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Adult Prostitution

Sex Work and Public Health in South Africa

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Summary of Submission

Sex work in South Africa is a crime. Sex workers' economic, social and physical vulnerability in South African society is created, sustained and exacerbated by laws that criminalise "sex for reward" transactions. These vulnerabilities are of particular public health concern.

This submission draws on the literature available on sex work and health in South Africa. It describes how criminalisation of sex work creates unhealthy living and working conditions for sex workers, exposes sex workers to a higher risk of physical violence, limits sex worker access to health services as well as increases the risk of HIV. It argues that the only way in which the public health concerns surrounding sex work can be addressed, while safeguarding the human rights of sex workers is through the non-criminalisation option as set out in the South African Law Reform Commission Discussion Paper.

Introduction

Since the beginning of the AIDS epidemic, sex workers as a group have been at high risk of contracting HIV and STIs (UNAIDS, 2002; Evans, 2005). Factors such as the criminalisation of sex work, concurrent sexual relations, the difficulties in using HIV prevention technology, on-going exposure to high levels of violence (in particular gender based violence), stigma and the barriers to accessing health care services compound and interlock to render sex workers particularly vulnerable to HIV/AIDS (Scambler and Paoli, 2008; UNAIDS, 2002; WHO, 2005; Open Society Institute, 2006) . It is therefore not surprising that HIV prevalence levels amongst sex workers in Hillbrow were found to be 45% in the late 1990s (Rees *et al.*, 2000).

Various conferences (Open Society Institute, 2005; RHRU, 2001; Hillbrow Health Precinct, 2007; RHRU & SWEAT, 3-5 February 2009; RHRU & SWEAT, 2009) and official government documents (Gauteng Multisectoral AIDS Unit, 2006) have acknowledged the importance of tailoring HIV prevention programmes to sex workers. Addressing a conference on adult sex work and public health in 2001 the national Minister of Health, Manto Tshabalala-Msimang, identified the connection between criminal prohibition and sex worker vulnerability, and officially committed the Department of Health to the legal reform process. She said:

“A key element of the new dispensation in South Africa is a formal commitment to promote and guarantee equality and to prohibit discrimination. This has been provided by bodies such as the Human Rights Commission and Commission on Gender Equality to monitor the government’s respect for human rights. Despite these changes, sex workers are still subject to widespread discrimination that prevents them from enjoying the rights that are ensured by the Constitution. [...] One strategy to improve sex workers’ lives would therefore be to remove laws that prevent them from working safely and from travelling to other countries to work legally. Legal challenge is only one part of the equation. Because of stereotypes about their profession, they are poorly treated by mainstream service providers and other institutions. Initiatives promoting sex worker participation in service provision and programme management play a central role in assisting sex workers. [...] The Department of Health and NGOs are fully supporting the process of reforming the law on sex work as it has implications for the provision of reproductive health services.” (RHRU, 2001),

More recently, South Africa’s National Strategic Plan 2007-2011 (NSP) explicitly rejected discrimination against sex workers, acknowledged the increased vulnerability of sex workers towards contracting HIV and recommended the rolling out of customised prevention packages for sex workers (Department of health, 2007). (See Appendix A for a summary of the provisions in the NSP that relate to sex work). Significantly, the NSP recommends that sex work in South Africa is decriminalised. Yet, despite recommendations and appeals on paper, very few specialised health programmes for sex workers exist, and South Africa seems to have little political will or local experience and expertise to draw from in addressing the challenges that sex workers face.

It is often noted that sex workers constitute an ‘invisible population.’ The deep-rooted stigma that attaches to the sale of sexual services, the on-going criminalisation of sex work the squalid conditions under which many work, compound the secrecy and mystery that attach to sex work and ensure that little information is available about sex workers’ health and wellbeing. For example, we do not know approximately how many women work as sex workers in South Africa, how the number of sex workers is affected by increasing unemployment or cross-border migration into South Africa, where their various places of work are, who their clients are, and indeed how many women would be willing to self-identify as sex workers. Much of the research on sex work in South Africa that is available focuses on Cape Town and Hillbrow, Johannesburg (Richter, 2008b).

The research that is available highlights the dire living and working conditions of sex workers and how the lack of legal protection compounds sex workers’ vulnerability to violence, ill-health and exploitation. Under the present criminal laws, sex workers, already viewed as a marginal and stigmatised group, are relegated to the ranks of criminals. This criminal status lends legitimacy to discriminatory and unsympathetic attitudes by those in the health, welfare and police services. Because the work is illegal, sex workers are unprotected by labour laws and the law of contract and are unable to mobilize or otherwise ensure safe working conditions. Their vulnerability as a group is thus exacerbated, deprived as they are of the benefits of the law (Sex Worker Education & Advocacy Taskforce *et al.*, 2002).¹

The most pertinent facts about sex workers in South Africa are summarised here and will be explored in more detail below:

- *HIV prevalence*: In studies done in 1998, HIV prevalence rates amongst different sex worker groups were between 45% - 69% (Rees *et al.*, 2000; Williams *et al.*, 2003).
- *Violence*: Sex workers often report violence (Vetten and Dladla, 2000; RHRU & SWEAT, 2009) and in particular police harassment and brutality to researchers; their complaints include police assaults, getting sprayed with tear gas, rape, extortion, and demands for sex or money as bribes (Pettifor *et al.*, 2000) (Wojcicki and Malala, 2001; Arnott, 2004; Gould and Fick, 2008; Fick, 2006; Richter, 2008a; Fick, 2005).²

¹ This submission draws substantially on the papers presented to the Constitutional Court in the *Jordan* case and in particular from the *amicus* submissions by the Centre for Applied Legal Studies (CALs), the Sex Worker Education and Advocacy Taskforce (SWEAT) and the Reproductive Health & HIV Research Unit (RHRU).

