Sex Workers

An Introductory Manual for Health Care Workers in South Africa
SEX WORKERS

An introductory manual for health care workers in South Africa

First Edition 2012

Benjamin Brown, Zoe Duby and Linda-Gail Bekker

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DEDICATION

This manual is dedicated to all Africans who have been discriminated against and denied the support and services they need.
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ACKNOWLEDGEMENTS AND THANKS

This manual has been made possible by the input and expertise of various contributors who have dedicated their support to a community in great need of attention. Without their efforts, this tool would not have been possible. We greatly appreciate the expertise, time and guidance they have provided. For this purpose, we give thanks to Marion Stevens, Stacy-Leigh Manoek from The Women’s Legal Project, Maria Stacey and Gordon Isaacs from Sex Workers Education and Advocacy Taskforce (SWEAT), and John Mkandawire from Wits Reproductive Health Institute (WRHI).

Our appreciation also goes to the Desmond Tutu HIV Foundation for providing use of the *Men Who Have Sex With Men: A Sensitivity Training Manual for Health Care Workers in Africa* training programme, which was used as a foundation for this manual.

The development of this manual would not have been possible without the generous support of the US Centers for Disease Control and Prevention (CDC) and the guidance of Marina Rifkin.

We would like to especially thank Chris La Rose and Warren Passin from ICF International for driving the development of this project. Also, special thanks is needed for Dr Andrew Scheibe, whose work with Key Populations in South Africa provided the platform needed for this project to take shape, and who also played a key role in the peer review process for this manual.

Thanks goes to all the peer reviewers for their precious time, invaluable feedback and input: Tim Barnett and Oratile Moseki from SWEAT; Marlise Richter and Matthew Chersich from the University of the Witwatersrand, South Africa, and Ghent University in Belgium; Fiona Scorgie from the Department of Obstetrics and Gynaecology, University of the Witwatersrand, South Africa.
Thanks also goes to all those stakeholders and partners who took part in the pilot training workshop: Thuthukile Mabuela from the National Department of Health; Elizabeth Gordon Dudu and Kate Ramushu from the Cross Over Project; John Mkandawire, Jennifer Qupe, Zodwa Makau, Jean-Pierre Kalala, Maylene Meyer, Monica Nkwanyana and Nonhlanhla Motlokoa from WRHI; Nokuthula Futwa from the International Centre for AIDS Care and Treatment Programmes; Maaza Seyoum from International AIDS Vaccine Initiative (IAVI); with special thanks to Doris Macharia from FHI 360 for hosting the pilot training workshop.

Our thanks goes to Sally Shackleton and the team at SWEAT for their pioneering work and dedication to the sex worker community. Thanks to all those at SWEAT who gave valuable input at the stakeholder meeting.

Lastly, we would like to thank His Grace the Archbishop Emeritus Desmond Tutu, whose dedication to communities in need, human rights and justice have made our work possible.

Thank you to everyone who has contributed to this project.

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Glossary

Alcohol
This includes beer, wine, and spirits. These substances act as a central nervous system depressant. Alcohol is usually ingested orally as a drink.

Anal Sex
Sex which usually involves the insertion of the penis into the anus (penile-anal penetrative sex).

Antiretroviral (ARVs)
Medication used to manage HIV; in combination, it can be used to treat and prevent HIV infection.

Anus
The exterior opening at the lower end of the rectum and bowels, through which solid waste matter is passed out of the body.

Anxiety
Intense worry or a feeling of lack of control, which affects how a person feels and behaves. Anxiety can cause very real physical symptoms.

Bisexuality
The sexual orientation in which an individual has romantic and/or sexual feelings toward both males and females.

‘Business’
The act of exchanging sex for money, goods, or favours.

Cannabis
Known as marijuana or dagga. This substance acts as a central nervous system depressant and hallucinogen. Cannabis is usually inhaled by smoking but can also be ingested orally.

Chlamydia
A group of sexually transmitted bacteria commonly responsible for ‘the drop’/urethritis/proctitis.
Client
The person with whom a sex worker exchanges money or goods for sexual activity.

Cocaine/Crack cocaine
Substances derived from the coca plant that act as a central nervous system stimulant. Cocaine and crack cocaine can be snorted, smoked and injected.

Depression
A low or depressed mood accompanied by loss of interest or pleasure in life and activities which lasts for a period of 2 weeks or more and is disruptive to everyday functioning. It is characterised by sadness, inactivity, difficulty concentrating and thinking, significant increase or decrease in appetite, difficulty sleeping and suicidal thought.

Discharge
Fluid oozing from an area of inflammation, which includes cells aimed at fighting infection and the infectious agent. Discharge may be seen coming from the penis, anus, vagina or throat as a result of selected sexually transmitted infections (STIs).

Discrimination
The unfair treatment a person or group may receive by others because of prejudice or stigma.

Drug addiction
A disease affecting the brain characterised by compulsive behaviour that is difficult to control. The individual has difficulty in resisting the urge to take drugs despite the negative consequences.

Drug dependence
When an individual has a physical dependence on the drug and becomes dependent on the drug for normal physiological functioning of the body.

Dual diagnosis
When two or more mental illnesses occur at the same time (e.g. drug addiction and depression).

Ejaculation fluid (Cum)
Fluid released from the penis during ejaculation (‘cumming’); many viruses and bacteria which are responsible for sexually transmitted infections can be present in this fluid.

Female condom
Loose-fitting polyurethane sheath with an inner ring at the closed end, and an outer ring at the open end, inserted inside the vagina or anus for protection against pregnancy and/or HIV and sexually transmitted infections.
Fingering
Using one or more fingers to stimulate the genitals, including the insertion of the fingers (into the anus or vagina).

Gender (versus Biological Sex)
The term ‘biological sex’ refers to biologically determined differences, whereas ‘gender’ refers to differences in social roles and relations. Gender roles are learned through socialisation and vary widely within and between cultures.

Gender identity
A person’s sense of self as male or female. While most people’s gender matches their biological sex, someone may be born biologically male, yet have a female gender identity.

Genital
Related to sexual organs.

Hepatitis
Inflammation of the liver, which may be caused by a virus, drugs or rarely diseases of the immune system.

Heroin
This substance belongs to the class of drugs known as opiates. It acts as a central nervous system depressant and analgesic. It is usually injected but can also be smoked. Also known as H, horse or smack.

Herpes
A group of viruses which are spread through direct contact. Herpes simplex type 1 is responsible for ‘cold sores’ – superficial ulcers around the mouth and nose. Herpes simplex type 2 causes most cases of painful sores found around the penis, anus or vagina (genital herpes).

Heterosexuality
Refers to the sexual orientation in which an individual has romantic or sexual feelings toward members of the opposite sex.

Homophobia
Discrimination, stigma, fear or hatred based on homosexuality, directed at gays, lesbians, bisexuals and transgendered people.

Homosexuality
Refers to the sexual orientation in which an individual has romantic or sexual feelings toward members of the same sex.

Incarcerated
Being in prison.
Human Papilloma Virus (HPV)
The virus responsible for genital warts. Different subtypes exist, some of which are associated with the development of anal, penile and cervical cancer.

Intersexed people
Previously referred to as ‘hermaphrodites’, this refers to individuals who are born with a combination of both male and female reproductive organs, chromosomes, and/or hormones that are either fully or partially developed.

LGBTI
Lesbian, gay, bisexual, transgender, intersex.

Lubricant
Substance which reduces friction during sexual intercourse. Lubricants can be water-based (e.g. KY Jelly®) or oil-based (e.g. Vaseline®, body cream, cooking oil). Latex male condoms should only be used with water-based lubricants, as oil-based lubricants deteriorate latex.

Male condom
Sheath placed over the erect penis before sexual intercourse. It prevents pregnancy and HIV/STIs by blocking the exchange of sexual fluids.

Methamphetamine
This includes speed, crystal meth, or tik which act as a central nervous system stimulant. It can be snorted, ingested orally, injected or smoked.

MSM
Men who have sex with men, including not only men who self-identify as gay or homosexual and have sex only with other men, but also bisexual men, as well as men who self-identify as heterosexual but have sex with other men.

nPEP
Non-occupational postexposure prophylaxis—the use of postexposure prophylaxis after exposure to an infectious agent which is not a result of work practices or exposure.

Oral sex
Contact between the mouth and tongue and genitals (penis, testicles, anus, vagina). Includes licking, sucking, kissing.

Patient
An individual who is engaged in some type of medical or health care service.

Phobia
Excessive anxiety or fear about a specific object or situation.

Postexposure prophylaxis (PEP)
The use of medication to prevent infection after exposure to an infectious agent. Preventive treatment (antiretroviral drugs typically taken for 4 weeks)
started immediately (within 72 hours) after exposure to the HIV virus in order to prevent the virus from developing inside the body.

**PrEP (Pre-exposure prophylaxis)**

The use of HIV medications to prevent HIV among individuals who are not yet infected with the HIV virus.

**Rectum**

The lower region of the bowels linking the descending colon to the anus. Also referred to as the rectal passage.

**Sex work**

An occupation in which a person exchanges sex with a client in order to receive money or gifts.

**Sex worker**

The term ‘sex worker’ is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting female, male and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally. Acceptable alternative formulations for the term ‘sex worker’ are ‘women/men/people who sell sex’. Clients of sex workers may be called ‘men/women/people who buy sex’. The term ‘commercial sex worker’ is not used because it says the same thing but in different words. Children selling sex under the age of 18 are considered to be victims of commercial sexual exploitation, unless otherwise determined (USAID definition).

**Sexual orientation**

The set of emotional, physical and romantic feelings an individual has toward others. These feelings and behaviours are usually directed toward men or women, or both men and women.

**Stereotype**

An oversimplified characteristic of a person or group that is usually driven by stigma.

**Street work**

Sex work that takes place in/on the streets.

**Substance abuse**

A pattern of repeated substance use despite the negative consequences (not to be confused with substance dependence).

**Stigma**

Shame or disgrace that is directed toward something regarded as socially unacceptable.
Transgender individual
A person who experiences their gender identity as being different from their sex at birth. Transgender women's gender identity is female, while their bodies at birth were male.

Transphobia
The fear, rejection, or aversion, often in the form of stigmatising attitudes or discriminatory behaviour, toward transsexuals, transgender people and transvestites.

Urethritis
Inflammation of the urethra, the pipe linking the bladder to the outside, along which urine passes. Commonly caused by the bacterial STIs such as gonorrhoea and chlamydia.

Transvestite
A person who wears clothes associated with the opposite gender in order to enjoy the temporary experience of membership of the opposite gender. A transvestite does not necessarily desire a permanent sex change or other surgical reassignment.

Transsexual
A person who is in the process of or has undertaken surgery and/or hormonal treatment in order to make his or her body more congruent with his or her preferred gender.

Venue-based sex work
Refers to sex work that takes place within an established structure as opposed to street-based sex work.

Warts
Growth on the skin, caused by a virus; human papilloma virus is responsible for warts in the genital area.

WSW
Women who have sex with women. This term includes not only women who self-identify as lesbian or homosexual and have sex only with other women, but also bisexual women as well as women who self-identify as heterosexual but have sex with other women.
Before using this manual or participating in a related training programme, please complete the following multiple choice questions.

A post-course assessment will be available at the end of this manual.
PREVIOUS EXPERIENCE WITH SEX WORKERS

1. In the last 3 months, how many patients have you had who engage in sex work?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any patients who engage in sex work
   e. I have no idea

2. In your career, how many patients have you had who engage in sex work?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any patients who engage in sex work

3. If you have had sex worker patients previously, how many did you refer to mental health services?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any patients who engage in sex work

4. If you have ever had sex worker patients previously, for how many did you provide risk-reduction counselling?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any patients who engage in sex work

5. Have you ever received sensitisation training for sex workers before?
   a. yes, I have received training on sex workers before
   b. no, I have not received training on sex workers before
   c. I am unsure if I have received training on sex workers before

KNOWLEDGE OF SEX WORKERS

1. All sex workers engage in sex work because
   a. they have a mental illness
   b. they need to survive and earn a living
   c. they enjoy having sex with multiple partners
   d. they were abused as little children
2. **Sex workers are at higher risk for HIV than the general community because**
   a. they frequently have large numbers of sexual partners
   b. they are often forced to have unprotected sex with clients
   c. they often experience stigma within health care settings and do not get effective health care
   d. all of the above

3. **Sex workers may be stigmatised because**
   a. they have a large number of sexual partners
   b. they are perceived as stealing married men from their wives
   c. they are perceived as encouraging crime
   d. all of the above

4. **Sex work stigma can be addressed in health care settings by**
   a. having a separate queue for sex workers away from the other patients
   b. encouraging the police to visit the clinic regularly
   c. addressing the use of inappropriate language used toward sex workers
   d. refusing to provide sex workers with the same services as other patients

5. **Sex work are affected by laws in South Africa that criminalise sex work because these laws**
   a. may make it more difficult for sex workers to access health care
   b. may make it more difficult for sex workers to report crimes, such as rape, that have been committed against them
   c. may result in stigma and discrimination
   d. all of the above

6. **Which of the following abuses have been reported by sex workers in South Africa?**
   a. being detained over weekends by police
   b. being forced to have sex with police officers to avoid arrest
   c. being physically assaulted by police officers
   d. all of the above

7. **Sex work occurs when there is an exchange of goods or gifts for sexual activity between**
   a. one man and one women
   b. one man and any number of women
   c. two men
   d. all of the above
8. Sex work is practised in
   a. a private home
   b. brothels
   c. clients’ cars
   d. all of the above

9. A sex worker should test for HIV
   a. every month
   b. once a year
   c. every 6 months
   d. as frequently as possible

10. Risk-reduction counselling is a behavioural technique meant to reduce HIV risk
    a. by convincing the sex worker to leave sex work
    b. by eliminating all risk that the sex work may be experience
    c. by decreasing the risk experienced by the sex worker according to his or her actions and circumstances
    d. none of the above

11. A sex worker can reduce his or her risk of getting HIV by
    a. using condoms with every client
    b. not having sex when an STI has not been treated
    c. getting tested for HIV and STIs regularly
    d. all of the above

12. Postexposure prophylaxis (PEP) is an HIV prevention tool that is available to
    a. all sex workers
    b. only female sex workers who have sex with men and women
    c. no sex workers
    c. only male sex workers who have sex with other men

13. Which of the following is NOT a sign of external stigma towards a sex worker?
    a. a nurse gossips to a receptionist about the sexual behaviour of a sex worker patient
    b. a counsellor believes that sex work is immoral and tries to counsel the sex worker to find another job
    c. a nurse asks a sex worker patient about the frequency of condom use with his or her clients
    d. a site manager refuses to hire an individual as a peer educator because they are a sex worker
14. Which of the following is a factor that affects the mental health of a sex worker?
   a. high levels of stigma and discrimination
   b. the unavailability of paved sidewalks in client-heavy areas of town
   c. difficulty in finding affordable clothing for work
   d. frequently available free and confidential HIV testing

15. An enabling health care environment for sex workers would have
   a. confidential and sensitised risk-reduction counselling
   b. included input from sex workers in the design of the service
   c. combination HIV prevention strategies for use
   d. all of the above

16. Combination HIV prevention for sex workers is
   a. useful because it addresses the multiple risks sex workers face
   b. far too expensive to roll out on a national scale
   c. inclusive of psychological support for sex workers
   d. none of the above

FOR THE FOLLOWING STATEMENTS, INDICATE IF YOU AGREE OR DISAGREE BY CIRCLING A NUMBER BELOW:

1. I do not like to have sex workers in my clinic.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree

2. Sex workers are immoral.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree

3. Sex workers deserve to get HIV because of the behaviour in which they engage.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree

4. If a sex worker came into my clinic, I would provide him or her services in the same way that I provide services to other patients.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree

5. If a sex worker wanted treatment for an STI, I would not provide it to them because they will just get infected again.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree

6. If a sex worker came into my clinic, I would advise them to find another type of job besides sex work.
   Strongly Disagree    1     2     3     4     5      6     7     8     9     10      Strongly Agree
7. I am comfortable providing health care services to a sex worker.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

8. I believe that I can effectively counsel a sex worker to reduce their risk of getting HIV.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

9. I am aware of sex worker-friendly services that a sex worker patient could be referred to for more in-depth care.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

10. I am aware of sex worker organisations that work in my community.
    Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

11. Sex workers do not have a right to take a lot of free condoms from health care centres – they should take only as many as other people are expected to take.
    Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

12. Sex workers have specific kinds of health care needs that need consideration in order to enable their best health outcomes.
    Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

13. Sex workers should be treated differently from other people – they are more vulnerable than other people and thus must be given special treatment.
    Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree
INTRODUCTION AND OVERVIEW

Why was this manual developed?

This manual was developed as a resource for health care workers working with patients who engage in sex work. Sex work is a common practice in South Africa. In fact, sex workers exist in every community across the country. They often choose to enter into sex work because of economic pressure, high unemployment and poor public education.

Some health care workers may have little experience in providing services for sex workers. However, sex workers are a highly at-risk population in South Africa and receive very little resources, attention, or respect within the justice and health care system. This reality is changing; the 2012–2016 National Strategic Plan for HIV and AIDS, STIs and TB specifically states that health care services need to be responsive to the health needs of sex workers.

Therefore, health care workers in South Africa need to be sensitised and informed about the specific risks and health needs of sex workers in order to improve health care services and contribute to the treatment and prevention of HIV and other health issues in this community.

How was this manual developed?

Information in this manual was developed collaboratively with expert contributors from across South Africa. All content was then compiled by a team of experienced editors from the Desmond Tutu HIV Foundation and appraised by a series of peer reviewers. The manual was presented at multiple engagement meetings with South African key stakeholders, academics and service providers in order to provide further opportunity for input, review and buy-in.
Who is the target audience for this manual?

This manual was designed for health care workers in South Africa who have varying degrees of experience with sex workers. It has been designed specifically for individuals who already have a basic understanding of and experience in health service provision.

What are the aims and objectives of this manual?

This manual aims to supply health care workers with the necessary information to provide effective care and support for sex workers within South African health care settings. This manual will also provide health care workers with an opportunity to understand and address both social and personal stigma toward sex workers.

After reviewing this training manual, health care workers should be able to:

i Understand what sex work is, the conditions under which it occurs, the reasons why sex work exists and how prevalent sex work is in South Africa;

ii Describe stigma and discrimination and how they specifically affect sex workers, why they occur, and various methods that can be used to challenge both internal and external stigma;

iii Explain how South African laws supports a sex worker’s right to health care and requires health care providers to establish a safe health care environment that is free from discrimination;

iv Understand the various mental health conditions that are common among sex workers, why they are prevalent in this community and how they affect the overall health of sex workers;

v Describe how to create enabling environments that offer acceptable, accessible and appropriate services to sex workers; and

vi Detail various ways in which sex workers can improve HIV and STI prevention behaviours and reduce their overall risk through behaviour change.

How is this manual structured?

This manual is divided into eight modules that address important topics related to sex workers. Each module includes a brief introduction, a set of learning outcomes, and series of questions and answers. A brief summary and list of recommendations is also included at the end of each module. Many modules include exercises and reflection tasks in order to provide an opportunity for assessment of knowledge, attitudes and beliefs. Furthermore, practical case studies are presented in story form throughout each module. The case studies are based on real experiences, and provide an opportunity
for participants to practise newly learned skills and knowledge. Pre-and post-course assessment have been included in this manual in order to measure levels of experience, knowledge and attitudes before and after completing the manual. More in-depth information and resources have been included in the appendices of this manual.

Is this manual part of a training programme?

This manual was designed as part of a full sensitisation training programme, but can also be used as a stand-alone resource. The full training programme should be led by an experienced facilitator and make use of the supplemental Facilitator’s Guide (please contact the one of the editors for a free electronic copy). Content in the manual was developed for both individual reflection and small group work. Health care workers who are able to take part in a full programme should review the information presented in the manual before attending, as the training programme will focus more on interactive and reflective activities. If a full training programme is not available, the manual can be used for individual study; however, it is recommended that small study groups be established in order to discuss the content with others.

What are the next steps?

The development of tools for South African health care workers is an ongoing process. This guide builds on the work of the Desmond Tutu HIV Foundation’s Training Programme for Health Care Workers on Men Who Have Sex With Men, first published in 2009. We encourage users of this manual and other stakeholders to provide input and suggestions for this training tool in order to improve on the current work. Comments can be sent to ben.brown@hiv-research.org.za.

A note on terminology

There are many words that can be used to describe someone who engages in the act of selling sex. This manual will refer to this community of individuals as sex workers, rather than prostitute or hooker or other insulting terminology. At the publication of this manual, sex worker is also the chosen term that sex workers have chosen to describe themselves. Additionally, this manual will refer to a sex worker who visits health care facilities as a patient rather than the more common term, client. This is done in order to reduce confusion, since the term client is also used to refer to the individuals who engage with sex workers.
Even though South Africa has a generalised HIV epidemic, there are still higher levels of infection and transmission within certain geographic areas, as well as among some key populations. For these reasons, despite certain general interventions (e.g. communication), key populations should be targeted for prevention, care, and treatment interventions – and this should be included specifically in provincial strategic implementation plans.

Amongst these key populations are sex workers and their clients.

The 4 Pillars of the 2012-2016 NSP:

- Pillar 1: Universal HIV testing and TB screening
- Pillar 2: Sustain health and wellness
- Pillar 3: Increase safety and reduce vulnerability
- Pillar 4: Changing societal norms and values

Within each pillar these key populations will need to be targeted with different but specific interventions, to achieve maximum impact.

Priority area highlighted by the National Strategic Plan for HIV and AIDS, STIs and TB, 2012–2016:

Ensure that health and social services are responsive to the needs of people living with or affected by HIV or TB, including orphans and vulnerable children, people with disabilities, elderly, adolescents, sex workers, drug users, and other marginalised groups.
Introduction

In many ways, sex workers are no different from other patients who are seeking health care services. Just like other patients, sex workers face certain risks to their health and have individual health care needs. Also, just like everyone else, sex workers may engage in behaviours that increase their risk for HIV and other STIs. It is important to note though that sex workers are at higher risk for HIV and STIs than the general population (1). All health care workers are obligated to provide effective health care services to each of their patients. This may be difficult to do for sex worker patients, because many health care workers may not understand their needs or the experiences they face.

