Sex workers' perceptions of AIDS and safe sex

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ABSTRACT

This is an exploratory study of sex workers' perceptions of AIDS and safe sex methods. Six escorts and eight street sex workers in Cape Town were interviewed. The responses indicated that sex workers are aware of AIDS but certain gaps in their knowledge still persist. Sex workers gain their knowledge in a haphazard manner as they are hesitant to utilize the existing health services. There are few intervention programmes aimed at sex workers. Although risk perception is high, sex workers are adamant that they are less at risk than non-sex working women. They accept the responsibility of ensuring safe sex with clients. The majority of sex workers indicate that they are in control of negotiating safe sex, except with violent clients. Condom use varies depending on the status of the sexual partner. Condom use is high with casual clients but significantly lower with regular clients and boyfriends. The study indicates a need for intervention which addresses the specific needs of sex workers. Intervention should include negotiation skills and the empowerment of sex workers. Peer-based intervention has shown to be most effective in addressing these needs.

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DECLARATION

The author hereby declares that this whole thesis, unless specifically indicated to the contrary in the text, is her own original work.

Signature of candidate

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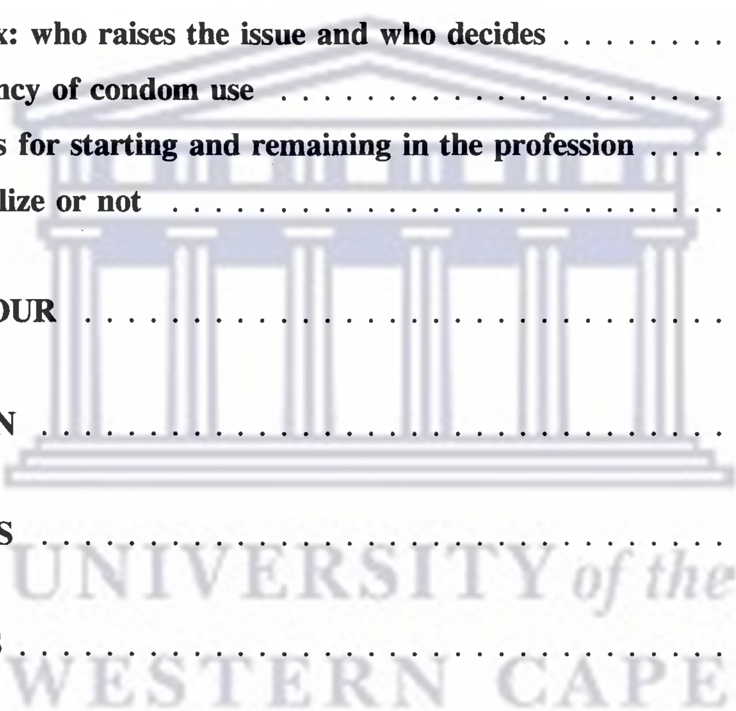
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INTRODUCTION

Through the ages disease has been associated with stigmatized and marginalized groups. The Acquired Immune Deficiency Syndrome (AIDS) is no exception. When AIDS was first diagnosed in 1982, it was thought to be a disease affecting only homosexuals. With the discovery of AIDS in the heterosexual population, the focus soon fell on sex workers. As female sex workers have vaginal penetrative sex with multiple and often transient partners during the course of their work, they frequently expose themselves to the risk of Human Immunodeficiency Virus (HIV) infection. They have been labelled a high risk group. Even though the tendency to view AIDS in terms of high risk groups rather than high risk behaviour has been challenged, the association of sex workers with AIDS seems to persist.

Unfortunately, the risk clients pose to sex workers is not taken as seriously as the risk sex workers pose to their clients. The media has played a major role in focusing society's attention on the danger sex workers pose to the rest of society, by reporting the incidence of HIV infection amongst sex workers and portraying clients, especially heterosexual men, as helpless victims.

According to Panos (1990) the stigmatization of sex workers has greatly influenced research on this group. They criticize the labelling of sex workers as a reservoir of disease instead of as a receiver of infection. They argue that this stigmatization does not only let everyone else off the 'risk hook' but also leads to measures designed to protect clients rather than the sex workers. Leonard and Thistlethwaite (1990) state that health efforts have shown no real concern for sex workers' lives, even though female sex workers are at far greater risk of contracting HIV from male clients due to women's greater physiological vulnerability to the virus.

In reaction to the notion of the sex worker as 'disease ridden', Roberts (1993) notes that sex workers are amongst the most health conscious in the community because they have to be. This sentiment has been echoed by various sex worker organizations around the world. 'We are professional about preventing AIDS, are you?' reads a poster recently

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distributed by the New Zealand Prostitutes Collective. This is an example of sex workers' attempts to remind the world that HIV 'doesn't travel on dollar bills' (Overs in Panos, 1990, p. 81).

In the absence of a cure for AIDS, prevention is currently the only weapon against infection (Baum & Nesselhof, 1988; Bull & Gallagher, 1994). In South Africa, a few organizations have therefore embarked on educational programmes amongst sex workers. However, the perceptions of sex workers towards safe sex methods are still relatively unexplored in South Africa (Schurink, Liebenberg & Schurink, 1993). Sex workers' knowledge of AIDS, their exposure to intervention programmes and obstacles to the practice of safe sex need to be investigated in order to identify areas of intervention.

This study is of an exploratory nature. I aim to create some understanding of the many issues facing female sex workers in the Cape Town central business district.

Chapter 1 explores how AIDS affects women. Further, sex work is defined and discussed from a feminist viewpoint. An overview of research on sex workers and HIV infection follows, including an examination of intervention programmes.

In chapter 2, the methodology of this study is discussed. This includes a rationale for following a qualitative approach and the use of the interview as the instrument of investigation. The procedure of the study and an ethics appraisal follows as well as a discussion of the process of analyzing and reporting the data.

In chapter 3, the study is reported and discussed. This chapter is organized according to the themes identified in the interviews. These include the following: what sex workers say about AIDS and how they gained their information; perceptions of risk and HIV testing; methods of protection; the negotiation of safe sex and frequency of condom use; reasons for starting and staying in the sex industry and finally, how sex workers feel about legalization.

Chapter 4 provides a summary of the research findings and its implications for intervention.

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CHAPTER ONE

LITERATURE REVIEW

Women and AIDS

It has been widely documented that an increasing number of women are being infected by HIV (such as Amaro, 1993; Deren, Tortu & Davis, 1993; Fullilove, Fullilove, Haynes & Gross, 1990). In South Africa, the first national HIV survey of women attending antenatal clinics in 1990 revealed an estimated seroprevalence rate of 0,76%. This had risen to 1,49% a year later, to 2,69% by 1992 and 4,69% by 1993 (DNHPD, 1994).

The percentage of HIV positive women in Africa is particularly high. This is largely because the predominant mode of HIV transmission in Africa is through heterosexual intercourse and women appear to run a greater risk of infection (Decosas & Pedneault, 1992; De Zalduondo, Msamanga & Chen, 1989; Feldblum & Fortney, 1988; Orubuloye, Caldwell & Caldwell, 1993; Schopper, Doussantousse & Orav, 1993).

HIV positive women not only have to cope with saving their own lives, but often are the primary caregivers of others infected with the virus, both in their capacities as health workers and within their families (AIDS Bulletin, 1994; Danziger, 1989). Due to the lack of adequate health care facilities in Africa, many of the infected and dying have to be cared for by women at home (Strebel, 1992). An infected woman is also at risk of passing the infection on to her infant. Looking after such children is particularly stressful for women who are themselves infected with HIV (Duke & Omi, 1991; Ehrhardt, 1988).

There appears to be a relationship between poverty and HIV infection. Those who are most afflicted by poverty are those most infected and affected by HIV and AIDS (Cochran, 1989; Cochran & Mays, 1989; Evian, 1993). Schoepf (1993b) notes that Africa has seen a feminization of poverty due to women's limited access to employment. Women are thus forced to depend on men for support. This leaves women

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in a powerless position to negotiate safe sex and this makes behaviour change difficult (Africa South & East, December 1993/January 1994; Kline, Kline & Oken, 1992; UNDP, 1993; Wallace, 1993). Intervention programmes therefore have limited success in poor regions (Evian, 1993). The limited success of such programmes can also be attributed to the undermining effects of poverty on self-esteem, assertive behaviour and effective decision-making. The resultant stress also often leads to substance abuse which impacts negatively on safe sex behaviour (Gordon, 1990).

Sexually transmitted diseases (STDs) are known to be a major co-factor aiding the transmission of HIV (Bassett & Mhloyi, 1993; Larson, 1990; Piot, 1993). Even though STDs can be largely prevented and treated, people of low socioeconomic status (SES) have limited access to facilities for the detection and treatment of STDs and to the provision of condoms (Evian, 1993). In women, STD symptoms are often less apparent. STDs are therefore less likely to be detected, resulting in less effective treatment and increased vulnerability (Strebel, 1995).

However, it is not only women of low SES who have difficulty in protecting themselves and others from infection. Due to socialization and the power imbalance evident in heterosexual relationships, women from all classes often have limited mobility and access to information. There are also psychosocial, cultural and legal barriers to decision-making and independent action by women (Erben, 1990; Gordon, 1990). In many cultures women are socialized to be financially and emotionally dependent on men. The fear of being rejected by a partner because one insists on safe sex often inhibits a woman from asserting her right to protect her health. To be assertive in the sexual act is also against the conduct of a 'good' woman. How these factors affect the relationship between sex workers and their sexual partners (including their boyfriends) will become clearer in the course of the study.

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An understanding of sex work

Defining sex work

Sex work[1] is not easily defined. It takes many forms and different communities attach different meanings to it. Much sexual exchange in Africa has a monetary component but it would be culturally inappropriate to define it as sex work (Standing, 1992). In some communities there is a social expectation that sexual services are exchanged for favours or cash. Common western definitions such as 'the granting of sexual favours for monetary gain' (Giddens, 1989, p. 195) would therefore be inappropriate.

According to Schurink et al. (1993) a definition should include that the act performed by the seller must have sexual significance for the buyer. This could include activities ranging from sexual intercourse to physical punishment. Sex work is also not limited to women providing sexual services to men. Other relationships include: men selling sexual services to women; men selling sex to men and women selling sex to women.

As the definition of Schurink et al. (1993) refers to a wide range of sexual services, I adopted their definition for the purposes of this study. They state that a sex worker is:

> any person who gains his or her livelihood partly or wholly by indiscriminately, without affection, exchanging sexual and/or non-sexual activities (e.g. listening to someone's problems, going out with someone or acting as someone's regular girl- or boyfriend) for money or for accommodation, food or other valuable articles
> (p. 5).

[1]. The sex workers interviewed in this study used different terms to refer to themselves and their profession. These terms included 'sex worker', 'prostitute', 'escort' and 'one who works on the street'. The term 'sex worker' is used in this study as it is the most widely used term in the literature.

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Sex work in context

Female sex work cannot be discussed without consideration of women's subordinate position in society, which includes their unequal economic position and their oppression in patriarchal society. An understanding of the basis of sex work is an important prerequisite for understanding the degree to which those involved have the capacity to change or modify their sexual behaviour in the face of an AIDS risk (Standing, 1992). As feminist theory places sex work within these contexts, it will be used as a framework. This section will draw mainly on Marxist, socialist and radical feminism, and will include criticism of feminist thought by authors from within the sex working community.

Feminism is not a unitary theory or movement and there seems to be little consensus about the position on sex workers within and between different schools of feminist thought. This discussion does not attempt to address the complexities of the current feminist debate but rather to reflect some of the general issues raised by feminist theorists.

Feminist theorists argue that apart from being an option for economic independence, the services offered by sex workers are also a fundamental and specific product of the nature of male-female sexual relations. They state that patriarchy defines and evaluates women in a way specific to their sex (Millett, 1989).

On this basis, women are divided into two categories: they are either depicted as 'good' women or 'madonnas' who are virginal, honourable, caring and married; or as 'bad' women or 'whores' who are promiscuous, seductive and dishonourable (Carovano, 1991; Jackson, 1987). 'Good women' are portrayed as passive and asexual. When they engage in sex, their sexuality is relegated to the socially sanctioned realm of sex for procreation. Their enjoyment of sex is secondary to that of men's and needs to be controlled (Bullough & Bullough, 1987; Friedli, 1992; Lutz, 1993). In contrast with 'good' women, are 'bad' women, such as sex workers. With regard to AIDS, it is only 'bad women' who are perceived to be at risk.

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Men's sexuality is seen as different to that of women's, being stronger, spontaneous, genital and demanding release. The double standards of sexuality not only offer men greater freedom to explore their sexuality, but also to be the dominant, powerful partner in the sexual relationship and to exploit women in order to satisfy their 'biological' needs (Holland, Ramazanoglu, Scott, Sharpe & Thompson, 1993; Smart & Smart, 1978). The double standards make it acceptable for men to seek release from sex workers, yet make it totally reprehensible for women to be sex workers and to some extent to be sexually active outside of a monogamous relationship (McIntosh, 1978). These double standards form the basis of society's stigmatization of sex workers.

Another criterion for evaluating women is their sexual attractiveness to men. Tong (1989) notes that women are socialized to express their sexuality in a way pleasing to men and to meet male sexual wants and needs as a matter of duty and pride. Feminist theorists often comment that women have been portrayed - and some perceive themselves - as sex objects. Radical feminists in particular regard sex work as the ultimate form of sexual slavery, which needs to be eradicated. Dworkin expresses this as follows:

> ... rape and prostitution will have to be seen as the institutions that most impede any experience of intercourse as freedom - chosen by full human beings with full human freedom. Rape and prostitution negate self-determination and choice for women; and anyone who wants intercourse to be freedom and to mean freedom had better find a way to get rid of them (1987, p. 170).

Male sexuality as well as men's greater economic bargaining power create a demand for sex workers. The economic oppression of women also precipitates the development of sex work. As men have greater control over the production processes, women face limited opportunities in the formal labour market and thus for economic independence. Customary discrimination has also prevented women from acquiring skills and equal education which would enable them to explore other avenues, independent of men. Unable to get a job, a woman may be driven to sex work as a means of survival (Schoepf, 1993a, 1993b; Wilson, Sibanda, Mboyi, Msimanga & Dube, 1990).

With regard to Sub-Saharan Africa, sex work can be seen to reflect the processes of widening socioeconomic differentiation which have produced major income disparities between classes and genders. Sex is an important currency through which the

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disadvantaged obtain a subsidy from the advantaged (Evian, 1993). Standing (1992) notes that without wider action on poverty and gender inequality, these forms of exchange are likely to continue to flourish or increase.

This section has highlighted women's relative lack of power in relationships and society. Sex workers are generally perceived in the literature as powerless, exploited women who are driven to sell their bodies because they have no other choice. Voices from within the sex industry such as those of Nickie Roberts (1993), Ruth Morgan-Thomas (1991) and Dolores French (in Taylor, 1991) offer a different perspective. While acknowledging the influence of patriarchy and male domination on women, they point out that the literature does not account for the sex worker who chooses to become and remain a sex worker. These writers reflect pride and dignity in their profession.

Roberts (1993) in her historical account of sex work, explains the origins of sex work and the status of the sex worker as goddess and nurturer. These writers state that for many, sex work is not a position of powerlessness. The profession has offered them control over their sexuality and has provided economic independence and freedom. According to Taylor (1991) many sex workers feel that feminists have contributed to their oppression by 'forcing moral judgements on them.' She states:

> Feminists accuse prostitutes of pandering to destructive male stereotypes and thereby prolonging inequality and abuses. Prostitutes accuse feminists of contributing to their marginalization and isolation by being as bad as the rest of society if not worse in ostracizing and criticizing them (p. 13).

These writers further argue that, although sex workers have become an integral part of most societies, the nature of their work is often seen as immoral and degrading, and is rarely viewed as what it is - a form of employment. It is not the work itself which is degrading and exploitative but rather society's stigmatization and marginalization of sex workers. Morgan-Thomas (1991) explains:

> ... sex workers are stigmatised, discriminated against, labelled as criminals and all too often blamed for spreading sexually transmitted diseases, including AIDS (p. 1).

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Review of literature on sex workers and HIV

Since the discovery of AIDS and HIV in the heterosexual population, research has paid considerable attention to sex workers. The research on sex workers and HIV seems to fall mainly into the following areas: incidence of HIV infection and STDs; the use of condoms; and intervention programmes.

Incidence of HIV infection

The incidence of HIV infection amongst sex workers has been investigated in many groups with varying results. While research is extensive, only the most relevant studies will be discussed. Low prevalence of HIV-1, HIV-2 and HTLV-1 infections was found amongst sex workers in Somalia (Scott et al., 1991). However, some studies have shown an increase in HIV infection (such as Nzila, et al., 1991). A follow-up study conducted in Spain (Estebanez, 1991) attributed the increase found amongst their population of sex workers to intravenous drug (IVD) use. Estebanez reported a great disparity in seropositivity amongst sex workers who are IVD users than those who are not. Other studies have noted a similar disparity (Bell, 1989; Magana, 1991; Mak, Plum & Van Renterghem, 1990; Morgan-Thomas, Plant & Plant, 1989). This indicates the importance of controlling for IVD use in studies which measure incidence of infection.