² Also see the recent submissions made to the South African Law Reform Commission by sex workers in Johannesburg. Available: <http://www.womensnet.org.za/campaign/decriminalise-sex-work-now> Accessed: 29 June 2009.

- *Working conditions:* A study in 2001 on sex workers in Hillbrow reported the high level of sexual coercion, and the high level of concurrent sexual partners (Reproductive Health Research Unit *et al.*, 2002). On average, the respondents had had sex with 10 clients in the past seven days. Remuneration ranged from R20–R100 (median R50). The findings of that study showed how structural factors such as poverty, violence, abuse, criminalisation and substance abuse restrict sex workers' choice and autonomy while also impacting on their physical and mental health. Most sex workers interviewed in the year 2000 in Hillbrow said that they would leave sex work 'immediately' if they were given the option (Nairne, 2000).
- *Rape:* Almost one-third of sex workers in the above study reported they had had sex against their will in the last six months (Reproductive Health Research Unit *et al.*, 2002). In a recent study in Cape Town, 12% of street-based sex workers had been raped by a police man (Gould and Fick, 2008).
- *Barriers to Safer sex:* A range of barriers to using condoms is often reported. Sex workers in Hillbrow noted that it is difficult to persuade clients to use condoms and that they feared a violent reaction if they insist on condom use (Pettifor *et al.*, 2000; Nairne, 2000). Some clients demand paying half-price when condoms are used, while the intense competition for clients weakens individual workers' bargaining power as the client could threaten to make use of the services of another available sex worker who does not insist on condom use (Pettifor *et al.*, 2000)
- *Stigma & health care:* Judgmental health care worker attitudes prevent sex workers from seeking health care services (Stadler and Delany, 2006). In the RHRU study, just under a quarter of the respondents reported having one or more STI symptoms (Reproductive Health Research Unit *et al.*, 2002).

Sex work is plainly a gender issue and patriarchal power structures are reflected in the transactions that occur: the vast majority of sex workers are female, while clients are generally male (Reproductive Health Research Unit *et al.*, 2002; Gould and Fick, 2008).

Definitions of sex work

The definition of sex work or prostitution is highly contested. Various definitions for sex work (or the more stigmatising term "prostitution") have been used in the literature. UNAIDS (2002) notes that no single definition of sex work would be able to cover the wide range of activities that centre on sex and money/resources. UNAIDS (2002, p. 3) guardedly employs the following definition for its texts: "Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously

define those activities as income-generating.”³ The Open Society Institute (New York) prefers a definition that emphasises the commercial aspect and the wide range of activities and forms that sex work can take: “[Sex work refers] to the varied forms of sexual commerce engaged by adults. Some forms of sex work are more informal and occasional; others are more regular and organized” (Open Society Institute, 2006) p.6.

In a study by the RHRU in which 202 female sex workers in Hillbrow were interviewed, the researchers noted how sex workers define their own work:

Sex workers clearly identify what they are doing as work, or ‘doing business,’ and distinguish this from their non-working lives as women who are girlfriends, mothers and providers. This is evident from the constant comment by sex workers that they perform a service, a job for men. They define their service as penetrative, vaginal sex with a condom, resulting in ejaculation in exchange for cash (usually R20). There is also an expectation that the sexual exchange will take place within a particular timeframe, up to 15 minutes (Reproductive Health Research Unit *et al.*, 2002, p.14).

The following extract from the first Pan-African sex workers conference is important:

Sex workers defined sex work as:

- “We are services providers and we are also targets to people out there who have these other and weird ways of doing things. We are multi-tasked people, we are mothers, daughters”
- “Having sex in exchange of money due to poverty, others are sex-a-holics and they need money. The state must recognise that we render a service, it is a profession. As sex workers we need to stand together and protect each other”
- “We are human beings who deserve like other people, we have feelings like others. We deserve to be treated with respect”
- It is a job, we support our families, we are single parents, and we are breadwinners.”
- “It is a career like any other, but in the eyes of society it is not and they call us names. So we have to show them that we are something more than just sex workers, we are peer educators. Need to educate clients and other sex workers who refuse to use condoms. Need to join movements.”

³ UNAIDS notes: “Policy and programme development is best served by language that is not stigmatizing and recognizes that many of those involved in sex work regard it as their source of livelihood. It should be noted, however, that no single term adequately covers the range of transactions taking place worldwide that involve sex work. The appropriate term to use for sex work is best defined relative to the local context. This definition may change over time as attitudes evolve. Priority must be given to reflecting how those involved in sex work perceive themselves in that role. Note, however, that the majority of sex workers do not define themselves as such and consider the work to be a temporary activity. [...] The term sex worker has gained popularity over prostitute because those involved feel that it is less stigmatizing and say that the reference to work better describes their experience.” (UNAIDS, 2002) page 3

- “Sex workers are unemployed women who are using their bodies to make a living”
- “A sex worker is someone who is earning and selling for an exchange of money. We help those who are in need of sex. We are market sellers because we are marketing ourselves”

What terms should we use?

Based on the discussion above, sex workers attempted to come up with common terminologies for the sex workers. It was apparent, that people had a range of ideas for what they would like to be called (as can be seen below), but the common idea behind all of this, was that whatever term was decided on, it must be steeped in respect and pride. Sex workers agreed that vulgar language would be considered extremely unacceptable such as whore, *magosha*, and prostitute.

