings, 2001) and this situa
problem emerged as a key barrier to the
having to wait for extended periods, combined with nursi ceived to

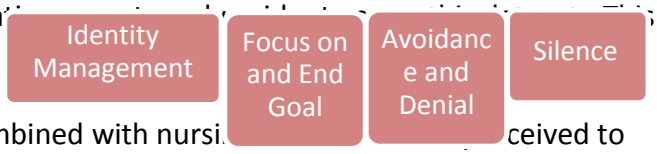


**Figure 1: Thematic Map**

working slowly or taking long lunches, made access to healthcare challenging for participants. In addition, their personal financial insecurity, as described by participants, compounded the obstacles to effective access to SRHC by preventing participants from using private and alternative avenues. Two participants commented as follows:

> *The line is too full there. Sometimes if you want to go by to go early you go by 5 [am] come back by 3 4 [pm] and those nurses sometimes they doing slow they talking doing what. They come the time comes they going to lunch just sitting there. Sometimes if you are too sick you can even die there* (Joyce).

> *The time when I was pregnant. I had to wake up So so early maybe around 3 o'clock you have to be already here ((at the clinic))* (Cindy)

The various inequalities in the health system are perpetuated by healthcare personnel in their everyday interactions. These findings are in line with those reported by (Gastaldo & Holmes, 1999), who also found that nurse inaction through going slow, line cutting and long lunches did nothing to challenge or address the under-resourced and demanding environment in which the nursing staff function.

Instances like the ones described above elicited immense frustration with the medical system, compounded by the frustration of being unheard voices in a system tensioned between caring for people without adequate infrastructure and personnel to do so effectively. This tension was reinforced by the use of a suggestion box at one facility which proved to be counterproductive to encouraging access to healthcare, as also reported by (Petersen & Bunton, 1997). Joyce's account of her experience of such a suggestion box highlighted this is an exercise in futility:

> *the suggestion box there ((said with a very sardonic smile on her face))... we must write out complaints* (Joyce)

The suggestion box represented a constant reminder of the futility of challenging the healthcare system, coupled with the demand to be a passive agent in a biomedical system. Where participants did try to complain to nursing staff, they were quickly silenced. Patients are expected to wait for many hours at sometimes inconvenient times without complaint for a treatment in which they have no say and may or may not receive. Patients reported not having a voice in the medical system.

Under-resourced and over-crowded public hospitals left participants with a sense that they were not cared for, that they were meaningless and could die without even being noticed. In contrast to this experience, SRHC services which cater to high risk populations in offering conveniently placed services at times when participants could freely access them were cited by some participants as fundamental to the accessing of SRHC.

> *You see we have a caravan mobile caravan each and every Friday here to check us* (Beauty)

> *…no they came to the hot* [hotel] *nor normally they would coming they used to write on a notice on the board that they is coming so like I knew I knew I had a problem so I had to go to them* (Cindy)

Clinic services which advertised their times and locations offered a convenient reminder of their availability and were reported to be sought more readily by participants. In addition, the familiarity of these services, their ready availability along with a medical history with these facilities made participants more likely to use the facilities. Such services are frequently geared towards high-risk populations such as sex workers or pregnant women. This gave some of the participants a sense of ownership over these services. Speaking about one of the sex worker-specific services, Sandra states:

> *I've got a file there. I'm always go there… Oh when i'm not feeling good i went there to my clinic [name] clinic*.

The use of the word "*my*" by Sandra highlights the positive connotation she attached to the clinic. Participants who reported a strong connection to a clinic reported more regular visits to that clinic. However, the same participants indicated a sense of betrayal at their participation in such services being revoked if SRHC services unexpectedly moved to another site or become unavailable:

> *…but they used to come here but now .hhh (.)((disappointment in her voice)) I don't know why they didn't come …I don't know why THEY DIDN'T <u>COM</u>E now <u>here</u> they used to come here* (Sandra)

Actions by healthcare service providers such as moving services unexpectedly or poor resource availability led participants to feel they had low control over their health and wellbeing. This finding is in line with the work of Bandura (Bandura, 1982, 1996), who noted that a low sense of self efficacy and sense of control disempowers people from acting on a concern, such as their health. Hence, such actions serve to isolate the participants from active involvement in their SRH. Additional literature highlights the importance of trust, which in the healthcare system is based on the fact that resources are on hand, that choices are available and staff is accessible (Thiede, 2005).

There were other ways in which the medical system took power and agency away from the participants. The dispensing of unmarked medication (a highly unethical and potentially dangerous practice) diminished the importance of the participants by providing an unspecified treatment that a participant felt obliged to take in order to achieve health. Simultaneously, the participant had no way of knowing what she was taking. One participant described an incident of being administered unmarked medication.

> *They gave me these tablets ((hands over unmarked medication)) … (3.0) but I think they are for the pains. I think this one is Panado and the other one I don't know. I'm not sure* (Katlego)

She produced the packet for inspection during the interview, but she could not definitively explain what the tablets were for. As she is an intelligent and capable being, this practice elicited frustration in her towards a healthcare system which she perceived as constructing her as unimportant as a person. This practice isolates participants from active involvement in their medical care. In the short term, unmarked medication may achieve some positive treatment results, but the long-term implication of the practice may be active avoidance of medical settings. This in turn could complicate medical treatments where long-term integration into the medical system is required (including the treatment of some STIs and HIV/AIDS).

Participant agency has been highlighted in multiple studies as central to SRH. O'Hair et al. (2003) and Vick and Scott (1998) found that people's inability to actively participate in their own SRH could lead to complacency around treatments, apathy in seeking any medical assistance, or the seeking of treatments through alternative means.

Self-medicating was one mechanism by which participants accessed healthcare. Participants who were unable to access treatments which they deemed necessary, or who were provided with ineffective treatments, frequently reported making use of alternative avenues in order to achieve health:

> *I went to the clinic but those tablets didn't help me. so I end up buying you see those those like a (stay) for a babies e:::: … I buy another thing I forget what but it written you can pour inside so now I that thing has finished because I was drinking and pouring because those tablets didn't help me… they say you must finish the course I finish but I can see it's the same so I say hm m let me try something else. Now its fine* (Gugu)

Evidence suggests that the availability of medication (whether clearly labelled or not) was critical to participants' giving an account of a positive health outcome, and to their indicating repeated use of the SRHC setting in question. This is evidenced in the account below where the comment to "*give me what I want*" was intended as a reference to antiretroviral treatment (ART). However, the unavailability of medication has been

highlighted by the South African Health and Demographic Survey (Medical Research Council, 2003) to be a barrier to access. One participant commented as follows:

> *Sometimes sometimes like let me say sometimes like you have TB they say you have TB we don't have TB medicine must come this date. Even if ARV sometimes they don't used to have it* (Joyce)

Participants' lack of control in the healthcare system was highlighted in multiple ways in their comments. Seeing different doctors or nurses on subsequent visits, or their dependence upon a referral system to access specialised SRHC services, inhibited the participants' effective accessing of SRHC. Participants who saw the same healthcare personnel at each visit spoke with greater confidence about their SRHC experiences and the findings indicate that they made more frequent visits to clinics where this was possible. They were also more likely to follow medical advice. Participants who had low control over their visits appeared to be less inclined to seek SRHC regularly or consistently. In addition, participants who were dependent on referrals for treatment reported a lack of cohesion in patient management, leading to their becoming displaced in the healthcare system and not receiving effective SRHC:

> *just that whenever you go find a different Dr don't find one Dr find different Dr's everyday but any way its difficult but that's how it is* (Cindy)

Cindy (above) highlights the fragmented nature of South Africa's understaffed healthcare system.

Rosah (below) attests to the fragmented treatment she has received for a chronic SRH complication. Her excerpt highlights a number of issues relating to her SRH complaint. Firstly, the complication spans a number of years, and at the time of the interview, had still not been effectively diagnosed or treated.

> *ya like this time ya (1.0) I'm very sick you see this body it is not my body. Since it starting June in June until now I'm getting slim. Cos I'm I'm lazy like to go but I'm very sick my womb is very sick .hhh I'm just waiting for the results you see…we are going to [Clinic 1] but there a clinic that you using to come here … they a give me tablet injection. Then they said uhu I supposed to get papsmear .hhh… I go to [clinic 2]. I don't know maybe they do pap smear or they take discharge for me. cos they said after I must come after 3 weeks and take the result. So when I get the result maybe they tell me I going to pap smea:r cos your:: your womb it got it cancer or*

*what a kind of infection see. I dunno Dr the one who's gonna tell me… I admitted there again. I move in [clinic 3] they said I don't have they don't have another treatment I don't know what they said I supposed to go and get it there (1.2) so (0.2) I'm waiting for the 26 so let me see my (1.0) my results. Maybe I gonna remove it or whatever I don't know because this pain this womb is so pain… my pain start me when's that (1.0) 2007… ya it start (.) maybe it stop maybe its gonna start this month. Stop maybe about 4 months after that it start again maybe it start maybe 3 5 months it stop like that see until now…I dr he never he said my womb it got inflection. I said which inflection he said ya he's supposed to take pap smear. I go to sonar then they said its like I got <u>cancer</u> (0.2) in my womb. So:…last year that is 20 2010* (Rosah)

This excerpt was taken from a ten-minute segment of the discussion, but much of the interview was spent unravelling her complicated medical history. It became apparent that this complaint had recurred since 2000. Secondly, her seeking treatment was marred by diagnostic confusion and further compounded by her being sent to and/or treated at a number of different clinics and hospitals. As a result of such treatment, she perceived healthcare workers to be unsupportive. In this regard, participants frequently emphasised their need for counselling due to immense physical pain or psychological trauma;

*so (manje) its bad in my life cos I'm just staying in pain you see I got pain always I got pain...it is hard li::ke is that there is not support at the clinic* (Rosah)

Evidence shows that a supportive environment is critical to accessing SRHC, and that the development of trust in such spaces fosters consistent and continued use of those services (Thiede, 2005). A lack of consistency and changing clinic settings, especially due to referrals, did not foster a sense of trust among participants. The participants mentioned some SRHC clinics as ones they regularly accessed, because of the trusted status these clinics held for some participants. Participant trust was based on a clinic's being able to diagnose and treat a problem, as well as the compassion and kindness shown by staff. In this regard, participants commented as follows:

*I know people there in [sex worker clinic name] clinic and I know they treat us how* (Sandra)

*the time I I I went there I met a one nurse she was very good to me. she was very good* (Pretty)

*e'ya they give us denzetrin they give us just tell them the condom busted they give us the treatment* (Cindy)

In contrast to others, some participants knew the names of medications they regularly received. This inconsistency, found both in individual accounts and across participant accounts, suggests inconsistencies in treatment between individual patients and between different patients, as well as between different healthcare initiatives. HIV- and STI-related medications appeared to be well known, whereas the participants could not name and/or describe medication or procedures relating to other SRH needs.

The findings suggest that there have been some improvements in the quality of healthcare offered in the public sector. This was particularly the case in relation to the management of HIV and TB. The data indicated that condoms were easily accessible through all clinics, VCT was appropriate, the management and continuity of such services was effective and treatments were usually available on time. Such efficiencies in the system strongly encouraged access to SRHC. The caring nature in which participants were handled by HIV counsellors is one such example, serving to strongly encourage the use of these services.

> *Those ladies they are very very good …They are good people eish they are not saying eieiei you have HIV why you didn't protect no. They are good people* (Joyce)

As is evidenced above, the reliability and non-judgemental manner in which certain services were made available was important to participants in accessing SRHC. Furthermore, such services were often reported to share information about health conditions. Knowledge-sharing of this kind had the knock-on effect of potentially improving health outcomes for participants' infants. For example, vaccine education proved to be important in ensuring that the participants returned to the clinic at regular intervals to vaccinate their infants. Through the knowledge-sharing efforts of the healthcare professionals at those facilities, the importance of this preventative measure was understood. In line with this finding, it was also found that those treatments that were well explained by medical staff were more likely to be completed, unlike treatments of which the women either did not understand the importance, or which were unlabelled. This finding also applied for birth control measures, which were often adopted at a school-going age, as shown below.

> *E::: they explain. They ask you firstly ekiragh (.) which injection ag do you want to take ekiragh especially if when you went to the school* (Lindiwe)

> *I won't lie I didn't know anything up until that place… they tell me but wo:: I wasn't sure* (Tumi)

The poorly resourced nature of SRHC in South Africa was highlighted by participants as a critical factor in obtaining SRH, treatments, information and prevention technologies. Some participants indicated that they had no knowledge of SRHC until the birth of their first child, as with Tumi, above. Inefficiencies in the system were perceived to have created hurdles for participants which led to reluctance to access SRHC in future, or and compounded naivety about when they needed to access SRHC. The inconsistent treatment participants received across their various healthcare experiences, including overcrowding and long waiting times, ineffective, unmarked or even unavailable medication and their perceived inability to effect change on the health system has created a sense of disempowerment in the participants, faced by a traditionally powerful and discursively commanding medical system (Petersen & Bunton, 1997; Foucault, 1975).

Participants' lack of agency and inability to participate in the healthcare setting has potentially long-term implications for the uptake of medical services. The inconsistencies both in individual participants' accounts and between participants' accounts indicate that there are constant shifts in the healthcare setting. However, the inequities found across these settings could, to some degree, be equalised through financial means.

#### *2.1.1.1 Money levels the public-private playing-fields*

Equity in healthcare systems is an incontestable goal, because poor financial security is strongly correlated with poor health outcomes (Rahman, Haque, Mostofa, Tarivonda, & Shuaib, 2011). Unquestionably, large disparities exist in the healthcare system in South Africa, in line with the economic disparities present in the country. It was therefore not surprising to find that participants' answers featured money as an equalising factor for participants' access to SRHC. Although public healthcare in South is free (Nattrass & Seekings, 2001), inequalities are rife and access to effective care are challenging. Under these circumstances, money offered participants an opportunity to equalise their accessing of SRHC. This took the form of access to SRHC through alternative healthcare providers, such as traditional healers or pharmacists:

> *GUGU: I was having a sore but it don't want to come out but when I wash myself I can feel it it was paining. So I went to the clinic but those tablets didn't help me. so I end up buying you see ... I buy another thing I forget what but it written you can pour inside so now I that thing has finished because I was drinking and pouring*

*because those tablets didn't help me... hu u I didn't because they say you must finish the course I finish but I can see its the same so I say hm m let me try something else. Now its fine... I told her that I got a sore here my friend is not a prostitute that one is working so. So she say what you wanna do ok she say let me go with you there by the chemist me I will explain tell them that if I sleep with my boyfriend I've got pain here because the sore was not coming out so so she's the one.*

*JC: you think they will treat you the same as they treat her if they know that you are doing sex work and she is not doing sex work do you think they will treat you the same way*

*GUGU: ... ((said with humour in her voice)) oi'ya there they will treat me the same because there they want money... as long as you say your problem ... so you explain the dr. Dr say ei give her what what sister* (Gugu)

When they perceived it to be necessary to do so, participants accessed SRHC through alternative avenues. The pharmacist mentioned by Gugu (above) assisted in addressing her SRH concern. In the pharmacy, her occupation was perceived to be completely irrelevant – her ability to pay for a treatment ensured effective access to the SRHC she asked for. Gugu later stated that she would return to the pharmacy for further treatment if the same SRH concern returned. However, she indicated that if a different SRH complaint arose, she would return to the clinic. While her decision to return to the clinic for other concerns is a positive outcome, the lack of consistency between her treatment at the pharmacy and that at the clinic may complicate her clinical picture in the longer term.

Furthermore, such an account suggests that where participants were let down by existing SRHC service providers, they were receptive to alternative healthcare providers in accessing SRHC. Additionally, their accounts suggest that SRHC was more equitably obtained through alternative healthcare service providers and that this may in turn discourage them from accessing correct and comprehensive SRH services over the short and long term. Concomitantly, the ability to pay for services made participants' work irrelevant in the equitable accessing of SRHC, which encourages them to access such alternative services when it is financially viable to do so.

Furthermore, it was not only the participants who realised the healthcare value of money, but the nurses themselves. One account was given of a nurse's sarcastically suggesting access through costly private alternatives:

> *m::: we must write out complaints. If you can talk that e::: what what they will say if you have your money why can't you go to the private hospital. That what we are doing our job here so if you you be fine just be patient. When the time comes you will get in* (Joyce)

With such remarks, healthcare personnel are perceived to reinforce the inequalities pervasive in South Africa's healthcare system by verbalising the need for patients to seek medical treatment through private and often costly means if they are not happy with what the public facility offers. Such findings are consistent with the global picture of South Africa's healthcare setting, with the poor being relegated to accessing healthcare in poorly managed and frequently under-resourced facilities (Elkins, 2008; Yanda, Smith, & Rosenfield, 2003). Healthcare personnel perpetuate such inequalities through "going slow", taking long lunches or dispensing incorrect medication (Petersen & Bunton, 1997).

In line with findings reported in the current literature (Baral et al., 2009; Campbell, 2000b; Cwikel et al., 2008; UNAIDS, 2009b; Wojcicki & Malala, 2001; Richter, 2008a, 2008b; SWEAT, 2010a), participants indicated that they lived in dire poverty:

> *it was 2000 I was pregnant with my last born. It was 7 month .hhh o::w I was suffering. (h) everyevery day I'll take two babies and then I'll go there you see the people selling tomatie potato when the left-overs I'll take them in the dustbin then I'll go to cook in my house until i found this job* (Beauty)

> *Then maybe he will take one hour 30 minutesie (1.0) … eish w w we et maybe one hour thirty minutes … <u>ya</u> eish yes yes I'm trying to say that. So its difficult baby… its diffidult… and then R30* (Beauty)

> *the normal it is R30* (Katlego)

In their accounts of their experiences of SRHC, they often defined the care received in terms of their impoverished state. Under such circumstances, hospitalisation could afford participants the opportunity for regular meals, a bed to sleep in and a daily bath. In their accounts they highlighted these amenities as luxuries that they perceived as central to receiving good care:

> *They was nice nice they come in the morning nicely and ask us (.) did we go to the bath we said yes. They come with foo::d so I didn't see any problems (*Sandra*)*

In such instances, the quality of nursing care or the long-term effectiveness of the treatment became irrelevant, compared to the stark contrast the participants experienced between

their usual daily struggle for food and financial security and the ready provision of basic needs by the hospital. Financial security as such thus becomes an important aspect in the accessing of SRHC. Whether it is a means to equitable health treatments or to encouraging medical compliance by affording women more humane living conditions, it should be carefully considered as an enabler of treatments, including SRHC.

The desire to be financially more secure and to be aligned with more normalised roles led many of the women to attempt to gain formal employment. One participant was unable to do so, due to her lack of formal documentation (a birth certificate or identity (ID) book):

> *So me I can't even get ID because I can't get I don't have birth certificate or whatever… I don't know how which you can't find a job because I don't have ID* (Gugu)

While some of the participants were employed, the employment was often short-lived due to the economic burden of supporting a family or an employment contract's ending. With the low levels of education seen across the group, and generally found amongst sex worker populations (Adamczyk & Greif, 2011; Leggett, 1999, 2001; Richter, 2008a, 2008b) and the current 25% unemployment rate in South Africa (Statistics South Africa, 2012), this finding is not surprising. As a result, participants tended to return to sex work as a means of survival or to supplement a meagre income.

Attempts to access formal employment were often related to internalised shame (Scambler & Paoli, 2008) relating to the participants' profession. As Campbell (2000b) explains, sex workers are displaced from traditional African norms of what it means to respect one's family. However, such norms stand in tension with the participants' need to provide financial support for their families. This tension compounds the shame felt by participants at the work they do, and led women to keep their vocational activities secret from their families while continuing to work under difficult conditions. This is highlighted by Cindy:

> *…ya it's very difficult for me to confront my parents… I don't think they would like it ya. And as a child I do respect my mom and I respect my parents and my elders and sisters and brothers I wouldn't like them to know this* (Cindy)

Participants who held additional employment on a regular basis appeared more self-assured and better presented. Their accounts indicated that they had far greater control over their lives. They were more organised with their finances – one woman reported having a bank

account into which she deposited her earnings. A sense of self-control (Bandura, 1982, 1996; Campbell, 2000) is pivotal to ensuring effective access to SRHC. Money was one area in which participants were either able or unable to achieve a sense of control over their lives and wellbeing. The participant who had a bank account commented as follows in this regard:

> *I just put my money in the bank. R50 R100 I make R100 that day I put it in the bank and then end month I give it to my sister that's it* (Connie)

Studies have shown that low self-efficacy and control in the healthcare setting hamper existing efforts at healthcare (Campbell, 2000; Scambler & Paoli, 2008). This is reflected in the immense sense of apathy amongst participants regarding accessing healthcare.