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The favourable effect of intervention on seroprevalence rates has been noted. Studies conducted in Zimbabwe (Chipfakacha, 1993) and Zaïre (Tuliza, 1991) found a decrease of HIV infection amongst sex workers. This is attributed to the growing awareness of AIDS and safe sex methods. One study reported that a STD/HIV control programme aimed at sex workers in Kenya was responsible for preventing between 6 000 and 10 000 new cases of HIV infection per year amongst clients and contacts of clients (Moses, Plummer, Ngugi, Nagelkerke, Anzala & Ndinya-Achola, 1991).

A significant association between HIV seropositivity and sex workers of low SES has been reported in Tanzania (Ngaiza, 1991) and Indonesia (Wirawan, Fajans & Ford, 1993). One such study conducted by Kreiss in Nigeria (in Standing, 1992) reported

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seropositivity rates of 66% amongst low SES sex workers and 31% amongst high SES sex workers. The higher incidence of HIV amongst sex workers of lower SES was largely attributed to their less favourable position to negotiate safer sex.

A careful review of incidence studies highlights the need to exercise caution in the interpretation of their results. For instance, the literature indicates an over-emphasis on testing sex workers for HIV in comparison with other members of society. Studies often reported high rates of HIV and STD infection amongst sex workers only, leading to the common, but questionable conclusion that this group can justifiably be called a 'high risk group' or a 'reservoir of infection'. However, the results are seldom compared with test results of non-sex workers. Also, existing studies did not always control for other important and confounding risk factors such as IVD use or blood transfusions. Schoepf (1993b) states that HIV positive results are interpreted differently in the case of sex workers and particularly in the case of African sex workers. According to her, the possibility that an African sex worker might have acquired the infection from a blood transfusion is seldom considered.

The sample in many studies consisted of sex workers attending STD clinics for treatment. This is problematic as the presence of STDs itself amongst these sex workers indicates that they might have engaged in unsafe practices which put them at greater risk of various infection, including HIV. Furthermore, although these sex workers did not necessarily represent the sex working community, the samples are often regarded as being representative and the results correspondingly generalized.

In conclusion, Morgan-Thomas (1991) notes:

> The over-emphasis on testing sex workers for HIV reveals that, although people believe that safer sex prevents further spread of HIV, they don't seem to believe that this is true when sex workers are involved (p. 1).

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Condom use and obstacles to safe sex practices

Given the above criticisms of HIV incidence studies, condom use offers a more useful area of investigation as the emphasis is on protection rather than on blame and stigmatization of sex workers. Such studies are also useful in highlighting areas which need to be addressed in further research or intervention.

One such study is that by Morgan-Thomas et al. (1989) amongst sex workers in the United Kingdom. They reported that 61.6% of sex workers interviewed always used condoms, 2% rarely and 6% never used condoms. The rest indicated that they used condoms 'usually' or 'sometimes'. Another study of sex workers in developing countries showed that sex workers used condoms in 81% of their sexual interactions with clients (Ferencic, 1991). However, studies in Thailand, the Philippines and Spain showed a much lower rate of between 25% and 45%.

According to Uribe (1991) sex workers who are childless, from a higher socioeconomic group and more experienced used condoms more regularly than other sex workers. Low-price sex workers appeared to have minimum education, limited knowledge of AIDS and other STDs, served the highest number of clients each week and reported the lowest levels of condom use (Ford & Koetsawang, 1991; Wirawan, et al., 1993). Not surprisingly, the highest rate of HIV infection was found amongst these women.

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As with women in the broader society, it is usually the responsibility of the woman to suggest safe sex (Bell, 1989; Holland et al., 1993; Mak & Plum, 1991). However, the task is made that much more difficult for social, cultural and economic reasons. Sex workers who are in a vulnerable position due to low socioeconomic status, lack of support, or the subordinate position of women in their society are often compelled to put themselves at risk in order to comply with their clients' demands (Pickering, Todd, Dunn, Pepin & Wilkins, 1992). For instance, it has been noted that although sex workers are motivated to use safe sex methods, many had less bargaining power than their clients due to their lower status in the community and their unfavourable economic position. The threat and/or fear of violence also often made the negotiation of safe sex difficult (Berer & Ray, 1993). Further, in spite of information campaigns amongst

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clientele, clients still made strong demands on sex workers for sex without condoms and often offered more money for unsafe sex (Neequaye, Neequaye & Biggar, 1991). For instance, a study of sex workers near the Thai-Burmese border reported that only 14% of clients used condoms (Swaddiwudhipong, Nguntra, Chaovakiratipong, Koonchote, Lerdlukanavonge & Chandoun, 1990).

Herasme, Pareja and Bello (1991) state that clients gave the following reasons for refusing safe sex: reduction of sensation and lack of feeling; fear of loss of potency image (macho threat); diminished erection; difficulty to reach orgasm; arousal of suspicions of sickness; discomfort caused by condoms; reduced control of their sexual role.

The cost and availability of condoms has also been investigated. Condoms are too expensive for sex workers (Leonard & Thistlethwaite, 1990; Panos, 1990). These researchers suggest that there needs to be greater access to free condoms in order to assist sex workers in promoting safe sex. Some sex workers have complained that although condoms are accessible, they are often not available when needed (Wirawan, et al., 1993). The distribution of high quality condoms is needed in order to increase availability and potentially facilitate their use.

A major obstacle to the use of condoms is the belief that condoms are ineffective (Hooykaas, Van der Linden, Van Doornum, Van der Velde, Van der Pligt & Coutinho, 1991). According to Feldblum and Fortney (1988) more research is needed to ensure the efficacy of condoms. Research on alternative barrier methods is also indicated (Berer & Ray, 1993). James and Wejr (1993) note that sex workers have found the female condom a valuable method of protection, particularly because it was under their control. They state, however, that the cost of the female condom makes it inaccessible to many and might tempt women to reuse them.

Other obstacles noted were vaginal irritation caused by condoms in women with more than three clients a day (Uribe, 1991) and lack of support by managers or owners of escort agencies and bars (Ferencic, 1991).

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In general, the literature around condom use and related problems is more useful than literature on incidence of infection as it highlights areas which need to be addressed in further research or intervention. It also indicates that the reasons behind the reluctance to use condoms on the part of the sex worker and especially the client need to be explored.

Condom use with boyfriends/regular partners

Studies on condom use often do not indicate whether the reported rate of use relates to interaction with casual clients or with regular clients. In particular, sex workers' non-working relationships are often not taken into account. This might be because of a failure to recognize that apart from being sex workers, these women are also mothers and lovers/girlfriends. The categorization of women into mutually exclusive social/sexual status pigeonholes such as 'sex workers', 'mothers' and 'wives' could be misleading and counterproductive. Day and Ward (1993, p. 218) state:

> It may be more relevant to consider sex workers' non-working lives, which are not associated with high rates of partner change or directly with the sale of sex, but which commonly involve unprotected sex.

The majority of studies which examined safe sex behaviour with partners reported a marked drop in condom use (such as Campbell, 1990). Carovano (1991) notes that sex workers face many of the same challenges in their private sexual relations as do their nonworking peers. Sex workers, like other women, usually have less decision-making powers in matters of sex and fear rejection by partners if they insist on safe sex (Orubuloye et al., 1993). Condoms have been associated with promiscuity, distrust and illness (Airhihenbuwa, DiClemente, Wingood & Lowe, 1992; Green et al., 1993). Holland et al. (1993) state that 'if love is seen to be the greatest prophylactic, then trust comes a close second' (p. 200). Condoms also serve an additional function for the sex worker in separating sex for work from sex for pleasure (Leonard & Thistlethwaite, 1990). Such studies indicate the importance of investigating condom use with boyfriends because sex workers could be more at risk in these relationships than with clients.

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Intervention programmes

The need for adequate intervention programmes amongst sex workers has been well documented (such as Chikwem, Mohammed & Ola, 1989; Kaptue, Zekeng, Djoumessi, Monny-Lobe, Nochols & Debuysscher, 1991). Effective programmes have been reported in Nairobi (Moses et al., 1991) and in Thailand (Sittitrai, 1993).

However, there are certain factors which impede such intervention particularly amongst sex workers. The illegal status of sex work in most countries makes it difficult for educators to access sex workers. There is also a lack of cohesion amongst sex workers and the industry changes rapidly as many women engage in sex work for intermittent periods according to changing circumstances (Ford & Koetsawang, 1991).

Carovano (1991) notes that the various intervention programmes implemented to date have involved five principal approaches. She summarizes these as follows:

> (a) Methods that truly seek to provide women with information and tools that will allow them to protect themselves, or at least give them a better chance at doing so.
> (b) Methods that seek to evade risk posed by HIV by providing sex workers with job training and alternative employment opportunities.
> (c) The harassment and/or arrest of women as a means of theoretically eliminating prostitution.
> (d) Routine HIV antibody testing of legally or semi-legally registered prostitutes.
> (e) Combinations of one or more of these approaches (p. 137).

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According to Carovano, only the first approach has proven appropriate or effective in preventing HIV infection in sex workers. She states that the other approaches either scapegoat women, are unrealistic or overlook sex workers entirely to focus instead on the protection of male clients. According to Priscilla Alexander, former co-director of COYOTE, the US National Task Force on Prostitution, discussions of how to reduce the spread of HIV infection emphasize the clients' risks and their convenience first and do not view sex workers as recipients of infection (in Panos, 1990).

Such an intervention programme was conducted in Zimbabwe (Chipfakacha, 1993). The study referred to sex workers as 'reservoirs of infection' and 'spreaders of STDs' and the emphasis of intervention was on the protection of the client. It suggested that sex

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workers had to be registered and a card system was introduced. According to Chipfakacha 'those who were found to have a disease had their cards withdrawn until such time as they were free from disease' (p. 41).

Educational messages need to be realistic. According to Overs (1991) the belief that sex work should not exist at all is one of the biggest obstacles to successful AIDS prevention amongst sex workers. She states that programmes which attempt to find alternative employment have generally been ineffective. Advocating monogamy amongst sex workers is also bound to be ineffective. In a study in India, researchers concluded that sex workers comprised the most resistant group to education (Rao, Swaminathan, Baskaran, Belinda, Andal & Saleem, 1991). The emphasis of intervention was, however, on reducing promiscuity.

The importance of involving sex workers in the planning and implementation of programmes has been highlighted by Overs (1991). Peer education has proven to be valuable amongst sex workers (Dorfman, Derish & Cohen, 1992; Mays & Cochran, 1993) and other sectors of society (Akinsete & Harris, 1992; Bull & Gallagher, 1994; Maticka-Tyndale, 1992). Peer educators can play an important role in preventing relapse from already established behavioural risk reduction (Stall, Ekstrand, Pollack, McKusick & Coates, 1990). Unlike outsiders, peer educators remain in the field where they become role models for positive behaviour change and are able to provide ongoing support.

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Safe sex amongst sex workers will not become a reality unless their clients are educated (Mak & Plum, 1991; Mitchell, 1992; Wilson, Chiroro, Lavelle & Mutero, 1989). However, the characteristics of clients as a group, their sexual activities and attitudes, and their knowledge of HIV/AIDS have only recently begun to be studied (Morgan-Thomas, Plant & Plant, 1990). This might partly be attributed to the difficulty in reaching this population. The main reason, however, seems to stem from the stigmatization of sex workers as 'disease ridden' and their clients as victims who need to be protected against the sex worker (Chetwynd & Plumridge, 1994). In their study of male clients in New Zealand, Chetwynd and Plumridge found that clients lacked

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initiative with regard to condom use and had a low sense of personal risk of infection. They conclude:

> In general this study points to the need to reorient our thinking about the roles played by workers and clients in the transmission of HIV, and to the need to fully study the barriers to these men's use of condoms in all their sexual encounters. (1994, p. 353).

Morgan-Thomas (1991) notes that besides those actually selling or buying the service, other people are involved in the sex industry. These include bar and brothel owners, taxi drivers, sex workers' boyfriends and sex business managers. Overs (1991) and Sittitrai (1993) suggest that these people can play an important role in promoting safe sex amongst clients. Each of these groups must be exposed to the same set of information and services so that they share and repeat similar messages.

Future programmes could benefit from the lessons learnt in previous attempts. Unfortunately, there are few studies which have evaluated the effectiveness of their programmes (Beaman & Strader, 1989; Cates & Bowen, 1989; Kelly, Murphy, Sikkema & Kalichman, 1993; Ostrow, 1989; Schopper, 1990). The existing studies on intervention programmes also offer scant information on the content and process of intervention. This makes it difficult to evaluate the studies and to benefit from the authors' experiences (Padayachee, 1991).

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In conclusion, this literature review indicates that there has been an over-emphasis on testing sex workers for HIV and STDs. Little is known about sex workers' perceptions of AIDS and the many factors which influence their safe sex behaviour. Even though intervention programmes amongst sex workers exist, few studies have evaluated the effectiveness of their programmes. These areas need to be investigated in order to develop appropriate health education amongst sex workers.

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CHAPTER TWO

METHODOLOGY

The present study attempts to understand the many issues facing sex workers and in particular how these issues relate to AIDS and risk reduction. This chapter will look at the use of qualitative methodology as a method of choice, the instrument used as well as the participants and procedure of the present study. My role as the researcher will be highlighted throughout the discussion.

In assessing the benefits of a particular methodology, it is important to consider the aims of the study, the nature of the participants as well as the subject matter (Mouton & Marais, 1990). Careful consideration was necessary in this study as the field of research posed certain challenges. One of the first decisions was whether to make use of quantitative or qualitative methods. Quantitative research roughly involves measuring the degree to which some feature is present, whereas qualitative research involves the descriptive understanding of a phenomenon (Kirk & Miller, 1986). Qualitative research is best used in unexplored areas, where it would be premature to define and measure patterns and variables.

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Qualitative methodology

Qualitative research aims to explore and understand an area. One of the ways in which an understanding is created, is through studying people holistically in their natural settings or environments instead of looking at separate variables of behaviour (Mouton & Marais, 1990). In this way, one acknowledges the influence of the environment on how people think, feel and act.

According to Skinner (1991) the qualitative approach focuses on experiential states of actors and their perceptions of a situation. It is concerned with meaning. It looks at ways in which subjective definitions of social reality are constructed, experienced and

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defined by social actors. Language is not regarded as a reflection of reality or the 'truth' but rather as a means to construct reality (Bruner, 1987; Miles, 1992; Potter & Wetherall, 1987; Taylor & Bogdan, 1984; Viney & Bousfield, 1991).

Instead of entering the field with preset tight hypotheses, hypotheses and foci are created during and as a result of the research. The emphasis is rather on investigating the variables in all their complexity and in context. This allows the researcher to be flexible. Burgess (in Schurink et al., 1993, p. 7) states that:

> (researchers can) formulate and reformulate their work, may be less committed to perspectives which may have been misconceptualized at the beginning of a project and may modify concepts as the collection and analysis of data proceeds.

Such flexibility provides the means for the collection of complex and rich data regarding different topics (Miles & Huberman, 1984). The flexibility was particularly useful in this study because the field was relatively unknown to me. Throughout the field work, interesting areas were discovered of which I was unaware at the beginning. I was able to follow up additional topics 'on the spot' and could introduce these topics in subsequent interviews. The flexibility also improved the flow of the interview and allowed me to adapt the sequence of questions to suit each participant.

Researchers have found qualitative method more suitable for sensitive topics such as sexuality (Griffin, 1986; Schoepf, 1991; Thomson & Scott, 1990). This allows the researcher to build rapport with the interviewee, to be flexible in the way the interview is conducted and to make use of both verbal and non-verbal information.

The ideas of qualitative research are in line with feminist research which questions positivism and the assumptions of scientific objectivity (Du Bois, 1983; Klein, 1983; Mies, 1983; Stanley & Wise, 1983; 1990; Wilkinson, 1986). Feminist researchers regard knowledge as provisional, culturally and historically specific, and both arising from and contributing to social interests (Burman, 1992). They stress that objectivity ignores the humanness of both the research 'subjects' and the researcher. Such a stance also implies that the behaviour of the researcher cannot be explained within the same framework as those she studies, it is therefore non-reflexive (Stanley & Wise, 1983). Feminist researchers state that it is impossible to operate as an objective and value-free

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researcher. They call for reflexivity on the research process, on the role of the researcher and on the project's progress (Burman, 1991; Du Bois, 1983; Griffin, 1986). In this study, I kept a diary in order to account for my role in the research process and its possible influences on the data.

Feminist research also acknowledges the influence of power relations, not only between researcher and researched but in society as a whole (Opie, 1992). With regard to the latter, it was important to take into account the power relations between sex workers and their clients as this influences the degree to which a sex worker can negotiate safe sex (Schoepf, 1993a).

I tried to be sensitive to the power imbalance between myself and the sex workers. The literature usually depicts the researcher as more powerful than the researched, as the researcher determines how the research will be conducted and reported. This argument was valid with regard to this study. However, when a researcher is dependent on access to a group who has the ability to refuse that access, the researcher is placed in a less powerful position. The sex workers I interviewed could have refused to speak to me. This made me feel less powerful than them. It is unclear whether the sex workers shared this perception. As the research progressed, I felt more accepted amongst the sex working community, and consequently felt more 'powerful'. Again, whether the sex workers shared this perception is unclear. With regard to the possible misrepresentation of sex workers' views in this study, every attempt was made to represent the data as accurately as possible.

Feminist researchers criticize the way in which research is traditionally conducted. They argue for research 'for' women as opposed to the traditional research 'on' women. Klein (1983, p. 90) explains:

> I define research for women as research that tries to take women's needs, interests and experiences into account and aims to being instrumental in improving women's lives in one way or another.

