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UNDERSTANDING THE DYNAMICS OF CONDOM USE AMONG
FEMALE COMMERCIAL SEX WORKERS IN DURBAN CENTRAL
SOUTH AFRICA

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Abstract

Despite the disastrous effects the HIV and AIDS pandemic has on economies of developing countries, sexual behaviour change has been gradually improving, but the epidemic prevalence remains above 10% in most Southern African countries. Econometric studies have shown a strong correlation between HIV/AIDS infection and casual sex. Where commercial sex is legalised, research studies indicate a decline in sexually transmitted infections (STIs), including HIV. A few African countries have made positive strides towards legalising commercial sex which could in some way contribute to curbing the spread of HIV among sex workers. It has been argued that while condom use is increasing in most African countries including South Africa, it remains low and inconsistent. Given that prevention is the mainstay of the response to HIV/AIDS, this research study pursued understanding the dynamics of condom use among female commercial sex workers (FCSWs). The investigation focused on understanding what determines condom use among FCSWs, whilst advancing the notion that men ought to be involved in HIV intervention programmes. Twelve in-depth interviews were conducted with FCSWs in Durban, South Africa. The research results suggested that barriers to condom use still exist in the form of drug and substance abuse, myths about the role of circumcision, retrogressive cultures, violence, competition for clients, and victimisation of sex workers by law enforcement agents, among other factors. Given these barriers, it could be argued that condom use interventions have, to a greater extent, managed to contain HIV infection rates rather than stop them, hence the need for more comprehensive condom use research, especially with sex workers who have multiple partners. Alternatively, sex work should be legalised as this legalisation is strongly associated with condom use among FCSWs.

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Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
CDC:	Centre for Disease Control
HBM:	Health Belief Model
HDM:	Health Decision Model
HIV:	Human Immunodeficiency Virus
FCSWs:	Female Commercial Sex Workers
MSM	Men having sex with men
StatsSA:	Statistics South Africa
SWEAT:	Sex Worker Education and Advocacy Taskforce
STIs:	Sexually Transmitted Infections
UNAIDS:	Joint United Nations Programme on HIV/AIDS
WHO:	World Health Organisation

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Chapter 1: Introduction

Southern Africa has been considered the epicentre of the Human Immunodeficiency Virus (HIV) epidemic. According to UNAIDS (2012), two-thirds of new HIV infections are in sub-Saharan Africa. The former director of the World Health Organisation (WHO) Global programme on Acquired Immune Deficiency Syndrome (AIDS) noted that South Africa was and may still be in the mature stage of a generalised HIV and Acquired Immune Deficiency Syndrome (AIDS) epidemic, where HIV is firmly established in the population (WHO 2007). According to UNAIDS (2012) statistics, there were approximately 34 million people infected with HIV in 2011 and, of these, nearly 23 million live in sub-Saharan Africa (UNAIDS 2012a). It has been estimated that 1.8 million people became newly infected with HIV in 2011 compared to 2.5 million in 2001 [25% decline] (UNAIDS 2012). The decreases in new infections highlight the positive impact of HIV interventions being rolled out globally.

A growing body of literature suggests that HIV epidemics are most concentrated in populations who are most at risk; these include sex workers, men who have sex with men (MSM), people who use drugs and in places where HIV epidemics occur in general populations, especially in developing countries (Baral et al. 2012a). Following years of HIV research, UNAIDS has identified key populations with increased risk of HIV acquisition and transmission and among them are sex workers (WHO 2013a). The understanding of the burden of HIV in populations who are at most risk is poor, hidden and stigmatised in many settings, largely because these populations are poorly represented in national HIV surveillance systems (Baral et al. 2012a). Available literature indicates that female commercial sex workers (FCSWs) are particularly at high risk of HIV infection in nearly every place where they have been studied (Overs and Loff 2013). Heterosexual transmission is responsible for more than three-quarters of HIV infections in Africa (UNFPA 2013).

Commercial sex work is a contested term and has been defined variously across the globe. According to Overs (2002), commercial sex is the exchange of money or goods for sexual services between a sex worker and a client (Overs 2002). UNAIDS expand the definition, stating that sex workers include female, male and transgender adults, and young people who

receive money or goods in exchange for sexual services, either regularly or occasionally (UNAIDS 2009). The contextual definition for FCSWs adopted in this research includes the following common concepts: material benefits that sex workers receive (money or goods for sexual services), the timing (regularly or occasionally) and how the sex workers regard themselves (including those who consciously define those activities as income generating, even if they do not consider sex work as their occupation (Overs 2002).

Between 2007 and 2011, sex workers' HIV infections were highest in sub-Saharan Africa where a third of them were HIV-positive, followed by Eastern Europe with 11%, with approximately 5% in Latin America; the Caribbean had 6.1% and Asia 5.2%; the Middle East and North Africa had an average of 1.7% each (WHO 2012). HIV prevalence of sex workers was estimated to be 30% in Yaoundé, Cameroon and 75% in Kisumu, Kenya (WHO 2013b). In other cities such as Lagos, Rio de Janeiro and Bombay, HIV prevalence among FCSWs was 20 times higher than women attending an antenatal clinic (Plummer et al. 1991).

South Africa has an estimated total population of 52.9 million and, of these, 5.26 million are infected with HIV/AIDS, which equates to a 12.6% HIV prevalence (Statistics South Africa 2013). The vast majority of HIV infections occur in the general population, whilst specific sub-populations including FCSWs, men having sex with men, transgender persons, among others (WHO 2012) continue to be at more risk of contracting HIV in South Africa. According to the South African Aids Council, the national HIV prevalence among South African FCSWs is estimated to be 59.6% (SANAC 2012), whilst the prevalence among women between the ages of 15 and 49 is estimated to be 25% (Baral 2012b). It is further estimated that nearly one-fifth of new HIV infections in South Africa are related to FCSWs (SANAC 2012). In essence, sex workers are drivers of the epidemic, due to the unprotected sex activities that they engage in with multiple partners whilst having limited access to sexual health services (Overs 2002).

KwaZulu Natal is the second largest province in South Africa with an estimated population of 10.5 million people. It is one of the three provinces with the highest HIV prevalence, estimated to be 27.6% in 2013 (Sishana 2013). According to the Sex Workers Education and Advocacy Taskforce (SWEAT), commercial sex workers were estimated to be 153 000 nationwide, inclusive of female, male and transgender (Stacey 2013). Gauteng Province has

the highest number of sex workers 22% [32 409] followed by KwaZulu Natal 16% [24504] (Stacey 2013). South Africa's mature HIV/AIDS epidemic is complex; it has been suggested that structural and behavioural dynamics that include patterns of concurrent partnerships, inconsistent use of condoms, substance and drug abuse, gender power relations and poverty influence the scourge (Kalichman 2010).

In response to the epidemic and STIs, the South African government rolled out a condom promotion programme nationwide. While condom use is increasing in the general populace of South Africa, it remains low and inconsistent in long-term relationships involving sex workers. According to SWEAT, only 5% of sex workers have access to HIV prevention services (Stacey, 2013), implying that some sex workers are not informed or have limited knowledge about condom use.

1.1 Problem statement

South Africa was hard hit by the HIV epidemic in the 1990s. The government responded to the epidemic by implementing HIV prevention interventions that included recommending that the populace abstain, be faithful and condomise [the ABC strategy] (WHO 2011). Although, the prevalence has been gradually decreasing in the general population of adults, from an average of 30% in early 2000 to just below 14% in 2012, it is still unacceptably high at an estimated 60% among sex workers (WHO 2011). Since heterosexual sex is the main way of transmission of HIV in South Africa, it becomes important to understand the dynamics of condom use by FCSWs, as they frequently engage in unprotected sex activities with multiple partners. Literature reveals that condom use is high among the general populace, but remains low and inconsistent in long-term relationships involving FCSWs. Given that prevention is the mainstay of the response to HIV (WHO 2011), understanding the dynamics of condom use among sex workers can contribute to the reduction of HIV prevalence and incidence among FCSWs.

1.2 Aims and Objectives

The overall aim of the research has been to understand and shed insights into the dynamics of condom use among FCSWs in Durban Central, South Africa.

Specific objectives of the study were:

- to explore and assess knowledge of correct and consistent use of condoms by FCSWs
- to assess the perceived barriers to condom use by FCSWs who operate in Durban Central
- to explore opportunities for using condoms
- to ascertain the socio-cultural and behavioral factors influencing condom use

1.3 Type of study and methods

This research was a qualitative study that targeted FCSWs who operated in Durban Central. In-depth interviews were administered to the research participants; emphasis was put on depth rather than breadth. Snowball sampling which falls under purposive sampling was employed in the study. Snowball sampling is a non-probability sampling method which can be used to collect data on a target population which is difficult to identify (Patton 1990). The method also involves the researcher identifying a few participants through accidental sampling or by asking the first few participants to refer the researcher to more participants who meet the criteria of the research and who might be willing to partake in the study (Sarantakosi 2005). In this case, sex workers were recruited in Durban Central through accidental sampling, referrals from sex worker contacts identified by SWEAT, an organisation that defends rights of sex workers in South Africa (Sarantakosi 2005). The reason for choosing this method was the anticipated difficulty in approaching FCSWs in another way. Desk reviews were done to augment the primary data that was collected. Questions were carefully designed to understand and create more knowledge about issues and perceptions of condom use as a protective measure against HIV/AIDS in South Africa.

1.4 Significance of the study

HIV prevention programme targeting groups with a high rate of partner change, including sex workers, have not only been recognised as a strategy to control the spread of HIV, but could

be useful as they serve as a means of helping FCSWs practise safe sex, thereby saving their lives and that of their partners. The use of condoms is desirable and cost-effective (WHO 2012) . Research has been carried out on HIV and condom use among FCSWs in South Africa; an example is the research conducted by Varga (1997) that examined condom use among FCSWs in Durban. The study explored the socio-behavioural factors of using condoms between FCSWs and their partners. The results demonstrated that inconsistent condom use was prevalent during transactional sex and in regular partnerships (Varga 1997). Since 1997, the general HIV landscape in South Africa has changed; a decrease in HIV prevalence and incidence rates has been recorded in the general populace (SANAC 2012).

Following research, it has been argued that implementing HIV prevention programmes among FCSWs has the potential to improve the health of individual sex workers as well as to curb HIV and STI transmission to the general population (WHO 2012). FCSWs therefore continue to be a key component of the HIV transmission dynamics in South Africa (Chen et al. 2007). As previously stated, the national HIV landscape has changed in the past decade and the study acted as a follow-up to the work done by Varga in Durban fifteen years ago.

Although, substantial research on HIV has been conducted, there is still a paucity of evidence with regard to understanding the determinants of condom use among FCSWs in Durban, South Africa. The HIV prevalence of 60% among FCSWs in South Africa is unacceptable, hence the need for more research on understanding ways of reducing HIV transmission in this group (SANAC 2013). The study thus builds on and contributes to HIV prevention studies and the field of sexual health behaviour in South Africa.