Therefore, in order to more effectively provide health services to sex worker patients, a general understanding of sex workers, their behaviours and the risks they face is needed. This module will provide an overview of the key topics covered in this manual. It will explore sex work and its origins, the characteristics and motivations of sex workers, as well as the common risks, human rights abuses, and stigma that sex workers face daily.

Learning outcomes

By the end of this module, you should be able to do the following:

i. Define sex work and describe sex work in South Africa
ii. Describe why people enter into sex work
iii. Explain why sex workers experience stigma and how it affects them
iv. Understand why sex workers are at higher risk for HIV infection
v. Describe other vulnerabilities that sex workers may face
What is sex work?

Sex work is the act of exchanging money for some type of sexual service. Most health care workers may be familiar with the type of sex work that involves a man paying a woman, sometimes referred to as a prostitute or hooker, to have sex with him. This is one example of sex work, but there are many more that will be further discussed in Module 2. Additionally, names like prostitute, hooker or call girl can be offensive and derogatory. The term sex worker is a more accepted term that can be used to refer to someone who engages in sex work. The term sex worker will be used throughout the rest of this manual. Sex work should not be confused with transactional sex. Transactional sex occurs when some type of sexual service is exchanged for gifts, shelter or drugs.

EXERCISE 1

Mind-map

When you hear the term sex worker, what is the first thing that comes to your mind? Write down a brief description of what you think of as a typical sex worker and consider the following questions:

Is the sex worker a man or woman?

What is he or she wearing?

Where does the sex worker work?

Does the sex worker live in a city or a rural community?

How old is the sex worker?

Why did that person start sex work?
Does sex work happen in South Africa?

Sex work happens in every village, every town and in every city in South Africa. In fact, sex work exists in every culture around the world and has occurred throughout history. It is estimated that there are between 135,000 and 500,000 sex workers in South Africa (1).

Who are sex workers?

A sex worker is a person who engages in sex work. Most sex workers in South Africa are female, but men also engage in sex work. Both male and female sex workers may engage in sex work with male and female clients. Transwomen also engage in sex work in South Africa. Transwomen are women who were born male but live their lives as females. Sex workers can be any race, come from any cultural background and can have any sexual orientation and gender identity. Many sex workers are also migrants from other places within South Africa and from other countries (1).

While sex workers in South Africa are a diverse community, there are some characteristics that are typically more commonly associated with sex workers. For example, most sex workers in South Africa are women. This includes both sex workers who were born female and those that were born male but live life as females. Also in South Africa, most sex workers are either black or coloured and come from low socioeconomic circumstances (1).

In South Africa, these common characteristics of being female, black or coloured, and coming from underresourced communities are not limited to just sex workers. They also are common in other occupations, such as domestic work. These characteristics reflect the social circumstances and contexts that encourage people to enter sex work.

Why do people engage in sex work?

People become sex workers for many different reasons. Typically, economic need seems to be the biggest motivation (1). A significant number of women in South Africa face difficulty in finding employment or supporting their families. Many sex workers say that sex work has allowed them to survive and put food on their table for themselves and their families.

Education and national citizenship are also factors that can influence a person’s reasons for entering into sex work. This is because sex work does not require a high level of education, nor does it require an identity document or proof of citizenship. These are things that a more formal job may require. In Hillbrow, Johannesburg, for example, there is evidence to suggest that 60% of sex workers may be from other countries or from other cities within South
EXERCISE 2

Case study

Take a moment and read the following case study about Nazli and consider the questions or comments below.

I was born in a better family and I went to school and I got married to a good husband and had three children. But God separated us with death. I looked for a job, and worked as a receptionist. Economically things started to be bad every day, [and] the money I earned was too small for me to look after my children. So I decided to come to Port Elizabeth for green pastures, so that my kids could enjoy their standard of living. When I got there I looked for a job, but found nothing. So, I had to spend one week sleeping outside, and struggling to find money for food. I met a friend who told me she is working in a hotel, but she didn’t specify what kind of job she is doing. We got together because I was in need of a job – so she told me this is the job. I had no choice because I needed shelter, food – that is when I started to be a sex worker. But my kids never died with hunger because I was providing them with food, clothing and schooling. I can’t say this job is bad because you don’t need qualifications or experience, you learn it in the field. Being a sex worker doesn’t mean you don’t do anything – God gave us brain[s] to think, eyes to see, hand to touch, and legs to walk (2).

1. How did your description from Exercise 1 compared to Nazli? Was it similar or different?

2. Consider why Nazli started sex work. Did she have other options? Would you have made the same decision?

3. Briefly describe what you think Nazli’s experience is like as a sex worker.

Is sex work illegal in South Africa?

Yes, sex work is illegal in South Africa. However, South Africa is currently in a state of law reform, in which many of the apartheid-era laws that make sex work illegal are being reviewed. This review is in line with many international trends to decriminalise or legalise sex work around the world.
Despite the illegality of sex work in South Africa,

- there are no laws that restrict a health care worker’s ability to provide medical care to sex workers;
- there are many laws in South Africa that protect a sex worker’s right to reserve effective health care; and
- there are many laws that require health care workers to provide unbiased and fair services to sex workers.

**Why are sex workers more vulnerable to HIV?**

There is little research about HIV prevalence among sex workers in South Africa. The studies that do exist show that HIV rates among sex workers are between 44% and 69% (1). These rates are significantly higher than the general population. Other African countries, such as Kenya, have shown that sex workers can account for approximately 14% of all new HIV infections (1). People engaged in sex work appear to be at increased risk for acquiring HIV through exposure to more sexual partners, higher threat of violence in sexual encounters, riskier sex, the use of substances during sexual encounters, and because of limited access to health care services (1).

While sex workers are committed to using condoms with clients, their adherence is reliant on cooperation by clients; this is not always something easy to achieve. Sometimes clients offer more money for sex without a condom, or threaten to go to other sex workers who will agree to sex without a condom (1). Clients also might pay more for riskier sexual practices, such as anal sex, without a condom. This means that more immediate survival needs take precedent over safer sex practices. For many sex workers, ensuring that they are able to provide for themselves at the end of the night can be more important than their long-term health.

An additional risk for sex workers is in their relationships with boyfriends and husbands, in which they might not use condoms. Sex workers are also vulnerable to violence from clients and partners, and have little access to recourse if they do experience violence, since they are considered criminals in the eyes of the police.

**What human rights abuses do sex workers experience?**

Every South African is granted certain rights by the Constitution. Some of these include the right to dignity, to freedom from violence, to bodily integrity, and to choose their profession. Unfortunately, for many sex workers, these rights are violated daily. Reports from many cities throughout South Africa show that sex workers experience significant harassment from the police (4). This harassment has been well-documented and includes arrest
without just cause, rape, verbal abuse and physical abuse (4). When sex workers attempt to pursue their right to justice to address these infringements on their rights, many are simply laughed at in police stations and refused any help (4).

Sex workers experience a very similar situation in health care facilities where they are commonly refused services and where their confidentiality is broken, thereby exposing their HIV status and/or their status as a sex worker. This may contribute to further stigma (4).

Discrimination and stigma from health care workers comes in many forms, and ranges from being very overt and blatant to unintentional and subconscious. Many health care workers are not even aware of how their own behaviours and attitudes may be stigmatising. However, despite an individual’s personal beliefs, it is the duty of health care workers to provide good health care to all and to optimise their practices and settings in order to do so.

**How can health workers improve conditions for sex workers?**

There are many myths and misconceptions about sex workers. These myths and misconceptions drive stereotypes and create stigma. Stigma can prevent sex workers from receiving quality health care and may also result in further discrimination. So in order for conditions to improve for sex workers, these myths, misconceptions and biases must change. Addressing myths that health care workers have about sex workers will change misconceptions and stereotypes, and in turn lead to a reduction in health worker stigma toward sex workers. In order for sex workers to begin to access effective health care, health care providers must be willing to see sex workers as human beings.

Challenging stigma can be difficult. Module 3: Sex Work and Stigma will detail this in more detail and provide useful tools for understanding how to address stigma in the health care setting.

Additionally, the South African National AIDS Council is also working to improve conditions for sex workers and has developed formal recommendations that include the following (3):

1. The development of sex worker–sensitised services within health care clinics and mobile sites that are staffed by sex worker peer educators;
2. The training of health care workers to reduce stigma and discrimination in health care settings;
3. The provision of male and female condoms and water-based lubricants;
4. The development of inclusive HIV prevention messages that involve sex workers;
5. The strong inclusion of sex workers in drug and alcohol rehabilitation programmes; and  
6. The inclusion of sex workers in the development of research about sex work.

### 10 INCORRECT MYTHS ABOUT SEX WORKERS

1. **All sex workers were abused as children.** Many people believe that child abuse is the primary reason that people engage in sex work, but this is untrue. Most sex workers engage in sex work for economic reasons. This will be explored further in Module 2.

2. **Sex work and human trafficking are the same thing.** While some sex workers are victims of human trafficking, this is not the case for all sex workers.

3. **Sex workers are all drug addicts.** Some sex workers do use drugs, but not all sex workers engage in drug use or are drug addicts. Sex work and drug use will be further explored in Module 6.

4. **All sex workers are immigrants.** Some sex workers are migrants from other places in South Africa or other countries, but not all sex workers are immigrants.

5. **All sex workers do not use condoms.** Module 5 will explore the many pressures put on sex workers to engage in sex without condoms, but not all sex workers engage in unprotected sex. In fact, many sex workers use condoms with all their clients.

6. **Sex workers are all uneducated.** Sex workers have a wide variety of education backgrounds. Some sex workers may have received little formal education, but many others are formally educated. Reasons why sex workers enter into sex work will be further explored in Module 2.

7. **Sex workers are not parents.** Many sex workers have families and engage in sex work in order to support their children.

8. **Sex workers are victims of post traumatic stress syndrome (PTSD).** While some sex workers do experience PTSD, not all sex workers engage in sex work because of it. Why sex workers engage in sex work will be further explored in Module 2.

9. **Sex workers are all teenagers.** Sex workers span a variety of ages.

10. **Sex workers are not able to have stable, loving relationships.**
SUMMARY AND RECOMMENDATIONS

- Sex workers are a vulnerable community that are at high risk for HIV infection and, as with any community in South Africa, deserve to be provided with the same level of respect and access to health care.
- Sex workers urgently need supportive medical treatment, as well as an acknowledgement of the constant struggles they face in the daily defence of their human rights.
- Many women engage in sex work as a way to provide for themselves and their family, and yet criminal laws encourage discrimination and create barriers for them to access support and care.
- A strong understanding of the sex work community is critical in order to provide effective health care for sex workers.
- Health workers have a duty to provide effective and fair services to all their clients.
- Health care workers must not make assumptions about who sex workers are, as they are a diverse group.
- Health care workers not make assumptions about why sex workers engage in sex work; there are many different reasons.
- Many of the existing myths and stereotypes about sex workers are incorrect.
Introduction

It is understandable that some health care providers may be unaware of the basic behaviours and common practices related to sex workers. This is because sex workers may attempt to remain fairly hidden within their communities, and they may not disclose themselves as sex workers when seeking medical care. It is important, however, to have a broader understanding of the basic practices and terminology related to sex work. This understanding can assist in providing effective medical care for future sex worker patients. This module will provide a more in-depth perspective into the logistics and realities of sex work in South Africa.

Learning outcomes

By the end of this module, you should be able to do the following:

i  Describe the key role players involved in sex work and how they can influence a sex worker.
ii Explain how sex workers engage with clients and understand the circumstances under which they make decision.
iii Describe the conditions in which many sex workers work and the effects these conditions can have on their health.
iv Understand the different types of sex workers and where and how they work.
v Understand how sex workers are affected by their interactions with police and their clients.
Is sex work really work?

Selling sex is a regular income-generating practice for many people in South Africa (1). Sex workers clearly identify their actions as legitimate work because they are providing a good or resource to their clients and receiving compensation in exchange. Sex workers consistently emphasise that they perform a service and a job for the sexual pleasure of their clients. Many sex workers define their service as penetrative sex with a condom, resulting in ejaculation in exchange for cash. There is also an expectation that the sexual exchange will take place within a particular time frame and include certain agreed-upon standards between the sex worker and the client.

How is sex work practised?

Sex work begins when a sex worker identifies a client. After meeting, the sex worker will determine what activities the client is interested in, and afterwards will negotiate a price with that client. If both the sex worker and client agree to the activity and the price, the client will pay the sex worker and they will then engage in the agreed-upon activity. There are many factors that can affect this negotiation process, however. For example, a sex worker may be pressured to secure the client because they may be worried about possible arrest by a police officer or the client being offered a better deal by another sex worker. In these circumstances, the sex worker may be more likely to take risks with his or her health and safety. For example, sex workers may engage in riskier sexual acts because the client may be willing to pay a higher price. This might include anal sex or sex without a condom. Also, the sex worker may feel pressure to secure the deal, and agree to get into the client’s car and risk being taken somewhere unfamiliar.

What type of sex do sex workers sell?

Sex workers sell all different types of sexual activities. Some sex workers may only perform certain types of sex – the most common types being penile-vaginal penetrative sex, manual masturbation, and penile-oral sex. Some sex workers, both male and female, also engage in penile-anal sex with their clients. The majority of sex workers have a set of services, which they provide, and services which they will refuse to provide. Many sex workers refuse to perform anal sex or group sex, for example. Others specialise in non-penetrative sex.

Where is sex work practised?

A common image of a sex worker in South Africa is often thought of as a woman who is getting paid by a man to have sex. This exchange usually
occurs at night in a dark alley or car. While some sex work in South Africa does fit this description, there are, however, many different settings for practising sex work.

Some sex workers do practise street-based sex work. This means that they wait or walk along certain streets or highways and engage with clients from the street. Sex work does not require a specific location, although many sex workers have identified locations within their community where it is easier for them to find clients and for the clients to locate them. While this may be an established meeting place, sex workers may travel with the client to other locations.

Not all sex workers work on the street. There are also sex workers who work from other establishments such as ‘massage parlours’, bars or clubs. This is referred to as venue-based sex work. Often sex workers who work in clubs will be forced to pay a cover charge for working there. There are also some sex workers who work privately, and use the Internet to advertise/find clients, or some who place advertisements in newspapers’ classifieds sections. These sex workers are sometimes referred to as call girls, and they tend to visit a client at their home or hotel room. Some sex workers may work within an established venue for sex work, sometimes referred to as a brothel.

**What is a brothel?**

A brothel is an establishment or building where multiple sex workers live and can host clients. In some cities, brothels may also be referred to as hotels. Often brothels are overseen by a manager who also coordinates the clients for the sex worker.

Conditions of brothels as well as the treatment received by a manager can vary greatly across South Africa. Some brothels may have strict hygiene standards and provide regular doctor visits and condoms to all of its sex workers, while others may have extremely unhygienic conditions, lack basic HIV prevention tools, and restrict sex workers’ movements in and out of the brothel (2).

**Do sex workers work alone?**

Some sex workers work alone, but others may work in association with some type of manager or pimp, who is responsible for organising clients for them. For sex workers in brothels, this manager – or madam if she is female – is responsible for running the brothel and organising clients for the sex workers who are based there. Other sex workers may work with a pimp.
EXERCISE 1

Case study

Please read the following case study about Ntombi, a young sex worker from Durban. Afterward, answer the following questions.

Ntombi is a 26-year-old woman who lives in Berea in Durban with her boyfriend Thabo and their 3-year-old son, Lindo. Thabo has a job as a fuel attendant at a nearby fuel station, and Ntombi is studying at college. On weekends Ntombi works in a brothel called Happy Endings. The madam at Happy Endings has an agreement with a few of the local hotels. When a businessman from the hotel requests a sex worker, the madam sends one of her girls. The madam agrees on a price with the client beforehand, when the client specifies what kind of girl he wants, and what kind of sex he wants. The madam then informs Ntombi of what the client wants, and it is Ntombi’s job to provide this to the client’s satisfaction. Sometimes the client demands things that he has not paid for or agreed to with the madam. For example, the client may ask Ntombi not to use a condom, offering to tip her generously. Ntombi knows that she only gets paid a portion of what the client pays the madam, and the cut that goes to the hotel, so it is very tempting to take the tip and not use a condom. Ntombi is on the contraceptive pill, so she doesn’t worry about getting pregnant.

1. How does Ntombi practise sex work? Is it different than what you expected?
2. Why do you think Ntombi became a sex worker?
3. What alternatives would Ntombi have if she was not a sex worker?
4. What risks do you think Ntombi faces in her work?

Who is a manager and what do they do?

A manager is someone who ‘owns,’‘protects,’ and/or ‘manages’ one or multiple sex workers. The term manager should be used instead of pimp; pimps are commonly associated with violence and drug use. Managers are responsible for attracting clients and negotiating with them for the sex workers’ services. Sex workers, in turn, are forced to pay a portion of the money they earn from the client. Often, managers will organise clients for the sex worker and negotiate rates and actions without the sex worker’s consent.
Sex workers across South Africa can have varied relationships with managers. Although many managers can be abusive and controlling, it is important to note that not all managers or pimps are bad. They can also play a positive role, assisting sex workers to get medical care, supporting the sex workers in getting clients, as well as providing security and protection from violence. More often, however, these managers can be a significant barrier for sex workers in protecting themselves from HIV and other STIs. This happens because often the manager will determine with whom and when the sex worker has unprotected sex. Additionally, they may restrict a sex worker from visiting a clinic to receive tests or treatment for HIV or other STIs.

**What do sex workers get paid?**

Most sex workers get paid in cash and not with items (e.g. clothes, gifts, cell phones). The amount that sex workers get paid varies greatly, and depends on where the sex worker works. For example, a sex worker who works on the side of the road in a small town might get paid very little, whereas a ‘high class’ sex worker who visits clients in their hotel rooms in a big city may get paid a large amount. The reality is that there is a financial incentive for engaging in sex work; sex workers often can earn more than if they were engaging in other forms of employment.

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**EXERCISE 2**

**Pros and cons**

Fold a piece of paper three times. In one panel write ‘brothel’, and list the positive and negative aspects that you think sex workers may face should they work in the brothel environment. On the next panel write ‘pimp’, and also list the positive and negative aspects that sex workers may experience should they work for a pimp. Repeat the same procedure for the remaining panel, entitled ‘street work’.

Once you have completed the exercise, please answer the following questions:

1. **Which of these conditions seems to have the highest risk? Are there risks that are common among each type of sex work?**

2. **For each of the circumstances, could you think of any ways in which the sex worker could improve his or her conditions?**

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How do sex workers interact with the police?

Some sex workers may be identified by the police and regularly interact with them. Since sex work is illegal in South Africa, sex workers are forced to adhere to the directions of the police, even when the police officers themselves are acting against the law or are corrupt (3). Some sex workers may pay police officers to let them continue working; this can take the form of a fine, when in reality the money that is paid to the police is simply pocketed (4).

Some sex workers will give their services away by having sex with the police officers in order to avoid getting arrested. Sex workers can also experience high levels of violence and abuse from police if they refuse to cooperate with them (5).

Various studies have reported the reluctance of sex workers to report rape and abuse to authorities due to fear and unsympathetic treatment by the police (6). Street-based sex workers (as opposed to those who are mainly based in brothels or hotels) are particularly vulnerable to crime and violence, as well as police harassment (7).

Do sex workers use drugs?

Many sex workers find themselves in circumstances where illegal substances are available. Sometimes, pimps will also encourage their sex workers to take drugs so that they are easier to control after they have become addicted. Therefore, sex workers become dependent on pimps for the drugs since the pimps can control their supply (8). In this situation, sex workers will often become more compliant with the pimp's demands, even if those demands may put their health at greater risk.

Also, some sex workers take drugs as a coping mechanism. In other words, they use drugs as a way to forget about their difficult circumstance, to numb themselves to any traumatic events they may have faced, or to ease the shame they may feel about what they are doing (9).

A recent study amongst sex workers in South Africa found that a third of respondents reported taking drugs in the last month, while half of respondents reported being drunk between one to five times in the last month (10).
EXERCISE 3

Case study

Sizwe is a 19-year-old man who moved to Cape Town from his family home in the Eastern Cape two years ago. He dropped out of school because his family were struggling to pay the fees, so he came to the city to find work. Sizwe spent three months sleeping on the streets when he arrived, as he didn’t know anyone in the city. One night when he was standing at the traffic lights, begging passing motorists for money for food, a fancy car stopped and the driver called him over. The man in the car was well-dressed and looked like a businessman. He asked Sizwe if he would be interested in doing some work for the man, to which Sizwe excitedly said he would. Sizwe got into the man’s car and was taken to an apartment nearby. The man explained to Sizwe that he had some wealthy male and female clients who were interested in meeting attractive local young men, and Sizwe would be paid well to spend the evening with one of these clients. The man told Sizwe that the client would probably want to have sex with Sizwe. At first Sizwe was shocked and was about to walk out, but then when he heard how much he would be paid, he decided to stay and try it out. That night Sizwe had his first client. Having never had anal sex before, he found the anal sex very painful at first, but the man was gentle with him, and at the end of the night Sizwe had more money than he had ever earned in a whole month. After a while Sizwe began to enjoy his work, and enjoyed the lifestyle that he could now afford.

1. Do male sex workers face different health risks from female sex workers?

2. What social challenges do you think male sex workers face that are different to female sex workers?

3. What factors do you think led Sizwe into sex work?
SUMMARY AND RECOMMENDATIONS

- Sex workers are a diverse community in South Africa. They exist in every racial and cultural group and they may be men, women or transwomen.

- Sex work can occur in a variety of locations, such as in the clients’ car or home, in a brothel, or in a secluded location in public.

- Sex workers may work by themselves or they may work with a manager.

- ‘Pimps’, ‘madams’ or ‘managers’ may have an adverse effect on the health and well-being of sex workers by encouraging the practice of risky sex and/or by limiting their ability to access health care. However managers can also have a positive effect on sex workers by facilitating their access to health care.

- Recognise that sex work is a job that some people choose to do.

- Recognise that sex work is a job that has risks like any other job.