Commonly accepted terms were:

- Sex worker is preferred over prostitute;
- Ambassador
- Nightwalkers
- amatoyis
- activist woman
- Survivors, because no matter where I go, there will always be clients to make money
- Off
- Ladies of the night
- Entertaining ladies
- Escourt

(RHRU & SWEAT, 2009) at pages 29-30

Another distinction is drawn by the anthropologist Janet Wojcicki who separates the sex work industry in Hillbrow from the sex-for-money exchanges that take place in township *shebeens* and taverns, such as in Soweto and Hammanskraal. She notes that the sexual relationships between the women and men in the township beer halls are much more ambiguous and fluid than the seemingly strictly commercial transactions that take place in Hillbrow: “It is unclear whether a woman will have a one-night stand with a man who buys her beers, whether she will enter into a semi-permanent boyfriend relationship with him, or whether she will ‘escape’ from the man after he buys her beers. Second, the amount of money or goods exchanged is not fixed, as it is in a hotel or brothel” (Wojcicki, 2002b, p.8). There seems to be less of a stigma attached to this money-for-sex exchange (called *ukuphanda*), while the woman sometimes also performs domestic chores for the man. These women do not identify themselves as ‘sex workers,’ nor do they wear ‘short skirts’ (which they identify with disdain as what sex workers in Hillbrow would wear) (Wojcicki, 2002b; Wojcicki, 2002a). Hunter describes similar phenomenon in Mandeni in KwaZulu-Natal and argues that money-for-sex exchanges sex are the main cause of HIV in this area (Hunter, 2007; Hunter, 2002).⁴

⁴Hunter makes the following important point about the spectrum of activities that constitute “transactional sex”: “Transactional sex has a number of similarities to prostitution. In both cases, non-marital sexual relationships, often with multiple partners, are underscored by the giving of gifts or cash.

While acknowledging that “sex work” is barely distinguishable from transactional and survival sex or “Sugar Daddy relationships”, this submission uses the term ‘sex work’ to refer to ‘adult commercial sex work,’ while employing the definition provided by Gould & Fick (2008, p. 5): “the exchange of sexual services for financial reward.”

Summary of research on sex work and HIV in Africa⁵

Sex workers are one of the most vulnerable of groups to HIV infection. They are also important and effective partners in halting the spread of the HIV epidemic in Africa. For these reasons, this area of research is an important in the study of HIV/AIDS. This section will summarise some of the main findings in the biomedical literature on sex workers and HIV in Africa.

The majority of sex workers in sub-Saharan Africa, as in other settings, do not define themselves as “sex workers”. Many consider the receipt of money or goods as par for the course in a sexual relationship and as quite distinct from sex work *per se*. This has a number of implications for public health and educational programmes that couch their programmes as “targeting sex workers”.

Sexually Transmitted Infections (STIs)

Sex workers carry a high burden of HIV and STIs. Comparison between the prevalence of HIV and other STI in the general population and that in sex workers and their clients clearly shows the disproportionate burden of these infections among sex workers and clients. For example, in 2002, HIV prevalence in Benin among adults in the general population was an estimated 2.3%, while prevalence was 44.7% among sex workers . Similarly in Guinea, national HIV prevalence was 2.8% compared with 42% amongst sex workers (Godin *et al.*, 2008). HIV prevalence was 18.9% in registered sex workers in Dakar, Senegal (2002 bulletin Senegal health ministry), 14.3% in 2001 in Mbour (coastal tourist area) and 29.8% in Kaolack in 2001, while the population HIV prevalence was 0.5% in 2002.

Transactional sex, however, differs in important ways: participants are constructed as “girlfriends” and “boyfriends” and not “prostitutes” and “clients”, and the exchange of gifts for sex is part of a broader set of obligations that might not involve a predetermined payment. The use of the concept “transactional sex” is intended neither to maintain inflexible distinctions between the categories of “prostitution”/“transactional sex”/“non-transactional sex” (indeed, sex, like all embodied practices, is always simultaneously material and meaningful in complex ways), nor to naturalize heterosexual sex, the principal focus of this article. (Hunter, 2002) p.100-101

⁵ This section is based on research-in-progress by Dr Matthew Chersich, International Centre for Reproductive Health, Mombasa, Kenya

Condom-use

Refusal by clients remains the most important reason for non-condom use (Luchters *et al.*, 2008). In a multiple response question in a study in Ghana, women cited client refusal (73%), receiving a higher payment (33%) and client brutality (43%) as reasons for not using condoms (Adu-Oppong *et al.*, 2007). About one in five (19%) sex workers in Antananarivo, Madagascar, had in the past month experienced having wanted to ask a client to use a condom but felt too afraid to ask (Behets *et al.*, 2005). Nearly three quarters of sex workers in that study also reported having had sex with a client who had refused their request for condom use.

Few of these sex workers believed their co-workers would decline a client who refused condom use. Of particular concern, 7% of non condom use was due to instructions from the owner of their working place. Much evidence suggests that where sex workers are poorly organised and when there are few alternative sources of income, they are less able to refuse a client who is unwilling to use a condom. A finding consistent across several studies is that clients offer sex workers more money for sex without a condom (Wojcicki and Malala, 2001; Karim *et al.*, 1995; Ntumbanzondo *et al.*, 2006; Umar *et al.*, 2001; Varga, 1997).