Where they could afford to do so, participants made use of private healthcare providers in order to access healthcare with greater equity. Such service providers were perceived to be less likely to openly judge or discriminate against sex workers, due to the transactional nature of the interaction. Such equitable treatment established these healthcare providers as more trusted collaborators in participants' obtaining SRH. Nevertheless, the use of these alternative services requires money, and participants seldom had the funds to enable them to use these services. Their earning potential was derived through the sale of their bodies. Defining their bodies in this way served to inhibit access to SRHC which, as discussed in Section 4.4, would be sought only at the point at which it had an impact on their ability to survive.

### 4.2.2 You are just a body

Participants reported being dehumanised and highly objectified in the medical setting. This was frequently expressed through reports of being treated as a body for medical scrutiny, or of immensely degrading and uncaring nursing treatment. The participants' accounts suggested that the objectification of patients in the healthcare setting creates a sense that healthcare personnel are insensitive and uncaring, as also reported by Haslam (2006). Such treatment occurred both in sex worker-specific services and in the broader healthcare setting.

Dehumanisation has been widely discussed in feminist literature. The practice of dehumanisation occurs through the objectification of women, in denying qualities of

meaning, interest and compassion, subsequently removing them from full moral consideration (Fredrickson & Roberts, 1997; Haslam, 2006; Check & Gulione, 1989). In writings on medicine, dehumanisation features as a critical factor through the lack of

> personal care and emotional support; its reliance on technology; its lack of touch and human warmth; its emphasis on instrumental efficiency and standardization, to the neglect of the patient's individuality; its related neglect of the patient's subjective experience in favour of objective, technologically mediated information; and its emphasis on interventions performed on a passive individual whose agency and autonomy are neglected (Haslam, 2006, p. 253)

Similar opinions are expressed by Ennis (1990) and Timmermans and Almeling (2009). Furthermore, accounts of objectification indicate that women are acculturated to internalise such views as their primary perspective of the physical self, thereby increasing opportunities for shame and anxiety, while diminishing awareness of internal body queues (Fredrickson & Roberts, 1997). These factors are vital when considering sex workers' access to SRHC, where objectification is trilateral – it is based on gender, race and vocation.

In line with the literature on dehumanisation, evidence showed the participants' experiences of the uncaring manner in which they felt they were being objectified in the healthcare system. This in turn created a set of risk factors for future access. The objectifying practices they experienced include the withholding of knowledge by medical staff, inhumane treatment of the participants, slow and often confusing diagnosis followed by ineffective treatments, and a refusal to allow the participants to be heard in the medical system. Such treatment created a disconnect between participants and the medical system. Participants' accounts implied that they felt completely undervalued in this system:

> *[.hhhhhhh] oh oh the first time I was going to labour. a:::h::... O::::(1.0) they TREAT me So BADLY **YO:! ...**they shout me they slap me here ((indicates inside of her thighs)) (0.5) O:h you are baby you want to get a baby:: (.) why you are doing this you are a small baby o:h yoyoyo they shout me. The Alexander clinic ( )...I was aeigh a: seventeen years old 1992...they were shouting me (.) ROUgh:: on me because see I'm getting a u when I get the baby I get the baby in the toilet ...I was down there in the toilet I was down there because they shout me then I move there in the labour room I go to the toilet and then I get the baby there... on my own ((laughs))... ya (h) they help me they (H)help me and then shout me shout me... ya shout me but I don't care*

*because my baby I get the baby and my baby's fine so ((indicates dismissive wave of hand))... yes I don't care ((laughs)) (*Beauty*)*

As evidenced across the data set and in some prior studies, such as that of Rippon (2000), violence in healthcare settings results in profound trauma for victims and becomes a critical barrier to accessing healthcare. The attitude of medical professionals that patients are bodies under scrutiny, or in this case, the combination of being a sex worker and a patient body, perhaps allows for immensely judgemental and cruel treatment to take place.

Malicious and degrading medical treatment such as that mentioned in the account above made it more challenging for participants to access healthcare in the future. Through actions such as these, nursing staff establish themselves as uncaring, malicious and at times vindictive in their handling of patients. The long-term impact of abuses at the hands of medical professionals continued to negatively affect participants' access to healthcare, in some cases more than two decades after the incident. This occurred through the negative association of the health setting, the expectation of repeat occurrences of such behaviour, or through the internalisation of patient powerlessness in the medical system. Elkins (2008) emphasises that the impact of bad experiences in the healthcare system can become a central barrier to accessing healthcare. In this regard, two participants commented as follows:

*I don't go there [name 1] clinic in [name 1] clinic I go collect my treatment only …I'm scared to go there because I used to go there in [name 2] clinic … its just that a:: I know people there in [name 2] clinic and I know they treat us how* (Sandra)

*no just I know me I know the nurses I know. Even if you jump the date the baby must go to the clinic one date you will hear them the way that they will shout at you. so imagine if you will tell them you what are you doing* (Joyce)

While some efforts are being made to redress such intense violations of women, especially during labour, more insidious forms of abuse appear to have become entrenched in the medical system. For example, Cindy described a recent, protracted and painful labour in which she was forced to be silent for fear of the nurses' punishing her if she made noise. Her account was embedded in the context of her having described another mother losing her baby:

*P1: oh the pain was:::... h oh::: it was too much yo::: I can't imagine it it was too much... ya of course you know the nurses if you making a lot of noise they will treat*

*you bad but if you just behave yourself they will e'ya treat you nice... I just told myself wow I'm in South Africa let me just behave myself. H:cos I was afraid. So I just behave myself until I get there... sometimes you know when others are telling stories they tell you hey if you make noise you end up losing your baby. Things like that. You see... so:: um:: (1.5) I just told myself I have to behave myself so I can go home holding my baby… Then we gave birth I also was hoping hopeful that my baby she would be negative but unfortunately she was positive as well. She's on ARVs right now but hey ya we coping...*

*JC: : ok and did they know your status and [major hospital name]?*

*P1: I'ya::*

*JC: ok did they offer you a Caesar did they offer you any drugs during your pregnancy during the birth*

*P1: °no they didn't°* (Cindy)

This account strongly suggests that participants may fear for their own and their child's safety during labour and subsequent delivery. It also intimates that nursing care, in line with evidence from prior studies, is perceived to be less than optimal, and at times may be seen as potentially life-threatening for pregnant women and their infants.

Across the data set, participants indicated a common belief that nursing treatment was callous and that they felt that, as patients, their rights did not matter. Such inhumane nursing care was frequently reported to have occurred during childbirth. Participants' accounts intimated that nurses bullied them into submission, expecting the participants to "*behave"* in a manner which demanded the least responsiveness from the nursing staff. Such bullying often took place in a system which could not guarantee the participants' or their babies' safety. This had a compound effect upon the participants' accessing of SRHC, creating anxiety as evidenced above for a child's wellbeing, which led participants to negate their own needs (in this case, pain management) in an attempt to appease nursing staff. Simultaneously, such treatment reinforced the participants' perceptions that they were sub-human, and hence, they did not request better treatment. This led to participants' being unable to access effective SRHC, either because they were not requesting treatment, or because they did not divulge vital information.

Maternity ward abuse by nursing staff has been widely publicised, with a growing body of evidence of the physical and verbal abuse of pregnant women by nursing staff in South

Africa. In an analysis of research spanning the 1990s, d'Oliveira, Diniz, and Schraiber (2002), found that the abuse of patients in facilities providing childbearing/maternity services has a serious effect on subsequent health service access and compliance, and on effectiveness and quality. In this context, Human Right Watch (2011) quotes Nolwazi Gaza, Department of Monitoring, Performance and Evaluation, as stating that "we must stop creating excuses [for poor maternity care] by fixing our system. We must also stop making excuses for nurses, saying that they are overworked. Yes they are. There could be a few rotten apples, or even those who are disillusioned. But there has to be individual accountability". The report adds that the abuse of maternity patients has an indelible psychological effect, severely constraining women's access to SRHC, leading to delayed diagnoses and treatment, while increasing the rate of mortality and morbidity of women and children. Such evidence highlights the plight of the sex workers who deal with discrimination on multiple levels and are then subjected to further marginalisation from the medical setting by a controlling and abusive staff.

Despite her commitment to a healthy pregnancy and infant, which is demonstrated by her monthly attendance at an antenatal clinic, the objectification of Cindy and the lack of compassionate nursing treatment she received, coupled with poor inter-clinic communication, led to her not being offered appropriate prevention of mother to child transmission (PMTCT) treatment during her labour. This resulted in her infant's contracting HIV. World Health Organisation guidelines (Moodley, Moodley, Coovadia, Gray et al., 2003; WHO Paediatric Antiretroviral Working Group, 2008) stipulate that PMTCT treatment should be offered to all HIV-positive pregnant women as the first line of defence against the spread of HIV. The withholding of such treatment (deliberately or by omission) positions a person such as the participant as a body requiring only the treatments deemed necessary by the nursing staff, and as an inactive participant in her own wellbeing. As both Bandura (1996) and Campbell (2000) show, positioning an individual as an inactive agent is problematic, particularly, in this case, in the accessing of healthcare. Hence, such practices inhibit access to SRHC. Such actions also displace the end users of such services from basic human rights, as they are not offered a priority treatment which should be readily available in South Africa. Cindy's acceptance of both her treatment and her child's status highlights the internalisation of being removed from a rights-based discourse. Moreover, the manner in

which participants are treated as bodies constrains their access to SRHC by displacing them from the most basic of human rights.

Furthermore, participants' accounts indicate that nursing care may be delivered in a manner that fails to recognise participants' concerns. The lack of compassion found in the healthcare setting has frequently been cited as a barrier to access. Elkins (2008) argues that the impact of bad experiences and the inability (or unwillingness) of nursing staff to share knowledge with patients has a significantly negative effect on access to much-needed services. In this regard, Joyce commented as follows:

> *the hospital ... sometimes they shout at you you see m ((sniffs loudly))... no just I know me I know the nurses I know. Even if you jump the date the baby must go to the clinic one date you will hear them the way that they will shout at you....just the shouting they ask um you think we are here to play? You you are what whatwhat this is your baby what whatwhat. If sometimes maybe I explaining to them what was the problem why didn't I come they didn't care* (Joyce)

Admittedly, participants may not always seek healthcare in line with what the nurses have recommended, but then, the uncaring attitudes of nursing staff often do not encourage regular visits. Participants' accounts suggest healthcare personnel often did not explain the reasons for participants' needing regular visits to them. In addition, where medical recommendations are made regarding regular visits, patients exercise choices in deciding whether or not to follow healthcare advice. When nursing staff chastise participants for missing return dates, such rebukes appear to revoke the patient's choice, even where nursing staff act in such a manner in an attempt to ensure medical compliance. This disregards participants' right to choose, repositioning them as bodies unable to make choices regarding their SRH. This in turn positioned participants as inactive agents in the medical setting.

In a study of access to healthcare for the learning disabled, Jacques and Stranks (2009) found that the lack of control as opposed to choice for patients is critical to their accessing of healthcare. They concluded that patients who were not consulted on the type of medical care or medication to be administered and/or who were not fully informed so that they could make decisions were less inclined to access even much-needed healthcare services effectively. By preventing sex workers or other patients from taking an active role in their

medical treatments – a role which could be achieved through improved knowledge sharing – effective access to SRHC is inhibited.

Callous treatment of participants gave them a sense of powerlessness in the healthcare setting, as also found in a study by Trummer, Mueller, Nowak, Stidl, and Pelikan (2006). As patients accessing healthcare, the participants were objectified. In such situations, participants gave an account to being under medical scrutiny in a process which largely negated their emotional needs, as described below:

> *the last time when they said push I closed my eyes to push but the last time (2.0) is but them the time that I get blind... but they not listen >to me<...Then the oth other sister saw me when I trying to eat I (2.0) I was ((indicates messing))...I told her I'm blind she was not sure and she was surprised <u>blind</u> ne (.) even after birth and I said yh::a and they called doctors (2.0) and every time at hospital (.) every time I wake up there was people around me* (Tumi)

In a medical setting, patients are dependent on medical professionals to diagnose and treat an ailment. A diagnosis depends largely on the patient's account of symptoms, and on the medical professional's believing this account and seeing it as plausible in combination with a physical examination to verify the account (Petersen & Bunton, 1997). This situation also applied to the participants, who reported a sense of helplessness in being entirely dependent on medical professionals' believing their accounts of their SRH concerns. Tumi highlights this experience in her report of her inability to communicate her blindness effectively in a medical setting. The participant suggests that her inability to see had be verified by an appropriate medical person before treatment could be administered. The account by Tumi of going temporarily blind while giving birth to her infant suggests chronic and unmanaged hypertension, which caused amblyopia or blindness in otherwise good eyes (Sibai, 2002). Due to the rarity of the complication she experienced, (Moser, 2007), the hospital staff were reportedly reluctant to believe her. As a patient, she held no power in the healthcare system and the right to speak was confined to the medical professionals surrounding her. Her account highlights how participants' bodies became the primary form of communicating their needs to SRHC service providers. In effect, they become mute in the healthcare system, stripped of their complexities as human beings, in favour of medical examinations to confirm their health status.

Tumi (above) also suggests that once the validity of her complaint was established, surveillance over her became a point at which power was exerted over her. In surveying her, the medical personnel gained knowledge of her condition, while she was dependent on them to look after her. She herself became increasingly anxious at the on-going surveillance and her lack of control over the situation. Her account of her blindness, as can be seen above, is marked by the anxiety caused by the intensity of the medical surveillance which she was subjected to: "*every time I wake up there was people around me."* While the constant surveillance may have been necessary in terms of monitoring her progress and ensuring effective assistance was available to her, the manner in which it was done created fear of the medical system. Tumi later stated: "*I was taking my baby not here cos after we went to hospital I was trying to forget*." She reports avoiding certain healthcare settings due to the trauma of this incident. Such actions have an impact not only on her health and wellbeing, but also on those of her infant, who had not been vaccinated at the time of the interview.

The objectification of patients may serve the purposes of a medical system based on empirical evidence, but it alienated the participants from accessing SRHC settings, because they became voiceless bodies for medical surveillance. This lead to poor communication and often patient neglect, a finding which ratifies the findings of other studies (Human Right Watch, 2011; Petersen & Bunton, 1997) that such factors lead to avoidance of healthcare settings.

While most participants did not manage to avoid the healthcare setting entirely, patient objectification and dehumanisation created problems for long-term and/or the consistent accessing of healthcare. This was most strongly evident in Rosah's account of a long-term SRH complication:

> *my pain start me when's that (1.0) 2007... ya it start (.) maybe it stop maybe it's gonna start this month. Stop maybe about 4 months after that it start again maybe it start maybe 3 5 months it stop like that see until now* (Rosah).

Participants Five spoke about recurring pelvic pain which began in 2000 and was initially treated in Zimbabwe. The pain began recurring at regular intervals from 2007, but she did not consistently seek treatment for it. When she spoke about times when she did seek treatment, she displayed confusion about the diagnosis and a lack of understanding about

the treatments she received. The excerpts below are accounts of an apparent recurring medical problem spanning a ten-year period, and marked by the same complaint of pain:

> *That think it blow up you see. go °wabum° you see… now he said I can't get a child again cos of that sickness* (Rosah)
>
> *your womb it got it cancer or what a kind of infection see* (Rosah)
>
> *I go to sonar then they said its like I got cancer (0.2) in my womb. So:...last year that is 20 2010 (.) e'ya. Then on (1.2) June↑((2011)) ya I needed to remove it but the dr refuse he said must I wait ... cos I'm young I said I don't need a child again it's too painful ne.* (Rosah)

Each attempt at accessing SRHC was reportedly experienced in isolation from the previous ones, leaving her with a sense that "*it is hard li::ke is ... if I go to the clinic they just give me the same tablets you see*". Rosah did not know what treatments had been administered to her, despite multiple hospitalisations. It was suspected that she had cancer, a rotten womb or STIs, was told that she was infertile and then that she was too young to have her womb removed in case she would like more children. The diagnostic confusion surrounding her case left her with a sense of helplessness. Her experiences of the healthcare setting are marred by inconsistencies, perpetuated both by the lack of compassion and the objectifying nature of her treatment. Her response to this situation is clinic card swapping in an attempt to access better treatment:

> *I never tell him that ur I for another file ... o::: (.) its just the first time is 2007 and this time is 2010 so I see that is gonna take long and I was very very sick that time I was going with another man is staying here he go with me (.) so me I neva never put a dr. That guy the one who go and open the file for me. so the time they ask me you got another file I said no cos I've already opened the file already I just leave it like that (*Rosah*)*

The act of clinic card swapping involves opening a new clinic card for subsequent clinic visits or using multiple clinics to treat (potentially related) ailments. When patients do so, no clear medical history can be traced and treatments are disjointed, potentially interfering with one another. Rosah uses clinic card swapping as a strategy to access SRHC. Her most recent experience in the healthcare system is indicative of her desperation to understand what is wrong with her. She suggests a commitment to accepting and following an appropriate course of action, stating:

> *I'll do exactly what they say (0.2) cos (1.2) I see that u I gonna be dead. If they say they wanna take my blood they take it if they say I got what what anything that you just say I gonna exc except cos I don't have choice now I'm sick.*

Her example shows how a reductionist biomedical focus upon patients' physical health can lead to patients' resistance to seeking healthcare.

In addition to this, Rosah's fear of a fatal illness may also have undermined her ability to access SRHC effectively. She clearly articulates that she will "*do exactly what they say*". Her fear of cancer or HIV is compounded by the confusing messages she has received from the clinics and the hospitals she has attended. This was further complicated by the misaligned and disjointed treatments reported, highlighting the objectified nature of patients in the healthcare setting. Such treatment reinforced her low sense of control over her SRH, and such treatment also encouraged acts of resistance which further complicated access to SRHC. This kind of situation is stressed as an important barrier to access to healthcare in studies by Campbell (2000), Jacques and Strakes (2009) and Kar, Pascual, and Chickering (1999) – it alienates patients from the healthcare setting, prevents effective treatment and reduces patients' overall wellbeing.

Moreover, Rosah's capacity to enquire about, engage with and actively participate in her treatment has clearly been reduced as a result of her exposure to a medical system comprised of doctors and nurses that did not clarify her illness, and failed to explain to her what appropriate courses of action should be taken, such as treatment and follow-up consultations, or signs and symptoms to be concerned about. Across the dataset, a similar inability to participate in their own wellbeing, as perpetuated by SRHC settings, was consistently found to be a key barrier to accessing SRHC. Participants frequently recounted having to accept a treatment, even knowing that it would be ineffective, or of unmarked medications being administered to them. Their accounts suggest that medical staff did not consider their ability to participate actively in their own SRHC important in encouraging them to access comprehensive SRHC.

Participants alluded to the dispensing of vitamins or repeat medications as being ineffective and unnecessary:

> *Sometimes you got infection but they don't give you stuff for infection they give you B-co and vitamin (.) it don't help nothing mos* (Gugu).

While the basis for this treatment may have been to improve health outcomes (Heaney, 2005), the lack of explanation given to participants for giving them particular medication created an immense frustration about the healthcare system, which was perceived as being uncaring and inattentive to the participants' needs. By comparison, when it came to HIV-related treatment, participants were well versed in the treatments available to them and their intended outcome:

> *ya they (SL) they give me thing pills to protect me and the baby then when I was 9 month 8 months they give me therapine that if I'm having labour pains I must drink it* (Joyce)

In this regard, Joyce mentions *therapine* – she probably means nevirapine.[3] Knowing the names of treatments suggests a greater engagement with the healthcare system and a stronger sense of agency and control in managing one's own health. Some of the data therefore suggests that participants to whom medications were dispensed which they both knew and were familiar with (as indicated by their knowing the name and intended outcome) were more likely to use the medication appropriately and achieve the desired outcome. They also gave more accounts of accessing SRHC more regularly. However, the same participants became increasingly frustrated when they were given vitamins instead of an appropriate medication, as highlighted by Joyce's comment, cited above.

In this way, participants' accounts suggest that they have been recast as ignorant in the medical setting. They reported feeling bound to take a medical treatment, even when they knew that it would be ineffectual. They also indicate that they are expected to be grateful for any treatments they receive, even treatments that were sometimes withheld or dispensed without clear instructions or labelling. These instances made access to effective SRHC increasingly challenging for participants who were effectively disengaged from managing their SRH. An excerpt from a conversation with Katlego demonstrates this situation:

> *KATLEGO: They gave me these tablets (.) for the pains ((hands over 2 UNMARKED packets of tablets. Clearly dispensed from a hospital but with no name or information written/printed onto the packets. Pills also unmarked))*

[3] Nevirapine is a PMTCT drug administered at delivery. The protocol for use predates 2008, when evidence suggested that it increased the risk of mothers' developing resistance to their regular ART. Participant Nine's infant was nine months old at the time of interview. Single-dose nevirapine is used during labour in conjunction with prenatal and post-partum regimens implemented to compensate for this side-effect (Moodley et al., 2003; Gray, Urban, Chersich, Bolton et al., 2005; McIntyre, Hopley, Moodley, Eklund et al., 2009).