In line with the principle of research 'for' women, I designed the interview in a way which included a needs assessment of sex workers. Instead of using an existing intervention approach, my follow-up intervention was informed by the outcome of the

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study in order to make it more meaningful and applicable to sex workers. The interview was also structured in such a way as to make information sharing a two-way process. This will be discussed in greater depth in the section: 'Procedure'.

Despite the advantages of qualitative methods, these methods have been criticized for being subjective and not scientifically credible. The validity and reliability of data, especially that on sexual behaviour, has been questioned (Brenner, 1985; Schopper, 1990; Simpson & Eaves, 1985). However, qualitative researchers not only challenge the 'scientific objectivity' of quantitative methods, but also suggest alternative ways of approaching validity and reliability. One of the ways of overcoming the problem is transparency of how the research was conducted (Bruinsma & Zwanenburg, 1992). Schurink et al. (1993) suggest that this should include an account of how entrée was gained, how data were gathered and how the gathered information was analyzed. Although it is difficult to replicate qualitative research because of the flexible and variable nature of the research process, there is scope for other researchers and the readers to test the findings. Strebel (1994) adds that validity and reliability can also be addressed through linking findings to other work of a similar genre and by checking theoretical assumptions. Triangulation, the use of multiple methods of data collection in a single project, is an important strategy to combat problems of validity. In this way different methods can to some extent compensate for the disadvantages of each individual method (Mouton & Marais, 1990). Unfortunately, time and financial constraints made it difficult to make use of triangulation in this study.

There are different approaches to analyzing qualitative data. However, all the approaches are concerned with understanding the meaning of communication, both latent and manifest, and involve the transformation of raw data through inferences and interpretation. Unfortunately there is little information on exactly how the analysis should be done (Miles & Huberman, 1984; Strebel, 1994). The method of analysis used in the present study will be discussed in the section: 'Analysis and Reporting Data'.

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The sample

Many forms of sex work exist. Furthermore, some activities which might be regarded as sex work by outsiders are not regarded as such in certain communities (Standing, 1992). While not ignoring the complexities of both urban and rural sexual relationships, I needed to focus my study due to limited time and resources. As women are particularly vulnerable to HIV infection through sexual intercourse, I concentrated on female sex workers who deal with a predominantly male clientele. The sample only included sex workers in the Cape Town central business district where there is a transient, cosmopolitan clientele. Only women who rely on sex work as their only source of income were included.

Fourteen sex workers were interviewed. Eight women worked on the street and six worked from escort agencies. One of the street worker interviews (sex worker 1) was interrupted by an outsider and I therefore decided to conduct an additional interview with another street worker. During the analysis, the data from the incomplete interview was, however, found to be valuable and I therefore included it in the discussion. Sex worker 8 was a male transvestite. I initially decided not to include the interview in my analysis as this study does not focus on male transvestite sex workers. However, the content of this interview did not differ significantly from the other interviews and it was therefore included. The similarities between the accounts of this sex worker and those of the female sex workers in this study raise interesting questions. Many of the difficulties faced by female sex workers have been discussed in the context of the position of women in a patriarchal society. It was therefore interesting that sex worker 8 experienced similar difficulties. Unfortunately, it is beyond the scope of this study to explore this in greater depth.

Street workers and escorts differ not only in terms of working conditions but also in terms of socioeconomic status (escorts belong to a higher socioeconomic group). Street workers usually worked from street corners. In some cases, women also worked at the harbour at certain times of the year. The women usually accompanied their clients to parking areas or hotels. Most of them operated independently. However, some women preferred to work with friends for security reasons.

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All the escorts were controlled by managers and shared their income with the agency. Some agencies operated as brothels in that all the transactions took place on the premises. At other agencies, women were required to accompany their clients to functions, hotels or their homes. At some of these agencies, drivers provided transport and some form of protection.

I decided to include interviews with both groups as I expected that these differences would influence their vulnerability and ability to negotiate safe sex in the following ways:

(a) Street workers might be more vulnerable due to their working conditions.

(b) The economic position of street workers might increase the likelihood of unprotected sex.

(c) Managers at escort agencies might discourage women to refuse a client who insists on unsafe sex.

(d) Street workers might have been more exposed to some forms of health intervention, while managers might make it difficult for health care workers to gain access to escorts.

Description of the sample

The ages of the street sex workers ranged between 17 and 24 years with an average age of 21,25 years. One escort was 43 years old. Five escorts ranged between 23 and 28 with an average age of 24,8 years. Five street sex workers and three escorts have children. There was a significant difference between the two groups with regard to level of education. The average level of education among street sex workers was Standard 7. Except for one escort, all the escorts had matriculated. Four escorts had studied at tertiary level. The characteristics of the individual sex workers appear in Appendix A.

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The instrument

Individual in-depth, semi-structured interviews were used in this study. One interview was conducted with each woman. Interviews have the following advantages:

(a) They permit the collection of the most extensive data on each person interviewed.

(b) They allow both parties to explore the meaning of central themes in the life-world of the interviewee.

(c) They are neither strictly structured, nor entirely non-directive, but are focused on certain themes.

(d) They provide the necessary flexibility to adapt methods to the needs of each individual research situation.

(e) Any misunderstandings by both parties can be checked immediately.

(f) They enable the interviewee to answer the questions as fully as she chooses and to motivate her response when required (Brenner, 1985; Mouton & Marais, 1990).

Furthermore, when a study involves sensitive topics such as sexuality and abuse, interviews are suitable as they offer the opportunity to establish rapport. I felt that this was particularly important as sex workers view outsiders with suspicion and questions relating to sexuality and safe sex practices might be regarded as intrusive or judgemental. The interviews also allowed me to get to know the field, including the language and terms used in the business.

According to Brenner (1985) the interview consists of three basic components: informants; interviewers; and information, while the setting of the interview also influences the process and information obtained. He explains:

> We can never assume that the accounts given are simply answers to questions; they are the joint product of the questions as perceived by informants and the social situational circumstances within which the questions were put to them (1985, p. 151).

This, however, can result in bias as the informants' cognitions of their experience can distort the interpretation of questions and responses (Brenner, 1985). The topic and questions can also influence the interview situation. Discussing sensitive and intimate

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material may deter informants from answering truthfully or accurately. Non-verbal cues as well as the perceived bias and ideology of the researcher may provide signs for the informant as to the 'correct' answer. This relates to the issue of social desirability, or the attempt to respond in a manner that confirms socially desirable behaviours (Brenner, 1985; Mies, 1983). Such bias could have influenced the data in this study. The sex workers might have felt compelled to answer in a certain way, especially in response to questions around safe sex behaviour and HIV testing. This possible bias will be discussed in greater depth in the section: 'Results and Discussion'.

Related to this are the personal characteristics of the interviewer, such as race, age, class and gender which can also be potential sources of bias. The interviewing style adopted by the researcher should also be regarded. One way of dealing with this is through reflexivity, which was discussed above, as well as honesty between the two parties (Klein, 1983).

Some authors stress the importance of the gender of the interviewer and interviewee. In a study on sexual behaviours by Schopper et al. (1993) they felt that the reporting of sexual activity and willingness to use condoms might have been biased due to men interviewing female respondents. Finch (1984) feels that a woman interviewing a woman is conducive to the easy flow of information. She states that women, more than men, are more used to accepting intrusions through questioning into private parts of their lives. They are less likely to regard such questions as inadmissible. Furthermore, both parties share a subordinate structural position by virtue of their gender. This creates the possibility that a particular kind of identification can develop (Finch, 1984; Klein, 1983). However, shared experiences on the grounds of gender should not be assumed as they could be overshadowed by differences of class and race (Lorber & Farrel, 1991; Stanley & Wise, 1990).

The differences in class and race between myself and the interviewees cannot be ignored in this study. The majority of sex workers in the study were those historically classified as coloured. These sex workers came from a predominantly working class background. It is unclear how they perceived me as a white, middle class woman and to what extent this influenced the data. It was interesting that the sex workers did not

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refer to class and race during their interviews. I was also silent around issues of race. My silence might have been due to my sensitivity around these issues at that particular time in South Africa. I therefore did not pursue it actively. The sex workers may have sensed my discomfort and may therefore have avoided the issues themselves.

However, there seemed to be an additional distinction between us, that of marginalized versus mainstream. In retrospect, I feel that I might initially have been too aware of not coming across as sharing the broader society's prejudice and discrimination against sex workers. In my initial interviews I tended to become over involved in the interview process in an attempt to reassure the women that I respected their views. As I became more comfortable with these differences and with my own views about sex work, I felt more at ease to acknowledge the differences during the interviews.

The recognition of differences was also evident in the way the women related to me. There was a clear distinction between 'them as sex workers' and myself as the 'outsider'. They tried to inform me about 'their world' and 'their jargon'. At the same time there appeared to be a need to stress similarities rather than differences. This was particularly evident in the way women spoke about why they entered the profession. It was also evident in the way the women endeavoured to shift the 'blame' for HIV infection from 'them' to 'us/everyone'.

I felt that being a woman was particularly helpful during the interviews. Sensitive questions such as those relating to STDs might have been more difficult to answer if the interviewer were male. There was also an acknowledgement of commonalities between us as women which might have made it easier for them to discuss certain issues. Remarks such as: 'you know how these men are' or 'one can never trust a man' were common and seemed to include a sense of shared experiences.

In conclusion, it is important to weigh the influence of class and race differences against the general aims and relevance of the research (Strebel, 1994). I felt that there were important grounds for undertaking the present study. These included the following: the

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urgency of responding to AIDS; the lack of research on the sex industry in South Africa; the stigmatization and marginalization of sex workers, including blaming these women for the spread of HIV.

Content of questions

The interviews included biographical data and open-ended questions pertaining to the research (see Appendix A). The open-ended questions related to the following areas:

a) Knowledge of AIDS
b) Perception of risk
c) Protection against infection
d) HIV testing
e) Negotiating safe sex
f) Health services available
g) Legalization

Most of the questions were selected on the basis of relevant literature. As mentioned previously, the initial interviews raised additional topics which were included in subsequent interviews. Such additional topics included attitudes towards the police and drug abuse. The direction of the interviews varied. In most cases I started with broad, general questions such as 'how did you start working on the streets' after which the woman was largely allowed to tell her story. I felt that this was less threatening than starting with questions relating to the personal arena of sexuality. Although a schedule was developed, it was seldom rigidly applied. A conversational atmosphere was largely maintained which was helpful in establishing rapport and a non-hierarchical relationship (Finch, 1984).

Procedure

Sex work is illegal in South Africa. The society stigmatizes the profession and its workers. Sex workers tend to be secretive and suspicious of outsiders. This makes it difficult to gain access to this community. My entry into the field was different for the

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two groups, and my approach also changed throughout the fieldwork as I became more street-wise.

As time equals money for the sex worker, I initially intended to pay the participants. My attempts to raise funds for payment were unfortunately unsuccessful. Payment would have been valuable in this study because it would have compensated for the possible loss of income during the interview time.

Contact with street workers was generally made by frequenting places where they solicited customers. My approach was similar to that of Schurink et al. (1993) who suggest that one should be truthful, but vague and imprecise. I introduced myself as a student from the University of the Western Cape who was doing a study on people who work on the street. In some cases I produced my student card as well as a letter from the university outlining my research. Great care was taken to establish trust and co-operation. I assured the women that the information provided by them would remain confidential. I gave the women the option of using pseudonyms. I explained the reasons for recording the interviews on tape. I also explained that the meeting would be divided into two parts: the first would include the interview; thereafter, I would spend time answering any questions they might have.

The reactions of the women varied. Some were very suspicious and immediately said that they were not interested. However, most of the women were willing to be interviewed.

At first, I made an appointment to meet with a woman at a place and time of her choice. However, the women seldom kept the appointments and I abandoned this method. It only worked when the meeting was scheduled to take place at a woman's home. I found the most successful method was to immediately interview those who were willing. Interviews took place in my car. The circumstances were less than ideal as we were at times distracted by pedestrians and traffic noise. On two occasions, women wanted their friends to join us in the car. The friends joined in the discussion and their contributions were included in the analysis. It is unclear to what extent the presence of friends inhibited the women during the interview.

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In the first month I spent approximately three nights a week in the field. I found that access became easier as women got to know me on the street. Those who had already been interviewed were often helpful as they would assure their colleagues that the interviews were 'safe' and helpful. Unfortunately, my field work had to be interrupted for two months and subsequently I could only spend one night a week in the field. It was extremely difficult to re-enter the field because of the rapid turn-over of sex workers.

Entry into escort agencies differed. At first I found it necessary to ask permission from the 'gatekeepers', in this case the escort managers, as suggested by Taylor & Bogdan (1984). My introduction was similar to that with street workers. In the majority of cases, the managers were uncooperative. Their reasons usually included unpleasant experiences with journalists in the past and an unwillingness to trust outsiders. In many cases managers said that the women would not be interested because the latter regard their work as private. These managers also did not want me to approach the women directly. I then decided to approach the women directly. I found that once I had explained my research to individual women, they were willing to co-operate. Therefore, I usually entered the agencies in the afternoon when only a few escorts were around. As with the street workers, information about the study and assurances of confidentiality were given to these women. All the interviews with the escorts took place at their agencies.

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In both groups, I found that once cooperation was secured, women were generally willing to talk and to answer questions. Only one woman did not want the interview to be recorded and I tried to take down as much as possible verbatim. The interviews lasted between one and four hours. The second section of the meeting usually took much longer. Questions raised by the women were usually around AIDS and safe sex. I would also make use of the opportunity to address any details around AIDS which they omitted or answered incorrectly during the interview. This was at times followed by other topics which often related to broader psychological issues, drug abuse, child care or legal matters.

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It is worthwhile to consider the relevance of the second section which included information and counselling. There have been different opinions on whether research and intervention are and should be separate undertakings or whether the urgency and ethics of AIDS work requires a combination of the two processes (Strebel, 1994). The inclusion of intervention in this study was largely motivated by the lack of intervention programmes for sex workers. The interviews often revealed misconceptions and myths regarding HIV and safe sex practices. I felt that it would be unethical not to address these issues in the second section of the interview. The transient nature of the industry also makes follow up difficult and in some cases impossible. My willingness to provide information on other issues not relating to AIDS was an attempt to give something in return for their time and participation. As I felt less of an intruder, I became less convinced that this needed to be part of my role as researcher. Paying the participants might have been a better and less time consuming option. However, these informal discussions proved to be valuable in terms of developing an understanding of the broader issues faced by sex workers.

Ethics appraisal

It was important that all sex workers participated on a voluntary basis. The interviews, recordings and transcriptions were confidential and were only available to the particular sex worker involved, myself and my supervisor. In order to protect confidentiality in this study, the women are not referred to in any way which may identify them. As mentioned above, I felt that it was important to supply information on AIDS, safe sex methods, HIV testing and services offered by clinics and organizations. Feedback about the outcome of the study was given to all the participants who could be traced at the time of completion.

Analyzing and reporting data

Transcription

All the recordings were transcribed verbatim from the tape onto computer. Except for two interviews, all the transcriptions were done by myself. Pauses, hesitations, unclear

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speech, as well as my input were indicated (see Appendix B for coding conventions). Being involved in the interview and the process of transcribing, has the advantage that I could include non-verbal information and impressions from my field notes in my analysis. However, I am aware that it is possible that my own understanding of what was being communicated could have influenced the data (Strebel, 1994). All the interviews were conducted in either Afrikaans or English. I decided against translating the Afrikaans texts as the texture and nuance would inevitably have been lost in the process (Strebel, 1992). In this way I could also avoid including my own interpretation of the meaning in the translating (Strebel, 1994).

Analysis

There is no standard method of analyzing qualitative data. Analysis was primarily thematic, concentrating on the major themes which occurred in the accounts. According to Miles and Huberman (1984) the finding of patterns is an easy and relatively natural process for researchers. However, due to the richness of material gained through qualitative methods, there is a danger of trying to cover too many topics in too much depth (Brenner, 1985). In addition to themes, I also included contradictions and exceptions as these provide a more comprehensive and accurate reflection of the phenomena (Potter & Wetherall, 1987). I did not regard the categories as mutually exclusive. Some of the quotes therefore fell into more than one category.

The transcriptions were also compared in terms of patterns existing within groups (such as drug using street workers versus non-drug using street workers) as well as between escorts and street workers.

It is difficult to demarcate the analysis into separate, independent stages as the process involved a continuous interplay and overlap of phases. What follows is thus rather a description of the process of analysis.

The initial stage of analysis involved an 'immersion in the data' (Strebel, 1994). Emphasis was on acquainting myself with the material and identifying themes and patterns (Potter & Wetherall, 1987). The selection of themes was based on the reading

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of related literature, the transcriptions and the initial aims of the study. The following themes emerged: AIDS; protection; HIV testing; services; negotiating safe sex; legalization. The transcriptions were read again and coded according to these themes. The marked sections, which included sentences, phrases or paragraphs, were copied from the text and grouped together in the themes. The original texts were checked again for additions and omissions.

The groups of coded text were read several times. Similarities, differences and contradictions emerged which resulted in sub-themes. During this process, some of the original sections had to be reclassified. Sub-themes were also created for sections which indicated a relationship or overlap between different themes. At this stage, I felt removed from the original texts and returned to the transcriptions. This helped to gain perspective. It gave a sense of the relative salience of different themes. This resulted in the inclusion of additional themes which appeared to underlie many of the existing themes. The original texts were studied again to check whether the themes corresponded with the data. Once the final themes and their possible interconnections were mapped, quotes were selected. Due to the wealth of data generated, many quotes unfortunately had to be omitted. I attempted to select quotes which were representative of the two groups and which could best illustrate particular views.