Socio-economic context of sex work

Overall, most sex work takes place within an unhealthy and unregulated working environment, with little or no promotion of safer sex, scant control over client's behaviour and the encouragement of a high client turnover. In areas with economic - and especially food - insecurity, sex work is often the sole option for women, especially those with dependants. For example, women who sold beer and sex to truck drivers and local men at a truck stop between Durban and Johannesburg, South Africa, described financial support of their dependent children or relatives as a key motivator for sex work (Karim *et al.*, 1995). Importantly, a study in Nigeria showed that hunger and food insecurity were particularly strong predictors of unsafe sexual behaviour among sex workers (Oyefara, 2007).

Mobile people, migrants and their families are more vulnerable to HIV than are populations which do not move around. This includes people who move from one place to another temporarily or permanently, as well as migrants who have taken up residence or remain for an extended stay within a foreign country. The most vulnerable mobile people are refugees and internally displaced people, who live through chaotic and often violent conditions. In such circumstances, protecting oneself against a possible risk of HIV may be seen as a low priority. Women and girls among this group can find themselves deceived or coerced into sex work to gain access to basic needs such as food, shelter and personal safety.

Women searching for work are also often highly mobile and vulnerable. Women may move to an area seeking employment, and then enter the sex trade out of financial necessity upon arrival. Alternatively, potential employment in the sex trade may motivate movement. Women from rural areas, in particular, may move in search of a better life in cities, drawn either by friends or family there or by images of cities as places of opportunity.

West African studies, in particular, show that female sex workers in a country are often not nationals of that country (Ghys *et al.*, 2002; Adu-Oppong *et al.*, 2007). Economic and political instability in neighbouring countries can lead to rapid changes in the nationality of sex workers in a specific country (Alary *et al.*, 2002; Ghys *et al.*, 2002). In Benin 58% of female sex workers interviewed had lived in the area for less than six months. The level of loss-to-follow up in studies among sex workers is generally higher than studies among other population groups, which may be indicative of the transient nature of this population (Steen *et al.*, 2000; Mukenge-Tshibaka *et al.*, 2002; Ghys *et al.*, 2001; Vickerman *et al.*, 2006).

Several studies have found that population mobility is associated with high-risk sexual behaviour and HIV among women (Aklilu *et al.*, 2001). Mobile women are more likely to report having received money or goods for sex than their non-mobile counterparts. Migrant populations face obstacles to accessing HIV information, health services and prevention commodities such as condoms. Newly-arrived women may not know which services to access and may face language barriers or be turned away by providers. Moreover, xenophobic discrimination and violence are all too common phenomena in African settings.

Sex worker health services

***Mobile interventions: the Sex Worker Project in Hillbrow*⁶**

It would seem as if the Reproductive Health & HIV Research is the only institution that provides sex worker-specific health services in South Africa.

The Hillbrow context

Sex Work in Johannesburg has been documented since the city's inception in 1886 (Fraser, 2008) and has become more closely associated with Hillbrow in the last few decades. Hillbrow - or, as Leggett terms it, the 'den of iniquity' (Leggett, 2002) — is one

⁶ This section draws on (Richter, 2008b)

of the most densely populated areas in Africa, with about 65 100 people per square kilometre (Statistics South Africa, 2003). Some commentators have pointed out that the population density of Hillbrow is five-times greater than New York City's (Silverman and Zack, 2007) . Ninety-nine percent of Hillbrow residents live in apartments or flats (World Organisation Collaborating Centre for Urban Health, 2007) and many live in unhealthy conditions in unsafe buildings (COHRE, 2005) . People's access to services is uneven and many poor residents of Johannesburg's inner city do not have access to water and electricity (Wafer *et al.*, 2008).⁷ Many residents tolerate these difficulties either because they need the work opportunities offered by the inner city, or because they have nowhere else to go.

Hillbrow is the first stop for many new arrivals in Johannesburg — either people from inside or beyond South Africa's borders (Gotz, 2004). A 2002 household survey of 200 people in Hillbrow found that 36% of hotel residents were not South Africans (Leggett, 2002; Leggett, 2005). Lewis, Rudolph & White call these cross-border migrants Hillbrow's 'hidden population.' (Lewis *et al.*, 2003) In popular consciousness, Hillbrow is known as a 'red-light district' and indeed three-quarters of respondents in the study by Leggett (2002) reported that there were sex workers in their building, while 25% of the women interviewed said that they sold sex. Literature on sex work in Hillbrow regularly states that there are between 5 000 and 10 000 sex workers operating in Hillbrow, but there is no accurate census data available to verify the estimates (Pettifor *et al.*, 2000; Rees *et al.*, 2000; IRIN, 2006).

Sex worker-specific health services in Johannesburg's inner-city

The RHRU is an academic and service-based organisation, at the University of the Witwatersrand, which conducts research into the fields of sexual and reproductive health and HIV, while supporting the public healthcare system through partnership with the Department of Health. Its head office is situated in Hillbrow, Johannesburg. The RHRU has provided health-related services to sectors of the Hillbrow population since its inception in 1994. The RHRU recognised that specialised healthcare services for sex workers in Hillbrow were necessary, particularly because sex workers often report limited movement and high levels of violence and stigmatisation as well as ill-treatment by healthcare workers (Pettifor *et al.*, 2000; Dunkle *et al.*, 2005).