*JC: ok doesn't say what they are*

*KATLEGO: m:: (3.0) but I think they are for the pains. I think this one is Panado and the other one I don't know. I'm not sure*

*JC: ok. (2.0) ok did they explain to you what they are?*

*KATLEGO: no they the:: the dr in the hospital told me because on the fiveth I'm going to get my TB at my TB tablets. So its better for me when I go to Hillbrow and I get my TB tablets. Then I must explain for them that I'm having a pain on the side so they can (1.0) .hhh do pap smear for me...I just her that I have got a pain here then she ask me when did I get my period and when was the last day I stopped then I told her everything and she gave me the tablets*

*JC: so she she didn't check you*

*KATLEGO: no she asked me if I'm having discharge or whatever and I say e'ya I'm having discharge and she says the best thing I must do is go to the hospital I must take that letter so I can go for pap-smear* (Katlego)

Her account highlights a number of factors. Firstly, it shows the ineffectiveness of dispensing unmarked medication – the patient's ignorance is reinforced and she is unable to engage actively in managing her SRH, displacing her from the health system. Secondly, dispensing unmarked medication carries the potential danger that a person may take unspecified medication (to which the person may be allergic, which may have side-effects detrimental to the person, or which may interfere with other medication) and adverse effects would be difficult to treat, because the substance is unknown. Moreover, the account suggests negligence on the part of the healthcare professional, who did not physically examine the participant. The clinic doctor's requesting that the participant seek treatment through an alternate healthcare service provider at a later stage suggests a lack of responsibility and responsiveness to her SRH needs. This in itself indicates a number of things:

- That SRHC is not effectively offered in many clinic settings,
- That healthcare personnel may behave unprofessionally in not taking full responsibility for their clients' rights, and
- The accepting of unmarked medication highlights that participants were expected to accept and be grateful for any medical treatment which they received.

As bodies cast outside a rights-based discourse, the participants were unable to request better services or improvements to the services they received. The lack of agency the participants they are required to display in health settings displaces them, and people in a similar situation, from full access to SRHC as a basic human right (Haslam, 2006; Fredrickson & Roberts, 1997).

Lack of participant knowledge of medical procedures was evident in the data set. In many cases, in integrated health facilities, participants did not understand procedures they had undergone. Their accounts indicate that informed consent was frequently not obtained, which constitutes a breach of patient rights (Alma-Ata Declaration, 1978). The coercion of patients into accepting a particular medical treatment or into undergoing a given procedure has also been reported in other studies. Human Right Watch (2011) argues that such coercion or bullying by medical staff poses a threat to the effective accessing of SRHC. In such instances, participants agreed to a course of action without full comprehension of the potential long-term implications of the procedure. This is evident in an account by Gugu, who was sterilised after the delivery of her third child:

> *JC: ok so they didn't explain that to you*
>
> *GUGU: they just tell me that we are <u>done</u> …hmm:: they just say...if you still want to continue its fine but it's a risk because you can't get 4 baby 3 babies with a caesarean and expect to be pregnant again because you don't know that one it will come straight or with a caesarean. Maybe you can die or the baby can die. They just say like that only*
>
> *JC: ok um do you still get your periods?*
>
> *GUGU: ya! Ya (*Gugu*)*

This account suggests that the risk factors described to the participant were in relation to the financial strain of more children and the impact of a fourth pregnancy or caesarean section. On further probing, the participant went on to indicate that she did not know what procedure she had undergone. However, she indicated that her menstrual cycles continued, which shows that her womb is still intact, eliminating certain procedures from the list of possibilities. The literature highlights the risks surrounding sterilisation for women (Lee, Son, Shin, Byun et al., 2012; Penman-Aguilar, Whiteman, Cox, Posner et al., 2012), very few of which appear to have been discussed with the participant. This coercion,

coupled with the withholding of information, prevented the participant from taking an active role in deciding on the best possible sterilisation procedure. Such incidents highlight the medical attitude in a public setting which nullifies patients' ability to manage their wellbeing actively. Such practices do not give them an opportunity to engage with their own health and, as a result, some may prefer to withdraw from medical settings.

The withholding of knowledge and coercing of patients by medical staff has been frequently cited in published studies as a critical factor inhibiting SRHC (Elkins, 2008; Human Rights Watch, 2011; Petersen & Bunton, 1997). This result is reflected in the immense sense of apathy amongst participants about accessing healthcare. They appeared to have accepted their powerlessness in health or other settings as standard practice. Very few participants gave an account which showed that they actively challenged this situation, and indicated resignation to this disempowered state. They did not try to discriminate between being subjected to these practices as sex workers or as women, but rather accepted that for them as female sex workers, powerlessness was inevitable.

The widespread biomedical objectification of participants in the healthcare services setting was perceived as a critical barrier to their effective accessing of SRHC. In combination with existing evidence bases, such findings indicate a need for urgent redress. This is further perpetuated by the verticalization of certain healthcare programmes.

### 4.2.3 The double-bind of vertical healthcare programmes

The recent and unprecedented increase in international support towards improving healthcare in developing countries has seen a large proportion of funding being channelled towards disease-specific or vertical healthcare programmes. The magnitude of such investments are positive, but their effect is diluted through their focus on particular healthcare projects, over and above broad-based improvements to healthcare, such as primary healthcare solutions, prevention measures and overall capacity building (De Maeseneer, van Weel, Egilman, Mfenyana et al., 2008).

In Johannesburg, there are a number of vertical healthcare initiatives that are geared to improving access to various SRHC services. These included prenatal, HIV, and sex worker-specific services. Accounts suggest that participants who required SRHC treatment in the broader healthcare setting were isolated from it because of poor information-sharing

between SRHC providers. This was evident from accounts of the healthcare referral system, which frequently failed to convey important information regarding patient healthcare correctly. This was highlighted in the case of Cindy, whose situation was discussed earlier – she has an HIV-positive baby, which suggests poor inter-clinic communication.

Such data suggest that for the participants, the verticalization of healthcare in an attempt to deliver particular services is not always successful. In this instance, the failure to deliver PMTCT to the participant effectively resulted in her infant's being infected with HIV. This finding contradicts existing claims that South Africa is able to deliver PMTCT to 95% of pregnant women (World Health Organisation, 2011). However, this finding is in line with international findings on vertical programmes which show that uncoordinated care is a barrier to accessing services (Hernandez, 2000; Atun, Bennett, & Duran, 2008).

Additionally, the high demand for services in developing and often under-resourced systems leads to increased waiting periods and extremely long queues, which then become an additional barrier to accessing services (Stadler & Delaney, 2006). Consistent with this, long queues for prenatal services were reported by participants, suggesting some of the challenges in accessing such programmes:

> *no its fine it was only the time when I was pregnant. I had to wake up <u>So so</u> early maybe around 3 o'clock you have to be already here* (Cindy)

In line with the *WHO Sexual and Reproductive Health Medium-term Strategic Plan for 2010–2015 and Programme Budget for 2010–2011* (World Health Organisation, 2010) and the MDGs for 2015 (United Nations, 2010), most vertical projects' particular emphasis is HIV/STI treatments. Such services focus on the delivery of services in a non-discriminatory manner. In this regard, many participants cited the sex worker-specific projects as easier to access. This can be seen in the excerpt from the interview with Sandra (below), who implied that familiarity with the service makes SRHC easier to access:

> *oh when I'm not feeling good I went there to my clinic [name] clinic. I don't go there [name] clinic ...collect my treatment only...I'm scared to go there because I used to go there in [name] clinic... its just that a:: I know people there in [name] clinic and I know they treat us how (.) that's why I go in [name] clinic* (Sandra)

The more humane treatment in some clinics drew participants to access medical assistance there. In such systems, some participants testified to receiving timeous service, to correct

medication being dispensed and to caring and compassionate nursing care. Nursing staff in such situations shared basic knowledge and were understanding to some of the women's needs. In many instances, the women felt able to discuss openly problems pertaining to condom breakage, or their HIV and STI concerns. Appropriate treatments were frequently dispensed to prevent the spread of disease. In particular, VCT personnel were perceived to be approachable and effective in their handling of patients. Participants stated that such services were offered outside of traditional, integrated healthcare settings. This was emphasised in relation to sex worker-specific projects where sex workers were separated out from the normal population.

*GUGU: [clinic name] upstairs cos even even our file is there* (Gugu)

The data show that although separate sex worker-focused services reduced fear of sex worker-specific discrimination, they inadvertently and in complex ways displaced the participants from more integrated healthcare service offerings. Such a move has thus had the short-term advantage of encouraging access to specific SRHC services, as was evident in some accounts of access through these facilities. However, in line with the existing literature (Petersen & Bunton, 1997), the findings of the current study show that the long-term implications are the inadvertent and further displacement of the population from a generalised healthcare setting.

In addition, many verticalized projects in South Africa appear to have been set up to specifically address issues relating to HIV/AIDS and STIs. While this has been done in line with global HIV trends, such an isolationist and reductionist approach has further perpetuated a vectorship discourse amongst the participants, unintentionally displacing participants from the "normal" population in perpetuating an internalised sense of "us" and "them". This was evident from references to the clinic as *"the best place for us girls to go. Especially if you on the street"* (Katlego); while commenting on people from the "outside" as follows: "*most of the people outside they don't like sex workers"* (Sandra); or "*so I think they will say no you having this pains you having this problem because you are a street worker"* (Katlego). This in turn created a sense that access to SRHC outside of sex worker specific services may be fraught with discrimination-based challenges. Encouraging participants to access tailor-made services may thus inadvertently fuel their fear of accessing healthcare in an integrated system.

*I don't know or me I I I I don't know I don't know I don't know that how is she going to react if she find out that me I am a sex worker and I need help* (Pretty)

*SANDRA: I don't go there [name 1] clinic in [name 1] clinic I go collect my treatment only*

*JC: why don't you go to [name 1] clinic for other things?*

*SANDRA: I'm scared to go there because I used to go there in [name 2] clinic…its just that a:: I know people there in [name 2] clinic and I know they treat us how* (Sandra)

Both Participants Six and Eleven (above) refer to general healthcare facilities in comparison to specialised sex worker clinics which they frequent. Moreover, they also suggested that as sex workers, they would be treated differently to the "normal" population by healthcare workers. In both cases, participants' accounts suggest a fear of unknown nursing staff outside of the clinics set up specifically for sex workers. This fear of the unknown inhibits access to general health facilities, which is critical in ensuring overall SRH amongst a group of women who engage in sex on a regular basis, who have had or will have children, who have regular partners and deserve access to a basic human right. Their accounts suggest how daunting they perceive accessing public healthcare to be in relation to the ease of accessing specialised services:

*JC: do you think that you get treated differently if you're not a sex workers as when you are a sex worker?*

*KATLEGO: if maybe they will find out that I'm a sex worker… I think you know people they are not the same so I think they will say no you having this pains you having this problem because you are a street worker and what and what. I don't know .hhh or maybe you you go there and they will say to you a:h this and that and that you know you see* (Katlego)

Such fear of accessing SRHC services was seriously compounded at times when they were obviously discriminated against by staff at sex worker-specific programmes:

*When you reach there ((sex worker clinic)) some they put their (.) hand glove where they put their hands in you when they check you they say yah m:: even your discharge is smelling. It shows that you just sleep without condom. While it's not like that infection is infection. You don't know sometimes you got it in the toilets. So (.) the nurse are not the same. Even show you looks how it looks but you are a lady it even smelling ((she is holding up two fingers as if discharge is on it and it is being shoved into her face as if the nurse has done this to her)) (3.0) so I we we just keep*

*quiet ... Sometimes you got infection but they don't give you stuff for infection they give you B-co and vitamin (.) it don't help nothing mos* (Gugu)

Gugu described an intensely degrading SRHC experience at the hands of a sex worker nurse (discussed in greater detail in Section 4.3.4. under Fear and Stigma). However, she went on to state: "…*you know people are not the same. Some of them they are high some of them they are right so you can't say the clinic has got a problem*." This statement suggests a reluctance to speak negatively about the clinic. Participants preferred to highlight individual responsibility for discriminatory behaviour within sex worker clinics, rather than apportioning blame to the clinics. They also chose their words carefully when speaking about the sex worker clinics. Their accounts suggested concern for openly criticising the sex worker programmes available to them.

Like the account above, participants spoke about SRHC primarily in relation to condom usage, HIV or STIs, requiring "cleaning", diagnosis or treatment. Only once they were prompted did they speak about SRHC in terms of pregnancy, family planning, and their own sexuality. This suggests that the focalisation of certain services has framed SRHC for these participants in terms of the HIV pandemic. The data indicate that the focalisation of SRHC services to the sex worker population has created a vector discourse with which the participants strongly identified. Such a focalisation upon disease treatments is a major source of criticism of vertical programmes (Hernandez, 2000), and the impact of such focalisation is evidenced in this data set. Obtaining services via these programmes fosters an intense fear of general facilities by segregating sex workers from the general population. In line with Aulette-Root (2010), hegemonic biomedical discourse is strongly represented across participants' accounts of SRHC. Such evidence suggests dominant and largely oppressive powers couched in medical language and marketed under the guise of disease-specific programmes.

While she was still being put at ease at the start of her interview, Cindy (below) insisted that she always used a condom. Katlego insisted that all doctors would want to know about her is whether or not she used condoms, and that this would position her as sufficiently compliant to deserve or access treatment. Across the board, all participants referred to themselves as requiring "cleaning", or as being "dirty":

*…smile (.) talk (.) nicely do what he want but I don't forget condom* (Sandra)

> *I think the most important thing what they will like to know is that I'm using a condom or I don't using a condom* (Katlego)
>
> *they give you flamegel doxyclin to clean yourself* (Gugu)

On the one hand, verticalized healthcare programmes address the immediate needs of an at-risk sub-population by providing much-needed services; on the other hand, participants' reports suggest that such programmes perpetuate the exclusion of sex workers from integration into the broader healthcare setting in fully achieving SRH. This occurred through physically separating programmes for this sub-population from other healthcare initiatives while implementing intensive and focalised HIV/STI campaigns:

> *…sometimes they call us for meeting for the sex workers. Tell us use condom always and they check blood everythings that you want* (Rosah)

The independence of such programmes from the broader healthcare setting and their isolation from a comprehensive healthcare approach is perceived as a double-bind. On the one hand, such programmes cater to the needs of their clients and offer much-needed services. However, on the other, they unintentionally also displace their client base from a complete range of SRHC services provided in an integrated medical setting. The literature indicates that the international trend is now to integrate such services in a cost-saving and co-ordinated approach towards healthcare (Atun et al., 2008; Hernandez, 2000).

Various research projects geared towards the collection of data about sex workers' sexual habits, HIV status and the use of microbicides were mentioned by participants. Such a focus on the population as an at-risk group has also unintentionally perpetuated the vectorship discourse surrounding this population. Seidel (1993) argues that marginalised groups are constructed and oppressed through discourse. She criticises the depersonalising medical discourse surrounding groups such as sex workers because such discourse stigmatises and misleads through the use of the term "high-risk group". Moreover, she points out how sex workers are further harassed, controlled and medicalised through such discourses.

Goudge, Russell, Gilson, Gumede et al. (2009) and Goudge, Russell, Gilson, Molyneux, and Hanson (2009) point out that people from marginalised groups have fewer opportunities to show their social value, while holding a greater risk of health concerns, they are also less likely to adhere to their treatments. Through the creation of well-meaning vertical programmes, these participants are increasingly displaced from SRHC.

In the biomedical setting, the vectorship discourse which has been built up around sex workers has created a set of hurdles which force the women to seek healthcare in relation to treatments perceived to be appropriate to the sex worker population as a whole, negating additional SRHC and other healthcare needs which women have. Such discourses are strongly aligned with the agenda of disease-specific programming. It is important to note that the needs of such women are frequently overlooked, with female sex workers being harassed into HIV/STI-specific programmes (Seidel, 1993). This discourse led many participants to believe that they were dirty or unclean, and unworthy of better healthcare treatment. The excerpts below include the consistent and widely used terms "to clean" or "to be cleaned" in relation to condoms "*bursting"* or to spreading HIV or STIs. Such consistent use of these terms across the data set could perhaps be indicative of the term's being used in the clinic setting, with nurses perpetuating a vector discourse amongst the women:

> *they said I I I its cleaning its preventing for if maybe that person is having HIV* (Pretty)
>
> *Even if you want something to clean yourself they don't ask you they just give you what you want and then check you* (Connie)

It was noticeable that participants displayed surprise at being treated with respect, and in a manner which reflects their constitutional right to dignity and access to healthcare. Their surprise at such functional moments in the health setting indicate not only the dysfunctional, cruel and degrading treatment to which they are often exposed, but a disconnection from their civil rights. This is highlighted below with regard to accessing HIV treatment through a sex worker clinic. Beauty's delight at being treated "*nicely*" by people who know "*that we are prostitute*" indicates a displacement from human rights as belonging to her, and as exclusive to non-sex workers:

> *BEAUTY: [clinic name] it treat us nicely... I don't know why but they treat us nicely*
>
> *JC: do you think they shouldn't?*
>
> *BEAUTY: I think because he knows that we are prostitute* (Beauty)

Inhumane and disrespectful treatment seems to have positioned the participants outside of understanding healthcare as a basic human right. They have in some senses become sex workers before being women. Interestingly, participants indicated some disparity between

how they expected to be treated and how they were treated in the sex worker clinics. Participants' expectations of medical care are dominated by fear of discrimination. The offering of non-discriminatory sex worker-specific programmes became a focal point for the participants, who claimed a sense of ownership over them. This was evident in the excerpt from the interview with Sandra, who said: "*I went there to my clinic* [clinic name]."

Interestingly, many of the interviews intimate that the women felt unable to openly criticise these clinics. Despite the service's not meeting all of their SRHC needs, it appeared as if they feared having the services revoked and their being left with less than they currently have of they criticised the services, for example, Gugu, has already been cited earlier as stating: "*You know people are not the same. Some of them they are high some of them they are right so you can't say the clinic has got a problem.*" Such a sense of appreciation for the clinic services created some tension, in that the women were reluctant to criticise the unit. This reluctance may stem from a fear of losing a valuable resource. Sandra (below) uses the phrase "*give me what I want*". Across the dataset, SRHC services were considered good in relation to providing STI/HIV medication, and not necessarily in relation to overall care, or the provision of broader SRHC service offerings. Sandra commented as follows:

> *er:: I can say I didn't find any problem when I go went to the clinic. They are always right to me. even if I go to the Esselen clinic they always alright to me ...they give me what I want I (.) don't see any problem. Yes:: (*Sandra*)*

The literature highlights the disease-specific focus of such projects in displacing patients from additional and increased general needs (De Maeseneer et al., 2008; Atun et al., 2008). Participants indicated their need for additional services such as integrated prenatal, birthing and childcare services, integrated SRHC and TB services, as well as readily available services to treat high blood pressure and asthma. Many of these forms of health care are currently a gap in the service offerings of verticalized healthcare programmes. Some participants mentioned the following:

> *I only wanted to test if I don't have TB* (Cindy)
>
> *N::o::: I want to do another ser ser this thing ((shows me asthma pump)) you know what* (Beauty)
>
> *the phone number is here ((pointing to participant info sheet))…O::h I need it that* (Lindiwe)

Participants who accessed services in a generalised healthcare setting or outside of verticalized sex worker-specific healthcare initiatives appeared better able to access a complete range of SRHC. Their accounts also suggested that they were more confident in doing so and that they had a more positive outlook on SRHC, as exemplified by the comment by Katlego:

> *Some other private dr they can help you properly but ei most of them I don't think they gonna give you the best treatment like at the hospital. Because like sometimes at the hospital they can take you to the theatre and check everything. Or maybe they see something that is serious they can call the social worker talk to you and (.) so that's why I prefer the priva government hospital* (Katlego)

The extract above suggests that accessing SRHC in a general health setting is conducive to a more positive attitude towards healthcare and a greater inclination to access SRHC. It also allowed participants an integrated healthcare experience in addressing their SRH concerns. Such data give further support to the argument that although specialised healthcare services offer what at the outset appears to be an environment conducive to a vulnerable population's accessing certain SRHC services, they may unintentionally displace the same women from the full range of SRHC service offerings. This in turn reinforces the displacement of sex workers from their basic human rights, whether through the criminalisation of the population or discrimination against sex workers for their perceived role in the spread of disease. Wilson and Neville (2008) also point out that vertical programmes offer problem-focused approaches to SRHC, but do not necessarily incorporate individual health needs or experiences, and tend to negate the varying individual contextual dynamics of the population. Hence, in such programmes, SRHC is not offered to sex workers in line with their maternal or new-born needs, for example.