1.5 Theoretical framework

The study was based on the Health Decision Model (HDM) and data analysis followed the theory's principles. The HDM is an advanced model of the Health Belief Model (HBM), first developed in the 1950s and fine-tuned to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV/AIDS (University of Twente 2013)

The model's principles state that people do not want to get diseases; in addition, precautions about health are determined and motivated by anxiety (perceived threat). The model suggests that

people will take calculated health decisions if they foresee a negative outcome. An example would be an instance where HIV can be avoided by using a recommended action such as the use of condoms in the prevention of HIV (Rosenstock 1974). The model further denotes that people must be confident to use condoms comfortably and with confidence (University of Twente 2013). The underlying concept of the original HBM is that HIV prevention behaviour is influenced and governed by beliefs of people or how they view HIV and the available preventative strategies used to reduce its occurrence (Maddux and Rogers 1998). Four constructs of the HBM are outlined as follows:

Table 1.1: Constructs of HBM

Perceived susceptibility	Vulnerability of contracting HIV
Perceived severity	The effects of HIV and costs
Perceived benefits	Efficiency of recommended actions to avoid contracting HIV or reduce the impact after infection
Perceived barriers	Costs of the recommended action

Source: Rosenstock (1974)

The Health Decision Model (HDM) is a modification of a number of models which include the HBM. In addition to the four constructs of the HBM, the HDM incorporates social and socio-economic aspects (Fan et al. 2004). The HDM states that behaviours and decisions about health are constantly made after interacting with other people (Fan et al. 2004). Thus, it is imperative to consider social variables (condom knowledge, past experience of using condoms, socio-demographic knowledge), socio-cultural factors, and patient preferences which put emphasis on critical trade-offs between benefits and risks (Eraker et al. 1985). These concepts allow the researcher to unpack HIV protective measures used by FCSWs and their clients. Using a condom to prevent HIV requires two people to cooperatively take action. This implies that a discussion of whether to use or not to use a condom as an HIV protective measures has to take place between an FCSWs and her client before the sexual act (Glanz and Rimer 1997).

HDM considers additional insights into why FCSWs and their clients may or may not follow the recommended HIV protective action and helps to identify leverage points for HIV

behaviour change. The model allows research to capture current views, while considering cultural values and social contexts in which participants live, making it the most relevant model to explore issues of condom use among FCSWs in Durban (Fan et al. 2004). In addition, the model was used to expound relevant modifying factors such as incentives, health professionals, law, violence, personal relationships, and operating environments that affect behaviour compliance in sexual activities (Eraker et al. 1985).

Table 1.2 below presents the HDM concepts, definitions and elaborate how the concepts were adapted in the study (last column bolded).

Table 1.2: Health Decision Model

Concept	Definition	Adaptation in FCSW study
General health beliefs	One's view or belief of getting a condition	Capture sex workers opinions of chances to get HIV; do they believe that they can get HIV?
Specific health beliefs	One's view or belief on the seriousness of the condition under discussion and the effects of the condition	Interrogate sex workers opinion of effects of contracting HIV; do they believe that the consequences of getting HIV are significant enough to try to avoid?
Patient preferences	Individuals weigh benefits and barriers of recommended action. Individuals' perceptions are important.	Identify trade-offs between benefits and risks to HIV protection
Experience	Previous health experiences influence present decisions	Capture perceptions of using HIV protection measures; do they believe in using condoms for HIV prevention?
Knowledge cues to action	Knowledge about condition can activate readiness to adopt and adapt recommended actions	Find out knowledge that FCSWs have about HIV, HIV prevention-condoms.
Social interaction	Social connectedness has an influence on our experience and knowledge	Capture cultural values and social context in which FCSWs live and how those influence their behaviour.
Socio demographic factors; Self-efficacy	Experience, knowledge, and social interaction can be influenced by age, sex, income, educational level etc.	Find out from FCSWs how confident they are on insisting on condom use, taking into consideration their age, level of education, income etc.
Previous health decisions	Previous health decisions influence present decisions.	Find out how previous health decisions influence present behaviour.

Source: Twente University (2013), Glanz, Rimer and Lewis (2002).

1.6 Outline of study

The first chapter provided background information of the study. The second chapter consists of a literature review on the dynamics of condom use among FCSWs. The section reviews prevalence of condom use among sex workers and factors that determine use or non-use of condoms in commercial sexual encounters. It also looks at the use of condoms with occasional and regular clients and other factors that influence the use or non-use of condoms

by FCSWs. The third chapter presents the methodology for the research study and explains processes followed when data was collected and analysed. The fourth chapter presents the results of this research study. The chapter captures the dynamics of condom use, influences of condom use and other underlying factors that contribute to the decision to use or not use condoms. Direct quotes extracted from interview transcripts are used to support results. The final chapter ties together the background, context, theoretical framework, concluding with analyses drawn from the in-depth interviews. It provides recommendations on the use of condoms by FCSWs in South Africa.

Chapter 2: Literature review

In order to begin exploring dynamics of condom use by FCSWs in Durban, it is important to understand the position and how sex work is regarded in Africa and in the larger international context. In this chapter, a landscape review of the literature is done in order to have a broader understanding of the dynamics of condom use by FCSWs globally and with particular reference to South Africa. Literature highlights that understanding risk behaviours and factors associated with the ability to negotiate safe sex and condom use remains important to curbing the spread of HIV in South Africa.

2.1 FCSWs and HIV

Literature on sex work portrays FCSWs as a population that is more vulnerable to STIs including HIV, because they do not have the means to acquire economic resources and influential positions of power to negotiate safer sexual behaviour (Kalichman 2010). Researchers further comment that men are more likely to initiate, dominate, and control sexual interactions and reproductive decision-making than women (Gupta et al. 1996). As a result of high HIV infection rates and multiple sexual partners, unequal power relations, the likelihood of a history of other sexually transmitted infections, and the circumstances of sex work, often involving alcohol, drugs and/or violence, sex workers are vulnerable to HIV and have been considered a key cluster for the transmission of the virus (Plummer et al. 1991).

2.2 Entry into sex work

Numerous reasons are put forward as to why females become commercial sex workers. In most African countries, poverty seems to be the main pressurising factor behind FCSWs. High levels of unemployment and lack of adequate social protection systems have resulted in extensive poverty, which renders people more vulnerable to contracting HIV (Bucardo et al. 2004, Statistics South Africa 2013). Pull factors cause rural young girls to migrate to cities in search of work and better life conditions, but most of them struggle to find meaningful work and are forced into selling sex due to financial necessity (WHO 2011). In a survey carried out by SWEAT, sex workers reported that they joined prostitution because they failed to secure meaningful employment (Gould 2008).

Faced with the challenges of the 21st century, some women regard sex as a commodity that has potential to bring economic benefits. According to Fick (2006), FCSWs sell sex after identifying the trade as the easiest way of earning money that they can find (Gould 2008). On the other hand, men create demand for sex and are willing to pay for it. Older men who in most cases are financially stable, purchase sex or offer gifts in exchange for sex from young women (Glynn 2001).

As previously mentioned, the root cause of sexual exploitation of young girls is directly linked to poverty (WHO 2011). Poor, homeless young girls fall prey to organised sex rings; they are exploited and at times forced to sell sex (WHO 2011). Older men prefer young sex workers and they lure them by offering to pay more for their services (Shisana et al. 2009). Globally, FCSWs are known to be highly mobile and research reveals that mobile women are more likely to be involved in sex work than their non-mobile counterparts (Aklilu et al. 2001, Basuki et al. 2002, WHO 2011). In addition, mobile sex workers face challenges of accessing health services, HIV information and prevention products such as condoms. As a result, some of them are not well informed about the risks associated with sex work.

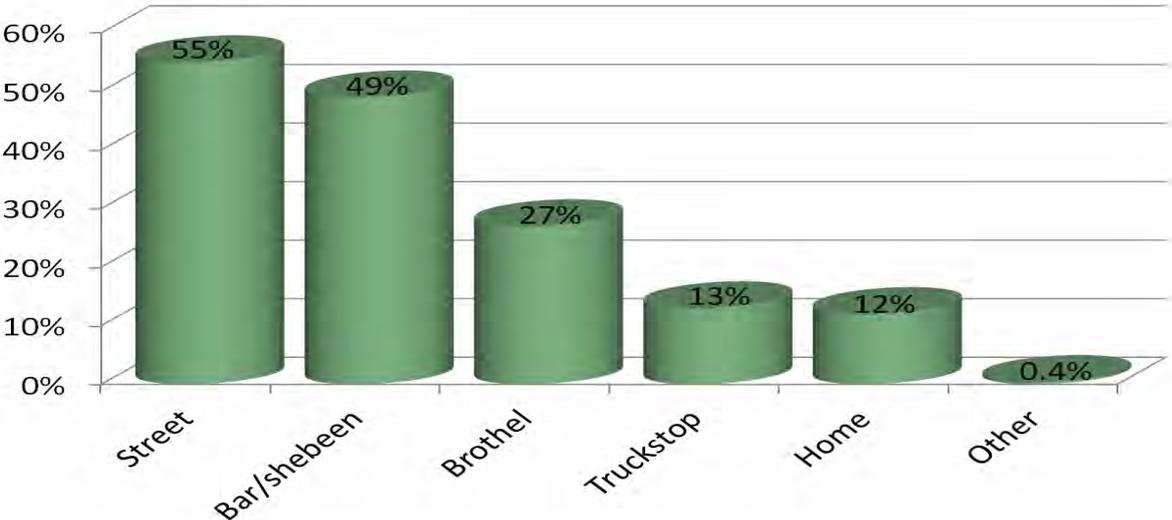
2.3 Different types of sex work

Globally, commercial sex work takes place in different settings (Overs 2002). In developing countries, sex workers primarily solicit their clients in streets, bars, highways, night clubs and provide services at a hotel, lodge or a place of the client's choice, as they lack access to legalised indoor places (Varga 2001). When lodges are used for sexual activities, the pimps, third parties, owners or managers of these premises are not directly involved. In fact, the sex workers deal directly with their clients, thereby eliminating a controller (Baral et al. 2012a). They negotiate payments for services and they are responsible for settling rent for use of the premises (The Synergy Project 2013).

In developed countries and parts of Asia, FCSWs provide services at legalised brothels; agents such as pimps, gatekeepers, owners, madams or mediators solicit clients and are responsible for appointment bookings on behalf of sex workers (Overs 2002). In most cases, the operations of sex workers in brothels are well stipulated, with the role of agents clearly stated (WHO 2011). The pimps, who are better placed to encourage condom use, have the

potential to impede its use. In Indonesia it has been reported that the pimps consider condom use as a threat to their business so do not promote its use (Basuki et al. 2002). Within the highly organised sex work, escort agencies and massage parlours engage sex workers of higher socio-economic status, while sex workers who are poor commonly solicit clients on the streets, in harbours, mines or bars (Karim et al. 1995). Officially, there are no registered brothels in most African countries, but research has put forward the argument that some lodges and massage parlours have been turned into informal brothels. More often, the social standing and demographic characteristics of FCSWs determine where they operate from (WHO 2011). According to SWEAT, the majority of FCSWs who operate from the streets are vulnerable to violence and experience abuse from law enforcement agents and clients (Stacey 2013). People who look down upon street work suggest that most sex workers lack support and reasonable safety in brothels and bars; this exposes them to violence and abuse from clients and police (Shannon et al. 2008).