In 1996, RHRU staff at Esselen Street Clinic began providing Thursday-evening healthcare services for sex workers. Through various research studies and sex-worker-specific projects, from 1998–2002, the RHRU designed an intervention to provide acceptable and effective STI treatment and prevention services to sex workers based in

⁷ The studies by the Centre on Housing Rights and Evictions (COHRE) (2005) and Wafer *et al.* (2008) employed qualitative research methods to document the experiences of inner-city residents. The studies do not contain quantitative data on the number of residents who live in dangerous buildings or do not have access to services.

the inner city. The intervention was designed in consultation with sex workers who had previously identified the need for more accessible services. The intervention took the form of a mobile clinic, which is staffed by a trained primary healthcare nurse and community healthcare workers. This mobile clinic visits a range of Hillbrow hotels (or 'brothels') on a monthly basis, and offers resident sex workers services such as HIV testing, pregnancy tests, STI diagnosis and treatment, PAP smears, free male and female condoms, family planning advice, referrals, health education and health talks. This is known as the outreach component of the Sex Worker Project (SWP). Sex workers can also access these and additional services at Esselen Street Clinic (a public primary healthcare clinic) where project staff are available to consult with sex workers at regular times. The services of the outreach component are aimed particularly at assisting street-based sex workers who may not be reached by hotel-based consultations.

One community health worker assists men especially and provides health talks to men in the hotel bars, whereby outreach services are provided. A recent addition to the SWP is the Exit Programme and Peer Educators component. Numerous sex workers have been trained to provide health education to their peers and to encourage their peers to make use of the SWP services. This cadre of peer educators receives on-going skills training to prepare them for alternative employment. It is anticipated that the Exit Programme will train interested sex workers to take up gainful employment in alternative forums.

In 2001, the RHRU, the Sociology of Work Programme at the University of the Witwatersrand and the Vrije University Amsterdam conducted research among female sex workers and their clients in an attempt to understand sex work as a form of work and to describe working conditions in the industry in Johannesburg (RHRU et al., 2002). In that study, 202 female sex workers were interviewed, in July and August 2001, about their experience with the pressures of making a living by engaging in sex work, the high level of sexual coercion, and the high level of concurrent sexual partners⁸. The findings were striking — on average, the respondents had had sex with 10 clients in the past seven days, and, by including non-client partners, the respondents had had sex with 11.1 different partners in the past seven days. Most clients had paid the respondents in money, not kind, and a significant proportion of partners (or boyfriends) had also paid for sex with the respondents. Remuneration ranged from R20–R100 (median R50), while main and regular partners seemed to pay slightly more for sex than the clients. In addition, it is clear from the findings of that study that structural factors such as poverty, violence, abuse, criminalisation and substance abuse restrict sex workers' choice and autonomy while also impacting on their physical and mental health (RHRU et al., 2002).

⁸ Defined as: 'partnerships [that] overlap in time, either where two or more partnerships continue over the same time period, or where one partnership begins before the other terminates' (Parker *et al.*, 2007)

This research showed that these hotel-based services were acceptable to female sex workers in terms of quality, accessibility and efficacy (Stadler and Delany, 2006). The services were shown to positively influence health-seeking behaviour, health awareness, and condom use among sex workers. In addition, the SWP intervention has encouraged a shift in perceptions of the hotels as 'diseased and dirty' to 'safe and healthy.' The new image has created an environment in which safer sexual practices are more often possible (Stadler & Delany, 2006). Essential components of the project's success have been attributed to a dedicated, non-judgmental and sensitive cadre of healthcare workers, a strong referral network, and efforts to forge good relationships with hotel managers and other 'gatekeepers' who control access to the sex worker population in Hillbrow (Richter *et al.*, 2008b; Richter *et al.*, 2008a).

Health and Sex Work in South Africa

The current socio-legal context within which sex work takes place has a powerful impact not only on the lives of sex workers, but also of their dependants, their partners, their clients and ultimately the health of broader society.

Public health arguments for the decriminalisation of sex work highlight the following consequences of the on-going criminalisation of sex work:

1. Increasing sex worker vulnerability to violence from clients, partners and police;
2. Creating and sustaining unsafe and oppressive working conditions;
3. Increasing the stigmatization of sex workers;
4. Restricting access to health, social, police, legal and financial services;
5. A negative impact on safer sex practices; and
6. Impacting on the ability to find other employment.⁹

All of these factors impact on sex workers' ability to protect themselves against HIV, to prevent HIV transmission to their sexual partners and clients, and to access HIV-testing, treatment and support.

⁹ This is a summary of the arguments that were advanced in the Constitutional Court in Sex Worker Education & Advocacy Taskforce (SWEAT), the Centre for Applied Legal Studies (CALS) & the Reproductive Health & HIV Research Unit (RHRU) (2002) Amicus curiae submission in the case *Jordan v State*. Johannesburg.

Access to health services

Sex worker access to health care services is limited. This is partly because of a fear of being discriminated against and partly because of a fear of the consequences of disclosing their identity. SWEAT's evidence is that this can include, for example, failure on the part of health clinic staff to treat STI status confidentially, negative attitudes, refusal to dispense sufficient condoms and unwarranted public accusations of being "vectors" of disease. It also includes threats by health service providers to inform the Department of Social Services of their work and an associated threat that their children will be removed from their care. The fear associated with being treated in this way if identities are disclosed reduces a sex worker's access to proper health services. This is particularly important in relation to ensuring HIV testing, supply of condoms and STI treatment.

Sex workers often do not trust health workers to protect their confidentiality - particularly in relation to the rest of their communities and fear the consequent response by their community and family. This also reduces access to health services (Stadler and Delany, 2006; Delany *et al.*, 2000b).