This evidence is supported by a number of studies that call for the decriminalisation of the profession in equalising legal, economic and health opportunities (Richter, 2008a, 2008b; Richter et al., 2009; Sisonke, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a). However, few of these authors call for maternal projects in aligning sex workers with a more complete identity.

The existing literature highlights the poor uptake of HIV services (Youth Lens on Reproductive Health and HIV/AIDS, 2008). The World Health Organisation (2011) reports

that in South Africa, only 55% of individuals who require Antiretrovirals (ARV) services use them. Such findings are indicative of the failings of vertical healthcare programmes to provide better coverage to those most in need. The gaps in care offered to participants with co-morbidities such as asthma and TB are further evidence of the need for improvements to healthcare service offerings, where access to SRHC would be improved through offering a wider range of services and improving the reach of such programmes.

Additionally, the inequalities and poorly resourced healthcare system described by participants could partially be attributed to the inadvertent negating of government responsibility to improve resources through private funding of specialised services. Some existing evidence suggests that using private funding in developing vertical healthcare programmes to scale-up public access obfuscates governments' responsibility to provide effective healthcare (De Maeseneer et al., 2008). In this way, healthcare risks becoming the responsibility of external funders and not of the South African government. This implies that, if such funding stops, such programmes cease to exist and clients are required to re-integrate into a public healthcare setting which has never been improved.

It should also be noted that the failure of healthcare service providers to match their interventions to the target population is a key reason for the underperformance of various SRHC programmes (Kurth, Celum, Baeten, Vermund, & Wasserheit, 2011; Padian, McCoy, Manian, Wilson et al., 2011). In this regard, participants indicated that their accessing of SRHC was tensioned between their actual (wider) needs and the needs aligned specifically with their profession by service providers. On the one hand, sex worker-specific programmes purported to offer non-discriminatory treatment (although this was not consistently reported by participants). On the other hand, vertical programmes offer highly specialised services to women who require far broader SRHC and general healthcare services.

#### *4.2.3.1 The condom as a politicised object*

The condom has held a political licence over sexual morality since the 1940s when governments and corporate enterprises failed to respond to the need for condoms as an STI prevention strategy (Gamson, 1990). Opposition to condom use is still driven, as it has been since the 1940s, by the Christian Church's abhorrence of its use because it is claimed to

promote premarital sex. It has become a political object (Gamson, 1990). The developing medico-moral discourse surrounding the HIV pandemic has created a discourse of judgement, relating the disease to "God's punishment". The condom has been imbued with the meanings propounded by this discourse (Seidel, 1993), affording this inanimate object great political power (Gamson, 1990). The recent focus on HIV/AIDS has seen the condom evolve into a means to secure the health of the populace and ensure the economic viability of South Africa. However, despite an increase in "condom education", the pandemic continues to grow. This political icon of the HIV pandemic carries with it a message of vectorship which may be problematic in itself, especially in the case of a marginalised population.

The condom has come to represent the fight against HIV/AIDS, and it is widely distributed across South Africa. Free condoms are available through clinics and NGOs advocating safer sexual practices and the uptake of preventative strategies. This was reflected in the data set, as the participants reported that they were able to access condoms freely using a number of different avenues.

> *from Esselen Clinic and ward 21 when I go there I collect them* (Tumi)
>
> *no you see if its finished there I go to the clinic myself. But even them those ladies ((referring to Sisonke)) … they used to bring it* (Gugu)

The intensity of the present biomedical focus on HIV, and a concomitant emphasis on the importance of condoms as a preventative method, was also widely evident. The use of condoms proved to be an interesting aspect of SRHC related to sex workers. Participants' stated that condoms were infrequently used as a contraceptive measure, but were rather ued in relation to the spread of disease. Condom adherence was usually reported prior to prompting, strongly suggesting their fear of judgement and a vectorship discourse associated with both condom use and with sex work. Despite the high self-report rate of condom usage, participants' fear of spreading disease was indicative of the internalisation of the discourse of sex workers as disease vectors.

> *no like right now I don't have when I use or when don't I use cos of my status I always use condoms.* (Tumi)
>
> *<u>NO NO</u> all the time Nohohohoho!! no condom no game … cos I don't know what he will bring for me or what sick I will give to him… so I think the most important thing*

*what they ((medical personnel)) will like to know is that I'm using a condom or I don't using a condom* (Katlego)

The majority of participants indicated a morality associated with the use of condoms. Such accounts suggest that liability or blame is apportioned to sex workers for the spread of disease. Condom use is therefore perceived as a moral imperative by the participants, because they as sex workers are "sexually risky". Thus sex workers have become the target of multiple "condomize" initiatives, as recounted by the participants. These initiatives include SRHC facilities and sex worker advocacy groups, all of whom distribute condoms and ask about condom use. While the need for condoms is vital to reducing sex workers' risk, the mass distribution of condoms to sex workers as a group and constant probing about their condom usage has by implication apportioned blame to them for the spread of HIV. This is highlighted in the excerpt below:

*JC: if he doesn't want a condom*

*SANDRA: no we can leave it … no no I don't want his money no matter he put another money I don't want it… I want a condom… ((slaps lips together. She is very reluctant to answer this question)) .hhh when I found out that I'm HIV positive in 2007 so I don't want to risk … So that's why I'm using condom always*

Fear of spreading disease rather than self-care was regularly cited as the reason for using condoms. Accounts given by participants indicated an internalisation of vectorship, which, while encouraging condom usage, created fear of being discriminated against when seeking SRHC. A comment by Gugu exemplifies the attitude the participants are faced with:

*when they check you they say yah m:: even your discharge is smelling. It shows that you just sleep without condom* (Gugu)

Many participants initially stated that they always used condoms. Probing, in line with the work of Stadler and Delaney (2006), frequently revealed this was only applicable to new clients. Condoms were not as frequently used with regular partners and/or clients. Such irregular usage increased the participant's risk of SRH complications. This, coupled with the medical response towards such populations, inhibits access to SRHC by highlighting the sex workers' "deviance" from "normalised" sexuality, followed by consistent condom probes at health-settings. Such probes are laced with moral judgements about condom usage or the failure to do so. However, it should be remembered that research has shown that in South

Africa it is "normal" heterosexual couples who holds greater responsibility for the continued growth of the pandemic (Venter, 2011).

Sex workers reported being unable to negotiate condom use when confronted by client violence. On being asked about condom usage, Beauty replied:

> *yes I use a condom ((very emphatic tone))… always… No if he doesn't want, I'll leave… u u unle u u you see when you you you first came here as like me. When I start to be prostitute (.) 2000 (1.0) ei it was my bad luck (1.0) because e (.) sometimes I get the uh rough customer he's going with a car so he say lets go so we go somewhere (.) when we there ah:: when when we there he said no uh bitch I don't want a condom and then he will (1.0) ((zulu word and indicates being strangled with her hands on her throat))… ya and then he will FUCK YOU without condom (*Beauty*)*

Her inability to negotiate consensual and safer sexual practices, coupled with the violation of being raped and the constant discrimination aimed towards sex workers by both popular culture and healthcare workers, makes access to a medical system strongly advocating condom usage particularly challenging. As Gugu has pointed out, medical staff may make judgements about condom usage, or not believe the women's accounts of what happened.

However, at other times, participants were agents of choice in negotiating condom use. Participants such as the one below could be proactive in negotiating usage through leveraging her clients' need for sex in negotiating safer sex:

> *but I don't usually (.) I've never had someone with that no ah I wouldn't say that... others they don't want two condoms. But I u I u a when they don't I just tell them that ok we can stop. B buts its a they <u>do</u> eventually they allow me to put it on*
> (Connie)

Although the current data is in line with existing studies which mention clients' tampering with condoms, or prolonged sex's rupturing condoms (Campbell, 2000), participants reported fearing nurses' retribution if the participants were to contract an STI. Treatment sought after a condom broke was referred to as "*cleaning*", as earlier excerpts have shown. The use of the word "cleaning" in this context is indicative of something being dirty. In this case it was a self-reference, highlighting the participants' internalisation of being dirty and requiring cleaning. The widespread and consistent use of this term across the dataset suggests that medical personnel refer to the "cleaning" of sex workers. Post-exposure treatments which could have been referred to as "*treatment*" or "*prevention*" were instead

referred to as “cleaning”, indicative of being unsanitary or contaminated. Furthermore, the constant reminder by medical personnel that the participants were at risk of HIV may have created a passivity around contracting HIV. This view was expressed by Connie:

> *JC: are you scared of what the results will be [ if you go back]*
>
> *CONNIE: [no I’m not scared I Iits not like the first time ne I was scared of it but (.) ah now I’m not cos it’s because I can when I get aids I can go to the clinic and get pills for free (.) a:::nd there’s only like it’s not (1.0) I’m not that scared no its ok* (Connie)

The condom as a politicised object has been thoroughly integrated in the sex worker community, but, while it reduces sex worker’s risk of contracting HIV and STIs, it further vectorizes the population. The current data, in line with the work of Aulette-Root (2010), shows that the discourse surrounding HIV and condom usage used in medical settings seems to have been adopted as authoritative and dominant, further positioning participants as deviant from the general population. This highlights their perceptions of themselves as morally accountable for the spread of disease.

### 4.2.4 Stigma and fear

The degree of stigmatisation the participants perceived themselves to be subjected to by healthcare personnel was strongly evident in the participants’ accounts. Stigma was enacted on all levels of healthcare, in both integrated and vertical programmes, towards women and towards sex workers. Gugu, as seen earlier, gave an account of the intensity of her humiliation when she was discriminated against by a nurse from a sex worker-specific programme:

> *When you reach there some they put their (.) hand glove where they put their hands in you when they check you they say yah m:: even your discharge is smelling. It shows that you just sleep without condom. While it’s not like that infection is infection. You don’t know sometimes you got it in the toilets. So (.) the nurse are not the same. Even show you looks how it looks but you are a lady it even smelling ((she is holding up two fingers as if discharge is on it and it is being shoved into her face as if the nurse has done this to her)) (3.0) so I we we just keep quiet ... Sometimes you got infection but they don’t give you stuff for infection they give you B-co and vitamin (.) it don’t help nothing mos* (Gugu)

She later pointed out that she self-medicates when she does not trust the clinic staff's diagnosis or treatment:

> *I went to the clinic but those tablets didn't help me. so I end up buying you see those those like a (stay) for a babies e:::::..those one like stuip dripels or (hermans) or ja. I buy another thing I forget what but it written you can pour inside so now I that thing has finished because I was drinking and pouring because those tablets didn't help me* (Gugu)

The participants recounted being subjected to inconsistent and often inhumane and discriminatory treatment, whether as sex workers or as women accessing healthcare services. This in turn made accessing SRHC increasing challenging, as it displaced the participants from a human rights-based discourse by reducing their awareness of their civil rights.

Such an account suggests that as sex workers seeking SRHC, participants could be displaced from basic human rights through cruel and degrading treatment. Moreover, such humiliation in the healthcare system created fear of future discrimination. This fear of pervasive stigma hindered access to SRHC through a debilitating fear of medical professionals taking such action against them:

> *° you know that stig that stigmatizing hey (.) if maybe you are with some some other patients maybe they tell the nurses this is a sex worker so I wont feel free*° (Connie)
>
> *I don't know or me I III don't know I don't know I don't know that how is she going to react if she find out that me I am a sex worker and I need help* (Pretty)
>
> *JC:... did the dr the hospital and jhb gen did they know that you do sex work?*
>
> *BEAUTY: No I didn't I didn't tell*
>
> *JC: why (.) what why didn't you tell them*
>
> *BEAUTY: (laughs)...(1.0) ei (.) eish I'm scared...[I was] scared (2.0) you see this thing we are doing (1.0) is not fine. but we are doing but is not ok. I don't want to lie to you. NO it's not ok (.) really we are just using our body (.) actually (.) but (2.0) its ok*
>
> *JC: what do you think the dr's or the nurses will do if you tell them. D do you worry about that?*
>
> *BEAUTY: uh No I don't think so because the people is not the same. So I I can't judge somebody (.) without talking No I can't judge it*

*JC: but do you think they'd judge you*

*BEAUTY: YA I think so ((nervous giggle)) ya I think so*

*JC: what do you think they would do, not treat you or that they would what do you think they would do when they judge you?*

*BEAUTY: I I I think he would not treat me as like a human being* (Beauty)

Participants indicated that they felt unsure how they would be received by either nursing staff whom they did not know or by nursing staff who discovered that they were sex workers. In line with an existing evidence base, this suggests that their fear of discrimination becomes debilitating in accessing SRHC, becoming a barrier to access (Scambler & Paoli, 2008; Stadler & Delaney, 2006).

The shame associated with sex work is frequently debilitating, in that sex workers are unable to speak openly about their work (Scambler & Paoli, 2008). This was evident throughout the interviews with the current participants – participants would indicate feeling unable to ask for a treatment, having to accept the treatment offered, or being unable to negotiate safer sexual practices in an environment which should be geared to improving their SRH.

In the example below, Pretty mentioned using a sponge to enable her to work while she menstruated. Despite the potential health implications, her economic situation and family dependants necessitated that she continue to work. The nursing staff warned her of the dangers of this practice, but they did not offer her an appropriate alternative, nor an environment in which she could negotiate an alternative and a healthier or less risky solution. Hence, she keeps her "intervention" a secret to retain the nurses' approval; however, as she states shortly afterwards "*this year I didn't go to the clinic*". The positioning of this statement in the interview indicated that the response from the health sector had made her less inclined to access SRHC regularly:

*I went again with the problem of the sponge… the sponge you know they ((other sex workers)) say they told me that if you are on periods and you want to work you put the sponge. So I put it. So but to come out was difficult. So I just told myself that I better go straight to the clinic… they just put their hand inside and put it outside… I put it today and then in the night and I went to the clinic tomorrow… e'ya they speak to me nice because they tell me that I must not use the sponge again because the sponge is::: dangerous…even now I'm still using it. I just put e e e Vaseline on top of*

> *it and then put it… ya. Ya but this time I don't stay with it for long time… ah haai this year I didn't go to the clinic. I think I went last year I wanted to put injection but I went once* (Pretty)

Despite the fact that she said the nursing staff "*speak to me nice*"*,* Pretty removed herself from clinic settings to avoid further incidents. She went on to admit that she cannot tell the nurses that she is still using this technique. In the case of clinics outside the scope of the sex worker-specific programmes, fear of discrimination led participants to engage in clinic card swapping, and withholding information linking them sex work.

Migrancy is another area which may pose a problem in seeking healthcare. Migrant status was a point of fear for those participants who came from a neighbouring country. Cindy, describing a harrowing birthing experience, stated: "*I just told myself wow I'm in South Africa let me just behave myself. H: cos I was afraid.*" Such a statement alludes to the need for migrants to behave in a particular fashion so as not to anger medical staff. Migrancy was also highlighted by other participants as being a factor which displaced some sex workers from SRHC. Accounts were given of medical staff withholding treatment from non-South Africans:

> *°°ya me I I I °° °think like that because sometimes you come to ° see like if you are a foreigner you went to the hospital they don't treat you like (.) a citizen of South Africa. Others they complain that hey the nurses say bla bla bla bla bla bla m::* (Pretty)

Studies by Matzopoulos et al. (2009), Richter (2008a) and UNAIDS (2009b) highlight the challenges to accessing SRHC for migrants in South Africa. Additionally, Coovadia et al. (2009), Campbell (2000), Johnson et al. (2007), Richter (2008a) and Wojcicki and Malala (2001) have highlighted the plight of migrant sex workers, and their increased risk of SRH complications.

Accessing SRHC services was reportedly easier when participants did not fear that it would be discovered that they are sex workers. In such situations, participants indicated a greater sense of control by speaking about SRHC with more confidence. They also indicated less fear of being publically exposed as sex workers:

> *JC: there do you think you could tell them?*

> *KATLEGO: I can tell them they don't have a problem with me. because when I go most of the time I take the condoms there. Maybe most of them they start to ask whats going (h) on I always get the c(h)ondom. .hhh but I'm there's nothing to be ashamed of by m:: because all they used to be ashamed of people who are trying to help you you are not ashamed of people you don't know from the street* (Katlego)

However, this was not always the case. Experiences of healthcare were incongruent, not only between participants' accounts, but also within participants' accounts. This is suggestive of inconsistencies in service provision. Such constant changes in the treatment received by participants perpetuated fear of discrimination. This occurred through discrimination being a possibility at every healthcare encounter, irrespective of the service provider. In dealing with shifting and often discriminatory treatment, participants had developed a number of coping strategies.

#### *4.2.4.1 Coping strategies*

The criminalisation of sex work in South Africa has created a discriminatory system in which sex workers must function (Fick, 2006; Richter, 2008a, 2008b; Richter et al., 2009; Sisonke, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a). In coping with such discriminatory practices and the concomitant cycles of blame, and the positioning of sex workers as vectors of disease, resistance towards the medical system was evident. This translated into avoiding the healthcare setting completely, through silence in disengaging with the health system (as indicated above) or through waiting for prolonged periods before accessing healthcare. While these strategies allow the women to circumvent the impact of negative feedback, they impose a framework through which they are enabled to access or prohibited from accessing healthcare services.

##### *4.2.4.1.1 Identity management strategies*

Participants alluded to the care with which they managed their identities in varying contexts. Keeping the fact that they are sex workers a secret has already been broadly discussed. Participants also engaged in "normalised" identities and activities to ensure access to SRHC. This was frequently done in relation to pregnancy, when the women were very obviously afforded an alternative point of contact with the health system. Participants reported taking their partners along for monthly scans, or engaged in sex for pleasure. Connie and Five offered examples of such actions:

*When I was pregnant my boyfriend was there … it was natural but there was nothing wrong* (Connie)

*E'YA YA I'M A WOMAN A WOMAN I SUPPOSE TO GET MY MAN* (Rosah)

Almost all the participants rented a flat or room outside the city centre. This allowed them to engage in traditional activities such as parenting, caring for the elderly or interacting with neighbours in various ways and they concealed their sex worker identities in these contexts. This finding is in line with the work of Campbell (2000), who highlights the importance of traditional roles, and that being displaced from these roles is a critical factor in sex work. The management of such identities in the general population allowed for participants to be assisted by lay persons in time of need. As an example, participants who went into labour or collapsed due to gynaecological complications were assisted by neighbours, family or friends:

*I nearly get my baby inside inside the house … but fortunately that someone called a ambulance then they come quick* (Joyce)

The findings were in line with the work of Sparkes (1994), showing that participants managed how, when and where they displayed their sex worker identity. This means that they controlled who saw them as sex workers and under what circumstances. Being able to regulate public displays of their sex worker identity gave participants a greater sense of control over their lives. A greater sense of control in general increases the likelihood of seeking SRHC. In particular, the ability to compose an alternate "normalised" identity in healthcare settings encourages access, as it reduces the fear of being identified as a sex worker.

One way of managing their identities was for the participants to engage in clinic card swapping:

*CONNIE: there'd like 3 clinics in Soweto… they don't say anything as long as you want them. Even if you want something to clean yourself they don't ask you they just give you what you want and then check you*

*JC: ok and um at that clinic do they know that you do sex work?*

*CONNIE: no I I uh I don't tell them… cos the only thing I do ne when I go is I don't use one card I change the card that they give me ne I change. I make (h)another one when I go there. I don't use one trace who are*

*JC: ok and why do you do that*

*CONNIE: cos I wanna clean myself ne I have to lie and say my discharge is so so that I can clean myself*

*JC: so they can't link you [and say that you're in sex work]*

*CONNIE: [say my name]*

*JC: ok ok (.) w what are you scared of if you keep the same card and they find out*

*CONNIE: maybe they would ask me and I would have to tell them what I do. I don't know what the person will say when I tell that I don't know what. So. so, I think its better when I do it like that… you'll be scared you wont get help so they just do what you want and then you leave* (Connie)

The excerpt above begins with Connie's implying that access to SRHC is easy via Soweto clinics. However, as the interview continued, it became apparent that her fear of being discovered to be a sex worker is severely hampering her access to equitable and effective SRHC. As Connie reports, card-swapping allows her to access healthcare when needed without fear that her sex worker identity will be discovered. The risk for her is that if she is seriously ill, has related treatable ailments or medications which are incompatible with one another, none of these problems are ever effectively addressed due to the lack of information available on any one of her clinic cards.