- Recognise the diversity of sex work and the need to listen carefully and non-judgementally to each patient to tailor your care to their specific needs.
Introduction

Sex workers experience stigma and discrimination in many ways. Stigma can adversely affect their well-being and overall health, and reduce the impact of HIV prevention programming. Sex workers can especially experience stigma within the health care setting and specifically from health care workers themselves. Understanding what stigma is and how it negatively impacts sex workers is an important step to providing better health care for sex workers. Therefore, this module will explore stigma and discrimination in more depth by providing an overview of the types and sources of stigma, and how it affects sex workers. Additionally, tools and suggestions will be provided that can assist in the support of a sex worker patient who may be experiencing stigma or discrimination.

Learning outcomes

By the end of this module you should be able to do the following:

i. Define stigma and discrimination
ii. Describe the different types of stigma, sources of stigma, and the ways in which stigma can negatively impact the health of sex workers
iii. Describe how to support a sex worker patient who may be stigmatised
iv. Explain how practices within clinics stigmatise and discriminate against sex workers
v. Explore personal stigma and how it affects the services you provide
vi. Describe ways in which stigma may be reduced in the work place
What are stigma and discrimination?

Stigma refers to the strong negative feelings or significant disapproval connected to a person, group or characteristic. For example, at the beginning of the HIV epidemic, a significant stigma developed toward people who were HIV positive.

*Consider Nozuko, a 23-year-old university student who recently found out she is HIV positive. When Nozuko discloses her status to her friends, they begin to act differently around her and no longer spend time with her after lectures. When she confronts her friends about their behaviour, they tell Nozuko that they do not want to be seen or spend time with someone who is HIV positive. In this scenario, Nozuko is being stigmatised because of the negative feelings her friends have toward her being HIV positive.*

Often, when people have feelings like Nozuko's friends toward others, it may cause them to act differently toward those they are stigmatising. For example, Nozuko's friends may no longer want to share drinking glasses with her or live in the same flat. This change in behaviour can often lead to discrimination, which is the unfair treatment of an individual or group because of a certain characteristic. If Nozuko's friends forced her to move out of their flat because she is HIV positive, she would be experiencing discrimination.

There are two types of stigma that can affect an individual or group and lead to discrimination. External stigma is stigma that is experienced outwardly because of the way in which a person is being treated by others. In Nozuko's case above, she was experiencing external stigma because her friends were stigmatising her and she was affected by their negative feelings and actions.

Often times, external stigma may result in another type of stigma, known as internal stigma. Internal stigma can occur when a person who is experiencing stigma begins to believe and accept the stigma he or she has experienced. After being treated so negatively by her friends, Nozuko may, over time, begin to think that she is in fact dirty or unclean and may begin to hate herself for being HIV positive. This is internal stigma, because Nozuko is now experiencing negative feelings toward herself because of the negative associations tied to her HIV status.

How is stigma developed?

Stigma can be developed with an individual, a family or even within a whole community. It develops because of many factors, but is often influenced by the values and beliefs of an individual or group. A person can become stigmatised when they are considered to be different from other people and when that difference is considered to be negative or undesirable. Often, a person's or community's values and beliefs determine what they believe is negative or undesirable. Religion and culture can also affect the values and
beliefs of communities and individuals. Therefore, stigma can be developed from values and beliefs, as well as religious and cultural practices. Later in this manual we will discuss the ways that certain beliefs, attitudes and values toward sex workers lead to stigma.

**EXERCISE 1**

**Stigma self-reflection**

Think back to a time in the past when you were in any way treated differently by other people. For example, it may have been a time when you moved into a new area and attended a new school, and the learners there teased you for being new to the area. It could have been when you were taken care of by a distant family relative who was not your mother or father, and the relative treated you with less love and affection than his or her own children.

Try to remember such an experience and what happened. How were you treated differently? Then answer the following questions:

1. In what way were you treated differently by others around you?
2. How did this make you feel?
3. How could you have avoided this situation?
4. How do you think this experience affected you in the long term?
5. What did you learn from this experience?

**What are the signs of stigma?**

In certain situations, stigma may be very clear, but in other circumstances it may be more difficult to identify. In some cases, individuals may even be unaware that they are stigmatising someone or that they are being stigmatised by others. Therefore, it is important to understand the signs of both external and internal stigma so that proper actions can be taken to address it.

Most of the signs of external stigma are centred around the way people interact with one another. These may include the following:

*Avoidance.* Avoidance occurs when individuals spend less time with or do not want to be around stigmatised people. This might include a person who begins to avoid a close friend because he or she is stigmatised.
Exclusion. Rejection occurs when individuals are no longer willing to associate or welcome stigmatised people in their lives. This might include a family member rejecting a stigmatised relative and no longer allowing that person to live with them.

Moral judgment. Moral judgment happens when individuals begin to see a stigmatised person as immoral or when they use their values to justify stigmatising someone. This might occur when an individual becomes stigma-tised because he or she does something that conflicts with the religious beliefs of others.

Stigma by association. Stigma by association occurs when those who associate with a stigmatised person are also stigmatised themselves. This may occur to someone who remains a close friend with a stigmatised person.

Gossip. Gossip happens with individuals begin to speak negatively about other people who are stigmatised. Gossip could occur within a social circle when one of the members becomes stigmatised.

Unwillingness to employ. Someone may be exhibiting external stigma when he or she is unwilling to hire an individual who would otherwise be qualified for the job, only because of certain characteristics that may be stigmatised.

Exercise 2

Identifying values, attitudes and beliefs

Learning to address both personal stigma and the stigma that may occur in your health facility is a process that begins with identifying what may cause stigma to develop. For many people, strongly held values and beliefs may lead to the development of stigma. Therefore, the first step to understanding and identifying stigma is to better identify your own values and beliefs. Take a moment to reflect on the following questions:

1. How would you describe your most important values?
2. What are the five most important beliefs that you have? List them below.
3. Can you identify for each of these values and beliefs, when you developed them, and why?
Abuse. When a person physical, emotionally or verbally abuses someone, they may be doing so because of stigma they may have toward that person.

Victimisation. Victimisation occurs when someone is blamed for problems that are unrelated to them and singled out for cruel or unjust treatment. People who are stigmatised may often be victimised.

Unlike external stigma, the signs of internal stigma may be much harder to identify because many of them occur within the individual and are focused on the way they feel about themselves. Some signs of internal stigma include the following:

Self-exclusion from services (including health services) or opportunities. Self-exclusion may occur when a stigmatised individual avoids opportunities due to fear of being further stigmatised, or the individual feels unworthy of those opportunities.

Perceptions of self. A person who is experiencing internal stigma may have low self-esteem, sense of self-worth or other self-confidence issues, including low self-efficacy or a low perception of their ability to conduct a specific task, like accessing health care.

Social withdrawal. Often a person who is experiencing internal stigma may disengage from their social networks.

Overcompensation. Overcompensation may occur when a person who is feeling internal stigma feels the need to overly contribute to a situation to make up for their perceived stigmatisation. This could happen when a stigmatised individual is overly grateful when someone is kind to them.

Mental health issues. Internal stigma may cause a person to become depressed or develop mental health issues. For example, a stigmatised person may develop generalised anxiety disorder because of continual stress and anxiety from his or her perceived stigma.

Substance abuse. Substance abuse may be the result of internal stigma because a stigmatised person may turn to drugs or alcohol in order to cope with his or her stigma.

Suicide, or attempted suicide. Sadly, some individuals may not be able to cope with their internal stigma and may turn to suicide in order to escape the pain of their stigma. In some circumstances, sex workers may resort to trying to kill themselves to escape the pain of stigma.
EXERCISE 3

Identifying stigma through self-reflection

The signs of internal and external stigma can sometimes be difficult to identify. Consider the following questions about stigma in your workplace:

1. Have you ever witnessed any of these signs of stigma within your own health care facility?
2. If other staff members were involved, what is their position in your health care facility?
3. What role did you play in each of the examples? Did you only witness the stigma or did you play a more direct role?
4. Can you think of any examples in which you were directly involved in the stigmatisation of a patient? If so, what happened?

Why are sex workers stigmatised?

In most cases, sex workers do not experience stigma for any one specific reason but rather due to a variety of reasons.

Sexual frequency and sexual taboos

Sex workers may experience stigma and are discriminated against because they engage in frequent sexual activity. Many societies have conservative views or taboos about sexual behaviour. This means that they have very restrictive beliefs about how sex should and should not occur. Therefore, sex workers may be considered immoral because they engage in sex outside of marriage or because they are promoting behaviours that the community considers taboo.

The associations to HIV and fear of transmission

Sex has become linked with HIV since it is the most common way that the virus is spread. Since sex workers engage in frequent sex, they are seen as carriers and spreaders of HIV. This is even the case when sex workers are HIV negative. In some cases, health care workers may especially stigmatise sex workers after assuming that they are HIV positive, and the health care worker may go to extra lengths to protect against HIV. This can often result in offensive behaviour, such as an unwillingness to touch the patient.
Stigma as women

Most sex workers are women, and women often experience unique stigma and discrimination in many places around the world. In certain cultures, both within and outside South Africa, women are not seen as being equal to men and are expected to willingly consent to the directions of a man. Furthermore, some cultures perceive sex workers to be ‘cheap’ women that do not deserve dignity or who have given their right to dignity away when they became sex workers. When this stigma is applied to sex workers, it can often mean that they are exposed to physical violence or rape.

Migration and xenophobia

Some sex workers are migrants from other communities in South Africa or immigrants from other countries. In these situations, they may experience stigma because they are seen as foreigners who do not belong in the community. They may be excluded because of their foreign status and may be unable to find other forms of employment.

The illegality of sex work

Most importantly, sex workers are affected by stigma because in many countries, including South Africa, sex work is illegal. Therefore, sex workers are perceived as individuals who are breaking the law. Some sex workers are also HIV positive, and experience stigma and discrimination because of their status.

Homophobia and male/transgender sex workers

Many communities discriminate against same-sex sexual behaviour, and many individuals may have a very strong aversion to homosexuals; this is known as homophobia. Male and transgender sex workers may engage in sex with male clients, and may therefore experience homophobia and stigma because of this behaviour. Transgender sex workers are also discriminated on the basis of gender identity; this can be referred to as transphobia. This means that they may display – through their clothing, make-up, hairstyle, and behaviour – a gender identity that is in contrast to the gender role that is expected of them according to their biological sex.

Double or overlapping stigma

Sex workers regularly experience double or overlapping stigma. Double stigma occurs when a person experiences stigma because of multiple characteristics. For example, a sex worker may experience double stigma for being both
female and HIV positive. Overall, sex workers experience multiple layers of stigma, and it is this overlapping stigmatisation that can make sex workers an extremely vulnerable population.

EXERCISE 4

Case study

Read the case study below and answer the questions that follow.

Gloria is a 32-year-old sex worker from Bloemfontein. She lives with her boyfriend in a flat on the outskirts of the city. Gloria has not told her boyfriend that she sells sex, but told him instead that she has a job working in a factory doing night shifts on the other side of town. One night Gloria gets beaten up quite badly by one of her clients who was drunk, and was demanding to have sex without a condom. The client ends up raping Gloria, without using a condom. Gloria is in pain and bleeding but she is too scared to go home and tell her boyfriend what happened, as she is scared he will throw her out of the house if he discovers she is a sex worker. Gloria tries to get a room in a nearby hotel, but the doorman of the hotel refuses to let her enter, telling her that they don’t allow ‘filthy hookers’ in the hotel. Gloria instead finds a place to sleep behind some empty crates and waits for the clinic to open. In the morning Gloria goes into the clinic to see a nurse. There is a long queue at the clinic and many people waiting to see the nurse. After waiting for a long time, Gloria is called in to see Sister Penny. Sister Penny arrived at work today to find that two of her co-worker nurses had called in sick, so Sister Penny has to see all the patients at the clinic on her own this morning. As a result, she is feeling stressed and tired by the time Gloria comes to see her, and is hungry as she hasn’t had time for her tea break. Gloria begins to tell Sister Penny what happened to her, and Sister Penny starts shouting at her, telling her that she is just a ‘dirty whore’ and she deserves what she gets. Gloria runs out of the clinic crying and feeling lost and hopeless.

1. What types and forms of stigma are present in this case?
2. Can you identify the ways in which Gloria is affected by stigma?
3. How do you provide appropriate support for this patient?
What affect does stigma have on sex workers?

Stigma can often lead to a person being excluded from society, feeling devalued and shamed. Both internal and external stigma can gravely affect the health and well-being of sex workers. Sex workers may experience abuse by their clients or pimps, but because of internal stigma they may also not feel worthy enough to seek health care. When sex workers do seek health care, external stigma can often make their experiences less than ideal. For example, nurses within community clinics who stigmatise sex workers may use insulting language toward them or blame them for whatever current medical condition they may have. Many reports have also indicated that many health care providers break the confidentiality of sex workers by exposing them as sex workers or even disclosing their HIV status to others within the clinic. Take for example the following testimonial from Lulu, a sex worker in Cape Town:

I stopped going to the clinic. They [the nurses] looked down on me for what I do. The last time, the sister started shouting at me in front of others. She said ‘why do you open your legs for so many? Because you are a prostitute? This is your fault, this is why you are sick now.’

Many sex workers may also not feel comfortable disclosing to health care workers that they engage in sex work because they are afraid of the negative stigma they may experience. In these cases, the health care workers are not provided full details of the patient’s risk or behaviour, and are therefore unable to provide effective health care or treatment.

Sex workers also experience stigma and discrimination when they attempt to report abuse or crime committed against them to police. For example, if a sex worker is raped by a client or otherwise physically assaulted, he or she may have difficulty in reporting this to the police. In many reports from South Africa, sex workers have detailed the lack of support they receive from police, often stating that upon reporting a rape, they are simply laughed at and told that ‘that was what you were looking for’.

How can stigma toward sex workers be addressed?

Many health care workers may have stigma toward sex workers. There are many ways this can addressed both individually and within the health care setting.
EXERCISE 5

Causes, effects and examples of stigma

Fold a blank piece of paper into three parts. Label left column ‘Examples’, the middle column ‘Causes’, and the right column ‘Effects’. Under ‘Examples’, think of every time you or someone else in your health care environment has stigmatised a sex worker. For each of these examples, identify the potential cause or reasons for the stigma and write this under ‘Causes’. Conclude by considering what the effect of each of these cases of stigma had on the sex worker and list these under ‘Causes’.

Once you have finished, compare your list to the table below.

<table>
<thead>
<tr>
<th>Examples</th>
<th>Causes</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name calling</td>
<td>Lack of knowledge or understanding</td>
<td>Withdrawal</td>
</tr>
<tr>
<td>Labelling</td>
<td>Lack of information</td>
<td>Depression</td>
</tr>
<tr>
<td>Gossiping</td>
<td>Ignorance</td>
<td>Loneliness</td>
</tr>
<tr>
<td>Making assumptions about someone</td>
<td>Religious beliefs</td>
<td>Isolation</td>
</tr>
<tr>
<td>Judging and criticism</td>
<td>Cultural beliefs</td>
<td>Sadness</td>
</tr>
<tr>
<td>Rejecting</td>
<td>Society’s norms and expectations</td>
<td>Anger</td>
</tr>
<tr>
<td>Excluding</td>
<td>Perceived difference</td>
<td>Feelings of hopelessness</td>
</tr>
<tr>
<td>Denying services to an individual</td>
<td>Fear</td>
<td>Low self-worth</td>
</tr>
<tr>
<td>Discriminating against someone</td>
<td>Competition over resources (e.g. health care or jobs)</td>
<td>Substance abuse</td>
</tr>
<tr>
<td>Prejudice</td>
<td></td>
<td>Self-destructive behaviour (e.g. not looking after health)</td>
</tr>
<tr>
<td>Physically attacking the individual</td>
<td></td>
<td>Lack of access to services such as health care</td>
</tr>
<tr>
<td>Chasing someone away</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Killing someone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Treat all sex workers with complete respect

This is an important reminder that all health care workers should treat patients in the same way they would prefer to be treated. Many health care workers have suggested treating sex workers just like you would any other patients. Take for example, the following quote from a nurse practitioner from Cape Town:
‘Instead of looking at the sex worker, I look instead at the woman. I see someone who is trying to work to provide for herself and her children. I myself am a mother and I know how hard that can be sometimes. When I see her like that, it doesn’t matter so much what she does for a living.’

Be careful to avoid using language that is stigmatising toward sex workers

It is common for sex workers to be described as ‘whores’ or ‘sluts’. This type of language is offensive and should not be used in a health care setting because it discourages sex workers from accessing care. You may find that this language is used by staff within the health care facility or from community members or other patients. Whoever uses this language should be discouraged in order to emphasise that the health care facility is non-discriminatory environment.

EXERCISE 6

Stigma in your workplace

Use the table you developed in Exercise 5 and brainstorm a way you can address each of the examples of stigma that you listed as occurring in your workplace. Take into consideration the cause of each example and how your solution would uniquely address that cause.

1. Are any of your personal values and beliefs that you developed in Exercise 2 associated with any of these examples?

2. Would you be able to realistically implement these solutions in your workplace?

3. If not, what barriers would you anticipate experiencing?

4. How could you overcome the barriers?

Lead by example or challenge stigmatising attitudes

Health care workers can influence their colleagues by leading by example and not treating sex workers disrespectfully. This can often be a reminder to other health care workers about the ethical standards that they should uphold within their position.

Additionally, if comfortable doing so, health care workers can actively challenge other counsellors or health care workers who show stigmatising attitudes to sex workers by providing correct information to them and
reminding them about the ethical responsibility they have to provide health care services to all people, such as this nurse from Cape Town:

‘I like to remind them [my colleagues] why they became a nurse. It is to help people. These women [sex workers], they are people too and they deserve our help.’

Get to know sex workers who frequent your clinic in order to break down stereotypes

Sex workers are an incredibly diverse population that is made up of people from all backgrounds. By making an effort to learn more about sex workers who are visiting a health care facility, new opportunities will be created that can challenge biases and misconceptions.

Training peer outreach teams to include sex workers

Many health care facilities employ some type of outreach or peer educator team. These teams work within communities to help facilitate the uptake of health care services. The sex worker community is often overlooked or is unable to be reached by these teams. This may be because sex workers work mostly in the evening, when peer educators are not available. Also, sex workers may work in parts of the community where peer educator teams do not want to go. When peer educator teams do engage with sex workers, they may be unaware of the best ways to educate them or connect with their circumstances. The best way to overcome these challenges is to include current or former sex workers within peer educator teams.

There are many benefits to including sex workers within peer educator teams. Mainly, they would be able to more easily connect with current sex workers in the community. They would also have a more in-depth understanding into the best ways to educate sex workers and address their needs. It may also be easier for sex workers to build trust with a peer educator who used to be sex worker, which would thereby increase the likelihood that sex workers would uptake services within the health care facility.

Make contact with sex worker-led organisations in your community

Review Appendix VI for the contact details of sex worker advocacy organisations in South Africa. Partnerships with sex worker-led organisations can greatly benefit health care facilities by promoting knowledge exchange, conducting trainings, acting as a referral partner for sex worker patients, and by acting as a local resource to answer questions regarding sex workers and stigma.
A stigma is defined as an attribute or quality that shames an individual or group of people in the eyes of another individual or group.

Stigma is a common experience for sex workers and impacts them in multiple ways.

The stigma experienced by sex workers can also lead to discrimination.

Sex workers who are HIV positive may experience the burden of double stigma, because they engage regularly in sexual activity and because of their HIV-positive status.

External stigma refers to how sex workers are treated negatively by others. Examples include gossip, being ignored, avoidant behaviour, judgement, abuse and violence.

Internal stigma refers to how sex workers feel and act because of external stigma. Examples include low self-esteem, depression, not seeking medical assistance, withdrawal from contact with people and suicide.

Stigma affects the health and wellbeing of everyone who is stigmatised and needs to be addressed.

Appropriate support and counselling can minimise the effects of stigma and assist sex workers in their well-being.

When working with a sex worker, a health care worker should (1):

- acknowledge his or her own personal experiences and history;
- consider and understand the cultural diversities of our country;
- be aware of personal attitudes and biases;
- recognise differences and exercise acceptance and tolerance; and
- understand how personal attitudes affect the quality of care.

Stigma in a health care facility can be addressed by:

- treating all sex workers with respect;
- avoiding the use of stigmatising language;
- providing correct information to colleagues about sex workers;
- holding colleagues accountable to non-stigmatising behaviour;
- including sex workers on peer educator teams;
- getting to know the sex workers that frequent your clinic; and
- creating partnerships with sex worker organisations.
Introduction

South African law has a significant impact on the lives of sex workers. The law can complicate the interactions sex workers have with health care workers. This can make service delivery to this population more challenging. In order to more effectively deliver services to sex workers, health care workers need to have a strong understanding of how South African law affects how they provide services and how sex workers engage with them. This module will review South African law and discuss its impact on both sex workers and health care workers. Through exploring these laws, health care workers will gain a better understanding of their legal obligations and receive suggestions on how to more effectively support sex workers.

Learning outcomes

By the end of this module, you should be able to do the following:

i Discuss the laws that protect sex workers’ right to health care
ii Understand the ways in which laws can impact a sex worker’s access to health care
iii Describes the ways in which South African laws impact health care service providers
iv Provide examples of ways in which a health care provider can support a sex worker
Is sex work illegal in South Africa?

Sex work is illegal in South Africa. This means that it is an offence to sell sex, buy sex, and to engage in other sex work-related behaviour (under the Sexual Offences Act 23 of 1957). Additionally, clients are criminalised (according to the Criminal Law: Sexual Offences and Related Matters Amendment Act 32 of 2007), and brothels are criminalised (under the Business Act 71 of 1991) in South Africa. South Africa is, however, in a state of law reform, with many of the apartheid-era laws that govern sex work under review. These proposed revisions follow many international settings in which sex work is decriminalised or legalised.

Is providing health care to sex workers illegal?

Even though sex work is illegal in South Africa, it is not illegal to provide health care services to sex worker patients. In fact, a sex worker’s right to health care is protected by the South African Constitution. Section 27 clearly states that everyone has the right to access health care services, and that no one may be refused emergency medical treatment. Also, other parts of the Constitution more broadly address a sex worker’s right to access care. For example, Section 10 states that everyone has ‘inherent dignity and the right to have their dignity respected and protected’.