A lack of concern for sex workers is also seen in the health and social services. Few if any services in Hillbrow provide specific psychosocial or legal assistance for sex workers. Sex workers have reported stigma, ill-treatment and verbal abuse from healthcare workers at public clinics (Nairne, 1999; Stadler and Delany, 2006). As an alternative, some sex workers typically seek assistance from private doctors, pharmacists, or traditional healers or use home remedies to avoid hostile or overcrowded public healthcare facilities (Stadler and Delany, 2006; Delany *et al.*, 2000a; Wojcicki and Malala, 2001). Sex workers often perceive traditional healers as less judgmental (Delany *et al.*, 2000a). Focus group discussions with sex workers in Hillbrow revealed that they would like health services that are hotel-based and staffed by a doctor or nurse who would examine and treat them effectively and respectfully (Delany *et al.*, 2000b).

The stigma that is associated with sex work is exacerbated by the laws that criminalise sex work and overlooks the role that men play in sex work as consumers of sexual services¹⁰. This stigma prevents many sex workers from seeking health care from health care facilities. Seshu describes it in the following way:

Stigmatization, which has its roots in the standards set by patriarchal morality, is experienced as the major factor that prevents women from accessing their rights. This impacts the lives of women in more ways than one. Some of the rights denied to women due to discrimination are:

¹⁰ Delany and Nielson call for a focus on the role that men play in the sex work industry and that programmes should target sex worker clients (Delany and Nielson, 2000)

freedom from physical and mental abuse; the right to education and information; health care, housing; social security and welfare services. (Seshu, 2003) p.4

HIV/AIDS

UNAIDS gives a number of factors that increase sex workers' vulnerability to HIV:

- stigmatization and marginalization
- limited economic options, in particular for women
- limited access to health, social and legal services
- limited access to information and prevention means
- gender-related differences and inequalities
- sexual exploitation and trafficking
- harmful, or a lack of protective, legislation and policies
- exposure to risks associated with lifestyle (e.g. violence, substance use, mobility)

(UNAIDS, 2002) page 2

Because sex workers have generally been overlooked in South Africa, research on HIV/AIDS and sex workers is limited. What we do know makes it clear that sex workers are very vulnerable to HIV. As noted previously, in a study conducted between 1996 and 1998, 45% of sex workers in Hillbrow were found to be HIV infected (Rees et al., 2000). Dunkle et al. (2005) (using data collected in the study by Rees et al., 2000) highlight the massive increase of HIV prevalence among sex workers in Hillbrow, citing data showing that, in 1986, only one sex worker in a sample population of 251 sex workers attending STI clinics in Johannesburg was HIV-positive. National HIV prevalence among antenatal clinic attendees in South Africa has increased from 0.7% in 1990, to 14.2% in 1996, to 29.1% in 2006 (Department of Health, 2007b); prevalence was most recently estimated at 28%, in 2007 (Department of Health, 2008b).¹¹ Therefore, it is likely that HIV prevalence in the high-risk population of urban sex workers has also dramatically increased since the 1996–1998 data were collected.

Pettifor et al. (2000) conducted focus group discussions with self-declared sex workers in 1997. The sex workers reported that their main problems were their clients'

¹¹ The apparent decrease in HIV prevalence between 2006 and 2007 should be viewed with reserve. In her foreword to the 2007 antenatal survey, the Minister of Health states that "the findings suggest that the South African HIV epidemic is on a downward trend" (Department of Health, 2008) at p. ii. Dorrington & Bourne reviewed the methodology employed in the 2007 survey and argue that the claim of decreased prevalence cannot be substantiated because of differing sample sizes and reweighting errors. They note: "An estimate of national [HIV] prevalence produced by a weighted average of the provincial prevalence using the method applied to the 2006 data (updated to use the 2007 mid-year population estimates) gives an estimated national prevalence of 29.4%, which suggests, given the overall uncertainty in the estimates, that overall prevalence probably has not declined from 2006 to 2007." (Dorrington and Bourne, 2008) at p. 755.

unwillingness to use condoms, police abuse, lack of sex-worker-friendly healthcare services, and other sex workers who have HIV. Dunkle et al. (2005) found that older years of age, being in sex work for a longer time, increasing the use of condoms and performing oral sex reduced Hillbrow sex workers' risk of contracting HIV.

Pembrey (2008) points out that it is not necessarily the high number of sexual partners that places sex workers at risk, but rather the inability to use condoms consistently and correctly. A multitude of barriers to using condoms is often reported. Sex workers in Hillbrow noted that it is difficult to persuade clients to use condoms and that they feared a violent reaction if they insist on condom use (Nairne, 2000; Pettifor et al., 2000; Wojcicki & Malala, 2001). Some clients demand paying less when condoms are used, (repeat?) while the intense competition for clients weakens individual workers' bargaining power as the client could threaten to make use of the services of another available sex worker who does not insist on condom use (Pettifor et al., 2000). Wojcicki & Malala (2001, p. 100) articulate the dilemma: "Sex workers have been cited as being particularly vulnerable to STD (and HIV) infection as they lack access to economic resources and positions of power, and as such may end up having to choose between economic survival and possible HIV infection." Their constrained choices are further highlighted by the fact that most sex workers would want to exit the industry if they had suitable alternatives (Nairne, 2000).

Mental health

Sex workers use different mechanisms to cope with the stigmatization. Some internalise it, splitting the sex work activities from other parts of their lives to maintain some form of normality. Some make use of drugs. Few have access to support structures and mental health services.

