TOWARDS DEVELOPING A POLICY FRAMEWORK ON RISKY BEHAVIOR AMONG COMMERCIAL SEX WORKERS: AN INTERVENTION RESEARCH STUDY

BY

EVODIA MALEKGOTA ANNA MABUZA-MOKOKO

SUBMITTED IN FULFULMENT OF THE REQUIREMENTS

FOR THE DEGREE

DOCTOR PHILOSOPHIAE
IN SOCIAL WORK (PhD)

IN THE

FACULTY OF HUMANITIES
DISCIPLINE OF SOCIAL WORK

AT THE

UNIVERSITY OF THE NORTH

PROMOTER: PROFESSOR D W MALAKA

DATE OF SUBMISSION: JULY 2005

DECLARATION

I hereby declare that this thesis is the result of my independent investigation, and that all sources used have been acknowledged by means of complete references.

I hereby certify that this thesis has not been accepted in substance for any other degree, and it has not been submitted concurrently for any other degree.

_____

Candidate's signature

DATE _____

DEDICATION

This work is dedicated to my children, Komane and Pitsi Mokoko; my parents Saxon and Martha Mabuza and relatives from both the Mabuza and Mokoko families.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation and gratitude to numerous people without whose contribution, support, guidance and encouragement the completion of this dissertation would not have been possible.

My supervisor, Professor D W Malaka for her motivation, guidance, moral support and inspiration throughout the course of this study.

My children, Komane and Pitsi Mokoko for their tireless inspiration and motivation and for regarding me as their social and academic role model.

My mother and father for their distant inspiration and motivation.

Lee Rocha-Silva for her tireless inspiration and motivation.

Joshua for his inspiration and motivation.

Dr Wendy Wechsberg for her inspiration, motivation and financial support.

Research Triangle Institute in South Africa, Dr Pundy Pillay, Messrs Viloshne Reddy, Winnie Gumula, Winnie Luseno, Rose George and Terry Swenzy for technical support.

My research respondents who made it possible for me to collect data through their willingness and cooperation.

Prof Oumar Bouare, for his guidance and inspiration.

Finally, I would like to thank God the Almighty for the strength, spiritual guidance and wisdom to complete this study.

TABLE OF CONTENTS

CHAPTER 1
GENERAL ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Sex work has recently been the subject of considerable public debate in South Africa. It has always aroused a wide range of emotions from the communities in which it exists. In fact, debates on sex work have generated various opinions that have ended in polarizing it. While some people are morally outraged by its presence, others are merely curious about it. Some view it as a threat, while others regard it as a necessary evil of major concern to researchers, nevertheless is how the South African legal system should respond to sex work and related problems such as substance abuse (linked with drug trading and trafficking) and unsafe sex patterns (linked with Sexually Transmitted Infections (STIs) including the Human Immune Deficiency Virus (HIV), which emanate from sex work. Approaches used by other countries towards sex work range from criminalisation, decriminalisation, regulation/legalisation, deregulation/ abolition, or a combination of the above. Long-term efforts are made towards eradicating sex work along with tolerating it, and keeping it away from the public view (Davis & Shaffer, 1994:2; South African Law Commission, 2002:1; and Leggett, 1998:22).

The incidence of substance abuse and risky sexual behaviour is of great concern to many researchers and policy makers. Statistics show that one in every nine South Africans is infected with the HIV and that 1,500 people are infected daily. The Kwazulu-Natal Province ranks amongst the highest HIV infected areas in the world, with an infection rate of 33% in the 15 to 49 years age group (UNAIDS, 2000:1; Department of Health, 2001:13; BBC World Report, 2000:3; Sunday Times, 2001:1-2). Annually, thousands of families in South Africa lose their loved ones-breadwinners, fathers, mothers, sisters, and brothers - to death caused by the HIV/AIDS pandemic (Department of Health, 2001:4; South African Demographic and Health Survey (SADHS), 1998:28; United Nations Economic and Social Council, 2001:2; Caldwell, 1995:167 and Rakgoadi 1994:1). Researchers indicate that 30% of the women infected with HIV in the United States, have been infected through heterosexual intercourse, while 70% have been infected through intravenous drug

use. A steady growth of female intravenous drug users (7%) was observed in 1986, while in 1988 there was 10% reported cases and 18% in the period from July 1993 to June 1994. In South Africa, there is still a need to observe the extent of intravenous drug use among female HIV/AIDS reported cases. An observation of sex workers in particular is crucial, as it will provide information on both heterosexual intercourse as well as intravenous drug use infection.

A recent study of the prevalence of HIV and syphilis among pregnant women attending antenatal care clinics in the country's public health sector in October 2002, used a sample of 16, 587 respondents and reported the following results:

In 2002, an estimated 5.3 million of South Africa's 44 million people had HIV compared to 4.7 million in 2001.

About 91 271 of the new cases were babies who became infected with HIV through mother-to-child transmission, an equivalent of 250 infections per day.

About a quarter of the pregnant women were HIV positive, similar to the figure in 2001.

The prevalence of the virus in the under 20years' age group, considered to the best barometer of the infection rate, had not risen for four consecutive years.

Amongst males, the highest incidence of HIV was found among mineworkers (20%).

These findings support the view that although the HIV infection rate is high, there is a significant slowing down in the spread of the epidemic in the country. However, South Africa is considered to have more HIV infection cases than any other country, because about half a million people are estimated to have died already of AIDS (Department of Health, 2002:11).

Research on AIDS in sub-Saharan Africa is determined by the nature of the epidemic in the region. All evidence continues to show that apart from vertical transmission from mother to child and infection from blood transfusions, HIV/AIDS is almost an entirely heterosexually transmitted epidemic. Factors such as an unusually high level of sexual activity outside marriage, an unusually high recourse by men to prostitutes, an unusual level of other sexually transmitted diseases and the avoidance of

circumcision by males have been scrutinized by researchers such as Caldwell (1995:167); Blacker and Zaba; (1997:55), Williams, MacPhail, Campell, Tjaard, Gouws, Moema, Mzaidume and Rasego, (2000:1); and the HIV/AIDS and Human Development in South Africa, (1998:24).

To some extent, sex work and prostitution have a similar effect on the number of sexual partners each person has and also whether they readily use condoms or not. In the South African Demographic and Health Survey, which was conducted in 1998, only 3% of the respondents (women) reported that they had had two or more sexual partners over the 12 months preceding the survey. The figure was slightly higher among currently unmarried women (4%) than among married women (2%). In their study Worjciki and Malala (2001:5) found that women reported using condoms on most occasions, yet they still contracted Sexually Transmitted Infections. Researchers, however, report that there generally, is a low condom use among sexually active people. The most common reason advanced for not using a condom had been that the women had been offered more money for “flesh to flesh” sex whereas those who had insisted on condom use had attracted fewer clients. The dry sex practice, which entails sex with partners who present a vagina that is small and dry, was reported as a popular process as men had regularly requested women to practise it.

1.2 MOTIVATION FOR UNDERTAKING THE STUDY

The link between substance abuse and risky sexual behaviour among the sex workers is little known in the South African society. Most of the studies conducted in South Africa were epidemiological in nature. Researchers focussed on patterns, trends, and the extent of these twin problems separately among the adults and school going children. The following are the reasons why the researcher studied these problems in combination in this study:

The researcher has been involved in the treatment and prevention of health related problems such as prostitution, substance abuse, and HIV/AIDS since 1981 while she served as a social worker in the employment of the Evaton City Council and subsequently as a researcher in the Human Sciences Research Council (HSRC). As a change agent, the researcher is determined to enhance

the social functioning of the people individually, in groups, and at community level in order to achieve tangible results. Research, which entails the mere observation of problems without any action towards alleviating them, overlooks the task of prevention in social work. In the study towards developing a policy framework on risky behaviour among commercial sex workers, researcher has attempted to engage respondents in the prevention and treatment of problems emanating from their work, in order to bring about change. The issues of substance abuse, prostitution and HIV/AIDS emanate from human values. In her practice she applies African values, although she has been trained in Western values. In her daily work as a researcher, she comes into contact with community and people's realities such as substance abuse, prostitution, and HIV/AIDS.

Sub-Saharan Africa has been identified as the worst hit region in the world with HIV/AIDS. It accounts for 70% of the global infections. According to the latest UNAIDS report on the global HIV/AIDS epidemic, in sub-Saharan Africa, HIV is reportedly "now deadlier than war itself: in 1998, 200 000 Africans died in war but more than 2 million died of AIDS". In 16 countries of the sub-Saharan region, more than one-tenth of the population aged 15 – 49 years has been infected. Even Uganda, which has been hailed for having successfully reversed the progressive trend of HIV infection, still has an estimated prevalence rate of 8%, a level that is higher than 5% (UNAIDS 1999: 2-4). This indicates that there is a dire need for further research and a constant review of policy in sub-Saharan Africa to alleviate the existing problems, which have a bearing on substance abuse and HIV/AIDS. It has further been observed that health care systems in the sub-Saharan region are practically overwhelmed and that many terminally ill people are nursed at home. At the community level, this implies that African women have an especially heavy burden as women, who are poor but remain the traditional care givers. A few community-based initiatives have emerged over the past decade in response to the devastating effects of the AIDS epidemic. Examples that are noteworthy here are the Mothusimpilo Project in Carletonville, South Africa; CINDI in Lusaka, Zambia; WAMATA and KIWAKKUKI in Tanzania; ZINZITHA in Zimbabwe, and TASO in Uganda. These initiatives provide care for bed-ridden HIV/AIDS infected patients, care for the

orphans, counselling as well as preventive education and support for people living with HIV/AIDS. Caring people have initiated the abovementioned projects. These initiatives provide benefits such as taking care of the infected and also disseminating information, which highlights the problem areas and possible solutions, as the current research is doing.

The Central Drug Authority Board (CDA): This statutory body enacted through the Prevention and Treatment of Drug Dependency Amendment Act, No.14 of 1999, coordinates services relating to the combating and prevention of substance abuse in the country and advises the ministers and Government departments on all issues pertaining to drug abuse, trafficking and trading. The researcher is in the Secretariat of this board.

1.3 STATEMENT OF THE PROBLEM

Despite many incidences of prostitutes that have been found murdered in South Africa, research, which involves prostitutes, is scanty. While debates on whether to legalize prostitution or not, are going on in parliament, the South African mass media thrive on stories about prostitution and the fact that it is an income-generating trade which is currently untaxed, yet it is a means of livelihood for a significantly large number of people. Prostitutes are, however, assailed by numerous problems such as violence, clients' refusal to pay, drug abuse, and sexually transmitted diseases including HIV/AIDS. In the current study, the researcher has focussed on prostitution as a problem and the extent to which substance abuse compounds problems that emanate from prostitution.

Prostitution and substance abuse are viewed as twin problems that affect public health. While a great deal of research has concentrated specifically on substance abuse, many researchers have agreed that substance abuse whether directly or indirectly, is either the cause or the effect of many problems that assail humanity (Rocha Silva, 1996:1; The National Institute on Drug Abuse, 1999:48; The National Drug Master Plan, 1999:1; The Drug Trafficking Act, 1992(Act 140 of 1992); The Prevention and Treatment of Drug Dependency Act 1992(Act 20 of 1992).

Thousands of people in South Africa are victims of HIV/AIDS which has been transmitted sexually, yet no research has as yet been conducted as to whether such people are directly involved in sex work, or whether they are victims who have been infected by sex workers. During the apartheid era, researchers in South Africa viewed problematic issues in isolation and never in combination, as they had to present results of the ethnic groups - black, coloured, Asian, and white separately. More research was accordingly presented as either the cause or effect of problems of the different ethnic groups. Statistics shows that one in every nine South Africans is infected with HIV and that 1 500 people are dying daily (UNAIDS, 2000:1; Department of Health, 2001:13; and BBC World Report, 2000:3). Efforts at preventing the spread of HIV infection would thus be attempted in this study.

1.4 AIMS AND OBJECTIVES OF THE STUDY

Whereas aims describe the broad goals of the study, objectives concentrate on short-term goals.

1.4.1 Aims

The primary aim of this study was to create awareness amongst sex workers so that they should view their lives as being of value and take precautions towards avoiding being infected or infecting others with HIV/AIDS, in the process of earning a means of livelihood. Sex workers would be implored to provide preliminary guidance to programme planners and policy makers regarding risk behaviours related to substance abuse and sex work preventive action and policy that would facilitate prevention efforts to be appropriately developed and targeted.

The secondary aims of the study were as follows:

To equip women sex workers with skills and knowledge to make decisions and create a more stable and healthy lifestyle.

To develop a peer-educator model that could be replicated in the other provinces.

To stimulate future research endeavours in new or under-researched areas on substance abuse and sex work.

To broaden the knowledge base of social work by developing knowledge and skills for social work practice in the area of substance abuse and sex work.

1.4.2 Objectives

To fulfil the aims as outlined above, the following objectives were set:

To conduct in-depth interviews with key informants and hold focus group discussions with female sex workers in order to gain insight into the drug abuse and sex work problem.

To review national and international literature on drug abuse and sex work theories and policies in order to have a clear understanding of the issues raised and gaps still existing in this field.

To develop, review, and modify guiding questions for use in the focus group discussions to suit the socio-cultural context of the participants.

To examine ways in which sex workers can protect themselves against harm, violence, and HIV infection.

To conduct process and impact evaluations of the HIV/AIDS and substance abuse prevention programmes through the administration of pre-test, post-test, and follow-up questionnaires.

To identify qualitative key contextual factors related to HIV risk behaviours among drug using female sex workers operating from hotels.

To identify strategies that maximise subject recruitment and participation in such intervention.

1.5 HYPOTHESES / ASSUMPTIONS

In order to guide the researcher and provide direction to the study, the following hypothesis were formulated:

If prevention initiatives are introduced when sex workers are already practising their trade, the risk of being unsuccessful becomes high, because sex workers would already have learned inappropriate and health compromising behaviour or risky sexual behaviour which they might find difficult to change.

This hypothesis will be explored within the limits of the following assumptions:

Risky sexual behaviour is a complex phenomenon, which is dependent upon a variety of factors that interact with and influence one another.

A comprehensive and integrated, culturally appropriate programme would lead to an increase in knowledge related to risky sexual behaviour. This would help sex workers to make informed decisions towards improving their lifestyles, self esteem, and establishing a strong bond with institutions that promote appropriate norms and values that reinforce society, such as the family, school, religious organisations, and good social clubs that do not serve substances of abuse.

1.6 RESEARCH METHODOLOGY

The human service professions (caring professions) are in need of a research methodology that integrates knowledge and practice (Rothman and Thomas, 1994:3; Mouton and Marais, 1990:5; Reid, 1995:2040; and Thomas, 1989:6). The gap currently exists between the application of knowledge and practice so that social work researchers are, therefore, challenged to provide information that will inform practice. Basic and applied research is complementary as one serves to advance knowledge while the other provides solutions to problems. The use of both methodologies is thus essential in the caring professions. Professions such as social work, psychology, nursing, occupational therapy, mental health, and education must forge links in order to complement one another to go beyond the mere advancement of knowledge, towards the active involvement in the solution of problems (De Vos, Strydom, Fouche and Delport, 2002: 22). Basic research findings of all social scientists should be used towards developing applicable theories and also for changing policies and finding solutions to existing problems (De Vos et al 2002: 384). In the study on developing a policy on risky behaviour among commercial sex workers, the researcher has used both the basic research methodology for data gathering, as well as the applied research methodology, for engaging the sex workers in discussions that provided information on their needs and problems as well as planning and taking action towards the solution of some of their problems.

1.6.1 Type of study

The researcher utilised the qualitative data gathering techniques, because the area under study is both sensitive and under-researched. Researchers recommend an exploratory study to unearth information that cannot be easily revealed by quantitative techniques. This study was exploratory. The type of model selected for this study was the intervention model. This model is sometimes referred to as the developmental or applied research model. It utilises both qualitative and quantitative data.

The researcher chose observation, in-depth interviews, and focus group discussions to other qualitative data collection methods such as case studies, as well as oral and life histories. In-depth interview and focus group discussions were emphasised. This choice was based on the findings of other researchers who advanced arguments that focus groups are extremely useful data collection techniques prior to programme planning and implementation (Martins, Loubsor, and Van Wyk, 1999:141; WHO, 1995:187 and Schurink, Schurink, and Poggenpoel., 1998:324 in De Vos and Greef in De Vos et al, 2002:307-308). The above-mentioned authors provided the following reasons on the advantages of focus group interviews:

They produce a wider range of information, ideas, and insight than individual responses secured separately (synergism).

They allow one participant's remark to trigger a chain reaction from other participants (stimulation).

They generate more original ideas compared to individual interviews (serendipity).

They provide the participants with the opportunity to actively participate in the study process and in improving their own lives (empowerment).

They provide opportunities for members to become aware of, to expand, and to change their thoughts, feelings, and behaviour regarding the self and others (self awareness).

Qualitative research aims at describing the social meaning that participants attach to their risky behaviour and the social processes by which the participants come to attach these meanings to their behaviour. It shifts the unit of analysis from the

individual and his/her cognitive decision-making to social interactions, relationships, and situations. It furthermore accepts that risky behaviour is the outcome of a complex interplay between individual and social factors. It also recognises that individual paradigms provide inadequate descriptions of the factors, which determine risky behaviour.

Generally there are two factors that contribute to the importance of qualitative methodologies in the field of substance abuse research. First, continually evolving patterns and trends of substance abuse within our society foster a fluid situation in which emergent and novel phenomena are integral facts of today's drug scene. Deviations from the status quo are an ever-present feature of drug abuse, that is, whether it is the appearance of a new psychoactive drug such as Methamphetamine "Tik" or the emergence of new problems associated with the abuse of controlled substances. Second, the value of qualitative methods in the substance abuse field relates to the types of information required of research. That is, the need for substance abuse research, as well as the resources and priorities allocated to it, is largely driven by the practical requirements of policy makers and professional interest groups. This research might aid the policymakers in taking good decisions concerning complex social issues (Lambert, and Wiebel, 1990:4).

1.6.2 Population and Sampling

Intervention researchers choose a constituency or population with whom to collaborate. A population manifesting issues that are of current or emerging interest to the researcher is selected for the study.

1.6.2.1 Population

For purposes of clarity, a geographic functional community can be described as a specific group of people who share a common need, concern or problem, and exist within a defined geographical community (Van Rooyen and Bennett, 1995:17). The other types of communities are geographical (representing people within a defined geographic boundary) and functional (representing communities of common interest across geographic boundaries). In this study, the term population refers to all commercial sex workers who reside and operate in Gauteng. Rothman and Thomas

(1994:29-30) indicate that research that addresses the critical strengths and problems of important constituencies has a greater chance of receiving support from the target population, professional community, and general public.

Several authors have defined a research population as the totality of persons or objects with which a study is concerned (Hall and Hall, 1996:106, 107; Grinnell (Jr) and Williams, 1990:118; Grinnell (Jr), Rothery and Thomlinson, 1993:132; and Rubin and Babbie, 1997:248). In collaboration with the total population of the study, researchers identify the specific targets and goals of intervention. However, if there are more people than the researcher can possibly contact in the target population, only a sample may be selected.

1.6.2.2 Sampling

In the current study, the researcher used the purposive sampling method to select sex workers who were eligible for inclusion in the study in accordance with the attributes described below, namely age, race, occupation (sex workers indulging in substance abuse particularly the use of crack/cocaine, alcohol, and other drugs). Further, indulging in risky behaviour (practising unsafe sex and having multiple partners) and the determination to stop sex work and having interest to participate in the study were additional criteria used for selecting the sample.

Age: Only sex workers who were between 18 to 50 years old were considered for the study. Research has shown that this age group is sexually active and can make any decision, as the Child Care Act, 120 of 1983 no longer covers them as they are referred to as young adults. This age group has a high rate of morbidity and mortality related to HIV and AIDS and indulges in risky behaviour (South African Demographic Survey, 1998:26).

Race: Only black female sex workers were invited to participate in the study because statistics shows that in South Africa the high prevalence of substance abuse and risky sexual behaviour occurs among poor and disadvantaged women, and is evidenced by the fact that hospitals are overstretched by this race group (HSRC Survey, 2002:5).

Occupation: Only women who practice commercial sex work or exchange sex for money or gifts were recruited for the study. The researcher assumed that training sex workers to practise safe sex, protect themselves physically, and

involving them to develop a policy that would protect their rights would improve the health status of the entire South African population. This would lead to a more responsible behaviour and acceptable life style in terms of the values outlined in the South African Constitution (1996: ILO 2001:12 and IML 2001: 10).

Exclusive use of crack/cocaine: In this criterion, use of other chemical substances and indulgence in risky behaviour were included. Only sex workers who were using crack/cocaine and other drugs while practising unsafe sex as well were recruited for the study in order to develop a prevention programme with the users.

Interest: Besides meeting the set criteria, only sex workers who were willing to sign the consent form (Appendix B) as a demonstration of their willingness, commitment, and interest to participate in the entire study were considered for the study. The researcher regarded this process as extremely important as it shows that the researcher was seriously considering the ethical issues relating to conducting research with human beings this aspect of research would minimise harm and also reduce attrition during the study.

1.6.3 Data gathering techniques

Basic research is defined as a scientific enquiry into a relevant problem. It provides the answers, which should contribute to an increase in the body of generalisable knowledge about a particular problem. In gathering data, researchers should strive to empower the participants in the study with the necessary skills to gain a better insight into their problem and also to devise a possible solution to their problem and thus regain their own sense of dignity so as to take collective action for their self-development (Grinnell, 1993: 20; Rothman and Thomas, 1994:5, Rahman, 1986:2; De Vos et al., 2002:412). In this study, the two main techniques that were utilised to gather data entailed in-depth interviews and focus group discussions. In-depth interviews were held with the key informants, that is, the drug distributors, sex workers, and gatekeepers at various hotels that accommodate sex workers. In-depth interviews provided the researcher with insight on data-gathering skills, which would elicit the cooperation of the sex workers while focus group discussions provided information on the needs and problems of the sex workers.

A total of eight in-depth interviews were conducted with ten gatekeepers (comprising five male security workers who were looking after the premises of low cost hotels where sex work took place, as well as two male and three female pimps who were running the sex work business with some police friend). These interviews helped the researcher identify women sex workers who could be recruited for participation in the study. Prospective participants were subsequently approached by the researcher who explained the purpose and ethical rules of the study in detail, emphasized confidentiality, and requested those who were willing to participate, to sign a letter of consent. A total of twenty (20) participants were finally selected as a representative sample from the population of female sex workers who had been identified. The participants in this research were engaged in providing information, analysing problems, suggesting possible solutions, and testing the viability of suggested solutions, such as experimenting with female condoms.

1.6.4 Description of the research process

In the conceptualisation of the first phase of intervention research, Rothman and Thomas (1994: 27) found several operations or activity steps to be of critical concern. The following phases mentioned by these authors guided the researcher in the current study during the problem identification and data gathering phases:

Identifying and involving participants in the study.

Gaining entry and participation from the setting.

Identifying the concerns of the population.

Analysing the identified concerns.
Setting goals and objectives.