Sex workers and their right to access care are further protected by other South African laws. The Sexual Offences act enforces the right of everyone to access PEP, and the National Health Act of 2003, further promotes the right of everyone to access medical treatment.

Are health care workers required to provide medical care to sex workers?

All South Africans are equal before the law and the South African Constitution binds all branches of government, including public health care settings, to ‘respect, protect, promote, and fulfil’ the obligations set out in the bill of rights. This means that it is every health care worker’s duty to provide to sex workers the same care and treatment that he or she provides to other patients. Health care workers may have personal beliefs that make providing care to sex workers challenging for them. It is important that health care workers see all sex workers as human beings who deserve fair treatment, and not as powerless victims or irresponsible criminals.

Unfortunately, this is not always the case, and many situations arise in which sex workers are unable to access or are denied care. Sex workers have reported situations where health care workers refuse treatment, provide inadequate treatment, and make very abusive remarks when discovering or even sus-
pecting the person is a sex worker. In some cases, critical prevention and treatment tools are withheld, including PEP, emergency contraception, STI treatment, drug treatment, and condoms and lubricants. Without these critical services sex workers may experience unwanted pregnancies, are at increased risk for getting infected with HIV, suffer with untreated STIs or engage in unsafe sexual practices without condoms or lubrication.

Are health care workers required to report a patient to the police if he or she is a sex worker?

Sex work may be illegal in South Africa, but South African law does not require that a health care worker report a patient to the police who has admitted to practising sex work. Section 54 of the Sexual Offences Act addresses the requirements for reporting sexual offences. It only requires reporting of sexual offences involving minors and people with disabilities. Therefore, health care workers are free to provide services to adult sex workers without being required to report them to the police.

How does the illegality of sex work affect the health of sex workers?

The fact that sex work is illegal in South Africa can create a variety of situations that negatively affect sex workers more than the general population. Health care workers should be aware of the following factors when working with a sex worker patient:

Lack of disclosure

Many sex workers are afraid that if they disclose their occupation as a health care worker they will be arrested. This is a critical dynamic for health care workers to understand in order to provide more effective care. If a patient does not disclose to a health care provider that they are engaging in sex work, then the health care worker will not be able to provide the most effective care. For example, if a sex worker is raped by a client, he or she may need to access PEP. If the sex worker is unwilling to disclose his or her occupation, he or she may be unwilling to share this experience with a health care worker. As a result, the health care worker would be unaware of the sex worker’s potential need for PEP. In this circumstance, because the sex worker was unable to disclose his or her status, the patient was unable to access an important HIV prevention tool.

Self-esteem and seeking health care

Some sex workers may experience low self-esteem or see themselves as less worthy of care since their form of employment is illegal. This can result in sex workers not seeking care for a condition until it is significantly advanced.
Unsafe and unhealthy working conditions

Since sex work is illegal, sex workers are unable to report unsafe or unhealthy working conditions that could negatively impact their health. This is because, if they were to report the unsafe conditions, they would also have to disclose their status as a sex worker and could potentially be arrested. As a result, sex workers could face continual threats to their health because of their working conditions. This is an important factor for health care workers to keep in mind, as it could affect the treatment they need to provide. For example, sex workers have reported that police will confiscate their condoms, or use these as evidence that they are practising sex work. This can force sex workers into not carrying or using condoms in order to continue to work even though the risk to their health increases.

Violence and rape

Sex workers are at high risk for rape and other forms of violence, but have fewer options than the general population to seek help or support should this happen (1). Because sex work is illegal, a sex worker is unable to report to the police that he or she was raped or assaulted without risking being arrested. This means that both police and clients can assault sex workers with little worry of any repercussions. Sex workers frequently report being assaulted, raped and pepper-sprayed by police during their arrests, even though they do not resist arrest (2). In addition, sex workers report being detained by police in conditions which deprive them of medical treatment, which are unhygienic, without food or adequate bedding, suggesting a disregard for police standing orders and for the basic rights to which all detainees are entitled.

The illegality of sex work in South Africa also affects a sex worker’s health by increasing their vulnerability to violence in a number of ways. Sex workers around the world continue to be murdered at rates higher than the general population. In fact, in some places standardised mortality rates for sex workers are six times those seen in the general population (3). In Cape Town there have been many reports of sex workers being murdered. Due to the fact that they are mostly female, sex workers remain particularly vulnerable to all crimes of violence against women. The incidence of physical violence, including rape, is higher among sex workers than among the general population. Violence links with social stigma and discrimination in producing disempowerment, and in some situations learned helplessness, giving the sex workers the message that their life does not matter.
Consider the following case study and answer the questions below.

Faith is a 42-year-old lady from Mozambique who came to South Africa a year ago to work as a fruit picker on a farm in rural Limpopo. She paid someone in Mozambique to organise a job for her, and left her children in her home town with her mother so she could come to South Africa to work. Faith has no papers, because she crossed the border illegally with a group of other immigrants who had also paid the people smugglers. Faith was dropped off at the farm where a job had been arranged for her. Faith gets paid R100 a week for picking fruit, and she sends the money back to her mother in Mozambique to pay her children’s school fees. Faith tried to find work on another farm that pays the workers more, but because she has no papers the manager would not hire her. Another worker on the farm suggested that she try to sell sex to the male farm workers, who were also migrants living far from their wives. Faith started selling sex to the men on the farm, and sending back the money to Mozambique. Faith does not use condoms with her clients because she does not know where to get them from, as the farm she works on is far from the nearest clinic. One night Faith was beaten up badly and raped by one of her clients, who was very drunk and refused to pay her. She decided to report the case to the police in the nearest town, and ask the police to help her get to a clinic. When she got to the police station, she had trouble reporting the case, as her English is very poor. The duty officer laughed at her, calling her a mkwerekwere, and making jokes. The officer asked her for her papers, and when Faith failed to produce a valid permit, the officer said that if she had sex with him, he would let her go without arresting her.

1. Were any of the sex worker’s rights violated? If so, which ones?
2. If you found yourself in this situation, how would you respond?
3. What options can you think of for this sex worker to report this misconduct?
Unfair treatment by authorities

Besides violence perpetrated on sex workers by the police, sex workers also report unfair treatment by the police. Sex workers are often arrested on local bylaws such as loitering, and then held by the police without charge. While they are in police custody, they may not be given access to their medication. This is a serious problem for sex workers who are HIV positive and need access to their antiretrovirals (ARVs). It is important to say that not all police treat sex workers badly, but unfortunately it is common. Sensitisation training for the police on the specific needs and vulnerabilities of sex workers would be beneficial.

Lack of documentation

The lack of access to documentation, such as identification (ID) books, negatively impacts some sex workers. This is particularly the case for sex workers from outside South Africa, some of whom may be illegal immigrants. ID books also pose a challenge for transgender sex workers, whose gender identity may differ from the biological sex recorded in their ID book.

How can a health care provider assist a sex worker patient who is experiencing these problems?

As a health care worker, it is important to recognise the negative impact that police and client abuse, unsafe working conditions, and violence can have on the health of a sex worker. In these circumstances it would be most appropriate for a health care worker to do the following:

Engage with the sex worker and provide them an opportunity to explain their experiences. This would give the provider an opportunity to assess the possible services that the sex worker may need. This may include the prescription of PEP, ARVs or counselling services.

Provide treatment for any wound injuries if a sex worker has been assaulted. Additionally, support their referral to services outside the scope that may be provided. Module 7 provides further details regarding the provision of services to sex workers.

Provide unbiased care in support of the sex worker. It is not uncommon for health care workers to perceive assault, such as rape or physical violence, as inevitable consequences of engaging in sex work. Further still, some health care workers may let this bias affect the level of service that is provided to a sex worker. It is the responsibility of every health care provider to give unbiased support to each of their patients. Module 2 on Stigma and Module 7 on Providing Effective Services offer a variety of strategies that can be used to provide unbiased care.
SUMMARY AND RECOMMENDATIONS

- Sex work is illegal in South Africa, but providing health services to sex workers is not.
- South African law requires that all health care providers deliver equal treatment and unbiased care to sex workers.
- Because sex work is illegal, sex workers may be unwilling to disclose information to health care workers, thereby limiting the services that can be provided to them.
- Sex workers’ health may also be impacted by violence, rape and unsafe or unhealthy working conditions, as their ability to report these circumstances is inhibited because of fear of arrest.
- Health care workers are not required to report sex workers to the police.
- Health care workers should probe sex worker patients to determine if they have been exposed to any human rights abuses that could impact their health.
- Health care workers should be aware of referral services and partners in order to connect sex workers with other care services.
Introduction

Providing effective medical care for sex workers means testing, treating and discussing HIV and STIs frequently with patients who engage in sex work. Given that sex workers experience a unique susceptibility to HIV and STIs, they need to be provided with risk-reduction counselling that fits their unique circumstances. Sex workers should also be provided with tools to protect themselves and their clients from HIV and other STIs. Health care providers should be well equipped with information and strategies that can support HIV prevention and treatment within the context of sex work. This module will provide an overview of such strategies, as well as describe common sexual risks of sex workers and discuss useful risk reduction techniques.

Learning outcomes

By the end of this module you should be able to do the following:

i. Explain why sex workers are vulnerable to and may have difficulty in preventing HIV and other STIs
ii. Describe ways in which sex workers can reduce their risk of HIV and other STIs
iii. Understand why it is important for sex workers to test for HIV and STIs regularly
iv. Describe the types of lubricant, what they are used for, and why they are important for sex workers
v. List current, new and potential HIV prevention tools that are available to sex workers
How are sex workers exposed to HIV and other STIs?

Sex workers, like everyone else, are exposed to HIV and other STIs through the exchange of bodily fluids, which includes blood, vaginal fluid and semen. This exposure is most likely to occur from direct contact during penile-vaginal, penile-anal, oral-penile or oral-anal sex with their clients. For more detailed information regarding HIV and STIs, please review Appendix I.

Are sex workers at increased risk for HIV infection?

Not all sex workers experience the same level of risk for HIV infection. Like the general population, their risk for HIV infection is dependent on the types of sexual acts they engage in with clients. Ultimately, it is not sex work as a profession, but rather the act of unprotected anal and vaginal sex, that puts sex workers at risk. Therefore, a sex worker who always uses condoms will be at less risk for HIV infection than a sex worker who never uses condoms. Sex workers do, however, encounter many pressures and daily risks when they provide services to clients. Therefore, they may be more likely than the general population to not use condoms during penetrative vaginal or anal sex, or to engage in sex while they have active STIs, thereby increasing their risks.

It is important to note that there is higher prevalence of HIV and STIs among sex workers and their client networks—which is even more of reason to make sure that every act is protected or risk is at least minimised.

 DIFFERENCES BETWEEN PENILE-ANAL AND PENILE-VAGINAL SEX

<table>
<thead>
<tr>
<th>Penile-Anal Sex</th>
<th>Penile-Vaginal Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>No natural lubrication in anus</td>
<td>Vagina produces natural lubrication when sexually aroused</td>
</tr>
<tr>
<td>Anus has limited elasticity</td>
<td>Vagina has elasticity and stretches</td>
</tr>
<tr>
<td>Colon and rectum only a single layer of epithelial cells (one cell thick)</td>
<td>Vagina much thicker epithelial layer (approximately 40 cells thick)</td>
</tr>
<tr>
<td>Tears easily with no lubrication</td>
<td>Vagina does not tear as easily, and is more robust</td>
</tr>
<tr>
<td>Presence of faecal matter possible (containing bacteria)</td>
<td>No faecal matter present</td>
</tr>
<tr>
<td>Many inflammatory cells (CD4 receptors) under surface in rectum</td>
<td>Fewer CD4 receptor cells in vagina than rectum</td>
</tr>
</tbody>
</table>
EXERCISE 1

Why engage in risky behaviour?

We all make hundreds of decisions on a daily basis. At some point, everyone makes a decision that results in engaging in a dangerous or harmful behaviour. Likewise, sex workers also have to make daily decisions about the types of activities in which they engage. Like the rest of us, there are always psychological, economical and social reasons for making decisions that could lead to risky actions.

To better understand why sex workers may be encouraged to engage in risky behaviour, think of a time that you engaged in a behaviour that may have been harmful to you. Use the list below for ideas, or think of your own. Think about why you took a chance.

- Smoking cigarettes
- Unprotected sex
- Driving while drunk
- Driving over the speed limit
- Using drugs
- Crossing the road when the light is red for pedestrians
- Placing a baby or child in the front seat of the car
- Eating a lot of fried food
- Walking alone at night in the street
- Not brushing one’s teeth
- Exercising less than three times per week
- Being very drunk

1. What were some of the reasons you took a chance a risky behaviour?

2. Did it have to do with pressure from another person?

3. Was it because you felt like there were no other options?

4. What factors played a role?

5. What are some of the reasons you think sex workers engage in risky behaviour?

6. How do they relate to your own reasons?
Why would sex workers engage in unsafe sex?

In order for sex workers and their clients to be protected from becoming infected with HIV through sexual intercourse, condoms need to be used during every sexual encounter. However, one of the risks that sex workers face when engaging in sex work is the reality that they may be unable to use condoms. This can occur for many reasons, such as the following:

**Client pressure.** There is often pressure from sex workers’ clients to have ‘live’ or ‘skin to skin’ sex (i.e. without condoms). Clients use many arguments to try to persuade sex workers to have sex without condoms: they argue that it will decrease their pleasure; that they will not be able to maintain an erection; that it will take them too long to orgasm; or that they might not be able to orgasm at all. Alternatively, they may assure sex workers that they are HIV negative.

**Financial incentive.** Clients often offer more money for sex without a condom or may not engage a sex worker unless they have sex without a condom. This can put sex workers in a challenging situation because sex work is competitive and sex workers have to find ways of repeatedly attracting clients, and getting them to return. If a sex worker insists on using a condom with a client who does not want to use one, they risk losing the client and their business. They therefore have to devise strategies to get and keep clients. Sometimes sex workers are aware that they are taking a chance – but weigh that up against the opportunity to make more money – short-term reward versus the chance (and statistically, it is only a chance) of a possible long-term negative consequence. In addition, clients do generally ejaculate quicker without condoms, and in sex work, time is money. Thus the quicker the client ejaculates, the quicker money can be made. Sex workers may also aim to exit the industry and tell themselves that taking short-term risks will enable them to make more money and exit quicker.

**Rape and violence.** In some cases, clients may use coercion and violence to force sex workers to have sex without a condom. Clients are not the only threat. Sex workers are also at risk of being raped by others, particularly by police and by intimate partners. Stigma against sex workers and the perception that ‘sex workers can’t be raped’ deters sex workers from reporting these crimes against them. In situations where women are forced into sex work, including cases of human trafficking for the purpose of sexual exploitation, they do not have control over their circumstances, including whether or not to use condoms.

**Existing HIV infection.** Sex workers who are already HIV positive may have a fatalistic attitude, reasoning that they are already positive, not understanding the fact that they can be reinfected with another, possibly more virulent strain of HIV.
Mental health and substance abuse. Studies show that people who suffer from depression and other mental health problems are less likely to practise safer sex (1). In addition, sex workers who use drugs and alcohol to cope with the stresses which are part of sex work, or to lose their inhibitions, are more likely to agree to have sex without a condom, use a condom incorrectly or agree to high-risk behaviours.

Condom breakage. Most sex workers have had the experience of condoms breaking. There are several reasons why condoms break, but the most common reasons seem to be poor quality condoms, expired condoms, condoms not being large enough, rough sex and the use of oil-based lubricants with male latex condoms.

WHAT IS LUBE?

Lubrication or ‘lube’ is a specialised jelly-like substance that helps reduce the friction between body parts. Lube can be applied to a penis, hand, inside a vagina, or inside a rectum before engaging in a sexual act in order to facilitate movement during sex. Lube is especially necessary for anal sex, since the anal canal does not produce any natural lubrication, or for vaginal sex if the vagina is dry and not producing natural lubrication. During dry sex, when no lubrication is present, the friction created by the movement between the vagina and penis or anus and penis can cause the penis, vagina, or rectum to be torn or bruised even to the point of bleeding, exposing the underlying cells to HIV or STIs. This friction during dry sex can also cause a condom to break. Lubrication helps prevent this tearing and thereby helps in reducing some of the risk and pain sex workers may be exposed to when engaging in unprotected sex.

Appropriate water-based lubricant, when used with male latex condoms, greatly increases the safety of the sexual encounter. However, in South Africa water-based lubricants are not widely available within the public health sector, and many sex workers are not familiar with them. Instead, many sex workers use other products which they have to on-hand as lubricants. Popular lubricants are Vaseline and baby oil. The problem with oil-based lubricants is that they frequently cause latex condoms to break.

There is also a myth that wearing more than one condom gives extra protection. However, two or more condoms may be more harmful than good. There is a chance of slippage and the condom may be left inside the partner. There is also a chance of air getting in between the two condoms and increasing the risk of the condom bursting.
For more information on the appropriate use of male and female condoms and lubrications, please see Appendix III.

**Intimate relationships.** Many sex workers consistently use condoms with their clients, but do not use condoms consistently with their regular sexual partners. For example, some people do not know that their partners are sex workers. Sex workers fear that if they tell their partners what they do for a living they will be rejected. They fear that if they request their partners to use condoms, they will be suspected of being promiscuous, and their secret will be discovered. Furthermore, not using condoms with intimate partners is a way of signalling that this is a different type of relationship than a sex work transaction, based on more than the exchange of sex for money.

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### VAGINAL PRACTICES

Vaginal hygiene practices are not often discussed, even between patients and health care professionals. However, these practices are fairly common. Some practices used by sex workers for the purposes of vaginal hygiene are actually not beneficial, and may indeed increase the risk of rashes and ulcers in the vagina, and consequently may increase the risk of HIV. In addition, some sex workers use products to dry out or tighten their vaginas, and these may also increase their risk. One reason for this is that, in sub-Saharan Africa, ‘dry sex’ is popular, as a dry vagina during intercourse seems to be equated with being young and innocent, whereas, a lubricated vagina is associated with being promiscuous. Sex workers report using various ‘home remedies’ including herbs, lemon juice, a cloth, cold water or antiseptics (such as Dettol) to dry the vagina.

> At least Dettol makes me dry always. I just pour it in my bath water and I believe it works because my clients always ask me if I am new in the field (2).

However, vaginal dryness places the woman at greater risk for HIV infection, as there is a greater risk of trauma to the vaginal tissue. The increased friction also increases the risk of the condom breaking (3).

**Lack of condom availability.** Access to safer sex materials is a key element of efforts to prevent HIV and empower people, whether HIV negative or living with HIV, to protect their health. Research conducted via interviews with sex workers in four African countries (i.e. Botswana, Uganda, Kenya and South
Africa) about their health and human rights found that many sex workers were unable to access enough condoms (4). The research found that condoms were sometimes available at brothels. In some hotels where sex work is practised, managers sometimes charge sex workers for free government-issued condoms or limit the number handed out to sex workers. There have also been reports of clinics limiting the number of condoms that sex workers may take. Other times, it may be the sex workers themselves that are embarrassed to ask for a lot of condoms, as they risk exposing themselves as sex workers. The story below is an illustration of this.

Me and my friend went to the clinic one day for condoms, and luckily that day the people distributing the condoms had just arrived, so they were taking them out in boxes. Because we were tired of having to come back for the condoms in small packs, we decided to just take two boxes each. The people who were delivering the condoms didn’t mind. They just joked with us about being ‘busy’, not knowing we are sex workers. Then the nurse said, ‘Obviously, they are sex workers. No one would take so many condoms. Why aren’t they taking them one by one? They are sex workers.’

Sex worker, Durban, November 2011

As far as the female condom is concerned, most sex workers who have experience with it find it very useful because it enables them to take control of their safety, and also because it is lubricated so additional lubrication is not needed. However, at present, the female condom is not available in all clinics, and where it is available it tends to run out quickly. Also, sex workers have reported that police may confiscate their condoms to use as proof against them that they are engaging in sex work. This practice may encourage sex workers to not carry condoms or bring fewer than they may need for an evening.

Lack of knowledge about condom use. The majority of sex workers are aware that condom use is necessary to protect them from HIV/AIDS. Sex workers also report that their clients are becoming increasingly knowledgeable about safe sex, as a result of safe sex education programmes in the workplace and elsewhere. For example, there are programmes aimed at educating men who work in jobs or areas where buying sex is relatively common (e.g. truckers, mine workers). This quote from a Hillbrow sex worker, Zanele, shows how important it is to educate both sex workers and their clients:

‘Most of our customers are aware of condoms now. They are getting peer education through their work. It definitely helps sex workers because less customers are asking for skin-to-skin sex.’
Nevertheless, there are still sex workers and their clients who do not understand the link between unprotected sex and HIV/AIDS; there are also myths which exist about aspects of sexual health. Sometimes, these myths are influenced by traditional beliefs and/or superstitions.

**RISK BEHAVIOURS – LOW, MEDIUM, HIGH**

**Low-Risk or No-Risk Behaviours**
Kissing, dancing, hugging, body rubbing and massage are no-risk behaviours for contracting HIV; mutual masturbation, if there are no cuts on the hand, penis, or vagina is very low risk.

**Moderate Risk Behaviours**
Oral sex without ejaculation is a moderately risky behaviour. Oral sex on a man is a higher risk than oral on a woman. The risk is increased when there are open sores in the mouth, or on the penis or vagina. Flossing and rigorous brushing before oral sex can cause small cuts in the gums, increasing the risk; mouthwash is an alternative. If there is ejaculate (cum) or vaginal blood present, oral sex is high-risk behaviour. Using a protective barrier such as a condom on the penis or a dental dam, a latex barrier that can cover the vagina or anus, can make oral sex a safer behaviour. Oral sex on the anus is very low risk for HIV, but like all unprotected oral sex has some risk for STIs; using a dental dam reduces this risk.

**High-Risk Behaviours**
Unprotected vaginal sex, anal sex and oral sex with ejaculate (cum) or vaginal blood are high-risk behaviours, as is using and sharing unsterilised drug injecting equipment. Unprotected oral-anal sex can also lead to hepatitis infection.