Figure 2.1: Sex work locations in South Africa



Source: Stacey (2013)

Sex work is rampant in many parts of Durban including Durban Central Glenwood-Umbilo residential areas. Clients, who in most cases are driving, openly pick up FCSWs during the day in Esther Roberts and Clark Roads in Glenwood. The community, through Bulwer

Community Safety Forum, have been making efforts to eliminate FCSWs by carrying out raids where they spray them with a toxic substance and throw raw eggs at them (Nair 2013). Despite all these efforts, sex work is still rife in Glenwood and surrounding areas.

A significant fraction of sex workers in sub-Saharan Africa regard themselves as occasional or 'part-time' sex workers (Elmore-Meegan et al. 2004). Some FCSWs regard sex work income as their basic income, while others regard it as occasional income (WHO 2011). According to Harcourt and Donovan (2005), sex workers are grouped depending on where they operate from, how they solicit clients, type of sexual services provided, income that the sex workers get, among other factors (Harcourt and Donovan 2005).

2.4 Clients of sex workers

According to Overs (2002), clients of sex workers are men who pay with money or other resources for sexual services, either explicitly or within an agreed package that includes other services such as entertainment or domestic services. Sex workers draw clients from a wide range of social classes and groups including the upper class, middle class, low class, the poor, married, unmarried, young, old, black or white and foreigners (WHO 2011). According to WHO (2011), some environments and places exacerbate the demand for sex work. Notably, common clients for FCSWs are men working as truck drivers, in the military, on ships, or as migrant workers in the mining sectors (WHO 2011).

Table 2.2 below summarises the type of sex work and the geographical area where the kind of commercial sex work is found or is most common.

Table 2.2: Type of sex work

Type of sex work	Geographic distribution
Street sex work	Common in most parts of the world especially where there is socio-economic breakdown – Africa, United States, UK, Europe, South and South East Asia, and Latin America
Brothel: organised sex and licensed	Found in countries where sex work is not illegal – Australia, India, South East Asia, Latin America
Sex workers solicit clients in alcohol-vending venues and are serviced on site or elsewhere.	Universal
Escort: Clients use phone or agents to contact sex workers. It is not common and expensive.	Universal
Private sex workers: Contacting sex workers is done through phone and services are provided in sex workers' premises.	Common in developed countries
Male settings: Clients are solicited in all-male venues such as barbershops, mining camps etc. Services are offered on site or elsewhere.	Universal
CB radio: Sex workers drive along highways using CB radio to exchange messages with potential truck driver clients. Services are offered at truck stops.	USA
Other methods: Clients are solicited through noticeboards, newspaper advertisements, sex worker catalogues etc. Services offered in brothels and indoor venues	Universal but in developed nations (UK, Sweden) or large cities, both clients and sex workers use cell phones and the Internet.

Source: Harcourt and Donovan (2005)

2.5 Condoms as HIV/AIDS prevention measure

According to the Director of the WHO Department of HIV/AIDS, Dr. Hirschall, sex workers have a higher risk of being infected with HIV and STIs than other sub-populations (WHO 2012). One of the innovative ways to fight HIV/AIDS has been the ABC (Abstain, Be faithful and Condomise) strategy or campaign (Okware et al. 2005). Most African governments including South Africa have rolled out mass media campaigns in the promotion of condoms, as one of the strategies to prevent the transmission of HIV/AIDS in the last few decades (UNAIDS 2004a). Behavioural interventions such as abstinence and being faithful have been

developed to relay health-related, psychological and social gains of not engaging in sexual activity. Over the years, research has indicated that such kind of interventions have little impact in the prevention of HIV transmission (Underhill et al. 2007). Other interventions that have been given priority include encouragement to lower the number of sexual partners, using female-controlled barriers, masturbation, avoiding physical trauma with sex and promptly recognising and treating sexually transmitted diseases (UNAIDS 2008).

2.6 Male condom

According to UNAIDS (2004), a male condom is a sheath worn over the penis, while a female condom is worn inside the vagina during sexual intercourse to prevent pregnancy, transmission of HIV and sexually transmitted infections (UNAIDS 2004b). Thus far, the male condom has systematically been proven to be the single, most efficient, available technology to lower sexual transmission of HIV and other STIs (UNAIDS 2004b). Basing on evidence from research among HIV heterosexual discordant partners, it has been concluded that if condoms are used correctly and consistently, the risk of HIV transmission is significantly reduced from men to women and vice versa (Holmes et al. 2004). Scientific laboratory studies have also proved that male latex condoms are impervious to communicable agents found in genital discharges (WHO 2013a).

While it is debatable whether one can attribute the drop of national HIV rates to any one programme, there is increasing evidence that targeted condom programmes have resulted in positive risk reduction and decreased levels of HIV infection in a number of countries with mature or concentrated HIV epidemics (WHO 2011). Uganda was one of the first countries that had high HIV/AIDS prevalence in the 1990s. The Ugandan government responded to the epidemic by increasing condom use, in combination with encouragement of delaying sexual debut; this resulted in the decline of HIV prevalence (Singh et al. 2003). Thailand implemented the 100% condom intervention which was associated with an increase in condom use among sex workers and their clients (from 14% to 94% from 1989 to 1993) and that had a dramatic positive impact in the transmission of HIV/AIDS to the general population (Hananberg et al. 1994, (UNAIDS 2004b). A similar policy in Cambodia resulted in stabilisation of HIV prevalence nationally, while substantially decreasing prevalence among sex workers (UNAIDS 2004b) In Brazil, the rolling out of condom promotion was done early

to HIV-susceptible groups and the general population – this successfully contributed to the continuous control of the epidemic (UNAIDS 2004b).

According to Wojcicki and Malala (2001), there are different ways in which the male condom might be used. The most common way of using the condom is through penile to vaginal sex or vaginal to penile sex, followed by penile anal sex and oral genital sex (Wojcicki and Malala 2001). Protection is compromised when people switch between unprotected oral sex to possibly protected vaginal sex, acts of vaginal (or anal) intercourse with delayed application or early removal of the condom (Wojcicki and Malala 2001). The Centre for Disease Control (CDC) guidelines recommends correct and consistent condom use in all sexual behaviours and activities (Workowski et al. 2010).

2.7 Female condom

The female condom was first introduced in the early 1990s; it received a lot of attention due to its prevention potential to help correct power dynamics in heterosexual relationships skewed in favour of men (Minnis et al. 2003, Mathenjwa and Maharaj 2012). The female condom gives women a variety of options in the protection from HIV, especially with men who insist on having unprotected sex. According to Mathenjwa and Maharaj (2012), for the first time women have the power to decide whether to use or not, and when to insert the female condom. Varga (2001), highlights that FCSWs have the option to fake unprotected sex by putting on or wearing a female condom charging more money. Further review of literature indicates that the device is effective in increasing protected sex acts six fold to eightfold and lowering the incidence of STIs (Hoke et al. 2007). However, there are scholars who maintain that the use of the female condom must not be overrated; they argue that its use still requires male cooperation and that women do not make sexual decisions alone (Chersich and Rees 2008). Although female condoms are available in public spaces such as bars, public spaces and health care centres, they remain underutilised as an HIV-prevention strategy in South Africa.

2.8 Dynamics of condom use

Most research and interventions targeting FCSWs have focussed on prevention of HIV and AIDS through condom promotion, with the emphasis being put on correct and consistent use,

with little attention being put on the timing of condom use negotiation (Brahme et al. 2006). A growing body of literature indicates that correct and consistent use of condoms is linked to communication between partners, which, in most cases, does not take place in African societies (Wong et al. 1994). In a study with FCSWs serving male truck drivers in a South African setting, women fail to negotiate to insist on condom use for fear of loss of income and physical harassment (Karim et al. 1995).

One contextual factor that determines the use or non-use of condoms pertains to working sites and the working conditions in which FCSWs find themselves. Condom use in developed countries seems to be higher in indoor settings and organised prostitution. Research conducted in Nevada points out that FCSWs operating in a legalised setting are in a better position to communicate and negotiate condom use with clients and management providing them with safe places, hence the chances of harassment are reduced (Hananberg et al. 1994, Albert et al. 1995). In India it was found out that street-based FCSWs are nearly three and a half times less likely to use condoms with clients when compared to sex workers who work in brothels (Brahme et al. 2006).

2.8.1 Economics and condom use

Anecdotal data suggests that sex workers who use condoms face large income losses because clients have a preference for condom-free sex (Rao et al. 2003, Bucardo et al. 2004). The importance of the economic situation of sex workers in determining condom use cannot be underestimated (UNFPA 2013). Economic incentives play a role in the determination of condom use by FCSWs in both developed and developing countries (Jackson and Highcrest 1996, Basuki et al. 2002, Bucardo et al. 2004). In developed countries, sex workers become more vulnerable and fail to negotiate safe sex during economic recessions. In most cases, males are financially more stable than women and dictate use or non-use of condoms during a sexual encounter with FCSWs (WHO 2011).

Money is the key determining factor in the willingness to engage in high-risk sex without a condom by FCSWs and that outweighs health concerns (Varga 2001, Bucardo et al. 2004). In South Africa, research has suggested that 67% of unprotected sex is due to financial incentives offered by male clients (Varga 1997). South African sex workers in Johannesburg

indicated that the common reason for choosing not to use condoms was the offer of more money for unprotected sex (Wojcicki and Malala 2001). In this study it was established that economic hardship and consequent competition between women for clients contributes to unsafe sex. In the early 90s, it was reported that FCSWs who accommodated sex without a condom attracted more clients than those who insisted on condom use (Wojcicki and Malala 2001).

2.8.2 Condom use in steady, regular and casual relationships

In several studies, FCSWs sexual partners are grouped into two groups namely: steady/personal clients and professional/casual (Varga 2001). Steady/personal relationships involve clients who have been in a relationship with sex workers for a considerable period of time. The relationships tend to develop due to frequency of service provision and trust that both partners build over time. As a result of trust, FCSWs regard regular clients as clean and safe, trustworthy, emotionally intimate and loving; this compromises the use of condoms for fear of losing regular income (Varga 2001, Adu-Oppong et al. 2007, Kayembe et al. 2008). Steady clients who are confident are likely to be afforded sex without a condom; attractiveness of clients also influences FCSWs decision to abstain from condom use (Martina et al. 1995). According to Varga (2001), steady clients contributed 8% of the unprotected sex with FCSWs in Durban.

In Mexico, FCSWs stated that they rarely used condoms with their steady partners for a number of reasons that included the view of condoms as symbolic barriers to intimacy, love and feelings of connectedness; non-use of condoms was regarded as a manner of distinguishing private life and their work (Castañeda et al. 1996). In another study it was observed that FCSWs reiterated that condoms create distance with their clients, thereby limiting intimacy behaviours such as kissing (Warr and Pyett 1999, Sanders 2002, Allen et al. 2003). In other instances, FCSWs avoided communication regarding condom use with their steady clients, while others lied about multiple partners (Syvertsen et al. 2013).