The intervention research process was used in the study towards developing a policy for commercial sex workers. This process helped the researcher to gain information from the respondents on the needs and problems of sex workers while they were actively participating in finding possible solutions to their problems. The researcher was facilitated to integrate both basic and applied research methods. Indeed, selecting the problem to be studied involves a decision by a researcher to invest

time, energy and personal resources in the investigation of a particular problem. Researchers affirm that problem analysis and planning are critical in determining the fit between the programme and the needs of the target population and provide a solid knowledge base for effective programme implementation (Mantell, Divittis, and Auer Bach, 1997:27). In addition, the phases of the research method that has been selected for the study need to be analysed in order to determine one or more of the following factors:

The extent of the difficulty, such as its incidence or prevalence.

The component aspects of the problem.

The possible causal factors.

The effects of the problem, including the behavioural, social and economic accompaniments.

Intervention shortcomings on how the problematic condition should be confronted.

1.6.4.1 Phase I: Problem analysis and project planning

The problem analysis and project-planning phase embraces activities that precede the development effort itself. It assumes a prerequisite, "material condition" that implies the existence of a "problematic human condition", such as substance abuse and sex work which can be addressed by developing a technology that the researcher may use. The existence of such a problematic human condition is often not recognised by, or obvious to, professionals or civilians. The main focus during this phase is thus to achieve this purpose of problem analysis and project planning.

This phase requires assessment skills because the selection of goals and intervention depends upon the proper assessment of resources, skills, and strengths to be utilised in resolving difficulties and in promoting development. Zastrow (1992:71) maintains that assessment skills are part of the common skills that are needed for social work practitioners. He alludes to Pincus and Minnahan's system theory to illustrate the necessity of assessment skills and mentions that social workers as the change agent system should possess assessment skills necessary for creating planned change to people who sanction or ask for their services, who are expected beneficiaries, in other words the client system.

Social workers are expected to bring about change to the target system, that is, the people, agencies, and/or organisational practices that the change agents wish to change in some measurable way in order to reach their set goals. However, social workers cannot effect change on their own. They have to work with the “action system”. This term is used to describe those whom the social worker works with to accomplish the tasks and achieve the goals of the change effort.

In this study, all team members were regarded as part of the change agent system. The study consisted of the subject of the study namely, the research assistants, the focus group facilitators, the experts (Community Advisory Board), and the service providers in the field of substance abuse and risky behaviour. The client system included the sex workers who met the criteria of the study (sex workers who were using crack, cocaine, alcohol, and other drugs) and were regarded as the subjects of the study. The sex workers formed the target of the study as the focus was on increasing their knowledge and changing their attitudes regarding practising unsafe sex and substance abuse. These sex workers were also involved in developing the substance abuse and risky behaviour prevention programme, implementing, and evaluating it. Hence, the sex workers were both the target and the action systems. Researchers coined the use of multiple interveners in one study as investigator’s triangulation (Riley, Marshal, 1999:39; De Vos, 1998:359, Rocha-Silva; 1998:8 and Gordis, 2000:13).

In the conceptualisation of the first phase of the intervention research, several operations or activity steps as adapted from Rothman and Thomas (1994: 27) were found to be important. These steps included the following:

Step 1 - Identifying and involving participants in the study.

Step 2 - Gaining entry and participation from settings.

Step 3 - Identifying concerns of the population;

Step 4 – analysing the identified concerns.

Step 5 - Setting goals and objectives.

(a) Activity step 1: Identifying and involving clients (participants/sex workers)

The researcher used the snowball method to recruit the sex workers in the hotels where they were operating, on the streets, in the bushes, near Atteridgeville, and in and around Marabastadt. She recorded the demographic characteristics of each sex worker but excluded their names. Anonymity was essential, yet the participants had to be provided with transport to a common venue for focus group discussions on a regular basis. The researcher formed a good rapport with the sex workers. She enabled them to identify her, by wearing a T-shirt bearing the words: Women's Health Coop Study NC. Appointments were made with the female sex workers verbally and on cellular phones or by leaving a message with the gatekeeper that indicated that a woman's study official would be visiting the hotel to meet them. After the interviews, the respondents were returned to their homes after they had each been paid a sum of R60.00 to cover the accidental loss of their time.

The interviews were held on the first floor of the Research Triangle Institute, Hatfield, - Pretoria. The venue was convenient for the sex workers, as it was free of noise and no one knew the identity of the respondents. A major ground rule was respect for one another and the need to accommodate one another's opinions. Food was served to ensure that each respondent was not hungry during the sessions and would at least receive regular balanced meals during the course of the study.

In the initial meeting, the researcher officially welcomed all the sex workers as participants of the study individually in order to screen them and request selected volunteers to sign consent forms. The researcher and her assistants were formally introduced to the participants. The researcher explained the role of the research team members. Subsequently, she explained what the purpose and context of the study was about and allowed the sex workers (participants) to pose questions for clarity. The researcher advised them on their status as participants in the study as volunteers, their rights to refuse to answer any questions, the legal liabilities of their participation, confidentiality, and the anonymity of their status, that is, their names would not be used nor revealed anywhere. The participants were also informed that if

for some reason, at any stage of the study, any one should want to discontinue, she should inform the team and she would not be forced to continue.

(b) Activity Step 2: Gaining entry and cooperation from settings

De Vos (1998:368) states that it is imperative to contact key informants (for example, the elite, service providers, and experts) as part of the problem analysis and project planning phase because they can explain local customs/practises to researchers and introduce them to gatekeepers who control access to the setting. Conversations with key informants help researchers understand what they have to offer and how to articulate the benefits for potential participants and members of the group or organisation. Successful intervention researchers form a collaborative relationship with representatives of the setting by involving them in identifying problems, planning the project, and implementing selected interventions. Collaboration helps provide a sense of ownership of the investigation. By working with those who can facilitate access, the researcher gains the co-operation and support necessary to conduct intervention research. Van Rooyen and Bennett (1995:18) mention that in the worker's (researcher's) engagement in entry into the community he or she would need to adopt a systems perspective, where all the systems available for possible co-operation should be contacted. These could include the individual as part of the community, a group within the community, and/or the entire community as part of the broader system or society.

In the current study, entry into the geographic functional community of the study, the hotels, streets, and bushes in and around Pretoria was not easy for the researcher. The researcher had to be introduced to one sex worker who through the snowball method got hold of the rest. Another advantage for the researcher was the fact that she had been a researcher at the HSRC and was familiar with various techniques that enhanced the study.

The researcher sought permission to conduct research from the then, University of the North Research Ethics Committee by submitting the research proposal to them for consideration. This proposal demonstrated a clear view of the research objectives and the researcher's commitment to sound ethical practice. She also stated in the

research proposal that the information gathered would not be used solely to develop academic theory, but to suggest practical solutions to the problem of substance abuse and risky sexual behaviour and to prevent health related morbidity and mortality to the South African nation as a whole, when the study is replicated. The Research Ethics Committee granted the researcher permission to proceed with the study. She was provided with a letter indicating that the project was under the Committee's jurisdiction, and that it was an officially approved activity with due academic credibility.

In addition, the researcher consulted the Research Triangle Institute, hotel owners, pimps, and distributors of drugs to these women, health officials, and other influential people in order to solicit their support for the study. It was not easy, as some gatekeepers tried to convince the researcher that the gatekeeper she had contacted was not very powerful. Due to the researcher's experience and respect for others' territories every problem was sorted out. The researcher too explained the purpose of the study and how it would benefit their health and the entire nation. Thereafter she stressed the intended outcome, the researcher's method to be used, her contribution to the project, as well as the support she needed from all the stakeholders. She informed the respondents that the study was for academic purposes and that she was a candidate for a D. Phil, degree registered with the then University of the North. A commitment for honest responses and regular attendance of sessions was sought from all respondents to enable the researcher to achieve her goal of developing a model for the prevention of substance abuse and risky sexual behaviour. All the stakeholders mentioned above committed themselves and their organisations to supporting the entire project.

(c) Activity Step 3: Identifying concerns of the population

De Vos et al (2002: 388) state that intervention researchers must avoid imposing external views of the problem and its solution. Once the researcher has access to the setting, he or she should attempt to understand the issues of importance to the population. The researcher may use informal personal contact methods and community forums (Rothman and Thomas, 1994:29), as Hall and Hall (1996: 30) remark that applied research is concerned not just with a descriptive "fact-gathering"

exercise, but with understanding the social situation in which the researcher is involved. It should be noted that in the current study, activity steps 2 and 3 were conducted concurrently, as it has been indicated earlier (Rothman and Thomas, 1994:9) that neither the intervention research phases nor the activity steps can be viewed as following each other rigidly. Therefore, when the researcher introduced the study to the leaders of the various stakeholders (gatekeepers, service providers and experts within the settings of the study, namely Pretoria City Centre and Periphery as indicated in step 2, she did what De Vos et al. (2002:41) refer to as "horizontal exploration". The purpose of horizontal exploration is to help the researcher to present problems into perspective. In this study the researcher solicited information, not only about substance abuse and risky sexual behaviour within the study setting, but also about other concerns, in order to ensure that none of the women's important concerns would be omitted.

The stakeholders who had expertise and practical experience shared their views about substance abuse and risky sexual behaviour with the researcher. They advised the researcher on how the sex workers could be reached and recruited. They also voiced their concerns relating to specific problems that sex workers encounter. They confirmed that substance abuse and risky sexual behaviour were rife among sex workers. They stressed that sex workers need to be trained on how to negotiate for condoms use and how they could protect themselves in case of trouble. They mentioned that policies that could protect sex workers were required, to enable them to seek law enforcement protection rather than to arrest them. Concerns relating to other problems that sex workers were experiencing such as rape, harassment, financial difficulties (poverty), assault, robbery, violence, and theft were raised as these too necessitated prevention programmes. They mentioned that such a study was needed and they would support it.

(d) Activity Step 4: Analysing identified problems

The purpose of this activity step is to analyse the identified problem as indicated and understood by the stakeholders (Rothman and Thomas, 1994:30-31) and Hall and Hall, 1996:48). The place of the researcher is to integrate the views of the stakeholders and provide feedback on those views so that everyone understands the

problem better than before. In the current study the researcher held informal discussions with the stakeholders in addressing the following key questions:

- Do sex workers need referral to effective and accessible health and other services?
- What should be done to improve the women's situation?

(e) Activity Step 5: Setting goals and objectives of the prevention programme

The final operation in this phase entails setting goals and objectives (Rothman and Thomas, 1994:312). Goals refer to the broad conditions of outcomes that are desired by the concerned community. Objectives refer to those more specific changes in programmes, policies or practices that are believed to contribute to the broader goals. In this phase, a careful problem analysis yields potential targets for change and possible elements of intervention.

An analysis of the problem of substance abuse and risk behaviour in Gauteng and a review of literature on the subject pointed towards the need for the development of a contextually relevant programme on prevention of substance abuse and risky sexual behaviour. The programme was intended for the prevention of the onset of substance abuse and risky sexual behaviour among the participants and to make every participant a "prevention specialist" with the following goals:

- To increase substance abuse and risky sexual behaviour knowledge.
- To decrease the attitudes favourable to substance abuse and risky sexual behaviour.
- To increase the willingness to stop someone from substance abuse and risky sexual behaviour.
- To increase the willingness to seek alternatives to substance abuse and risky sexual behaviour.
- To decrease the behavioural intentions to substance abuse and risky sexual behaviour.

- To increase among others assertiveness, decision making, resistance, and self regulation skills.
- To develop a positive self concept.

The objectives of the prevention programme included:

- Conducting in-depth interviews with sex workers, to impart comprehensive information on substance abuse and risky sexual behaviour.
- Undertaking observation visits in the evening at the hotels, routes, and streets to evidence how the sex workers conduct their business in order to increase the researcher's first-hand experience of the problem.
- Interviewing people who worked with sex workers to gather information on the type of prevention programme they think could work.

1.6.4.2 Phase II: Information Gathering and Synthesis

The "information gathering synthesis" phase might be subtitled, "not Re-inventing the Wheel", in terms of the phases of intervention in Rothman and Thomas (1994:31-32). When planning an intervention research project, they state that, it is essential to familiarize oneself with what others have done to understand and address the problem. Such knowledge acquisition involves identifying and selecting relevant types of successful practices of individuals or organisations. The outcome of this phase is a list of apparently functional elements that can be incorporated into the design of the intervention. These authors indicate that there are three activity steps in this phase, namely:

Using existing information sources;

Studying natural examples;

Identifying functional elements of successful models;

(a) Activity Step 1: Using existing information sources

A literature review usually consists of an examination of selected empirical research, reported practice, and identified innovations relevant to the particular topic under study. Computerised databases may be particularly helpful in retrieving possible sources of information. Intervention researchers must, however, look beyond the literature of their particular fields (De Vos, 1998:390 and Fawcett, Suarez-Balcazar, White, Paine, Blanchard, and Embree, 1994:31–33 in Rothman and Thomas). This process is essential since societal problems do not neatly confine themselves to the various human and social science disciplines. Intervention research must thus contribute to both the "scholarship of discovery", namely, the generation of new knowledge about behaviour environmental relations and the "scholarship of integration" by establishing new linkages between concepts and methods of various disciplines (Rothman and Thomas, 1994:32).

This aspect in this research is illustrated through the literature review presented in Chapters Two and Three, which shows that the problem of substance abuse and risk behaviour continues to escalate despite an array of diversified efforts to alleviate it. Furthermore, the literature review has revealed several factors that a prevention programme should include, namely:

- Peer education: Equipping the participants with various skills that would enable them reduce the chances of substance abuse and risk behaviour because a lack of such skills is associated with the prevalence of substance abuse and risky sexual behaviour.
- Information on the dangers of substance abuse and risky sexual behaviour: Raising awareness about the dangers of substance abuse and risky sexual behaviour would bring about a reduction in the behaviour of young people, especially female sex workers.
- Perception change approach: Changing perceptions about substance abuse and risky sexual behaviour. For example, making a moral issue a public issue should lead to the adoption of more appropriate ways of dealing with this problem of substance abuse and risky sexual behaviour.

The researcher used various sources as demonstrated in the subsequent two chapters in collating the information concerning the subject. She reviewed books,

journal articles, computerised search services (Internet), and various databases. Besides examining journals and books that were exclusively associated with social work, the researcher reviewed cross-disciplinary literature from databases such as Psychlit, SAINET, Ananzi, Yahoo, Google, and Medline. She also personally approached many university libraries in the country, other than the University of Limpopo (Turfloop campus). These included libraries at the University of South Africa, the University of Pretoria, the University of Limpopo (Medunsa campus), the Human Sciences Research Council, the Medical Research Council, the Department of Social Development Library, and the Resource Centre, and the City of Johannesburg Library. The researcher also approached government departments to review policy documents and relevant local statistics. The interlibrary loans systems were further used for additional information which was not available in the libraries that had been visited. By integrating information from the various fields of study, the researcher achieved what Rothman and Thomas refer to as, a “scholarship of discovery” and a “scholarship of integration”. De Vos et al. (2002:359) refers to the use of multiple sources of information in analysing data within a single study as theoretical triangulation.

(b) Activity Step 2: Studying natural examples

A particular useful source of information is achieved by studying natural examples, that is, involving people who have actually experienced the problem (Rothman and Thomas, 1994:32–33). Natural examples include, among others, victims of a particular situation or those with knowledge about it, such as service providers, who can provide insights into which interventions might or might not succeed and the variables that may affect success. Studying natural examples may be particularly valuable in helping the researcher to understand the methods and contextual features that may be critical to success.

In the current study, the researcher used natural examples in a collective form coupled with anonymity of the subjects/participants. The researcher involved women who used substances and also engaged in risky sexual behaviour, because this study aimed at empowering this population. The researcher conducted focus group interviews (a qualitative data gathering technique) and in-depth interviews with key

informants or gatekeepers in the environment of the study in order to gain more insight into the problem and to assess the variables that may affect the success of a prevention programme on substance abuse and risky sexual behaviour. A focus group interview has been described as a carefully planned purposive discussion among a group of individuals on a single topic or defined area of interest for a limited amount of time in a permissive non-threatening environment (Schurink, Schurink, and Poggenpoel, 1998:314 in De Vos; World Health Organisation, 1995:187; Krueger, 1994:6; Hall and Hall, 1996:159; and Rubin and Babbie, 1997:573).

It is important at this stage, for the researcher to present more information on the focus group study and the in-depth interviews so that the reader might have a clearer understanding of how the two techniques were used in the current study.

Designing the focus group interviews' guide

An initial set of loosely and broadly framed questions for discussion also referred to as a focus group agenda or guiding questions (Martins et al., 1999:140), was adapted from Wechsberg, Zule, and Burroughs, 2003:669-700). It was reviewed and modified from the original version on the basis of two pilot focus group interviews. Twelve guiding questions, which were posed to elicit in-depth information and insight into the participants' perspectives of prevention programmes on substance abuse and risky sexual behaviour, were formulated to cover the following questions: (See Appendix C):

- What do you remember about the Pilot Women's Co-Op Study?
- What was most helpful about the study?
- What was least helpful about the study?
- What were people on the street saying about the study?
- What do women say about the female condoms?
- Have you heard any negative comments or harm caused by women who participate in this study?
- Have there been any changes in police activities directed at sex workers since the beginning of this study?

- Regarding the cards for training the sex workers to protect themselves, what should be added?
- Is it realistic to expect the sex workers who take part in the study to stop abusing substances and sexually risky behaviour?
- What advice should be given to sex workers to help them set their short term and long term goals?
- How might this intervention help women sex workers?
- What other suggestions do you have for a policy to improve the lives of the sex workers in this field?

Conducting focus group interviews

When conducting focus group interviews, the following factors should be taken into consideration:

- ***Facilitator selection and preparation***: Five facilitators or moderators were selected to facilitate the focus group discussions. These facilitators were chosen because they were equipped with skills during a training session that was organised and sponsored by RTI. They possessed communication skills such as listening, probing, reflecting, paraphrasing, attending, observing, and responding which the researcher regarded as necessary when conducting focus group interviews (Riley et al., 1999:137–138; De Vos & Fouche, 1998: 90 in De Vos; Feldman, 1995:31; Lindlof, 1995:33 and Schurink et al., 1998:319 in De Vos). Further training was conducted in order to ensure that the facilitators had a similar understanding, were sensitive to the female sex workers, and to promote the principles of social work to enable them to understand the ingredients of human relationships such as empathy, congruence, and being genuine. The facilitators were provided with further training to ensure that they were well equipped to deal with anticipated challenges such as disruptive behaviour or feelings; and their own biases.
- ***Number of focus groups:*** The eighty participants who constituted the sample of the study were divided into16 focus groups and were randomly assigned to five trained facilitators. The researcher and one moderator facilitated one group.

Further, the individual members were randomly assigned to either a standard group or intervention group. The difference between these groups was that the standard group received gifts and the intervention group received gifts and cards, a tool to train them to protect themselves during their sex work. The facilitator of each group was neutral but the group members could freely interact with one another.

- ***Size of focus group:*** There were sixteen focus groups. Each of the first fifteen groups had six participants, while the sixteenth group had five members only. The group size was small enough for all the participants to have the opportunity to share insights, identify themselves as members, engage in face-to-face interaction, and exchange thoughts and feelings among themselves. It was also large enough to provide diversity of perceptions as recommended by other researchers in the literature review (Schurink et al., 1998:317 in De Vos; Swanepoel, 1997:103; Feldman, 1995:39; Mears, 1995:7; Smit, 1995:26; Stewart and Shamdasani, 1998:3 and Martins et al., 1999:139). The seating position in each group was in a circle in order to stimulate communication between the group members.

- ***Procedure:*** The procedures followed in the focus group interviews in the current study, were derived from Krueger (1994:113). Accordingly, the facilitators welcomed the participants and put them at ease. They made them feel relaxed in order to develop trust amongst themselves. The participants initially sat in pairs and introduced themselves to the group. This process was an “ice-breaker” activity to create a comfortable environment in which the participants felt free to share their opinions. The researcher requested and secured permission to audiotape all discussions. The participants were encouraged to provide as much information as possible and were reassured that all their ideas would be regarded as acceptable and valuable. The focus group participants were told that they were free to argue, disagree, question, and discuss issues with one another in the sessions while the researcher and assistants monitored the discussions by checking that all the issues that were raised were addressed. They encouraged adequate information giving and the maintenance of a lively and relevant discussion. It was necessary from time to time to “probe”, in order to elicit additional information or clarification. The

moderators took notes using notepads and recorded the focus group discussions on audiotapes.

The discussions of focus group interviews were recorded accurately without changing the words or leaving out material. The focus group discussions were facilitated in English and translated into Sepedi, Sesotho, Setswana, and Xhosa, because the participants came from different ethnic groups and did not always understand English, as their education level was generally low. Participants were free to respond in their home languages. The facilitators observed and recorded non-verbal cues in each group, for example, the emotional tone of the discussion, important hand gestures, and unusual behaviour especially when one of the white facilitators wanted some clarification.

The researcher deemed it necessary to conduct in-depth interviews among the gatekeepers as well in order to complement the focus group results in the current study, because some researchers have confirmed the following facts about in-depth interviews:

- Reality can be reconstructed from the world of the interviewee.
- They enable the interviewer to obtain an "insider view" of the social phenomenon under study.
- They enable the interviewer to explore other avenues of research emerging from the interview.
- Socially and personally sensitive topics such as deviant behaviour, problems in relationships, sexual behaviour and unemployment could be discussed more openly.
- They facilitated an understanding of the life world of the research subject as the researcher is in a position to explore the subject in more depth (De Vos, 1998:300; Denzin, 1978:6; and Frey Fontana, 1993:368; Denzin and Lincoln, 1994:583; and Mouton, and Marais, 1996:212-214.)

Designing an in-depth interview's guide

A schedule as adapted from Wechsberg, Zule, Lam, Hall, and Ellerson (2003:669–700) was designed. About eight in-depth interviews were conducted with the

gatekeepers. The researcher designed the questionnaire in such a way that it had direct relevance to the issues which had been raised during the focus group interviews (Appendix C). The gatekeepers were asked the following questions:

- What do you remember about the Women's Coop Study?
- What did people say about this study on women's health?
- How can trust and credibility be created with female sex workers?
- How might this intervention help female sex workers?
- How can female sex workers who use alcohol and other drugs be reached?
- What are some of the barriers to women's participation in the study?
- How can women be helped to stay in the study throughout all the follow-up procedures?
- How can the female sex workers' community be reached without threatening their business?
- Did you notice or hear about any female sex workers experiencing problems?
- Do you think that study participants who take steps to reduce their sexual and drug use risky behaviours will experience changes in the level of violence in their lives?
- What suggestions do you have for this intervention to help decrease the level of violence in sex workers?
- Have there been any changes in police activities directed towards female sex workers, harassment of sex workers or changes in clients' behaviours since the pilot study last year?
- How can this study help women feel more in control to achieve any personal goals?
- How do you feel about having former female sex workers being part of the study staff?
- Do you have any suggestions for the study?

Administration of the schedule

The researcher interviewed the gatekeepers using the interview guide to assist in focussing the discussion. The consent form was explained to each gatekeeper before every interview. It was subsequently signed when the interviewee agreed to participate in the study. Permission for the researcher to use an audiotape was secured from each interviewee before its use. The preferred language of the interviewee was used during the interview. Finally, the data from the interviews were transcribed and analysed in order to find solutions to the problem of substance abuse and risky sexual behaviour.