Her actions reflect not only the harmful effects of discrimination, but also how, across the data set, the women felt the necessity to either protect their family from the disgrace of sex work or to protect themselves and their children from the potential for retribution by family or community members (this topic is also discussed under social networks, see Section 4.4.3.). The participants' perceived powerlessness in the face of discrimination resulted in a number of management strategies, but these further displaced them from care. The fear of being discovered to be sex workers in an unknown setting necessitated keeping their sex worker identity a secret. They would employ this strategy even though at times they knew a particular healthcare worker, which gave participants a greater sense of ease in seeking SRHC.

Across the dataset, the participants seemed to perceive themselves in two distinct ways in relation to SHRC. The first identity was that of the sex worker, who is an undervalued and dehumanised object for male sexual pleasure. In strong contrast to this, there is the identity

of a woman who is a mother, daughter or wife and who requires access to a complex range of SRHC services, in line with her role as a more complex and complete being. In this latter role she is often more determined to access SRHC. The use of vertical programmes in providing SRHC to sex workers was shown to reinforce the distinctness of these identities. This is evident from participants' speaking about people from the "*outside*" as not liking sex workers, versus people who work with sex workers and understand them:

> *most of the people outside they don't like sex workers (2.0) that's why I say maybe I don't know. I'm not sure* (Sandra)

The sex worker role requires that participants "clean" themselves for their sexual duties. The healthcare which they have access to in this role is in relation to their cleanliness as objects for men's sexual gratification. As mothers and wives, they required and sought out broader SRHC when they were pregnant, birthing, or required a pap-smear. In this role, participants were responsible about their ARV regimes, they regularly checked womb pains, or would go for monthly pregnancy scans at the clinic.

Interestingly, while the participants appreciated the better treatment offered in sex worker-specific programmes, their accessing of these services was complex and tensioned between the need for SRHC services and their immense desire to be recognised as complete women. While participants who strongly identified with their sex worker identity struggled to understand the care they received from these projects; women who strongly aligned themselves with a complex identity chose to access a wider range of SRHC, often through generalised healthcare settings. However, accessing integrated healthcare services frequently necessitated concealing their sex worker identity, as is evident below:

> *°when is it hard° ((thinking))… if I don't go to the Esselen clinic or I want to go somewhere no I I don't think it is difficult because I I won't tell that that I'm a sex worker ya ya* (Pretty)

Participants who identified themselves in more complex ways and who reported greater confidence when dealing with clients, also reported confidence in accessing a broader range of healthcare services outside of sex worker projects, with very little reported anxiety. However, they hid their sex worker identities from the healthcare professionals they dealt with. The hiding of such an identity indicated that, while they were able to view themselves as productive members of society contributing to their own and their families' wellbeing,

they were not unaware of the implications of being a sex worker and retained the shame associated with this work. They frequently accessed public SRHC services independently of their sex worker identities, but reported some unpleasant incidents where the women's primary work was discovered.

#### *4.2.4.1.2 Silence*

Silence has previously been found to be a coping strategy when dealing with traumatic events (Tankink & Richters, 2007). Participants frequently mention being silent in relation to accessing SRHC, to maintaining social relations or to their inability to express immense sadness and anxiety about their work. The earlier comment from Gugu, who experienced extremely inhumane treatment at the hands of a nurse, is cited again here for its pertinence in showing the use of silence as a strategy to avoid conflict in a healthcare setting:

> *When you reach there some they put their (.) hand glove where they put their hands in you when they check you they say yah m:: even your discharge is smelling. It shows that you just sleep without condom. While it's not like that infection is infection. You don't know sometimes you got it in the toilets. So (.) the nurse are not the same. Even show you looks how it looks but you are a lady it even smelling ((she is holding up two fingers as if discharge is on it and it is being shoved into her face as if the nurse has done this to her)) (3.0) so I we we just keep quiet* (Gugu)

As is evident above, such callous treatment by medical professionals frequently remained unchallenged by the participants, who chose silence as a coping strategy to contain a potentially explosive and hurtful situation. In this instance, rather than challenge the nurse on her assumptions, Gugu chooses to remain silent, to some degree defiant in her mind. She is determined to get "*what they give you and leave*". This finding corroborates that of other studies which have found silence to be an important and useful tool in managing conflict (Jewkes, Penn-Kekana, & Rose-Junius, 2005; Nduna & Jewkes, 2011).

In sub-Saharan Africa, silence is often valued as a sign of maturity and valued as a mechanism for controlling one's emotions (Richter & Panday, 2006). However, silence can be very damaging in a number of ways. Firstly, it prevented participants from expressing their needs, or challenging the dispensing of medications they deemed inappropriate. The powerlessness which this created is an obstacle to their access to SRHC (Campell, 2000

2006). In addition, the use of silence constrained participants from presenting a full clinical picture to the nursing staff:

> *so the time they ask me you got another file I said no cos I've already opened the file already I just leave it like that* (Rosah)

As has already been explored, Rosah has very serious SRH complications and has undergone multiple treatments, problematised by confusing diagnoses. This account suggests that her desperation to be swiftly treated and to avoid confrontation with nursing staff led her to open a new clinic card, inadvertently further complicating her diagnosis and treatment.

Silence was also frequently used to maintain the status quo in a social context in general, and in family relations in particular. This was evident from participants' keeping their sex worker identity a secret, not only for fear of discrimination enacted by family members, but also to protect family members from the shame of sex work:

> *P1: ya:: like you know with your parents its very difficult for me to just go tell my mum that thats the work I'm doing you know they*
>
> *J: ya*
>
> *P1: ya its very difficult for me to confront my parents*
>
> *J: do you worry about about that they would be angry with you that they would beat you or be sad. Like what's the::: (.) tell me*
>
> *P1: I don't think they would like it ya. And as a child I do respect my mom and I respect my parents and my elders and sisters and brothers I wouldn't like them to know this* (Cindy)

Nduna and Jewkes (2011) highlights protecting family members and avoiding conflict as a feature of their work on silence amongst young people in the Eastern Cape, South Africa. While such a coping strategy in situations not directly related to SRHC does not directly inhibit access to SRHC, the cumulative effect of being unable to express or discuss emotional aspects of their work is critical to sex workers' mental health and hence had an impact on their access to SRHC:

> *if I have a problem I keep quiet if it heavy I open my room close my room cry a lot so that I'm fine, °I'm getting out°* (Joyce)

As numerous prior studies have pointed out, the voicelessness experienced by marginalised people such as the participants in this study is strongly associated with psychological distress, a sense of despair, disempowerment and hopelessness, leading to ill-health. Psychological wellbeing has been highlighted as critical to accessing healthcare (Sidum, Bloom, & Durvasula, 2012). The prevalence of silence reported in this study suggests that poor psychological health may be inhibiting SRH seeking behaviours.

Additionally, silence may be used as a coping strategy because participants felt that they had no voice or would not be heard if they did speak out. In a medical setting, they perceived themselves as not being heard by decision-makers and key personnel. The discounting of the value of a suggestion box, as argued earlier, is a prime example of their perception of being voiceless.

Similarly, the policing system does not hear their pleas for mercy or their cries for help when they are abused. When both the public protectors (the police service and the health service) constantly devalue and discriminate against sex workers, they are frequently considered to be connected (DeMarco, Miller, Patsdaughter, Chisholm, & Grindel, 1998). Hence, both systems represent an undervalued and voiceless context for the participants. This perpetuates a generalised fear of healthcare, which is discussed in great detail under the requisite theme (see Section 4.3.1.1.2).

#### *4.3.4.1.2 Denial and avoidance*

In line with the work of Fredrickson and Roberts (1997), it was found that the shame surrounding sex work created an immense need to hide and escape the gaze of others, including that of healthcare workers. This culminated in the avoidance of the healthcare setting. In doing so, participants chose to wait for prolonged periods before accessing SRHC.

Moreover, the cumulative effect of the multilevel discrimination through police action, healthcare worker interactions and public displays of discrimination led participants selectively to "tune out" their sexuality and SRH needs in dealing with their daily working lives. This was evident through the self-objectification displayed by participants when they described their bodies, discharge or vaginal sores in line with biomedical discourses. Participants could describe physically visible problems very articulately (for example, as Lindiwe, below, does), such as a discharge or vaginal sores:

*I don't have some discharges. They are normally like human I gegh ((very guttural sound))* (Lindiwe)

However, their accounts suggest difficulty in articulating less visible concerns, pain or emotional distress. Such findings indicate a struggle in attending to their physical needs, and in caring for themselves. As a prime example, most participants initially denied the need to speak with someone about their experiences, only whispering a need for emotional support once the interviews were complete, and recording had ended. This showed the vulnerability they felt about this need, and their struggle to articulate such a need. This habit of denying and avoiding their physical and emotional needs is a critical inhibitor of access to SRHC. Moreover, other forms of denial were discernible in the data, with an impact on health seeking activities:

*CONNIE: m::: I (.) went (2.0) oh I went to test uh they said I was negative I was supposed to go back for a window period but I didn't*

*JC: ok why didn't you*

*CONNIE: I don't know ((laughs))(h) I don't even know how I went to test I I don't know I just did it. I thought maybe I just told myself that I was negative I'll go back I don't know when and test maybe* (Connie)

One participant displayed denial through a lack of fear of her risk, or the severity of contracting HIV:

*no I'm not scared I Iits not like the first time ne I was scared of it but (.) ah now I'm not cosits because I can when I get aids I can go to the clinic and get pills for free*.

In the face of a medical system which deems patients and sex workers in particular as inactive or passive agents, participants highlighted the struggle they face in self-care. Contracting HIV is perceived to be an inevitable factor in sex workers' lives. However, Connie's denial of the severity of this possibility enabled her to continue working while minimising the need to regularly check her status. In this she aligns herself with biomedical discourses of being passive in managing her health, but in this case, to the detriment of the HIV cause:

*JC: are you scared of what the results will be [ if you go back]*

*CONNIE: [no I'm not scared I Iits not like the first time ne I was scared of it but (.) ah now I'm not cosits because I can when I*

*get aids I can go to the clinic and get pills for free (.) a:::nd there's only like it's not (1.0) I'm not that scared no its ok* (Connie)

The reductionist biomedical approach discussed earlier led participants to access SRHC infrequently and irregularly, while engaging in delay and denial tactics. Such a tactic led to a denial of the importance of services such as pap-smears, of any link between sex work and disease, or of the need for treatment. This allowed the women to delay their accessing of the healthcare system until their health began to affect their ability to work. It also led participants to seek SRHC outside of sex worker projects, keeping their sex worker identity secret in an attempt to reclaim a more complex and complete identity while managing their health needs and avoiding discrimination. In a further attempt to manage their health, they also sought treatments from traditional healers, via religious practices or through self-medication.

Below, Katlego, who stated that she did not use the sex worker-specific programmes, went on to argue that while diseases may be contracted from sex work, this could be related to the dirty environment in which she works, and not to the sex aspect of sex work: "*no I mean that maybe when we breathe maybe I don't know.*" Her denial of the role which sex has in diseases is evidence of a denial of a link between sex work and SRHC problems. Participants repeatedly denied the link. Coupled with a strong biomedical focus from political HIV agendas they stated that HIV was the only disease related to sex work:

*no:: I I I can't say because I'm not sure maybe its from here or where I go. But the way I see it is maybe its from here because sometimes you find a condom lying all over so you never know… no I mean that maybe when we breathe maybe I don't know* (Katlego)

*JC: and you don't get sick from your yo any other sick (.) from your job*

*SANDRA: other sick no no* (Sandra)

*A:::ll of us: we are sick… (.)HIV* (Beauty)

However, such denial appeared in many complicated forms, and participants oscillated between acknowledging the dangers of sex work and denying their existence. On the one hand, their denial was as a direct result of the biomedical focus. Such discourses had been internalised by participants, as displayed through Beauty stating that "*A:::ll of us: we are sick… (.)HIV.*" On the other hand, the women used denial in circumventing the constant

negative medical discourse regarding sex work, while taking a reductive approach to their health risk and denying its existence. This approach allowed them to engage in minimal contact with the health system, as they perceived their risk of SRH complications to be low. By adopting this strategy, they are able to continue functioning as sex workers under the guise of minimal health threats. Such an attitude is important to their functioning, as participants indicated that they felt they had limited to no additional options for economic survival. Since sex work has become the economic cornerstone of their existence, it necessitates a denial of health threats to ensure that continuing this work remains feasible as a money-generating *business*.

Rosah offered one example of long-term avoidance of the medical system. During the interview, she described on-going womb pains which she has experienced for more than ten years. Her attempts at accessing healthcare were rife with instances of being objectified by the medical system and her continued avoidance of a confusing and uncaring health system. This led her to develop a severe SRH complication, evidenced in her physical and emotional state at the time of the interview. Although the pain was chronic and was recurring with increasing intensity, she avoided seeking consistent healthcare to address the ailment. Her denial of the severity of the problem, delays in seeking care and attempts at managing her pain through alcohol consumption meant that effective access to treatment had been impossible.

#### *4.2.4.1.3 Focusing on an end goal*

Participants' focus on obtaining medication as a mitigating factor in tolerating nurse or doctor abuses was evident:

> *But they shouted at me and I told myself that I just wanted what I wanted and then I'm leaving* (Connie)

Participants frequently used the adjective "fine" in relation to unfair treatment or even in relation to violence. It was as if they expected nothing less than to be abused and poorly treated by the broader community. Such internalisation and self-objectification seemed to suggest their complete acceptance of their lot in life, as reflected in the use of the word "fine" with regard to violent or ineffective healthcare:

*whenever you go find a different dr don't find one dr find different dr's everyday but any way they fine… ah:: I'ya:: you know it's difficult but that's how it is and that's fine* (Cindy)

As it stands, access to SRHC for these participants and probably many other sex workers, is tensioned between the services available to them and devised specifically for sex workers, and their needs as mothers and women. It is further complicated by a healthcare system which is strained to the utmost to meet the most basic of human rights in providing health services. In addition, discrimination enacted across SRHC settings causes widespread fear of exposure, resulting in coping strategies which further hinder access. Such problems are further compounded by the violence which these women are exposed to daily, which increases their fear of discrimination while rendering them increasingly vulnerable and ill-equipped to cope emotionally.

## 4.3 Displacement through Violence

Violence is considered a criminal justice, human rights and health issue. It has the highest impact amongst those with low education, where there are poor employment rates and little housing security, high population densities and an elevated HIV risk, as among these participants. The World Health Organisation defines violence as the "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation" (World Health Organisation & Global Campaign for Violence Prevention, 2008).

Violence proved to be an important influence on sex workers' health and access to SRHC. It not only increases the risk of complications, but also inhibits access to SRHC. According to Lichtenstein (2006), violence is often an unrecognised barrier in women's ability to access HIV medical care regularly. The dehumanising treatment which participants mentioned and constant sexual objectification appeared to legitimise their rape, beating, torture and other forms of victimization (Fredrickson & Roberts, 1997). Consistent with prior evidence (Leggett, 1999, 2001; Richter, 2008a; Scambler & Paoli, 2008; Stadler & Delaney, 2006; UNAIDS, 2009b; Wojcicki & Malala, 2001; World Health Organisation & Global Campaign for Violence Prevention, 2008; SWEAT, 2011a), the current data show that violence originates

from two distinct groups: clients and police. Hence, two major subthemes were identified: *Police brutality* and *Client violence*.

Police brutality had a direct bearing on SRHC by increasing participants' risk, while actively withholding access to healthcare services from them and compounding a generalised fear of healthcare services.

### 4.3.1 Police brutality and harassment

Police violence featured as a critical aspect of sex workers' access to SRHC. As a criminalised population, sex workers frequently fall under the control of the police. Geared to the protection of the public interest and imbued with massive judiciary powers, police expend substantial energy in the management of this allegedly deviant population. Such enactments of power mean that sex workers are often at the mercy of police officers who frequently abuse their position of power (Richter, 2008a, 2008b; Richter et al., 2009; Fick, 2006; Sisonke, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a).

According to the participants, this was done through the ratification of discrimination in punitive and often violent ways. Such actions actively increased participants' risk of SRH complications, while further displacing the women from SRHC services. Participants described being subjected to police torture and violence, bribery and rape, as well as the withholding of healthcare in acts of brutality. Such violent treatment of participants created a generalised fear of healthcare services. Thus, the police function as a critical barrier to the participants' accessing SRHC.

#### *4.3.1.1 Enactments of discrimination*

South Africa has ratified many international charters on Human Rights (Bruce, 2002), yet police harassment and brutality continue unabated. The impact for sex workers on both their SRH and their access to SRHC is dramatic. In line with existing research (Richter, 2008a, 2008b; Fick, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a), this violence was found frequently to take the form of extorting bribes of money or sex in exchange for freedom, which reinforced widespread mistrust of the police. The intensity of police brutality was evident from the participants' reports of frequently being raped, beaten, and pepper sprayed (both in the eyes and genitals) by the police:

*last month I was arrested here by police and they arrest us for loitering so when I was there in police station John Vorster I told them that um:: I'm in treatment can we can they take me to go to my place and collect my treatment cos I'm on treatment and they didn't want... I was very veryvery cross:: that day because I didn't find my treatment because of them... I told them I'm taking ARVs they didn't want to come with me and collect my pills so I was not feeling good that day. Yes:: (*Sandra*)*

Participants stated that the withholding of healthcare by police is a critical barrier to their accessing SRHC, and such acts of withholding access to healthcare were repeatedly found in the data set. This unconstitutional withholding of healthcare by police from sex workers is well documented in published sex worker accounts of police harassment and brutality (Fick, 2006; Richter, 2008b; SWEAT, 2006, 2011a; Fick & SWEAT, 2006).

South Africa's *Constitution* clearly states that all prisoners should have access to medical treatment (Government of South Africa, 1996). In particular, ARV protocols clearly emphasise the importance of adherence and timely medication in preventing drug resistance (Vervoort, Borleffs, Hoepelman, & Grypdonck, 2007; McIntyre et al., 2009; Bangsberg, Moss, & Deeks, 2004; Sethi, Celentano, Gange, Moore, & Gallant, 2003). As Lichtenstein (2006) also reports, violence becomes a barrier to HIV healthcare. In this instance, the police themselves are a barrier to SRHC, and the underlying message of such police treatment is one of dehumanisation and a lack of worth. As one participant commented,

*They are not taking you as a person, not even as an animal* (Joyce).

Pepper spray was reported to be frequently used by the police in interacting with participants and other sex workers:

*the police they found me inside I was busy with the client then they found me there then they (1.0) ((voice gets thick with emotion)) take the client off me and then there (.) the time I say I want to woke up then the police say no I mustn't wake up I must sleep like that. So they take the pepper spray (2.2) he pepper spray me my va my vagina ((tears running down her face and horror as if she is reliving it)) eish I shouted I cried that day! I cried I run to the (2.0) to get some water so that I can wash myself (.) but even after I wash it it (.) BURNING. I stayed in the house for 3 days for 3 to 4 days! ((sniffs loudly)) if I want to pee it was a problem. ya it was a problem. You know that day I sit down I ask myself that must I quit to be a sex worker? Because eish my vagina was paining was burning (.) inside! after they pepper spray me you*

> *get some snot clap so that you so that they know you cant see their faces and can't see their nametags. ya(.) so eish it was terrible that day* (Pretty)

The above account suggests that although there is clear evidence of the solicitation of sex, the police chose to physically and psychologically enforce their power and dominance over the participant in an attempt to punish her. The literature reveals the regularity with which police brutalise sex workers in this way (Fick, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a).

Pepper spray (*Oleoresin Capsicum)* is the oily residue from the pepper plant. Exposure causes mucosal irritation, with symptoms ranging from tingling to intense burning and blistering or even bleeding. It is known to cause severe respiratory responses (as was evident from one participant's account of an asthma attack following a police attack). Evidence suggests that while some symptoms disappear in a few hours, individuals have been found to display symptoms in excess of three months after exposure (Smith, 1999). Such instances of police violence result in immediate SRH complications, causing potential harm to vaginal tissue (Wilson, 2006; Loening-Baucke, 1997).

Pepper spray is typically used by police as a means to subdue persons resisting arrest. However, evidence from this data set and other research (Fick, 2006; Richter, 2008a, 2008b; Richter et al., 2009; Sisonke, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a) indicates that pepper spray is not required in the course of arresting sex workers. The use of the spray can therefore only be interpreted as unnecessary, illegal, inhumane and malicious. Such treatment creates massive mistrust amongst sex workers of police personnel, and a fear of other legal systems treating them with equal bias (Fick, 2006). This generalisation of fear is a central factor in constraining sex workers' access to SRHC.