Despite the evidence that FCSWs are aware of the dangers of engaging in unprotected sex, promoting condom use in settings of regular non-paying partners of sex workers in Malawi resulted in more than a 20% increase in condom use with professional or casual clients, but

condom use with regular partners did not increase (Walden et al. 1999). This implies that FCSWs insist on condom use when providing services to professional or casual clients (professional or casual clients are male clients who do not necessarily have a relationship with female sex workers). The majority of FCSWs entertain clients they do not know and have hardly any information about them. Sex with casual clients is strictly on business terms, with consistent condom use all the time (Varga 1997). Casual clients are considered “dirty” “unsafe”, “untrustworthy” and emotionally sterile (Varga 2001). In studies carried out in Zimbabwe and Benin, commercial sex workers differentiated condom use between steady partners and professional clients. Even where condom use by FCSWs increased, it still remained low in steady relationships as compared to professional relationships (Ray et al. 2001, Alary et al. 2002). FCSWs in Johannesburg, South Africa indicated that they were not prepared to engage in unprotected sex with a stranger, but would throw away their HIV-protection values with steady clients who were considered to be a source of steady income (Wojcicki and Malala 2001).

2.9 Risk perception

The HIV infection rate among FCSWs varies by geographical epidemic typology, structure of sex work, and overlapping nature of HIV-risk behaviours such as alcohol intake. There are essentially three forms of risk: behavioural, biological or biomedical, and structural risks (Cwikel et al. 2008). At individual level are behavioural risk factors such as experiencing high-risk sexual exposures through many concurrent multiple partners. Biologically or biomedically includes the high prevalence of bacterial sexually transmitted infections in sex workers; the synergistic relation between HIV and STIs compounds their risks (Baral et al. 2012a). Structural risk factors such as poverty, sexual violence, power dynamics of sex work, legal and regulatory factors among others have been shown to contribute to sex workers’ increased risk of HIV infection by limiting their ability to negotiate safer sex (Rosenheck et al. 2010).

Further analysis of FCSWs sexual behaviours by scholars has pointed to the relationship between higher service charges and perceived risk of contracting HIV/AIDS (Ntumbanzondo et al. 2006, Rou et al. 2007). Sacco et al. (1990) suggests that the HIV status of partners has an influence on the use of condoms; study participants who believe or assume that their

partners are not infected by HIV may easily accommodate sex without a condom and assume that they are negative. It is also argued that HIV positive clients may deliberately conceal their status out of fear that condom use will be insisted upon (Sacco et al. 1990). Some studies have found a strong association between HIV-negative participants and inconsistent condom use with paying clients (Maharaj 2006, Anderson et al. 2007, Shobo 2007). Other FCSWs would insist on condom use during vaginal sex but not oral sex, as they allege that clients took longer to reach orgasm when putting on condoms (Wojcicki and Malala 2001). In Indonesia, the main reasons for FCSWs not using condoms were the beliefs that boyfriends, native Indonesians and healthy-looking clients cannot spread STIs. At times sex workers do not use condoms after taking antibiotics as an HIV preventive measure (Basuki et al. 2002).

2.9.1 Influence of substance abuse

Scholarly articles reiterate that alcohol and drug use are associated with increased risk behaviour due to the impairment in both judgement and decision-making (Kalichman et al. 2008, Wechsberg et al. 2008). The abuse of alcohol and other intoxicating substances is rampant among younger and poorer sex workers in Africa (Macklean et al. 2010). When intoxicated, FCSWs' ability to negotiate correct and consistent condom use is compromised (Clift et al. 2003). Taking alcohol, dagga or hard drugs such as mandrax negatively affect the use of condoms among FCSWs (Varga 1997). The recurring point from various international studies is that substance abuse is common among FCSWs and that intoxication does not only affect sexual decision-making but also impedes condom use (Lowndes 2007). According to WHO (2011), FCSWs negotiate and insist on condom use before getting drunk but, when intoxicated, the use or insistence of condom use is compromised.

2.10 Sociocultural factors

South Africa is a country with various traditional practices, beliefs, norms and values that unfortunately negatively contribute to increased risky sexual practices in the general populace. Cultural practices include contraceptive use, dry sex practices, unequal gender power relations, polygamy, violence and sexual violence, sexual networking, perspectives on sexual orientation, explanatory models for disease and misfortune, among others (UNESCO 2002). Although contemporary influences have been blended with local tradition, there are some practices that are dominant and put both women and men at risk of contracting

HIV/AIDS. The extent to which both males and females are able to define several characteristics of their sexual lives, for example, the power to negotiate for safe sex, is critical in determining their vulnerability to HIV/AIDS.

Socio-cultural norms define and contribute to masculinity and femininity, which in turn create unequal power relations between women and men in society (WHO 2011). The power imbalance gives men authority, access to information, resources and freedom to make decisions on sexual issues; women are expected to be submissive and thus are more vulnerable to HIV than men.

African patriarchal societies encourage men to be dominant in all sexual activities. This implies that men make decisions about the use or non-use of condoms as an HIV preventative measure. In addition, the African patriarchal societies encourage men to engage in risky sexual behaviours as a way of proving manhood. Multiple partnering is closely linked to constructions of masculinity, which define them as the norm for men (Peacock and Levack 2004). In many cultures, variety in sexual partners is seen as essential to men's nature (WHO 2002). Relative to women, men are more likely to have multiple partners simultaneously, more likely to be unfaithful to their regular sexual partner, and more likely to buy sex (Peacock and Levack 2004).

The influence of harmful cultural norms and practices such as dry sex puts FCSWs at the risk of contracting HIV/AIDS. Dry sex or vaginal douching is one of the cultural practices that aims to increase men's sexual pleasure (Baleta 1998). Dry sex involves cleaning of the vagina with a variety of substances in an effort to make it dry before or after sex; such a practice has the potential to disturb the genital mucosa or to cause inflammation, increasing the risk of acquiring HIV by women (WHO 2011). It has also been suggested that bacterial vaginosis, associated with vaginal cleansing, could be an intermediary factor between vaginal practices and HIV infection (WHO 2011). In a study carried out in Kenya, it was found that the insertion of substances in vaginas by sex workers puts them at higher risk of acquiring HIV (Sandy et al. 2012). According to Bagnol and Mariano (2008), this practice has negative implications for the uptake of HIV prevention strategies such as microbicides and condoms. Some sex workers use a variety of substances as a way of reducing the chances of contracting HIV after engaging in unprotected sex (Sharma 2006).

Acculturation has seen some of the black population practising anal and oral sex, which puts them at higher risk of contracting HIV/AIDS, as condoms are rarely used in these acts. In South Africa, research suggests that sex workers who had only performed oral sex had a low risk of contracting HIV, but sex workers who practised anal sex were three and a half times more likely to get HIV (Wechsberg 2006). In a nutshell, men are perceived to be superior and women are perceived to be inferior; as a result, men are expected to make final decisions about the use of condoms during sexual intercourse.

2.11 Physical violence

Violence against women is a common challenge in South Africa and it is strongly linked to masculinity and femininity issues as dictated by culture. Violence is not just a matter of individual acts and behaviour, however. Violence is institutionalised and rooted in histories and structures of inequality and oppression, including patriarchy, colonialism, racism, and economic exploitation (Peacock and Levack 2004). In an attempt to maintain superiority, it is reported that men often use violence over women (Benson 1998) and FCSWs are not spared from physical and sexual violence. FCSWs are regularly raped; condoms are rarely used in such situations and this increases the risk of contracting HIV infection (Wojcicki and Malala 2001). In a study carried out in the Free State Goldfields, South Africa, FCSWs were afraid to insist on condom usage as they feared violence from clients (Leclerc-Madlala 2003). Research conducted in Bangladesh, Namibia, India and Canada reveal that many street sex workers experience violence in the form of rape, being beaten, slashed, choked, among other acts (Hubbard and Zimba 2003, Shannon et al. 2008). What further complicates the situation is that the FCSWs cannot report such kind of abuses because sex work is illegal in South Africa.

According to WHO (2013a), women who are physically abused lack the confidence to negotiate safer sex; their partners become violent if denied condomless sex. FCSWs targeting truck drivers between Durban and Johannesburg failed to insist on condom use because clients complained that sex without a condom was not satisfactory and clients became more violent (Karim et.al. 1995). Furthermore, FCSWs live precarious lives, are sometimes harassed by law enforcement agents and at times cannot afford to have condoms, which increases their vulnerability to HIV and other health concerns.

2.12 Other issues

The current legal situation in South Africa involves the criminalisation of sex work with consequences such as the abuse of sex workers' rights, violence against them and abusive treatment by law enforcement agents (Farley 2005). Criminalisation seeks to decrease or eliminate the sex industry and is supported by activists who oppose sex work, basing their arguments on moral, religious or feminist grounds (Hughes and Roche 1999, Brents et al. 2010). Without protection by the law, FCSWs are left vulnerable to HIV/AIDS and other human rights abuses. They are raped, forced to have sex without condoms, and physically abused by clients and agents (Mossman 2007). Research suggests that where sex work has been legalised, for instance in the Netherlands, Germany, Iceland, Switzerland, Austria, Denmark, Greece, Turkey, Senegal and the State of Nevada in the USA, levels of violence against FCSWs are low. The legalisation of sex work is associated with the improvement of relationships between sex workers and police, a decrease in trafficking or commercial exploitation of women, and FCSWs are better placed to negotiate condom use with clients (Mossman 2007).

Promoting condom use without making them available is futile. A growing body of literature indicates that improved availability of free condoms in high risk places leads to increase in condom use among people with multiple partners (Glanz and Rimer 1997). Condom promotion in Thailand resulted in condoms being frequently used which led to a drop in HIV prevalence. In other studies, it has been established that there are other variables that interfere with non-use of condoms with clients, which include the age of the female sex worker, marital status, literacy level, financial status, poor social support, her family being unaware of sex work and a lack of participation in FCSWs support groups, among other reasons (National Institute of Medical Statistics 2010). In India, it has been reported that knowledge that HIV can be prevented was associated with use of condom for penetrative sex between FCSWs and their clients (Dandona et al. 2005).

In another study that assessed condom availability in clinics, shops, and other outlets in rural and urban South Africa, the results indicated that condoms were readily available in public health facilities (100%) but were not readily available in non-health facilities [10%] (Gilmour et al. 2000). The study concluded that condom awareness was not equally proportional to

condom availability. It has been argued that condom use depends on whether the condoms are available at the time of sex, convincing clients to use condoms or clients convincing sex workers to use condoms (Dandona et al. 2005).

2.13 Conclusion

The chapter provided a comprehensive overview of existing literature on dynamics of condom use by FCSWs across the globe. Literature revealed that sex work is common in most African countries including South Africa and the dynamics of condom use by FCSWs is an important feature of the transmission dynamics of HIV (Steiner and Cates 2006). FCSWs have knowledge of the importance of using condoms in HIV prevention. A growing body of literature indicates that there is inconsistent use of condoms by FCSWs in regular or steady relationships. Some of the reasons that influence the non-use of condoms with regular or steady partners include fear of loss of income, trust, intimacy and physical violence. Female sex worker who work in legalised brothels are better placed to negotiate condom use when compared to those who work in societies where sex work is criminalised. Condom use promotions have successfully been run in a number of countries, supporting the fact that prevention is better than cure. The next chapter discusses the research methods, instruments used and ethical considerations for the study.