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In reporting the data, an attempt was made to interpret and explain the different trends. The interpretations were based on relevant literature as well as my own impressions during the field work and analysis. Finally, I returned to the original texts to test the interpretations which I had generated within their context. This helped me to check for possible distortions and omissions (Strebel, 1994).

To conclude, qualitative research is a useful way to study a population which is relatively unknown. In this study, I attempted to use qualitative research as a tool to explore the perceptions of sex workers. The following results offer hypotheses and directions for future research.

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CHAPTER THREE

RESULTS AND DISCUSSION

This section will firstly look at how sex workers talk about and understand AIDS, its transmission and where they gained their information. This will be followed by their perceptions of risk and to what extent they feel able to protect themselves against infection. This includes sex workers' opinions about power relations and abuse. The frequency of condom use follows as well as their views around sex work and its present legal status. Throughout the section, implications for intervention as well as links with literature will be highlighted.

What sex workers say about AIDS

Some of the women spoke about AIDS as an epidemic, a virus. They gave factual, medical information about the disease.

> ... 'n virus wat in jou bloed is ... (1)[2]
>
> It's HIV, a sexually transmitted disease. (E)
>
> Well, it's basically a disease that breaks down the immunity systems so that the body, you can die from any common disease because your body can't fight the disease. (D)

However, the majority were less specific and less factual. Women spoke in vague terms about AIDS. They regarded AIDS as a terrible, dangerous illness which cannot be cured and which results in death. The delayed onset of symptoms contributes to this perception.

> AIDS, ... it's a very deadly poison (laughter) ... ooh, fuck it
> Researcher: Wat bedoel jy 'deadly poison'?
> ... it's a ... how can I say ... it's a ... em... it's a germ that can never be cured ... so ... em ... XX there's no cure for AIDS, nothing ... the only thing you can do is, use a condom, prevent AIDS. (3)

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[2]. Street workers are indicated in brackets from 1 to 8 and escorts in brackets from A to F.

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AIDS is something that you can't see or feel. XX 'Lyk ek soos iemand wat AIDS het?' Dan sal ek net sê: nee, ek kan nie sien op jou gesig jy het AIDS nie, want AIDS is nie soos 'n puisie wat jy kan sien nie. (2)

... and that it can stay in your blood for a while, ... em, before it can be detected by a blood test, which is the scary thing but ... (D)

Some believed that there were HIV positive clients who deliberately infected sex workers because they knew the latter would not have been able to tell whether they were positive or not.

Miskien het party van hulle 'n ... AIDS dan wil hulle dit nou oordra na jou toe, dat hulle nou 'n grudge het, ons is nou hoere en ons het nou, party van ons het AIDS en party van ons het nie, so bedoel hulle nou. (4)

... he's a young, white guy, he's riding in a white Datsun, he's mad, he's picking up gay people, then he make them dead because I think one of the gay people give him AIDS and he doesn't know what gay people it is. XX So he said he's takes revenge on the prostitutes, the gay people, all of us. (8)

Paradoxically, sex workers said that they would know almost immediately whether they are infected.

Want ek het nog nooit siek gevoel agterna hy my gebruik het nie of voor hy my gebruik het nie, soos nou brand en sulke goed sê hulle is nou die eerste symptoms, maar ek het nog nooit nie. (4)

Hulle gaan nie vir jou sê hulle het AIDS nie. Hulle gaan net vir jou gebruik en die volgende dag as jy wakkerskrik, en jy ... dan kry jy, jy sal aanvoel iets is nie reg nie. (3)

Related to this, is the notion of 'cleanliness': AIDS and other STDs are associated with dirt and with being dirty. Women and their clients spoke of 'being clean', meaning not being HIV positive. STDs were commonly referred to as 'vuilsiek'.

Maar die ding is, die kliënt wat ek doen en die kondoom breek, kan skoner wees as wat ek iemand ontmoet en ek het 'n ernstige verhouding met hom. (B)

Jy kry dit deur vuilgeid ook, as jou huis klompe vullis in het, dis besmet, aan die een kant lê nou die besmette water en jy gaan nou per ongeluk nou net gebruik daarvan of nou so. Want ek het baie gelees dis van vuilgeid ook wat jy AIDS kan kry. (4)

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When asked about AIDS, some women referred to the symptoms. AIDS was described as a degenerative, 'fading away' illness.

> Dis different stages, eers die ... jy raak swak, jou hare val uit ... sulke stages. (1)
>
> Ek weet jy word maerder by die dag en jy raak sieklik, jy kry siekte, soos ... hoe kan ek nou sê, jy kry kliere waar jy nie moet kliere kry nie en so nou en ... raak jy nie bleek nie? (4)

Some sex workers tried to understand the origins of the illness and expressed interest in how and where it originated.

> Maar hulle het mos gesê in die Ou Testament, daar gaan 'n siekte kom wat die hele nasie gaan uitroei. Nou ek dink dis die AIDS, AIDS siekte wat die hele nasie gaan uitroei. So ek dink so. My ouma het ook gesê, die siekte wat nou uit is, is die AIDS wat hulle daai tyd in die Ou Testament gesê het gaan die hele nasie uitroei want alles word waar, verstaan jy? Net soos die oordeelsdag wat uit die see kom. Ek lees mos altyd die Bybel. XX Want in die Bybel het mos gestaan die siekte wat gaan uitkom is, daar gaan nie 'n cure wees vir dit nie en baie gaan sterf van ... van die siekte. (4)

With regard to transmission, the majority of women identified sexual intercourse as the major route, but other routes were also mentioned.

> Die dinge, seks, en drugs, die naalde, en goed nou so. (5)
>
> You can get it orally, there's three kinds of ways you can get it. You can get it through three kinds of sexual activities, orally, vaginal and anal. I know that. I know that you have to use a condom and that a condom isn't a hundred percent. (A)

A great deal of confusion existed as to whether HIV could be transmitted through oral sex and kissing. This was the most common question asked during the question time following the interviews. There were also certain myths regarding transmission.

> ... many ways ... you can get AIDS through kissing a gay. A gay ... and a ... sometimes you can get a ... AIDS, through using a homosexual's make-up as well. (3)

The majority of the sex workers were aware of AIDS but had gaps in their knowledge, mainly with regard to the etiology and outcome of AIDS. This corresponds with research conducted amongst sex workers in other countries (Green et al., 1993) and in South Africa (Schurink et al., 1993).

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Many sex workers relied on medical explanations of the illness and drew comparisons with other epidemics and illnesses. However, the overwhelming majority of descriptions involved the perception of AIDS as something vague, invisible, dangerous and incurable. Their responses reflected uncertainty and fear about the illness. These views might have arisen in part as a result of some of the following factors:

Firstly, sex workers, like most people, are excluded from the medical and scientific culture, yet they need to rely on experts for information and assistance. This contributes to the view of AIDS as vague, invisible and dangerous. According to Strebel (1994, p. 128):

> The ordinary person is thus disempowered, lacking in such expert knowledge and unable to take action without access to this medical world and its professional language. So paradoxically, while the medical paradigm is one which implies individual responsibility for illness, it also communicates the need for outside 'expert' intervention to deal with the problems.

Secondly, the medical knowledge about AIDS as well as education messages change rapidly. Although this was not mentioned by sex workers in this study, the changing messages might have contributed to the uncertainty and fear as it might have created the impression that even the experts whom they relied on were uncertain about AIDS.

Attempts by the sex workers to explain the origins of the illness, the association of AIDS with dirt and the emphasis on symptomatology, might have been ways they were trying to make the disease more tangible. A single, fully integrated message is needed which addresses conflict and contradictions and is relevant to the everyday lives of these women. Furthermore, Maticka-Tyndale (1992) states that it is important to present new information in the context of prior information in order to avoid 'mixed messages' and further possible confusion.

Care should also be taken not to present information in an overly fear-arousing manner. Schoepf, Engudu, Nkera, Ntsomo and Schoepf (1993) state that training strategies should include concrete steps which participants can take in order to develop their capacity to control risky situations. According to Mays and Cochran (1993) such an approach lessens the likelihood of engaging in denial, adopting a fatalistic attitude, or dismissing the information.

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The emphasis sex workers placed on cleanliness might have been a result of, and reaction to, society's traditional perception of sex and more specifically sex work, as dirty. However, sex workers' branding of HIV positive people as dirty, not only stigmatized infected people, but might also have been a way they distanced themselves from the illness, i.e. 'only dirty people have AIDS' and 'as long as you keep clean, you will not be infected'.

The inaccurate beliefs of dirt/cleanliness, as well as the emphasis on symptomatology both need to be addressed. As Crawford, Turtle & Kippax (1990, p.135) explain:

> Inaccurate beliefs or gaps in knowledge may combine with each other and with prejudices predating the AIDS scare to provide a basis for reliance upon particular (unsafe) strategies.

The influence of inappropriate messages on sex workers' perceptions of AIDS has been discussed. Whether existing sources of information are adequate and appropriate needs to be considered.

Sources of information

Women stressed that they were eager to learn about AIDS and that they made a deliberate effort to broaden their knowledge. Some said that thorough knowledge was important because of their profession.

> Dit is 'n moet dat hulle (sex workers) moet weet van AIDS. Mens kan nie staan hier en geld maak en besigheid maak en nie weet watter siekte jy kan kry van ander mense nie. (4)

> I also read a lot. You know, so ... every article I see on AIDS I read, every single one, I see it, I read it. (C)

However, it seemed they gained their knowledge in a haphazard manner - they read articles, notices and posters whenever they saw them. The major sources of information were clinics and the mass media.

> As ek iets sien van AIDS dan lees ek dit, koerante, tydskrifte, brosjures. Ek het al gesien as jy na party publieke toilette toe gaan, dan kry jy 'n pamflet van AIDS daarop. En soos wat jy nou jou hande staan en was dan kyk jy net terloops. So vir die rukkie wat jy tyd het om iets te lees, vang jou oog net iets hier en daar en jy lees dit, en dis dit, en jy gaan maar aan. (B)

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> Meestal die TV of as ek na die clinic gaan vir kondome of so, kry ek maar meestal die boekies, dis al inligting wat ek maar meestal gekry het. (F)

> By die kliniek as ek gaan vir my inspuiting, sal ek altyd lees van ... em ... AIDS wat op die muur is, blaaie, bladsye, sal ek altyd lees. (6)

Other sex workers, clients and church groups also played a role.

> Meeste van die meisies praat mos maar, verstaan? So dit is eintlik hier in die agentskap XX Ek meen ons praat baie onder mekaar oor AIDS en em, die inligting wat jy ten minste optel, miskien is dit genoeg om hier te bly. (F)

> Kyk die mense het gekom van die kerk af, van die koffiehuis, hulle het altyd gekom. Dan praat hulle met die meisies en, ek is 'n Moslem, ek is nou wel nie Christen nie, maar ek gee hulle 'n hearing, so man, gee hulle altyd 'n hearing. (5)

> You see the thing is, how the girls know about Age (sic) is because, em, street people who work on the street they come and talk every night to the girls on the street. It is a kind of church organization. Then they come, then they give you condoms, then they give you a piece of paper that you must read on AIDS then they give you papers that you read about God and all those things. (8)

Although many gained information through clinics, it usually did not directly involve the clinic personnel. The following concerns were raised about the existing sources of information.

> Researcher: Gesels jy met hulle oor jou werk?
> Definitief nie. Nee, hulle het miskien al 'n suspisie dat jy 'n prostituut is, hulle sien mos die meisies wat die kondome kom haal. XX Maar ek sal nie sommer saam met hulle daaroor praat nie. Ek is nie geworry oor wat hulle sal sê nie, dis net, ek is net bekommerd dit kom dalk by my ouers uit, en my familie en vriende en ek wil nie so iets hê nie, verstaan jy? (F)

> I want to go to the clinic sister and found out about it but you know I'm so shy. [Why?] I'm so shy ... but ... maybe God sent you to me now. XX As ek met die klinieksuster wil praat, is daar altyd baie mense ... em, susters om haar. (6)

> ... with the nurses at the clinic they, they're rushed, they don't get paid reasonable salaries em, you know, so I'd rather go to a doctor and pay a bit more and know everything is fine. (A)

> Em ... I don't know, because they're (clinic staff) quite conservative there, you know. They might suspect because I often go and get condoms, you know but I don't, I'd rather they didn't know.
> Researcher: Why is that?
> Em, because they probably look down on it, you know. (D)

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Most sex workers stressed that they were eager to learn about AIDS and some linked their seriousness to their perceived risk of being infected. Apart from church groups who often combine evangelical work with AIDS education, there are few organized education programmes aimed specifically at sex workers. As expected, street sex workers had been more exposed to health intervention than escorts. Current intervention and services provided by church groups and the Family Planning Clinics appear to be inadequate. This might be one of the reasons for the gaps in knowledge about AIDS which was discussed in the previous section.

With regard to intervention by church groups, Mays and Cochran (1993) point out that some risk reduction messages (such as: 'have sex but protect yourself') clash with the conservative, religious theology of particular denominations. Such interventions usually have a greater emphasis on converting sex workers than on safe sex education. One could speculate that this might increase the guilt and conflict experienced by some women about their profession and serve to increase denial about risk.

Family Planning Clinics appear to play a useful role in supplying condoms but play a less significant role with regard to education. Sex workers in this study as well as in Johannesburg and Durban (Schurink et al., 1993) complained about the negative attitude of health workers towards people in the sex industry. Further research is needed to determine what would make it easier for sex workers to discuss their concerns with clinic staff. A clinic or drop-in centre for sex workers should be considered as well as training of clinic staff to interact with stigmatized women (Berer & Ray, 1993). In addition, Karim, Karim and Preston-Whyte (1992), in their assessment of staff at clinics in Durban, note that more staff and improved facilities are required.

As discussed in the literature review, education programmes tailored to the needs of specific groups are needed. However, both escorts and street sex workers in this study did not welcome AIDS education programmes by outsiders as they regarded their work as private. The reluctance seemed to stem from a fear of exposure and stigmatization. Fear of arrest has also contributed to their distrust of outsiders. Another factor, which has not been mentioned elsewhere in the literature, is sex workers' distrust of journalists. When I initially approached the women for interviews, many were reluctant

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to be interviewed because they thought I was a reporter. Many sex workers and agency owners have had unfortunate experiences with reporters. They regarded reporters as opportunistic voyeurs who would betray their trust through exposure and sensation and thereby contribute to society's stigmatization of sex workers. All these factors make it difficult for researchers and outside educators to gain access to the sex industry.

Sex workers might also feel that outside educators blame them for the transmission of HIV. A possible way of overcoming this might be by establishing peer information networks (Crawford et al., 1990; Kelly et al., 1993; Ulin, 1992). Apart from the advantages of peer education outlined in the literature review, peer educators could also have a better understanding of the particular difficulties facing sex workers.

This raises an important question of whether the branding of certain groups as 'high risk' increases denial and has a negative effect on prevention. This will be explored in greater detail in the following section.

Perception of risk and HIV testing

We have seen that the sex workers in this study were aware of AIDS. However, perceived risk is more important than knowledge for behaviour change to occur (Ostrow, 1989). It is therefore important to examine to what extent these women perceived themselves as being at risk.

Most of the women agreed that they were at risk. However, they felt strongly that they were not at any greater risk than any other person. They stressed that anyone could be infected.

> Ek dink elke mens op hierdie aarde staan 'n kans om AIDS te kry. XX Want jy sien, ek kan in 'n ongeluk wees, ek kan AIDS kry, ek kan die dag trou, ek weet nie wat gaan my man doen nie. Mans is so skelm, as jy eers in hierdie besigheid is, dan weet jy, dis iets ongelooflik, okay, ek gaan nie weet wat hy doen nie. So die ding is, dis ewe risky all over. (B)

> Enige een kan dit kry. Normale mense kan ook AIDS kry, because why, Liberace is dood van AIDS en .... klomp.
> Friend: dit staan voor enige een se deur.
> Ja. Liberace is nie ... hy's dan 'n hoë ... international. ??? Dis nie net prostitute wat dit kan opdoen nie, daar's ... ons kan nou net 'n mistake maak. Daar kan

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'n vroumens in Mitchell's Plain sit en ... dit kry. XX Enige iemand, enige iemand. En wat is die laaste ... ster, Freddie Mercury, hy't dit gekry van Queen. XX ... ek kom hier uit, dan is die vir my 'n werk, en ek beskerm myself ... XX En ek kan miskien, ek kan miskien in my persoonlike lewe kan ek AIDS kry en ek kan miskien hier niks oorkom nie. Mens moet versigtig wees al kant toe. (1)

Some added that sex workers were in fact more careful and knowledgable than others. They were therefore less likely to be infected and to spread the disease. As these sex workers explained:

And I can tell you something, I think a man has a better chance of getting AIDS from a woman he picks up at a bar and having a one-night stand than one who gets it from us. 'Cause we know what the situation is and we're extremely careful and that's why when we have people come round and say, oh, we are the main cause of sexual diseases and shit like that, it's bullshit. Because we are so careful and we are, em, giving a service and we don't ask men to come to us, men come to us, and we give a service, you know, and there's been a lot of discrimination against us in the newspapers and everything you know. But I mean, you can think for yourself, I mean, you know the danger that you're in and you try and avoid it, you're not stupid about it. You know, the only difference is that we get paid for it, so what. That's our choice. (A)

Mense dink altyd ons alleen, ons wat sulke siektes kry
Friend: maar dit is tog nie so nie cause ons is meer versigtiger as ...
Dis nie dat ons meer versigtiger is nie ...
Friend: ons is meer versigtiger, ja because as 'n mansmens kom hierso en hy wil nie sonder 'n FL nie, dan gaan ons nie. (1)

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There was a difference of risk perception within the sample. Escorts saw themselves and their work as very different from street sex workers. They also emphasized the difference in clientele.