Rationale for using participant observation technique

The researcher deemed it necessary to conduct participant observation on the streets where sex work existed, at low cost hotels in order to observe the behaviour prevailing regarding the drugs and sex work business. She also visited brothels and was amazed that inspite of having made an appointment, she was always misunderstood and mistaken to be a sex worker too. Some researchers maintain that this technique is fundamental to all research process (Denzin and Lincoln, 2000:673).

The researcher observed and experienced the following, that:

- The phenomenological approach is important in participant observation, as it provides the researcher with some insight into the manifestations of reality. The researcher thus visited low cost hotels to interact with the sex workers, to see the type of drugs they used and the type of clients who frequented those settings. However, whenever the researcher parked her car in the evening on the street that was used for operating sex work, she was assailed by sex workers who just boarded her car without invitation as they regarded this activity as a business deal.
- The focus is on the everyday and natural experiences of the respondents (Mouton et al, 1987:22. The researcher strove to gain feelings and impressions by experiencing the circumstances of the real world of the participants, living alongside them and interpreting and sharing their activities. So she walked the streets and visited brothels and low cost hotels. Bryman (2000:96) states: “For

qualitative researchers, it is only by getting close to their subjects and becoming an insider that they can view the world as a participant in that setting."

- In order to gain insight into the real meaning of people's behaviour in particular situations, it is of the utmost importance that the researcher should study and know the customs, lifestyles and cultural contexts of the respondents in a culture sensitive manner (Sheppard, 1995:270; Van der Burgh, 1988:63). The streets, brothels and low cost hotels that were visited provided the required insight.
- In participant observation, the researcher endeavoured to experience and embrace the lives and daily routine of the female sex workers.
- The procedure followed by the researcher allowed her to play the dual role of data collector and interpreter of the data (Coertze, 1993:77).

(c) Activity Step 3: Identifying functional elements of successful models

In this study, the primary data gathered from the participant observation, focus groups, and in-depth interviews as well as the secondary data gathered from the literature survey, raised several issues that were crucial to the programme design and implementation. The prevention programme was designed to reflect the following characteristics:

- to be linked to theory.
- to reflect real life situations.
- to be sensitive to the needs of women sex workers.
- to be monitored and evaluated periodically.
- to utilise trained female sex workers to provide peer education.

1.6.4.3 Phase III Design

De Vos et al. (2002:407) views design as the planned and systematic application of relevant scientific, technical, and practical information to the creation and assembly of innovations. The "model design" phase is characterised by two activity steps, namely:

Designing an observational system and

Specifying procedural elements of the intervention.

(a) Activity Step 1: Designing the observational system

According to Rothman and Thomas (1994:35), in this activity step, researchers must design a way of observing events related to the phenomenon under investigation. The designed observational system should address factors such as how many individuals and how much behaviour must be observed, the length of observation sessions, the size of intervals within the sessions, and the availability of trained observers. The type of observation method depends on the nature of the phenomenon to be observed. For instance, the direct observation method may be used for events that are easy to observe while self-reporting may be used for events that are difficult to observe.

The observation method was applied when the researcher visited the venues where the sex workers could be found. Key informants guided the researcher in recruiting sex workers who abused substances. Activity step 1 entailed the following procedures:

- **Visiting business sites:** These comprised low cost hotels, hair saloons and open veld. The researcher observed that these sites exposed the sex workers to unhealthy working conditions.
- **Securing cooperation of gatekeepers:** This was essential as entry into low cost hotels could be obstructed. The purpose of the study was explained to the gatekeepers and their cooperation was sought to gain excess to prospective respondents to the study.
- ***Size of people visiting:*** Five observers visited the venues. These observers comprised three black and two white researchers and research assistants.
- **Description of the research team:** The nature and amount of work to be carried out was such that a single researcher would not accomplish it all by herself. Five observers carried out the research.

(b) Activity Step 2: Specifying procedural elements of the prevention programme (intervention)

Rothman and Thomas (1994:35) state that by observing the problem and studying naturally occurring innovations and other prototypes, the researcher can identify procedural elements for use in the intervention. These procedural elements should be specified in detail so that other typically trained change agents can replicate them. The purpose of this observation was for the researcher to understand the conditions that the sex workers were working in, so that she could recommend improvement.

1.6.4.4 Phase IV: Early development, pilot testing and implementation of the programme

During the "early development and pilot testing" stage, Rothman and Thomas (1994:36) mention that a preliminary intervention design is evolved to a form that can be evaluated under field conditions. This phase, includes the following three activity steps:

Developing the important operations of the prototype for use in pilot testing;

Conducting a pilot test and;

Applying design criteria to the preliminary intervention concept (De Vos, 1998:395; De Vos, et al. 2002:409, Fawcett et al. 1994:36; and Rothman and Thomas 1994:37).

(a) Activity Step 1: Developing a prototype or preliminary intervention

Rothman and Thomas (1994:36) suggest that by this stage in the design process, preliminary intervention procedures are selected and specified. The procedures are discussed with experts and consumers to get feedback, which would help refine and simplify the prototype for intervention.

In this study, a community advisory board that comprised experts in the field of substance abuse was formed. The experts were from South Africa while some were from North Carolina in the United States of America. Some respondents were included in the board to represent victims of substance abuse and sex work. The Community Advisory Board members brainstormed and adopted the procedural

elements that have been specified in step 2 of phase III. In addition, the Advisory Board members developed the contents of the intervention sessions as described below:

- ***Intervention 1: Self-concept, modelling, peer pressure, and decision-making***

Intervention was based on the assumption that:

- The intervention session assumption: Women who engage in sex work and use substances of abuse are defiant in one or more of the following intervention areas: self-concept, decision-making, negotiation, and communication.
- Aim: The aim of this activity was to empower the women on assertive negotiation skills in order to assist them to resist peer pressure that might influence them to be engaged in risky sexual behaviour and to develop the self-concept and decision-making skills.
- Process of the programme: Women would meet in a boardroom at RTI where the overview of the programme would be given and where they would be given an opportunity to know one another better. The peer facilitator would encourage the female sex workers to share their experiences and information that would encourage one another to acquire knowledge on issues such as etiquette, self-respect, self-esteem and empowerment. Each woman was offered an opportunity to share her opinion and experiences in terms of the above-mentioned areas of intervention. After some discussion the peer facilitator would summarise the information so that everyone would understand it.

- **Intervention session 2:**

This entailed an overview of the knowledge, attitudes, and behavioural intentions regarding substance abuse and risky sexual behaviour. The aim of this session was to provide them with information on knowledge, attitudes and behaviour related to substance abuse and risky sexual behaviour. In this session, female sex workers were taught to understand the situation they were working in, and they were empowered with survival skills.

(b) Activity Step 2: Conducting a pilot study

Pilot tests are designed to determine whether the intervention would work or not, in other words “to see if the beast would fly” (Rothman and Thomas, 1994:36-37). A pilot study is one way in which the prospective researcher can orientate himself or herself to the project he or she has in mind. Mouton (2001:103) has warned, that one of the most common errors in doing research is that of not piloting or pretesting while MacBurry (2001:228-229) mentions that the temptation to skip the pilot phase should be resisted because a little effort can greatly increase the precision of the study. Researchers should never start the main inquiry unless they are confident that the chosen procedures are suitable, valid, reliable, effective, and free from problems and errors, or that at least, they have taken all possible precautions to avoid any problems that might arise during the study (Sarantakos, 2000:291). The pilot study is indeed, a prerequisite for the successful execution and completion of a research project. Its function is the exact formulation of the research problem, and a tentative planning of the modus operandi and range of the investigation. In this study a pilot study entailed experimenting with respondents initially. The remarks and recommendations they made were used to redesign the questions on the cue cards which were later used with the final group of respondents (Appendix D).

(c) Activity step 3: Applying designs criteria to the preliminary intervention

The substance abuse and risky sexual behaviour prevention programme was then implemented in the light of the information highlighted in the information gathering and synthesis phase, the model design phase, and the current phase. Rothman and Thomas (1994:37) in De Vos et al. (2002: 411) state that this activity step has to do with developing guidelines of the intervention in order to guide the application of the programme according to the established criteria. In accordance with this, the study team developed the guidelines for the current study’s programme. The guidelines entailed that the programme should focus on substance abuse and risky sexual behaviour prevention.

1.6.4.5 Phase V: Evaluation and advanced development

The “evaluation and advanced development” phase addresses the question of the effectiveness of an intervention model. In this phase, techniques that are utilised

include quasi and true experimental designs, single-subject designs, as well as psychological and behavioural assessment. The use of research methods in this phase, is not to provide programme appraisal for practice purposes; but to contribute to further programme design and development in order to facilitate adoption and widespread use of a programme (Thomas, 1989:587-589, in De Vos et al., 2002:412; King et al, 1987:32; Klitzner et al, 1994:57; and Mantell et al., 1997:27). The four major activity steps in this phase are the following:

Selecting an experimental design.

Collecting and analysing data.

Replicating the intervention under field conditions.

Refining the intervention.

1.6.4.6 Phase VI: Dissemination

De Vos et al. (2002:414) state that since diffusion and adoption are closely related and are generally carried out concurrently, they should be considered together as dissemination. Further, commenting on the last phase of the new model, namely dissemination, Rothman and Thomas (1994:39-43) mention that once the intervention has undergone all the other phases, it is ready to be disseminated to organisations and other audiences. Several operations or activity steps that lead to the success of the process of dissemination and adaptation are as follows:

- Preparing the product for dissemination.
- Identifying potential markets for the intervention.
- Creating a demand for the intervention.
- Encouraging appropriate adaptation.
- Providing technical support.

1.6.5 Data Collection Methods

The two main techniques that were utilised in this study were in-depth interviews with key informants that is, the distributors of drugs to the sex workers, and gatekeepers at various hotels that accommodate sex workers in order to elicit information on how

to improve, the methodology of data collection. Thereafter, focus group discussions were conducted to extract information related to the situations of the women.

Rothman and Thomas (1994: 27) mention several operations or activity steps that are of critical importance during the problem identification and data gathering phases. These comprise the following:

Identifying and involving the participants in the study.

Gaining entry and participation from the setting.

Identifying concerns of the population.

Analysing identified concerns.

Setting goals and objectives.

In this study, the researcher was guided by these activities which she carried out meticulously as explained in 1.6.4.

1.7 RATIONALE FOR THE STUDY

Many young people in South Africa are at risk of substance abuse, risky sexual behaviour, including sex work and the transmission of HIV and AIDS, as well as related public health and social pathologies. They are at a critical stage of experimenting with substances and sex work. The incidence of substance abuse and risky sexual behaviour is of great concern to researchers and policy makers. The mass media reveal statistics on the number of young people at the pick of their careers, who are either involved in fatal accidents or die of substance abuse related causes on a daily basis. In his opening speech in Parliament, the South African President, urged the government and private sectors to develop programmes that would save talented musicians from the scourge of substance abuse and be empowered with skills and knowledge to enable them to face the challenges that are ahead of them. The Social Skills Development Act, No.97of 2003 was developed specifically for this purpose and must be implemented soon. Young people are the future leaders and the country needs to invest in them. Globally, the country that develops its youth is measured as developed as it will have enough reserves to lean against in times of economic turmoil. A variety of programmes have to be tailored to

meet the specific and general needs of this group (National Drug Master Plan, 1999-2004:13, White paper on Reconstruction and Development Programme, 1994:41; and Edmonds and Wilcocks, 1995:8).

The social work profession recognises that investing in young people could serve as an important preventive measure towards substance abuse and risky sexual behaviour. Many youth are affected by poverty, which often results in their dropping out of school. Without any skills, many may resort to risky income-generating jobs such as the sex or drug trade. Moral degeneration programmes are thus needed to help the youth refocus and prepare for a better future. These programmes have to be initiated by different professionals while social workers serve as coordinators who monitor their success and guard against any duplication of services. A cost effective service delivery system entails a multi-disciplinary approach, which is monitored by social workers.

Viewed against this background, the aims and objectives of this study are in line with the mission and vision of the Social Development department as outlined in the White Paper on Welfare No 108 of 1996 and the National Drug Master Plan 1999–2004. The combating of substance abuse among young persons is a priority area in these policy papers as it seeks to prevent young persons from substance abuse through providing them with information on the dangers of substance abuse so that they can make an informed decision to refrain and abstain from using substances.

1.8 SIGNIFICANCE OF THE STUDY

South Africa is showcasing the gains of ten years' of democracy. The rationale for this celebration is to indicate to the world that wounds created by the Apartheid regime have been healed and the country is a unified state. Above all, it wants to demonstrate that it is one country that has succeeded in uniting eleven ethnic groups as one nation. It wants to show that resources can be saved by the elimination of duplication of services. All South Africans now have equal access to social services while including foreigners and refugees are afforded some measure of social security. This process is based on democratic values, social rights, and fundamental human rights as enshrined in the Constitution of South Africa (1996:1).

All professionals are required to position themselves appropriately in the South African dispensation and to demonstrate their relevance. Hence, the challenges of the merging of institutions of higher learning and financial supports for the disadvantaged sector of the society in those institutions should serve as proof of the stability of the nation. The National Plan for Higher Education (2001:60) has singled out research as the principal tool for the production and advancement of new knowledge essential for national growth and industrial competitiveness. In addition, it increases the ability to solve pressing social changes and concomitant social problems. The current study was prompted by this need for research to solve social problems.

The findings of this study will have implications for policy-makers, programme planners, academics, and practitioners and donors in the field of substance abuse and risky sexual behaviours in terms of determining the focus to tackle the related problems, policy development and implementation, programme formulation, curriculum development, and service delivery respectively. The findings will enhance social work practice, education and training, as well as policy and programme development. They will also enhance the young people's understanding of the dynamics of substance abuse and risky sexual behaviour.

Practically, the study's findings will also contribute to the body of knowledge that has been established by local stakeholders in the field of substance abuse and risky sexual behaviour.

1.9 PROFILE OF THE AREA OF THE STUDY

This study was conducted in Tshwane among the following designated areas: Marabastadt, Sunnyside, and dilapidated hotels around the inner city of the Tshwane Metropolitan area in Pretoria. These areas are usually regarded as deteriorated areas as they do not follow any rules and regulations concerning the control of behaviour. Many people reside temporarily in these areas, as they have a home elsewhere in South Africa or outside its borders. There is a high influx of people in and out of the city while there is no community cohesion and participation. The Tshwane municipality is reconstructing the area. The languages predominantly spoken are *Sesotho, Sepedi, Setswana*, and *Isizulu.* These languages have a strong influence of *Sepedi*, which characterises the Tshwane dialect. However, other languages, such as *Xitsonga*, *TshiVenda*, *Afrikaans*, English, *IsiXhosa, IsiNdebele, IsiSwati and Tsotsi taal* (the Language spoken on the street) are also spoken. Students who come to Tshwane for tertiary education also populate this area. Most of these students are young persons who are often still experimenting with various substances, are free from parental guidance, and conform to peer pressure. It is important to mention that there are numerous churches in the inner city. These are well attended by the students, who reside in the nearby areas.

1.9.1 Infrastructural factors that had an impact on the study

A major factor that makes the city conspicuous is that most people come to Tshwane to seek employment or for schooling. The following could be regarded as infrastructural factors that facilitate livelihood in Pretoria:

Transportation and communication: The area has a well-developed transportation infrastructure in the form of taxis, buses, trains, and different modes of cars. Telephones are available as a mode of communication.

Housing infrastructure: There are both formal and informal types of housing to accommodate people with varying lifestyle. Overcrowding and problems related

to it such as misuse of substances and other risky behaviour are common in the inner city.

Employment: There are various employment opportunities in Tshwane. The private and public sectors are the largest employers for people.

Unemployment is high in Tshwane, regardless of employment opportunities being available for skilled people. Many women who are not skilled and come to Tshwane for the purpose of seeking employment end up joining the sex work industry.

Poverty: An overwhelming number of people from poverty stricken areas often come to Tshwane to seek employment. Those without skills either accept low paying jobs or cannot find jobs at all, hence, the high number of poverty-stricken people some of whom engage in risky behaviour as a means of livelihood.

Educational opportunities: In Tshwane there are various educational institutions available amongst others, there is the University of South Africa, the University of Limpopo (Medunsa campus), the University of Pretoria, and the Tshwane University of Science and Technology. Majority of students who reside in the inner city are outsiders who have come to Tshwane for educational purposes.

Customs and traditional practices: Some people in Tshwane still indulge in traditional practices such as traditional healing, male circumcision/initiation and ancestoral worship.Belief systems upheld differ from one person to the other; hence some people practice family planning while others do not. Condom use too, is acceptable to some but not to all people.

1.10 DESCRIPTION OF THE REFERENCING SYSTEM

The researcher used the Harvard System reference format. All sources from which ideas, quotations, and information obtained were acknowledged. Inverted commas in the text indicate where quotations have been made. The names of the author, year of publication and page numbers, have been provided for references in the text. For articles that are anonymous, the first key words of the article have been treated as the name. In the case of government publications, the name of the section of the government that published the document has been listed first, then the name of the document and the date have been written. When a corporate body is responsible for

a publication, the name of the body has been used, followed by the year, a colon, and the page number(s). Regarding Legal Act citations, the name of the Act, the number of the Act, the year of publication, followed by the section as well as the page number(s) have been provided. Boldface has been used to represent important phrases and subtopics, while Italics have been used to indicate important citations. The capitalization of words has been minimised, while the Reference section at the end of the report represents the list of all the sources such as books, journals, newspaper articles, and government gazettes. Article and chapter titles are not underlined, but appear in boldface characters. Regarding journal articles, both the volume and issue numbers have been provided. Appendixes A – F form the last part of the text.

1.11 LIMITATIONS OF THE STUDY

The researcher observed the limitations in the study:
The following limitations of the study were anticipated and/or observed:

- Anxiety and inhibition when talking about drug use and sex. Whereas use and even abuse of some substances e.g. alcohol is acceptable among some groups, use of drugs like mandrax, dagga and cocaine is not acceptable at all. The topic on sexuality is perceived as taboo in many communities. The researcher anticipated this problem and had to make some effort to using techniques drawn from sociological experts such as Biestek (1957: 103), Perlman (1968: 13), on establishing rapport. The researcher utilised the following:

- Accurate empathy: the ability of the worker/researcher to perceive and communicate accurately and with sensitivity both the current feelings and experiences of another person and their meaning and significance.

- Nonpossesive warmth: This concept also referred to as “unconditional positive regard” indicates the ability of the social worker or researcher’s communication of respect, acceptance, liking, caring, and concern for the client or sex worker in a nondominating way.

- Genuineness: This is the ability of the worker or researcher of “being himself or herself” and being “real”. The researcher was always responding with

spontaneity, and not being defensive or displaying a professional response. The responses were genuine and not preconceived by the goal of the study.

- Selection bias: The researcher selected respondents who met specific criteria that is only women who indicated that they were practising sex work and using crack/cocaine and alcohol. Sex workers who did not admit to using drugs for fear of reprisal were excluded from the study even if they were known to be using or showed symptoms of alcoholism. The sample was race and gender specific and excluded male, white, coloured and Asiatic sex workers.
- The study concentrated in the city centre of the Tshwane Metropolitan area only and not in the entire Gauteng Province. Only information pertaining to patterns and scope of sex work was elicited while the intervention programme that was tested was suitable for sex workers who met the specified criteria only.
- It was difficult to trace some respondents when conducting follow up interviews and five (5) respondents were reported to have died of HIV/AIDS related causes. The researcher had to travel long distances to track the women as they often migrated from Tshwane to Johannesburg or from the city centre to the surrounding townships in Tshwane.
- The police officers and drug dealers that were exploiting female sex workers aggressive. They openly swore at the study team and stated that the study negatively affected the female sex workers availability for work. They also threatened the women with arrest if they continued to participate in the study.
- Pimps and handlers of the sex workers were openly hostile to the study team. They maintained that the team members were making the sex workers unavailable for work.
- It was difficult to compare the findings of the current study with those of previously conducted studies as the areas of focus were different. Whereas the current study used the qualitative data gathering method, other studies had been epidemiological in nature. In addition, the current study focused on intervention by identifying problems and providing solutions in order to ameliorate the situation.
- Literature in the study of the connection between substance abuse and sexual risk behaviour was limited to South Africa only.

1.12 DEFINITION OF CONCEPTS

Abolitionism refers to the midway between the prohibition promoted by prohibitionists and the freedom conferred by a more regulatory approach, and is based on two important principles namely that: (i) prostitution is a free choice, (ii) but it is immoral; prostitution should, therefore, be tolerated but not considered for legislation. In this context, legislation is aimed at preventing the disruption of the public order for instance the prohibition of hooking.

Binge drinkers refer to those who consume five or more drinks at one sitting (Leigh et al. 1994, 39: 34).

Condom use indicates a thin sheath of rubber, latex, polyurethane, or similar material that fits tightly over the penis and is used for contraceptive purposes and the prevention of sexually transmitted diseases such as AIDS, syphilis, gonorrhoea, and genital herpes (Barker, 1999:97). In this context the researcher has used this concept to refer to a condom as a protective sheath which prevents against sexually transmitted diseases including HIV and AIDS, hence she has alluded to male and female condoms.

Criminalize means that certain or all aspects of (adult) prostitution are prohibited as criminal offences. It happens when behaviour is formally noted as prohibited in the Criminal Code.

Decriminalise refers to the removal of laws that criminalize (adult) prostitution. It pertains to running a brothel, profiting from someone else's prostitution, facilitating travel for the purpose of prostitution, and communicating for the purpose of prostitution.

Empowerment is the process of giving people the power to choose and carry out improvements in their own lives (WHO, 1995:14). According to Potgieter (1998:9) empowerment refers to helping individuals believe that they have the ability to

accomplish the goals that they have set for themselves. In this context the WHO's definition has been adopted in this study

Developmental approach as defined in the White Paper for Social Welfare (1997:6) the developmental approach enhances principles of economic and social empowerment. It involves target populations to a large extent in their own development.

Epidemic/Pandemic Epidemic refers to the occurrence of a disease, disorder or social problem that spreads rapidly and affects many people in a community within a relatively short period. Pandemic refers to social problems, diseases or mental disorders that appear on a broad scale throughout a specific large area (such as a city, a nation, a continent or the entire world) (Barker, 1999:156, 345). The researcher uses these terms interchangeably in this study.

Drug Abuse implies the inappropriate use of alcohol or other chemical substances. In this study, the concept has been used interchangeably with substance abuse to refer to the habit of sex workers using drugs/substances in the process of plying their trade.

Heavy drinkers refers to those who reported drinking large quantities of alcohol each day before plying their trade.

IDUS refers to injecting drug users

Judiciarization consists of bringing before the courts an accused person who meets the criteria determined under the Criminal Code. **Dejudiciarization** is finding redress outside the court system when a person breaks the law. With respect to prostitution, dejudiciarization means other than the courtroom to deal with offences.

Legalise means that (adult) prostitution is allowed within the framework of the law and that previously prohibited behaviour becomes legal. By legalising prostitution, it becomes regulated, and thus gains occupational status. Legalisation provides prostitution with a set of rules under which the trade is exercised. Work permits,

registration, and mandatory periodical check-ups all fall under the domain of regulation. Authorisation of brothels and the creation of designated areas for prostitution are examples of regulating prostitution.