The stigma attached to the criminality around sex work also means that non-sex workers feel free to express their moral disapproval towards sex workers through, for example, name calling, throwing things at them and physically assaulting them. Recourse to criminal action in these cases is difficult, because this exposes the sex worker to self-incrimination.

Factors that impact on health

Poverty

Many people who sell sex are already extremely vulnerable as a result of gender inequality and poverty. In the vast majority of cases, women sell sex because their options are limited and it provides a means to earn enough money to feed, clothe and educate their dependants.

The Institute of Security Studies and SWEAT conducted one of the biggest surveys of sex work in Cape Town in 2007 and 2008 and their study is informative on the working and living conditions of sex workers. They found that 76% of sex workers entered sex work as they needed the money (Gould and Fick, 2008). Most sex workers remain in the industry because they are able to earn more by selling sex than they could in other jobs that may be available to them.

One respondent in the study noted:

“Well, I worked for many years in a factory in the clothing industry, but then with all the difficulties in the industry, I was retrenched. I am the only person bringing in money in my family and I needed to make money. (Street-based sex worker)”(Gould and Fick, 2008) p.26

Campbell conducted research amongst sex workers near the Carltonville Mining community in the North West province. She uncovered four general themes of why sex workers took up sex work at the mine:

- The death of a parent or both parents;
- Leaving school after becoming pregnant;
- Running away from the hardships of home; and
- Leaving an abusive man (Campbell, 2000)

Sex workers in this study – as in many other places in South Africa - live in poverty and sex work becomes one of the few survival options open to them.

The RHRU’s *Women at Risk* survey revealed that 90.5% of respondents were single and never married and 65% reported having children (Reproductive Health Research Unit *et al.*, 2002). Their experience is that many women take up the work as a consequence of poverty induced, for example, by the lack of male support, single parenthood, by divorce, after rape or infertility. Sex work should be understood in light of high levels of female unemployment, limited education of women and the consequent lack of skills. Very few sex workers have skills that would permit ready access to the employment market. Women’s choices must also be understood in the context of a history of male migrant labour and urbanisation which took men to cities and caused the break-up of families.

The criminality associated with sex work has adverse consequences for accessing social services. Many state-initiated programmes to assist people with social security and food may overlook sex workers. Because of the stigmatised nature of the sex work industry and negative attitudes, sex workers may not feel entitled to claim social assistance such as the Child Support Grant. In particular, because of a fear that children will be removed from their care if their identities are disclosed, access to disability and child support

grants is inhibited. Sex workers also fall outside the definition of “employee” for the purposes of unemployment benefit legislation. Even though sex workers have specific needs, for example in relation to their children, the criminalized nature of the work means services are not specifically provided to this group.

It would be necessary to have specially targeted sex worker programmes in order to progressively realise their rights, enshrined in section 27 of the Constitution¹².

Migrancy¹³

Hillbrow’s ‘hidden population’ of foreign migrants and its ‘invisible population’ of sex workers may increasingly intersect and overlap. Political turmoil and economic hardship in parts of sub-Saharan Africa (particularly Zimbabwe) have increased cross-border migration into South Africa. Although data on the number of migrants in South Africa is difficult to obtain, NGOs and researchers have noted the increase of undocumented migrants and refugees who seek shelter in South Africa and the abuse and hardship that they frequently endure at the hands of South Africans (Kharsany, 2008; Médecins Sans Frontières (MSF) – South Africa, 2008; SAPA, 2008; Treatment Action Campaign, 2008).

A June 2009 report by the Consortium for Refugees and Migrants in Southern Africa (CORMSA) notes the following:

[...] the number of migrants in South Africa is rising, but South Africa’s foreign-born population is still far lower than many imagine. Importantly, migrants are not distributed evenly throughout the country: they compose 4.1% of the urban population, but only 1.6% of rural residents. While a small number of these international migrants have humanitarian needs, most are self-sufficient. (Consortium for Refugees and Migrants in Southern Africa, 2009) at page 28

In addition, it is well documented that cross-border migrants struggle to access documentation and basic services to which they are entitled (Veary, 2008; Consortium

¹² Section 27 (1) Everyone has the right to have access to -
(a) health care services, including reproductive health care;
(b) sufficient food and water; and
(c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.
(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.
(3) No one may be refused emergency medical treatment.

Barriers to sex worker access to socio-economic rights are explored in more detail in (Sex Worker Education & Advocacy Taskforce *et al.*, 2002)

¹³ This section benefitted from input and research by Jo Veary (Forced Migration Studies Programme, University of the Witwatersrand).

for Refugees and Migrants in Southern Africa, 2009). Many new arrivals to Johannesburg are absorbed into Hillbrow and its informal economy, and anecdotal evidence points to an increase in the number of female sex workers from beyond South Africa's borders (IRIN, 2006; Sex Work Networking Forum, 2008). Even before the wide-ranging violent attacks on foreign migrants in Johannesburg, Cape Town and Durban in May 2008, a high level of xenophobia directed at cross-border migrants had been reported, in particular in Hillbrow.

The 2002 household survey in Hillbrow found that 62% of non-South Africans interviewed reported that they had been assaulted by local residents 'merely for being foreign' (Leggett, 2002). Local residents were not the only culprits: a 2004 study on the police force in Johannesburg found that xenophobia among police officers appears widespread (Masuku, 2006). It can be postulated that these high levels of discrimination and intolerance, and the fact that those persons without relevant documentation can be easily deported and prosecuted by authorities, creates additional and often insurmountable barriers to foreign migrant sex workers' ability to access health services. Recent research confirms that cross-border migrants struggle to access documentation, experience negative interactions with the police, and find it extremely hard to access basic healthcare services, including anti-retroviral therapy (Consortium for Refugees and Migrants in Southern Africa, 2009).