Dit is vir hulle makliker om geld op straat te maak om hulleself te onderhou met hulle dwelmgewoontes en al die klas van goed as wat dit is om in so 'n club geld te maak. Want op die straathoek kan jy gaan staan, en vinnig, vinnig geld maak. Hier nie. Hier moet jy persoonlikheid hê, jy moet met die kliënt socialize en jy kan nie net 'n dommetjie wees wat hier werk nie. ... Jy sien, ek dink daar's 'n groot persoonlikheidsverskil tussen ons en die meisies op die straat. (B)

It's not, like, lowly people can't afford us that's why I do see a difference between us and the girls on the streets too because there for fifty bucks you can get anything. XX Listen I could just as well go stand on the street, but I don't because I have more respect for myself. XX But people don't understand that, they see escorts and think 'Hooker'. That's it. And there's a big difference. People don't understand us and why should we try and make people understand us. (A)

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Some of the women felt that, because they used adequate protection, they were not at risk.

> Researcher: Dink jy dat jy miskien AIDS kan kry?
> ... a ... ek gebruik 'n condom. Met wie ek gaan en wie vir my optel, ek gebruik 'n condom. (6)
>
> Researcher: Do you think you are at risk?
> No
> Researcher: Why not?
> I am too careful. (E)

In both groups there were some women who denied or minimized their risk of infection.

> Researcher: Dink jy dat jy 'n kans staan om AIDS te kry?
> (giggling) ja, obviously, almal staan 'n kans. Ek meen, wat nou nie seksueel aktief is nie, hulle is nou 'n ander saak, verstaan jy.
> Researcher: Hoe kan jy jouself beskerm teen AIDS?
> Om nie seksueel aktief te wees nie, dis al (laughter). (F).
>
> Ja, em, some people was telling me ... the only question there to ask me is if I'm not scared of AIDS.
> Researcher: What do you usually say to them?
> You know, I doesn't answer them because I, because I really don't know. XX Dan sê ek, ek is 'n bietjie bang, maar wat anders kan ek doen ... ja, om geld te kry.
> XX Researcher: Dink jy dat jy AIDS kan kry?
> Ja, ek het nog nie daaraan gedink nie. (7)

Responses varied with regard to HIV testing. It seemed that for some women, testing alleviated their fear of AIDS and in some cases, reduced risk perception. For a few women, other tests such as 'check-ups' and pap smears also served this purpose.

> Sure I think there's a risk in this business we're in even though we use condoms there's still a risk. But I have an AIDS test every six months. (C)
>
> En toe breek die condom ... o, toe's ek so versigtig ... ek het so vuil gevoel van kop tot tone ... en ek het clinic toe gegaan, ek het gegaan vir 'n pap test, toe's daar niks fout met my nie, hulle't vir my gesê als is okay. (6)
>
> Em, then I have, once a month I had a full-on medical aid test.
> Researcher: Watse soort toets is dit?
> Hele liggaam, full-on. (3)

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Some had not been tested or retested because of fear or because they have not had unprotected sex with a client. Others were unsure about the logistics of testing.

> Ek sal gaan, ek sal gaan ... maar ek het mos nog nie sonder condom geslaap nie. (5)

> I haven't had an AIDS test for quite a while because I feel quite healthy and ... I really don't believe that I've got it, you know but ... ja ... ja ... (D)

> Researcher: Hoe sal jy kan uitvind of jy AIDS het of nie?
> Oe, dit sal ek nou nie weet nie. Ek sal seker by 'n dokter moet uitvind. (6)

> Ek weet nie eers actually wat dit is, hoe is 'n AIDS toets nie. Ek weet nie of hulle nou net jou bloed trek, of hulle nou in dinges gaan kyk nie. [O nee, hulle trek net jou bloed.] (Laughter) Ek het altyd sulke klomp dinge gedink. (2)

Very few women had contemplated the possibility of a positive result. It seemed as if my question: 'what will you do if you had to be HIV positive' caught them off balance. Their answers reflected a sense of hopelessness and despair, even suicide. Some indicated that they would have to leave the city or the profession.

> It will be terrible. I think I will be depressed. I don't think I will tell anybody ... I will stop working as an escort. (E)

> O hete, ek sal my seker doodhuil. Eintlik is ek nie bang om dood te gaan nie, maar ek dink so aan my seun, vir my is hy nog 'n babatjie. (6)

> If God decided he would take me away then He must just take me away. He must not take me away with AIDS or a sickness that I must suffer from but then I'll kill myself. (8)

It seems that most women saw themselves at risk of infection. However, they strongly rejected the high risk label. They seemed to shift between identifying with the broader society (anyone can get it) and with the sex working community (there is a greater chance that they can get it). Furthermore, some of the escorts said that escorts were less at risk than street sex workers.

Overall, it appeared as if there were no real differences in risk perception between street sex workers and escorts. Most of the sex workers successfully made the link between unsafe sex and risk of infection. Researchers and educators have realized the need to shift their approach from 'high risk groups' to 'high risk behaviour'. In this study, the notion of a 'high risk group' was seen as yet another derogatory label which society has added to the 'slut/bad woman' stigma. By focusing rather on behaviour, one

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removes the blame for infection from sex workers and other stigmatized groups (Panos, 1990). It also gives people a sense of control over the disease when they practise safe sex.

There were no definitive characteristics of those who saw themselves at risk and those who minimized or denied risk. However, risk perception and regular HIV testing seemed to be negatively influenced by the following: high levels of secrecy; conflict about being in the profession; and substance abuse.

The sex workers who experienced conflict and guilt about being in the profession tended to be very secretive about their work and were reluctant to perceive themselves as sex workers. By denying their profession, they also denied that they were at risk. These women were also reluctant to be interviewed and did not welcome possible AIDS education programmes by outsiders. Conflict, denial and secrecy about sex work seemed to negatively influence risk perception and attitudes towards intervention. This has not been mentioned previously in the literature and may be an important area for further investigation. Ways of promoting a sense of community as well as pride and dignity in the profession may also need to be considered. Some ideas around this are raised in the final chapter.

The relationship between substance abuse and unsafe sex has been well documented (such as Kline et al., 1992). None of the women in this study reported using IVDs which are usually associated with HIV transmission. However, many used mandrax and alcohol on a regular basis. These substances impair cognitive functioning which could increase the chances of having unprotected sex (Wirawan, et al., 1993). Substance dependence also makes women more likely to throw caution to the wind in order to obtain drugs. Intervention thus needs to address substance abuse and closer links with existing drug treatment centres are needed.

The lowest level of risk perception was evident in a sex worker (sex worker 7) who had minimal knowledge of and interest in AIDS and who displayed generalized high risk behaviour, particularly substance abuse. According to Mays and Cochran (1993) the perception of the danger of AIDS could be relative to the hierarchy of other risks

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present in her life and the existence of resources available to act differently. For sex workers in her position, more immediate concerns might include survival needs, such as obtaining shelter and securing the safety of themselves or their children (Mays & Cochran, 1993).

Apart from the real risks and lack of resources and alternative employment, self-esteem and subjective perceptions about one's ability to effect change and exercise control over one's life (self-efficacy) need to be considered. Perkel (1991) states that there is a link between self-esteem and self-efficacy, and risk perception and behaviour change. Although this did not receive much attention in this study, my impression throughout the interviews was that such a link did exist. According to Cochran and Mays (1989), intervention should confront the denial of risk which in turn will lead to an exploration of the possible underlying self-devaluation.

A further interesting trend was that the majority of sex workers were silent around the possibility of infecting their clients. Some, however, expressed their concern about infecting their boyfriends. The risk of vertical transmission to children was not a part of this study. It was also not raised by any of the women. As discussed previously, the literature suggests that intervention should also address social responsibility and not only the protection of an individual. Such an approach might be particularly useful for those who do not regard themselves as being worthy of protection. Most of the sex workers in this study were single caregivers. It might therefore be useful to include this approach in an intervention programme.

Views and behaviour regarding testing varied. Some made a point of going for regular 'check-ups' but it was unclear whether this included HIV testing. It seemed as if testing and 'check-ups' functioned as a means of alleviating fears about infection. Others were too scared to be tested. Some felt it was unnecessary because they have never had unprotected sex. This was said despite the fact that they had previously mentioned that they were sometimes forced to have unprotected sex by violent clients. Very few had, however, contemplated the possibility of a positive result. This, as well as the reluctance to be tested, might have been because their work and their bargaining power depended on being HIV negative (Berer & Ray, 1993).

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In general, the responses and attitudes to HIV testing indicated that intervention should provide information about the logistics of testing. More effective advertising of existing testing centres is also needed. Although testing should not be a substitute for safe sex behaviour, it can be a useful opportunity to provide information and to promote safe sex as part of pre- and post-test counselling. In many instances, counselling is currently not offered, especially when testing is done by a medical doctor in private practice. The training of doctors and medical students in pre- and post-test counselling should therefore be considered.

In interpreting the responses, one should be aware that questions pertaining to risk and HIV testing might have been perceived by the women to be labelling them as irresponsible and 'disease ridden'. Women might have felt that they needed to give the 'right' or 'responsible' answer. Sex workers who are HIV positive might also have been reluctant to reveal their HIV status. It is therefore necessary to investigate what approach, and by whom would make it safer for women to discuss these issues.

Methods of protection

All the sex workers used condoms to prevent infection. As an additional form of protection, some refused to provide certain services.

> Maar, die werk wat ek doen, bly ek weg van semen af, ek bly weg van soen af, ek bly weg van orale seks af. Ek, ek probeer so min as moontlik kontak kry, fisiese kontak kry met die persoon wat die liggaam aangaan. Sodat as hy dalk die virus het wat sluimerend is, ek hom nie kry nie. Ek kan dit nie bekostig nie. (B)

> You see the thing is, I've been working on the streets, but the thing is, I never go around with a guy. I always convince him not to have sex with me, then I rather have a blow job with a condom on. And if he don't want to, then I don't go with him, you see, and ... (8)

Cleanliness was also seen as a way of preventing infection.

> Toe sê hy (doctor) vir my: douche gereeld, een keer 'n maand met betadine, savlon of iets en dan een keer 'n week met louwarmwater. En ek doen dit nou al vandat ek 21 is. So ek sorg dat ek absoluut higiënies is. (B)

> I use condoms and I stay clean. You keep yourself clean. As soon as you are finished with a client, you wash. Before I start, I also take a cloth and wipe off his private part. I also inspect his private part for any sores. (E)

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Apart from protecting them from HIV infection, condoms were also used as a method of contraception and to prevent other STDs.

> Em ... to prevent VD en daar's so klomp siekte, fuck hulle. (3)
>
> Researcher: Hoekom het jy begin om kondome te gebruik?
> Sy (Family Planning) het vir my gesê sodat ek nie verwagtend moet word nie. (7)

Condoms also functioned as a barrier between them and the client. This played an important role in separating sex as work from sex as pleasure.

> I suppose for men it's the, I don't know, from a man's point of view it's better without a condom but em, from our point of view we actually like a condom, it's like a barrier, feels like a barrier between us. XX ... ja, it's not as intimate ja, and they don't actually come inside you, you know so from that point of view it's like you don't feel quite so bad about it. XX I don't kiss the clients [mmm, why is that?]. Em, I don't know, I just don't like to ... it's just too personal. You know just, ag, I'll kiss them on the neck and, I just don't like to kiss them. (C)
>
> As ek 'n blowjob doen dan sit ek 'n kondoom op. Want ek sê vir hulle ek eet met my mond en soen my baba met my mond waarvoor, en ek bid met my mond, waarvoor moet ek nou met 'n man gaan wat ek nie ken nie sonder 'n kondoom. (4)

There was a certain level of distrust in the efficacy of condoms. Some of the sex workers therefore used lubricants or two condoms at a time.

> En, indien ek gemeenskap met 'n kliënt het, dan gebruik ek twee kondome, en dis extra strong en touch wood, nog niks het met my gebreek nie. XX Daar's 'n groot kans dat een kondoom kan breek, al is dit extra strong. Nou as daai een kondoom snap, jy hoor dit, so dan het jy darem die tweede kondoom om jou te beskerm. Jy stop, jy sit weer 'n kondoom op. XX Die kliënt kry jou nie opgewerk nie, okay, so, hy gee nie om of jy reg is of nie reg is nie, as hy sy ding wil doen, dan sal hy dit doen. En hy kan dit nou insteek en uittrek en weer wil insteek, dan kan hy vashak en daai kondoom kan snap, jy sien. So met KY jellie, jy sorg dit is glad, dit is so glibberig soos kan kom. (B)
>
> Soms van die condoms by die hospitaal het party sulke klein gaatjies in. Ek het al gekyk van die condoms, so ek prefer liewer om my kondome by 'n apteek te kry en nie te gebruik wat die hospitale en die kerk vir die meisies verniet gee nie ... Ek het al gekyk al deur die microscope, hy't sulke klein gaatjies in hom. So jy kan nie verseker wees met daai condoms nie. (3)
>
> ...like people tell me a condom is not 100% and, I'm too scared for that, because sometimes, a girl told me about a condom that broke in them and then they had to go to the hospital. That's why I'm scared of that. (8)

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Some of the sex workers entertained certain myths regarding protection. These usually involved the use of lubricants.

> Nou wat van, jy het seks met 'n man, hy gebruik nie 'n kondoom nie, maar hy breek nie sy water in jou nie. Wat gebeur dan?
> Researcher: Is dit iets wat jy partykeer doen?
> Wel, ja, dit is hoekom ek vra. XX Want party van die meisies het gesê dis nie nodig om altyd die kondoom te gebruik nie siende dat hulle aanhou skeur. Siende dat al gebruik jy nie 'n kondoom nie, dan sal jy nie siektes of infeksies optel nie, want KY jellie is bestand daarteen. (F)
>
> Gewoonlik sit ek 'n bietjie, vat ek 'n bietjie baby oil. (6)
>
> There's a kind of ointment which you can only get in the chemist ... it cost you quite a lot of money, R135. Em ... sommige tye as jy daardie ointment het, dan hoef jy nie eers 'n condom te gebruik nie. XX Jy smeer dit in jou onderlyf in voor jy met 'n man gaan. Dit is eintlik, dit keer vir enige soort siekte wat die man het, dan sal die man nie ... a ... hoe kan ek sê, it won't touch the vagina. (3)

Sex workers generally relied on condoms for protection. No one reported any problems with regard to accessibility or cost of condoms as they are usually obtained from Family Planning clinics. This was consistent with the accounts of sex workers in Johannesburg and Durban (Schurink et al., 1993) but contrary to the findings of studies in other countries (Leonard & Thistlethwaite, 1990; Panos, 1990).

Condoms not only served as a method of protection against HIV, other STDs or unwanted pregnancies but also as a barrier between sex workers and their clients. They reduced intimacy and made sex work less real. The need for distance between them and their clients was also evident in their reluctance to kiss their clients. The use of the condom as a barrier will be discussed in greater depth under: 'Frequency of condom use'.

Some of the sex workers felt they could not rely only on condoms. Perceived high risk activities were therefore also excluded. This was also found by Day and Ward (1993) in their study of sex workers in London. Some of the alternative methods of protection mentioned in this study, such as the use of two condoms, and the use of oil-based lubricants, are problematic as they could expose sex workers to the risk of HIV infection. A better option is to use appropriate lubricants to prevent condom failure.

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Unfortunately, these products are not available free of charge at Family Planning Clinics. The provision of lubricants free of charge or at minimal expense, as well as information about their correct use is urgently needed.

Berer and Ray (1993) also suggest that intervention should include input on how to identify brands of condoms which meet international and national standards. They argue for a greater variety of barrier methods to appeal to the varying tastes of people. According to them, innovations could take three forms: new variations in male condoms, virucide preparations and better female barrier methods.

Unfortunately my study did not shed light on sex workers' views about the female condom as it was not yet available in the country at the time of the interviews. According to James and Wejr (1993) the female condom has been found to be a valuable method of protection by sex workers because it is a method of protection which is under their control. Sex workers would be less dependent on their clients' cooperation. Although these condoms are now available in South Africa, they are extremely costly. This makes their regular usage unlikely. My recent informal discussions with sex workers and AIDS educators revealed that some sex workers use one female condom per night for all their clients. This could have severe implications for male to male transmission. Further research and education on the use of the female condom in sex work is therefore needed. Once again, it raises the issue of the urgency for affordable contraception (Gordon, 1989).

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Safe sex: who raises the issue and who decides

When sex workers solicit their clients, who decides whether condoms will be used? Most of the sex workers said they assumed the responsibility of introducing the subject and of insisting on condom use. At times, this involved educating the client.

> En toe explain ek vir hom: 'don't you learn about AIDS in your country?' Dan sê hy vir my: 'yes, yes, yes, you're talking about AIDS,' so. So sê hy vir my, en so praat ons sommer oor die hele subject XX Dan sommer ernstig, dan wil ek sommer in sy kop in prop (laughter). So sê ek sommer: A.I.D.S., you know, there's no cure, so vir hom. (5)
>
> Maar nou as ek hulle weer vertel van AIDS dan is dit weer so 'n lang storie en, en dit vat tyd ook. En dan agterna dan lus jy sommer nie meer vir hulle nie. XX

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> Sometimes wil die customers nou nie 'n condom gebruik nie, maar dan moet ek vir hulle kan oortuig en vir hulle, somtyds dan sê ek sommer vir die customers van AIDS en dan verstaan hulle. (2)

All the women felt that clients were usually willing to use condoms but there were some men who refused to use condoms.