**How can sex workers reduce their risk of being infected by or spreading HIV and STIs?**

HIV and STI risk reduction refers to any action that can lower the chance of someone becoming infected by or spreading HIV or STIs. Common methods include remaining abstinent, staying faithful to one partner, always using condoms when engaging in sex, and lowering your number of sexual partners. These are useful tools for a variety of populations; however, for sex workers this is not the case.
Remaining abstinent, faithful to one partner, or lowering their number of partners would be challenging for most sex workers, since all sex workers rely on numerous clients (sexual partners) on a frequent basis in order to provide for themselves. Additionally, while some sex workers use condoms with every client, others may be pressured to engage in unprotected sex if a client offers them a higher price to do so. Again, since sex workers rely on the business from their clients for survival, should they be able to make more money through riskier sex, many sex workers might choose to do so.

These are significant barriers for sex workers in reducing their risk for HIV and STIs, and one of the reasons they are considered to be a highly at risk and vulnerable population. Even in these circumstances, however, there are strategies that will not reduce sex workers’ risks entirely but could provide some level of protection to them. These include the use of water-based lubricants, getting STIs treated, using PEP and reducing the level of bodily fluid that comes in contact with their bodies.

**Using male and female condoms**

Using latex male condoms or female condoms may be one of the most effective means for sex workers to prevent HIV and STIs. Unfortunately, clients of sex workers may insist on or force the sex worker to not use condoms. Male and female condoms can be used for penile-vaginal sex, penile-anal sex, and penile-oral sex. Female condoms, while providing the same protection as male condoms, offer a different experience that may be more acceptable to clients who insist on not using condoms. For penile-anal sex, a condom must be used in addition to lubrication.

For more information on the appropriate use of male and female condoms and lubrications, please see Appendix III.

**Lubrication**

One of the first ways that sex workers can reduce their risk is through the use of water-based lubricants, commonly referred to as lube. Lube typically is produced in two varieties, water-based lube and oil-based lube. Water-based lubricant is made from water-soluble materials, whereas oil-based is derived from oil. Both types of lube provide the same effect; however, only water-based lubes are designed to work with latex condoms. Oil-based lubrication will cause latex condoms to break during sex, and should never be used with latex condoms. Oil-based lubes or other oil-based products such as hand lotion, Vaseline or cooking oil should never be used with latex condoms. Both male and female sex workers should be provided access to water-based lubrication, informed of its usefulness, and made aware of the dangers of using oil-based lubes.
IDENTIFYING AN STI

Excerpts from the World Health Organisation guidelines for the management of STIs, 2003

The feasibility of providing STI case management must be ensured within any health care setting, whether within the public or private sector. An essential component providing STI case management is privacy for consultation. Facilities that are also required are an examination table or couch with adequate lighting, gloves, syringes, specula, sterilisation equipment and laboratory supplies.

For individuals seeking evaluation for an STI, appropriate care consists of the following components:

- Obtaining patient history, including behavioural, demographic and medical risk assessment.
- Physical examination, particularly of the genital area.
- Establishment of a syndromic or laboratory-based diagnosis.
- Curative or palliative therapy, using the most effective antimicrobial for the pathogen, at the first port of call of the patient.
- Patient education and counselling (where counselling services are available), including information on the following:
  - Compliance
  - Nature of infection
  - Importance of partner notification and partner treatment
  - Risk reduction and prevention of further STI transmission
  - HIV risk perception and assessment
- Clinical follow-up when appropriate and feasible.

There are four major components of STI control:

1. Education of individuals at risk on modes of disease transmission and means of reducing the risk of transmission.
2. Detection of infection in asymptomatic subjects and in subjects who are symptomatic but unlikely to seek diagnostic and therapeutic services.
3. Effective management of infected individuals seeking care.
4. Treatment and education of the sexual partners of infected individuals.

The prevention of STIs is based primarily on changing the sexual behaviours that put people at risk, and on promoting the use of condoms.
Getting tested and treated for STIs

Another method through which sex workers can reduce their risk of HIV and STI infection is through getting current STIs treated and cured. This is because STIs cause swelling and increased blood flow to infected areas, and infections which cause sores (or ulcers) break the skin's surface. The increased blood flow and broken skin make it easier for HIV and other infections to enter the body (5). If, for example, a sex worker was infected with gonorrhoea in her throat and provided oral sex to a male client who ejaculated in her mouth, she would be at increased risk because the open sores in the back of her throat would offer a channel through which HIV and other infections could enter.

If sex workers get screened, tested, and treated regularly for STIs, they may have the opportunity to treat new infections that could otherwise increase their exposure to other STIs. Sex workers should be made aware of the dangers of engaging in sex while STIs are present and active. If they are unable to abstain from sex until the STI is cured, they should be heavily encouraged to use a condom during this time.

Early and frequent testing of STIs is critical for sex workers because many STIs, particularly in women, do not show any symptoms and may not readily alert a sex worker to the need for treatment, while still increasing their risk for HIV infection.

Postexposure prophylaxis

Post-exposure prophylaxis (PEP) could help reduce a sex worker’s risk of HIV infection. PEP refers to a treatment that can be given to an HIV-negative person who was exposed to HIV within the last 72 hours. PEP first requires that an individual take an HIV test to determine their HIV status, since PEP is only effective for individuals who are HIV negative. It then requires the person to take a daily regimen of ARV drugs for 28 days. These drugs can cause side effects such as diarrhoea, headaches, nausea/vomiting and fatigue. Some of these side effects can be quite severe, and it is estimated that one in five people give up the treatment before completion (5). The aim of this regimen is to allow a person’s immune system a chance to provide protection against HIV, and to prevent HIV from becoming established in someone’s body.

PEP can be an effective means of preventing HIV infection for sex workers who may have been exposed to HIV because of sexual assault or a broken condom. The regimen must be strictly adhered to and should be distributed according to the guidelines of the health care facility that is administering it.
It is important for health care workers prescribing PEP to counsel their clients on the importance of drug adherence and on managing minor side effects of the medication, but to refer serious side effects for specialist care. Common side effects are temporary and can be relieved with standard medications against pain, fever, and nausea. Completion of the 28-day course is necessary for maximum efficacy of PEP medication.

For more information regarding biomedical HIV prevention and the use of ARVs to prevent HIV, please review Appendix V.

### HPV VACCINE

In addition to the testing and treatment of STIs, all sex workers should be encouraged to vaccinate against HPV, the human papilloma virus. If not already infected, this vaccine can help protect female sex workers from strains of HPV that can lead to life-threatening cervical cancer. Further information regarding HPV can be found in Appendix I.

All sex worker patients should be made aware of the benefits of the vaccine and additionally educated about the following symptoms that could indicate the presence of an STI:

- Burning urine
- Sores on the vulva, labia, vagina, penis, testicles, anus, or surrounding area
- Abnormal discharge (pus) from the vagina, penis, or anus
- Painful genitals—testicles (balls) or pubic region
- Swollen glands on the inside of the leg
- Growths on the labia, vulva, vagina, penis, testicles, anus, or surrounding area
- Pain or bleeding with defecation (bowel movements)
- New-onset painful vaginal or receptive anal intercourse
- Itchy genital area, vagina, labia, vulva, penis, or anus

For a more detailed review of common STIs and their syndromes, please refer to Appendix I.

### How can health care workers support sex workers to lower their risk?

Health care workers have a special opportunity to engage with sex workers and offer them tools, strategies and services that can significantly reduce their risk of HIV and STI infection.
**Encouraging and providing HIV and STI testing**

Since sex workers are at high risk for HIV exposure, they should be encouraged to test for HIV and other STIs as frequently as possible. (For more information on common STIs, see Appendix I.) A minimum of once monthly testing should be encouraged for every sex worker patient. Should sex workers be diagnosed with an STI or HIV early, and get treatment early, it could substantially decrease their risk of passing their infection on to others. Testing early can also lower their risk of developing long-term complications from the STI and improve their overall treatment options.

**Providing referrals for other services**

Health care workers may have limited time or resources to fully provide the range of services needed by sex workers; however, their needs may still be met through referral to care. Support for mental health issues and reproductive health are strong examples of services that may require referral for more extensive care. Module 6 will cover mental health in more detail, and Module 7 will provide more insight into providing services and referrals for sex workers.

**Providing education**

Each engagement with a sex worker in a health care setting offers an opportunity to ensure that they are fully educated and aware of HIV risks and the prevention tools available to them. Health care workers should take this opportunity to provide facts and support to sex workers.

Furthermore, health care workers should educate sex workers by dispelling common misconceptions or myths associated with HIV. For example, it is a common misconception that HIV-positive individuals do not face any risk if re-exposed to HIV after they have become infected. This is known as HIV reinfection and, unfortunately, it can significantly reduce future treatment options as well as increase a patient’s viral load. Many HIV-positive sex workers are at significant risk for HIV reinfection because they may be unaware of the consequences and forced to engage in unprotected penetrative sex.

Health care workers should also actively work to educate sex worker patients against the dangers of infecting their clients. If a sex worker is HIV positive, he or she risks infecting the client if they have unprotected sex. Should their client have other sexual partners, such as a wife or girlfriend, the client could then risk spreading the infection onward as well. HIV-positive sex workers can play a critical role in the prevention of HIV by minimising opportunities for the secondary transmission of the virus.
Providing counselling

Many health care workers may assume that sex workers should be counselled to discontinue sex work. However, this is highly ineffective and discouraged. Sex workers rely on the income from sex work for survival and are unlikely to discontinue sex work easily. A more effective method of supporting sex workers is to provide risk-reduction counselling in order to assist them in reducing their risk behaviours.

EXERCISE 2

Risk reduction assessment

Consider the risk reduction strategies detailed in this module and answer the following questions:

1. Which of these risk reduction methods does your clinic/health care centre provide?

2. Are these services available to sex workers in your clinic? If so, do you think they are offered in such a way that a sex worker would feel comfortable accessing them?

3. If not, how would you suggest improving these services or making them accessible to sex workers?

What is risk-reduction counselling?

Risk-reduction counselling is a behavioural intervention that attempts to decrease an individual’s chances for acquiring HIV or other STIs. This is achieved by helping people identify and change specific behaviours that may put them at risk for becoming infected and by reinforcing healthy behaviours.

The main objective of risk-reduction counselling is for patients to set realistic goals for behaviour change that could reduce their chances of contracting or transmitting HIV. As a prevention tool, risk-reduction counselling is the most effective when it is patient-centred, meaning that the counselling session focuses on the specific risks, needs and thoughts of the individual patient. Risk-reduction counselling can easily be conducted during an HIV test or during a medical consultation, and can be adapted to any patient.
How can risk-reduction counselling be applied to sex workers?

Risk-reduction counselling should be conducted with sex workers just like any other patient, as long as it takes into account their specific needs, background and challenges. Therefore, each risk-reduction counselling session will be unique and require different strategies and approaches. While there is no standardised risk-reduction model specifically for sex workers, there are a number of factors that can influence a risk-reduction session with a sex worker.

Confidentiality

The first and most important influencing factor is confidentiality. Fundamental to providing ethical care for any patient is to keep strict confidentiality at all times. This is true for sex workers in particular, because they may or may not be open about the profession to the general public. Should their identity as a sex worker be made public, they could face significant stigma and discrimination. For more information about stigma and discrimination, please see Module 3: Sex Work and Stigma. Guaranteeing confidentiality with sex worker patients may also encourage them to be more direct and open regarding their sexual practices. This will provide a significantly more effective platform from which to conduct a risk reduction session.

Being non-judgemental

Another significant factor that can influence a risk-reduction session with a sex worker is the personal beliefs of the health care provider conducting the session. Stigma was discussed in Module 3. Health care workers’ personal bias and stigma can negatively impact the level of service that they can give. It is therefore essential to conduct a risk-reduction counselling session with an open mind and to direct the session toward the risks identified by the patient.

Creating an enabling environment

Health care workers need to create a caring and welcoming environment where patients feel comfortable to discuss their risk behaviour and sexual practices. This can be achieved by emphasising to the patient that participation is voluntary. Additionally, using caring and non-confrontational language is helpful. Many patients may not disclose their risk behaviour due to fear of embarrassment. In these cases, helping to normalise their behaviour can assist in helping the patient to discuss further.

For more detailed guidance on risk-reduction counselling, see Appendix II. Risk reduction counselling can help sex workers identify various ways that they can reduce their risk for HIV and STIs.
EXERCISE 3

Case study

Consider the following case study about a sex worker from Cape Town and answer the following questions.

Monica has been doing sex work for 14 years, and while she has occasionally had unprotected sex with clients, she understands the necessity of using condoms, and normally does so. Last month, the police and the neighbourhood security committee implemented a campaign to clear the area of sex workers where Monica works. So Monica instead went to a hotel in the next precinct, which is a sex worker hot-spot. She was soon offered a room by a bouncer in the hotel, on condition that she provide him with sexual services. Monica used a condom but, after intercourse, Monica noticed that the condom had broken.

By Monday morning, Monica noticed that her vagina was itchy. She visited a mobile clinic run by an NGO, but did not tell the nurse that the condom had broken; she only mentioned her symptoms. She was not sure how the nursing sister would respond to her story of the condom breaking, and worried that she might interrogate her or discover that she was a sex worker. Monica was also worried that nursing sister would reprimand her for being irresponsible.

Two weeks later, Monica was feeling nauseated and weak, and she had missed her period. She feared she was pregnant, and decided to go for a pregnancy test. Monica goes to a local sex worker advocacy group, where they refer her to a friendly clinic. They did a pregnancy test, which was positive, and booked Monica for a termination of pregnancy at her request. They also tested her for HIV and STIs, for which she tested negative. However, Monica knows that she is in the window period for HIV infection, and she is worried.

1. What are Monica's risk behaviours? Can you identify other facilitators that increase her risk?
2. What strategies would you suggest to Monica in order to reduce her risk?
3. Can you identify any barriers or challenges that Monica may face in trying to access health care?
4. Use the above scenario to role play a risk reduction counselling session if you have a partner available. Switch roles after completing the first session. Consider which methods you found the most effective and useful when counselling Monica.
SUMMARY AND RECOMMENDATIONS

- There are many circumstances in which sex workers engage in high-risk sex and have limited opportunities to protect themselves properly from HIV and STIs.
- Health care providers should educate sex workers about the risk of HIV transmission and engage all sex worker patients in risk-reduction counselling.
- Risk reduction for sex workers must take into consideration their unique circumstances, and health care providers should work within those circumstances to encourage the sex worker to identify areas where risk can be reduced.
- Sex workers may not always be able to reduce their number of partners or use condoms with each sexual act. Therefore, they should be encouraged to test for HIV and STIs regularly, use water-based lubricants, and seek PEP if they are eligible.
- The Wits Reproductive Health Institute has developed the following recommendations for all health care workers (6):
  - Test sex worker patients for HIV and STIs.
  - Emphasise that the only protection against HIV is consistent and proper condom use.
  - Explain the effects of unprotected sex, and that a burst or slipped condom is the same as unprotected sex.
  - Encourage the use of lubrication and continual checking to make sure the condom is still in place.
  - Explore ways to encourage the use of condoms through using marketing skills to sell the idea of safe sex to clients.
  - Explain why STI treatment and testing is important and how it can contribute to the reduction of HIV transmission.
  - Discuss issues around rape and sexual assault, including PEP.
  - Explain why HIV testing is advantageous and emphasise the need to repeat HIV tests.
  - Encourage HIV-positive sex workers to get regular check-ups and CD4 counts, as well as treatment for opportunistic infections.
  - Explain the benefits of ART and the importance of knowing one’s status.
MENTAL HEALTH AND SEX WORK

Introduction

Mental health issues such as anxiety, depression and substance dependency affect many people in the general population. These issues can influence a person’s well-being and many other parts of their lives. Mental health issues can affect a person’s ability to do his or her job and may even lead to other health problems.

Mental health issues can also affect sex workers, like the general population, but because of the nature of sex work they may be made more vulnerable to mental health issues. Additionally, because of the risks associated with sex work, there may be greater consequences associated with mental health issues.

Understanding the ways in which sex workers can be affected by mental health, and the ways it affects their lives, can support a better interaction with health care providers. Therefore, this module will provide an overview of common mental health problems that can occur as a result of sex work, discuss the importance of mental health service provision for sex workers, and explore the impact that mental health has on the overall health of sex workers.
Learning outcomes

By the end of this module, you should be able to do the following:

i Define and list the common symptoms of anxiety, depression and substance abuse
ii Explain why sex workers may be more vulnerable to anxiety, depression and substance abuse
iii Explain how to support a patient who suffers from anxiety, depression and substance abuse
iv Discuss what substances are commonly used in your community, what they are called, how they are taken, and their effects
v Explain how substance abuse increases the risk of contracting HIV among sex workers

Do sex workers engage in sex work because they are mentally ill?

It is a misconception that sex workers engage in sex work because they are mentally ill. Individuals engage in sex work for a variety of reasons, the most common of which is because sex work provides an income and financial support. Module 1: Introduction to Sex Work and Module 2: Common Behaviours of Sex Workers further explore these reasons.

Are mental health issues common among sex workers?

Mental health issues are common among sex workers because they are regularly exposed to many factors that can result in the development of a mental health illness (1). Mental health illnesses develop for many reasons, but in some circumstances they can be related to events that a person continually experiences in his or her life. Often, events that lead to mental health illness are those that result in continued stress, violence, instability and/or trauma.

The issue of mental health is relevant to sex workers because sex work can often occur under poor working conditions and environments. These conditions are unable to be regulated because sex work is illegal in South Africa. Therefore, sex workers are continually and regularly exposed to unsafe and dangerous environments that can lead to the following:

Stigma and Discrimination

- High levels of internal and external stigma
- Discrimination in health care settings and in the community
- Hardship in accessing health care
• Difficulty in getting identity documentation and other legitimate privileges afforded to others
• Family rejection
• Substance abuse

Violence and health vulnerability

• Unsafe work spaces and a lack of civil, social and public health protection (2)
• Extreme forms of violence, including police abuse, interpersonal violence, and violence from clients, partners and the community
• Increased vulnerability to HIV and STIs

If an individual experiences any of the above, he or she is more likely to develop a mental health issue. It is common for sex workers to experience many of these factors at the same time, which results in mental health issues being common among sex workers.

A final factor that can lead to the development of mental health issues in sex workers is the reality that sex workers may be regularly exposed to traumatic events.

How do traumatic events impact the mental health of sex workers?

A traumatic event is any experience that is significantly emotionally disturbing or distressful. Traumatic events may provoke extreme emotions, thoughts and behaviours. A traumatic event differs from a common negative experience in that it generally leaves a lasting mental and emotional impact. Unlike the general population, traumatic experiences can be very common for sex workers. Consider Sipho’s experience in Port Elizabeth.

Sipho is a sex worker who regularly spends his evening with other friends in a common part of town known to be good for picking up clients. One evening Sipho witnesses his friend get into a fight with a client who refuses to pay him. The client violently attacks his friend and eventually stabs him to death. Sipho has trouble going back to that spot and as a result is not finding as many clients. Weeks later, Sipho is struggling to leave his home because of feelings of overwhelming fear.

Sipho experienced a traumatic event when he witnessed his friend’s death, and is likely suffering from depression because of it. Witnessing death is one of many examples of traumatic episodes that sex workers may experience regularly. Other examples of traumatic events include police harassment, rape, torture, trafficking, physical or sexual assault, corrective rape (the rape of a gay or lesbian person by someone who believes they can ‘correct’ the victim’s sexuality), or child abuse. For the general population, a person may
experience one or two of these traumas in their lives, but because of the nature of sex work, sex workers may likely experience them all. Additionally, unlike other populations, sex workers may then be challenged with finding effective care and counselling to deal with the trauma.

**What are the common effects of trauma?**

The effects of trauma can result in various symptoms ranging from physical to emotional. Some effects that may be evident in sex worker patients follow:

- Difficulty in sleeping or nightmares
- Irritability
- Actively avoiding any reminders of the event
- Developing various phobias or fears that were not present beforehand
- Withdrawing socially from others
- Using alcohol and drugs to numb feelings

Most significantly, traumatic events, especially when experienced over a period of time, are one of the causes of depression, anxiety and substance abuse among sex workers.

**What is depression?**

Depression refers to a prolonged period of where a person experiences a low mood. It is ordinary for most people to have ‘ups and downs’. Someone may feel miserable on a Monday morning, but very happy on payday, or their birthday, for example. When depression is talked about, however, it refers usually to a ‘down’ that is normally longer and more intense than just a bad mood. There are many symptoms of depression. Signs and symptoms of depression may include the following:

- Feeling sad
- Being unable to enjoy things that would usually be pleasurable
- Feeling apathetic and lacking motivation to act
- Feeling hopeless
- Feeling lonely and cut off from other people
- Feeling tired and having no energy
- Feeling worthless, guilty, or bad about oneself
- Sleeping poorly – either sleeping too much or too little
- Experiencing a change in eating habits – either eating too much or too little
- Contemplating or planning suicide
- Having difficulty concentrating and poor memory retention
- Experiencing changes in patterns of sexual behaviour
- Having suppressed rage or anger
Even a few of these symptoms, if severe, can lead to difficulties in day-to-day functioning and can significantly impact sex workers.

**What is anxiety?**

Anxiety is a normal emotion in everyday life and is closely related to fear. It has been around as long humans have had to defend themselves from wild animals. Anxiety prepares the body by involving other organs, like blood, lungs and muscles, which then enable the ‘fight or flight’ response.

In our everyday lives, anxiety in small amounts helps us perform better, for example, in exams (3). Anxiety affects not only how a person feels, but also how he or she thinks and processes his or her thoughts. At the extreme, all these components of anxiety can reinforce each other in a vicious spiral leading to the experience of immense fear, often leading to panic (or a panic attack) whereby a person experiences intense apprehension and a sense of not being in control, and where feelings of unreality in relation to themselves or the world may occur. When people feel anxious they may exhibit mental (in the mind) and physiological (in the body) signs and symptoms (3).

Anxiety can manifest symptoms both mentally and physiologically. Mental aspects can include fear, uneasiness and worry. Physiological aspects can include sweating, shaking, heart racing, nausea, pins and needles, dizziness, shortness of breath, feeling of choking, chills or hot flushes.