Chapter 3: Methodology

The previous chapters brought to the fore previous research results on condom use by FCSWs across the globe. This chapter describes the methods used in data collection and analysis in the study. The first part describes the study context; the second part explains the methodology used, justifying why in-depth interviews were used and stating the strengths and weaknesses of the data collection technique. The last part of this chapter dwells on the limitations and ethical considerations of the study.

3.1 Study context

Durban is a coastal city with a harbour and many hotels at the beachfront which are frequented by female sex workers from different parts of the world. Durban sex workers were the focus of this work because KwaZulu Natal is the second most populous province with 10.5 million people [19.7% of total population] (Statistics South Africa 2013). Furthermore, the province has the highest HIV/AIDS prevalence (15%) in South Africa (UNFPA 2013). Participants were drawn from the Durban Point area, South Beach, Glenwood, Berea, Umbilo and Morningside residential areas (see Figure 3.1 below).

in-depth interview guide was developed; it outlined a set of issues that were explored with each participant. The guide served as a checklist and ensured that all relevant issues about condom use were covered with each respondent, although the researcher was free to explore, probe, and ask questions that explicated and expounded on the dynamics of condom use by FCSWs.

The main advantage of in-depth interviews was that it allowed the researcher to collect detailed information that would not have been possible through other collection methods, such as surveys (Patton 2002). The interview guide gave room for the researcher to carefully decide on how to use the limited time available by sex workers. The guide helped in interviewing a number of different people in a systematic and comprehensive way, by delimiting in advance the issues to be explored. Thus, the guide gave direction and sequence in which questions were asked, giving the researcher the room to probe important issues about the use of condoms (see Appendix 3 for the In-depth interview guide). Through establishment of rapport, the researcher engaged the participants in agreeing to a set of rules that guided the interviews. On the other hand, in-depth interviewing had its own disadvantages. Although the researcher emphasised the importance of honest answers and took precautions to avoid overgeneralised responses, there were chances that the interview data was possibly distorted as a result of personal and recall error of the researcher (Patton 2002).

3.3 Data collection process

The study targeted FCSWs who worked in Durban Central, South Africa. Data was collected from participants who were recruited with the assistance of SWEAT through its subsidiary Sisonke. SWEAT is an organisation that has been advocating for sex workers' rights in South Africa for the past two decades. Snowballing was used as the sampling method in the study. Snowball sampling is a non-probability sampling method which allowed the researcher, with the assistance of Sisonke, to identify and recruit eligible participants. After being interviewed, the first few participants referred the researcher to other potential participants who met the criteria of the research and were willing to take part in the study. Snowball sampling was used because it was anticipated that recruiting FCSWs for the study was going to be difficult. Prior to the interviews, the researcher had a meeting with the coordinator of Sisonke where the aims, objectives and ethics considerations for the research were explained. During the

meeting, it was agreed that the coordinator would assist in the identification and recruitment of participants. Following that, three participants were recruited and were individually interviewed at different venues which were agreed upon by the researcher and the participants (Sarantakosi 2005). The venues ranged from bars, lodges (brothel rooms/organised rings), and beach terraces. The first three participants subsequently made referrals and other FCSWs were recruited.

The interviews were conducted by the researcher who had experience in conducting qualitative research. The interviews were carried out in English only because the researcher could not speak Zulu or other South African local languages. Rapport was established during the consenting process; this ensured that participants felt at ease before the interview commenced. During the consenting process, the researcher discussed the aims, objectives and ethical considerations for the research with participants; this ensured that participants understood the importance of confidentiality in the study. This was done as a way of encouraging participants to answer questions truthfully without fear of repercussions, thereby increasing the validity of the research. In addition, the research was interactive; relevant literature was reviewed and augmented the research data and preliminary results informing questions, recruitment, data collection strategies, and analysis.

On average, each interview lasted 45 minutes; field notes were taken during the interviews and these were converted to detailed transcripts immediately after each interview. Data collection took place in March 2014 and participants under the age of 18 were excluded from the study.

3.4 Data analysis

As previously stated, the interviewing was interactive and, as such, the process allowed the researcher not only to further inform and expand on questions, literature, probes and data collection strategies, but clarification was further sought from different participant groups on areas of agreement as well as areas of divergence (Patton 2002). Data analysis was done simultaneously with data collection. Transcripts of data collected were manually coded and thematic content analysis was done. Themes were identified using a coding framework based on the interview schedule. This process involved going through the data several times,

comparing each element, sentence and paragraph with other elements of the write-up. The content analysis included familiarisation of themes. Some of the themes included attitudes and beliefs of FCSWs on the use of condoms, the perceived barriers to condom use by FCSWs, opportunities for using condoms, and socio-cultural and behavioural factors affecting the use of condoms. It is also important to note that the interview guides were constructed in line with themes that answered the study questions. The final stage of the data analysis involved deducing possible and reasonable explanations of the results. Thereafter, the results were synthesised into a final dissertation report.

3.5 Ethical considerations

The study was approved by the University of KwaZulu Natal Ethics committee and every effort was made to adhere to strict ethical standards in undertaking this project. Attention was given to sensitivity to sexual issues, especially considering that a male researcher was carrying out the interviews. Informed written consent was sought from all study participants before carrying out the interviews. Anonymity of the participants was preserved as the consent forms were not labelled and there was no way to link the data collected with study participants. Research data was held in confidence, and field notes were kept in a locked file cabinet which could only be accessed by the researcher and the study supervisor.

3.6 Limitations of the study

Obtaining the ethical approval took a longer time than expected, leaving little time to carry out the study. Although snowball sampling allowed the researcher to find a sample of commercial sex workers willing to talk about their personal sexual experiences with condoms, it also limited the sample to particular female sex workers that excluded up-market brothels and sex workers operating in their homes. Throughout the research, it was observed that the research participants were not comfortable with spending a lot of time with the interviewer; they raised concern about time wastage without meaningful financial rewards. This led to a high refusal rate which could imply that the research results might have missed crucial information from other sex workers. Some participants who had been identified through referrals refused to take part in the study, citing fear of being published in a local weekly newspaper. Some potential study participants who had been identified through referrals failed to turn up for the interviews.

The researcher was a (black) male and this could have had negative implications on the way the participants responded. Efforts to establish rapport were done before conducting the interviews and this helped to put the participants at ease. Participants who could not speak English were excluded from the study because the researcher could not carry out the interviews in Zulu or any other South African language. The other limitations had to do with the analysis method. The researcher interpreted the data alone and that might have influenced the results through preconceived biases. The results were not generalisable but they provided insights into future condom interventions targeting FCSWs, and could act as an example of what could be happening in other places in South Africa.

3.7 Conclusion

This chapter presented the methodology and research methods used to explore and understand the dynamics of condom use among FCSWs in Durban Central, South Africa. The study setting, Durban Central, was described, highlighting the general population and the high HIV prevalence in the province. The study used in-depth qualitative research methods and the advantages and disadvantages of this method were explained. Finally, the overarching limitations and ethical considerations associated with this study were explained, with a focus on the precautions taken to guarantee objectivity while minimising bias in data collection.

Chapter 4: Results

This chapter presents the results of the study based on the analysis of data that was collected from twelve FCSWs in Durban Central. The attributes of the HDM were adapted and used to extract data from the participants, as explained in the theory section in the introduction.

Table 4.1: Demographic characteristics of study participants

Participant ID	Age	Type of sex work	Location
P1 SA	23	Bars	Town central (Point)
P2 ZIM	32	Brothel	Downtown hotel (brothel)
P3 SA	29	Bars Morningside	Morningside
P4 SA	32	Street	Umbilo/ Glenwood
P5 SA	26	Street	Umbilo/ Glenwood
P6 SA	23	Night clubs	Glenwood/Berea
P7 Zim	24	Brothel type	Downtown lodge
P8 SA	20	Bars	Town (Point)
P9 SA	27	Brothel type	Downtown lodge
P10 SA	19	Restaurants/street	Davenport/Glenwood
P11SA	18	Street	Town central (Point)
P12 SA	30	Beachfront/Street	South Beach area (Point)

The mean age for the participants was 25; the majority of FCSWs were South Africans (10) with only two foreigners from Zimbabwe included in the study. Among the participants, there was one Indian woman whilst the rest were black. The participants were drawn from bars, brothels and street locations.

4.1 Poverty

The majority of the participants cited poverty as the biggest pressurising factor for joining the sex trade. Family responsibilities and obligations required them to earn money. Ten participants were single parents who had financial obligations to fulfil:

When I joined this oldest profession things were really hard for me and I was down; sometimes my daughter would wear a plastic bag from checkers supermarket in place of a diaper. I even resorted to using my clothes as nappies, that's how desperate I was. Things were hard, my mother was a single parent and looked up to me after the passing of my father in 2000. (P4)

Two participants who were single parents highlighted that they had dropped out of school as they could not afford the school fees. They blamed their lack of education as the main reason why they were failing to secure employment or proceed to higher education. All the participants stressed that failure to get formal employment left them with limited options.

I did go to school but I dropped out before standard 6. I have been trying to get a job but nothing has materialised so far. That is why I introduced myself to sex work. (P3)

Another participant reiterated that poverty and family responsibilities pushed a lot of women to become sex workers:

I am poor, have no job, not educated and the only way I can make money to support my child is through selling my body. Nobody wants to do this . . . nobody. (P4)

I look after my siblings through earnings from sex work, which was my only way out. I had nowhere to turn whilst food had to be put on the table. (P12)

The two Zimbabwean sex workers also cited poverty as a driving factor in becoming sex workers in a foreign country:

I could not find a job in Zimbabwe and when I came here in 2008 things were tight. I struggled to make ends meet as an adult who grew up surrounded by aunties who were sex workers; the easiest option for me to get money was becoming a sex worker. This dirty money will bring me out of my poverty. (P 2)

4.1.1 Being self-reliant

The second reason for becoming a sex worker, which is closely related to poverty, was controlling personal destiny. FCSWs highlighted the desire to be independent:

I wanted to be in charge of my life, I didn't want to feel useless financially depending on my husband and other people. I wanted to have power, to be in charge and to feel important. (P2).

One other study participant stated that she faced rejection from family members who thought that she had no purpose with her life; hence she wanted to prove that she could make reasonable decisions in her life:

I failed matric and misused funds to go back to school. Everyone at home thinks that I am spoilt and they are reluctant to live with me but now I earn my money and I live my life my way. (P11)

4.2 Drug and alcohol playing a role in the individual becoming a sex worker

The abuse of drugs and alcohol played a role in influencing three participants to become sex workers. Once the participants had got addicted to alcohol and drugs, the demand for money increased and that required them to sell sex:

When my mother died, we as children failed to service the house bond. Each child went on his way and as the youngest daughter I ended up in Point (red lights area). I had nowhere to go and my friend introduced me to drugs and alcohol and one thing led to another and the end result was sleeping with men to earn money to buy drugs. (P5)

Sometimes I do things that I regret and don't understand. Most of the times, I blame intoxication for my reckless behaviour. I don't know. (P8)

4.3 Perception of risk of HIV infection

FCSWs who worked in lodges (hotels/brothels/organised rings) exhibited correct HIV prevention knowledge and they explained that they always insisted on condoms with clients. FCSWs soliciting clients from the streets revealed little knowledge about HIV prevention, the risk of engaging in unprotected sex and the importance of using condoms consistently. A few participants noted that they were prepared to compromise on condom use when offered more money. FCSWs also suspected that sex workers who operated underground or who did not want to be regarded as sex workers were more likely to engage in unprotected sex. In such a scenario clients would not know that they would be dealing with FCSWs and the use of condoms might be compromised. Given the high risk associated with multiple partners and acquiring HIV, FCSWs expressed their preparedness to stop sex work if they found other means of earning a living. A few participants reported that friends played a big role in influencing their decisions to become sex workers. Social and economic factors were cited as force factors exacerbating the growth of the trade.