> Maar die ... kyk nou, wat stop vir my wat ek nie ken nie, ... is hulle so vol probleme, wil hulle glad nie 'n condom aansit nie, dan klim ek outomaties net uit, uit die motor uit. (6)

> Ja, hulle gebruik kondome met die mansmense, die homosexuals, but once they get involved with a woman, they don't like to use a condom. XX I'm getting four customers a night and two of them don't like to use condoms and that make me furious, you know. (3)

> It amazes me how men, for the few seconds of pleasure, are prepared to risk their lives. (A)

Clients offered various reasons for not wanting to use condoms and some offered more money for unprotected sex.

> En jy kry die kliënt wat vir jou sê: 'ja, maar ek is skoon'. XX Hulle het blykbaar moeilikheid om gemeenskap te hê met kondome. Dit is gebrek aan stimulasie, daai klas van goed. (B)

> Soos sommige van hulle sê 'if I'm gonna use a condom then I'm gonna feel like somebody that's taking a bath with a pair of socks on' or something like that (laughter). XX 'Then I could have done it myself', or 'I could have used my hand'. (2)

> The other guy tell me, something about a condom ... one time he screwed a girl with a condom and the time he took the condom off his em ... cock, em the condom was making a, the thick part on the condom, it was making a mark on his cock and he don't want to use it again. It actually gave him a rash around his cock. (8)

> Dan offer hulle 'n mens R100 of R150 dan sê ek: 'ek wil dit nie hê, ek gaan met 'n kondoom'. Dan laat ek die man net verbyry. (4)

> Oh, I've had a guy offer me R5,000 in cash, upfront, I had it and everything. I said to him, 'sorry I could spend it in ten minutes tomorrow, and my life is more important to me'. (A)

Most of the women said that in the event of a client refusing to use a condom they usually found it easy to refuse him or to convince him to use condoms.

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> Jy paai maar vir hulle, hulle het nie 'n ander keuse nie.
> Researcher: En as hulle nog steeds nie wil nie?
> Dan loop ek uit, ek meen, dis mos nie nodig nie. (F)

> As ek die kliënt die eerste keer vat, dan maak ek dit vir hom duidelik: met 'n kondoom, of niks. XX Ek weier absoluut om dit te doen, ek is jammer, ek meen, ek gaan nie daai risiko loop nie. Ek meen ek is hier om geld te maak, nie om siektes op te tel nie. XX As hulle 'n probleem met dit het, sê ek vir hulle: 'fine, jy kan my betaal vir die halfuur wat ek by jou sit, maar dis 'n self-help. Ek raak nie aan jou nie, ek kom ook nie naby aan jou nie.' (B)

> Maar die wat teenaan is, dan sê ek maar net vir hulle 'no, then you just go ahead, go and find yourself somebody' ... XX A-a, as hulle nie wil 'n condom gebruik nie dan moet hulle maar net hulle kar vat en mooi good-bye en hulle geld maar stuff where it don't belong. (2)

The client's risk of being infected by the sex worker was also used to convince a client to use a condom.

> ...clients do say that and say 'but I haven't got AIDS' and then I turn round to them and say 'how do you know I haven't' and then I find they're very quick to use a condom. (C)

> Somtyds dan sê hulle sommer, 'nee, ek het nie AIDS nie, hoe kan ek AIDS hê? Lyk ek soos iemand wat AIDS het?' Dan sal ek net sê: 'nee, ek kan nie sien op jou gesig jy het AIDS nie, want AIDS is nie soos 'n puisie wat jy kan sien nie.' (2)

Some women felt that their sexual desirability put them in a powerful position to convince clients. This view seemed to be based on the notion of men's sexuality being unstoppable and uncontrollable. This woman explained:

> But one thing I'll say, when a man is horny, he'll give you anything and do anything. So after a while they say 'alright, you know, I'll try and use a condom.' But they'll never say 'no, I'll go for another woman.' XX Look, it also depends on you, as a woman, you know how to make a man feel good, that's it. And in this business you don't have to be the prettiest or the best built, but your personality makes you popular or doesn't make you popular. And that's it. (A)

One way of ensuring safe sex was to negotiate it right in the beginning. Street sex workers received payment beforehand and left the money with a security guard or friend. Money therefore became an important trump card in ensuring safe sex.

> ... ek kry eerste die geld, hy betaal in advance dan, dan gaan ek saam met hom. Daar as hy weier, hy moet dit net aansit. (1)

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> Want as ek in 'n man se kar klim, hy moenie sommer ry nie, as hy ry, sê ek: 'stop, I want to get out.' Ek wil eers net praat en ek los mos die geld agter by security. En ek sê hy moet altyd eers die number plate kyk, al stop 'n kar of waar ook al. XX Hier by die security. Dan los ek dit maar by hulle dan gee ek maar vir hulle iets, hulle's maar ook honger somtyds, dan gee ek maar vir hulle iets of ek koop vir hulle boerewors roll, bring ek dit vir hulle. (5)

> Ons (sex worker and friend) gaan saam, ja. So as een ou nou vir my stop, dan gaan ek vir hom, dan hou sy my geld vir my. As ek terugkom, vat ek die geld by haar. As een ou nou vir haar kom, dan hou ek weer haar geld. As ons met twee ouens gaan, dan betaal hulle vir ons op die plek. (4)

Although women saw themselves to be in a more powerful position than their clients, the roles were reversed in the case of violent clients. Women, especially street sex workers, are disadvantaged because of the need to enter the client's space, for example, their car or hotel room. The majority of women experienced physical and/or sexual abuse. Here safe sex took a back seat to survival.

> If you tell the guys, the rude guys, if you come down a parking spot or whatever and they get rough with you or they want to hit you or whatever, they just drop you there and they went on, whatever, but they agree with you when you are moving, but when you came by the spot then they want to do what they want to do with you.
> Researcher: And then, what do you do?
> Well, then, I must just let it happen. Because sometimes, the guy's got a gun then you can't defend, I mean, then you can't argue with him or do something to him because he's holding you with a gun. XX You can't tell them, 'do it with a condom.' You can't do them, do it without a condom because that time they so hard up they don't mind even to go without a condom. XX That time there's nothing on my mind because I've just got a fright in me, so I don't think about AIDS or something like that. (8)

Most escorts felt less vulnerable to abuse because they were protected by the agency. This influenced the degree to which they could insist on protected sex.

> No, they can't force us they can't. We're on the premises or, well I've never had a problem I suppose they could try and force you in their homes if you're there but basically the agency knows where you are and all that kind of thing, there's about 1% who does refuse if you don't and we just give them the money back and we leave. That's what we do. (C)

> Ek loop uit, hy kan niks aan jou doen nie, want die bestuurder van die plek is ten alle tye hierso. So, jy het daai manlike beskerming. XX So, dit is beter om in 'n plek te wees wat die fasiliteite het wat jy nie hoef uit te gaan nie. (B)

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Another factor influencing safe sex practises as well as the power balance in the relationship was supply and demand. When business was good, women felt more powerful and it was easier to insist on safe sex. During difficult times, some women were prepared to lower their prices, accept more money for unprotected sex or engage in unsafe sex.

> Researcher: Wat sal jy doen as hulle vir jou meer geld aanbied?
> Miskien daarvoor gaan (laughing).
> Researcher: Is daar kere wat jy daarvoor gaan?
> Ja, wanneer die geld reg is. (F)

> As ek nou so R100 gecharge het, dan sê hy miskien: 'take it to R150.' Maar somtyds as jy nou desperate is, dan sal jy nou sonder 'n condom gaan.
> Researcher: Desperate is vir geld?
> Ja. As die werk nou swak is. (2)

> You know, sometimes, a, in the middle of the week, I mean, in the middle of the month, the money is, it's very little. Then sometimes a man stops by you and he offered you 50, 30 till 50 bucks. I mean, sometimes you couldn't ... decided which you want it or not, sometimes you just take it. XX The end of the month, then it's good times, then the money is, it's flowing like. Then you've got quite a lot of money which normal rates, the girls used to ask the guys a R150 just for about 10, 20 minutes. (3)

> Dan doen ek niks nie want ek het die geld nodig. Dan gaan ek maar net saam met hulle. (7)

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Apart from the above situations in which women were powerless, sex workers generally did not regard themselves as powerless and abused. As power is crucial in negotiating and ensuring safe sex, it is worthwhile to consider other ways in which their power was evident. These situations included payment, manipulation of clients with regard to tips and what happens on the job. Women often referred to men as fools or children.

> I only have sex once a day with one client, okay. What I do is, okay, the whole thing that I've discovered ... it's more like ... em ... shit man, mind games than anything else.
> Researcher: What do you mean by mind games?
> If you can, for instance, if a client asks you, 'what turns you on'. Now obviously if I can get out of it to sleep with a clients that walks in, I'm going to do it. So what I do, I say to them: 'you know what really turns me on is if I sit in front of a guy, fully clothed and I see him wank himself'. So the thing is that, men are such idiots, they actually fall for that or else what I do is, I sit in front of them, and I start wanking them, like I put KY-jelly or cream on, okay, I play with their balls and wank them, I just carry on talking. By the time the guy finds out, he's coming, you know. So he doesn't actually concentrate, you know. It takes you a bit longer, but it's worth it. It's better than actually

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sleeping with a client. XX Ja, want wat ek doen, is, as ek klaar is met 'n kliënt, dan sê ek vir hom: 'ja, so, het jy dit geniet?' Dan sê hy vir my: 'ja.' Dan sê ek vir hom: 'so, hoe lyk dit met 'n tip?' Die gevolg is dat, hy voel te sleg om vir jou te sê, 'nee'. So ek doen dit met kliënte wat ek sien geld het en dit werk soos 'n bom. (B)

Nee ons breek hulle kassies ope, o hene. Steel enigiets van hulle. Dis goed, hulle trek mos gou. XX Of hulle skoene, maar okay, hulle dra nie lekker tekkies nie. XX Dan het jy mos 'n hele wack in jou sak in, die hele se geld, dan klim jy mos nou smart af, dan sê jy net vir die ou die hele trip wat jy nou hier in die Kaap is, dan sê jy nou: 'o, ek is lief vir jou, ek is lief vir jou.' Maar, dan weet ek, ek is nie lief vir jou nie, ek is lief vir jou geld (laughter). XX Maar as ek inkom in die hotel in, dan gaat ek hulle nog altyd 'n apie maak, ek gaan nog altyd hulle geld vat. Dan sê ek vir hulle, 'gaat shower, los jou klere hier.' Dan skud ek net hulle sakke uit dan loop ek weg met die taks. Daais wat ek doen met die Jappe. (2)

And to a certain degree they can, they can demand from us, to a degree [mmm]. But we also say in our own rights, you pay for my company that's it, if I don't want to give you any sexual favours I don't give you any sexual favours and that's it, you know and ... XX I work hard, I make my money, I laugh all the way to the bank, I have everything my heart desires and I'm happy that way. XX ... remember the man is a child, it's how you talk to him and handle him. You must never get aggressive with a man, talk to him like a child, men are like children. (A)

While the women felt in control in their working relationships, some suggested, however, that they played a submissive role in their personal relationships with their partners.

Toe kry ek en hy 'n argument toe slat hy my en hy hou aan skel en toe gaan ek toe na haar. (5)

O, as hy my nou hier kry, hy sal my net sê: 'jy moet sorg dat jy by die huis uitkom'. En as ek by die huis uitkom, en dan sal ek net môre moet sien hier kom 'n pak aan vir my of something like that, maar agterna dan's als weer okay.
Researcher: Hoe bedoel jy 'n pak; slaan hy vir jou?
Ja, so, 'n klappie, 'n klappie en 'n skoppie. En dan agterna as ek weer begin so bietjie traantjies en dan hou hy my weer vas en dan's alles nou weer okay. (2)

As seen above, the dominant picture is one in which the women assume the responsibility for negotiating safe sex. Sex workers saw this as part of the service they provided. At times, this entailed educating the client about AIDS and safe sex. Some clients refused to use condoms or offered more money for unprotected sex. These findings were consistent with other studies on sex work (such as Leonard &

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Thistlethwaite, 1990; Neequaye et al., 1991). A comprehensive and effective risk reduction campaign should therefore look at ways of educating clients.

Women generally regarded themselves as powerful in their relationships with clients and usually felt in control of the negotiation process. Sex work offered the women the opportunity to be financially independent and autonomous. This influenced their perception of power. By regarding the interaction purely as an opportunity to make money, they were also more emotionally detached than the clients. The absence of emotion and sexual desire on their part put them in a stronger position and aided in convincing clients to use condoms. The opposite was also true: the emotional involvement and dependency in personal relationships made women less powerful. Here, women seemed to play a more traditional, submissive role.

Although sex workers said they always insisted on safe sex, some were prepared to have unprotected sex for more money or during times when the demand for sex work was less.

The women's perceived power in relation to their clients, was contrary to the general view of sex workers as submissive, powerless and abused (Millett, 1989; Standing, 1992; Tong, 1989). It is important to guard against the danger of overemphasizing sex workers as victims. It might not only be a distorted view but may also help to perpetuate the image of women as powerless victims.

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The power relationship was, however, reversed in the case of violent and abusive clients who forced sex workers to have unprotected sex. In these situations, men had the upper hand. Most of the women seemed to exclude these incidents when talking about their bargaining power.

The women's perception of abuse was interesting. Some of the women spoke about incidents which seemed extremely traumatic and involved severe forms of abuse. However, the way in which these stories were told was incongruent with the nature of the content. Women often spoke in a matter-of-fact way, and told these stories almost as an aside or to illustrate a different point. Some laughed and joked about incidents of

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abuse. Some showed more distress when speaking about favourite items such as sentimental jewellery lost in the process, or not being payed. It was difficult to make sense of this. The perceived incongruence might be a reflection of the anxiety which results from such incidents - not only because of the threat to their safety but also because they have no control over their health in these situations. There might thus be a splitting off of emotion or denial of the anxiety and fear related to these experiences.

Another reason might be related to the different worlds of myself as researcher and that of the sex worker. Coming from a background in which such incidents are out of the ordinary, I might be more likely to regard it as 'abusive', 'invasive' and traumatic. For the street sex worker, abuse might be one of the hazards of the job and therefore not unexpected. This is in line with Mays and Cochran's (1993) notion of a 'hierarchy of risk' which was discussed earlier. The focus of sex work is on income and therefore, loss of money or property is regarded as more abusive. Sex is only the commodity. In conclusion, it seems to suggest that what appears to an outsider to be abusive, is not necessarily so for the party involved. Whether something is abusive or not, depends on the meaning attached to the act. This view is similar to Levett's view of children's perceptions of sexual abuse (1988).

Frequency of condom use

In this study all of the sex workers practised safe sex, but not all of them practised safe sex all of the time. There appeared to be a great difference in safe sex practices depending on whether the other party was a casual client, a regular, a sailor or a boyfriend/partner. Most of the women practised safe sex with casual clients. They were adamant about it and would rather lose a client than to put themselves at risk. In a few cases, however, this rule did not apply. Apart from the reasons mentioned in the section above, a few women had unprotected sex if the client looked 'clean' or if they liked the client. Some were unclear about why and with whom they had unprotected sex.

> Wel, ek sal eerste sien hoe hy is. En ... as ek nou sien hy's ordentlik en alles. XX As die ou jonk is en aantreklik is, dan gee ek nie om nie. Maar as die ou nou nie my smaak is nie, voel ek nie gerieflik nie. (7)

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> Ek weet nie, dis maar meeste saam met my boyfriends soos ek sê, maar met my kliënte, meeste van die tyd. XX
> Researcher: Hang dit van die kliënt af?
> Nee, definitief nie. Dit hang van my af, soos wat ek voel.
> Researcher: Hoekom sal jy partykeer besluit om nie 'n kondoom te gebruik nie?
> Ek het nog nie so daaraan gedink nie. So ek kan nie vir jou sê nie (giggle). (F)

Women varied in their safe sex practices with regular clients and sailors. Most of the women insisted that their regular clients use condoms. Some eventually stopped using condoms at their regulars' request. The motivation behind this was usually because they believed they were the client's only sex partner (except for his wife/girlfriend). Some women who worked both on the streets and on ships, demanded safe sex on the street (often also with their regulars) but not on the ships. Women felt that because the sailors spent most of their time at sea, their risk of infection was lower. They also believed that they were the sailors' only sexual partner.