In addition to the use of pepper spray in torturing sex workers, the account above mentions the beating of Pretty to prevent her from identifying the (police) offenders. This strongly suggests the officers' awareness of the illegal nature of this interaction. Accounts such as Pretty's attest to the complete disregard for human rights by the very people tasked with upholding them.

Similar cases of police torture have been well documented by sex worker advocacy groups and a number of paralegal organisations (Fick, 2006; Richter, 2008a, 2008b; Richter et al.,

2009; Sisonke, 2006; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a). Bruce (2002) stresses the violent nature of the police force in general. Over a five-year period between 2005 and 2010, there was a 50% increase in attempted murder and a 100 per cent increase in cases of serious assault opened against police officials (Newham, 2011). Not surprisingly, sex workers have become a population actively targeted by police. A 2011 media release by SWEAT criticises National Prosecuting Authority (NPA) guidelines for the management of "prostitutes" by police. The NPA document itself encourages constant surveillance and harassment of sex workers by police (SWEAT, 2011a). Adherence to these guidelines will perpetuate perceptions of the police as insensitive and untrustworthy in their dealings with sex workers.

Participants attested to being unable to report rape or beatings to police due to their intensely discriminatory behaviour:

> *sometimes I get the uh rough customer he's going with a car so he say lets go so we go somewhere (.) when we there ah:: when when we there he said no uh bitch I don't want a condom and then he will (1.0) ((zulu word and indicates being strangled with her hands on her throat))… ya and then he will <u>FUCK YOU</u> …Maybe you call the police he says no or or ya you will call the police and then he will come police when he come he will ask and then what is wrong? And then hei hei …he say ((hand gesture of get lost))* (Beauty)

Sexual violence is an extremely traumatic experience and has serious physical and psychological ramifications (Tankink & Richters, 2007). As survivors of rape, several of the participants received no form of medical assistance. This occurred in complex ways, ranging from police excluding participants from their constitutional rights, through to overt physical violence that constrained direct access to services. The internalisation of such inhumane treatment led to participants' believing themselves unworthy of any human rights. This was reflected in their describing acts of violence such as rape as everyday occurrences and their choosing not to seek healthcare after incidents of rape.

The World Health Organisation (2003a) defines rape as

> …any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. (p. 6)

As Gugu (below) reported, police frequently extort sex from participants. Such acts of violence are perceived to involve asserting control, power and dominance over the victim in an aggressive manner. Participant accounts demonstrate their resignation to being considered sexual commodities.

> *Some when we are arrested we just beg them they just leaveus we gonna pay 50:50 to leave us. They say those 2 they can pay you 2 you must come and fuck with us. I cant go and sleep with police station if he say he want sex I give them sex they drop us I come back* (Gugu)

The normalisation of violence for sex workers coupled with a legal system which, rather than protecting and defending them, is itself a vehicle of abuse and violence produces SRH problems and constrains access to preventative and curative services for these conditions. Control and aggression against them displaces sex workers from actively seeking SRHC. This applies particularly after women have experienced acts of sexual violence, when women are immensely vulnerable and require sensitive medical and police attention. Participant accounts such as that of Beauty (cited earlier) in conjunction with evidence from prior studies (Jewkes, Dunkle, Nduna, & Shai, 2010; Richter et al., 2009; Richter, 2008b, 2008a; SWEAT, 2006, 2011a; Fick & SWEAT, 2006; SWEAT, 2010a) indicates that sex workers have nowhere to turn, even then they are exposed to an aggressive and often violent client base (discussed in the next section), violence enacted by police and violence in the health sector.

Law enforcement should play a critical role in protecting the rights of victims during (and after) acts of violence (Rodriguez, Craig, Mooney, & Bauer, 1998). The South African Justice Department's (1998) *Guidelines for the management of victims of sexual offence* clearly states that "it is essential to try to win the victims trust during the first meeting" (p. 1). The *Guidelines* go on to state that empathy should be shown to victims and that victims should be listened to and comforted. The dismissive treatment that Beauty described is evidence of the gross violation of these guidelines. Moreover, police care is highlighted as critical in improving access to post-exposure care and in ensuring effective criminal prosecutions (World Health Organisation, 2003a; South African Department of Justice, 1998). However, evidence suggests that sex workers are actively targeted by police if they choose to report rape (Fick, 2006). Such police insensitivity and discrimination was cited by participants as a critical barrier to accessing SRHC.

#### *4.3.1.1.1 Money secures freedom*

As discussed previously, money featured as a critical point not only in securing equitable access to SRHC, but also in securing temporary immunity from police harassment. Participants reported being forced to pay bribes to the police as central to securing freedom from extreme forms of police brutality or on-going harassment:

> *some of them don't arrest they just say you and you and the person you are fucking R20 R20 you understand me I take out R20 maybe there are 2 cops the person was fucking give R20* (Gugu)

The current data are strongly aligned with existing evidence bases (Richter, 2008b, 2008a; Fick & SWEAT, 2006; SWEAT, 2010a).

The participants reported that spending their meagre earnings has a twofold impact upon access to SRHC. Firstly, it places additional financial pressure on the sex workers, which results in their having less money available to spend on their SRH. Secondly, the police often demand sex as a currency for extortion. This further reduces the women to a particular kind of citizen – one whose body is more appealing than the money she can pay. Thus the participants were further dehumanised by both formal and informal interactions with the police services.

#### *4.3.1.1.2 Police brutality causes a generalised fear of public healthcare*

Police and medical personnel are supposed to be champions of public protection, giving them immense power over the community. However, evidence shows that both police and healthcare personnel frequently discriminate against marginalised and criminalised populations. The connection between medical and legal abuse in state systems has been demonstrated internationally(Parmet, & Northeastern University, 1989). Such medico-legal abuse compounds fear of both settings in a cycle which discourages access to healthcare. For participants, fear of such discrimination becomes debilitating in their accessing of SRHC, especially at times when these women desperately need it. The closeness of this association was highlighted by Pretty after she had described being pepper sprayed by police:

> *PRETTY: no i didn't go to the clinic I jus:::::: s:: wit in the house I didn't go to the clinic....hh I was °so scared°... I was scared that eish (1.0) hey (.) you know even me I*

*was confused that hey eish maybe I go to the ((voice breaks)) doctor go to the clinic ((regains composure)) maybe (2.0) they will talk me:: (voice trails off)) (2.0) you know. so I was just scared.*

*JC: you were scared that they would also be mean to you?*

*PRETTY: yaeish! Hei! (2.0) you know* (Participant 11)

Such accounts strongly suggest that participants associate the police and healthcare workers with one another. Thus, violations in one sector were associated with either sector, as is seen above. The work of Scambler and Paoli (2008) also shows that such discriminatory treatment has created a debilitating fear in accessing of SRHC. Foster (2007), Freeman (1999) and Hägglund and Wadensten (2007) suggest that fear of humiliation or fear carried over from prior experiences inhibits patients from accessing medical care. Fear is frequently cited as a barrier to healthcare, and such police treatment clearly incites fear. Cambpell, Nair, Maimane, and Sibiya (2005) highlight fear as a critical barrier to accessing HIV services, as do Sierra and Stansbury (2004). The perceived generalisability of stigma and fear across health and the criminal justice system thus appeared to produce not merely pockets of fear but a general distrust of the entire public protection service system.

The significance of this is that sex workers have been abandoned by the public protectors, believing themselves unworthy of access to human rights. With such a low sense of control and internalisation of objectification (Campbell, 2000; Scambler & Paoli, 2008; Fredrickson & Roberts, 1997), they are highly unlikely to access SRHC.

### 4.3.2 Client violence

Client violence was a regular occurrence in participants' reported experiences. It frequently centred on the payment of services. While incidents of intense client violence are central to both risk and access, it is the everyday interactions with clients such as those described by Rosah (below) which highlight the manner in which sex workers are objectified across their daily interactions. Data strongly indicated the high incidence of daily humiliation and degradation at the hands of clients.

*he fuck me fuck me maybe about hour after that maybe you say I'm tired and the thirty rand is small so you can't take long time like this for thirty rand. He tell you I need my release give me my money back. .hhh and if you look at him you see that you gonna be dead or: killed so you just leave him pray to God* (Rosah)

The above excerpt speaks to multiple aspects of participants' daily experiences. While this quote highlights their immense vulnerability to client violence, importantly, it speaks to the participants' economic plight. Poverty impedes SRHC access through two predominant avenues. Firstly, sex workers are undervalued and undervalue themselves. This creates a situation in which they either do not seek healthcare or where they accept poor service or no services as normalised in their already unequal existence. Secondly, they are unable to buy equitable SRHC opportunities, relegating them to using the under-resourced and discriminatory public health sector.

While client violence was described as being unjust, it was often spoken about in a very conversational manner, as if such violence was normal. This is clearly demonstrated in the excerpts by Cindy and Two (below), with the use of "*ya well well with a man you know"*, which is indicative of a discourse regarding widespread, common knowledge of how men behave"

> *he'll fuck you but after that he said I want my money back I didn't cum you see↑ so when you see no I don't want to give your money back he will hit you* (Beauty)
>
> *They just (.) say I'm paid let me do whatever* (Tumi)
>
> *Ya well well with a man you know they always rough. Especially with our work. One he tells you I've paid my money so I really need to enjoy you* (Cindy)

The use of the term "*I've paid my money so I really need to enjoy you*" is in line with much work on sexual objectification and dehumanisation – Fredrickson and Roberts (1997) and Haslam (2006), for example, suggest that such rhetorical devices point to the legitimisation of rape and victimization by an often violent client base. The current study suggests that the risk of violence was workplace specific. Street sex workers felt at greater risk of violent attack. They described the streets as being more unsafe. This finding is very much in line with evidence from prior studies which highlight the plight of street sex workers (Leggett, 1999). With their low social standing, client paucity and limited economic resources, participants often had to choose between travelling with clients or not earning any income. Getting into a client's car is seen as a compounding factor in intense violence; with rape, beatings or even murder being frequent outcomes. These incidents were described without emotion and none of the women sought healthcare after an incident of rape.

*maybe he stab you you die ((slaps hands)) so you do anything. Or he take you he said lets enter in the car like this lets go somewhere in dark place you need money you enter he go and drop you there(1.0) in dark place and he'll maybe take all the things that you have take shoes clothes you remain nothing. Then you come there (.) with leg you you see there are (bills) that you get it in the street there are too much sometimes… it it risky. (0.2) cos (1.0) our life is in danger. Sometimes you gonna get your life in danger place (1.0) sometimes many many girls pass away (1.0) go with guy go with you dark place after that he kill you* (Rosah)

*sometimes I get the uh rough customer he's going with a car so he say lets go so we go somewhere (.) when we there ah:: when when we there he said no uh bitch I don't want a condom and then he will (1.0) ((zulu word and indicates being strangled with her hands on her throat))… ya and then he will <u>FUCK YOU</u> without condom* (Beauty)

The lack of emotion expressed in their accounts of such attacks and reluctance to seek healthcare indicated an internalised sense of self-objectification and discordance between participants' and their constitutional rights. Some prior studies show that violence significantly diminishes a person's ability to access SRHC effectively by creating a sense of fear, depression, feeling ill or worn down, coupled with a sense of being ashamed (Lichtenstein, 2006). Participants indicated their need for counselling and also reported frequent gastrointestinal complaints and headaches. Recent work by Sidum et al. (2012) notes that such complaints may be an indication of psychological distress amongst trafficked victims, making this a likely explanation for the frequency of such complaints. In addition, the World Health Organisation (2003a) notes an increase in somatic symptoms following sexual assault. With Katlego, diarrhoea was the most common complaint:

*sometimes I used to go to the clinic maybe for (.) when I have diarrhoea* (Katlego)

The accounts of the women in this study corroborate other research that suggests that high exposure to violence and the nature of this violence produces an elevated risk profile for SRH concerns and complications. Simultaneously, such exposure increases women's risk of mental health concerns, which in itself decreases their ability to participate effectively in or even seek out SRHC (Lichtenstein, 2006; Sidum et al., 2012). Concomitantly, the normalisation of violence and the internalisation thereof is counterproductive to existing efforts to improve sex worker's access to SRHC. This is reinforced by client-sex worker interactions such as that reported by Beauty:

> *the people is drunk he'll hit you say no I don't want to buy this ((points to her genitals)) (1.2) what is this ((point again)) .hhh* (Beauty)

The account above suggests the demeaning manner in which clients refer to sex workers. In this account, the client's reference to her vagina as "*this*" reformulates the woman as a whole into a vagina. Her complexity is lost and she becomes just "*this*". As the client holds the power in their relationship, her ability to reject the statement is lost, suggesting that she in some sense accepts herself as being nothing more than an object of sex, a body for the pleasure of others.

Client drinking has been found to be a key factor in violence and the degradation perpetrated against sex workers (Rekart, 2005; Jewkes, 2011). Participants described drunk clients as the most aggressive and brutal. In line with this, they argued that the presence of alcohol exacerbated client violence and discriminatory practices. Such findings strongly support prior evidence linking alcohol and violence (Alcohol and Drug Abuse Research Unit, 2006; Rekart, 2005). The participants comment as follows:

> *drunk he'll hit you say no I don't want to buy this ((points to her genitals)) (1.2) what is this* (Beauty)

> *you got somebody that is drunk and then he start to fight you there maybe he stab you you die* (Rosah)

In addition to the on-going cycle of physical violence they were exposed to at the hands of drunk clients, participants' accounts also suggest that clients engage in verbal displays of disgust at sex workers:

> *the client some are understanding some are just rude they gonna tell you like pay me your I gave you my money you have to do what I'm asking for (h)you see .hhh (.) and shame I don't want to lie some other clients are rude rude °rude rude° especially those ones who drink alcohol and ah::… m:: and then he'll come here an make noise "hey you prostitute and what and what and what .hhh and we've got wives at our homes and what you see those thing." That not necessary to come and tell us here on the street* (Katlego)

Such constant and unabated exposure to dehumanising treatment creates a set of risk factors for participants requiring SRHC. This occurs in complex ways and displaces them from human rights, feeding into a cycle of abuse where participants either do not seek SRHC or accept substandard care. A negative self-image is perpetuated by a reductionist client

approach to participants. Clients are central to the perpetuating of negative discourses and internalisations, expending what appears to be a great deal of energy in humiliating and degrading sex workers.

Contrary to the general sense of being valueless, some participants expressed the possibility of earning R1 000 in one night; but this was not common practice and required a very specific set of circumstances. Such circumstances included a wealthier and more generous client, or a white client:

> *the normal it is R30 but others give us R50 or R70 it depend what kind of a person you found like white people they can give you 200 500* (Katlego)

Participants who recounted such experiences appeared to value themselves more and expressed greater control over their lives. This resulted in less self-objectification and displays of a greater sense of self-worth, which was evident, for example, in their successful use of a security guard in dealing with difficult clients and in their ability to negotiate the venue where the transaction would take place. This confidence extends into the SRHC situation:

> *the dr that I did talk that side she was ok she didn't have a problem with me. because when I've :: (.) she's the one who did advise me to go and do the HIV test… and then I went… Even before she did advise me before i:: I find out that I got TB. One day it happened I was <u>sick</u> my back was just painful and she told me you know what the best thing you can do it can happen we help you but we will never know what a the real problem is. It better you go and check for your HIV and TB test and all of that. You see* (Katlego)

In summary, sex workers are demonised and hidden members of the population, displaced from their value systems and unable to ask for assistance from public protectors (the police and the health care system). Rape, sex bribes, unpaid sex and rough sex are all normalised in a sex worker setting. This is perpetuated by police and healthcare worker enactments of discrimination, coupled with sex worker objectification by clients. Such neglectful and disrespectful treatment appears to both hamper access to SRHC and discourage sex workers from attempting to access available services, as they believe themselves to be undeserving of better treatment.

## 4.4 Motherhood

Motherhood proved to be a vital access point to SRHC for participants. It afforded them the opportunity to reclaim a sense of agency and their ability to effect change in their lives. The theme incorporates pregnancy, motherhood and childcare which all proved to be times when the women actively sought out SRHC.

Like Beauty (below), many of the women stated that their children's welfare was the primary reason for engaging in sex work:

> *It was 2000 I was pregnant with my last born. It was 7 month .hhh o::w I was suffering. (h) everyevery day I'll take two babies and then I'll go there you see the people selling tomatie potato when the left-overs I'll take them in the dustbin then I'll go to cook in my house until i found this job* (Beauty)

All but two participants had children. The women often referred to being mothers, or to the importance of their children as a motivation for working under such deleterious conditions:

> *its very hard because my family are at home< I supporting uh 2 my kids its only because me I'm want to support them to support my kids °you see°* (Lindiwe)

In many cases, prenatal care was the participants' first point of entry into the healthcare system. It was also often the point at which participants discovered their HIV status.

> *I start during my pregnancy went to the clinic* (Lindiwe)

Prenatal treatment is a vital part of both mother and child healthcare (United Nations, 2010). Prenatal care was reportedly accessed for regular scans, to book a hospital bed and for HIV testing:

> *see how the baby is inside the womb. Is the baby fine don't you have any complications and like that* (Cindy)

Many of the participants reported being HIV positive, but none of them followed the advice of nursing staff to breastfeed their infants, as shown below:

> *JOYCE: the time I was pregnant (3.0) .hhh you know they are checking for HIV...hh so I go to check for HIV. .hhh I found myself I was positive... so I think maybe medicine it was for the baby* (Lindiwe)
>
> *JC: Do you breast feed…*

*JOYCE: no me I chose not to °I don't want to put my baby in the risk°... I was I I was just thinking they told me I can breast feed for 6 months... ya they (SL) they give me thing pills to protect me and the baby then when I was 9 month 8 months they give me Therapine that if I'm having labour pains I must drink it...I go on last of last week to the clinic to check my CD4 count it was 3 3000 something they said I'm not on the stage to take ARVs... no if I'm not feeling fine I'm going to the clinic... nawhe when I'm not feeling fine when maybe I see something different on my vagina when sometimes maybe I don't get it pains appetite costey told me if maybe there something wrong with my body I must come... so if something not good I go there sometimes I see that I losing weight I go there. Cos the reason that I go myself that I'm losing weight too much I take my CD4 count maybe I need antivirals but they said no* (Joyce)

Participants' concerns regarding breastfeeding centred on the transmission of HIV to their infants. Through choosing not to breastfeed despite receiving medical advice to the contrary, participants showed that being HIV-positive did not preclude them from making decisions regarding their and their babies wellbeing. Thus, the identity of motherhood and the meaning attributed to it seemed to allow them to engage actively with the medical system:

*GUGU: they give me a tablets ne you say I must keep it when I have the pain before 2 hours I must drink it. I drink it even now they check is not not positive is negative*

*JC: ok does she go and did you breast feed*

*GUGU: no. They say I can free free feed it until 6 months but I was scared. Because where I was positive already since (Pelecon) they give people whose HIV (9 pelecon) each and every month they give me ... I don't eat my treatment because they say my CD4 count still fine. but now they say after 6 months now in August I have to go again to take a CD4 count again. Because 6 months 6 months* (Gugu)

Participants reported adhering to their ARV regimens during pregnancy and after childbirth or in relation to their children. They also reported more frequent HIV testing and condom usage during pregnancy, and this was often presented in relation to being responsible mothers:

*I said I want to check the blood m: (.) because I want to protect my children* (Beauty)

*as for me I have 3 people that I have to take care of so can't sleep with someone without using a condom* (Connie)

*JC: why did you go there? were you worried that you were sick or were you just going for check-up*

*LINDIWE: u I ker some people (2.0) <u>IN LIFE NE YOU NEED TO KNOW YOUR STATUS</u>. M::: that is why I went to check my blood test. So they can take my blood test and check in a ker laboratory. So that I can <u>know</u> my status* (Lindiwe)

Motherhood and pregnancy in particular present a unique opportunity in the healthcare setting, one which was actively accessed by participants. The participants also engaged the healthcare system when caring for their young children. This care thus represented a key point at which participants accessed healthcare, for a sick infant or for age-appropriate vaccinations:

*ya they told me that if if cos she was going to get injection you see. They told me that if the baby it not good that if she take the injection after late after she must take that injection in that date so so they will know* (Joyce)

In line with World Health Organisation and the MDG 2015 recommendations (World Health Organisation, 2008, 2010), SRHC includes perinatal care for infants such as vaccinations and infant care. By highlighting such times as critical to their accessing appropriate healthcare, the participants showed a greater sense of responsibility towards their and their infants' health at this time. In line with this sense of responsibility, participants reported actively seeking better educational and care opportunities for their children than they themselves had received. Pretty was an example of this – she only achieved a Grade 10 education, but her children were well educated through her earnings as a sex worker:

*so I take kids to school they finish matric and then I take them to college 3 years to college with the money that I'm doing here* (Pretty)

It was through motherhood that the participants reported being able to re-humanize themselves. As sex workers, they often described abuse, degradation and humiliation. Yet as mothers they displayed pride in their ability to contribute towards their families. This was seen across all accounts which included or mentioned children. Participants prided themselves in being able to take care of their families.