Neo-abolitionism is based on the principle that people are free to use their bodies in a manner consistent with the respect of human dignity. The human body is not to be used as merchandise, and prostitution is an unacceptable commercial relation. This approach rejects the distinction between forced prostitution and voluntary prostitution. Neo-abolitionists promote the decriminalisation of prostitutes, but the criminalisation of Johns and pimps.

Prevention refers to action taken by social workers and other social service professionals in order to minimize and eliminate those social, psychological, or other conditions known to cause or contribute to physical and emotional illness and sometimes socio-economic problems (Barker 1999:374). In this context, the researcher refers to all activities which can be carried out by social workers to deter the continuous spread of substance use and risky sexual behaviour among sex workers and the entire population as they play roles such as enablers, information disseminators, and educators in the primary prevention of these twin diseases.

Problem drinkers refers to persons who display at least three of eight major symptoms indicating an increased tolerance or desire for alcohol, an impaired control over drinking; symptoms of withdrawal; or increased social disruption.

Prohibitionism rests on the principle that prostitution is a violation of human dignity, and for this reason it should be stopped. Under this system, all the players and areas of prostitution are regarded as illegal. In countries where it is in effect, prostitutes suffer the most and bear the brunt of such sanctions.

Promiscuity/Prostitution Promiscuity refers to casual, frequent, and indiscriminate sexual encounters while the latter refers to the illegal act of offering oneself for sexual contact with another in exchange for money or other gifts or benefits (Barker, 1999:382 and Garner, 1996:510). In this context the researcher has used these

concepts interchangeably when referring to commercial sex workers or prostitutes as promiscuous persons.

RSA refers to the Republic of South Africa (currently known only as South Africa)

Sexuality refers to the characteristics of an individual that essentially pertain to the reproductive function, including anatomy and physiology, primary and secondary sexual traits, sex role patterns, and behavioural characteristics (Barker, 1999:439).

Sexually transmitted diseases are venereal diseases, which are infectious since they are passed from one person to another through coitus or other intimate contact. Sexually transmitted diseases include gonorrhoea, chlamydia, genital herpes, syphilis and HIV and AIDS (Barker, 1999:439).

Recently refers to having had intercourse in the three months prior to being surveyed (Centres for Disease Control and Prevention, Youth Risk Behaviour Surveillance, 1999: 3.

Risky sexual behaviour refers to behaviour that puts people at increased risk for being infected with sexually transmitted diseases, unintended pregnancy, and sexual violence. It also includes using condoms inconsistently, having multiple sexual partners, having regretted sexual intercourse, or having sexual intercourse with a casual partner during one's lifetime.

Sex work entails the occupation of trading sex (sex worker). This concept has been used interchangeably with the concept prostitution. In the current study the concepts sex worker/prostitute will refer only to women who earn an income from trading in sex. Males who engage in similar activities have not been included in this study.

Socio-economic class refers to social status as well as the economic positions of people in the society. It is referred to as the categorization of groups of people in terms of specified demographic variables, such as the level of income or education, location of residence, and value orientation (Barker, 1999:458).

Substance abuse refers to maladaptive patterns of using certain drugs, alcohol, over the counter medicines, some household detergents, and toxins despite their adverse consequences (Barker 1999:470).

Treatment entails correcting or alleviating a disorder, disease or problem (Barker, 1999:493). In this context the researcher refers to social work treatment whereby social work techniques are applied to alleviate the problem experienced by the sex workers.

1.13 ORGANISATION OF THE STUDY

This study has been presented in five chapters, which have been organised as follows:

1.13.1 Chapter One: This is the general orientation to the study. This chapter provides an overview of the study that includes the statement of the problem, the aims and objectives of the study, the motivation for undertaking the study, and the assumptions of the study. It provides the research design and methodology and integrates them into practice in terms of the six phases of intervention proposed by Rothman and Thomas. It also provides a description of referencing, definitions of concepts, and a conclusion.

1.13.2 Chapter Two: A critical review of substance abuse and sex work is given in this chapter. The reasons for the problem of substance abuse and sex work are important to this study to demonstrate whether it is a national problem as well as a social problem of high magnitude. In this chapter, responses and perspectives to address this problem have been explored.

1.13.3 Chapter Three: This chapter provides an overview of the link between substance abuse and sexual risk behaviour based on existing literature and its policy implications to control the problem. It examines what other scholars have contributed and what needs to be covered by this study. It also exposes approaches which are relevant and also what is missing in existing literature.

1.13.4 Chapter Four: This chapter deals with the presentation, analysis and interpretation of data and strives to present, analyse, and interpret the data that were gathered during the intervention research process in order to address the initial propositions of the study.

1.13.5 Chapter Five: Here a summary of findings, conclusions, and recommendations have been presented. This chapter reviews the study by providing a synopsis of the major aspects of the study. It takes a comprehensive view of the study, ranging from the restatement of the problem, the aims and objectives and assumptions of the study, and a summary of the findings. Finally, conclusions have been drawn from the data and recommendations have been provided.

1.14 CONCLUSION

Substance abuse and risky sexual behaviour among women sex workers is a global problem. Sex work is prevalent in developing countries with inadequate resources, especially those in the sub-Saharan Africa. Special efforts and initiatives to alleviate poverty and related problems such as substance abuse, drug trafficking and trading, HIV/AIDS and others are being made by the South African government at all levels. The overview of the study has been presented. The researcher has indicated the importance of investigating the sex work problem in the South African context in order to influence policymaking and how the South African legal system should respond to sex work and related problems. She has further; alluded to the fact that substance abuse and risky sexual behaviour among Sex workers are global problems that spread like veld fires throughout the world. The Provincial Substance Abuse Forums, local Drug Action Committees and Mini Drug Master Plans at Non Governmental, local government, provincial, national and international levels are aimed at reducing substance abuse, if not uprooting it to create a drug free society (South African National Drug Master Plan, 1999-2004:1-30). South Africa is a member state of regional and international structures and ratified the UN conventions on preventing drug trafficking and is participating effectively in reducing the twin problems mentioned above. Currently, the country is in its second session of

implementing the National Drug Master Plan that outlines how it should tackle the problem of substance abuse.

The widespread tolerance of risky behaviour by the public, however, makes it difficult to prevent such a problem before it spreads to the fabric of society and destroys the norms and values that cement and shape people's behaviour. Indeed, the social work profession is faced with a huge challenge to prevent and reduce substance abuse and HIV and AIDS among sex workers. The profession has to design a policy and develop programmes that will reduce the social ills identified among risky target groups such as sex workers. Social work has to be proactive in order to be at the same level as the advanced societies of the world that have tackled similar problems. In developing countries the social work profession has to benchmark its programmes and not waste resources in reinventing the wheel, while successful best practice models are available internationally.

It is evident that substance abuse and risky behaviour among sex workers are worth researching in the new South African dispensation where the goal is to create a drug free society, informed citizens, and meeting the basic needs of all people. This study is in line with the vision of the National Drug Master Plan of establishing a drug free society and following the guiding principle of the developmental approach, namely that the combating and prevention of substance abuse is not the responsibility of a single department but the concerted efforts of every one in South Africa. Furthermore, the developmental approach advocates for building human capacity, self-reliance, and the full participation of all stakeholders in tackling problems that affect the social development of South Africans (White Paper for Welfare, 1997:4, and Midgley, 1996:2). It also promotes the economic development of the affected individuals, such as the sex workers. They need to participate in the development of the policy that affects their daily lives. In short, they have to be trained and provided with alternative employment to sex work.

CHAPTER 2
AN ANALYSIS OF THE LINKS BETWEEN SUBSTANCE ABUSE AND RISKY SEXUAL BEHAVIOUR AMONG SEX WORKERS

2.1 INTRODUCTION

In South Africa sex work has become a subject of considerable public debate since the 1990s when the new democracy was ushered in. Sex work is an issue per se that needs serious governmental intervention. Throughout time, sex work has aroused a wide range of emotions from communities in which it exists. Researchers have indicated that no society has completely accepted sex work as a valid job and an integral part of the community. Sex work is sometimes abhorred or tolerated but never fully condoned. The overall view of sex work is that it is an embarrassment.

Sex work has evoked different views. Whereas Faith based organisations question people's moral standards as set out in the Holy Scriptures, government officials point out issue of the failure to manage the problem lack of protection and provision for safety and security (the mandate of the government to protect the vulnerable groups through enacting policies and regulations). Police officials have been mandated to provide safety and security to the civilians. The failure of this sector to deliver the services that they have been mandated to carry out, is an indication of incompetence and calls for a need to retrain them to provide the service in a competent manner and assist them to control or eradicate the problems of sex work. The feminist sector views this problem as the continuation of the entrenchment of the patriarchal system - the ultimate exploitation of women. Sex work epitomises an important indication of how far males can achieve gender equality in a manner that is acceptable even to the Human Rights sector. Sex workers perceive their work as a way for survival and a job taken without a better choice. Families perceive sex work as an embarrassment that is associated with evils and diseases. They often choose to turn a blind eye to the problem and pretend that it does not exist. Societies in general are battling on how best they should handle the problem of sex work. Currently, there are varied approaches to sex work. These approaches point to criminalisation, decriminalisation, regulated, deregulated or a combination of the above. The main goal that needs to be achieved is to keep sex work invisible, yet this does not

eradicate the problems associated with the trade. This study aims at finding ways to deal with, minimise, or eradicate problems that are associated with this trade.

In this chapter, an overview of substance abuse and sexual risky behaviour among sex workers is given to expose sex work as a major social problem that South Africa is facing in recent years. The problem of substance abuse and related risky sexual behaviour has been examined more closely in order to demonstrate the link between substance abuse and risky sexual behaviour amongst the sex workers and to help develop a policy to facilitate intervention by a variety of professions. This chapter analyses the extent to which experts in the field have tackled the problem of substance abuse and risky sexual behaviour. It actually demonstrates that the link between substance abuse and risky sexual behaviour among sex workers is extremely complex, as it involves many factors that can be studied intensively as they relate in triangulation to substance abuse, HIV, and sex work. The researcher is of the opinion that intervention programmes for sex workers should allude to substance abuse as well, as this problem is prominent among the sex workers.

In order to gain insight into the problem of substance abuse and risky sexual behaviour, it is important to look at case analyses of research, which have been conducted in South Africa. These entail problems emanating from injecting drug use (IDU), unsafe sex, and drug use in general. Researchers in South Africa have revealed that prior to the installation of a democratically elected government in South Africa in 1994, various factors restricted both the choice and use of illicit drugs to cannabis, mandrax (a sedative and blend of the pharmaceutical drug methaqualone and an antihistamine), and cannabis-methaqualone known as the “white pipe” in combination. Drug users in South Africa have been found to consume as much as 80 percent of the Mandrax produced world-wide (Pluddermann and Parry, 1999:82, Brenen, 1998:3). These researchers state that substance abuse is common among sex worker populations. The link between sex work, alcohol, and illicit drugs has been observed by a number of researchers who have confirmed that drug dependence is certainly the reason that leads some women to embark upon sex work. Furthermore, it has been asserted that sex work may foster the harmful use of both legal and illegal drugs. Sometimes, drug-dealing networks overlap with those of sex work. The precise levels of drug use among South African sex workers are

uncertain (Plant, 1990:10, De Graaf, Vanwesenbeeck, and Van Zessen, 1999:277-288, The National Institute on Drug Abuse and the US Department of Health and Human Services, 1998:81-88). Although the South African Drug Advisory Board stated that intravenous drug taking was not prevalent in South Africa (Drug Advisory Board, 1997:5), more research is required to confirm that this condition has not changed over the past seven years. Most researchers argue about the influence which substance abuse might have on the safety of sex workers. Some studies have confirmed that drug use among sex workers might increase their vulnerability to violence and abuse in general, due to the fact that drug abuse affects the Central nervous system. In this regard, the dangers of the street are exacerbated because of the disinhibitory effect of some substances and the effect of increased impaired judgement when one is under the influence. Sex workers who use substances may also be less responsive to health-care messages and may be less inclined to enforce safer sex practices. It has been noted that drug using clients may become aggressive and violent towards sex workers (Karim, Karim, Soldan, and Zondi, 1995:152–1525, and Brenen, 1998:2).

This chapter is the point of departure for the next chapters of this study and will shed some light as how these phenomena interlink. It also describes how South Africa can be a leading example in terms of developing policy to protect this high-risk group for sexually transmitted diseases, in particular HIV infection.

2.2 THE LINK BETWEEN DRUG USE AND HIV INFECTION AMONG SEX WORKERS

Although sex work is an old occupation, which can be traced back to biblical times, HIV was only discovered in the 1980s. The link between drug use and HIV infection among sex workers can, therefore, be traced back to almost twenty years ago. Numerous studies have found drug users to be disproportionately likely to be involved in the sex industry or to engage in high-risk sexual behaviour. Drug injecting also contributes to an increased incidence of HIV infection through the transmission of the virus to the children of the drug-injecting mothers and through sexual contact between drug injectors and non-injectors (UNODCCP, 2001:1; World Health Organization, 1998:3).

The possibility of contracting an STD, including HIV and AIDS, is positively associated with the number of sexual partners a person has. The fact that prostitution, by its very nature, would increase the number of sexual partners of the prostitutes, and also their clients, could be considered as a contributory factor for elevating the health related problems. In this regard, it is important to note that prostitutes and their clients are, therefore both high-risk populations for HIV and AIDS. Findings of numerous researchers reveal that sex workers put their health and lives at risk. The following studies clarify this phenomenon:

- A study conducted in South Africa at a popular truck stop midway between Johannesburg and Durban, revealed that ten out of twelve prostitutes interviewed reported working seven days a week (Karim, Karim, Soldan, and Zondi. 1995:1521-1525).
- In a study conducted in Glasgow, the United Kingdom, prostitutes reported working 5.2 nights per week and servicing 7.1 clients per night. Seventy-two percent of them were also involved in private non-commercial relationships with either their spouses or their steady partners or boyfriends (McKeganey, and Barnard, 1996:395-407).
- In another study conducted in Glasgow among female street worker prostitutes, it was found that respondents had typically worked 5.5 evenings per week and had each provided sexual services to 6.4 clients per night (Green, Goldberg, and Christie, 1998:321-335).
- A study conducted among male prostitutes in the Netherlands, where prostitution is decriminalised, showed that street and home prostitutes worked an average of twenty-six to twenty seven hours per week (De Graaf, Vanwesenbeeck, and Van Zessen, 1999:277-288).
- A study conducted among heterosexual commercial sex workers in the Netherlands, showed that, of the 193 women interviewed 136 had worked as prostitutes and had on the average 115 customers per month. About 99 of the men interviewed indicated that they had each visited an average of eight prostitutes in the preceding four months. The data revealed that prostitutes had unprotected vaginal intercourse with an estimated average of 160 persons in four months (Hooykaas, Van der Pligt, and Van Doornum, 1998: 525-532).

After reviewing several European studies, Johnson (1988:1017-1020), concluded that female sex workers have low levels of HIV infection unless they also happen to be intravenous drug users. This evidence showed a zero level of HIV infection among the sex workers in Copenhagen, London, Nurenberg, and Paris. Research, however shows that some of the sex workers in other areas had been exposed to HIV infection: Athens (6%), Federal Republic of Germany (1%), and Pordenone near Venice (71%). Half of the infected women in the Federal Republic of Germany and all those in Pordenone were found to be intravenous drug users. A multi centre US study as reported by the Centres for Disease Control (CDC) indicates that sixty-two or 10.9% of a study group of 568 sex workers were HIV seropositive (Lange, Snyder, Lozovsky, Kaistha, Kaczaniuk, and Jaffe, 1987:757-561). These researchers reported that 34 percent of a sub-sample of Baltimore sex workers with heavy drug use histories were found to be HIV seropositive. HIV infection was found to be highest in the predominantly black centre city areas. The Centres for Disease Control (1987:20) also indicated that HIV infection was 0-57 percent among female sex workers in nine selected US cities; however, the corresponding position among male sex workers remains unclear.

Coutinho, Van Andel, and Rysdyk, (1988:207-208) furthermore reported results of a study of thirty-seven male sex workers working in brothels in Amsterdam. These researchers had also collected data from thirteen male sex workers who were attending a clinic for sexually transmitted diseases. They found that four out of thirty men who had been tested were HIV seropositive; although only one of the respondents was an intravenous drug user. These authors concluded that the prevalence of infection in male sex workers was apparently not higher than in other groups of homosexual men with multiple partners. The clients of male sex workers may be a relatively high number of bisexual men who want to hide their homosexuality, and in this way male sex workers can be a bridge to the spread of STDs and HIV into the general population.

In their study in Amsterdam, Van den Hoek, Coutinho, Van Haastrecht, Van Zadelhoff, and Goudsmit, (1987:55-60) revealed that 28% of a study group of intravenous drug users and drug using sex workers were HIV seropositive. These researchers found that, one HIV seropositive female sex worker had transmitted HIV

infection to her non-intravenous drug-using lover. They had not been using condoms. Coutinho et al, (1988:59) concluded that the majority of women in their study had engaged in sex work. They also found that quite a substantial number of the male respondents had engaged in sex work. Heterosexual transmission from infected drug using sex workers to their clients is an alarming possible means of spreading HIV to the general population. Goldberg, Green, and Kingdom (1988:1-3) report that among HIV seropositive people in Glasgow, were twenty-six women, all of whom were drug using sex workers. Much publicity was given to a female sex worker in Edinburgh who, though allegedly HIV seropositive, continued to have sex with approximately thirty men each week.

A study conducted in Nigeria, reported that the incidence of extramarital relations varies considerably according to the respondents' level of education, type of marriage, religion, and spousal closeness. More importantly, knowledge of multiple sexual partners as a risk factor for HIV/AIDS is inversely related to extramarital affairs (Isiugo-Abanihe, 1994:122-123).

Haverkos (1998) investigated the relationship between HIV/AIDS and drug abuse in America, from an epidemiological perspective. He focussed on issues relating to prevention and noted that the first wave of the HIV/AIDS epidemic, which began in the 1970s and 1980s, had involved primarily homosexual men; while the second wave which followed shortly thereafter, consisted mainly of injection drug users. The third and current wave was more broadly based. In his study he found that the most rapidly increasing rates of AIDS now being reported are among women, minority populations, heterosexual men, and non-injection drug users. While the greatest numbers of cases are still composed of IDUs and men who have sex with men, the continuing and widening spread to other groups through high risk, HIV-related drug and sexual behaviours, was becoming an even more worrisome national public health problem. He noted that several prevention strategies have been shown to be helpful in reducing risky behaviours and/or reducing transmission rates. He commented that, drug treatment and especially methadone treatment was helpful, and that, a number of community based outreach interventions were helpful too, in preventing risky behaviours such as education packages, condom and bleach distribution, HIV testing, and pre-and post test counselling, needle and syringe

exchanges, and referral to drug treatment and other services. The issue of high-risk groups was identified in this study as fuelling HIV/AIDS (Haverkos, 1998:5, in Gottheil and Stimmel(ed) 1998).

An earlier study by Flexner (in Goldstein 1979:23-29) identified four principal social costs to society due to the prostitution problem. Flexner argues that prostitution causes harm in society where it exists. Problems such as personal demoralisation, economic waste, the spread of venereal diseases, social disorder and crime were associated with prostitution. He also indicates that any person in the general population, who habitually or intermittently has sexual relations more or less promiscuously for money or other mercenary consideration, is a prostitute, even if he or she does not practice the trade openly.

In South Africa, researchers have argued that discussions of sexually transmitted diseases and sex work should be held with due attention being given to people who purchase sexual services (such as the clients, punters, Johns, and Tricks). Masterdom and Strike (1988:56) emphasise that male personnel, largely unmarried and living away from home, are more likely to be promiscuous than if they would be in other settings. They mention that during the Boer War, as many as half of the British troops suffered from venereal diseases while in the First World War, the proportion reached 20 percent in some military troops. This risk associated with combatant troops, was identified again during the Second World War and in a 1973 study of 400 Australian soldiers serving in Vietnam it was shown that an STD incidence of 27 percent prevailed.

Rosenberg, and Weiner (1988:418) have drawn a link between sex work and sexually transmitted diseases in general and with HIV in particular: They maintain that: prostitutes are considered a reservoir for the transmission of certain sexually transmitted diseases (STDs). However, a variety of studies suggest that the human immunodeficiency virus (HIV) infection in prostitutes follows a different pattern than that for STDs. HIV infection in non drug using prostitutes tends to be low or absent, implying that sexual activity alone does not place them at high risk, while prostitutes who use intravenous drugs are far more likely to be infected with HIV. Prostitutes who do not use intravenous drugs probably face their highest risk from steady

partners who may be infected with HIV and other STDs and with whom barrier protection is generally not used. Rosenberg et al (1988:420) notes that infection rates are high among female sex workers and appear to be related to sexual activity.

Researchers have observed that the pattern of infection in Africa is very different from that noted in Europe and North America. Intravenous drug use is seldom detected in blood samples taken from female sex workers in Africa. Neequaye, Neequaye, Mingle, and Ofori Adjei (1986:978) report that in a study of ninety-eight female Ghanaian sex workers only one was found to be HIV seropositive. However, other African studies have indicated higher levels of HIV infection among female sex workers. These include 26% in Kinshasa, Zaire. Mann, Quinn, Piot, Bosenge, Kalala, Francis, Colenbunders, Byers, Kasa Azila, Kabeya, and Curran (1987:345) state that there were 16-46% in Nairobi, Kenya and 82% in Rwanda (Van den Perre, Clumeck, Careal, Nzabihimana, Robert-Guroff, De Mol, Freyens, Batxler, Gallo, and Kanyamupira (1985:4).

Rocha-Silva (1993:83) maintains that intravenous drug users tend toward risky sexual behaviour. She states, that female IDUs frequently engage in prostitution, mostly in exchange for money, and sometimes for both money and drugs. While female IDUs appear committed to the use of condoms, males are less inclined to use condoms. In her study one quarter (25%) of the IDUs indicated that information on how people who inject drugs can protect themselves against AIDS was generally not accessible.

Williams, Ansell and Milne (1997:889-891) analysed case records of 86 patients who were injecting Wellconal and found that 2% tested seropositive. This was much lower than in other parts of the world. No sharing of injecting needles was reported in this study. Ramjee, Karim, and Sturm (1998), found that 50% of 145 female sex workers were HIV seropositive, from the study conducted at truck stops in KwaZulu Natal, South Africa. In addition, Rees, Beksinska, Dickson-Tetteh, Ballard, and Htun (2000:1) established that 45% of sex workers in Hillbrow, Johannesburg, in South Africa, were HIV seropositive. Their screening included an interviewer-administered questionnaire and physical examination including HIV testing and diagnosis of current sexually transmitted infections. In total 247 women were screened, of whom

46% had been operating as sex workers for less than a year. Almost half (45%) of the women were HIV positive. HIV status was significantly associated with condom use (p=0.0003) and the number of clients seen per day (p=0.005). The duration of the time as a sex worker was not found to be associated with HIV status since, those working for three or more months showed similar levels of infection to those working for one year or more. The study confirmed that sex workers in Hillbrow exhibited the characteristics of a core transmitter group. Interventions are now addressing the issues of safer sex and health care of sex workers living and working in this area. Similarly, William, MacPhail, Campbell, Taljaard, Gouws, Moema, Mzaidume, and Rasego, (2000:1) found that 60% of the HIV sex workers in the Carletonville mining site in South Africa were HIV seropositive. Interventions included the full commitment of all the local stakeholders including the state, the private sector, the trade unions, and local community-based organisations. Valuable lessons learned from this study concerned the reasons for the continued spread of the epidemic and some success has been achieved, especially in the empowerment of women at high risk and the mobilisation of people from all sectors of the community to join the fight against HIV and AIDS.