> Only if he's a regular steamer then I go without a condom but if I don't know this bloke then I insist him to take a condom. But if it's a guy that comes to you every week or every second week and you knows what he's up to and what ... then it's okay. As long as you know that this person is clean.
> Researcher: So do you say: 'it's all right, you don't have to use a condom'?
> No, he says it. He says: 'listen here, I don't feel like ... having intercourse with you with a condom because that's no feeling.' Then obviously you would say yes or whatever. (3)

> Nee, nie met hulle (sailors) nie. Ek het net twee steady ouens, dis sjinese. Net twee steady sjinese. Dis al. XX Dis nie jong manne nou, dis, dis ... hoe kan ek sê, hulle is 'n goeie ouderdom en ... as hulle in ander ports kom, hulle vat nie, hulle vat nie ander meisies nie. En die ouens sê vir my ook, hulle wil nie ander meisies vat in ander ports nie, so vir AIDS want ek praat met hulle so. (5)

> Maar op die pad is dit different. A, op die skip is hulle mos nie baie lank nog hier nie [o, ja?] en miskien is ek ook al meisie want hulle kom ook net in die port in en van ons vandaan af, dan gaan hulle, soos nou agt maande wegbly en okay, dan gaan hulle nou in 'n ander port in stop, miskien vir olie, of so. Maar altyd, ek gebruik nie 'n condom saam met hulle nie. XX Because daai is manne wat, you know, daai is amper wat jy lief word vir hulle ook. Somtyds dan raak jy lief vir hulle. (2)

None of the women used condoms with their boyfriends. The most common reasons given were that their partners were faithful to them, and that condoms reduced intimacy.

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> Die plastic ... maak donsies. In die pad is dit ... verskillend soos met 'n verhouding [ja?]. In 'n verhouding is seks mos lekker, maar hier is dit net ... geld. Vir hulle is dit lekker, die mans. (1)

> Want ek trust hom actually en ek weet vir 'n feit hy slaap nie rond nie. Hy werk vir die vullis. (2)

> I don't use a condom with him (boyfriend) at all. Now I've got to be careful because I've got to protect him. Look, this is my job, if I sleep with a man here, it's my job. When I go home my private life, I'm very private and I only believe in having one boyfriend. When I first meet a guy and we decide we're gonna have, become boyfriend and girlfriend, I do use a condom, until I know him and know how he is in his private life [mmm]. But when I have sex with a client, that's what it is, it's sex, it's not making love, it's not cuddling, I don't kiss my clients, I don't give blow jobs, they don't do things to me, it's just sex. You know you touch, that's it. [mmm] But with my boyfriend, it's not just sex, sex is like the final part, it's for him to have enjoyment. XX Because to me a condom puts like a distance between you and the guy. I could be wrong because they say you must use a condom always, but I think I've known my boyfriend long enough to know whether he sleeps around. (A)

> I have got a boyfriend I see, but I don't use a condom with him em, he's a divorced man, em, I know he doesn't sleep around.
> XX Researcher: You said that you know that he doesn't sleep around, are there ...
> Well, I'm not 100% sure, he could do, but I mean that I'm not 100% sure, em just because we're lovers I suppose, you know and he doesn't want to and he's got a very, he's quite a wealthy man and, I don't think he's stupid, you know. And em, got a very high powered job and he's quite ??? in fact he's a very wealthy man. So, and he's not stupid. So I wouldn't, if he has been sleeping with anyone else that I don't know about I'm positive he does use condoms. I would think so. (C)

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As in other studies, condom use therefore depended greatly on the status of the sexual partner (Mak & Plum, 1991; Philpot, Harcourt & Edwards, 1991). It appeared that the less intimate the relationship, the greater the likelihood that condoms were used for protection and as a barrier between them and their clients. The more familiar the client, the less infectious and 'dirty' he appeared. However, these distinctions are not water-tight as some sex workers did not practise safe sex with abusive casual clients, when the casual client offered more money, or when they found the client attractive.

Sex workers could therefore be at risk of HIV infection. They have no guarantee that their clients are, or remain uninfected. Behaviour change in their relationships with regular clients and sailors is difficult, as these clients provide a steady income for the

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sex worker. It is important for them to please regular clients. They therefore have less negotiating power in these instances. In spite of their acknowledgement of the delayed onset of symptoms, sex workers also seemed to feel that knowledge of a client could be substituted for condom use. In some cases working relationships with sailors appeared very similar to relationships with partners and emotional involvement might account for the reluctance to use condoms.

As in other studies, sex workers did not use condoms with their boyfriends (Day & Ward, 1993; Dorfman et al., 1992). It was interesting that many women emphasized that their relationships were open and trusting despite the fact that most of them kept their profession a secret from their boyfriends. As discussed earlier, sex workers said that they could be more at risk in their non-working relationships and emphasized that the 'wives at home' could be in greater danger because they trusted their husbands. However, in their personal relationships, they exposed themselves to the same risk as 'the wives at home'.

Problems with promoting condom use in the private lives of sex workers might be similar to the problems experienced by the majority of non-sex working women. Sex workers seem to assume a submissive, traditional role in non-working relationships. It is therefore more likely that the boyfriend makes the decisions regarding condom use. Women often fear that their partners will leave them if they insist on safe sex (Berer & Ray, 1993). These authors and Schoepf (1993b) feel that intervention should include role plays to help women anticipate negative responses and to find ways to overcome these. They also suggest teaching women techniques to put a condom on a lover without him noticing.

For sex workers, condoms play a vital role in separating sex with boyfriends from sex with clients. We have seen that condom use is a tangible way of creating boundaries and barriers between them and their clients. The lack of condom use therefore signals intimacy. Because condoms are associated with distrust and distance, unprotected sex is seen as a way of expressing love and trust. In their personal relationships, sex is pleasurable and condoms reduce their enjoyment.

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Day and Ward (1993) suggest developing distinctions between different types of sexual activities. They encourage, for example, the idea of different types of sex or activities in different relationships. This might make it easier for women to introduce condoms into non-working relationships. According to them:

> If these distinctions were developed, condoms might become less central to the demarcation between work and the rest of life. It is possible also that different types of condoms might come to stand for different relationships (p. 219).

Reasons for starting and remaining in the profession

In this study, women had different reasons for entering the profession. These ranged from having to support a child, or being retrenched, to wanting to raise money for a specific project such as paying university fees for themselves or a child. For many, sex work offered a way out of surroundings which limited their freedom and independence. One of the trends was that sex work enabled them to raise their living standard and to become financially independent.

> Ek is baie ambisieus en ... ek wil nie die res van my lewe hier wees nie. Ek wil vorentoe gaan en al daai, maar okay, dinge vat tyd.
> Researcher: Hoekom is jy nou hier?
> Hoekom is ek hier? Om my lewe op te bou. En ek doen dit, al is die hoergeld ... poesskulde, pantoffels (laughter). (1)

> ... toe sê ek vir myself: nee meisie, jy gaan nou regkom. Toe sê ek, nee die girls trek so aan en so aan in die Kaap in. En hulle kry dan so gou geld en dis mos quick money making [ja]. Nee, toe dink ek wag, ek gaan nou in die club instap, die waar die Chinese nou by jol [ja]. Ek gaan in, die ouens smaak my, ek is ook nie lui nie, ek gaan saam met hulle skip toe. Next oggend toe kry ek geld, oe, toe's ek net innie geld in (laughter). Toe's dit te lekker. XX Net vir die geld daarvan, net vir die klere meestal en om darem vir ander te kan bewys ek het ook 'n stukkie, ek het ook wat julle het. Never mind hoe ek kom daaraan nie, maar ek het ook wat julle het. (2)

> It is the cost of living today. A lot of women want to be more independent.
> Researcher: Do you think you are independent?
> Yes. I make my own money. (E)

> Look I've got a degree in business psychology and, but I can't find a job [mmm] and I'm not prepared to work for a lowly salary of R1,500 a month. Why should I if I can make R6,000 a month? XX Everybody to himself. I mean, I laugh all the way to the bank, I couldn't give a shit about what other people think about me as long as I know what I think about myself. That's why when, when I walk into a hotel and the porter might look you up and down and

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think, mmm, there goes an escort and everything, I couldn't care because I know I make five times more money than what he makes. (A)

Sometimes I think ag man, I can drop this and go look for a job in a factory or some other place but when I go look for a job then I have to go wait from the Monday till the Friday, or from the first of the month you have to wait for money till the end of the month where I can get money every day, you see. And instead of working for a boss for his little money I can make my own money and I make a lot of the money on the streets, that's what I'm thinking about. (8)

There were also other reasons why they started and stayed in the profession.

Die pad het my baie sterk gemaak en ... XX ... jy kan ... mans beter behandel en ... jy weet hoe om sterk te wees met hulle. Jy kan enige soorte man, al is hy so groot soos Table Mountain, maar jy kan hom behandel. Ek behandel vir hulle want ek sou al dood gewees het hier. As jy nie weet hoe om 'n man te behandel nie ... ja, ek het al net sulke groot mans gehandle, gehanteer. (1)

Researcher: Wat is vir jou die lekkerste ding van die pad?
The money. There's fun in it. XX Jy kan lag sometimes the way mansmense kan is [ja?]. As hulle miskien so hot raak, dan lag ek myself meestal klaar. XX En dan sometimes dan smaak jy weer so 'n ou, dan doen jy dit net uit lus uit, dan worry jy nie actually oor die geld nie. But agterna dan wil jy die geld hê, jy wil die geld hê (laughter). (2)

I'm more independent, I've got more courage. I've learnt a lot and I'm much stronger. (E)

... because it's relaxed and ... you can sit and have a few drinks ... the whole thing is it can be fun ... it can be ... em ... not too many rules and regulations. (D)

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Some of the women also did sex work to finance their drug habits, mostly mandrax and alcohol. Some women reported paying approximately R170 a day for mandrax.

Wel, die rede hoekom ek uitgekom het vanaand is om geld te maak om drugs te koop. (7)

Okay, I'm a button smoker, dis ook maar net vir pille en vir klere en ... om lekker te lyk nou. (2)

Ek het vandag ses pille gerook voor ek gekom het. XX Ek kan sonder dit (mandrax) veral as ek company het, dan sal ek nou nie worry nie. Geld is mos 'n duiwel, as jy geld in die hand het. (6)

Some expressed conflict about being in the profession. This was often related to society's prejudice and the resultant need to be secretive about their work.

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> You know, they always say you can make a lot of money, which I still believe but em … I've been uncomfortable with it, getting in to it, a bit of guilt … but I'm sure that things will be better, like, ja, ja.
> Researcher: Guilt about what?
> Em, like guys coming here that are married or have girlfriends, things like that but … em … I'd like to stick it out here. XX … you know, there's a lot of like fear involved about … it not being legal and … I sometimes think why am I doing this but now I know … I'm getting money and I'm living, I'm surviving, that's the main thing, but … it's, it's … (D)

> But I call myself as (sic) a hooker. And, a, I know it's, it's a really em, something wrong I'm doing, but I got no other alternative to do. XX Em, God made us not to sell our bodies, but to give it. But, a, not to me, I mean if I do give it away to each and everybody what will I eat, where would I stay, you see. (3)

> Researcher: Hoekom wil jy nie weet hulle moet weet nie?
> Nee, dis … my mense is baie religious, hulle is converted, ek kom uit 'n godsdienstige huis, maar ek wil nie die indruk gee ek is op die straat nie. Dan dink hulle sleg van my en dan word ek verhoed van hulle huise af. (4)

> You know it is a double life, you know, I mean, I don't let other people know what I do. I just say I don't work or I work in a restaurant, you know, that kind of thing. And em, my older son is very against me doing this. XX … but as I said there's no work and I can't not work, you know, so that kind of thing. (C)

Women had different ways of dealing with the conflict and the stresses of the job. These included denial, rationalization as well as drug abuse. Some of the women decided to work in the sex industry for a specific period. In a way, this might also be a way of detaching themselves from the work.

> I don't mind to smoke out R1 000 a night for mandrax.
> XX Researcher: Why do you smoke?
> It make me feel lekker, man. It takes your worries away, your frightness away, all that things. XX Most of the times the cops is around and picking up the girls. Now you've been drugged and you, you think, ag man, they can pick me up, I feel lekker, I can go sleep now in the jail or whatever. (8)

> Doing this, maximum, I'm not going to give myself more than a year. Because what I'm afraid of is, some females get so used to the money, okay, and then, it affects their relationships, it affects them as people. It cracks them emotionally and I will not allow that to happen to me. And I will not allow what I am doing, by being a prostitute at this stage, let that interfere with my future, it's not worth it, it's really not. (B)

> You can't do this job for long. I, I said to myself, three years; I've got just over a year and a half to go and by then I'll have everything I want [ja] and then I

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> can settle down and do my own thing. But you've got to do this job and have a plan in mind, you can't just do it indefinitely, that doesn't work. (A)

However, it is not that easy to stop. Some said sex work was addictive.

> Nee, die einde van jaar, dan's ek klaar. Dis my finale jaar [by die universiteit?] ja. So ek is klaar met die agentskappe, hopelik, anyway, hopelik.
> Researcher: Hoe bedoel jy hopelik?
> Nee, hulle sê mos: ''n whore is 'n whore'.
> Researcher: Dink jy dis waar?
> Ek weet nie, man, ek weet nie, man, ek weet nie. Miskien sal ek terugkom, deeltyds, so, soos nou, maar ek wil nie.
> Researcher: Hoekom sal jy nie wil nie?
> Wie sal dit geniet? (F)

> Em, em, yes I am a hairdresser by profession and I started doing this to put my older son through varsity and then the reason I stopped, I didn't stop, I planned to stop after he finished varsity was because the money is so good ... and the money is so bad in hairdressing. XX A, it is good money you see. So that's why it's hard to get out of it, very hard, but the thing is I'm getting older and older and there's a certain age limit where you've got to stop, you know there is. (C)

> ... dan hardloop ek weer so weg vir vier maande, dan kry hulle my weer en dan wys ek hulle maar net elke keer, hey ek gaan dit maar net weer doen en hier agterna sê my ma net vir my, 'ek kan jou nou nie keer van niks af nie. Want jy wil mos nou so lewe, nou lewe maar so. As jy eendag 'n stroller word, ek kyk jou nie aan in die pad nie.' Maar ek weet mos ek sal mos nie 'n stroller word nie. XX Dis al 'n hobby al, dis al in my al en ek weet ook nie. XX Sien, dis amper soos 'n vlooi vir jou knyp en sê: hoe, krap gou hier, krap gou hier en dan krap jy ook net daar en môre as jy weer kom kyk, dan sien jy dis ook weer stukkend en dan sê jy, ag, dis maar krapmerke, dis niks nie. (2)

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It is thus clear that sex workers entered the profession for diverse reasons. In some cases, they resorted to sex work because of unemployment or because they lacked the skills for available work. Other sex workers chose to enter the field as it was more lucrative than other careers. This was consistent with the reports of sex workers in Durban and Johannesburg (Schurink et al., 1993).

In their study of Gambian sex workers, Pickering et al. (1992) found that women do not go into sex work because it presents the only alternative to destitution. In my study, it was clear that sex work had distinct advantages over other forms of employment. For many, sex work offered the opportunity to move out of situations which restricted their freedom. Sex work, by and large, is a career in which women worked for themselves,

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and could determine when and how they worked. The work enabled them to earn significantly more than they would in other forms of employment. Sex work provided immediate cash in hand and thus women felt financially independent. In many ways, sex work offered power rarely found in other forms of employment.

All these factors make sex work 'addictive' as few other jobs offer the advantages of sex work. Although some women expressed their dissatisfaction with being in the profession, very few had looked for alternative forms of employment. Unless alternative employment was more lucrative, it is unlikely that women would leave sex work if they found other work.

This is very different to the popular images of the sex worker as the 'bad woman', or one who has been 'led astray' or alternatively, who has been 'driven into prostitution'. These stereotyped images link up with the stigma surrounding sex work as well as the notions of the sex worker as exploited and powerless. Roberts states:

> ... given the paucity of options women still face today, sex work is often the most assertive choice they can make. To condemn women for becoming prostitutes, or continually to divert attention from their demands to the small minority who are forced into the life, is to ignore whores' courage and add to their burden. (1993, p. 332).

Entering the profession is not an easy decision to make, nor an easy life to lead, for the work - especially on the streets - is hard and tiring, with the law and public prejudice combining to make life extremely difficult and dangerous. Women dealt with conflict and stresses in various ways. One way of detaching themselves from their work was by deciding to work for a specified period. In this way, they did not have to identify closely with the profession and did not necessarily see themselves as sex workers. Another form of denial was substance abuse. Many women abused substances in order to make their work 'less real'. It helped them to deal with the fear associated with the work and also relieved guilt.

In any form of intervention one should avoid contributing to the conflict and guilt experienced by these women as it will only increase denial and negatively effect risk reducing behaviour. It is important to view sex work as a career (Day & Ward, 1993;

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Schurink et al., 1993). Some sex workers stressed that they provided a service to the community. They provided an outlet for frustrated and dissatisfied husbands devoid of emotional attachment, thus safeguarding others' relationships.

Emphasis should therefore not be on trying to 'convert' or 'rescue' the sex worker, but on making their work safe. Drug treatment programmes should also take cognisance of the function of substance abuse in sex work. In this regard, support groups could be valuable as they could provide women with alternative ways of dealing with conflict and guilt about their profession.

To legalize or not

Throughout the study, I have highlighted the detrimental effects of criminalization on health intervention efforts and research. The psychological effects of practising an illegal trade as well as the lack of protection against clients have also been noted. As sex work is illegal, sex workers cannot turn to the police for protection. The abuse of sex workers by the police has recently received attention in the media (Bisseker, 23 August 1994). In this study, many sex workers reported abuse by the police and some mentioned this as one of the major hazards of the job. Many had been arrested, had had their earnings and possessions confiscated, and had suffered humiliation and sexual harassment during custody. It was also reported that some policemen abused their power and authority by forcing sex workers to pay protection money to avoid arrest, or by raping sex workers in return for 'protection' against arrest.