It is at the point of this more complex identity structure that participants were able to access more generalised SRHC. Prenatal and birthing facilities are currently not included in sex worker-specific vertical programmes. Therefore, the women integrated into more

general health systems in order to access these services. They appeared to appreciate the anonymity that pregnancy or childbirth gave them when accessing healthcare. The accounts suggest that on matters of SRH, they preferred to be treated as women and mothers to being treated as sex workers who required access to sex worker-specific SRH services:

> *JC: when you got pregnant with your baby what was it like*
>
> *TUMI: >its< nice >I was< I was enjoying every minute* (Tumi)
>
> *when I was pregnant my boyfriend was there ((the clinic)) I've never had a problem there or with my body or ur: my child birth I would be lying* (Connie)

In this way, pregnancy equalised the treatment of participants with that of other women and mothers. This in turn encouraged the accessing of services in more normalised situations, despite the inherent inefficiencies in the healthcare setting. This in some way allowed participants to reintegrate into the healthcare system. The concerns experienced by sex workers during these times were perceived to be "normal":

> *My pregnancy ei it was very nice. It was wonderful* (Tumi)
>
> *[oh t]he pain was:::…h oh::: it was too much yo::: I cant imagine it it was too much…ya of course you know the nurses if you making a lot of noise they will treat you bad but if you just behave yourself they will e'ya treat you nice* (Cindy)
>
> *T: I was awake but they put injection in spinal cord… it was fine it was alright because even my baby ah me I was not taking care of it I was just sleeping they co they it sleeping here in the cot the sisters some of them they come to take her those ones who used to work night shift. I sleep when I wake up I don't find her. Bring it again. You see* (Gugu)

Tumi experienced her pregnancy as wonderful. Nurses' treatment of the women during delivery was spoken about as being consistent with how other mothers were treated (Cindy, above). Accounts of pregnancy-related scans, caesarean section incisions and pain management through spinal blocks were evident in more recent births, all of which appear to be aligned with global best practice (Rigg, Jamrozik, Myles, Silbert et al., 2002). In addition, the length of hospital stays surrounding birthing appears to have been appropriate (3 – 4 days) (Liu, Heaman, Kramer, Demissie et al., 2002). Midwifery skills were evident in reassuring participants during the final stages of labour:

> *a::h my second born I was in labour nicely in Johannesburg hospital johnsburg gen jo'burg gen it was nice... they treat me nice... they didn't shout me (1.0) they treat me nicely nicely* (Beauty)

Such instances of more attentive, better quality and more caring SRHC gave the women a better sense of control over their wellbeing, seemingly encouraging future accessing of SRHC. Participants were willing to return to such settings, preferring the treatment received there to other healthcare settings where discrimination was rife and treatment inconsistent. As with Sandra (below), participants who have had positive healthcare experiences spoke more positively about SRHC generally:

> *hhhh but they they left me in one room so I was crying there when I hear pain I was shouting outside nurse nursenurse come comecome. And one come and treat me very nicely till I gave birth* (Sandra)

Although the participants reported having positive experiences as mothers accessing healthcare, they also frequently mentioned substandard SRHC. Participants recounted waiting in long queues to be seen at the prenatal clinic, seeing multiple doctors across a pregnancy, prolonged labour without any medication and in one case not being given PMTCT, resulting in an HIV-positive baby. The account by Tumi of going temporarily blind while giving birth to her infant suggests the clear and urgent need for improved access to prenatal care for women. It also indicates that even when services were debilitating and appalling, participants felt that they are better than nothing. There was a sense that they could not complain about substandard services, as they could access some healthcare, rather than none at all.

Participants seemed to wait for prolonged periods before seeking healthcare. They frequently only sought it at the point at which their ailment was debilitating and their ability to financially support their families was in jeopardy. At this point they would check their HIV status or persist with a challenging diagnosis. In this way, being mothers or being responsible for a family encouraged the accessing of SRHC.

> *I've got too much stress. Cos 1 I need money (1.0) you see. I supposed to pay where I'm staying my child everything and me I supposed to get what it cost money. Cos if I never get money my child he gonna die with hunger. And my mother call me that in Zimbabwe there now its its...its bad there's no mielies meal (1.0) so there another*

*people they selling maize. Just that it cheap now do if you get money it cheap now and then me I'm sick I don't have power to work* (Rosah)

Rosah's recurring pelvic pain has already been discussed in some detail (see Section 4.2.2.). One aspect of her and many other participants' seeking healthcare was in relation the survival of their families. Participants stated that they often waited to seek SRHC in relation to motherhood and frequently only seeking it at the point at which they could no longer earn and provide for their children or other dependents.

Resistance to seeking healthcare was seen in relation to more private aspects of their lives. Pap smears became a point at which the women regained their humanity in refusing the procedure. They do not perceive pap smears as critical to the everyday functioning of their bodies and therefore did not access this service unless their health began to impinge on their ability to provide for their children. Data indicates a sense of dignity around pap smears, with participants not wanting certain private aspects of their lives intruded upon. This is clearly shown in the excerpt below, where Pretty whispers "*°and do it°".* In addition, the look of disgust coupled with horror at the thought of it, and her flustered response of "*u: (.) you know (1.0) it's just be(.)cause u I don (.) I don't have (.) that problem that goes with(.) but I think if you it comes: ya I I I would have do it",* marked by pauses and stuttering, indicate her unwillingness to undergo the procedure:

*PRETTY: .hhh they ask me about the the pap smear. They ask me that did I ever do a test for pap smear. So: I told them that no I didn't didn't do it*

*JC: and did they do a pap smear for you?*

*PRETTY: no they ask me if I'm ready then I should come °and do it°*

*JC: ok and have you done it*

*PRETTY: no I I didn't*

*JC: I saw your face. What stops you from doing it?*

*(2.0)*

*PRETTY: u: (.) you know (1.0) it's just be(.)cause u I don (.) I don't have (.) that problem that goes with(.) but I think if you it comes: ya I I I would have do it*

It was only at the point of motherhood and reclaiming their humanity that participants allowed additional medical procedures to be carried out. As sex workers they often

described abuse, degradation and humiliation. Yet as mothers they displayed pride in their families and their ability to contribute towards their families. They found a point of access which allowed them to be whole, and complex beings, not one-dimensional objects. Hence, the sex worker became a woman and was no longer simply an object under scrutiny. It was at this point that SRHC devised for sex workers was no longer acceptable. In reclaiming their humanity, these women became more than just bodies allowing them to access a broader range of SRHC services.

### 4.4.1 Social networks

As sex workers, in their communities, they are discriminated against and dehumanised to such an extent that they feel they must hide their profession in order to be accepted by family members and to align themselves with traditional norms. Simultaneously, they are pressured to provide financially for poverty-stricken families, which results in increased risk exposure to SRH concerns because they then engage in high risk sexual behaviours. In the broader community, the discrimination enacted against sex workers left the participants isolated and marginalised. Thus, their position in social networks where discrimination, dehumanisation and internalisation intersect can either hinder or encourage access to SRHC.

As sex workers, the participants appeared to have a very tenuous connection to the outside world. Discrimination against this population is so rife that all but two participants had hidden their work from family, neighbours and friends. The immense shame associated with the profession, coupled with traditional value systems, left many of the women displaced from their family in their daily experiences and needs. Denied all human attributes, the necessity to conceal their work was assessed against the immense need to support their families financially and emotionally:

> *But I'm the one who responsibility in that place. So that's why I came here. BUT is not good for me cos even my health even now when I go inside with a guy (1.0) it's hard cos I'm thinking that (2.0) its paining. Painful its painful. If I (inside) with a man °sho° (0.2) then it start its pain dunno what I will do. But (.) I don't have choice cos (2.5) it the way I get the money… tsh.hhhhh I'm scared. Don't know (.) its hard to tell my family that what I'm doing. cos my mother he's gonna eish (2.0) he's gonna hate this (1.0).hhh can't believe (1.0) gonna get a heart attack (1.0) this is not my son my*

*child only one girl that I have in my life (.) Ahh is a prostitutes ah: my mother I can't. I can't like this* (Rosah)

*ya its very difficult for me to confront my parents… I don't think they would like it ya. And as a child I do respect my mom and I respect my parents and my elders and sisters and brothers I wouldn't like them to know this* (Cindy)

Many of the women were the head of their households, and frequently their income was the only financial support the family received. Through either the loss of parents or an unplanned pregnancy they had been thrust into a position of financial responsibility. Such changes in their circumstances, coupled with the pressures of poverty and low education levels, led to the trading of sex for greater financial stability. The money earned through sex work offered the women the ability to survive, as well as a sense of autonomy in providing for their families. Yet, they felt unable to disclose their profession to their families out of fear of familial discrimination and punishment. This fear was coupled with intense shame associated with the profession.

The cycle of shame and blame (Scambler & Paoli, 2008) made access to SRHC challenging. Whether discrimination and blame are enacted by healthcare providers, the police, clients, the community or family members, the impact upon participants was compounded into an immense internalised sense of shame and worthlessness. It is this that has the greatest effect on their accessing of SRHC. In this regard, Katlego's comment is typical:

*I think they will be sad because you know the problem is I can't tell my granny sometimes when we watching TV when she see the girls on TV with small skirt the she say ↑wo:w those are the girls from Hillbrow and those things and what whatwhat. Now I see that what if I'm going to tell her that I'm also doing this thing you see... I'm going to break his heart... I just have to act like eishits my (h)first time I saw these people on TV. I don't know nothing what going on... inside it is hurting when I'm alone why she why I I have to lie for my granny. Sometimes I II it comes and I try to tell her then:: when I have to go and talk to her then eish something just stop me and say no you don't have to … its not nice … everyone likes a granny they understand… When you have a problem. But sometimes they don't* (Katlego)

Katlego described having a very close and loving relationship with her grandmother. Yet this excerpt depicts the challenges of hiding her lifestyle from a person whom she loves. Her fear of her grandmother's discovering her work is so great that she closets this aspect of

herself, shrouding it in secrecy because of shame and guilt, even though it is how she provides for her family. This was the case for all participants.

> *no I can't tell him ((horror in her voice at the idea)) I can't tell him because::: the time I started come here in Jo'burg he told one of my aunt that we know I'm here in Jo'burg and I didn't finish the school and he know that I'm doing the sex worker. So if he found out I'm doing that he going to take my kids from me... they were very small. And <u>then</u> he told me that <u>I will bring disease for them</u>* (Pretty)

Through the account given by Pretty (above), it is evident how ingrained negative views of sex workers are. Her father's perception that she would be an unfit mother, necessitating the removal of the children for fear of disease, almost acts as a punishment for her "disgraceful" behaviour. Apparent in this is the blame apportioned to sex workers for the spreading of disease, both physical and moral. Although this participant is educating her children, she bears the yoke of familial prejudice against sex workers.

It is through discrimination experienced on multiple levels that the participants' internalise a deep sense of shame for their work and their bodies. Displaced from traditional norms and positioned in a cycle of shame and blame reduced their access to basic human rights. In this cycle they became increasingly afraid of the potential for future discriminatory practices, and this hampers future access to SRHC (Scambler & Paoli, 2008; Stadler & Delaney, 2006). The constancy of this cycle and persistent negative input into their lives has led to a negative self-image. This was reflected in references to themselves as "*magosha*", "*us girls"* and "*us prostitutes"*. Such a negative self-image is also reflected in the high rates of depression found amongst sex worker populations, and has been linked to low health seeking behaviours (Sidum et al., 2012; World Health Organisation, 2003a).

In the few cases where women had either a friend or family member available to assist them in times of crisis, their accessing of SRH appeared to be more regular. The ability to speak openly with a family member or friend seemed to enable the participant to discuss health concerns or get feedback and advice. It also allowed them to question their self-objectification in reconnecting with their bodies and meeting their physical needs. Thus the two participants who reported having told a family member about what they do for a living, gave accounts of SRHC through implied early action in meeting their SRH needs and fewer SRH complications, with greater confidence in accessing the sex worker-specific services:

> *eish! (3.0) °you know (1.5) I don't want to lie. One of one of my younger sister knows what I'm doing. I told her that I'm doing this job. Like if I've got problem … m::: you know I know I wanted her to know that maybe sometimes I have got a problem she must know that what I was doing… you don't have to hide! M:: m:: even if its hard you must know you must know where to go* (Pretty)

Friends were seen to act as conduits through which such care could be accessed. This played out through the calling of an ambulance, assisting with the birth of a child, or speaking to a pharmacist on behalf of participants:

> *I nearly get my baby inside inside the house … but fortunately that someone called a ambulance then they come quick* (Joyce)

In many cases, social capital only came into play in relation to non-sex work-related health concerns, such as pregnancy, womb problems or generalised health concerns. To the participants it appeared as if they were more likely to be aided by neighbours and friends if their line of work was unknown, if their health complaint was unrelated to sex work or was more closely aligned with traditional health concerns:

> *they see me like hm m something wrong they take me to hospital. When I reach there I find people who come before me they say drink (.) that tablets of yours let us take you first. I went there half past 12 I was finished to get a baby* (Gugu)

Gugu reported going into labour with her third child on the street without telling anyone working around her. Once her co-workers realised what was happening, they took her to hospital. In the hospital system, she was encouraged by other women to take the PMTCT treatment and was received well by the nursing staff, who expedited her delivery. Thus the identity of motherhood elicited community help and facilitated access to SRHC. By contrast, the shame associated with sex work and compounded by familial discrimination hinders access to SRHC. This sense of shame was compounded by the message of moral accountability sent through community organisations such as the church.

## 4.5 We are Sinners!

Participants frequently mentioned God or religion. This occurred in multiple ways throughout the dataset and implied a problematic relationship to their accessing of SRHC. They described a morality that is frequently attached to the work which they do, which makes them as sex workers "sinners" in the eyes of God:

*You see this thing we are doing (1.0) is not fine. but we are doing but is not ok. I don't want to lie to you. NO it's not ok (.) really we are just using our body* (Beauty)

Religion featured as a barrier to accessing SRHC. While participants' religious beliefs offered them hope of alternate employment, such beliefs appeared to carry with them some form of moral judgement. Participants' accounts indicated that the church positions them as sex workers as sinners – this perceived moral culpability inhibited their accessing SRHC, as was clearly articulated by Joyce:

*JC: how long sometimes will you wait* ((before seeking SRHC))

*JOYCE: I wait me. my problem is I don't like hospital you know my mother she's a Christian. Most of the time if I'm sick she will say let's pray. God she he (.) will (.) Help us. Then I become fine. or if I'm sick if I'm at home I'm going to the church the pastor pray for me I become fine so these things of hospital is NOW cos I have baby or something. But if I home my mother she's a Christian she believe too much in God so. I think you understand this thing... yes me I believe. Even I if doing this thing ((referring to sex work)) I know God is around. God she's alive... the thing I'm telling myself is God will not hear my prayers because of the thing I am doing of the sin that I'm doing here. You see (.) I'm praying I'm coming here which means I'm bathing and going to the dust again* (Joyce)

As has already been discussed (see Section 4.3.4.1.2), delaying accessing SRHC for extended periods was found to be common practice. Joyce explains that she (and more specifically her mother) is very religious and that her ability to get better is directly related to her belief system. She feels that if she behaves in a dishonourable manner, she will not be healed: "*God will not hear my prayers because of the thing I am doing of the sin that I'm doing here. You see (.) I'm praying I'm coming here which means I'm bathing and going to the dust again*." She highlights a moral culpability in her situation, dictated by her religious beliefs. Hence, her waiting to seek healthcare is related to her feeling unworthy of treatment and of being healed by either God or the medical system.

Many participants referred to God and to the church. While the church may advocate respecting human rights, it also positions sex workers as sinners. This displaces them from societal norms, assigning blame to a sex worker, not only for her situation but for the spread of disease. Because of this, participants were further alienated from their communities, their families and friends. This compounded the shame they already felt due to a systematic

degradation enforced on multiple levels of society and extended to feeling unworthy of treatment for diseases related to their vocation. It culminated in their not seeking SRHC.

A study by Emeka (2011) argues that religious beliefs can inhibit parents from seeking proactive medical help. Christian-based HIV behaviour modification interventions have been criticised for rejecting condom usage, while preaching abstinence and faithfulness (Dietrich, 2007). In this regard, Foucault (1975) provides an interesting perspective on the role of religion in managing the health of a population – he argues that sex and sexuality are managed through legislative and religious mechanisms. Sex work, as deviant from the norms of appropriate sexuality, is targeted by such frameworks in an attempt to realign sex workers with the "normal" population. Thus, the morality and concomitant judgements participants reported are inherited from the South African criminal justice system, but also from religious discourses. Sex workers have been discursively positioned, and have internalised a sense of being sinners undeserving of healing. In a literal translation of sexual sin and ill health, participants internalised a sense of sin from multiple religious doctrines. Thus, some participants (as shown above) suggested that as sex workers they are not worthy of healing through SRHC.

# Chapter Five:
# Implications, Conclusions and Limitations

## 5.1 Implications and Conclusions

Health-seeking behaviours are constrained on all levels by individual and structural factors which impact sex worker accesses to SRHC. This report offers a human rights-based approach to sex worker access to SRHC - cognizant of the impact reductionist biomedical methods may have on our understanding. The use of detailed accounts of sex workers' SRH, and their experiences and perceptions of accessing SRHC, has allowed for a critical analysis of the interplay between themes such as criminalisation, discrimination, the present healthcare system, risky behaviours and psychosocial dynamics in gaining insights into the factors that facilitate or hinder sex workers' access to SRHC. Much of the current research into health fails to understand SRHC inequalities in a complex social world. Literature in the policy analysis and epidemiological traditions has outlined various structural factors which impact access to SRHC. While extremely valuable these traditions have largely neglect the experiences and perceptions of sex workers as key agents in these structures. Through taking these participants' accounts seriously, this highlights these complexities and as such contributes to our growing picture of SRHC challenges and promises in South Africa.

Access to basic health services is a fundamental human right, upheld in the Declaration of Alma-Ata (Alma-Ata Declaration, 1978) and further articulated by South Africa's Constitution (Government of South Africa, 1996). However, in reality many people in South Africa do not have equitable access to even the most basic services, and the gap between those who have and those who do not is widening (Hall & Taylor, 2003). As a criminalised and marginalised population, the voices of sex workers in this problem of access are often ignored. Thus they are doubly removed from fully participating in human-rights based advocacy for equitable health for all South Africans. This project is an attempt to provide these key agents with a voice through highlighting the plight of sex workers in their struggle to effectively access equitable SRHC.

An analysis of these voices suggests that services should be made available which are acceptable, accessible and of good quality, in a place and time which ensures accessibility. A broader range of SRHC services in line with human rights standards needs to be included (UNAIDS, 2009b). This study gives evidence for the need for policies which are poised between a human rights approach to SRHC and the global drive to address infectious diseases such as HIV and STIs. Yet, there is incongruence between the ideal of human rights and universal healthcare, and the experiences of sex workers attempting to access SRHC in Johannesburg City Deep. The healthcare system is under-resourced. While funding has been allocated to the redressing of political and socio-economical inequalities of the past, these were not always reflected across this data set. Service offering appeared to have been scaled-up in relation to HIV prevention, treatment and care – particularly surrounding PMTCT, however additional service offerings were lacking or non-existent; and where available were on high demand leading to excessively long waiting periods. This led to a lack of effective service provision, with evident gaps in the services offered to women. Where functional moments existed they were often overshadowed by gross negligence.

Participants' experiences of SRHC indicated multi-level discrepancies in treatment. The one-sided view of SRHC presented in public and semi-privatised sectors has left gaps in the service offering. While some of these are specifically SRH related, other more general needs highlight the plight of marginalised populations displaced from accessing basic human rights. In the short-term, a more holistic approach to projects may lead to greater interactive opportunities in addressing HIV related concerns. In the long-term, this research forms part of a growing body of evidence calling for reform in South Africa's primary healthcare system in scaling up SRHC to meet the MGD 2015 and the ideals laid out in South Africa's Constitution.