Available evidence clearly indicates that sex workers and their clients are high-risk groups with regard to long established sexually transmitted diseases. In many areas varying proportions of sex workers have already been exposed to HIV infection or have developed AIDS. In Europe and North America, HIV infection among sex workers is attributable to intravenous drug use (sharing infected injecting equipment) rather than to sexual contacts. Notably, in Africa and in other areas, for example Athens, intravenous drug use does not appear to be a factor, but heterosexual transmission is more pronounced. The United Nations reported that a number of clinical trials had showed that the spermicide nonoxinol-9, which some sex workers use as a spermicide together with a condom, could be harmful. Among the effects of the spermicide are skin breakdown and the risk of contracting AIDS (Elford, Bolding, Maguire, and Sherr, 2000:266-271). Another sexual risk behaviour among sex workers is the tendency to engage in sex with more that one partner without investigating their HIV status.

In order to gain insight into the problem of substance abuse and risky sexual behaviour, it is important to look at case analyses of research, which have been conducted in South Africa. These entail problems emanating from injecting drug use (IDU), unsafe sex, and drug use in general. Researchers have revealed that prior to the installation of a democratically elected government in South Africa in 1994, the choice and use of illicit drugs was restricted to cannabis, mandrax (a sedative and blend of the pharmaceutical drug methaqualone and an antihistamine), and cannabis-methaqualone known as the "white pipe" in combination. Researchers revealed that drug users in South Africa consumed as much as 80 percent of the Mandrax produced world-wide (Pluddermann and Parry, 1999:82, Brenen, 1998:3). These researchers state that substance abuse is common among sex workers. The link between sex work, alcohol, and illicit drugs has been observed by a number of researchers who have confirmed that drug dependence is certainly the reason that leads some women to embark upon sex work. Furthermore, it has been asserted that sex work may foster the harmful use of both legal and illegal drugs. Sometimes, drug-dealing networks overlap with those of sex work. The precise levels of drug use among South African sex workers are uncertain (Plant, 1990:10, De Graaf, Vanwesenbeeck, and Van Zessen, 1999:277-288, The National Institute on Drug Abuse and the US Department of Health and Human Services, 1998:81-88). Although the South African Drug Advisory Board stated that intravenous drug taking was not prevalent in South Africa (Drug Advisory Board, 1997:5), more research is required to confirm that this condition has not changed over the past seven years. Most researchers argue about the influence which substance abuse might have on the safety of sex workers. Some studies have confirmed that drug use among sex workers might increase their vulnerability to violence and abuse in general, due to the fact that drug abuse affects the Central nervous system. In this regard, the dangers of the street are exacerbated because of the disinhibitory effect of some substances and the effect of increased impaired judgement when one is under the influence. Sex workers who use substances may also be less responsive to health-care messages and may be less inclined to enforce safer sex practices. It has been noted that drug using clients may become aggressive and violent towards sex workers (Karim, Karim, Soldan, and Zondi, 1995:152–1525, and Brenen, 1998:2).

2.2.1 Condom use

Research indicates that condom usage among sex workers is low. Clearly, sex workers to a large extent engage in unsafe sex practices. For example, in Mainland China, a study of 3 297 sex workers revealed that only 13% of the respondents stated that they used condoms, (6.7% used often, while 14,6% used rarely) and 65,5% had never used at all. In the Netherlands, a study of 193 women revealed that 136 had worked as sex workers and each had an average of 115 customers per month. In another study comprising a sample of 157 male respondents, 99 men revealed that each had visited an average of eight sex workers in the four months preceding the study, and that all the women, who had been visited, had engaged in unprotected vaginal intercourse; each with an estimated average of 160 persons in four months (Hooykaas, Van der Pligt, and Van Doornum (1998: 525-532).

A study conducted in South Africa by researchers at the University of Natal in 1998 amongst truck drivers, revealed that most truckers (about 70%) had always engaged in penetrative sex, while 71% had never used a condom. Only a few of the truck drivers had sometimes used condoms but never used condoms with their wives. This then placed their wives at risk for HIV/AIDS. About 74% of the truck drivers reported that they were engaging in risky sexual behaviour with their wives, despite the fact that they had heard about AIDS. Of these truck drivers, about 77% associated AIDS with an incurable disease. It was established that about 29% of the truck drivers who engaged in sexual activity with sex workers never used condoms (Ramjee, and Gouws, 2000: 2). In May 2001, the Medical Research Council conducted a study, which confirmed the findings that condom use in South Africa was still low among the sex workers and truck drivers.

2.2.2 Substance abuse

Available research in South Africa has demonstrated that drug using sex workers report having much larger client volumes than non-users. They report having as many as nine clients on busy and good nights. They work seven nights a week, and their work is carried out even during the day. In comparison, the sex workers who are not drug dependent have an average of two to four clients per night and generally

work only four to five nights a week (Ramjee, and Gouws, 2002:13 & Leggett, 2000: 9)

Women who have been in the industry for some time usually complain that the use of crack has resulted in an increase of the number of women on the street and driven down the median age. Increased competition has also driven down prices for commercial sex workers, forcing them to handle greater volumes of clients in order to maintain their income levels. This has also led to an increase in the demand for unsafe sex – such as condom-free sex and anal sex – as the competition among the sex workers has reduced their ability to refuse business. These dimensions have clear implications for HIV transmission. Some sex workers blame crack for the increase in client violence. The problem of crack use has negative social health implications as it is linked with the spread of HIV and AIDS, mainly through its overall disinhibitory effect on safe sex practices (UNODC, 2002:42, and Leggett, 1999a:83-86).

Parry and Pludderman, 1999:3have noted that before 1994 only cannabis and mandrax were commonly used illicit drugs in South Africa. However, after the democratic elections (1994) South Africa experienced an increase in the availability and use of many other substances such as cocaine, LSD, amphetamine, ecstacy and heroine.

In 2002 the World Health Organisation commissioned a study to determine the link between alcohol and risky behaviour in South Africa in 2002. This study confirmed that there was a link between drug use and HIV infection. The findings of this study have major public health implications in South Africa, as HIV/AIDS infection has been observed to be highest in Sub-Saharan Africa.

People are inclined to freely indulge in unprotected sex while under the influence of drugs. It is important to note that in South Africa, the major mode of transmission of HIV is unprotected heterosexual sex. Non-injecting drug use is a significant factor that influences risky sexual behaviour (unsafe sex) and, therefore, leads to the sexual transmission of HIV. Researchers have observed that unprotected sex is more common among those who are under the influence of drugs due to a loss of control

of the libido. In other words, in the context of sexual intercourse, the main psychoactive effect of drug abuse is to:

- Alter an individual's judgement.
- Make it more difficult to say "no".
- Make it harder to negotiate the use of a condom.

It is estimated that about 85% of infections occur through heterosexual transmission, while 10% occur through mother-to-child transmission and the remaining 5% occur through same sex transmission, injecting drug use, and occupational exposure (Parry and Karim, 1999:81-88).

There is no distinctive line between cause and effect between sex work and drug use. Research has indicated a high incidence of substance dependence among persons working in prostitution. Sex work is stressful hence; Pauw and Brener (1997:82) comment that it is important to understand the role that drugs play in prostitution. Quite a significant number of respondents inform researchers that drugs relieve stress and help prostitutes cope with their work (Baldwin, 1997:100, and Pauw and Brener, 1997:82).

2.3 THE LINK BETWEEN SEX WORK, SUBSTANCE ABUSE AND HIV/AIDS

Leggett (2002) observed that the link between sex work and drugs in South Africa more closely resembles the American situation than the British one, both in terms of the drug of choice as well as the question of causation. British studies have shown that about half of the sex workers began working in sex work in order to support their drug use, however, Leggett noted that in South Africa, there is currently insufficient information on the direction of causation, on whether drugs are leading women and men into prostitution or whether prostitution causes persons to use drugs (Leggett, 2000:26, and South African Law Commission 2002:49).

The legal, moral, and social censor of sex workers/prostitutes has increased dramatically since the advent of HIV/AIDS. Female sex workers in particular are perceived as the bridge between an HIV infected population and the general

population. The perception of the policy-makers and the media, regarding this problem, is that the protection of the public health justifies draconian legal measures and moral intolerance.

Researchers have noted that punitive measures to control the sex trade, such as increased criminal penalties, mandatory testing, and electronic monitoring will further erode prostitutes' ability to negotiate safe sex and increasingly alienate them from public health initiatives (Brock, 1989:6; Plant, 1990:198, Pedian, 1988:413 and Alexander, 1991:12). In addition, the following measures were identified as sexually related HIV risks that should be considered when investigating this problem:

- Multiple partners (number of sexual partners).
- Drug risk sexual partners (composite of three items: number of drug injecting, other drug using, and needle-sharing partners).
- Sex exchange risk partners (composite of the following four items: how often gave or got money for sex; and how often gave or got drugs for sex. The responses might be: 5-7, 2-4, 1 day (s) a week and1-2 times only; or never
- Unprotected sex (How often used condoms for sex. Responses might be all, most, half, some of the time; or 1-2 times only; never).
- Sexual partner risk composite (composite of multiple partners, drug risk sex partners, sex exchange risk partners) Magura, Rosenblum and Rodrigues, 1998:75).

2.4 INJECTING DRUG USE AND HIV AND AIDS IN SOUTH AFRICA

Two studies were conducted in South Africa during 1991-1992 to provide some insight into the link between injection drug use and HIV/AIDS. Among these there were 33 Injecting drug users (IDUs). Only one respondent indicated that s/he had AIDS. The lone respondent, however, denied ever having shared syringes or needles with other drug users (Rocha-Silva, 1993:23). This study reported the rate of injection drug use as being higher in females (37 percent of the sample) than in the males (20 percent of the sample). The respondents tended toward risky sexual behaviour. Females were frequently engaged in prostitution, mostly in exchange for money, but sometimes for drugs. In the other study, a sample of 86 IDUs were selected from 2

hospitals in Johannesburg. The respondents were all patients who were injecting wellconal. This study was a retrospective study (case analysis) of IDUs and it entailed an analysis of the case records of respondents. Two percent HIV antibody positivity was encountered. Although this was far lower than in any part of the world, this study gave an indication that injection drug use is in existence in South Africa. However, no sharing of needles was reported, as is the case in other parts of the world (Williams, Ansell, and Melne, 1997:892).

Concerning the issue of injecting drug use, in South Africa researchers indicate that its prevalence is low. The data available on IDU, however, indicate that the studies had been conducted only in the treatment centres in Gauteng. As more research into drug use is being carried out in South Africa recent evidence on the different provinces indicates that the injecting of heroin is increasing. A longitudinal study carried out by the Medical Research Council indicates that 51% of heroin patients in Cape Town reported using it by injection. The figure reported for such patients in Gauteng is 36% (SACENDU 2002a and SACENDU 2002b in the United Nations Office on Drug and Crime, 2002:43). This evidence shows that the majority of heroin use occurs among the younger white middle class population in the major urban areas, namely Cape Town, Johannesburg and Pretoria. Users are mainly male and the ratio for male and female heroin users is lower than for other illicit drugs. This limited evidence suggests that there is a transition from smoking to injecting as a route of administration among some heroin users. While efforts must therefore remain focused on addressing transmission via heterosexual sex, a failure to address IDU in South Africa may result in leaving open a space for the disease to affect the population by an additional route. It should also be noted that treatment centres are not affordable to the majority of South Africans and it cannot, therefore, be conclusively stated that IDU transmission of HIV in South Africa is significantly low as long as the under resourced areas have not yet been researched.

2.5 A THEORETICAL ANALYSIS OF RISKY BEHAVIOUR IN SOUTH AFRICA

The literature regarding risky behaviour indicates that such behaviour is mainly established during early adolescence. This phenomenon has an impact on boys, girls, young adults, and later adults in relation to morbidity and eventual mortality. A

study undertaken in the Greater Cape Town area on risk-taking behaviour among high school students of all races provided preliminary data for understanding the phenomenon. Three of the eleven official languages Xhosa, English, and Afrikaans were used in this study with respect to substance abuse, the proportions of smokers were extremely lower among the African girls and boys than among the non-African boys. There were high proportions of marijuana (dagga) used among the 18 years old boys. Importantly, it was found that in the same group about 6% reported using a combination of mandrax and marijuana also practised intravenous drugs and skin piercing. Other risk factors that are culture specific include practices such as heterosexual anal intercourse as a means of contraception or preservation of virginity, dry sex, blood letting by healers with the use of traditional tools. It is also speculated that new risk factors may emerge from commercial sex workers (CSW) who have sexual contact with western tourists who visit this part of South Africa (Broomberg, Steinberg, Masobe, and Behr, 1991:31; UNESCO/UNAIDS, 2000:21 and the National Institute on Drug Abuse, 2000:92).

2.5.1 Conceptual perspectives on risky sexual behaviour as fuelled by substance abuse among sex workers

The following are the theoretical frameworks in substance abuse and the sex work arena in this study. Wide ranges of theories influence contemporary social work practice. Social work practitioners and educators are confronted with the formidable task of developing a systematic, testable, and usable risky behaviour or substance abuse and sex work theory for practice in this context. The theory-building efforts are at a crossroad: whether to test existing theories against practical situations or whether to test the practice against the rigours of theories. Whichever route is taken for theory building, social workers are expected to have a catalytic influence that shapes the basic ideas of risky behaviour theories. The social work profession is thus challenged to develop usable, testable, and internally consistent theories in order to sustain the profession and be on the same footing with fellow practitioners in other medical and public health fields.

Despite the fact that social workers handle various problems from all walks of life, from the cradle to the grave, they have not as yet developed theories that are specific

to substance abuse and sex work. Among the risky behaviour theories described below, none addresses all aspects of substance abuse and sex work. Each theory is not sufficiently advanced to make accurate predictions of the behaviours of sex workers engaged in substance abuse. Social workers utilise a variety of theories from other related fields to form part of a jigsaw and complete the puzzle. In fact, it is impossible to formulate a self-contained theory. This means that other aspects of different theories may be considered when designing risky behaviour prevention programmes until a more comprehensive paradigm evolves, in order to sharpen the design for future research endeavours. Empirical investigations are, therefore, required to develop additional constructs so that risky behaviour may be fully understood. An exposition of theories that attempt to explain behaviour provide a theoretical framework that will accommodate the phenomenon of substance abuse and sex work in its totality and guide research along systematic lines. For the purpose of this study, the following theories have been reviewed:

2.5.1.1 The Causal Theory

Researchers agree that social problems have social causes (Ross, 1992:218). It is important to note that social factors have a major influence on which individuals have access to various drugs, and social attitudes, as well as the laws of any given country, determine which drugs are acceptable for casual or recreational use and which are prohibited. Substance abuse and sex work are perceived as the products of a particular way of doing things. Both issues depend on the social attitudes that exist in a society. The nature of a society often determines the kinds of unpleasant feelings induced in its members, as well as the kinds of behaviours that are viewed as socially acceptable. Generally, in a community where drug use and/or sex work practice is widely acceptable, the number of users tends to be high and they manifest diverse personal characteristics. When a particular form of drug use meets with severe disapproval, those who use it despite such sanction tend to be very different from the average person in the society in terms of attitudes and emotional adjustment, even before use (Ross, 1992:218).

The causal theory for human decision-making, attitudes, and social norms influences the use of substances and engagements in sex work. Personal beliefs and

evaluations concerning the outcomes of drug use and sex work determine these attitudes and social norms. For example the perceived probability of detention (the presence of the police) and the probability of hurting others seem important aspects that lead some people not to engage in substance abuse and sex work. These beliefs are conducted in a larger system within which the behaviour occurs.

This theory views substance abuse and sex work as consequences of a complex interaction of causal factors, many of which are social rather than individual in nature (Donovan, 1989:274). In this regard, intervention programmes are not conducted at individual levels such as re-education, rehabilitation, and/or punishment are not conducted at individual levels but rather are conducted in a larger system within which the behaviour occurs. However, countermeasures targeted at both the societal and personal levels must be viewed as mutually exclusive levels of intervention. In order for the theory to be successful the programme should be integrated, so that complementary/ counter-measures are aimed at both personal and socio-cultural factors (Donovan, 1989: 293).

2.5.1.2 The Public Health Theory

The Public Health Theory focuses on prevention of problems/diseases. It is applied to an entire population. For example, prudent condom usage and education advice for preventing sexually transmitted diseases including HIV and AIDS may be provided to the entire population. A measure that is to be applied to an entire population is relatively inexpensive and non-invasive. The public health theory assumes that an individual's choice with respect to behaviour, for example sex work and substance abuse, is exercised within and constrained by a wider social framework. The theory acknowledges empirical evidence (Rocha-Silva, 1997:4 and Plant and Plant, 1992:3) that:

- The general level of availability of and demand for substances in the community is positively associated with the general level of substance use in that particular community.
- The general level of substance use in a community is positively related to the level of associated problems, for example, sex work and substance abuse in that community.

- There are socio-cultural role models, such as parental, siblings, peer pressure, limited participation in church activities, family breakdown, and psychologically knowing about substance use, believing in the rewarding nature of substance use and being personally attracted to substance use, the variables that contribute to substance use, and related problems such as substance abuse and sex work in the community.
- The socio-economic or socio-demographic circumstances, such as the level of education, unemployment, poverty or economic deprivation have an influence on substance use and related problems such as sex work.

It is further assumed in this theory that substance use and sex work prevention programmes should address all the factors listed above. This implies that prevention programmes should be holistic and should tackle the problems of substance use and sex work within a larger set of related factors (Sox, 1994:1589-1595; Williams and Wilkins 1989:10 and Mertens, Carael, Sato, Cleland, Ward, and Smith, 1994:1359-1369).

In this theory, the epidemiologic approach is utilised. A major goal of epidemiology is to identify sub groups in the population who are at high risk for diseases. The reason for the identification of such high-risk groups, is that there is need to expose the characteristics that put them at high risk and to try to modify those factors. It is important to note that by identifying high risk-groups preventive efforts can be directed towards activities such as screening programmes for early disease detection, at populations who are most likely to benefit from any interventions that are developed for the disease.

The epidemiological approach is a multi-step process which begins with determining whether an association exists between a factor (such as an environmental exposure), a characteristic (such as an increased serum cholesterol level), and the development of the disease in question. In this regard the researcher needs to study the characteristics of groups of sex workers and the characteristics of individual sex workers. If there is an association between the exposure (unsafe sex) and the disease (HIV infection), then the causal relationship can be confirmed. Appropriate

inferences may also be derived regarding a possible causal relationship from the patterns of the associations that have been found. If there are differences in terms of geographical variations of these same groups with similar characteristics, the researcher needs to establish the reasons for the existence of such differences through instituting investigation (Koblin, Holte, Lenderking and Heagerty.2000: 455; Sulogoi, Wagner, Ciccozzi, and Rezza, 2004:1440-14420).

The public health theory emphasises prevention of problems on an equal level with treatment. Prevention is cost effective and broad-based as it targets the entire population and not individuals as treatment does. There are two approaches to prevention, namely, the population based approach and the high-risk approach. In discussing prevention, it is helpful to distinguish between primary and secondary prevention.

- Primary prevention denotes an action taken to prevent the development of a disease in a person who is well and does not have the disease in question. For example, a person can be immunized against certain diseases so that the disease may never develop. Alternatively, if the disease is environmentally induced, the person can be prevented from exposure to the environmental factor involved to prevent the development of the disease. In the case of lung cancer, for example, people need to be stopped from smoking.
- Secondary prevention refers to the identification of people who have already developed a disease, at an early stage in the disease's natural history, through screening and early intervention. For example, most cases of risky sexual behaviour among sex workers can be detected through screening for sexually transmitted infection at a clinic. The rationale for secondary prevention is that if we can identify a disease earlier in its natural history, intervention measures will be effective (Williams and Wilkins, 1989:10 and Mertens, Carael, Sato, Cleland, Ward, and Smith, 1994:1359-1369).

The Public Health Theory can also be used to target high risk groups such as sex workers, substance abusers and others. For instance, in this study, a high risk group of sex workers who abused substances was targeted with a preventive measure in order to curtail the spread of HIV and AIDS or Substance abuse. A measure that is

applied to this high-risk sub-group of the population may be more expensive and often more invasive and inconvenient. High-risk approaches more often require a clinical action to identify the high-risk group to be targeted.

It is important to indicate that a human disease does not arise in a vacuum. It results from an interaction of the host (a person), the agent (a bacterium) and the environment (a contaminated water supply). Although some diseases are largely genetic in origin, virtually all diseases result from an interaction of genetic and environment factors, with the exact balance differing for different disease (Strathdee, 2001:1281-1288; Centers for Disease Control, 1990:273-275; Friedman, Jose, Deren, Des Jarlais, and Neaigus, 1992:393-304 and Centers for Disease Control, 1994-1995:684-991).

A disease can be described as the result of the following epidemiological triad:

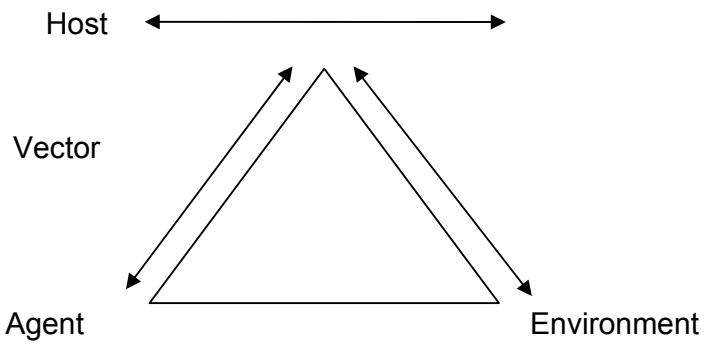


Figure I

Source: Gordis, 1996:13-14; Hulley, & Cummings, 1988:4-8 and Rocha-Silva, 1998: 12).

According to this diagram, a disease is the product of an interaction of the human host, and infections or other types of agents and the environment that promotes the exposure. A vector, such as the mosquito or the deer tick, is often involved. For an interaction to take place, the host must be susceptible. Human susceptibility is determined by a variety of factors including genetic background and nutritional and immunologic characteristics. The immune system can be determined by prior experience both with natural infection and with immunization. Diseases can be transmitted in a direct or indirect manner. Direct transmission, for example, involves a

sex worker and a client. Indirect transmission can involve a contaminated water supply (Gordis, 1996:13-14; Hulley, & Cummings, 1988:4-8 and Rocha-Silva, 1998: 12).