**How do depression and anxiety affect sex workers and their overall health?**

Depression and anxiety can have many negative effects on sex workers. As mentioned earlier in this guide, sex workers rely on income from clients in order to provide for themselves. If a sex worker is unable to work because he or she is depressed, too anxious, or lacks motivation or self-esteem, the sex worker is then unable to earn a living. Furthermore, for HIV-positive sex workers, depression can affect adherence to treatment which has a significant impact on their overall health. If a sex worker is depressed, he or she may be less motivated to practise safe sex with a client, and could potentially get into a risky situation. Anxiety can limit a sex worker’s willingness to engage with others, which may include health care service providers. It may even minimise the sex worker’s ability to work, see clients and support himself or herself. Some people who experience high levels of anxiety or depression may further be encouraged to turn to alcohol and other substances to cope with or numb their intense feelings so that they can return to work even in face of the anxiety and depression.
**Why do some sex workers use substances?**

Not all sex workers engage in substance use. However, as described above, some turn to substances like alcohol, dagga (cannabis), tik, cocaine or heroin (see glossary for definitions of these) in order to numb the feelings of anxiety or depression that may have resulted from experiences they had while working. Other sex workers may engage in substance use because it in some way makes their jobs easier to do by lowering their inhibitions or by making them more social. Still other sex workers may engage in substance use at the encouragement of their partners, pimps or managers. Some managers will use drugs and substances as a way to further exert control over their sex workers. A manager may typically get his or her sex workers addicted to drugs, which makes the sex workers even more dependent on him/her, because he/she has now become their drug dealer in addition to their manager. This enables the pimp to exert control over the sex workers, reduce the amount of income that he/she gives to the sex worker, and encourage or force them to engage in sexual acts with clients that the sex workers otherwise would not.

Abuse of drugs and alcohol can make sex workers more vulnerable to HIV and STIs because it may cause them to engage in riskier sexual behaviour, such as not using condoms, not worrying about consequences or outcomes of their actions, or by feeling an inflated sense of courage and fearlessness.

On top of this, the use of substances can create additional stigma for sex workers in the community and in health care settings. Module 3 further discusses the effects of double stigma among sex workers.

**How does drug dependency affect sex workers?**

Drug dependency is a complex and often chronic brain disease. It occurs when the use of a drug dominates a person’s life and becomes a compulsive behaviour that is hard to control. When a person is experiencing drug dependency, he or she has extreme difficulty in resisting the urge to use drugs despite the negative consequences and harmful effects. Drug dependency is considered a mental illness because it changes the chemistry of the brain, which leads to changes in an individual’s behaviour. This is due to changes in the brain structure and function, which then leads to taking the drug despite the negative consequences. These changes occur in some of the same brain areas that are affected by other mental disorders, such as depression, anxiety or schizophrenia.
Common signs of drug dependency

- Drug seeking behaviours (obtaining the drug from multiple doctors, illegally obtaining the drug)
- Cravings for the drug
- Preoccupation with obtaining the drug
- Misusing the drug for intoxication or pleasure
- Dependence and withdrawal upon stopping the drug
- Interference with normal life functions (decreased work productivity; decreased motivation; social, family, and relationship problems)
- Continued use despite negative consequences

Drug dependency is challenging to overcome and it should not be expected for a sex worker to be successful at the first attempt to quit. In fact, overcoming drug addiction may take months or years and often requires continuous attempts involving methods such as therapy, support groups and self-exploration (4).

Drug dependency can particularly affect sex workers. Often, in order to sustain their drug addiction, sex workers will engage in high-risk activity such as unprotected sex. Additionally, drug addiction can make the treatment of other health-related issues more difficult to treat. For example, if a sex worker who is HIV positive develops an addiction to tik, he or she may be less likely to take ARVs regularly. This makes the sex worker’s treatment more challenging, and also promotes the spread of HIV through secondary infections.

How can health care workers support mental health issues among sex workers?

Mental health is a critical factor in the successful treatment of sex worker patients. It can influence other tools that are being implemented and inhibit other treatments or therapies that may be provided. Health care workers may have varying levels of capacity to manage mental illness. Comprehensive mental health support may be beyond the scope of many general health facilities, but there is still a lot of support that can be given by health care workers.
What can a health facility do to support mental health issues among sex workers?

- Provide sex workers with a welcoming environment in which they feel comfortable to disclose information to a health care worker.

- Encourage sex workers to engage honestly. Health care workers will then have the opportunity to gather more information regarding their circumstances and be better equipped to refer the patients for more significant care.

- Health care workers should be familiar with referral pathways that are available in their community. They will then have the capacity to connect sex workers with mental illness to effective mental health services.

- Health workers should be educated on the presence and impact of mental illness in the lives and health of sex workers.

- Health care workers who have an opportunity or the resources to deal first hand with mental illnesses should conduct a non-judgemental and thorough psychological assessment on all sex worker patients in order to establish a feasible treatment plan. Sex worker patients should be continually monitored throughout their treatment in order for them to cope with the effects of their mental illness.

- Health care workers should take into consideration the impact that mental illness may have on any other treatment they are providing to sex worker patients. For example, sex workers with mental illness may be neglectful in taking long-term medication or may find it difficult to return to a clinic for follow-up visits. These factors should be considered when developing a care and retention plan for a sex worker patient.

- Attempts should be made to link sex worker patients with supportive psychotherapy or other related services that may be available.
SUMMARY AND RECOMMENDATIONS

- Stigma, discrimination, homelessness and violence may cause mental health problems.
- The most common mental health issues which health care workers are likely to come across are depression and anxiety.
  - Excessive anxiety, often as a result of chemical imbalances in the brain (e.g. noradrenalin, dopamine and serotonin due to drug use), has a negative effect on a person’s ability to function.
  - Depression and anxiety can be treated with counselling, medication or a combination of both.
- Substance abuse is common in the sex work industry, and may lead to increased risk-taking behaviour as substances might create disinhibited behaviour (no sense of consequence).
- Substance abuse should be managed by a health care professional.
- Health care workers should provide a non-threatening environment where sex workers feel comfortable to disclose any mental health-related information.
- Health care workers should be aware of the major signs of depression, anxiety and trauma in order to adequately respond to the needs of a sex worker patient.
- Health care workers should be aware of accessible referral pathways where sex worker patients could be linked for mental health support.
- Health care workers should take into consideration the effect that drug dependency and mental health issues can have on the overall care plan for a sex worker patient.
- Health care workers should collect multiple types of contact details in an attempt to prevent loss to follow up with sex workers who may be experiencing drug or mental health-related issues.
Introduction

Every health care worker has an ethical and legal obligation to provide effective, equal and non-discriminatory health care to all patients. This manual has shown, however, that because of stigma, discrimination, and misinformation, this level of care and access is often not provided to a significant majority of sex workers. This lack of sex worker-friendly services is an incredible problem for the sex worker community and for South Africa, since sex workers face high rates of HIV, STIs and human rights abuses.

Every health care worker has a unique opportunity to change this reality by providing better services to all sex workers. This module will provide an overview of the services that should be offered to sex workers, as well as describe opportunities to improve and expand current levels of service provision.

Learning outcomes

By the end of this module, you should be able to do the following:

i. Explain why providing effective and sensitive health care to sex workers is important
ii. Describe common barriers to health care that sex workers may experience
iii. List the standard and extended services that should be made available to sex workers
iv. Describe multiple methods to improve current service provision for sex workers
Why should health care workers provide sensitive health services to sex workers?

Sex workers are part of every community across South Africa and they deserve fair and health care services just like other patients. Sex workers may engage in high risk behaviour and also experience human rights abuses, stigma and discrimination. All these factors increase their risk of HIV infection and can affect their access to sensitive health care services. Health care workers are legally and ethically obligated to address these factors.

Legal and ethical obligation

The South African Constitution protects all people and provides for health care access for all. Therefore, health care workers are obligated by law to provide fair and equal health care to sex workers. Please review Module 4: Sex Work, Health Care and the Law for further information. In addition, all health care workers are bound by a common code of medical ethics that hold them accountable to provide medical care and treatment. Therefore, health care providers are ethically obligated to provide the same type of health care to sex workers as they do to other patients. To do otherwise would violate this moral obligation.

Impact of the broader community

Health care workers also need to take into consideration the impact that service delivery for sex workers could have on their broader community. Improving the health of sex workers will directly benefit the communities in which they live and work. This is because people engage in sexual activity with sex workers on a regular basis. If a health care worker refuses to treat a sex worker, they are in actuality allowing a way for HIV and other STIs to continue to spread through the overall community.

How can a patient be identified as a sex worker?

Identifying whether or not a patient engages in sex work is a necessary first step that a health care worker must take before they are able to provide effective health care services to sex workers. If health care workers do not identify patients who engage in sex work, then they may be unable to provide the necessary services that these patients require. This could facilitate an increased risk of HIV and STI infection for the patient. In some health care settings, it is very easy to identify sex workers, or in some cases, sex workers may even self-identify. In other settings, this may be more difficult because sex workers may not disclose their behaviour out of fear of discrimination. This poses a challenge to health care workers because they will not be able to deliver appropriate services if they are unable to properly identify their patient’s needs.
Sex workers are a highly diverse community and, therefore, there are no set characteristics that can identify a patient as a sex worker based on appearance alone. The best way to identify patients who are sex workers is to have a direct, confidential and non-judgemental way of documenting their behaviours. This documentation should occur for every patient in order to not single out or isolate sex workers. When assessing any patient, they should be asked if they have ever exchanged money for sex. In order to facilitate a trusting environment, it is important to emphasise to all patients that the questions are confidential, and reassure them that they will not be criticised or judged for their responses. Patients should be informed that, by being honest with the health care worker, they will be able to receive the most effective and appropriate support and services.

Do sex workers require a different kind of health care service?

A sex worker can benefit from many of the same health services as other patients in a health clinic. For example, all sex workers can benefit from HIV testing, STI screenings, and risk-reduction counselling, just like other community members. These services can be referred to as standard services. These standard services are likely available at most health care facilities already, although it is important to remember that they should be sensitised to the needs of sex workers. In addition to standard services, there are also a number of additional services that can benefit sex workers. These are known as extended services and will be discussed later in this module.

**WHAT ARE THE STANDARD SERVICES THAT ALL SEX WORKERS SHOULD BE OFFERED?**

Many of the clinics and health care facilities in South Africa already provide the standard services that sex workers should be offered, including the following:

- HIV counselling and testing
- ARV referral or distribution for sex workers who are HIV positive
- STI treatment
- Reproductive health services
- Referral or provision for mental health counselling
- Peer education or outreach
- Screening assessments for violence, rape, human rights abuses and drug dependency
How can standard services be sensitised for sex workers?

The services listed above are likely already available in most clinic settings; however, very few are sensitised to the unique needs of sex workers. Sensitive health care services are those services that take into consideration the unique circumstances of sex workers. Sensitive services also create an enabling and welcoming environment for sex workers, which encourages open and non-judgemental discussion between a health care worker and the sex worker. The following services are a few examples of how standard health care services can be sensitised to better meet the needs of sex workers.

HIV counselling and testing

Sex workers should be tested more frequently since they engage in frequent and potentially higher-risk sexual activity. HIV and risk-reduction counselling should be adjusted to take into consideration the working environments of sex workers. This is further discussed in Module 5: HIV and STIs Among Sex Workers.

ARV referral or distribution for sex workers who are HIV positive

Sex workers who are HIV positive and qualify for ARVs should be linked to a sex worker-friendly ARV clinic. Beginning ARVs is not only important for the health of the sex worker, but also because it can significantly lower the risk of passing the virus on to their clients. Since sex worker patients may be more mobile than other patients, it may be necessary to help support them to pick up their medication from other clinics.

EXERCISE 1

Assessing your facility’s service provision

1. Which of the services listed above does your health facility offer to patients?
2. Would these services be easily accessible to sex workers who were visiting your facility? Why or why not?
3. How would you describe the experience of a sex worker who did access one of these services at your health care facility?
STI treatment

Sex workers are highly susceptible to STIs and should be encouraged to test for them regularly. Anal STIs are often overlooked and should be assessed as well. Where available, the HPV vaccine should be distributed to female sex workers in order to lower the risk of cervical cancer. Some clinics require that patients bring their sexual partners into the clinic when they are receiving treatment for STIs. This is ineffective for sex workers and can often place them in a compromising position.

Reproductive health services

Female sex workers are also exposed to the risk of unwanted pregnancy. Health care workers should discuss contraceptive needs with female sex workers with particular emphasis on dual protection and emergency contraception (1). Information should be made available on termination of pregnancy where appropriate.

Referral or provision for mental health counselling

Given the risk of developing mental health issues among sex workers, any sex worker seeking services should also be screened for common mental health illnesses such as depression and anxiety.

Screening assessments

Sex workers face a significant risk of being exposed to violence, human rights abuses and assault. These circumstances may also lead some sex workers to develop a dependency on alcohol/drugs. Therefore, sex workers should be screened for drug use, history of violence and past abuses. This information will support health care workers in a better ability to refer sex workers to additional care as needed.

HIV prevention education and risk-reduction counselling

Health care workers should always educate sex workers about HIV prevention and safer sex practices. Particularly for sex workers, the most important message and strategy is encouraging them to decrease the number of unprotected sexual acts they have with clients.

What are the barriers of sex workers to accessing standard services?

Following are some of the major barriers that sex workers may face when trying to access health care services.
Hours of operation

The standard hours during which clinics are open for services may not be available to many sex workers, thereby preventing them from even having the opportunity to access care or treatment.

Stigma and discrimination

Module 3 discussed the ways in which stigma and discrimination can affect sex workers and prevent or discourage them from accessing health care services.

Mobility

Some sex workers are very mobile and do not stay in one particular community for too long. Other sex workers are migrants who may have only recently arrived in a community or country. Overall, the mobility of the sex worker community can make accessing health care challenging, as they may be unaware of the structure of the community-based health care.

Lack of confidentiality

Violations of confidentiality in the health care setting can be potentially dangerous for any particular patient. For sex workers, however, a breach in confidentiality can result in increased stigma and ridicule, and add to the difficulty of them visiting a particular clinic.

How can individual health care workers affect the delivery of standard services to sex workers?

Health care workers are a critical part of making a service sex worker-friendly. The values and beliefs of health care workers can either encourage sex workers to uptake the health service, or can drive sex workers away. If a health care worker has a negative attitude toward a sex worker, the health care worker will likely not communicate effectively with the sex worker or will negatively affect his/her experience in the health facility. This can easily cause sex workers not to return to the service. Therefore, it is important for health care workers to understand their beliefs and values and, when working with a sex worker patient, to communicate clearly and in a non-judgemental way (1).
How can health care workers improve the delivery of standard services to sex workers?

Even though they are just one part of a much larger system, a health care worker does have the potential to considerably influence the services a sex worker may receive. All improvements should follow a rights-based approach. This means that each improvement should respect sex workers’ human rights and accord them basic dignity, and include basic sexual and reproductive health rights (e.g. informed decision-making, choices, and confidentiality).

Below are various strategies that health care workers, as individuals, can use in any health care setting to improve services for sex workers.

✓ Be informed about sex worker behaviour

Understanding the common sexual practices and behaviours of sex workers will allow health care workers to interact more genuinely with sex workers and build a stronger patient-provider relationship. It is also important to be aware of the different types of people involved in sex work, and not to make false assumptions about their risks or behaviours (1). Health care workers may have a personal curiosity about sex worker behaviour. While it is acceptable to ask questions regarding a patient’s behaviour, it is inappropriate to do so out of curiosity. All questions should be directly related to health care service provision.

✓ Do not make assumptions about the behaviour of sex workers

Not all sex workers are the same and, as mentioned throughout this manual, there is a wide variety of behaviours and actions in which sex workers can engage. Health care workers should not make automatic assumptions about patients who are sex workers. For example, it would be inappropriate to assume that all sex workers do not use condoms.
Instead, patients should be treated as individuals and have their risk assessed one-on-one. Additionally, do not assume all female patients are not sex workers. Asking questions about sex work, anal sex and so forth, should be integrated into routine risk assessments.

**Do not include judgemental or personal values in service provision**

It is not the job of health care workers to judge their patients, because this will not provide a patient with any helpful service. For example, if a man is in a relationship with a woman but having sex with other women ‘on the side’, a health care worker should not encourage him to stop having sex with others because he is cheating on his girlfriend. Instead, the health care worker could encourage the man to decrease his risk of HIV infection by always using condoms with his sexual partners, creating open communication with his girlfriend, and undergoing regular HIV testing.

**Respect confidentiality**

Health care workers should ensure that sex workers’ right to privacy and their right to anonymity are protected at all times.

**Address stigma in the health care facilities**

This may be the most important strategy to implement in order to improve services for sex workers. Module 3 contributed a number of suggestions for how this can be accomplished.

**Provide patient-centred advice and recommendations**

Health care workers should encourage patients to make their own decisions by exploring their options rather than getting direct advice from a health care worker. Health care workers should also recognise that sex workers are usually highly motivated to improve their health and well-being. This is a strength that should be built and encouraged.

**Use sex worker-friendly language**

As long as the health care worker is comfortable, using the same language that sex workers use to describe their behaviour can create a stronger sense of understanding and connectedness. For example, sex workers may make the distinction between sexual partners and clients with whom they have sex. Accurately conveying this distinction when discussing behaviours with a sex worker will show that the health care worker can understand and relate to them, thereby increasing the
likelihood of the sex worker returning. Use language that is open and honest about sex, does not judge any sexual behaviours and does not refer to some acts as acceptable and some as not acceptable.

✅ Ask for clarification

Health workers should ask for clarification from their patients if there is a term/wording or behaviour that they are discussing that is unfamiliar. Some health care workers may feel the need to be perceived as ‘knowing every-thing’, but it is better to seek clarification and be better equipped to support your patient.

✅ Engage with sex workers who visit health care centres and those in the community

There is no better way to improve health care services for sex workers than by engaging sex workers and getting direct feedback regarding the health care services. Integrating current or former sex workers into peer educator teams is an effective means of engaging the sex worker community, and provides a channel through which feedback can be derived.

✅ Anticipate retention challenges

Retaining sex workers in health care may be a challenge given that some sex workers may not be able to access services during regular hours. Additionally, sex workers who use substances may have poor follow-up because of their drug use. It is important for health care workers to not get frustrated if sex worker patients do not return to the clinic regularly. Instead of scolding a sex worker when he or she misses a monthly HIV test, a health care worker should rather work with the sex worker to identify barriers to attending monthly tests when he or she first arrives.

What extended health services can support sex workers?

Sex workers can readily benefit from sensitised standards services offered by most health care facilities. There are, however, additional services that can further benefit sex workers. These services may require additional resources or not be readily available at some health facilities.

Peer education and outreach into sex worker areas or hotspots

Sex workers may not be attending certain clinics because they are unaware of their services or because they have had bad experiences in the past. Therefore, outreach into sex worker social networks and areas is useful in order to spread knowledge about a particular facility and to provide an
opportunity for sex workers in the community to have their questions answered regarding the service.

**Mobile services that bring clinics to sex workers**

Some sex workers may not be able to access health clinics because of restrictions with their working conditions or the times at which they are required to work. Therefore, sex workers could significantly benefit from a mobile unit that provides medical services closer to where they are working or are stationed for the evening.

**Extended or enhanced hours of operation**

Since not all sex workers are able to access clinics during normal working hours, it is possible to have an extended hours sex worker-only clinic at certain times. This extended service would then provide sex workers with a safe space that they could access in a more efficient way.

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<th>STANDARD VERSUS ENHANCED SERVICES FOR SEX WORKERS:</th>
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<td><strong>Standard services</strong></td>
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<td>Enabling environment</td>
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<td>HIV testing</td>
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<td>ARV distribution</td>
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<td>Reproductive health services</td>
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**How can health care facilities more effectively provide health services to sex workers?**

A welcoming and safe environment is one in which sex workers have access to appropriate, acceptable and accessible health services without fear, stigmatisation or disempowerment. This means that sex workers could access the same services as other patients without being discriminated against or ridiculed. Overall, services must be culturally appropriate and based on
the needs of the local sex worker population. Ideally, services would be conveniently located and accessible to sex workers. Below are a few suggestions of ways in which health care facilities can be improved to better suit the needs of sex workers.

☑️ Improve confidentiality. A key identifier of a health centre that is supportive to sex workers is one in which sex workers can access and make use of the services and at no time have their identity or medical information compro-mised. Sex workers will be highly unlikely to continue to access a service after a break in confidentiality, given the reality that some sex workers do not disclose their profession to the communities in which they live.

☑️ Make all services voluntary. Even through sex workers are a high-risk community, no medical service or health screening should be forced upon them. Sex workers should not be pressured into testing or treatment; instead, health care workers should respect sex workers’ rights to choose what health care is acceptable.

☑️ Provide programs that support sex workers. Whatever programmes or services that are offered should be geared toward supporting sex workers in improving their health and lessening their risk. This is in contrast to programmes and services that immediately encourage sex workers to quit sex work.

☑️ Be adaptable and flexible. Sex workers are an incredibly diverse community and may require staff to continually learn and accept new practices, people, and ways of life rather than forcing people to adapt to certain ways of defining themselves. Logistically as well, services should be flexible and bulked together. Sex workers may not frequent health care facilities or return on a regular basis. In this case, health care facilities should be flexible in having the ability to offer a sex worker various tools, screenings or treatments in one clinic visit.

☑️ Provide condoms and water-based lubricants. All health care centres that serve sex workers should regularly keep full stock of male and female condoms and lube, all of which are necessary tools for all sex workers.

☑️ Involve sex workers (1). Involve sex workers and, where appropriate, other community members in all stages of the development and implementation of interventions.

☑️ Target sex worker clients (1). Recognise the role played in HIV transmission by clients of sex workers. Include a male community education worker on outreach teams to interface with the male clients of sex workers on safer sex practices.
Provide support and debriefing for health care workers. Health care facilities can improve services for sex workers by also making sure that their core resource, health care workers, are also being supported. Providing counselling and health care services can create significant mental and physical stress. Health care workers should be provided some level of debriefing counselling or support in order to guarantee that they are able to perform and cope in their health care setting.