The social and economic factors cited by participants are discussed in the next section, in order to give a broader picture of issues that indirectly or directly influenced the use of condoms among research participants.

4.4 FCSWs' HIV prevention preferences

All the participants concurred that they were susceptible to contracting HIV as they had sexual intercourse with multiple partners and clients. They also concurred that the end result of contracting HIV was death; hence they acknowledged the importance of using condoms correctly and consistently all the time. Realising their vulnerability and the severity of HIV, FCSWs weighed up the trade-offs between benefits and the risk of acquiring HIV:

I can teach others about correct condom use but I also do risk things. At times it is easy to say things and what complicates condom use is that every sex is different. (P12)

For me HIV prevention is about male condoms but the reality is that every client has certain preferences which we as service providers do consider. Remember the customer is the king so I do compromise at times. (P6)

4.5 Trade-offs between benefits and risks to HIV protection

The majority of participants had correct knowledge of HIV protection, especially the use of male condoms. Five participants were also familiar with the use of the female condom although they noted that the male condom was the most frequently used. The majority of FCSWs clearly understood the importance of using the condom correctly and consistently as an HIV prevention method:

We have been taught about condoms in school; we read about prevention everywhere, I even hear it on radio and see it on TV. Every sex worker is well aware of the health safety precautions that we should consider. (P8)

Responses gathered suggest that FCSWs who work in brothels were more aware about condom use than their counterparts who solicited clients in the streets. They could clearly explain the importance of using condoms to avoid reinfection from different strands of HIV infection. Their knowledge could be associated with HIV interventions targeting sex workers working in more or less formal settings. Some of the participants did not compromise on condom use, as one participant noted:

My motto is always condoms, condoms, condoms. I have boxes of condoms in my room and they never run dry despite being busy. I will not take chances with these alcoholics who behave like kids. The HIV poison has been poured in the well that we all drink from and we need to use condoms all the times. Even those who are infected need to protect themselves from it. (P7)

A sex worker working at another brothel reiterated that condoms have to be used all the time:

Even if the customer looks rich, young, beautiful and even good in bed . . . he must always put on a condom. It's not about himself but I am protecting myself from reckless men who want unprotected sex from us. (P2)

I need to be extra careful with condom use because here (city hotel/brothel) I service the rich, the poor, educated, uneducated, locals and foreigners and I would not want to take a risk hence I insist on condom use. (P7)

FCSWs workers who solicit clients from the streets in the Glenwood-Umbilo residential area exhibited insufficient knowledge on the correct and consistent use of condoms. The majority of these sex workers came from the high density areas and did not always insist on condom use. One participant did not have correct HIV knowledge and believed that HIV is transmitted through sperm:

I sometimes have sex without a condom but to be safe from HIV, I make sure that the client doesn't release inside and that way I stay safe from HIV. (P4)

4.6 Long term partners

Knowledge was not the only determinant in the use of condoms by FCSWs; other factors such as preferential treatment offered to long-term partners also contributed to the non-use of condoms. Six participants mentioned that they had permanent partners, with three of them having two or more simultaneously. In the relationships, the long-term partners were responsible for their basic needs such as monthly rentals, school fees, groceries and general upkeep. Because of the nature of material support that they received from long-term partners, FCSWs in return did not use condoms, thus exposing themselves to the risk of contracting HIV and STIs. It was highlighted that the majority of long term partners were married men. FCSWs reported that some of their permanent partners were unaware that they were sex workers. One participant from a city brothel indicated that she did not have a steady boyfriend in South Africa but had a long-term boyfriend back in her home country, Zimbabwe. Her boyfriend was not aware that she was a sex worker; he was told that she worked as a waitress in a hotel. The participant noted that the boyfriend trusted her and as a result they no longer used condoms during sex:

During the first year of our relationship we used condoms but as the trust built on like in any other relationship, condoms were totally eliminated. He gives me gifts and takes care

of my needs and let me emphasise that materially I make sure that I still benefit from him and in. (P2)

Another participant explained:

I am Indian and involved in a steady relationship with a black guy who does not know that I am a sex worker. I am currently staying with friends and when I really want to relax and get pampered I go to him and in return he gets unprotected sex for free. (P1)

After divorcing her husband, one participant struggled to live without a man in her life. The participant had met her boyfriend in a bar and since then they had been in a relationship. When business (sex work) was low, she turned to her boyfriend for free food and accommodation. In return the partner was rewarded through condomless sex:

I am divorced now and am used to having a man in my life. My boyfriend is the man in my life. With him I make love which is different to the way I do business, so there are no condoms to talk about. In fact we never talk about them or even my work. That's how it works. (P1)

Another participant reported that she had a long-term boyfriend who was nearly twice her age. The boyfriend, who was financially stable, paid for her accommodation, bought food and catered for her pocket money. The participant referred to him as her 'money link' meaning that the boyfriend was her source of income. In return, she offered him attention, unprotected sex and oral sex which she thought he could not get anywhere else.

He is my money link and will do whatever he wants including oral sex. (P6)

The sexual relationship was cemented with gifts that the FCSWs received from their long-term partner and that compromised condom use. One participant explained:

He is much older than me and I don't care. He demands unprotected sex and I give him. Truly how can I deny him what he wants when he is my money link. I don't want the money to stop linking so I will do anything for him including blow jobthat's survival for me. (P7)

The same participant had another boyfriend of her age with whom she also had unprotected sex. She regarded her younger boyfriend as a true partner, hence both partners did not insist on condom use. Unlike the older boyfriend, the younger boyfriend could not meet her financial requirements:

We are of the same age and we click. I want to feel young and we experiment a lot with him and unprotected sex romps are the norm. The most important thing is that he must trust me and that's it. They are only two in the game. Others don't get that golden treatment of not using condoms. (P6)

4.6.1 Regular clients

FCSWs working in brothels did not entertain the notion of having regular clients because they insisted that all clients must pay for services rendered. On the other hand, participants in bars and streets highlighted that regular clients were treated differently. Three participants noted that they had regular clients but they did not regard them as long-term boyfriends. Clients were regarded as regular because of the high frequency of getting services from the same person. The regular clients were given contact details, for instance, cell phone numbers. They were offered discounts when business was low and at times they were offered services on credit. Despite the offer of such favours, participants insisted that the use of condom was not compromised:

The few benefits that regular clients get include getting a discount when business is low, allowing them to have longer sessions compared to others, free interaction whilst searching for new business but they do not enjoy unprotected sex. All other terms and conditions of work apply. (P8)

The other participant noted that she had clients she regarded as regular but insisted on the use of condoms with all of her clients:

Being regular doesn't translate to unprotected sex. He is still a client and condoms are used all the times. (P5)

As mentioned above, participants in brothels did not treat regular clients differently:

I do not have a permanent relationship; all I think about is making a living through my business. If a client wants to get service from me all the time it is not a problem but the regular concept doesn't work here. I always use condom . . . condom and condom. (P2)

One participant highlighted that, although they regarded sex work as business, there were times when sex workers wanted to behave and be treated like any other woman. The participant reiterated that they got burnt out with work and needed someone who gave them love and emotional support.

Despite being a sex worker I am still a woman. I need attention and to be spoiled. I am normal and I cannot be using a condom all the time. I also want to enjoy sex and to reach orgasm and I will offer condomless sex to my trusted regulars to reward highly for the services. (P10)

Another one clarified that the rapport that existed with regular clients compromised condom use:

I have regular clients who now have my contact details, there are a few times that I have had unprotected sex with my clients and on those occasions it's usually with a regular customer. (P5)

4.7 More money for unprotected sex

Unlike FCSWs who plied their trade in brothels, most participants who solicited clients from the streets noted that the use of condom was compromised when clients offered more money for unprotected sex. FCSWs acknowledged their susceptibility and the consequences of engaging in unprotected sex but could not afford to turn away customers who were at times hard to find. They reported that each case was dealt with differently, taking into consideration the merits and demerits, based on the risk of contracting HIV:

We are in this business because we need money and at times customers demand unprotected sex justifying such moves by the physical appearance or attractiveness. At times I accept especially when I am drunk . . . I don't act rationally; will do anything to get the much needed cash. I feel like I am already in mud. (P8)

One participant blamed customers for taking advantage of their desperation to demand sex without condoms. She pointed out that men were reluctant to put on condoms and should be targeted with condom interventions. The FCSWs needed money to survive and would do anything for that. Sex workers compromised condom use when clients were few:

At times I just play along with what my client wants but it is surprising that in this day and age men still demand unprotected sex. I don't understand the rationale behind such demands and I think they need help. I personally become more vulnerable to such offers during some periods, days of the month when clients are hard to come by. After struggling to find client then someone comes like manna from heaven and offers to pay more for unprotected sex, I will definitely go with them because I would be in need of the money. (P4)

Participants noted that they became more vulnerable when business was low. Despite the fact that sex workers soliciting clients in the streets had sex in abandoned buildings, lodges or

clients' cars, they were disturbed by weather conditions, for instance, the rainy conditions, and harassment by law enforcement agents:

At times we are disturbed by police and the rains but my child will need to eat and at times I expose myself to the dangers of HIV by accepting more money for sex without a condom but there is little that I could do. (P4)

One participant blamed clients who were suspected of being HIV positive of deliberately infecting them with HIV. She argued that HIV positive clients who knew their status punished sex workers by offering more money for unprotected sex. The participant cited a client who frequented the Glenwood Street who was suspected of being HIV positive but always offered more money for sex without a condom. Despite suspecting him to be HIV positive, the FCSWs always entertained him out of desperation:

There is a certain white guy who frequents this place with a ford bantam (car), he pays R400.00 for unprotected sex and my colleagues claim that he is HIV positive. I always try to avoid him but he has already slept with more than 75% of the girls who work from here. (P5)

4.8 Condom use experience

The participants were confident and explained how condoms were used. Three-quarters of the participants indicated that they had previously attended condom demonstration sessions. Two participants who plied their trade in brothels had experience of using female condoms. The participants highlighted that the male condom was reliable if put on correctly:

Condom prevents HIV and we have been taught on how to use them correctly. During the course of my work it has burst a few times and it had more to do with the putting it on . . . if air is trapped inside then there is high likelihood that it would burst. I prefer putting it on his organ; I believe sex workers have better experience than clients . . . but every sex act is an experience on its own coz we service different clients. (P2)

4.8.1 FCSWs' responses to unprotected sex

As previously stated, qualitative data from the study suggested that most sex workers who worked in brothels or lodges had relatively high awareness of the importance of using condoms as compared to their counterparts who solicited clients in streets. They reported that they always insisted on condom use and, when faced with the temptation of being offered more money for unprotected sex, they tried to trick such clients. According to them, drunken

young men with new wealth usually demanded sex without condoms. After assessing the drunken state of the client, the FCSWs revealed that they would put on a female condom without the customer's knowledge and charge a high rate for the unprotected sex. The FCSWs indicated that they were prepared to employ any tactic to ensure that they earned more money without compromising their sexual health. One of the clients who operated from a city hotel (brothel) commented:

I normally charge R100.00 for a 5 minutes round. If drunken clients want unprotected sex, I rush to the toilet and put on a female condom and come back and provide the service. Most of these drunken customers, all they want is to take out their thing and put so they do not even realise that there is a female condom and I get my R300.00 or R400.00. If they discover that I cheated them then I make them pay the normal R100.00. (P7)

Another participant explained:

I can tell the client that sex in the dark is the best and with erection on men can listen and do anything. In darkness, they won't even realise that I was wearing a female condom. (P7)

4.9 Perception of risk with oral and anal sex

FCSWs believed that anal sex with or without a condom increased their chances of contracting HIV. Ten participants looked down upon anal sex but nevertheless practised it at the request of clients. They regarded it as dirty and the lack of lubrication was a worry for most of the participants.