2.5.1.3 Risky Behaviour Theories

Notions of risk behaviour in the field of HIV prevention and the addiction to substances are largely derived from epidemiological categorisations which play a key role in constructing lay and scientific understanding of the problems of AIDS and injecting drug use. The risk behaviour examined is situated rationality that focuses on the individual rationality and social action that focuses on social factors which give rise to individuals' situated risk perceptions and actions. Risk needs to be considered as a socially organised rather than an individual phenomenon. The fundamental limitation of theories of risk behaviour, upon which most research designs are based, is associated with the concept of individual rationality (Rhodes, 1995:25). Most HIV prevention responses, such as syringe exchanges or safer sex campaigns, are based on theories of health behaviour, which view risk perception and behaviour change to be the product of individual cognitive decision-making. These theories assume risk taking to be the outcome of individuals' rational decisions based on the perceived costs and benefits of risk behaviour (Fishbein, Middlestadt, and Hitchcock, 1994; DiClemente, and Peterson, J.L. (eds), 1994: and Terry, Gallois, and McCamish, (eds) 1992:30).

Research has proved that the sharing of contaminated injecting equipment efficiently transmits the Human Immunodeficiency Virus (Ramos R. 1990:128, Centers for Disease Control and Prevention, 1999:45-48). This study has therefore focussed on sex workers who abuse drugs in order to explore the extent of the problem in South Africa. Moreover, the researcher acknowledges that, the social nature of drug injecting, the complex dynamics of drug sharing, and interaction of drug use with high-risk sexual behaviour present a serious problem for the design of effective intervention.

Social theories of risk behaviour are theories of cognition; as such they are largely unable to conceptualise risk as being the product of social actions (Wildavsky,

(1983), Krimsky, and Golding, (1992) in Rhodes, 1997:213). These authors maintain that the risk behaviour theory should view the meanings which participants attach to their actions as produced through social interaction itself. This process would shift the unit of analysis from individual factors to social factors, such as particular social interactions, relationships or situations, with the aim of understanding how risk behaviour is socially organised.

It is important to understand how risk is socially organised. Two key developments in risk behaviour are situated rationality and social action theories. Findings illustrate that situated rationality theories tend to be conceptually limited to an analysis of individual rationality, which fails to capture the distribution and influence of power in negotiated actions and the habituated nature of risk behaviour. In contrast, social action theories aim to understand the interplay of social factors, which give rise to individuals' situated risk perceptions and actions. These findings highlight the important role that qualitative research plays in questioning, as well as complementing, dominant scientific constructions of risk. Future theories of risk behaviour in the field of HIV prevention as well as other health domains need to consider risk as a socially organised rather than individual phenomenon. Finally, understanding what risk actually means to participants themselves provides the necessary data for public health interventions to create the conditions where risk reduction becomes possible (Rhodes, 1997:208). In this section, the researcher intends not to defend risky behaviour caused by substance abuse and sex work but to reinforce and recapitulate theories related to substance abuse and sex work as they evolve, and then emphasise their relevance for the many challenges confronting the social work profession within the helping and service delivery professions to meet the current challenges. For the purpose of this study the following theories have been reviewed. The following, are two strands of the risk behaviour theory which aim to analyse the individual factors to social factors.

- **Situated Rationality Theory**

This theory maintains that individual rationalities about risk are situation dependent. Drawing from cognitive and behavioural theories, it emphasises that differential perceptions of risk and rational behaviour can exist (Bloor, 1995:593, Parsons, and

Atkins, 1992:439). It also emphasises that individuals' decision-making about risk does not occur in a context free vacuum, but conceptualises individual risk behaviour as the outcome of socially situated risk perceptions (Rhodes, 1997:213).

The most important notion is the recognition that epidemiologically defined risks such as sharing injecting equipments are perceived in the context of other risks and dangers, which to the participants themselves may be considered more immediate and important. This illustrates the relativity of risk. That is, if epidemiological measures of HIV risk behaviour are adequate to explain or predict why drug users engage in actions known to carry HIV risk, then it is necessary to capture the relative importance given by drug users to HIV transmission in the context of other risks and dangers associated with their lifestyles. It is also important to note that risk behaviour such as unprotected sex is not simply the product of individual actions but the outcome of negotiated actions between at least two people (Rhodes, 1997:213).

- **The Social Action Theory**

While the situated rationality theory emphasises a plurality of rationalities, and tends to reduce action to the unit of individual decision-making, the social action theory aims at making advances over the situated rationality theory in two ways. First, the social action theory recognises that as negotiated actions, risk behaviour is the product of social interactions. In terms of sexual negotiation, it shifts the unit of analysis from the individual to the social relationship. Second, the theory recognises that individual perceptions and social interactions are influenced by social context and network norms. For example, in the same way as everyday modes of injecting behaviour may be structured by group norms and values, individual risk perceptions are mediated by social norms about what "risk" is, as noted by anthropologists that: If a group of individuals ignore some manifest risks, it must be because their social network encourages them to do so. Their social interaction presumably does a large part of the perceptual coding on risks (Douglas, 1986:66).

In fact what is assumed to be a case of individual "choice" by most behavioural theorists, is viewed by social action theorists as arising from the interplay of social factors exogenous to individuals themselves. This sheds light on the misguided faith

that most health promotion campaigns have, in encouraging individuals to make "healthy choices". It also makes explicit one of the key limitations of any theory of behaviour based on the concept of individual rationality. Behavioural theorists presume that, choice assumes that risks are systematically calculated by individuals. It is important to note that because risk perception is socially organised, in part by social norms and context, they are socially calculated as well. Therefore, behaviours that are habitual do not demand risk assessment or calculation for their doing; they are simply done. If certain risk behaviours such as the buying or injecting of drugs, are routine to those who engage in these behaviours, they may be less the product of individual rational calculations about risk and harm than of socialised habituation. Understanding the social organisation of risk behaviour does not merely complement conventional epidemiological understanding, but also questions it. For these reasons, future theories of risk behaviour in the field of HIV and substance addiction need to consider risk as a social, rather than an individual phenomenon (Rhodes, 1997:216-217).

Risk behaviour theories can be analysed from three main perspectives namely, the behavioural, feminist and legal-moral perspectives.

- **The behavioural perspective**

The behaviour perspective recognizes that disorders of goal-directed behaviours rest on some combination of physiological need, conditioned learning, and choices. Treatment is focused on stopping the behaviour by helping the client to choose to act against it. This help is delivered effectively through group therapy. Recourse to such methods as the pharmacological management of the drive (methadone, nicotine patch, naltrexone, and antiandrogens) to mention just a few, interrupts the conditioning that sustains the behaviour, and treatment for comorbid conditions can assist the process. The problem associated with the treatment of behaviour is that of stigmatisation. One cannot attempt to stop behaviour without, at some level, deploring it. This stigma must ultimately be justified to the clients and others. For example, group therapy in which clients are encouraged to identify themselves as persons with behaviour problems such as the Alcohol Anonymous (AA) protocols of introduction: "I am Bill; I'm an alcoholic" or in the case of the sex worker "I am Maria; I

am a sex worker" acknowledge the stigma and indeed may employ it therapeutically (McHugh and Slavney, 1998:291).

- **The feminist perspective**

The proponents of this paradigm maintain that equality of women depends directly on their ability to eliminate male sexual oppression. It is believed that equality cannot exist as long as sexual subordination to men continues to exist. Sex work is, therefore, intrinsically abusive. Within the client-sex work relationship, males break a few societal rules in visiting a sex worker but the sex workers break many rules in selling sex.

Women in sex work defy social control and, therefore, threaten the basic structure of society. Society regulates sexual activity and reproduction through the institution of the family (Jesson, (1993:10). Marriage is viewed as a private contract, while sex work is viewed as a public contract which delineates the males' sexual ownership of women. Women cannot therefore, divorce themselves from sexual regulation by society. Historically, women who were not considered male property, (such as divorcees and sexually active single women) had a considerably more difficult time obtaining legal protection than did married women and virgins (Miller and Schwartz, 1995:6). To date, marginalized women, for example sex workers, are not afforded the same privileges and protection as other individuals in a democratic society (Shaver, 1994:6). Sex workers lack the protection of the full extent of the law when they are victimised (Fairstein, 1993:7; and Frohmann, 1992:6). Prosecutors often do not prosecute cases involving sex workers' complaints (Frohmann, 1992:6), and, in many cases, they automatically dismiss sexual assault complaints initiated by known sex workers (Fairstein, 1993:7). To make their plight worse, very few street sex workers report their social problems to the authorities (Silbert and Pines, 1982:20) as cited in Destinys-end, 2004:7).

Advocates for the sexual equality paradigm suggest that sex workers are victims and their problems occur from psychosocial determinants involved in street sex work, such as violence, drugs, and HIV risks. Sex workers are victims of societal shaming,

which involve outcasting and labelling. They are also victims of negative childhood experiences including physical, sexual, and emotional abuse.

Sex work is described as exploitative, oppressive and inherently dangerous. It is also described as sexual abuse and as a vehicle through which women's social and economic inequality continues. Feminists argue that the process of becoming a prostitute entails the systematic deconstruction of an individual woman's belief, feelings, desires and values. Upon entering prostitution a woman typically acquires a new name, changes her appearance, and creates a fictitious past. To be a prostitute is to be an object in the market place: a three dimensional blank screen upon which men project and act out their sexual dominance. Thus the word prostitute does not imply a deeper identity; it is the absence of identity: the theft and subsequent abandonment of self. What remains is essential to the job: the mouth, the genitals, anus, breasts and the label (Giobbe 1991 as cited by Bell, 1994:128). Some women, who regard prostitution as their free choice, however challenge this view. Sexual equality activists attribute the notion of free choice to the tenets of the domination theory. They maintain that women who live under the oppressive conditions of patriarchy have no real free choice but are victims of false consciousness.

- **The legal-moral perspective**

Researchers generally agree that sex work is a predatory evil, which by preying upon society, feeds the insatiable appetite of organised crime, fosters all manners of criminality, spreads venereal diseases, and victimises and depraves the sex worker. As a consequence of sex work, there are high numbers of murders, suicides, accidental deaths, diseases, disorders, violence, and corruption in society. If uncontrolled, sex work is a quick route to a deteriorated quality of society. The public must, therefore, continue to protect itself by insisting on the maintenance of sufficient legal sanctions so that the criminal justice system may be afforded the ability to protect society (Bandura, 1989:128-141; Jemmott, Jemmott, 1991:228-234; and Weber, Roy, Blais, 2001:3).

The Roper Poll (as cited in Weitzer, 1991:1) has revealed that 69 percent of Americans stated that it was important to enforce the prohibition of sex work. The

visibility of prostitution in a community is said to attract other forms of crime and pose health hazards that may reverberate throughout neighbourhoods. Intravenous drug use exacerbates the risk of transmission (Cohen and Alexander, 1987:2; Cohen, Navaline, and Metzger 1994:233-241). The drug needs of addicted sex workers often cannot be met through sex work alone. Drug-addicted women may introduce additional crime into a community to support their habits (Incardi, Lockwood, and Pottieger, 1993:20).

Flower (1998:159) maintains that religious leaders view sex work as sinful and immoral. Through this view, sexual promiscuity condemns one to an ill-begotten fate. Consequently, women involved in sex work are believed to have fallen from the grace of God and are thought of as “fallen women” who have drifted from the path of virtuousness and righteousness. The supporters of moral and religious perspectives represent all denominations, classes, races, and demographic groups. Their goal is to clean up Society by eliminating amoral sexuality and immoral sex industries. Hence, moralists support the legal sanctions established by lawmakers.

Indeed, legal definitions of sex work have historically encompassed a double standard by largely focussing on female sex workers and not their male clients. In the United States of America, the current law varies from state to state. “Payment for sexual acts is strictly prohibited in 38 states. Solicitation laws are enforced in 44 states. In other states, sex work is banned through vagrancy, curfew and loitering statutes” (Flowers, 1998:146). Current enforcement of the law reflects old stereotypes as arrest rates suggest that women should continue to bear most of the blame for the sex work industry. For example, of all sex work arrests in 1995, 53 570 were sex workers, while fewer than 7 000 were suspected clients of the sex workers (Flowers, 1998:146).

Given the above scenario regarding the situation of the sex industry, one tends to question the reason for this imbalance in perceptions and arrest rates. According to Schriver (1998: 68), those who benefit are those who define it, fit well in it, enforce it, attribute perspectives, standards, and ways of relating as a result. Sex workers represent those at the margin. To be at the margin is to be at the fringe, partial to the whole, lacking in power and resources, to be defined by those at the centre. It is the

position of being the object of study as opposed to being the participant of study. The female identity, in general, is, therefore, at a scientific disadvantage. The sex worker identity, more specifically, violates the beliefs that espouse male sexuality as active and initiatory and female sexuality as passive and responsive. The sex worker identity, therefore, defies logic, as she is often an active and initiatory participant. This dissonance in science necessitates the need to develop models of pathology and deviance, in order to create explanations that coincide with a one-dimensional reality of women as sexually passive. This scientific reductionism fuelled the need to sanction such activity.

Polit, and Hungler, (1995:3) Maintain that those with power create a world that is an extension of their desires and interests. In a country dominated by patriarchy (literally translated to mean rule of fathers) and because the men are the ones that visit the sex workers, man becomes a walking contradiction. As a result, those who wield power are protected and those at the margins are prosecuted. Sex workers are women who defy their subordinate roles. They violate the constructed reality of sexual passivity and become the instrument through which moral disintegration occurs. They, therefore, become sanctioned over the actions of male clients whose constructed reality normally displays them as sexually active. Thus within the dyad of sexual exchange, women become both the focus for research, the result of which is often pathology, and the focus of sanction, the result of which is prosecution.

The proponents of this approach maintain that as long as discrimination in arrest rates continues to occur, sex work will continue to be a challenge for legal moralists. Following the tenets of the legal-moral paradigm, controlling the industry of sex work holds little promise so long as the majority of offenders (men) continue to remain largely outside the prosecutorial powers of the law. Some efforts to curb the demand for sex work might involve penalising those men who purchase sex, seize and impound vehicles, publish clients' names in local newspapers and charge stiff fines (San Francisco Task Force, 1996:12, Coyote, 1996:12; Pony, 1996:11, and SWEAT, 1998:10). In general, sex work is classified as a misdemeanour charge; sex work related charges include vagrancy, curfew, loitering, solicitation, pandering, and procuring females for sex work purposes.

2.6 POLICY IMPLICATIONS BASED ON RISKY BEHAVIOUR THEORIES

Two major viewpoints namely, the feminist and the legal-moral paradigms are distinguishable here.

2.6.1 The feminist/Sexual Equality Paradigm

Sexual equality proponents maintain that rescue, as opposed to enforcement, should be at the forefront of social policy and programmes regarding sex work. Social policy favour should be accessible to health care and social services. Interventions and prevention should be geared towards aiding the street sex workers to escape or avoid sex work. Escape is the only way to empower women. Criteria for intervention should address bridging the gap between those who are most vulnerable and effective social services. Currently, the programmes that exist are provided by outreach means, which use mobile vans, case management, and residential treatment methods. All these programs promote the same fundamental philosophy of a non-traditional, flexible approach of building relationships, working through indigenous networks, and meeting the physical and emotional needs of clients. Weiner (1996:7) describes the Mobile Van Project in New York that began in 1989 as a van equipped with HIV prevention information and testing, condoms, and clean needles. The goal for this programme as with similar outreach programmes, is harm reduction. Case managers and counsellors conduct outreach programmes in poverty-stricken areas to provide counselling and referrals for service. This project was funded by the state, city and federal grants for AIDS projects.

A more comprehensive project called Second Chance began in Toledo, Ohio, in the United States of America in the 1993s and ended in 1998. It operated from the inner city community centre that had existed in the vicinity for more than 100 years with well-established roots in the community. This programme entailed a case manager working intensively with street sex workers wishing to leave sex work. The programme included a 12 step, drop in sex workers anonymous group, a sexuality group, one-on-one counselling, advocacy, goal setting, basic needs, and emergency money available for material necessities. This project was funded by the city and churches, and worked closely with informal street networks as well as with the court system and women's shelters.

Another approach towards alleviating problems of sex workers is illustrated by the work of the Genesis House in Chicago. Here, the women are housed in a residential facility where they participate in the same type of groups, including 12 steps process which entailed: programs and sexuality groups. For those involved in residential programmes, groups and basic services too, are made available including food and clothing along with the use of the telephone to contact worried family members or to make appointments with service providers. Both Second Chance and Genesis House emphasised the spiritual component, believing that involvement in street sex work and the problems associated with it, such as drug use, childhood sexual abuse, and violence, injure one's emotional, physical and spiritual health which all require healing (Genesis House, 1992:10; Second Chance, 1998:15).

Although each approach to assist victims of sex work uses different modes of service delivery, all the approaches have the same goal and they confirm that working with street sex workers requires a non-traditional, flexible approach. Therapists using the various approaches believe that street sex workers are not easily served through traditional agency service delivery mechanisms. The nature of prostitution is such that these individuals do not always present themselves as acceptable clients for agencies (Weiner, 1996:103). The sexual equality paradigm, confirms that working with street sex workers challenges social workers to operationalise their values of self-determination and acceptance. In reality, operationalising the value of self-determination takes on a new meaning that could propose the legalisation of sex work. Feminists base their arguments on three theories namely the domination, the critical and the Free choice theories.

2.6.1.1 The domination theory

The domination theory, as perceived by feminists, suggests that sex workers who claim to have chosen sex work are victims of false consciousness. False consciousness suggests that oppressed persons unconsciously internalise the dominant ideology. This theory states that women who claim to enjoy and freely engage in heterosexual sex have been shaped by the practices and ideology of male dominance. Women have been taught to eroticise domination and while they may

believe they are giving consent, they are in reality, engaging in ritualised forms of domination, which have become familiar (Wahab and Sloan, 1997:5).

Miller (1993:7) maintains that many women involved in sex work have suffered sexual and physical assault, robbery, beatings, stabbings, and kidnappings. Sexual equality proponents suggest that prosecution actually exacerbates the problem associated with street sex workers and does little to rid society of the sex work problem other than to force it underground where it becomes even more risky to the victims involved. Feminists suggest that people should deal with the realities of street life, which tend to claim that sex work is victimization. By studying the lives of women and allowing the female voice to be heard, science would be inclusive, yield increased accuracy, and provide society with a more informed knowledge base upon which to judge human behaviour (Harding, 1991:7).

2.6.1.2 The critical theory

Feminist critical theorists believe that a reality exists, but a person may attain stronger objectivity by focussing on knowledge obtained from and by those marginalized by society. Within this conception, it is believed that the oppressed have the ability to understand both the oppressed view and the view of the dominant culture. For survival, the oppressed have to learn the culture of the oppressor but the dominant culture has not been forced to learn from the oppressed. Therefore, science as dominated by men is science that is biased. The assumptions within the legal-moral paradigm that good girls trade it and bad girls sell it are assumptions that are inherently flawed (Harding, 1991:8). In fact what is believed to be a known priori, becomes questionable. The era, when the voices of marginal women are sought out and heard, knowledge would begin to more accurately reflect reality.

The proponents of the critical theory hold the view that a critical examination of history is needed to rectify distorted scientific conclusions on sex work. Women as sex workers are neither inherently pathological nor are they solely responsible for the moral decay of the country. They are victims of historical patriarchy and oppression. These theorists strongly maintain that sex work evolves around domination and victimisation.

2.6.1.3 The Free Choice Paradigm (Postmordenism)

The free-choice proponents provide a theory on the construction of sex work. Jolin, (1994: 77) proposes that choice is at all times linked to full personhood. Restricting a woman's choice, for any reason, reduces her status as a full equal human being. Making choices for others always implies having control over them while the freedom to choose provides people with an inalienable equality, and minimises the status of the woman as a full human being.

The term sex work was initially coined by the performer, and activist Carol Leigh, to refer to prostitution that was associated with sinful and deviant behaviour to sex as work (Alexander, 1987:9). Local groups in the United States of America came together during the 1980s to form an international coalition of grass roots organisations called The International Committee for Prostitute Rights (ICPR). Two World Whores Summits were held in the 1980s. These summits connected the Third World women with the First World women. The key themes to sex work are: women sell their services, not their bodies, and it is a woman's free choice to practise sex work in as much as free choice can be achieved in a patriarchal, racist, and sexist society (Bell, 1994:130).

Consequently, in the United States of America, organisations known as Call Off Your Tired Ethics (COYOTE) and Prostitutes of New York (PONY) were formed. They have remained the two vocal groups active in the struggle. The leadership of these organisations rested in the hands of sex workers, although membership was open to any person. The prominent figures in these organisations are Norma Jean Almodour, spokeswoman, and Margo St. James, president of COYOTE.

Free-choice proponents attempt to connect the struggle of sex workers' rights with the struggle of women's rights in general. They argue that the feminist struggle is about obtaining independence, financial autonomy, personal strength, female bonding, and sexual self-determination as in the right to have an abortion, the right to choose a same sex intimate relationship, the right not to receive female circumcision, and the right to sell sexual services. Overall, the right to choose one's sexuality and the assumption of control over one's own body are the bases of their argument. Women should have the right to have sex for reproduction, recreation, or remuneration (Bell, 1994: 106). According to this perspective, assessing the rights of those regularly deprived and most marginalized in society is a measure of people's future struggle. Bell (1994:106) states that the struggle should focus on sex work, since sex work is where society inflicts the most oppression and control.

Free-choice proponents are postmodernists. In postmodernism, reality is subjective and is, therefore, rooted in the subjective experiences of the individual or group in question. Truth is variable, complex, and unique. Postmodernism accounts for the contradiction found in people's lives (Harding, 1991:9). In this regard, the researcher's stance is one of open interactiveness with the study participants. The notions of researcher bias or researcher's values are acknowledged. It is an interpretive paradigm, one that is inductive and process oriented. This means that post modernism requires the use of qualitative methods. The overall goal of qualitative research is to understand the feelings, viewpoints, and ideas of the respondents without any restriction.

Free-choice activists respect the complexity and pluralism found in women's lives. These proponents allow people who had been viewed as objects of theory to become participants in formulating theory. Postmodernism rejects the idea of reduction to the singular, with the singular being concluded from the abstract view of man. The construction of the prostitute according to sex workers' rights groups is multiple. It manifests the sex worker as a healer, sexual surrogate, teacher, therapist, educator, and political activist (Bell, 1994:106). This paradigm rejects notions of the domination theory. It states that this ideological orientation has shaped the interpretations of many researchers who refuse to believe that the words of sex workers are true (Wahab and Sloan, 1997:7). A sex worker's job can, therefore, be seen as both

empowering and dehumanising. The assertion is made that not only does reality differ across women but it may also conflict and differ within one woman. Just as one's job can be viewed at times as both empowering and dehumanising, so is the case too with sex as work.

2.6.2 The Legal-moral Paradigm

The legal-moral paradigm is implemented by using four models of enforcement, namely, the laissez faire, the control, the regulation, and the zoning models. The laissez faire model often develops in large cities with overburdened police forces and scarce resources (Reynolds, 1986:37 and Destinys-end, 2004:4).

The fact that other crime rates are so high, coupled with the futility of trying to enforce a law that is impossible to enforce effectively, leaves the police to make a conscious choice not to enforce the law. Furthermore, the economic well-being of the city depends upon adult tourism and conventions. Reynolds (1986:37) reports that city officials do not wish to suppress sex work due to the revenue it indirectly generates to the city. Accordingly, tourists expect to find these luxuries during their stay and may be attracted to the idea of booking conventions, meetings, and vacations in those particular cities. The examples of these cities in the United States of America include San Francisco, Miami, and Las Vegas. Sex work, therefore, generates funds for the country yet the sex workers are not taxed on the profits they make as long as there is no policy that recognises the sex trade. The following models indicate law enforcement activities, which are used on sex workers:

2.6.2.1 The control model

The control model emphasises enforcement of law and is basically supported by courts and city. Reynolds (1986:39 and 41) states that the main support for repressing sex work comes from the community, as the citizens express displeasure with any public activity that offends the community standards of decency. These communities are usually homogenous urban vicinity, small towns, or middle class suburbs. They consist of families, some of whom morally condemn the idea of sex work while others just prefer that the sex trade be conducted in someone else's

areas. This model forces sex work to operate underground and out of sight. As long as community pressure on the police is consistent, sex work will remain underground.