EXERCISE 3

Case study

Sister Betty is sitting in her consultation room when a young woman enters. The young woman, who is wearing a very short skirt and low-cut top, sits herself down and, speaking very quickly and loudly, demands that Sister Betty give her the emergency contraceptive pill. Sister Betty tells the woman to calm down, and says that first she must ask her a few routine questions and fill out some paperwork. The young woman starts shouting at Sister Betty, saying that she has come here to ask for help and now she is being treated badly by the staff. Sister Betty tells the young woman that she is not treating her any differently and wants to help her, but that she has to ask her a few questions before she can give her the emergency contraceptive. The young woman gets out of her seat shouting that just because she is a sex worker, it doesn’t mean she should be treated like dirt. Before Sister Betty can say anything the young woman storms out of the room, slamming the door behind her.

1. Why do you think the young woman acted in the way that she did?

2. What would you have done in this situation?
In 2007, the WRHI developed the following key principles that health care facilities and health care workers should follow in providing services to sex workers (1):

- **Attitude.** Adapt a non-judgemental attitude when working with sex workers.

- **Informed choice.** Encourage your patient to make his or her own decisions and explore options rather than giving direct advice. Remember, it is your patient who must live with the consequences of his or her decisions, not you.
WRHI RECOMMENDATIONS

- Confidentiality. Ensure that sex-workers’ rights to privacy, confidentiality and anonymity are respected.

- A rights-based approach. Respect sex workers’ human rights and accord them basic dignity; include basic sexual and reproductive health rights (e.g. informed decision-making, choices, confidentiality).

- Respect. Respect, acknowledge and use sex workers’ views, knowledge and life experiences.

- Involvement of sex workers. Involve sex workers, and, where appropriate, other community members in all stages of the development and implementation of interventions.

- Encourage and empower responsibility. Recognise that sex workers are usually highly motivated to improve their health and well-being; build on this strength. Remember, sex workers are part of the solution.

- Skills development. Build capacities and leadership among sex workers in order to facilitate effective participation and community ownership.

- Target the whole sex worker setting. Recognise the role played in HIV transmission by clients and third parties (i.e. target the whole sex work setting, including clients and third parties, rather than only sex workers).

- Acknowledge diversity. Be aware of, and adapt to, the diversity of sex work settings and of the people involved. Do not make assumptions, and be careful not to stereotype. You are working with a diverse group of people who are involved in similar work. This involves engaging with individuals and being flexible in service delivery.

- Respect the patient’s feelings and privacy. Ask for information relevant for health care, rather than personal curiosity. It is easy to cross the boundary from information required for the effective provision of services to one’s own personal curiosity about the lifestyle and sexual practices of a sex worker.
Screen for abuse/violence
PEP/emergency contraception appropriate?
Refer to appropriate services: Rape Legal Shelter Counselling Sex worker organisation

Screen for substance abuse and/or mental health
Substance use counselling necessary?
Refer to appropriate services

Offer sexual and reproductive health services (including contraception and cervical smear)

Screen for other noncommunicable diseases

Offer an HIV test
HIV test results: Positive
WHO Clinical staging in line with local guidelines and CD4 count
CD4 count above 350
ART
Provide info on HIV transmission and give condoms and lube

HIV test results: Negative
Post-test counselling
Providing info on STI and TB transmission and give condoms and lube
STI or TB present: treat
No STI or TB present

The purpose of this flow chart is to provide a basic guideline of things to consider when seeing a Sex Worker patient.

Ensure that you stick to your facility guidelines at all times.

Screening for STIs and TB

Providing Sex Worker-Friendly Services

Follow-up
Introduction

Taking an active role in supporting change in your health care facility can be challenging, but it is a necessary step to providing more effective care for sex workers in your community. This module will not contribute new information about sex workers, but instead will assist you in the development of an individualized action plan that you can implement within your health care facility in order to provide better care for sex workers in your community.

Learning outcomes

By the end of this module, you will be able to do the following:

i  Identify both individual and facility-based barriers/challenges in your clinic
ii  Identify specific areas of change to address in your health facility
iii  Set a SMART goal for change
iv  Explore the facilitators and barriers toward enacting change in your facility
EXERCISE 1

Identifying areas for change in your health facility

Sex workers experience many barriers and challenges when accessing health care services. This can range from stigma and discrimination to breaches in confidentiality. Think back to the barriers you came up with in Exercise 3, Module 7. Using these examples, list the challenges that you believe most affect sex workers at your clinic. If you are not able to identify barriers for sex workers (perhaps you do not know of any that attend your clinic), then select barriers that make it difficult for other types of patients. Once you have completed your list, divide the barriers into two groups. First list those barriers or challenges that are linked to individual health care workers (either you or colleagues) and then list those that are associated with facility-level difficulties (operational time, service limitations). Fill in the table supplied on page 81 with your answers.

For the purposes of this exercise, select one of the above challenges or barriers that you would like to support in changing at your health care facility.

Understanding the cause of the barrier/challenge

Before you develop specific actions to achieve your goal, it is helpful to first understand the main causes behind the barriers you would like to change. Identifying the underlying cause of a barrier will better support you in determining a course of action to take to correct it.

For example, suppose that sex workers did not attend your clinic and this was the problem you were attempting to change. This problem could have many different causes. Are sex workers not coming because they do not know about the services you offer at the clinic, or is it because they have come before but had poor experiences? Each of these causes led to the same problem (sex workers not attending your clinic), but they would require drastically different courses of action to change.

Setting a goal for change

Now that you have identified a barrier/challenge and its causes, begin to consider how you would like to see it change. In other words, set a goal that you would like to achieve by changing this barrier/challenge. When setting goals for change, make sure they fit within the SMART criteria:
## EXERCISE 1 (TABLE)

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Cause(s)</th>
<th>Type of Cause</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: PWID do not come to this clinic</td>
<td>Staff stigmatising PWID</td>
<td>Individual</td>
<td>Hold sensitisation training with staff</td>
</tr>
</tbody>
</table>
**Specific.** Your goal should be clear and direct (e.g. Over the next 4 months, I would like to conduct two training sessions in my clinic to address stigma among the staff).

**Measurable.** You should be able to effectively monitor your progress toward your goal. It should not be ambiguous.

**Attainable.** You should be able to actually reach your goal within a set amount of time.

**Realistic.** Your goal should be feasible and not impossible to reach.

**Timely.** Your goal should be able to be achieved in a reasonable amount of time.

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**SMART Goals**

The following goals illustrate the components of the SMART criteria:

**Goal:** I will reduce stigma in my workplace.

This goal is not specific because it does not indicate how stigma will be reduced. The goal is also not measurable: how will stigma be monitored? The goal does not indicate a set amount of time, so it is not attainable. This goal may or may not be realistic, depending on the health care worker’s position and the organisation of their clinic. It is difficult to indicate if this goal is timely, because the actions associated with it are not specified, measurable or attainable.

**Goal:** I will attempt to reduce stigmatising behavior in my workplace over the next 2 months conducting a 2-hour training with the 10 counsellors in my clinic to better sensitise them to the experiences at our clinic of PWID.

This goal is specific because it states how the goal will be achieved and with whom. The goal is measurable because it indicates not only the amount of time it will take, but also when the training will take place. This goal is attainable because the timeframe, amount of work and individuals involved are clearly stated and could easily be implemented. It is very realistic to conduct one training session for 10 individuals; and it is realistic to assume that education will assist in lowering stigma among health care workers. This goal is timely because it provides a sufficient amount of time needed to carry out the activities that have been declared.
EXERCISE 2

Understanding SMART Goals

For each of the following goals, determine which of the SMART criteria are met and which ones are not. Afterward, rewrite each goal to better fit the SMART criteria.

1. I will make all of my colleagues work with sex workers.
2. I will address stigma in my work place.
3. I will set up a stigma committee in my clinic that consists of nurses, doctors, and counselling within 2 months of my training.
4. I will ask each of my sex worker patients in the next 3 months about their experiences in my clinic and how they think I can improve them.
5. I will get 100 new sex workers to attend my clinic by next month.

Achieving your goal

Use the following questions to assist you in developing a specific plan to address your goal for change.

1. **How long will you need to achieve your goal?** Consider if this is a goal that you can work on daily, or if you will need a certain amount of time before it can be implemented. Will you need to repeat an action regularly to achieve this goal or will you be able to achieve it once off?

2. **What resources will you need?** Will achieving this goal require other people, or are you able to achieve it by yourself? Will this goal require additional funding or other tools that your facility would need to contribute? Will you or your colleagues need to contribute additional time during work hours to achieve this goal?

3. **Who will need to be involved to make this goal a success?** Will this be a goal that you can implement by yourself or will you need to involve other staff? If other staff are involved, from what level will they be employed?

4. **How will you determine whether or not you have reached your goal?** Will your goal be achieved at one final point, or can it be achieved in smaller increments and timeframes?

5. **What challenges do you see that may be a barrier toward achieving your goal?** A barrier could develop during the planning or implementing
of your action plan. Are there facility or individual barriers that could prevent you from reaching your goal?

6. **What do you need to make your goal a success?** What are the most important parts of your goal and action plan? How can you guarantee that those parts are available to you for your plan?

**Establishing a next step**

Change can sometimes be difficult, and achieving big goals can understandably feel overwhelming. The most effective way to make progress toward a large goal is to break that goal down into smaller ‘action steps’. Each action step should be easily achievable and move one step closer to achieving your overall goal. If a person succeeds with enough of their action steps, they eventually make progress toward achieving their overall goal.

Take, for example, someone who is trying to lose a lot of weight. What steps are needed to achieve this? Perhaps their first step could be to get a gym membership or to learn more about good nutrition habits. Whatever the next step may be, it is easier to focus on and achieve than their major goal of weight loss.

Take into consideration your goal. What is the very first step you can take when you return to your health care facility?

**Conclusion**

Sex workers in South Africa are urgently in need of better care and support. This manual has detailed the significant challenges and barriers that they face on a regular basis. It has explained the effects of stigma and discrimination, and it has explored how human rights abuses increase sex workers’ vulnerability to HIV and STIs. Most importantly, it has illuminated the impact that health care facilities and individual health care workers can have on the ability of sex workers to access much-needed health care. Knowledge can often be one of the most important facilitators of change. Therefore, in conclusion to this manual, consider the following:

- **What information was the most useful to you?**
- **What knowledge do you feel is critical to pass on to your fellow health care workers?**

Despite the difficulties that sex workers face in accessing health care services, there is still great potential for change. This opportunity for change begins with health care workers and with public health facilities. Ultimately, the way that sex workers experience and access health care services in South Africa is entirely dependent on people like you and the decisions you make in moving forward.
Key Populations

Sex Workers are not the only group of people who experience many of the issues discussed in this manual. Other groups who have specific needs, experience high levels of stigma and discrimination, and have difficulty accessing health care include Men who have sex with men (MSM), People who Inject Drugs (PWID) and other people who use drugs, Migrant populations, Prisoners, and Transgender people. Individuals from across these populations are subject to the same vulnerabilities and are often treated unfairly in the health care setting. This manual has focused on sex workers, but much of what is covered here also applies to these other population groups.

A minimum service package for all key population groups should include:

- Access to non-discriminatory and quality health care services
- Peer-based outreach activities
- Provision of appropriate information, education and communication material
- Provision of male and female condoms and condom-compatible lubrication
- Voluntary and confidential HIV counselling and testing
- STI and TB screening
- Referral for sensitive provision of: HIV, STI, TB treatment, care and support, substance abuse and mental health services; post-exposure prophylaxis (PEP) and reproductive health services, including family planning, termination of pregnancy and cervical cancer screening programmes
SEX WORKER
SENSITIVITY TRAINING
POST-COURSE ASSESSMENT
AND QUESTIONNAIRE

Thank you for completely this manual on sex worker sensitivity training. Please take a moment to complete the post-course assessment. This can used to compare your change in knowledge since the beginning of the course.
SEX WORKER KNOWLEDGE

1. People mostly engage in sex work because
   a. they have a mental illness
   b. they need to survive and earn a living
   c. they enjoy having sex with multiple partners
   d. they were abused as little children

2. Sex workers are at higher risk for HIV than the general community because
   a. they frequently have large numbers of sexual partners
   b. they are often forced to have unprotected sex with clients
   c. they experience stigma within health care settings and do not get effective health care
   d. all of the above

3. Sex workers may be stigmatised because
   a. they have a large number of sexual partners
   b. they are perceived as stealing married men from their wives
   c. they are perceived as encouraging crime
   d. all of the above.

4. Sex work stigma can be addressed in health care settings by
   a. having a separate queue for sex workers away from the other patients
   b. encouraging the police to visit the clinic regularly
   c. addressing the use of inappropriate language used toward sex workers
   d. refusing to provide sex workers with the same services as other patients

5. Sex work in South Africa is illegal because
   a. it decreases the number of men who try to buy sex from sex workers
   b. it discourages young women from entering into the sex field
   c. it protects sex workers’ ability to access health care
   d. the laws criminalising sex work in the Constitution have yet to be removed

6. Which of the following abuses have been reported by sex workers in South Africa?
   a. Being detained over weekends by police
   b. Being forced to have sex with police officers to avoid arrest
   c. Being physically assaulted by police officers
   d. All of the above
7. In South Africa, sex work is defined as an exchange of goods or gifts for sexual activity between
   a. one man and one women
   b. one man and any number of women
   c. two men
   d. none of the above

8. Sex work is practised in
   a. a private home
   b. brothels
   c. clients’ cars
   d. all of the above

9. A sex worker should test for HIV
   a. every month
   b. once a year
   c. only every 6 months
   d. as frequently as possible

10. Risk-reduction counselling is a behavioural technique meant to reduce HIV risk
    a. by convincing the sex worker to leave sex work
    b. by eliminating all risk that the sex work may experience
    c. by decreasing the risk experienced by the sex worker according to his or her actions and circumstances
    d. none of the above

11. A sex worker can reduce their risk of getting HIV by
    a. using condoms with every client
    b. not having sex when an STI has not been treated
    c. getting tested for HIV and STIs regularly
    d. all of the above

12. Postexposure prophylaxis (PEP) is an HIV prevention tool that is available to
    a. all sex workers
    b. only female sex workers that have sex with men and women
    c. no sex workers
    c. only male sex workers that have sex with other men
13. Which of the following is not a sign of external stigma toward a sex worker?
   a. A nurse gossips to a receptionist about the sexual behaviour of their sex worker patient
   b. A counsellor believes that sex work is immoral and tries to counsel the sex worker to find another job
   c. A nurse asks a sex worker patient about the frequency of condom use with his or her clients
   d. A site manager refuses to hire an individual as a peer educator because they are a sex worker

14. Which of the following is a factor that affects the mental health of a sex worker?
   a. High levels of stigma and discrimination
   b. The unavailability of paved sidewalks in client-heavy areas of town
   c. Difficulty in finding affordable clothing for work
   d. Frequently available free and confidential HIV testing

15. An enabling health care environment for sex workers would have
   a. confidential and sensitised risk-reduction counselling
   b. included input from sex workers in the design of the service
   c. combination HIV prevention strategies for use
   d. all of the above

16. Combination HIV prevention for sex workers is
   a. useful because it addresses the multiple risks sex workers face
   b. far too expensive to roll out on a national scale
   c. inclusive of psychological support for sex workers
   d. none of the above

FOR THE FOLLOWING STATEMENTS, INDICATE IF YOU AGREE OR DISAGREE BY CIRCLING A NUMBER BELOW:

1. I do not like to have sex workers in my clinic.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

2. Sex workers are immoral.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

3. Sex workers deserve to get HIV because of the behaviour in which they engage.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

4. If a sex worker came into my clinic, I would provide him or her services.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree
5. If a sex worker wanted treatment for an STI, I would not provide it to him or her because the sex worker will just get infected again.
   Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

6. If a sex worker came into my clinic, I would advise him or her to find another type of job besides sex work.
   Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

7. I am comfortable providing health care services to a sex worker.
   Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

8. I believe that I can effectively counsel a sex worker to reduce his or her risk of getting HIV.
   Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

9. I am aware of sex worker-friendly services that a sex worker patient could be referred to for more in-depth care.
   Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

10. I am aware of sex worker organisations that work in my community.
    Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

11. Sex workers do not have a right to take a lot of free condoms from health care centres – they should take only as many as other people are expected to take.
    Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

12. Sex workers have specific kinds of health care needs that need consideration in order to enable their best health outcomes.
    Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

13. Sex workers should be treated differently from other people – they are more vulnerable than other people and thus must be given special treatment.
    Strongly Disagree 1 2 3 4 5 6 7 8 9 10  Strongly Agree

If you would like to receive more information on the Pre and Post course assessments, please email ben.brown@hiv-research.org.za)
Human Immunodeficiency Virus (HIV)

HIV is a virus that is spread by bodily fluids, affects the human immune system, and causes AIDS. Receptive unprotected anal and vaginal sex carry the highest risk of becoming infected with HIV. Unprotected penetrative penile vaginal or anal sex also carries a high risk of contracting HIV. Oral_penile sex, oral-vaginal, and oral-anal sex also carry some risk of HIV infection, but this risk is much lower. The chance of getting HIV is higher if there are cuts or sores in the mouth or around the vagina, penis and anus.

In HIV-positive persons, vaginal fluids, ejaculation fluid (semen, cum) and blood carry the most number of viruses. However, pre-ejaculate (pre-cum) may also contain HIV. Removing the penis before ejaculation during oral, vaginal or anal sex still carries a risk of HIV transmission.

A few weeks after infection of HIV, a flu-like illness may be experienced. Fever, skin rash, sore throat, muscle pain, and tiredness may be present. During this time, HIV is very easily spread to others.

Years without any obvious symptoms may follow until the immune system (the body’s army which fights sickness) weakens. Infected people may then develop tuberculosis, chest infections, skin rashes, sores in the mouth, diarrhoeal illnesses and some types of cancer. They may also lose weight.

HIV is a manageable infection. Regular medical follow-up is needed to prepare individuals to start antiretroviral therapy. Once started, antiretrovirals need to be taken daily for life. The decision on when to start is based on clinical and laboratory criteria, which are often country-specific due to variable resources and patient readiness. Treatment usually consists of at least three different types of drugs.
All sexually active individuals should be offered HIV testing every 6 months to a year. For people who have many risky exposures (unprotected anal intercourse, multiple sexual partners, concurrent partners, transactional sex), HIV testing should be done more regularly – every 3 to 6 months. Individuals who present with flu-like symptoms (fever, tiredness, skin rash, muscle pain, joint pain, sore throat) 2 to 10 days following risky sexual exposure should have HIV tests repeated 6 weeks and 3 months after the event to pick up possible early HIV infection. The spread of HIV can be greatly reduced if HIV diagnosis is made early, since most infections are spread from individuals who are in the early stages of infection and are often not aware that they are spreading it to their sexual partners (1-2).

The use of antiretrovirals to prevent HIV

Antiretrovirals have been shown to provide some protection against HIV infection among HIV-negative people. Antiretrovirals should be given ONLY by a qualified health care worker. Their use for HIV prevention before and after exposure are linked to possible risks of viral resistance. At present, access to these prevention methods are limited, but may increase as drug prices decrease and research results become available.

One STI treatment, Acyclovir, which is used to treat the STI herpes, is to be considered for clients who are at risk of recurrent outbreaks to prevent transmission of HIV (3).

Common bacterial infections

- Neisseria gonorrhoea (causes gonorrhoea or gonococcal infection)
- Chlamydia trachomatis (causes chlamydial infections)
- Treponema pallidum (causes syphilis)
- Haemophilus ducreyi (causes chancroid)
- Klebsiella granulomatis (previously known as Calymmatobacterium granulomatis, causes granuloma inguinale or donovanosis)

Common viral infections

- Human immunodeficiency virus (causes AIDS)
- Herpes simplex virus type 2 (causes genital herpes)
- Human papillomavirus (causes genital warts and certain subtypes lead to cervical cancer in women)
- Hepatitis B virus (causes hepatitis and chronic cases may lead to cancer of the liver)
- Cytomegalovirus (causes inflammation in a number of organs including the brain, the eye, and the bowel)
Urethritis (Urethral discharge syndrome, drop)

Neisseria gonorrhoea and Chlamydia trachomatis are the bacteria or germs which commonly cause most infections in the urethra (the pipe joining the bladder to the outside). Chlamydia is known as a ‘silent’ disease because the majority of infected people have no symptoms. If symptoms do occur, they usually appear within 1 to 3 weeks after exposure. In women, the bacteria initially infect the cervix and the urethra (urine canal). Women who have symptoms might have an abnormal vaginal discharge or a burning sensation when urinating. If the infection spreads from the cervix to the fallopian tubes (tubes that carry fertilized eggs from the ovaries to the uterus), some women still have no signs or symptoms; others have lower abdominal pain, low back pain, nausea, fever, pain during intercourse, or bleeding between menstrual periods. Chlamydial infection of the cervix can spread to the rectum. Men with signs or symptoms might have a discharge from their penis or a burning sensation when urinating. Men might also have burning and itching around the opening of the penis. Pain and swelling in the testicles are uncommon. Men or women who have receptive anal intercourse may acquire chlamydial infection in the rectum, which can cause rectal pain, discharge, or bleeding. Chlamydia can also be found in the throats of women and men who have oral sex with an infected partner.

Some men with gonorrhoea may have no symptoms at all. However, some men have signs or symptoms that appear 1 to 14 days after infection. Symptoms and signs include a burning sensation when urinating, or a white, yellow or green discharge from the penis. Sometimes men with gonorrhoea get painful or swollen testicles.

In women, the symptoms of gonorrhoea are often mild, but most women who are infected have no symptoms. Even when a woman has symptoms, they can be so non-specific as to be mistaken for a bladder or vaginal infection. The initial symptoms and signs in women include a painful or burning sensation when urinating, increased vaginal discharge, or vaginal bleeding between periods. Women with gonorrhoea are at risk of developing serious complications from the infection, regardless of the presence or severity of symptoms.

Symptoms of rectal infection in both men and women may include discharge, anal itching, soreness, bleeding or painful bowel movements. Rectal infection also may cause no symptoms. Infections in the throat may cause a sore throat, but usually causes no symptoms.