Condoms are often used as evidence of sex work. Street sex workers were thus hesitant to carry condoms and some escort agencies did not keep condoms on their premises. This has severe implications for safe sex practices. One could hypothesize that legalization or decriminalization would offer protection to the sex worker who would then have access to avenues which could protect her against abuse. Legalization also has implications for safe sex intervention. It was therefore necessary to explore how women felt about law reform. In the light of the above, it was surprising that most of the women were against legalization or decriminalization. Most of them could not provide clear reasons why they wanted sex work to remain illegal. Some also felt that more

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women would enter the profession. More emphasis was placed on AIDS and the danger to clients or inexperienced sex workers, than on increased competition.

> The biggest reason is then you will hear more about people being murdered here or murdered there because some of the people don't know how the things work on the streets. Like em, like us who standing for the past years. We can, when a guy stop at us we can normally, we can check a guy out whether he is okay or whether he's not okay, you see. Like when you are new, you just come to the street because it is legal, and the guy stop at you, you don't know. (8)

> Daar's party van hulle (sex workers) wat vir die mans con en dan sê hulle 'wag, ek gaan nou net my geld by my vriendin los, dan kom ek terug' en dan kom hulle nie terug nie. Nou baie van hulle voel ongelukkig en ek kry vir hulle baie jammer, al is hulle wit mans en kleurlinge en swart mans. XX So dis gevaarlik vir hulle ook, hulle lewens is ook in gevaar. Ek weet, ek is lief vir my medemens so ek sal nie wil sien dat iemand kry seer nie, verstaan jy? (4)

Some spoke about the effects of legalization on HIV infection.

> No, AIDS has got nothing to do, legally; the legalizing of escort agencies has got nothing to do with any kind of sickness in this country, whether it's AIDS or any other ... XX The amount of AIDS is still gonna be the same. It's still the same amount of men that's gonna pick them up, they've just got a wider choice of girls. (A)

> I mean, if it's legal then em, the girls and the guys they don't worry because they know it's legal then they can just pick up a girl wherever they want to and that's how AIDS is then gonna ... grow further on the streets. (8)

> I do think they should legalize it, because then, em, and they should have like clinics where the girls ... Actually overseas, they have to have AIDS certificates and things like that. From that point of view I do think they should legalize it. Because it's still going to carry on anyway it is. XX Well, I think it should be a law that they should actually have to have regular check-ups. I mean I do it out of my own, but I know a lot of the girls don't. I think very few of them go for AIDS tests. (C)

Women did not want to loose the benefits of a tax free job.

> Want ek wil nie tax betaal nie (laughter). (F)

> If they legalize it, we're going to start having to pay tax but then again how will they ever know how much money we're making, 'cause there's no receipts in this business; everything is discrete, I can tell them I made one booking a night, and for that I made one-fifty but my client could have given me eight hundred Rand so I don't even know what they're gonna do. XX Legalizing is only going to be money-wise, the government's gonna make money out of us it's not gonna do anything to prevent AIDS, it's not gonna stop guys from walking in the door ... (A)

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These two women spoke in favour of legalization.

> Okay, dis 'n slegte ding dat dit onwettig is, want em, die ding is dat, as hulle dit wettig maak, dan kan hulle meer higiëniese toestande skep, hulle kan die prostitute van die strate af haal, in agentskappe laat werk, ek meen, dis nie te sê dat as prostitusie wettig is, hulle kan op elke straathoek gaan staan nie. Hulle moet prostitusie so wysig, laat dit spesifiseer dat jy moet in agentskappe werk. Want as jy op straat is, kan jy nog steeds gebust word, okay. Sodoende, gaan jy, jy gaan meer 'n sekere standaard meisie kry, wat in 'n sekere plek werk. (B)

> ... knowing that it is illegal, there is always this amount of fear that ... is this client a cop or isn't he because when I first got into the business the cops were, they could ... catch you, you know. (D)

Contrary to what was expected, the majority of women were opposed to legalization or decriminalization. Apart from those who mentioned the current tax free benefit, most of the responses were vague and contradictory. This might be because, firstly, some had not yet thought about the issue, secondly, because they did not have enough information about the implications of the various legal options or, thirdly, because they distrusted and were disinterested in anything to do with the authorities.

With regard to the impact of legalization on the spread of HIV infection, women felt that legalization would either have no effect or would increase the rate of infection. However, some escorts felt that street sex workers should be controlled through registration or mandatory HIV testing.

There have been various appeals for legalization through the years. Recently, local authorities have begun to reconsider the legal status quo and the Minister of Health, Dr Nkosasana Zuma, has called for the legalization of sex work (Argus, 2 April 1993; Venter, 19 October 1994).

The rationale behind calls for decriminalization and/or legalization both here and in countries abroad has been based largely on health concerns, particularly that of HIV infection (Die Burger, 3 April 1993; Hustler, November 1993). The experiences in other countries have shown that legalization per se is not necessarily beneficial to the sex worker, nor beneficial for health promotion. In practice, legalization is usually to protect the client and the rest of society and not the sex worker (Campbell, 1993).

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Legalization therefore commonly involves control. In other countries this has involved mandatory HIV testing and compulsory registration (Amaro, 1993; Erben, 1990; Pickering et al., 1992).

In his review of the history of other STDs, Gordon (1989) mentions that compulsory public health measures do not control the AIDS epidemic. Sex worker organizations point out that these measures violate the rights of sex workers (Roberts, 1993). Registration and mandatory testing stigmatize and marginalize sex workers by reinforcing the notion of sex workers as 'disease ridden' and let the client and the rest of society off the hook (Roberts, 1993; Taylor, 1991). Registration also makes it difficult for sex workers to leave the profession as this form of identification may lead to discrimination by subsequent employers.

These measures usually mean that HIV positive sex workers are not allowed to continue with their work. Berer and Ray (1993) warn that this could increase the spread of infection. They say:

> Clients with HIV would not stop going to sex workers. All clients would feel safer because they would think women with HIV had been removed. They would continue to demand unsafe sex with sex workers and with their own partners, and could transmit HIV to all of them. Thus, more uninfected women would become infected (p. 193).

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Another form of control is red-light districts which allows sex work to be practised only in specific areas. In this way, health authorities claim it will be easier for them to gain access to sex workers. However, the overriding motivation seems to be to keep the 'problem of prostitution' out of sight. This is evident in the statement by Dr John Sonnenberg of the Cape Town City Council, motivating why Sea Point should be declared a red-light district:

> It is removed from the face of the central business district we would want to show to tourists, and is away from the upmarket business area. (Sawyer, 2 April 1993, p. 15)

One of the main problems with the legal status quo is that it drives sex work underground, thus making it difficult for health educators to gain access to sex workers. Legalization which imposes regulations on sex workers could have the same effect.

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Many escorts have mentioned that if sex work were to be legalized and they have to pay tax, be registered, or go for mandatory testing, they would work privately.

From a health and human rights perspective, the best legal alternative appears to be decriminalization of the sex industry. Instead of enforcing HIV testing and safe sex behaviour, sex workers should be encouraged and motivated to do so. A system of self-regulation through the establishment of professional standards for the industry, set by people in the industry, might be more effective than compulsory measures imposed by law or health departments. This would free the police to rather concentrate on crime which involves victims.

No form of intervention in or legislation for the sex industry will be workable and effective if the sex workers do not play a major part in the planning and implementation of the process. Even though the possibility of legalization is currently under consideration, sex workers are left out of the negotiating process. This is extremely short-sighted as proposals, whether based on discrimination and prejudice or on 'humanitarian' grounds, might well be unrealistic and ineffective. As 'D', a French sex worker says (quoted in Roberts, 1993, p. 298):

> Everyone's discussing what should be done for the prostitute, what kind of laws should be made for her ... Are they going to do the same thing with shopkeepers or journalists? What right have they got to always want to make decisions for us? To protect us from pimps. That's the excuse. From the beginning of time, they've always made a song and dance about pimping to avoid listening to our problems, to muffle our voices. On the left, on the right, among feminists, among Christians, everybody wants to protect us.

To conclude, the responses of sex workers outlined in this chapter, highlighted various areas which need to be considered in the planning of intervention programmes amongst sex workers. These areas provide pointers for further research.

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CHAPTER FOUR

CONCLUSION

This study explored the issues facing sex workers, particularly with regard to AIDS. The results of the study should be regarded as tentative and the views presented by the sex workers in this study are not necessarily representative of the sex worker industry. Many issues have not been explored due to financial and time constraints. The sex industry is still relatively unknown in South Africa and this study is a contribution towards a greater understanding of the industry. Important areas regarding intervention and directions for further research have been highlighted.

It was clear from the findings of this study that the sex workers were aware of AIDS. However, there was some confusion about the etiology of AIDS and certain myths persisted with regard to transmission. The majority of the sex workers spoke in vague terms about the epidemic, reflecting their fear and uncertainty around AIDS. This, as well as attempts to explain the origins of the disease, the association between AIDS with dirt, and the emphasis on symptomatology, might indicate the need for concrete information and skills to deal with the epidemic. The gaps in their knowledge about AIDS could be partly attributed to the lack of adequate intervention programmes aimed at this population. Although Family Planning Clinics play a vital role in providing free condoms, sex workers were reluctant to discuss their work and safe sex concerns with the clinic staff. Most therefore gained their information in a haphazard manner, mostly via the mass media, posters or pamphlets. Further research is needed to determine what would make it easier for sex workers to discuss their concerns with clinic staff and other health educators.

The majority of sex workers considered themselves as at risk of infection but stressed that sex workers were not at any greater risk than anyone else. Escorts felt they were less at risk than street workers. Risk perception seemed to be negatively influenced by high levels of secrecy, conflict about being in the profession, and substance abuse. These points have not been mentioned elsewhere and need to be explored in greater

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depth in future research. The influence of self-esteem and self-efficacy on risk perception was not a focus of this study and might be an important area for further investigation.

The majority of sex workers were silent around the possibility of infecting their clients. Some, however, expressed their concern about infecting their boyfriends. The risk of vertical transmission to children was not a part of this study. It was also not raised by any of the women. This could be explored in future.

Views regarding HIV testing varied. For some, 'check-ups' functioned as a means of alleviating fears about infection. Others were too scared to be tested or were uncertain about the logistics of testing. Some responses were contradictory. Some sex workers said that they had not been tested because they have always used condoms. This was said despite the fact that they mentioned elsewhere in the interview that they were sometimes forced to have unprotected sex, or that they had unprotected sex when the client offered more money.

All the sex workers identified condoms as the most common means of prevention against infection. Condoms also served as a barrier between them and their clients. They reduced intimacy and made sex work less real. However, they distrusted the efficacy of condoms to protect them against HIV and some would therefore combine or substitute condom use with alternative methods. Some of these methods, such as the use of inappropriate lubricants, or two condoms at a time, could put them at risk of infection. Information about the correct use of appropriate lubricants seems to be needed as well as research on alternative forms of protection such as affordable female barrier methods.

Sex workers assumed responsibility for introducing and providing condoms. Although it appears that sex workers were motivated to practise safe sex, their responses about condom use were contradictory. Sex workers might have felt that they needed to provide the 'right' or 'responsible' answers to questions particularly related to condom use. For example, sex workers said that they were adamant about insisting on safe sex and usually felt able to either convince a client to use condoms or to refuse to do

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business with him. However, this rule did not always apply. Some sex workers did not use condoms if they liked a client or when he offered more money for unprotected sex. There were also instances in which sex workers were forced to have unprotected sex by violent clients. Condom use also varied depending on the status of the sexual partner. The more familiar the sexual partner, the less infectious he seemed and the lesser the chance that condoms were used. Condom use was thus high with casual clients but decreased markedly with regular clients and sailors. Here familiarity and trust seemed to replace condoms. No one used condoms with boyfriends. Condoms were associated with work, distance and distrust and the lack of condoms thus with pleasure, intimacy and trust. These findings indicate that sex workers could put themselves at risk of infection by some sexual partners as they have no guarantee that these partners are and remain uninfected.

Contrary to the popular view of sex workers as 'abused' and 'powerless', most sex workers portrayed themselves as being in a powerful position to negotiate safe sex, except in the case of violent clients. Street sex workers were more vulnerable to abuse by clients than escorts, who enjoyed some protection from the agencies. Sex workers voiced many advantages to being a sex worker. The independence and freedom of sex work influenced sex workers' perception of power in relation to their clients. Some therefore described the work as addictive and indicated that the advantages of sex work make it difficult for people to leave the profession. However, the work is stressful and many experienced conflict and guilt about being in the profession. Sex workers dealt with the conflict in various ways, including denial, rationalization and substance abuse.

Despite the disadvantages of the legal status quo which leave sex workers open to abuse by clients and the police, most sex workers were opposed to legalization. Apart from saying that they did not want to forfeit the benefit of earning tax free money, most of the reasons were unclear and contradictory and reflected little understanding of the impact of different forms of legal reform. However, sex workers' perceptions of law reform did not receive adequate attention in this study. A fuller exploration of sex workers' views could be valuable in informing the current debate around legalization.

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There are many factors which impede intervention amongst sex workers. Some of these are sex workers' reluctance to trust outsiders and the lack of cohesion amongst sex workers. Appropriate intervention programmes could assist sex workers in their attempts to protect themselves from HIV infection. The following areas of health intervention have been identified in this study:

a) Safe sex workshops in agencies, parlours and amongst street sex workers. The emphasis of workshops should be on providing and sharing skills, particularly with regard to negotiating safe sex with clients and effective preventative methods. These workshops should involve a great deal of participation by sex workers as a way of personalizing the risk of infection. The most effective form of intervention is run by peer educators. Sex workers therefore need to be trained as facilitators.

b) A condom and lubricant delivery service to escort agencies and street sex workers.

c) Liaison with existing health services, especially Family Planning Clinics and drug treatment centres, in order to find a way in which these services could best benefit sex workers. This entails the training of staff to work with sex workers and the possibility of opening clinics specifically for sex workers.

d) Prevention programmes aimed at the clients of sex workers.

e) Psycho-social, health and legal support free of discrimination against sex workers.

f) Support groups to promote pride and dignity in the profession and to decrease conflict and guilt, and thus denial and low risk perception.

g) The education of police officials about sex worker issues and the building of a supportive working relationship between sex workers and the police. In the absence of legalization, police officials should be encouraged to protect sex workers from abuse by clients and not to confiscate condoms, thereby interfering with sex workers' attempts to protect themselves from infection.

In addition to identifying the above areas of intervention, this study culminated in the formation of the first sex worker organization in South Africa. The organization, Sex Worker Education and Advocacy Taskforce (SWEAT), was formed in Cape Town in

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September 1994. The aim of the organization is to address the needs identified in this study as well as in the work amongst male masseurs by a field worker of the AIDS Support and Education Trust (ASET). SWEAT, which consists mainly of sex workers, endorses the World Charter of Prostitutes' Rights and is based on similar sex worker organizations in other countries, such as COYOTE in the United States of America, The New Zealand Prostitutes' Collective and the England Prostitutes' Collective. Like these organizations, SWEAT not only aims to provide safe sex education and to lobby for sex workers' rights, but also to instil a sense of community and pride in the industry (Roberts, 1993; Taylor, 1991).

In conclusion, this study posed certain challenges to me. Throughout the study, I found that my initial perceptions of sex workers were constantly tested. In this regard, I was at times caught in a struggle between what I expected to hear and what was actually there. In any study of stigmatized groups, it is particularly important to be aware of the influence of one's own prejudices and stereotypes in order to do justice to the people under study. To date, much of the research on the sex industry has depicted sex workers as disease ridden and has contributed to the stigmatization of the profession. In order to aid the reduction of HIV transmission a shift is needed from blaming sex workers to exploring ways in which sex workers can protect themselves against infection.

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APPENDICES

APPENDIX A:

Description of sex workers

Sex Worker	Age	Race	Educational Level	Number of Dependents
1	24	'Coloured'	Std 9	1
2	17	'Coloured'	Std 7	None
3	22	'Coloured'	Std 9	1
4	19	'Coloured'	Std 7	1
5	24	'Coloured'	Std 6	1
6	24	'Coloured'	Std 9	1
7	20	'Coloured'	Std 7	None
8	20	'Coloured'	Std 6	None
A	23	White	University degree	None
B	23	White	University student	None
C	43	White	Std 10	2
D	28	White	University student	None
E	26	'Coloured'	Std 9	1
F	24	'Coloured'	University student	1

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APPENDIX B:

Content of the questions

Identifying data:

a) Age.
b) Marital status.
c) Number of children.
d) Years working as a sex worker.
e) Full time/part time.
f) Other sources of income.
g) Average income through sex work per month.
h) Average number of clients per week.

Questions:

1) Tell me what you know about AIDS?
2) Where did you get the information?
3) Do you think you are at risk of being infected?
4) Have you ever had a STD?
5) If so, did you receive treatment?
6) How do you protect yourself against infection?
7) What makes it difficult for you to protect yourself?
8) Do you use condoms?
9) How often do you use condoms with your clients?
10) Are they (clients) willing to use condoms?
11) Why/why not?
12) Do you use condoms with your regular clients?
13) Why/why not?
14) Are you in a relationship?
15) Do you use condoms with your boyfriend/husband?
16) Why/why not?

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17) Where do you get the condoms?

18) Can you get condoms for free?

19) Where?

20) What will make it easier for you to protect yourself?

21) Do you think sex work should be legal?

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APPENDIX C:

Coding conventions

... : pauses and hesitations

XX : irrelevant section deleted

[ ] : my comments

??? : tape inaudible

( ) : non-verbal communication of participant

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