2.6.2.2 The regulation model

This model operates in cities where there exists a noticeable amount of legal sex work. These include massage parlours and escort services or legal brothels. This model dictates that those engaged in such activities be licensed. These licenses do not permit carriers to engage in sex work, but are ways to regulate activities. For example, officials can institute health standards and severely fine any agency, massage parlour, or brothel that employs unlicensed sex workers. The most beneficial factor to officials is that they can collect taxes on such activities.

2.6.2.3 The zoning model

The zoning model may incorporate the other three models. In the zoning model, adult entertainment is concentrated in specific areas away from residential areas. Within these concentrated areas, establishments are regulated and police assume a laissez faire position, while at the same time adhering to the strict control model type enforcement in residential areas. Examples of this model in the USA, include the French Quarter in New Orleans, and Sunset Strip in Los Angels. It is also used in the Netherlands, where sex work has been legalised and decriminalised.

Zoning laws seem to have been chosen as an equitable response to the sex work problem in communities that are affected. However, these laws appear to force women into congested and unprotected areas where they fall prey to victimisation by pimps, extortionists, and rapists. Because the members of the vicinity where zones exist, do not want zones near them, causes zoning to be placed in industrial areas that are dangerous and isolated. Eventually, zoning neither, removes the criminalized stigma and associated ramifications, nor does it protect basic human rights. For example, being labelled a criminal places women at the risk of losing custody of their children (San Francisco Task Force, 1996:10).

Reports show that street sex workers are disproportionally prosecuted when compared to sex workers in other areas of the industry (San Francisco Task Force,

1996:9). In this regard the free-choice proponents put the blame on prosecution and zoning laws meted out by the lawmaker to control the problem of sex work. In addition, the reason may be that street sex workers are likely to be poor and the majority are black, as compared to other sex workers who are white and are in the minority. Arrest affects the street sex workers more than any other vulnerable group (Flowers, 1987:46). The arrest rate erroneously suggests that sex work is a black and poor phenomenon (Wahab and Sloan, 1997:7).

2.6.2.4 The Deterrence model

In communities where stricter penalties are imposed, sex workers are prosecuted (San Francisco Task Force, 1996:12). The deterrence theory, is a popular approach among classic criminologists. It depicts crime as an activity which can be deterred by creating a judicial atmosphere that guarantees certain, swift, and severe punishment of the criminal. This model entails conducting regular sex sweeps and assigning undercover officers to suppress some street sex work. The financial burden of such enforcement is huge, as it was found that in Toledo, Ohio, a single sex work arrest cost $2920 (Wlliamson, 1993 in Destinys-end, 2004:4). This cost estimate includes the total cost to operate the police division, municipal courts, probation, and the regional jail divided by the number of sex work arrests.

Because the Legal-moral paradigm is concerned with social control, enforcement, and deterrence as key approaches to contain and suppress sex work, it is important to note that progressive cities are attempting to tighten zoning laws while conservative cities are calling for stricter laws and penalties (Stephanian, 1996:4 and Toledo City Council (1993:4). By opting for stricter zoning laws, proponents of social reform are hoping to contain the sex industry within designated zones and thus relieve the surrounding areas of problems associated with street sex work such as traffic congestion, noise, cruising, and exposure of children to sex work (Stephanian, 1996:4).

Despite the exorbitant cost of enforcement, the deterrence theory appears to be the approach adopted nationally. The deterrence theory neglects the complexity of individual lives and assumes that the pressure to commit a crime is fairly constant. It does not take into account the fact that different offenders experience different

pressures and that criminal behaviour, like all behaviour, is subjective, and that it is determined by need and desires relative to many variables including opportunity, group norms, formal and informal sanctions, and pleasure versus pain. The deterrence theory maintains that the risk of being caught will lower the probability for violations when, in fact, risk is considered as subjectively calculated, by the individual (Webb, 1980:29). The Deterrence theory assumes that individuals are rational beings and, therefore, make their choices based on rational decisions. Most law-abiding citizens are law abiding because they have "internalised the socialisation process and not the written law and its sanctions (Webb, 1980:24).

Critics of the legal-moral perspective have also pointed out its failure to resolve problems associated with sex work Shaver, 1994 in Destinys-end, 2004:5). In direct contrast to the legal-moral paradigm, they indicate that there are the free choice and sexual equality paradigms. Whereas the legal-moral model functions from an ideology of the criminalisation of sex work, the sexual equality paradigms call for the decriminalisation of sex work.

2.7 CONCLUSION

This chapter alluded to the extent of the problem of sex work, drug abuse and risky behaviour as experienced by women all over the world and in particular in South Africa. Different theories on these problems were explored as well as policy implications that are based on the theories.

The implications, which have been discussed above, provide insight into the problems of controlling and containing sex work in countries where it exists. The significance and distinctions surrounding differing ideological positions that flow from these paradigms have implications for both policies and implementations. Proponents for the criminalisation of sex work might be inclined to use the information of this study to justify not only stiffer, swifter sentences, but also to advocate for intervening early before women become heavily involved in drugs and crime. Although stiffer and swifter sentences have been criticised as not actually influencing crime prevention and deterrence, criminalisation proponents may use this information to advocate for stronger penalties hoping to force women out of the sex work business.

CHAPTER 3
A REVIEW OF THE POLICY ON SEX WORK WITH SPECIAL EMPHASIS ON SOUTH AFRICA

3.1 INTRODUCTION

Sex work is an ancient trade, which provides a high income to the traders. Many governments, however, do not tax sex workers, as the trade is not officially recognised as an income-generating job. Sex workers experience many problems in their work, yet of late the trade is gaining recognition as a tourist attraction in some countries. Many sex workers are reluctant to abandon their trade and as such, their human rights must, be respected as they, like all other citizens of a country, deserve to be protected against harm from clients and infection from diseases. To be successful, HIV prevention programmes should involve sex workers too, as they know and understand the problems, which emanate from risky behaviour that renders them conducive to infection. There is need for governments to recognise sex work as an income generating trade which must be taxed. With training and better working conditions, sex workers should then be recognised as income-generating workers that must be subjected to taxation. A non-judgemental attitude towards sex work would increase the number of taxpayers and the safety of both the workers and their clients. Such recognition of the trade would also reduce the harmful consequences related to sex work (Perkins, 1991:30; San Francisco Task Force, 1996:10; **Http://www.bayswan.org** and **http://www.whoreact.net**; SWEAT, 1998:10; Coyote, 1996:12; and Pony, 1996:11).

In many countries, policy aimed at the protection of sex workers, however, has proved to be ineffective and inappropriate. The failure of policy aimed at protecting sex workers is mainly due to the fact that in its development, sex workers (the core group that is targeted) are often excluded. The social work problem-solving process emphasises involvement of the person with a problem in the solution or alleviation of his or her problem. Sex workers too, must be actively involved in the solution of sex work problems, both directly and indirectly. In this chapter, the needs and **rights** of sex workers have been explored in the hope that a policy on sex work in South Africa would equate sex workers' rights to those of the rest of the society and provide

respectability to the profession that is wreaked with scandal yet continues to thrive amidst all obstacles. In this chapter, the researcher has analysed a number of approaches and has indicated how each is implemented in South Africa and also in other countries as a measure of protecting sex workers, their clients, and the entire society. The researcher argues that, the involvement of sex workers in the effort aimed at alleviating the HIV pandemic and other problems emanating from sex work is necessary.

3.2 A REVIEW OF POLICY ON SEX WORK GLOBALLY AND IN SOUTH AFRICA

Many societies make an effort to find the means which would prove best in handling the problem of sex work. There are varied approaches to sex work. These approaches evolve around activities such as: criminalisation, decriminalisation, regulated, deregulation, or a combination of the above. Many countries view sex work as a problem rather than an industry. They make hopeless attempts to keep the problem invisible, as they have realised that no effort, whatsoever, can totally eliminate sex work. Traders would rather go underground than abandon the trade. When the trade is practised underground, it becomes froth with complex problems that may endanger the health and welfare of many people.

Currently, there are three approaches to address the problems of sex workers. These are: criminalisation, regulation, and abolition. While these approaches differ in the extent to which the criminal law is considered appropriate regarding the intervention with sex workers they, however, seem to share the following two considerations:

- Protection of sex workers from exploitation by third parties, and
- Protection of the public from adverse effects of or exposure to sex work.

3.2.1 Global attitudes on sex work

Despite the negative attitudes of the majority of people towards sex work, in some countries, for example the Netherlands, Canada, and Australia, the sex trade has been legalised:

3.2.1.1 Legalisation

Legalisation of sex work, however, does not mean a wholesome acceptance of the trade, but rather, it entails regulation of the trade within specified boundaries. In a legalised system, the law defines certain conditions and zones within which sex work is allowed to occur. Sex work, which occurs beyond legislated boundaries, is deemed illegal. Many countries continue to criminalise all forms of sex work except for sex work practised through escort services or licensed brothels (zoning and licensing requirements for brothels to be determined by the proper municipal authorities). In the Netherlands, the sex industry was legalised in 1999. Prior, to this period, a system of de facto decriminalisation existed whereby, although sex work was illegal, it was tolerated in practice (Brents, and Hausbeck, 2005:270).

3.2.1.2 Regulation

Regulation (sometimes referred to as legalisation) permits sex work in certain forms, usually through zoning (confinement to certain areas) or licensing (allowing a limited number of prostitutes to work in certain areas of a city). Regulation views prostitution as a necessary evil if not a social necessity. It indicates mere tolerance of the trade. Its aim is not total eradication but rather control of the sex trade by limiting it to some areas of town where it will not offend the rest of the citizens, and where adequate police protection could be afforded to the sex workers.

Regulation is the preferred approach of liberal minded officials who are willing to try something other than criminalisation, but still wish to maintain control over prostitution. Regulation of sex work, however, has not proved particularly successful in some countries where it is practised. In fact, in Australia and Canada, the sex workers' civil rights have been adversely affected and under-ground prostitution continues to exist in tandem with legal prostitution, thereby defeating the entire purpose of the regulatory scheme. In these countries, prostitution is governed by a series of laws, which combine criminalising all aspects of sex work. Like in other countries with total criminalisation, regulation of sex work in these two countries has not eradicated it, nor has it resulted in effectively controlling it. Government stance towards sex work influences the extent of tolerance of law enforcers. In some countries, government has compromised, by creating a form of regulation, which

seeks to protect sex workers from exploitation while it also protects the residents from the "nuisance" of exposure to prostitution (Bell, 1994:294; Best, 1998:1868; Brents, and Hausbeck, 2001:320, and Brents, and Hausbeck, 2005:270; COYOTE, 1996:9 WHISPER, 1998:8).

3.2.1.3 Criminalisation

Prostitution can be governed by a series of laws, which combine to criminalise all aspects of sex work. The legalisation system maintains that sex work is legal only under certain strict conditions. These conditions entail, having a license to operate, registration and/or undergoing mandatory health testing for sex workers. If a sex worker fails to abide by these rules she would be declared to have committed a crime that would make her liable to arrest and prosecution. This system, however, does not take sex workers' interests into account and in most cases these measures are neither effective nor practical to apply, as sex work is diverse. There are, for example, sex workers who operate from street corners selling sex in order to survive, while high-class sex workers work out of their private homes and earn a significant amount of money. Pimps control some sex workers and or gangs while other sex workers operate from massage parlours and escort agencies. Sex work is highly stigmatised and those who engage in it are usually forced by circumstances to be in this type of work (The South African Law Commission, 2002:191, and Alexander, 2001:5).

The criminalisation system maintains that sex work and all associated activities are criminalised. This system applies in South Africa and other countries where legalisation of sex work does not yet apply. In South Africa, it is the sex workers and not the clients who are criminalised, whereas in Sweden, it is the client who is criminalised and not the sex worker.

3.2.1.4 Decriminalisation

Legalisation suggests that the sex industry is tolerated, but requires special regulations in a way that implies its difference to other industries. In this system the law defines certain conditions under which sex work is allowed to occur. If sex work occurs outside these laws, it remains illegal. In this regard, legalisation differs from

decriminalisation in that it implies the existence of a legal industry, with an illegal industry still operating outside its borders.

Decriminalisation refers to the removal of laws that criminalise adult commercial sex work. It means that the sections of the Sexual Offences Act that criminalise adults selling sex or profiting from the sale of sex will be abolished and will not be replaced with other laws. It is also possible to decriminalise sex work but continue to criminalise the third party. South Africa being one of the countries in the world that has ushered in human and labour rights in 1994, has decriminalised sex work and recognises the needs and problems of sex workers. In this regard, experience which has been gained from other countries, will guide the process to be followed in the regulation of the industry. Mistakes that were made by other countries, especially the oversight of excluding the target system when policy is made, should not be repeated. Involvement of the sex workers in the review of the present policy would be effective in controlling the industry within a human rights framework (SWEAT, 2002:2; COYOTE, 1996:9 WHISPER, 1998:8, The South African Law Commission, 2002:191, and Alexander, 2001:5).

3.2.2 A review of the attitudes of South Africans towards sex work

In 1994, the new democratic government of South Africa introduced human and labour rights in the country. The implication of these rights is that equity, justice, and fairness prevail for all sectors of the community. Sex workers too, cannot be discriminated against. They deserve recognition, service, and protection, hence a review of the South African policy on sex work is overdue. In keeping with the Human Rights and Labour Laws, policy must be adapted. While many countries continue to criminalise all forms of sex work, except for sex work practised through escort services or licensed brothels (zoning and licensing requirements for brothels are determined by the proper municipal authorities) in South Africa, sex work is still regarded as illegal. The attitudes of South Africans towards sex work have been shaped by laws which were enacted in the pre-democratic era as well as those of the post-Apartheid era.

3.2.2.1 The historical development of policy on sex work in South Africa

It is important to note that interventions targeting individuals such as sex workers' behaviour change are likely to be more effective if they provide people with not only the knowledge, but also the practical means and personal skills to change their behaviour. This can include the distribution of condoms and clean syringes or providing treatment for drug problems (practical means) and improving individuals' negotiation skills around condom use (personal skills) (World Health Organisation, 2003:4). It is, therefore, imperative that the development of policy for sex work in South Africa should be viewed against the background of the two separate eras. Currently, in South Africa, sex work and all associated activities, such as brothel keeping and soliciting are criminalised under the Sexual Offences Act No. 23/1957, which is currently under review. The relevant sections of the Act are:

- Sections 2 and 3: Brothel keeping.
- Section 19: Soliciting.
- Section 20 (1) (a A): Unlawful anal intercourse for reward.
- Section 20 (1) (a)-(d): Living on the proceeds of prostitution.

A review of Pre Democratic Era Policies on sex work in the RSA

Although several legislations have been enacted in South Africa, there is however, no specific policy that addresses the specific needs and human rights of sex workers. Debate on the legislation of sex work commenced as early as 1868, when the Cape government promulgated the Contagious Disease Prevention Act. In terms of this legislation, sex workers were required to undergo compulsory medical examination for venereal diseases. This was followed with the passing of the Police Offences Act in 1882, which stipulated that sex workers who loiter in public places for the purposes of sex work or solicitation could be prosecuted. In 1893 the Cape Parliament passed legislation aimed at eradicating child prostitution.

The regulation and prohibition of sex work which was initiated in the province then known as the Cape colony, resulted in the migration of sex workers and pimps to the other provinces - a phenomenon that prompted the three provinces of the time, namely the Transvaal, Natal, and the Free State governments to follow in the

footsteps of the Cape Colony by passing legislation relating to brothel-keeping, pimping, and the procurement of prostitutes. All these colonial enactments remained in force until 1957, when they were repealed by the promulgation of the Immorality Act (now referred to as the Sexual Offences Act.

The Sexual Offences Act, No.23/1957:3-14 focussed on a number of offences relating to brothel keeping, procuring women and children to prostitution, the enslavement of females as prostitutes, soliciting prostitutes and living on the earnings of prostitution. Until 1987, there was no law in South Africa, which prohibited anybody from engaging in sexual intercourse in order to receive material or pecuniary reward. The thrust of the Sexual Offences Act prior to 1987 was, therefore, on prohibiting aspects and manifestations of sex work in the public interest and not to prohibit sex work as an occupation. There were also other types of legislation focussed on regulating sex work-related activities. These included the following:

- The Health Act, No. 63/1977:16, Section 34 (a) which stipulates that the Minister of Health could authorise regulations that restrict or prohibit any trade or occupation.
- The Aliens Control Act, No. 96/1991:15, Section 39, designates persons who live or have lived on the earnings of prostitution, or have received any part of such earnings, or have procured persons for immoral purposes as prohibited persons, entailing special danger to health. This section allows the Minister of Health to take measures towards preventing or restricting such danger.
- The National Roads Act, No. 54/1971, an amendment, Act of 1998:68, Section 58 (2), creates an offence against any person who without a written permission of the Board or contrary to the terms of such permission, carries on any trade or exposes, offers, or manufactures for sale any goods on a national road or in a building restriction area.
- The Aliens Control Act, No. 96/1991:15, Section 39, designates persons who live or have lived on the earnings of prostitution, or have received any part of such earnings, or have procured persons for immoral purposes as prohibited persons.

- The Child Care Act, No. 74/1983:6, Section 14, stipulates that whether a parent or a guardian of a child, or any other person who has custody of a child has caused or conduced to the seduction, abduction, or prostitution of the child or the commission of immoral acts by the child, is a factor to be considered by the court in an inquiry whether such parent, guardian, or person is unfit or unable to have custody of the child. There were also various municipality by-laws, which prohibited designated activities if performed in public. These included the City of Pietermaritzburg General by-law, whereby sex workers are offered alternative choices so that they may not be seen operating on the street, as they are perceived to be an eyesore for the entire town and the tourists industry that would promote the economy of the town.

- The Immorality Act, No.101/1987:14. In terms of the 1987 amendment to the Immorality Act (now known as the Sexual Offences Act), efforts for prohibiting sex work have been enacted by the South African Parliament. Section 20 (1) (aA), inserted into the Act by the amendment provides for the following: "that any person who has unlawful canal intercourse or commits an act of indecency with another person for reward, is guilty of an offence". Criticism levelled against this section 20 (1) (aA) by the Ad Hoc committee of the State President's Council, which was appointed to make recommendations on the effectiveness and the efficiency of the Immorality Act was noted. Among others the State President's Council noted that sex work could not be eradicated by measures under criminal law. The following observations were made in Section 20 (1) (aA) of the Sexual Offences Act;

  * Although this section is gender neutral, in that it is applicable to both male and female sex workers, it creates a double standard in the policing of sex work by failing to establish an offence against clients of sex workers.

  * It criminalizes the right of a sex worker to a livelihood, in that it robs him/her of his/her right to support himself/herself and his/her family.

  * It is motivated by moral considerations that have no basis,

* It ignores the violation of fundamental rights involved in its enforcement coupled with the high costs of entrapping, apprehending, investigating, trying and eventually arresting the sex worker.

The criticism levelled against the Sexual Offences Act, No. 23/1957 is that the penal sanctions do little, if anything, to make a hardened prostitute abandon her way of life. The Act still stops short of stating that it is an offence to be a prostitute. It does not clearly define the concept prostitution, yet it uses it in the description of various offences. The Act merely makes provision for criminalising sexual services reward.

- **A review of Post apartheid era policies on sex work in South Africa**

Due to the current criminalised status of the industry, reliable data on prostitution are difficult to obtain. In fact, it is difficult to estimate the number of persons working in sex work in South Africa. In addition, the sex work situation also continues to change due to factors such as the general economic climate, law enforcement trends, drug trends, and patterns of migration, seasonal considerations, and the viability of alternative informal opportunities. In fact, the sex work industry remains transitory due to the fact that persons working in this industry enter and leave the industry at will (Pauw and Brener, 1997:33 and Leggett, 1998:30). Sex work in South Africa entails various activities, such as the pornographic media industry, massage parlours, live performances such as “strip” shows (also known as teasers), brothels, escort agencies, and outdoor or street sex work.

The Film and Publication Act, No. 65/1996:13-17, Sections 25-29, provides for the lawful possession, distribution, and exhibition of adult pornographic material, provided that these actions take place within the framework constructed by the Act.

Although the sector of the adult sex industry generally referred to as “prostitution” is formally criminalised, the system in practice is a hybrid mixture of criminalisation and legalisation. There are some instances where police or the prosecuting authorities, though formally in place, do not enforce criminal prohibitions. It should be noted that although the majority of persons working as sex workers in South Africa are women, there is also a significant percentage of male and transgendered sex workers.

There are trends of operations among sex workers that have been observed from recent research and intervention projects in South Africa, such as:

- Knowledge, attitudes and general sexual behavioural patterns and practices among prostitutes and other persons with regard to sexuality and AIDS-related matters (Schurink, Liebenberg, and Schurink, 1993:15).
- Prostitution in Durban, with specific reference to the inner city area (Posel and Leggett, 1999:157-167).
- The trucking industry and HIV interventions, specially concentrating on prostitutes and truck drivers in KwaZulu-Natal (Posel and Leggett, 1999:157-167).
- Condom usage among prostitutes in Durban (Marcus, 1995: 80-84; Karrim et al., 1995:1521-1525; Kraak, (1993:125-138; and Ramjee 1998:346-349).
- Factors increasing the risk of HIV infection among street prostitutes in Cape Town (Varga, (1998:22).
- HIV interventions with hotel-based prostitutes in Hillbrow, Johannesburg.
- Informal prostitution that has developed around the mining communities.
- The relationship between drug use and HIV in South Africa, conducted among prostitutes in Cape Town, Johannesburg, and Durban (Leggett, 1999:14-20).

3.2.2.2 Attitudes of South Africans in support of criminalisation of sex work

The following arguments have been voiced in support of the policy on criminalising sex work in South Africa:

- Many people have moral objections to sex work.
- People are concerned that sex work is a public health risk.
- Sex work is associated with a number of other crimes, such as drug trafficking or petty theft.
- People also seek to reduce the public nuisance manifestations of sex work such as noise, litter, and public indecency.

- Some people believe that sex work amounts to the sexual exploitation of women
- Many people are concerned about trafficking in women and children.
- There are many concerns about sexual exploitation of children and women in general.

All these justifications assume that criminalising sex work can and will eradicate the sex industry. This view, however, has been proved untrue, in South Africa as well as in other countries around the world. In fact, the criminalisation of sex work simply means that the industry is forced to operate underground and that it cannot be controlled or regulated in any way. This effectively ensures that none of the concerns listed above can be dealt with.