Coupled with this is the manner in which participants were perceived to have been objectified and dehumanised by a system which purports to be championing the public interest. Such objectification has to some degree been consolidated in vertical sex worker programmes which were reported to have actively separated sex workers from the 'normal' population. Developed to increase the accessibility of services for this marginalised population, the highly focalised, disease specific nature of such programmes has further displaced participants from a broad view of SRH. Thus they are given centre stage in an HIV

and STI vector discourse. Furthermore, the internalisation of a 'sex worker' identity as deviant and disease ridden is inadvertently perpetuated by these programmes. Greater sensitivity should be exercised in the development of messaging for use by healthcare professionals and advertising campaigns.

In this study, prenatal, VCT and sex worker programmes were all highlighted as forming part of South Africa's verticalized SRHC programming. Such programmes are aligned to global standards of healthcare. The World Health Organisation, for example, states that "*each country needs to periodically assess its overall surveillance system so that this continues to reflect national disease control priorities, improves efficiency and takes advantages of new methods and techniques to strengthen surveillance*" (2006, Beauty). They also propose that political endorsement is a prerequisite. This is indicative of a strongly biomedical focus to manage health outcomes. The inclusion of country level assessments politicizes this matter. While leveraging existing resources in encouraging the wellbeing of the population, this also serves to encourage politically led surveillance and management. This is enacted through the creation of independent and vertical healthcare initiatives with the primary goal of addressing deficits in healthcare management. Despite supportive policies and high donor support, this approach has had persistently poor health outputs. They are isolated in providing individualised SRHC solutions. This causes distortions to service delivery as was strongly evident in this dataset. Vertical programmes are removed from integrated public health facilities meaning that capacity building in the public health sector is not prioritised and never developed. Should donor funding be withdrawn or end, the clients of these projects will be required to reintegrate in a healthcare system which has not been scaled-up and remains ill-equipped. The shortcomings of such programmes requires urgent redress in containing the heterosexual spread of HIV (Chopra, Lawn, Sanders, Barron, Karim et al., 2009) and in strengthening partnerships geared to developing the public health sector.

While the focus of SRHC is currently aligned to the MDGs (UNAIDS, 2008), such services should not be provided in isolation to the detriment of a broader view of SRHC. Current sex worker programmes in Hillbrow fail to account for the prenatal requirements of their client base, referring them to alternative clinics. While vertical prenatal clinics are vital for service delivery, a long-term scale up of SRHC is required in ensuring the effective roll-out of a broad range of SRHC services. Accessing perinatal, prenatal and postpartum care for sex

workers offers the opportunity to integrate in a broader healthcare setting. This should not be ignored as an opportunity to encourage the uptake of health seeking behaviours, in particular aligned to SRHC. In the short to medium term, sex worker healthcare programmes should revise their goals in aligning their projects with the needs of sex workers as mothers and as sexual human beings rather than vectors of HIV transmission. Through this they may see an increased uptake of all available services in ensuring they have a population receptive to HIV/STI interventions. This response however, will be insufficient beyond the short-term. The long-term scale up of primary healthcare services is critical to ensuring access to health services. This should incorporate a broad based SRHC service offering available to all women irrespective of their work. Services should be provided which are consistently available and delivered, and training should be tasked with reducing discrimination.

The on-going and dehumanising treatment of sex workers as "*magoshas"* and vectors for the spread of disease in healthcare settings, displaces them from accessing SRHC. Where sex worker accountability for the spread of disease has been strongly implied, heterosexuality needs to be more integrated in HIV prevention messaging (Chopra, Lawn, Sanders, Barron, Abdool Karim et al., 2009; Venter, 2011). This further perpetuates multi-level vector discourse, as seen in the politicised drive for condom usage which appears to be intensified amongst sex worker populations. The internalisation of this discourse augments intense shame and self-blame, which in turn leads to the avoidance of SRHC facilities so closely aligned to HIV, and may result in only 5% of sex workers being able to access healthcare (SWEAT, 2011b). The lack of control that experienced, particularly as bodies in the medical system, could be negated through initiatives which encourage greater agency. One such option would be to allow clients to choose the healthcare professional (VCT counsellor or nurse) they wish to see. In doing so, a sense of agency and a greater sense of control would be evoked, while potentially improving nurse performance through active patient demands for better care.

The persistency of multilevel discrimination functions singly and cumulatively to inhibit access to SRHC for sex workers. Such on-going acts of persecution have caused a generalised fear of healthcare settings, leading to various coping strategies. The silent nature with which the women reported accessing healthcare, their need to secret their

work and their denial or avoidance of healthcare settings are all aggravating factors in access to a vital healthcare service. Furthermore, the use of silence and avoidance or denial strategies led to an underreporting of SRH complications. Intensive healthcare and policing drives should be undertaken, both in existing facilities and in training to improve the care-experiences of this marginalised population in encouraging universal access.

Where the focus on sex workers as carriers of disease is degrading and dehumanising, participants' experiences and perceptions of themselves as mothers, daughters and women seemed to erode accounts of stigma and healthcare avoidance. The internalisation of an unclean body and self, displaced them from belonging to a community and caused fear of discrimination and abandonment. Yet their ability to achieve a state of health seems to be intrinsically linked to their social support networks and their immense sense of responsibility towards their families. In a population of women who are increasingly likely to engage in acts of resistance towards the medical system and who become docile to it around issues of family, perhaps the inclusion of a more generalised health programme which included maternal and infant interventions, engaging the women as women, mothers and sexual human beings would increase uptake, retention and regularity of access to the health facility. The isolated nature of the HIV/STI focus along with the vector discourses associated with it alienate the women from discourses of motherhood and womanhood, serving to constrain access until such time as the medical issue impedes her ability to earn and as such provide for her family.

The clear importance of keeping health for the good of the family should be leveraged for the teaching potential which they hold. Teachable moments (Lawson & Flocke, 2009) are central to ensuring on-going and successful accessing of SRHC. In so doing, women regain control over their sexual wellbeing through understanding their bodies as central to their being. Additionally, improvements to medical care through the uptake of more advanced procedures and better management strategies would prove fruitful in encouraging more positive care outcomes. Motherhood is a prime example of where teachable moments could effectively be utilised, through improving prenatal, antenatal and postpartum care, encouraging educational efforts geared at both mothers and children in addressing gender disparities both in the immediate and long-term while aligning with MDG 4 (UNAIDS, 2008). Vitally, this is a point of reclaiming a complex identity which sex workers are all too often

stripped of in efforts which become counterproductive to their initial intent. SRHC programmes which engage sex workers as women and mothers may be found to have greater success in attracting a client base which can be easily retained, and which leads to more holistic wellbeing for the long-term success of the programme and the women who use it.

Continuity of care was a point of concern; referring to different clinicians each visit or a system of apparent ongoing, interclinic referrals. Women who reported greater continuity in their care also gave account to more regular visits to clinics and appeared to have a more positive outlook on their wellbeing. Continuity in healthcare can be achieved either through seeing the same doctor at subsequent visits or through building a relationship with a particular nurse.

It is imperative that discriminatory treatment in such services be addressed as a matter of urgency. Educational programmes should incorporate health literacy in encouraging overall SRH. Pharmacies should be leveraged as a point of contact, with appropriate training being provided to staff. Further to this, the National Health Insurance plan (Department of Health, n.d.) must provide for marginalised populations in ensuring that they are not further displaced from access to SRHC due to their vocation. Such a move would potentially see sex workers realigned and realign themselves with discourses of human rights and access to healthcare, in encouraging the uptake of SRHC.

Internalisation of dehumanisation stemming from the health sector was compounded by police brutality and client violence. Here participants were further removed from moral consideration and repositioned as sub-human agents. Harrowing accounts of police brutality, harassment and withholding of medical services served to increase participants' risk of SRH concerns. Concomitantly they served to further displace them from access to healthcare. Perhaps decriminalisation or regulation of this industry would enable the fostering of partnerships between police officials and sex workers in addressing criminal activities. The New Zealand and New South Wales' model of decriminalisation and partnership fostering has shown this to be an important way to improve sex worker-police relationships (Sidum et al., 2012). The building of long-term police-sex worker relationships is a vital aspect of both access to healthcare, in fostering gender equality and in addressing an often criminal client base. Such collaborations require time and flexible models of

engagement alongside educational frameworks in decreasing discrimination while improving communication mechanisms.

Greater emphasis should be placed upon the clients of sex workers, including their role in sex worker risk, mechanisms to address this, and criminal activities including violence. The work by Jewkes et al. (2011) highlights the violent nature of men who purchase sex, their proclivity to rape and links to criminal activities. As shown in this research, it is the constant acts of brutality and violence which increased participants' risk. Violence from all sectors has a massive and cumulative psychological impact. Their inability by participants to access counselling, gynaecological or legal assistance, reinforced a sub-human status in further displacing them from a rights-based discourse. From this position, access to healthcare resources is something only 'others' can attain.

Fear of discrimination, whether enacted by healthcare professionals, police, clients or the general public forces a tensioned accessing of SRHC. This fuels feelings of being undeserving of better treatment. Additionally it caused a debilitating fear of future exposure, which hampered efforts at access. Overall, the constant and unbaiting message that sex workers are a reservoir of STDs and HIV, are vectors of vice (Fraser, 2008, cited in Richter, 2008), a source of disease or a threat to society (Wolfers & Van Beelen, 2003) has left participants with nowhere to turn to for help. Even faith based organisations were implicit in such messaging, leaving the women feeling increasingly unworthy of assistance from any sector as they navigated a path between the righteous and the needy in accessing SRHC.

Objectified in the healthcare system, criminalised by the judicial system, abandoned by their communities and at the mercy of a violent client base, sex workers are completely displaced from the human-rights discourses that supposedly underpin healthcare practice in South Africa. They are reduced to being bodies under scrutiny by every micro- through macro-level system they engage with. The internalisation of discourses surrounding their potential role in the spread of disease; their inability to contribute towards a community or families' functioning; and their objectification has left them by and large apathetic towards a healthcare system which is dysfunctional at best. It is only at the point of reintegration of the sex worker to a whole being that they will reengage with the health system.

South Africa *"urgently needs a broadened vision of health care in which treatment and preventive programmes for HIV and other disorders are incorporated into a comprehensive primary health-care system and are supported by detailed planning, assessment, and monitoring*" (Chopra et al, 2009, p. 1027). The current biomedical focus on HIV is unlikely to reduce the rate of new infection while creating a discourse which displaces certain 'at –risk' groups of healthcare. The addition of a broader focus on addressing gender disparities, violence, family and discriminatory legislative frameworks would prove successful in increasing the uptake of SRHC.

## 5.2 Strengths and Limitations

This study offers a perspective on sex worker access to SRHC through the eyes of eleven participants. Participants' voices were privileged as a source of understanding the complexities of SRHC. Due to a lack of available secondary data, it was impossible to triangulate these against alternative data sources in further validating the findings of this study. As such this study forms part of a broader realism ideal in understanding the complexities of sex worker access to SRHC. However, the data is transferable to other populations with similar contextual dynamics due to the widespread nature of such socio-economic, gender-disparate and SRHC concerns amongst female street- and hotel-based sex workers.

The study fails to include the accounts of healthcare and policing officials in developing a clear picture of sex worker access to SRHC. Furthermore, the study partially vectorizes sex workers through the use of biomedical discourse. While every effort was made to avoid understanding sex workers within this framework, its entrenchment within both public health literature and the participants' constructions of themselves in line with this made moving away from such a discourse very challenging. Additionally, while the study advocates for the decriminalisation of sex work, care should be taken in effectively addressing under age sex work and human trafficking into the sex trade - both of which have been highlighted as by-products of decriminalisation. By virtue of the sampling strategy, this study has focused primarily on the experiences of female, street –based sex workers. Finally, language proved to be a barrier to accessing international migrant sex workers, and the inclusion of a more equitable sample of their experiences of SRHC in South Africa.

## 5.3 Recommendations for Further Study

Future studies should incorporate secondary data in order to develop a realistic view of sex worker access to SRHC. In addition, studies of this nature should be carried out across South Africa, particularly in relation to existing sex worker SRHC programmes, to establish the widespread impact of vertical programming on this population.

Further work is required in establishing the complexities for a broader sample of street-, hotel- and brothel-based sex workers, as well as male and transgender sex workers. This will also validate the transferability of these findings across sex worker populations.

Additional work is required to understand mechanisms to reduce the enactments of discrimination by policing and healthcare officials in ensuring the ability of sex workers to access SRHC at all times.

Finally, research could understand the impact of HIV messaging campaigns upon the consumer, in unravelling the role that prevention messaging plays in behaviour change.

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# Addenda

## Addendum A – Sisonke

Sisonke, the Sex Worker Movement of South Africa, is a Not-for-Profit Organisation and a Non-Governmental Organisation (NGO). It was launched nationally in 2003, and it is run by sex workers. The organisation aims to unite sex workers, improve their living and working conditions and fight for equal access to rights, while educating, uplifting and empowering sex workers (SWEAT, 2006).

Sisonke has a branch based in the Hillbrow Health Precinct (HHP), Johannesburg. This branch works actively with the RHRU, the Esselen Street Clinic and mobile clinic services. Of the 484 member base, 180 are active. Members' ages range from 20 years upward. The membership includes both indoor and outdoor sex workers. Sisonke also has a number of international migrant members (SWEAT, 2010b).

## Addendum B – Jefferson Lite Key

All attempts were made to transcribe language as it was spoken, without imposing the rules which govern written language. As such, apostrophise have been omitted, as have many full stops and or commas. The following Jefferson transcription symbols (Jefferson, 2004) were incorporated within the transcripts to assist with data analysis:

| | |
|---|---|
| [ ] | indicates an interruption in speach |
| < > | spoken very quickly |
| > < | spoken very slowly |
| _____ | emphasised |
| **Bold** | shouting or spoken VERY loudly |
| ° ° | whispering |
| (h) | breathy or plosive speach |
| ::::: | used after a sound to indicate the sound is dragged out. For example e::::: (makes and eeee) |
| (.) or ….. | a brief pause in speech |
| (2.1) | timed pause. The bracketed number indicated the time in seconds |
| (( )) | researcher notes |
| ↓ | significant decrease in pitch |
| ↑ | significant increase in pitch |

## Addendum C – Participant Information Sheet

University of the Witwatersrand

School of Human and Community Development

Private Bag, 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4599

Dear Madam

My name is Jenny Coetzee, and I am conducting research for the purposes of obtaining a Master's Degree in Research Psychology at the University of the Witwatersrand. The aim of my research is to try to understand what factors impact upon the use of sexual and reproductive health services. I am concentrating on individual accounts of sexual and reproductive health services.

Much of the existing research which I have read focuses on HIV and sexually transmitted infections in relation to sex work. This has led to sex workers' being considered in terms of this and not in terms of access to their basic human rights. Understanding the dynamics involved in accessing sexual and reproductive healthcare would help to expose the public, academic and medical personnel to more accurate information. This in turn will provide better information available to both them and the policy-makers who design interventions and programmes, especially those organisations involved in improving access to human rights.

This project is being run under the supervision of Professor Brett Bowman. We would like to invite you to participate in this study. Participation in this project will involve being interviewed by me at a time convenient to you. The interviews will be conducted from the Sisonke office near to the Esselen Street Clinic. The interview will last approximately 1 hour. With your permission I will record the interview, as everything that you say is important and to ensure that whatever you tell me can be analysed accurately. Everything that you say will be kept confidential and no identifying information will be included in the report.

Please understand that your participation is voluntary and you are not being forced to take part in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may decline to answer any questions which you do not want to answer. You may also withdraw from the research at any time by telling me that you don't want to continue. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. You will be reimbursed for your cost to participate (including travel, hours of work lost and any calls made to me).

As you will have been contacted by either Sisonke or a fellow worker to participate in this research, it is possible that your identity will be known to them. However, I will try to conceal your identity in the final report. In the report or any other publication, I will refer to you by a unique code number or pseudonym (another name).

The risks associated with participation in this study are no greater than those encountered in daily life. However, should you feel after speaking with me that you wish to consult a clinic on any potential problems, the Esselen Street Clinic in Hillbrow will be able to help you in a non-judgemental manner. If you feel that you would like to seek counselling services for some of the issues which you have spoken about, a service is available free of charge from the Emthonjeni Centre on Jan Smuts Avenue, Braamfontein. It is just inside the Wits university campus. You can call them on (011) 717 4513.

The tape recordings and transcripts thereof will not be seen nor heard by any persons other than my supervisor and myself. They constitute the data for this project and as such are an important element in the study. Both the recordings and subsequent transcriptions will be safe kept on a password protected computer. These will be destroyed after five years.

You may refuse to answer any questions you prefer not to, and you can at any point withdraw from the study. Should you choose to participate in the study, please complete the form below. Should you have any further questions or concerns please feel free to call, sms or email me on 084 761 1193 or jennyc@iburst.co.za. My supervisor can be contacted at 011 717 8335.

This research will contribute both to a larger body of knowledge on the accessing of sexual and reproductive health services, as well as to your own understanding of the factors which

impact your circumstances.  A one page summary of the research results will be made available on request.

Warm regards,

Jenny Coetzee

I have read and understood the Information Sheet

Signed _____

Date_____

## Addendum D – Participant Consent Form

University of the Witwatersrand

School of Human and Community Development

Private Bag, 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4599

Participant Consent Form

I_____ have read and understood the participant information sheet and I hereby agree to being interviewed on sex worker accounts of sexual and reproductive healthcare. I understand that:

- I am participating freely and without being forced in any way to do so.
- I can withdraw at any point should I not want to continue and that this decision will not in any way affect me negatively.
- I can refuse to answer any questions which I do not want to.
- I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.
- I understand that no information which identifies me will be included in the research report and my responses will remain confidential.

Signed_____

Date_____

## Addendum E – Recording and Quotation Consent Form




University of the Witwatersrand

School of Human and Community Development

Private Bag, 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4599

Recording and Quotation Consent Form

I _____have read and understood the participant information sheet and I hereby consent to being tape-recorded during the interview with Jenny Coetzee. I understand that:

- The tapes and transcripts will only be read and listened to by Jenny and her supervisor. No other persons from any organisation or in their personal capacity will be privy to these.
- Both recordings and transcripts will be safe kept on a password-protected computer. They will be destroyed after 5 years.
- I agree to being quoted verbatim in reports written in relation to this project.
- I understand that all identifying features will be changed, this includes my name.

Signed_____

Date_____

## Addendum F – Over 18 Consent Form

University of the Witwatersrand

School of Human and Community Development

Private Bag, 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4599

I _____hereby certify that I am 18 years of age or older and as such am eligible to participate in this research.

Signed_____

Date_____

## Addendum G: Participant Demographic Information

| ID | AGE | CHILDREN (Age & born once she was a SW or before) | HOME | DEPENDENTS | EDUCATION | SELF - REPORTED HIV[4] | PARTICIPATION IN OTHER STUDY | PART-TIME OR FULL TIME |
|---|---|---|---|---|---|---|---|---|
| **Cindy** | 30 | 1 (10 months, SW) | Zimbabwe | Child & family in Zimbabwe | O levels | HIV +ve | Yes | F/t |
| **Tumi** | 25 | 1 (5 yrs, before SW) | Pretoria | | Grade 11 | Not stated | No | F/t |
| **Beauty** | 36 | 3 (18, 15, 11; 2 before, 7 mths pregnant when started SW) | KwaZulu Natal | 3 children living with her | Grade 9 | HIV +ve | No | F/t |
| **Connie** | 27 | 1 (3, SW) | Soweto | Sister and granny | Grade 11 & auxiliary nursing | HIV -ve | No | P/t |
| **Rosah** | 30 | 1 (13 yrs, before SW) | Zimbabwe | Entire family including 7 siblings | | Suspects she is | No | F/t |
| **Sandra** | 28 | 1 (9yrs, before SW) | Eastern Cape | 1 Child | Dropped out in matric | HIV +ve | No | F/t |
| **Lindiwe** | 33 | 2 (8, 4 yrs, before SW) | Welkom | Whole Family | Grade 12 failed | HIV -ve | Yes | P/t |
| **Katlego** | 27 | 0 | Randfontein (other side krugersdorp) | Granny | Grade 8 | HIV -ve | No | P/t |
| **Joyce** | 24 | 1.5 (pregnant when started SW) | Nelspruit, Mpumalanga | 1 Child | Grade 12 | HIV +ve | No | F/t |

[4] Participants were not asked their HIV status during the interviews. This was volunteered information.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Gugu** | 28 | 3 (last born once SW) | Mpumalanga | 1 Child and minder | Grade 10 (intense maternal abuse forced her to drop out) | HIV +ve | No | F/t |
| **Pretty** | 38 | 3 (all before SW; all children have completed tertiary level education through money from SW) | Limpopo | Children | Grade 10 incomplete | Not stated | No | F/t |