It's more dangerous, as there is no lubrication but some men enjoy it as they say it's more tight there than the usual way. But with no lubrication condoms can easily burst. (P5)

Nearly all participants concurred that they indulged in oral sex for more money although they were not sure about the susceptibility of acquiring HIV:

Even if there is a condom, blow job costs more. There are clients who want it without a condom and I entertain but not sure about the chances of getting HIV. (P11)

Another one clarified on oral sex:

The good thing about blow job is that I can really scrutinise his thing before anything happens. If it is rotten I will obviously insist on condom use. (P2)

4.10 Circumcised men and condom use

Circumcised men were perceived as HIV-free by one participant who solicited clients from the Glenwood-Umbilo area. The participant thought that the circumcised men were not only clean but were seen as safe from HIV, hence they were treated differently:

I sometimes allow circumcised clients to have unprotected sex because it has been proven that they are less dangerous from HIV, their penises have a thick skin which makes it impossible for the HIV to pass through. (P5)

One participant thought that sucking the penis was less risky and she would not use a condom:

I don't use condoms on blow jobs as some of the clients do not like that and I don't feel exposed to HIV. (P4)

The other participant who serviced the affluent Morningside shopping centre highlighted that her customers were usually rich business people who cared about their lives:

Florida area is frequented by gentlemen and normally does not have problems with issues of condom use. (P3)

4.11 Low risk sex

One participant cited that men were prepared to pay more to sex workers perceived as low risk. The participant reported that she lived in the Berea area and did not portray herself as a sex worker; neither did she associate with any of them. She frequented sports bars in Glenwood and lied to her clients that she was a student at the university. The participant said that most of her clients believed her, but the greatest challenge was that her clients regarded her as less risky, hence were reluctant to use condoms:

My clients think I am that naughty college girl from Port Shepstone and as a result I at times have failed to negotiate condom use. It's like the customer saying . . . you said you are not a sex worker, so I trust you and worry not about condoms. . .it's like a one night fling sort of thing . . .It's so scary at times but life goes on hey. (P6)

Another sex worker who operated from a night club indicated that she always insisted on the use of male condoms but there were exceptions when she accepted condomless sex. She regarded foreign white tourists as rich and generous people who were adventurous and always

wanted to experience sex with black women. The participant highlighted that she regarded tourists as less risky clients, hence she did not insist on condom use:

I do not normally accept sex without a condom, but to be frank with you, there a few foreign (white) clients who are offered that privilege. These people are nice and they treat us well and I do not think they are high risk people. Just imagine that this other day I got a client who offered to pay me R800.00 for one round of unprotected sex at the beach and I agreed. After that he requested my phone number I didn't hesitate to give him. That client contacted me after 2 days and paid me R800 again for another round. Sometimes it is tempting but I only do that to a few international clients. (P3)

4.12 Influence of previous health experience and decisions

The HDM points out that previous health decisions can have an influence on present condom use behaviour by FCSWs in the prevention of HIV. The majority of the participants were not worried about their health and HIV status. Only two participants indicated that they insisted on condom use because they knew their (HIV negative) status. One of them commented:

Lifeline offers free voluntary counselling and testing and I tested HIV negative recently. I expected that result and I always insist on condom use because I know where I stand as I frequently get tested. (P9)

Another participant got seriously ill at one point and thought that she was going to die. When she sought medical assistance at a nearby local hospital, the nurses advised her to test for HIV and tuberculosis. The participant was not interested; she feared the worst result (positive) because condoms sometimes burst during the course of her work. Some participants argued that female sex workers who were HIV positive or suspected to be infected by the virus acted recklessly:

At times I feel that I am already dead . . . meaning I am a moving grave so I just don't care . . . condom or no condom . . . so long cash. (P11)

Some of our colleagues have a I don't care attitude, maybe because they already know their status (positive). I hear them say a customer can say that here is my penis which is infected with an STI and I am offering R300.00 for it and people will accept them for the sake of money offered. They can just say I will use the R40.00 to seek medical attention and the R260.00 for other things which I may want. (P5)

The other participants indicated that they preferred not to be tested for HIV and that their previous health decisions did not influence their present behaviour. One participant commented:

I will get tested when I am ready for a permanent relationship, for now I am enjoying my work and I don't want to stress myself with the toll of the unknown results. I believe if you look for things you will get them and I am not looking for HIV. (P6)

4.13 Barriers to condom use

Few barriers were identified to condom use by participants. FCSWs negotiated the price of sex before anything happened, thus those who solicited clients in the streets negotiated the price before going with the clients, while those who solicited clients in bars negotiated condom use just before the sexual encounter. The condoms were readily available in lodges, the FCSWs had access to free condoms in public toilets and they could afford to buy the condoms at a cost of R10 per packet. Four issues which emerged as barriers to condom use were men's reluctance to use condoms, competition for clients, violence and the abuse of drugs.

4.14 Men's reluctance to use condoms

The use of a condom during sex requires female sex workers and clients to jointly take action, which implies that a discussion about condom use takes place between both parties involved. Most female sex workers had knowledge of HIV and its consequences and as a result they insisted on condom use. Further probing pointed to the reluctance of men to use condoms as an HIV prevention measure during sex. As alluded to earlier on, one participant, suspected by female sex workers to be HIV positive, was alleged to be deliberately spreading HIV through condomless sex. Other participants reiterated that clients could oppose using condoms out of drunkenness and lack of knowledge:

Some alcoholics give us hard time; they want to enjoy flesh to flesh as they insist that that's the best forgetting about HIV. (P9)

It was also reported that some men determined the use of condoms by merely considering physical appearance of the FCSWs, whilst others complained that sex with condoms was not the best:

Some men say I am strong meaning that I do not have HIV and others say sex with condoms is not nice. (P12)

4.15 Client competition

The competition for clients among FCSWs was fierce. According to participants, age, physical appearance and dress were some of the factors that clients considered when engaging sex workers. Negative effects of competition culminated in non-use of condoms, low rates for services and sometimes violence being inflicted on FCSWs. During the interviews, it was claimed that some desperate FCSWs voluntarily offered unprotected sex to clients in the face of stiff competition:

This job is hard and its survival of the fittest especially when clients are scarce as gold. If you behave like a virgin with many demands and limitations, clients can sometimes leave you going to those who happily agree to offer sex without a condom. So this creates a lot of subtle pressure to give in to condomless acts. (P4)

4.16 Violence and condom use

FCSWs lamented that they faced a great deal of harassment from the police, married women and their clients. They pointed out that in some instances the law enforcement agents conducted raids and, when caught, they had to pay fines. To avoid harassment from law enforcement agents, sex workers resorted to soliciting clients without carrying condoms:

We are being harassed by police and the resident's committee's members. If the police find us with condoms in our bags or pockets they will conclude that we are sex workers. I no longer carry condoms around and if it happens that the client doesn't have condoms then that's tight for both of us. (P5)

Some participants expressed disappointment that some clients refused to pay or became violent when asked to pay for services rendered. Participants concurred that violence was a major factor contributing to the non-use of condoms:

Clients can be very rough. Some can actually threaten you with a knife and you won't be able to resist anything. Just imagine a client who picks a person and drive to a faraway place and demand unprotected sex for a minimum fee and if you try to resist they threaten to push you out of the car or to leave you in the middle of nowhere. There will be no other option . . . it sucks. (P10)

I was married and my husband frequently mistreated me. He would beat me up for no apparent reason and when I went home my mother would send me back to him. But I

couldn't take it any longer and this time I left him and lied to my mother in Phoenix that I am now working as a waiter in a bar. (P1)

4.17 Drug and alcohol compromising condom use

FCSWs soliciting clients in the streets seemed to abuse alcohol and drugs when compared to their counterparts who worked in lodges or hotels. Participants stated that over-consumption of alcohol and intake of drugs compromised their condom negotiating skills. They became less attentive and failed to stand up for what they believed in:

When I get drunk I sometimes lose my mind and only to find my bottom wet without realising it . . . they would have sex with you without a condom or they will have sex with you for free, without paying even a rand. (P11)

FCSWs noted that they used alcohol so that they could cope with their work:

It's embarrassing to be doing this work and to find the guts to do our work effectively we get intoxicated. (P3)

4.18 Conclusion

This study has brought to the fore interesting data revealing that sex workers are still offering unprotected sex, despite being aware of the risks associated with it. They cited pull and push factors which influenced their decisions to engage in risky behaviours. One of the striking points from the results is that the decision to use condoms is made by two people; hence it becomes important to consider the reasons why men are reluctant to use condoms. The next chapter will discuss the results, implications and the recommendations.

Chapter 5: Discussion

5.1 Summary of results

There are several limitations inherent in the research that warrant caution in interpreting the results. The first one has to do with the limited time frame of the data collection period. Due to ethical approval delays, data was collected in one week instead of the planned three weeks. Secondly, a few participants refused to partake in the study, citing various reasons. Some potential participants were not recruited as they could not communicate in English. These limitations notwithstanding, there were several useful insights gleaned from the study that can influence condom use interventions in the future.

The HDM states that sex workers' behaviours can be determined by their opinions of chances of contracting HIV. Sex workers, however, highlighted that they often outweighed the risks of contracting HIV/AIDS when offered more money; as a result, they failed to insist on condom use. The outstanding issue from the research is that FCSWs compromised the use of condoms when offered more money for unprotected sex by clients (Jackson and Highcrest 1996, Bucardo et al. 2004). Sex workers struggle to make ends meet and the notion that rejecting clients who request sex without condoms implies dying of hunger came out strongly; hence it was used as justification to having sex without a condom. The results are consistent with what emerged from a Ugandan study: that consistent condom use among FCSWs is still hampered by economic and relationship factors (Matovu and Ssebadduka 2013). In a study carried out in Indonesia, the main reason for female sex workers not using condoms was the belief that boyfriends, native Indonesians and healthy-looking clients cannot spread STDs (Basuki et al. 2002). It can therefore be argued that availability of condoms is not an issue any more, but that other factors such as poverty play a pivotal role in the use of condoms by FCSWs (Varga 1997, Varga 2001, Wojcicki and Malala 2001).