The tests used to identify the exact germ causing the infection are expensive and not normally needed. These tests are commonly done on urine or from a sample of the fluid on the inner lining of the penis. Infection with both germs
at the same time is common, and the WHO recommends treatment of both germs with a combination of antibiotics in resource-limited settings. One can be reinfected and need to be retreated whenever symptoms are present (4).

Genital ulcers

Genital ulcers, or sores, may be either painful or painless. The former are most commonly caused by the herpes virus and the latter most often by syphilis. Other causes of genital sores include lymphogranuloma venereum, chancroid, primary HIV infection, granuloma inguinale, trauma, cancer, drugs, Behcet’s disease and Reiter’s syndrome (5).

Genital herpes

Genital herpes consistently accounts for roughly 20% of new HIV infections at all stages of the epidemic, making it the most significant STI driving the transmission of HIV (6). Infection is for life and no cure exists. Most commonly, a few painful sores are found on or near the penis and anus, surrounded by a red area. This virus can also cause sores on the mouth (cold sores), which usually heal by themselves. These cold sores on the mouth are not necessarily caused by sexual contact. The virus is spread through direct contact. By touching open sores with a body part (hand to vagina, hand to penis, penis to anus, mouth to penis, mouth to vagina, etc.) the virus can be passed to other people. The virus may also be spread from person to person even if there are no open sores and the skin is intact (4). Treatment (an antiretroviral—acyclovir) is expensive and not freely available, and works to control the sores if it is started early. Treatment is needed for severe sores or for those which do not heal.

Syphilis

Syphilis is caused by bacteria and can first appear as a painless sore (ulcer) on the labia or vulva, penis, anus or surrounding area. This sore heals, and individuals may then develop a rash, swollen glands, and muscle and joint pains. These symptoms then disappear and the person may be symptom-free for many years. The bacteria continue to live in the body and may spread to cause disease in the testicles, heart and brain. Often, syphilis is only diagnosed in a blood test. Penicillin, given as three injections over 3 weeks, is effective for treating most cases of syphilis (7, 5).

Viral hepatitis

Viral hepatitis may be caused by one of a group of viruses which directly affect the liver, most of which can be spread in the same way as other STIs. Hepatitis C is more of a problem among intravenous drug users.
**Hepatitis A**

In Africa, many people become infected during childhood. Lifelong protection can be obtained from natural infection or through immunisation. It may be spread through oral-anal sex. In adults, the disease is usually short lived—causing nausea, vomiting, yellowing of the skin (jaundice), abdominal pain, swollen glands, and joint pain. For those not previously infected, there is an effective immunisation available for hepatitis A (8).

**Hepatitis B**

Hepatitis B is spread through bodily fluids, similarly to HIV; but unlike HIV, hepatitis B can be prevented by vaccination. Hepatitis B infection is common in Africa. Most individuals are able to recover fully from hepatitis infection; however, between about 1 in 4 and 1 in 20 have long-term infection, depending on whether it started in childhood or adulthood. Some of these people develop scarring of the liver (cirrhosis), which may cause the development of liver cancer (5).

Individuals who are infected with HIV and hepatitis B need special attention due to the medications used to treat the infections and the possibilities of liver problems. Treatment for hepatitis B is very expensive, not very effective, and only available in areas with extensive resources. Hepatitis B vaccination is recommended for all people who practise riskier sex, such as sex workers and MSM (9).

**Human papilloma virus: genital warts and cervical cancer**

Another virus, HPV (the human papilloma virus) is the precursor to cervical cancer and causes warts in the genital area. Cervical cancer is a very slow-growing cancer, and PAP smears are provided to screen for these. The genital warts appear as growths around the genitals and/or anus of both men and women. Sometimes they are itchy, and they may bleed if scratched. Warts often heal without treatment. Large warts need treatment with medication or may need to be surgically removed. Warts may be numerous, and become very large in HIV-positive individuals. The presence of warts around the genitals or anus is a sign of unprotected sex (10). Occasionally infection with HPV may lead to anal cancer, which is 17 times more likely to occur in MSM than in non-MSM (11).

A vaccine (Gardasil®) is now available for the prevention of HPV infection. Owing to the cost of this vaccine, access is currently limited but is available in the private sector.
Other STIs and rectal STI

Lymphogranuloma venereum (LGV) is another infection caused by a type of chlamydia bacteria. It may cause a sore in the genital area and swelling of the glands in the groin, and result in abscesses. Antibiotics are needed to treat this infection (12).

Many of the bacteria mentioned above may cause infection in other parts of the body. Neisseria gonorrhoea and chlamydia may also infect the anus and mouth. Infection in the anus may cause painful bowel movements and painful receptive anal sex, and there may be a white or bloody discharge from the anus (proctitis). Diagnosis may be made by direct observation using a protoscope – an instrument inserted into the anus that allows a health care professional a better view of the lining of the anus. Laboratory tests on a sample from the anus can also be used to make the diagnosis. Treatment is by means of antibiotics to cover the most likely bacteria (10).

Infection in the mouth may cause a painful, swollen throat and mouth. White fluid may also form on the back of the mouth. Genital herpes may also infect the mouth and cause cold sores (8).

Clients with symptoms should not wait for them to go away, but should be seen by a health care professional. Infestation with parasites like lice (crabs) and scabies, which is a possible cause of itchiness in the genital area, should also be part of STI screening.
Following is an outline for one particular method of risk-reduction counselling.

**Step 1: Assess the behaviours of clients**

In order to assist clients in developing risk-reduction goals, it is first important to gain a better understanding of their sexual practices, including both safe and risky behaviours. Particular focus can be placed on behaviour from the previous 3 months, as this may impact their need for further HIV testing. This basic assessment can be achieved by asking them key questions regarding the number and type of sexual partners they have, the types of sexual acts in which they have engaged, and their use of alcohol or other substances.

**Step 2: Assist clients in identifying a risk behaviour to address**

Clients should select a behaviour that they are motivated to change. Generally, this will be one that is causing them some type of physical or emotional distress or other negative side effects. It is important that clients be significantly involved in choosing which behaviour to address. When they are actively involved in the identification process, they will be more motivated to follow through on the risk-reduction goals or strategies than if the counsellor selects the behaviour.

**Step 3: Discuss the cost and benefits of this behaviour**

Once a behaviour has been selected, it can be helpful to assist clients in exploring and understanding the reasons why they engage in this behaviour. This will involve discussing their motivators or benefits for doing so. Additionally, it is critical also to explore and discuss the consequences of this behaviour, in
other words, the costs the participant will pay for engaging in it. For example, when discussing the cost and benefits of engaging in unprotected anal sex, a participant may list such benefits as it feels good, it is more intimate, or it is cheaper than buying condoms, while some costs might be the danger of becoming infected with an STI or HIV, or the fear and emotional stress associated with not knowing his or her HIV status. The counsellor should use the cost and benefits listed by their clients to assist them in understanding why they engage in the risk behaviour and why they should consider altering that behaviour.

**Step 4: Set goals**

Once clients have a deeper understanding of why they engage in the risk behaviour and motivators that influence them, they should create a personalised goal to change this behaviour in some way to become safer. This goal should be specific, achievable, realistic and measurable. Goals that are less detailed can be difficult to achieve or follow through with. Most importantly, a behaviour-change goal should be realistic for clients and based on their specific circumstances. Setting a behaviour-change goal that is impossible for them to achieve right away may lead them to become demotivated or disappointed in themselves. For example, it may be unrealistic for a client who very regularly has a large number of sexual partners to set a behaviour-change goal of becoming monogamous. Instead, a smaller but achievable goal might be for such clients to always use or increase their use of condoms with all of their sexual partners, which may also be something that they can sustain over time.

**Step 5: Discuss barriers**

It can also be helpful to discuss with clients any potential barriers that may prevent them from achieving their goal and to help them to develop strategies to overcome them. Barriers could include things like pressure from friends or an addiction to a drug. Predicting potential barriers that could make behaviour difficult for the client is particularly helpful if you have infrequent contact with clients or will only see them once.

**Step 6: Reinforcement**

Ultimately, changing behaviour can be a difficult process; therefore, it can be helpful to make clients feel proud and motivated when they conclude their session, and to remind them that with a new goal comes a new opportunity to improve their behaviour. Furthermore, it needs to be stressed and emphasised that not all sex workers engage in risky behaviour. Clients may easily be engaging in a number of safe behaviours that they enjoy, and reinforcing these behaviours is a great way to encourage their self-esteem and support behaviours that are protecting their health.
Male and female condoms

A condom is a protective sheath used during anal, vaginal, or oral sexual intercourse. It creates a physical barrier between the genitals and sexual fluids of two partners engaging in intercourse. It can be used for contraception, and/or HIV and STI prevention. There are two main types of condoms – male condoms and female condoms.

Male condoms are usually made out of latex (rubber). Female condoms are usually made out of polyurethane (a thin strong plastic). Male condoms made out of polyurethane also exist (but are not widely available) – these are useful for avoiding latex allergies.

Currently, the female condom is approved for vaginal use only – that is why it is called the female condom. However, female condoms can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection (1).
Table 1 compares the male condom with the female condom.

**Table 1: Similarities and differences between male and female condoms**

<table>
<thead>
<tr>
<th>Male Condom</th>
<th>Female Condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latex (rubber)</td>
<td>Polyurethane (plastic)</td>
</tr>
<tr>
<td>Water-based lubricants only (e.g. KY Jelly®)</td>
<td>Any lubricant, preferably water-based (although oil-based lubricant, such as Vaseline®, body cream, or oil are also possible)</td>
</tr>
<tr>
<td>Can break if not used correctly</td>
<td>Does not break easily</td>
</tr>
<tr>
<td>Some men find it too tight/restrictive</td>
<td>Not tight on penis</td>
</tr>
<tr>
<td>Must be put on/taken off the erect penis immediately before/after penetration</td>
<td>Can be inserted before penetration and left in for longer</td>
</tr>
<tr>
<td>Does not conduct heat</td>
<td>Warms up to body temperature</td>
</tr>
<tr>
<td>Must be worn on the penis (insertive partner)</td>
<td>Can be inserted into anus (receptive partner) or used over the penis (insertive partner)</td>
</tr>
</tbody>
</table>

**How well do condoms work?**

When used correctly and for all sex acts, condoms are 80–95% effective at preventing HIV and STIs. These estimates are based on research among heterosexual couples engaging in regular sexual intercourse using condoms consistently (2-4). Often, however, individuals do not use condoms correctly or consistently (5), resulting in potential exposure to HIV/STIs.

Male and female condoms are manufactured according to strict quality standards and are tested for strength, leakage, lubrication, proper packaging and labelling.

**Instructions for correct male condom use**

1. Store condoms in a place away from heat and humidity. Check the expiration date on the package. Check that the package is not damaged and has no holes by feeling the air in it.
2. Do not rip or puncture the condom when opening the package. Open it with the fingers, NOT with teeth, scissors, a knife or anything sharp.
3. Check that the condom is not dry.
4. Make sure the tip of the condom is the right way around – the lubricated side should be on the outside, and the condom should roll down easily.
5. Pinch the tip (teat) of the condom with one hand. This removes the air and makes space to hold the semen.
6. Place the condom on the erect penis and unroll it to the base of the penis with the other hand, while still pinching the tip of the condom. If uncircumcised, pull back the foreskin before putting on the condom. After it has been put on, push the foreskin forward again (toward the tip) to let the foreskin move without breaking the condom.

7. Smooth out any air bubbles.

8. Add a water-based lubricant (e.g. KY Jelly*) to the outside of the condom if necessary. Do NOT use oil-based lubricants.

9. If the condom breaks or slips during intercourse, STOP, remove the broken/used condom, and put on a new one.

10. After ejaculation, hold the condom at the base of the penis and pull it off before the penis softens.

11. Remove the condom, taking care not to spill any semen.

12. Wipe any ejaculate off the penis.

13. Make a knot in the condom and dispose of it appropriately out of the reach of children.

14. Use a new condom for each new act of intercourse.

Instructions for correct female condom use

Method 1: Use by receptive partner

1. Check the expiration date.
2. Find the arrow on the packaging and tear downwards.
3. Insert the female condom into the vagina or anus.
4. Either keep or remove the inner ring, depending on preference. The inner ring can be used to insert the female condom, and then be removed thereafter.
5. Leave the outer ring on the outside of the body.
6. Add lubricant to the inside of the female condom or on the penis if needed.
7. Guide the penis inside the outer ring into the female condom. If the penis enters to the side of the female condom or pushes one of the sides of the outer ring inside the vagina or anus, STOP, adjust the outer ring, and start again.
8. To take out the female condom, twist the outer ring and gently remove.
9. Tie a knot and dispose of it in the trash.

Method 2: Use by insertive partner

1. Remove the inner ring. The ring can be placed on the outside of the condom, as this can provide additional stimulation to the receptive partner.
2. Place the condom over the erect penis like a sock.
3. Add lubricant to the condom and/or to the partner’s anus/vagina.
4. Holding both rings in place at the base of the penis, insert the penis into the anus or vagina.
Challenges of using the female condom include difficulty inserting and keeping it in place, irritation, unpleasant texture and noise of the condom (6-7).

Advantages of female condoms are that they allow for more sensation by the insertive partner their material and texture means that the receiving partner/cannot feel the condom. Female condoms are a more satisfactory option for men who do not enjoy using male condoms.

Lubricants

Lubricants (or ‘lubes’) are substances that reduce friction between the penis, vagina, or anus during sex. Lubrication helps prevent condom breakage, and decreases the risk of slippage during anal sex (8). Lubrication is very important during anal sex in order to prevent anal/rectal trauma.

Water-based and oil-based lubricants

There are two main types of lubricant: water-based and oil-based.

Water-based lubricants can be used with male latex condoms, as they do not damage the latex. Examples include KY Jelly® and Assegai®. Most male and female condoms already have water-based lubricant on them; however, adding lubricant is especially important for anal sex, as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing.

Oil-based lubricants must NOT be used with the male condom, as they damage the latex and may increase the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil and petroleum jelly (e.g. Vaseline®).

In many communities throughout Africa, water-based lubrication is not freely available and may be too expensive for most individuals to buy. In these cases, many individuals use other substances that provide lubrication during sex. It is critical when counselling clients about alternatives types of lubrication that only water-based products are used. It is important to also educate a client that alternatives to lubrication that are oil-based, such as butter or fat, are just as dangerous to use with a condom as oil-based lubricants.

Giving advice on lubricant use to clients

- Ask the client whether he/she usually uses lubricant during sex.
- If he/she does not use lubricant, ask whether the client ever experiences pain or discomfort during sex.
- Explain what a lubricant is and inform him/her of the importance of ensuring smooth intercourse in order to minimise pain and the risk of tearing/bleeding.
• Explain that a lubricant can be used during intercourse regardless of whether a condom is used.

• Explain that condom use is the safest way to prevent HIV infection during sex, and that you recommend using a lubricant to ensure smooth intercourse (this is particularly important for anal sex, as the anus does not produce natural lubrication).

• If possible, demonstrate correct lubricant use and give out water-based lubricants during the counselling session.

• Explain to clients that water-based lubricants (e.g. KY Jelly®) can be bought at most pharmacies.

As a counsellor, it is important to be able to explain to clients what lubricants are and the differences between water-based and oil-based lubricants, and to recommend water-based lubricants.
APPENDIX IV

SOUTH AFRICAN NURSING COUNCIL – CHARTER OF NURSING PRACTICE, 2004

(Excerpt from the Charter of Nursing Practice)

The Constitution of the Republic of South Africa lays the foundation for ensuring that all people are treated equally and that each person is afforded basic rights. Nurses must at all times protect and maintain the rights of people they provide care to.

These rights are contained in the Bill of Rights in the Constitution of the Republic of South Africa and must be adhered to all times... Do not discriminate on the grounds of race, colour, creed, gender, religion, culture, politics, social status, personal attributes or the nature of the health problem... Nurses must not permit considerations of religion, nationality, race or social standing to influence the quality of the care they render.
Preexposure prophylaxis

Another potential HIV risk reduction tool for sex workers is preexposure prophylaxis (PrEP), which refers to a prevention tool that involves HIV-negative patients taking a daily ARV in order to prevent HIV. PrEP is a very new biomedical HIV prevention tool that has only shown efficacy in one trial including only men who have sex with men (MSM), but could provide up to 44% additional protection against HIV. Since PrEP is currently only proven to be of limited efficaciousness in reducing HIV among MSM, it should only be offered to a sex worker who is MSM (1).

Vaginal and rectal microbicides

Microbicides are gels or creams that are designed to be inserted into the rectum or vagina before sexual intercourse. In 2009, a clinical trial showed that vaginal microbicides added an additional 33% protection from HIV (1). Unfortunately, a publicly-available microbicide is not on the market, but could be a potential HIV prevention in the future. Likewise, rectal microbicides are still being research to determine their ability to prevent HIV in men and women. Both of these tools could someday be potential tools that sex workers could use to protect themselves from HIV.
APPENDIX VI

ORGANISATIONS THAT WORK WITH SEX WORKERS IN SOUTH AFRICA

National

SWEAT (Sex Worker Education and Advocacy Taskforce)
19 Anson Street, Observatory
Main office: +27 (0) 214487875
Helpline: 0800606060
(Sisonke – Johannesburg: 011 358 5304 )

Limpopo

TVEP (Thohoyandou Victim Empowerment Programme)
T: 015 963 1222

KwaZulu Natal

Lifeline Durban
T: 031 303 1344
Crisis phone: 031 312 2323

Gauteng

Wits Reproductive Health Institute: Esselen Street Clinic
T: 011 725 671

Services provided: HIV counselling and testing, TB screening and treatment, psychosocial support groups, mobile clinic outreach services, ARV initiation
Cross Over Project (COP)
Location: 5 Inez Street, Sunnyside, Pretoria, and
Shelter: Plot 202 Tambotie Street, Grootvlei
Mobile: 072 674 3245
E-mail: crossoverproject2@gmail.com

Services provided to sex workers: counselling, shelter for abused, raped, abducted, child trafficking, training of sex workers, referral for treatment, support groups/income generation projects

Tshwaranang (Legal Support)
T: 011 403 4267

North-West Province
Lethabong Legal Centre
T: 012 270 1343

Beaufort West
PSH (Partners in Sexual Health)
T: 023 414 4169

Eastern Cape
East London High Transmission Area Project
T: 043 742 2651

Western Cape
Rape Crisis
T: 021 447 9762 (24-hour line)

Woman’s Legal Centre
T: 021 424 5660

Health4Men
T: 021 447 2844

Mosaic
T: 021 761 7585

Abuse Helpline
T: 0800 24 64 32

Trafficking Helpline
T: 0800 555 999

POWA (People Opposing Woman Abuse)
T: 011 642 43 45/6
Emergency help numbers

**Lifeline**
National Counselling Line: 0861 322 322
National AIDS Helpline: 0800 012 322

**Alcoholics Anonymous**
National 24-hour helpline: 0861 HELP AA (435-722)

**Narcotics Anonymous**
National 24-hour helpline: 083 900 69 62
REFERENCES BY MODULE

Module 1: Introduction to sex workers


2. SWEAT. As related in her Digital Story. 2010. Used with permission by SWEAT.


Module 2: Common behaviours and practices of sex workers


Module 4: Sex work, health care and the law


2. Women’s Legal Centre, legal proceedings papers.


Module 5: HIV and STI prevention among sex workers


Module 6: Mental health and sex workers


Module 7: Providing sex worker-friendly services

Appendix I


Appendix III


Appendix V

Additional resources and readings:


Sex Workers:
An Introductory Manual for Health Care Workers in South Africa

This training manual provides an introduction to the knowledge and skills necessary for health care workers to effectively provide non-judgmental health services to sex workers. Even though sex workers are part of every community, and sex work is a common practice in South Africa, stigma and other barriers prevent sex workers’ ability to access effective health care. The exclusion and marginalisation of sex workers increases their vulnerability to HIV, and undermines the ability of HIV interventions to be effective, while contravening human rights and public health principles of freedom from discrimination and access to health services.

In order to meet objectives established in South Africa’s National Strategic Plan for HIV, STIs, and TB (2012-2016), health care workers must provide more appropriate and sensitive health care to all South Africans, including sex workers.

This manual was developed in partnership with SWEAT, the Sex Work Education and Advocacy Task force, as well as contributors from across South Africa in order to provide health care workers with the most up to date information and informed perspectives regarding sex workers and their health needs.

This manual is comprised of 8 modules:
1. Introduction to Sex workers
2. Common Behaviours and Practices Of Sex Workers
3. Sex Work and Stigma
4. Sex Work, Health Care, and the Law
5. HIV and STI Prevention Among Sex Workers
6. Mental Health and Sex Work
7. Providing Services to Sex Worker-Friendly Services
8. Creating a Plan of Action for Your Health Facility

Additional contents include:
- Pre and Post course Assessments
- Resource and referral information
- Glossary

Partners
The Desmond Tutu HIV Foundation (DTHF) is a registered non-profit organisation focused on the pursuit of excellence in research, treatment, training, and prevention of HIV and related infections. The DTHF operates community sites in greater Cape Town, South Africa, providing treatment, testing, and outreach services to at-risk communities.

SWEAT is a registered non-profit organisation based in Cape Town, South Africa and working nationally. Established in 1996, SWEAT delivers education, counseling, legal services, and skills training to adult sex workers in the context of the HIV epidemic. SWEAT is a leading voice for sex workers in the Southern African region and advocates for the protection of the human, legal, and labour rights of sex workers.

Since 1969, ICF International has been serving government at all levels, major corporations, and multilateral institutions. With more than 50 offices and over 4,500 employees worldwide, ICF brings deep domain expertise, problem-solving capabilities, and a results-driven approach to deliver strategic value across the lifecycle of client programs. ICF offers professional services along the entire continuum of HIV/AIDS, public health program, and development needs—from multidisciplinary research and evaluation, to management consulting, marketing and communications, training and technical assistance, and information technology. ICF partners with clients to conceive and implement solutions and services that protect and improve the quality of life, providing lasting answers to society’s most challenging management, technology, and policy issues.