The research from Hillbrow in 2002 showed that a relatively small percentage of sex workers were from other countries – only 11% (Reproductive Health Research Unit *et al.*, 2002). The number of foreign migrants to South Africa has increased in the last years, not least of all because of the political turmoil in Zimbabwe. In the context of increased cross-border migration into South Africa, and against the background of the global financial recession, it is likely that more foreign migrant women will be drawn into sex work as a survival strategy. These women are particularly vulnerable to abuse, exploitation and being underserved by social and health services.¹⁴

Brussa identified a number of barriers for foreign migrant sex workers accessing health care services:

- * Because of their illegal status they do not have a valid health insurance, and consequently, they have no access to the health care system and health promotion measures.
- * Because of their precarious, insecure and marginalised situation, they have no access to information about their rights to, and possibilities for, getting HIV/AIDS/STD prevention and treatment, even if they are insured. Under those conditions, putting safe sex into practice is not a priority anymore.
- * Because of the repressive policy towards migrant sex workers, these people distrust all kinds of authorities, including health care services, which means that they do not make use of those services.

¹⁴Melissa Petro writes that "Migrant women sex workers tolerate not only the rigors of sex work, but also those conditions exacerbated by xenophobia and racism, as well as the challenges of any immigrant worker of any job"(Petro, 2006) at page27.

* Because most of the health care services are not prepared to deal with a multicultural population, i.e. they do not make use of cultural mediators, migrant sex workers are usually discriminated and misunderstood.”
(Brussa, 1999)

It is clear that the law that criminalises sex work deepens the vulnerabilities of foreign migrant women who take up sex work (Consortium for Refugees and Migrants in Southern Africa, 2009).

Conclusion

This submission has shown that sex workers’ economic, social, mental and physical vulnerability in South African society is created, aggravated and sustained by the criminalisation of sex work. Not only do these laws impact directly on sex workers’ dignity and freedom, but they create barriers to sex workers accessing the socio-economic rights guaranteed by the Constitution. Sex workers are threatened by a range of overlapping vulnerabilities – gender, socio-economic status, literacy rates, stigma, HIV-status as well as nationality – and it is vital that this group in particular should be served by caring and effective health care services.

The on-going criminalisation of sex work erects barriers to accessing health care and has a grave impact on sex worker health. This affects not only health on an individual and societal level, but also has a far-reaching effect on the public health of South Africa and the Southern African region.

A recent systematic review of the literature on effective interventions to prevent HIV and other STIs amongst sex workers in resource-poor settings, found that combining sexual risk reduction, condom promotion, and improved access to STI treatment, reduced the risk of HIV and STIs to sex workers involved in the intervention (Shahmanesh *et al.*, 2008).

The importance of structural interventions, policy change, and the empowerment of sex workers in reducing HIV and STI prevalence was also emphasised. This research provides a strong rationale for the provision of sex worker-specific health and social services, dismantling the discriminatory legal environment, and safeguarding the human rights of sex workers – all elements that are contained in South Africa’s National Strategic Plan.

This submission provided evidence that it is a public health imperative that sex work be decriminalised. Not only should the laws that criminalise sex work be struck down and replaced by a legal framework that recognises and safeguards sex worker health and human rights, but sex worker-specific health care programmes should be implemented. South Africa’s AIDS epidemic will only be contained if one of its most vulnerable groups

is not further marginalised by the law, but their legal position in South African society acknowledged and safeguarded.

The sections in the National Strategic Plan relating to sex work should be implemented as a matter of urgency – starting with the recommendation that sex work should be decriminalised.

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Appendix A

Extracts from sections of the NSP that relate specifically to sex work

HIV & AIDS National Strategic Plan for South Africa 2007-2011

3.3 Populations at higher risk

(g) Sex workers

Sex work is not readily defined but includes a wide range of informal and formal activities that relate to the exchange of sex for material benefit. Key characteristics include frequent and repeated exchange of sex with multiple sexual partners usually for monetary gain. Sex workers are predominantly female. Sex workers are at high risk of HIV infection and are vulnerable as a product of higher partner turnover and a limited capacity to ensure safe sex during each and every sexual encounter. Very little is known about HIV prevalence amongst sex workers or their clients in South Africa, but both groups are linked to sexual networks that overlap with the broader epidemic.

Ensuring Equality and Non-discrimination against Marginalised Groups: The NSP is committed to challenging discrimination against groups of people who are marginalised, including people with disabilities, orphans, refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men, intravenous drug users, and older persons. All these groups have a right to equal access to interventions for HIV prevention, treatment and support.

The NSP recognises that several higher-risk groups, such as sex workers and drug users, face barriers to accessing HIV prevention and treatment services, because their activity is unlawful. The NSP therefore recommends:

- The decriminalisation of sex work.
- The finalisation and implementation of the Prevention and Treatment for Substance Abuse Bill, and its incorporation of HIV harm reduction measures.

Intervention Packages

Intervention package: definitions

(viii) Prevention package for sex workers and their clients, includes:

Dedicated services including promotion of VCT; access to male and female condoms; STI symptom recognition; information on gender rights.

Goal 16: Ensure public knowledge and adherence to the legal and policy provisions

Objective 16.3 Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalised groups

Intervention:

Develop and distribute information materials on rights to HIV prevention, treatment and support that responds to the special needs of:

- Sex workers
- Children and adults with disabilities
- Drug users
- ...