One participant highlighted that a client who was suspected of being HIV positive offered more money for sex without condoms, raising the suspicion that he could be deliberately spreading the virus to FCSWs. The fact that there are clients who request sex without a condom is distressing and calls for further investigation. Some study participants suspected that FCSWs who entertain such demands may be HIV positive but no longer care about their

lives. Basing on the results, it can be argued that the majority of FCSWs have basic information about condom use and the consequences of not using them.

The study results revealed that issues of trust and affection in steady relationships have an impact on the use of condoms. Sex workers in steady relationships find it difficult to insist on condom use as they fear that their partners will withdraw their financial support. The results are consistent with findings from studies carried out by Varga (2001), Martina (1995) and others. According to Castan~eda et al (2006), sex workers in steady relationships find it difficult to insist on condom use due to a number of reasons that include, but are not limited to, trust, intimacy and connectedness. Although issues of trust seem to be given as justification for non-use of condoms in steady relationships, the results revealed that sex worker partners are not aware that their partners work as sex workers, thus being put at risk of contracting HIV. Unlike clients who request or offer more for unprotected sex, FCSWs' partners are not afforded the chance to make informed decisions about using condoms or not.

Despite the HIV prevention knowledge that is in the public domain, sex workers who come from poorer backgrounds and who solicit clients from the streets have a low knowledge regarding the proper use of condoms and have many misconceptions about HIV transmission (Bucardo et al. 2004). One participant regarded circumcised men as low risk partners compared to clients who were not circumcised; she used that justification to give in to demands of sex without condoms. While it has been proved that circumcision reduces the chance of getting HIV by 62% (WHO 2011), it is discouraging that people use it as licence to engage in risky sexual behaviours. The belief that circumcised men are clean and safe from HIV is dangerous and may reverse gains that have been made in reducing the prevalence of HIV in South Africa. The other misconception that emerged had to do with men's ejaculation. Street sex workers believed that withdrawal when ejaculating reduced the chances of transmitting HIV. In addition, a few participants perceived white clients as clean and therefore free from HIV. These misconceptions indicate that some FCSWs do not have sufficient knowledge about HIV prevention; this requires intervention. Most of these participants solicited clients in the streets and come from high density areas. The HDM dictates that knowledge about HIV status could activate readiness to adopt and adapt recommended HIV

prevention actions; the lack of it means that HIV prevention through condoms could be compromised.

The results reveal that sex workers in more organised sex rings exhibit more knowledge on condom use than those soliciting clients or servicing clients in the streets. FCSWs in brothels are not interested in having long-term partners, hence they always insist on the use of condoms. The same group note that they do not insist on the use of condoms with their unsuspecting long-term partners. When approached by clients who demand sex without condoms, FCSWs in organised rings deceive these clients by wearing female condoms without the client knowing, and then charge more money. The striking point from the research is that FCSWs aim to earn more money under any circumstances.

Given the national and international attention that HIV/AIDS and condom use has been given in the media, it could be argued that every citizen who is sexually active should be aware of the consequences of risky sexual behaviour and be responsible for preventing the spread of HIV by using condoms. The literature review indicates that the spread of HIV is high among people with multiple partners, but sex workers disagree with that notion. Analysis of results suggests that the spread of HIV could also be exacerbated by sex workers who do not want to be seen and regarded as sex workers. The fact that participants reported that some FCSW's clients regard this group of FCSWs as less risky poses a great threat to the spread of HIV to unsuspecting men. The participants argued that men are generally cautious when they seek the services of sex workers, but were concerned that they might not exercise the same degree of caution and condom use with sex workers who operate underground. The results call for future condom interventions that target sex workers who operate underground, or engage in multiple relationships/casual sex for monetary gains.

Whilst discussing the dynamics of condom use among sex workers in Durban, it became apparent that sex workers are also involved in oral sex. Although this was not the main focus of the study, the results revealed that sex workers entertain clients who are interested in oral sex, especially white clients. Sex workers noted that anal sex exposes them to HIV/AIDS because of absence of lubrication; they reiterated that condoms must always be used. The issue of more money for condomless sex is dominant throughout and that brings back the debate once raised by former South African president, Thabo Mbeki, who believed that the

main problem of Africa is poverty and not HIV and AIDS. The results point to the notion that FCSWs engage in risky behaviours because of poverty. The sex workers regret getting stuck in the sex trade and failing to insist on the use of condoms. Women are pushed into sex by the hope of economically empowering themselves to escape poverty. They feel trapped as they do not possess the necessary requirements to secure work in competitive markets.

Nearly all the participants concurred that condoms are very important in the fight against HIV, but they reiterated that the use of a condom is determined by both the sex worker and the client. The research results also revealed that men tend to have an upper hand financially and, in a patriarchal society such as in South Africa, men culturally dominate a woman, which implies that they influence the use and non-use of condoms. The discussion that takes place before sex is crucial in the determination of condom use. In addition, the sobriety of involved parties is important as condom use decisions can be strongly compromised by the use of drugs and alcohol. The underlying issue about use and non-use of condoms during sex is that HIV prevention programmes should target both men and females as the use of condoms is determined by both parties. Above all, there is a need to empower sex workers so that they can confidently negotiate condom use.

Study results indicated that sex workers experience a difficult life in the sex industry. They face a constant threat of violence from clients and law enforcement agents. With competition for clients, physical violence exacerbates, as do condomless sexual activities. What further complicates sex workers' vulnerability is the perception that, despite being careful, HIV infection can be contracted through condom breakage and/or slippage with clients (Wojcicki and Malala 2001, Basuki et al. 2002, Bucardo et al. 2004). The results show that lack of enough HIV prevention knowledge, lack of confidence to negotiate condom use and poverty all contribute to the non-use of condoms during sex by sex workers. It is therefore imperative to improve sex workers' condom use by programmes, especially to sex workers soliciting clients in the streets and those operating underground. The condom prevention programmes must involve men; the fact that some sex workers' clients still request sex without condoms is a matter of serious concern. Research has shown that "interventions targeting structural and behavioural level risk factors for HIV among sex workers decreases have proven successful for increasing protective behaviours and decreasing HIV and STI transmission" (Baral

2012a:1). Countries that have data on condom use reveal that more than 80% of sex workers used condoms with their last client but UNAIDS estimates that less than half of sex workers in the world have access to HIV prevention programmes (Baral et al. 2012a). In view of the results, this calls for a renewed HIV strategy that includes condom use and that targets both the micro (individual) and macro (structural) factors that facilitate an enabling environment for condom use.

5.2 Implications and conclusion

The spread of HIV infection continues to gather momentum, despite the efforts being made by governments and non-governmental organisations to inform, educate and empower citizens of the disastrous consequences that sexual risk behaviour has on society, communities, families and individuals. Whilst common sense, logic and science knowledge inform one that the use of condoms are the most effective HIV prevention method, their usage among FCSWs has not been consistent. Interventions to promote condom usage among FCSWs ought to address drug and substance abuse, ignorance, myths on the role of circumcision, retrogressive cultures, violence, competition for clients and victimisation of sex workers by law enforcement agents. Consistent condom use among FCSWs is still hampered by economic and relationship factors. For successful condom use, it is imperative to design intervention programmes for both FCSWs and clients. In addition, interventions to promote condom use ought to focus on empowering women to become self-reliant.

The future for an HIV-free generation remains bleak unless the barriers to condom usage are extensively addressed. It is time that African governments seriously consider motions to decriminalise commercial sex so that FCSWs can operate in safer environments, as their counterparts do in the more economically developed regions of the world. Alternatively, the law should not only punish women but also men who create the demand for condomless sex. Further research is necessary to better understand why sex workers' clients still request sex without condoms and it is worth exploring ways of empowering sex workers to negotiate the use of condoms and safer sex.

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Appendix:1



11 March 2014

Mr Bothwell Manyonga (213568457)
School of Built Environment & Development Studies
Howard College Campus

Protocol reference number: HSS/1481/013M

Project title: Understanding the dynamics of condom use among female commercial sex workers in Durban Central, South Africa

Dear Mr Manyonga,

FULL APPROVAL NOTIFICATION – COMMITTEE REVIEWED PROTOCOL

With regards to your response to our letter dated 20 December 2013. This letter serves to notify you that your application in connection with the above was reviewed by the Humanities & Social Sciences Research Ethics Committee, has now been granted **Full Approval**.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol

Yours faithfully

Dr Sheelika Singh (Chair)

cc Supervisor: Professor Pranitha Maharaaj
cc Academic Leader Research: Professor MP Sithole
cc School Administrator: Ms Meera Dalthaman

Appendix 2: Gate keeper's letter



To whom it may concern

Ref: Request for assistance to recruit sex worker study participants by Mr.B. Manyonga

I confirm the request by Bothwell Manyonga for Sisonke to assist in recruiting sex workers to participate in his study entitled, '*The dynamics of condom use among female sex workers in Durban central, South Africa*'. Sisonke is a sex workers' national movement in South Africa that ensures the rights of sex workers are defended and that sex workers have access to health and other services in South Africa. Condom use research has the potential to helping female sex workers practice safe sex and that indirectly benefits the general population of South Africa.

After having read the summary of the proposed study and given the importance of the research to the health and well-being of sex workers, Sisonke will assist Bothwell in the recruitment of study participants in Durban central once the ethical approval is granted by University of Kwa Zulu Natal.

Kind regards

Thulisile Khoza

SISONKE Provincial Coordinator

Durban

Appendix 3: In-depth interview guide

A study to understand the dynamics of condom use among female commercial sex workers in Durban Central, South Africa

- Introduce self and explain study
- Obtain consent
- Set ground rules

(Note to interviewer: Themes must guide the questions to be asked. Probes do not have to be asked as they appear here. Rather, phrase questions according to the flow of the discussion).

Theme	Probe
a) Can you tell me something about yourself?	<ul style="list-style-type: none"> • Age, education • Marital status <ul style="list-style-type: none"> ○ <i>Married – for how long, divorced, or single?</i>
b) Sex work	<ul style="list-style-type: none"> • Can you describe your work to me? <ul style="list-style-type: none"> ○ How long have been working in sex industry?
c) Locations	<ul style="list-style-type: none"> • Where do you find clients? • Where do you find it safe to work from and why? <ul style="list-style-type: none"> ○ <i>Probe: How safe is the recruitment place and process, assertiveness, and power to turn down clients?</i>
d) Clients	<ul style="list-style-type: none"> • Types of clients – Probe regular/steady/permanent partner or private/ commercial • How do you screen clients? <ul style="list-style-type: none"> ○ <i>Probe heterosexual, anal and oral sex.</i>
e) Sexual Behaviour Circumstances surrounding use of condoms	<ul style="list-style-type: none"> • Do you use a condom during sexual encounters? <ul style="list-style-type: none"> ○ <i>Probe use with different sexual partners e.g. regular/steady/permanent/commercial etc.</i> ○ Probe who initiates/determines/decides. • <i>Negotiation of condom use – easy? Difficult? Why?</i>

	<ul style="list-style-type: none">• What are other determinants of condom use?<ul style="list-style-type: none">○ <i>Probe influence of friends, alcohol, drugs, violence, availability of condoms, competition for clients.</i>
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