The criminalisation of sex work in South Africa not only infringes on the human and labour rights of sex workers, but also limits job opportunities for unskilled workers. The impact of the criminalisation of sex work has the following repercussions:

- The Sexual Offences Act, No.23/1957 as it currently stands violates the fundamental human rights of sex workers, as guaranteed in the South African constitution. This includes sex workers' rights to the equality, dignity, privacy, freedom, and security of the person and freedom of trade, occupation, and profession.
- By forcing the industry underground and effectively ensuring that the police do not protect sex workers, criminalisation of the industry increases sex workers' vulnerability to violence and exploitation.
- Sex workers' access to health, social, police, and legal services are limited, as they often are afraid to reveal their occupation for fear of being discriminated against.

The Sex Worker Education and Advocacy Taskforce (SWEAT) has heard numerous reports from sex workers that health officials are rude to them and threaten to have their children removed from their care.

In South African law, prostitution is currently dealt with in terms of the Sexual Offences Act, Act 23/1957, although other legislation, such as the Aliens Control Act, Act 96/1991, also contains some provisions that are relevant to prostitution. In addition, municipal by-laws play an important role in the legal control of prostitution. Sex work is criminalized in South Africa. It is illegal to sell sex, to profit from the sale of sex, or to run a brothel. The criminalized status of the industry means that no regulatory body exists to enforce standards for work. In addition to abusive working conditions, the criminalisation of the sex industry results in sex workers' increased vulnerability to all forms of violence, and increased stigma. The continued criminalisation of sex work is also a major factor preventing effective HIV prevention programmes amongst sex workers and their clients. Earlier reports indicate that the law is very difficult to enforce in South Africa and the industry is forced to operate underground as health service providers cannot assist the sex workers (Alexander, 2001:5, and South African Law Commission, 2002:186). This has resulted in sex workers experiencing abusive working conditions and their increased vulnerability to all forms of violence and stigma.

Sex workers are unable to ensure that they have fair and safe working conditions, as labour legislation does not apply to the industry because it is a criminal offence. This is particularly relevant for sex workers working in the indoor industry as they are sometimes forced to work in appalling conditions. SWEAT has dealt with cases in which sex workers have been required to work 20 hour shifts at some brothels, not being allowed to leave the premises and being subjected to hefty fines for breaking house rules.

- This Act criminalizes the right of a sex worker to a livelihood, in that it robs her of her right to support herself and her family.
- It is motivated by moral considerations that have no basis,
- It ignores the violation of fundamental rights involved in its enforcement, coupled with the high costs of entrapping, apprehending, investigating, trying, and eventually arresting the sex worker.

- **The Role of SWEAT**

SWEAT serves as an arbitrator between the sex workers and their employers by reviewing the human rights of the sex workers. During June 1999, SWEAT obtained a High Court interdict against the management of an escort agency, preventing it from infringing on the human rights of sex workers working at some agencies.

The interdict was based on the statements indicating that escorts were forced to work excessive hours, in some instances up to 19-hour shifts per day. SWEAT intervened as the workers reported that they could not leave the premises of their employers and were not allowed to have personal visitors. In some cases, the workers were expected to share their beds with other workers and were also threatened that the nature of their work would be revealed to their family members. Some brothel managements had confiscated the identity documents and other personal belongings of the workers. Those who had been recruited from far had no support system and had difficulty leaving the agency.

The code of conduct set out and agreed on by agency management, sex workers, and SWEAT were as follows:

- Theft or extortion from clients would lead to dismissal of the masseur.
- No drugs would be permitted on work premises.
- Managers must check the identity documents of sex workers to ensure that they were over the age of “consent”.
- Sex workers must practice safer sex at all times. This includes using a condom, even for oral sex.
- Sex workers would be given a copy of the agency’s rules and the penalties for breaking them.
- Core working hours would be established and masseurs would be given time off from work.
- Minimum prices would be explored so that reasonable prices would be paid for services offered.

3.3 POLICY IMPLICATIONS FOR SOCIAL WORKERS AND POLICY-MAKERS

The goal of social work research is to develop new theories or to influence policy (De Vos, 1998:6). This study is particularly, aimed at influencing policy towards the development of a framework on risky sexual behaviour among sex workers. Policy forms an integral part of the social work profession. Social workers have an obligation to themselves, society, and the recipients of their services. Their policy implementation processes should be based on the knowledge in the field of policy. Their policies should apply a bottom-up approach, namely, that the consumers of the policy should influence it. Consultative workshops should be conducted throughout the nine provinces in order to develop a policy that addresses real issues on the ground.

Social workers have to mobilise and facilitate civilians to develop policies that will protect the vulnerable groups in the society. They have to network and consult extensively for the entire process of policy formulation and implementation. They can enable the legislative and administration processes of the policy. Rational policy-making about the protection of sex workers requires a detailed knowledge of sex workers and their complete participation.

Various approaches to contain the issues of substance abuse and sex work relation have been outlined in this study. One might ask a question as to whether the law is able to differentiate a victim from a perpetrator. In the case of standard prohibited behaviours, it generally can. For example, the victim of a homicide can be distinguished from the perpetrator. Of course, there are exceptions to these standard scenarios, where the victims themselves face criminal charges. An example might be a situation where a victim of sexual assault is convicted of contempt of court for refusing to testify against her attacker (Hampton, Oliver, and Magerian, 2003:540; Eby, Campbell, Sullivan, and Davidson, 1995:570 and Hearn and Jackson, 2002:166). It is important to note that social service workers are also challenged by situations where their clientele may be faced with two-sided prohibited behaviours. In this regard, the criminal law is hard pressed to distinguish the victim from the perpetrator. It might identify the perpetrator as the victim that needs to be protected from him or her. Consequently, the perpetrator becomes the victim of his or her own

behaviour (Hampton, Oliver, and Magerian, 2003:540; Eby, Campbell, Sullivan, and Davidson, 1995:570 and Hearn and Jackson, 2002:166).)

It is also important that social service workers should take cognisance of the limitations and difficulty involved when victims are being punished. For example, in the case of a sex worker, the criminal law may shift from the phenomenological world (the facts) to a different mode of reasoning. It moves from an analysis-based mode of reasoning (evidence enabling deduction) to one based on consequentialism or teleology (the goals underlying behaviour). Criminal law tends to justify its intervention by the need to protect the vulnerable groups (children and women). Consequently, when the law loses it causes service workers as well, to lose sight of the (ultimately inexplicable) reasons why the offence was brought before the courts in the first place (Chesney-Lind, 1997:6; Flowers, 1998:8; McGuire, Birthistle, Carrington, and McManus, 1995:275-276; Muller, Stark, and Guogenmcos-Molzmann, 1995:275-276; and Shewan, Reid, MacPherson, and Davies, 1995:1264).

- The other implication is that criminal law restricts an individual's liberty to take the life or property of others. Consequently, it institutes specific rights and freedom, i.e. the right to enjoy life and property. Fundamental problems arise where the law seeks to restrict the very rights and freedom that it provides. An example is prostitution, where the law seeks to restrict the very rights to enjoy one's own body and the freedom provided for it by the law.
- The advent of AIDS in the 1980s has helped to cast doubt on prohibitionist policies on illegal drugs. Toward the end of the decade, it was discovered that intravenous drug users had a high rate of HIV and other pathologies such as hepatitis. In fact, intravenous drug use was the second leading cause of infection among men, after homosexual and bisexual practices, and the second leading cause as well among heterosexual women. Repressive policies, based on prohibition of use, do not make it possible to adequately inform users or to adopt risk reduction and preventive measures, such as needle exchanges or supervised injection sites and methadone maintenance. The increase in harm reduction practices in a number of countries would be based on this new reality. It is important to note that prostitution, drug abuse, and AIDS frequently coexist (Carr, Goldberg, and Eliot 1996:498-497).

Very substantial health gains can be made for relatively modest expenditure on interventions to reduce risks. However, the maximum possible health gains will be attained only if careful consideration is given to the costs and effects of interventions. Risk reduction strategies need to be based on a thorough analysis of the best possible evidence on the health effects and the costs of technically feasible interventions, undertaken by themselves and in various combinations:

"In promoting social and economic justice with populations at risk, social workers in direct practice join other social workers and groups to promote social action and legislation that redress wrongs resulting from unfair decisions and dysfunctional policies and practices" (Hepworth, Rooney and Larsen, 2002:7).

The trends that have been observed in sex work in South Africa are as follows:

3.3.1 Indoor sex work

Indoor sex work occurs within brothels, escort agencies, massage parlours, private homes, clubs, hotels, and bars. Various indoor sex work businesses range from commercial, residential, and industrial zones (Zetler, 1999:2).

Researchers have identified different sectors within the indoor industry. Those that were identified operating in Durban, were sex workers working on the street, sex workers working in the seamen's tourists' clubs, and- escorts, masseuses, and call girls (sex workers working from the classified advertisements of the local newspapers). In addition, each sector has unique working conditions and shows its own demographic patterns (Posel, 1999:12-16).

- **Private workers and call girls**

These are the sex workers who group themselves and operate together as an informal collective. Private working call girls operate from the same premises. They set their own conditions of work. They generally share the rent and expenses and do not give a cut of their earnings to any management structure. They place their own advertisements, make their own bookings, and choose their own hours.

- **Independent contractors**

The owners of the premises let their properties to the sex workers on an hourly basis and operate as independent contractors. The sex workers and the management or owners of the premises enter into a particular contract on how they will operate and respect the agreements.

- **Advertising**

To attract clients, indoor businesses and call girls advertise their services freely in daily newspapers and other publications, irrespective of the fact that the industry is criminalized.

3.3.2 Outdoor sex work in South Africa

It is difficult to estimate the number of outdoor sectors that operate in South Africa. This is due to the transitory nature of the business. Another reason is the high levels of distrust of strangers prevalent among outdoor sex workers. Researchers often experience difficulties obtaining information about them. A study conducted on 349 street sex workers in Durban, Cape Town, and inner city Johannesburg, distinguished two types of outdoor sex workers. The fast living sex workers are generally located in or near the central business districts of each city such as Greenpoint in Cape Town, the Point, the Beachfront area in Durban, and near certain residential hotels in greater Hillbrow in Johannesburg. This group was characterised by high client volumes, higher than average rates for sexual services, higher incomes, and high levels of drug abuse. These sex workers are more likely to be white and older than the average sex workers.

Subsistence sex workers were found in more remote and isolated areas such as industrial zones, truck stops, and townships. The client volumes and incomes for this group are low. The use of drugs other than alcohol and dagga was rarely reported. A large number of these sex workers were black. Many were living in informal settlements and supporting their families with their earnings from sex work.

- **The role of pimps in outdoor sex work**

In South Africa pimps are implicated in the organised crimes relating to trafficking in persons. The study conducted by the Medical Research Council, established that the majority of sex workers worked independently while only a few operated with their husbands and boyfriends. The relationship between the pimps and sex workers was seldom abusive and exploitative. The primary function of the pimps was to offer assistance to sex workers by protecting them while they were soliciting clients, safeguarding their money and belongings, and taking down registration numbers of clients' vehicles (Pauw and Brener, 1997:31). In the study that was conducted in Durban, for example, it was found that the majority of outdoor workers operated without a middleman (pimp). Leggett (1998:160) states that the study showed that very few of the women had "boyfriends" or pimps. The main advanced reason for this lone operation was that it was expensive for the outdoor sex workers to keep pimps on the street.

3.3.3 Working conditions of sex workers

Working conditions of indoor and outdoor sex workers differ. In the following discussions, the working conditions of sex workers have been explored accordingly.

3.3.3.1 Working conditions of indoor sex workers

The fact that sex work is illegal, protective measures contained in the labour legislation such as the Basic Conditions of Employment Act, 75/1997:1-22 or the Occupational Health and Safety Act, 85/1993:1-11, do not protect sex workers. This indicates that even when the sex workers are forced to work in agencies under circumstances approximating slavery, they do not have recourse to the remedies available to other workers. Some of the sex workers who happen to be employed by legitimate businesses have the benefit of acquiring regular flats and have a bank account, as they have definite employers and employment addresses. This distinguishes them from outdoor operators who walk the streets and do not have employers or definite employment addresses. An additional factor of distinction between sex workers who have employers and those who do not is in the fee charged.

In the majority of indoor sex workers, the management sets the fee charged. The sex workers are not allowed to undercut management prices, but they are able to accept tips over and above the preset fee from clients. In some cases the tips are paid through the management. This then provides management with information on the value of the amount the sex worker makes on tips.

Stability is not generated in sex work. Generally, management does not expect any sex worker to remain at a particular business for a long period of time. Misunderstandings between the employer and employee often evolve around the worth of each sex worker (financially), the hours of work, leave or sufficient time off from work to relax.

Working hours vary considerably amongst businesses. Management sets the working hours, so that the duration of shifts differs greatly. Usually, sex workers are required to be present only when there is a request from a client. Sex workers are sometimes requested to spend about twenty hours a shift on the premises. The overall duration of working hours at premises is too long as reported by the respondents from other studies. There are rules that govern behaviour in some premises. The breaking of rules may result in punitive measures meted out against the perpetrator. The most common form of punishment for breaking rules often entails the payment of a fine.

Fines are meted against those who violate rules in indoor businesses and are a form of punishment. This is a major source of conflict between management and sex workers. As the fines are regularly retardant, discontent is prevalent among sex workers hence the Sex Workers Education and Training (SWEAT) has been formed to serve as an advocacy group.

3.3.4 Working conditions of sex workers in the outdoor sector

With regard to income, each outdoor sex worker determines her own fee.

In a study conducted in Durban, Cape Town, and inner city Johannesburg by Leggett (1999:27) it was found that almost half of the group of sex workers had reported that

they were making more than R4000 per month while 42% had reported having more than 20 clients per week. However, over 80 percent of the subsistence sex workers saw fewer than 10 clients and earned less than R200 per week. Race was an important variable in terms of the rates charged by the participants in this study. Over 75% of the white women reported charging more than R90 for vaginal sex, while 83% of the black women reported charging less than that.

As outdoor sex workers are inclined to be lone operators they are often faced with many risks since they have no pimps to protect them. They work alone, and conduct most of their business at night, in isolated places. Once sex workers have reached an agreement with the client, they need to enter the client's space, such as his car and or home, which puts them in a vulnerable position for abuse by clients. Studies conducted in South Africa have indicated how sex workers suffer from violence inflicted by their clients. Sex workers in Pietermaritzburg reported that clients subjected them to violence such as beating, raping, and abandoning them in isolated places. They were sometimes left naked while at other times they were thrown out or forced to jump from moving vehicles (Pauw and Brener, 1997:33, Marcus, 1995:82, and Karrim, 1995:1523).

3.3.5 Policy related to law enforcement

There is no national policing strategy regarding sex work in South Africa. Currently, enforcement policies are determined on the level of individual police stations or by the prosecuting authorities in a particular area.

3.3.5.1 Law enforcement with regard to indoor sex workers

In terms of the provisions of the Sexual Offence Act, 23/1957 prohibiting sexual acts for reward, brothel-keeping, and facilitating sex work, the indoor industry is subject to regulation by means of the municipal by-laws pertaining to, for example the granting of business and liquor licenses. These municipal by-laws are not enforceable against the sex work business only, but against any business not complying with licensing requirements.

South Africa still lacks a single consistent national policing strategy regarding the indoor industry, with the general approach being recognition that the enforcement of the Sexual Offences Act, 23/1957 is a personnel intensive effort requiring methods such as continuous surveillance or entrapment. For example, the fact that the Asset Forfeiture Unit of the National Directorate of Public Prosecution brought a series of applications against the owner of The Ranch, an indoor establishment in Rivonia, Gauteng, indicates that police and prosecuting authorities, on occasion, choose to enforce the Sexual Offences Act No 23/1957 as well as the Prevention of Organised Crime Act, No. 121/1998:4, against indoor agencies.

3.3.5.2 Law Enforcement with regard to the outdoors sector

Law enforcement within this sector is similar to the indoor establishment. Police and municipal law enforcement officials against sex workers primarily employ the municipal by-laws rather than the Sexual Offences Act, No.23/1957. These by-laws penalise those who loiter or make a public nuisance of themselves. Researchers have found that certain law enforcement practices may undermine public health initiatives. The police sometimes confiscate condoms in order to use them as evidence against perpetrators of the sex work practice (Pauw and Brener, 1997:34).

Law enforcement is associated with other problems such as, police harassment. Outdoor sex workers generally report high levels of harassment by the police. A study of sex workers at a truck stop in KwaZulu Natal found that participants had been harassed by the police and were forced to provide free sexual favours. Other researchers have found that violence by police officials towards sex workers was common. Police abuse of power often includes rape, violence, unlawful arrest, and unlawful detention (Ramjee, 1998:147).

3.4 AN OVERVIEW OF RESEARCH FINDINGS IN RELATION TO POLICY IN SOUTH AFRICA

There has been limited research on sex work in South Africa. Researchers on sex work have merely confined themselves to issues of safer sex practices, accessing health facilities, and drug use among sex workers.

3.4.1 Safer Sex Practices

In South Africa, condoms are made available without charge to whoever wants them. Such condoms are easily accessible at public places such as clinics, public toilets, and community centres. However, condom use is reported as low as evidenced by the high HIV/AIDS infection in South Africa. Research conducted among sex workers in South Africa has shown that there is a high degree of condom use with clients and a high degree of non-condom use with personal partners (Brock, 1989:6; Plant, 1990:198, Pedian, 1988:413 and Alexander, 1991:12).

3.4.2 Accessing Health Services

As sex work is associated with the transmission of infections such as STI including HIV/AIDS, it is essential that sex workers should submit to regular medical check-ups.

Research has however, revealed that sex workers do not always feel comfortable visiting state funded clinics providing primary health and STD care. The reasons they advance for their reluctance to visit health facilities are reportedly the negative attitudes of clinic staff and the perceptions that other clinic attendees would judge them negatively (Meyer-Weitz, Reddy, Weitjts, Van den Borne, and Kok, 1998:39-55).

3.4.3 Drug use among sex workers

Research conducted among sex workers indicates that there are varying levels of drug use and substance dependence among South African sex workers. It was found that twenty-four of the twenty-five sex workers who had participated in the survey conducted by the Medical Research Council (Williams, Gouws, Colvin, Sitas, Ramjee and Karim, 2000:1-2) had used some illicit drugs in the six months preceding the survey; while fourteen were regular substance users. Only two participants reported having used heroin and they reported that this was a once off experience. The most common substances that had been used alone and with other drugs were alcohol and the “white pipe” (combination of cannabis and methaqualone). The researchers noted the growing frequency of crack cocaine. The sex workers ascribed their getting into drug use to do with dealing with the pressures of prostitution or the life that had

led them into prostitution (Williams, Wyatt, Resell, Peterson, and Asuan-oBrien, 2004:278).

The MRC reports that many sex workers who have been in the industry for some time complained that crack had increased the number of women on the street, and driven down the median age. Reportedly, increased competition had driven down the prices of sex work, forcing sex workers to handle greater volumes of clients in order to maintain their income levels. The low prices in sex work have in turn increased the demand for unsafe sex such as condom-free or anal sex, due to the willingness of addicts to do anything to obtain drug money. Some women have blamed crack for an increase in client violence, including rape (Parry, and Abdool-Karim, 1999:2)

3.5 CONCLUSION

The review of policy on sex work globally and the role it plays in South Africa, in particular the paradigms, perspectives, models, and prevention programmes available in the country, has important practical implications for adopting, adapting, developing, implementing, monitoring and evaluating similar programmes. A review of literature on the above-mentioned aspects has made the researcher aware that sex workers, as drug users, need a specific set of HIV prevention strategies tailored to meet their specific needs. The major strategies include access to drug treatment centres for those who are dependent and who continue with risky behaviour associated with sex work and substance abuse. The illegality and marginality of the sex industry has raised a number of complex issues that cannot be easily resolved. However, some of these issues can be improved through the implementation of comprehensive HIV interventions.

National level agreement is required among all the role players in the field of sex work, substance abuse, and HIV and AIDS. For example, among the law enforcement and criminal justice system, the possession of a condom by a sex worker must not be used as evidence in court as his or her intent to commit or solicit prostitution. In the case of brothel owners and managers, possession of a condom must not be used as evidence of intent to commit the more serious offences of pimping, pandering, and procuring. Such agreement is consistent with the portfolios such as Justice and Social clusters and MinMEC recommendations to operate interdepartmentally.

CHAPTER 4
DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

It is important to note that more research is needed to inform social work practice, especially in the area that would integrate theory and practice. In this regard, research has shown that the human service professions (the helping professions) are in need of a research methodology that would connect knowledge and practice (Rothman and Thomas, 1994:3; Mouton, and Marais, 1990:5; Reid, 1995:2040; and Thomas, 1989:6). The intervention research methodology, which has been used in this study, appropriately integrates theory and practice. In the current chapter, the researcher strives to present, analyse, and interpret qualitative data that were gathered during the intervention research process. The data have been presented in a sequential and interpretable form.

The current study's methodology endeavours to forge links between research and practice. The study has used basic research whose objective is exploration. This is a scientific enquiry into a relevant problem that provides answers, which contribute to an increase in the body of generalisable knowledge about the particular profession. The researcher in this study strove conscientiously to empower the participants to understand and solve their own situation and problems, to become aware of their own potential, and to regain their own sense of dignity, to take collective action for their self-development (Grinnell, 1993; Rothman and Thomas, 1994; Rahman, 1993 in De Vos (ed) and Strydom, Fouche, and Delport, 2002:483).

Many women engage in the sex trade in order to survive economically. They abuse alcohol and other drugs to overcome their fear and shyness while they do their work. Sex workers generally come from historically disadvantaged backgrounds. They are poorly educated and lack the skills necessary for formal or informal legal employment (Wechsberg, 2002:3). In order to provide skills to the sex workers and work towards developing a policy on sex work in South Africa, the researcher in this study involved participants in an intervention process that was adapted from De Vos et al (2002:396-418).

4.2 THE INTERVENTION RESEARCH PROCESS

Intervention research includes much of the already established research methodology of the social and behavioural sciences, including quasi and true experimental designs, single-subject designs, as well as psychological and behavioural assessment. It is important to emphasise that the use of research methods in the evaluation phase of intervention research is not to provide programme appraisal for practice purposes; but, to contribute to programme design and development and ultimately to proceed to the adoption and widespread use of the process (Thomas, 1989:587-589, in De Vos et al., 2002:396; King et al, 1987: 32; Klitzner et al., 1994:57; and Mantell et al., 1997:27).

4.2.1 The Initial Phase

The four major activity steps, which were used in the initial phase of the intervention process, were the following:

- Selecting an experimental design.
- Collecting and analysing data.
- Replicating the intervention under field conditions.
- Refining the intervention.

4.2.1.1 Selecting an experimental design

In this study, the participants were involved in refining the instrument, which would be utilised in intervention. The instrument was subsequently used to teach the women to negotiate safer sex with their clients and partners. This helped to empower the women to take control of their lives and to take decisions that would have minimal repercussions. The key informants who reported their observations to the researcher verified the benefits of this activity on the women. In addition, the community board of advisers assisted with the refinement of the tool used to empower the women. They also provided advice on how the sex workers could be helped and on how their working conditions could be improved.

Dissemination

After the initial phase had been completed with the women sex workers and processes such as a pilot study and an evaluation through focus group discussions had been done in this study, the researcher informed the sex workers and relevant stakeholders about the intervention tool which would be used (dissemination of information). De Vos et al. (2002:414) states that, since diffusion and adoption are closely related and are generally carried out concurrently, they should be considered together as dissemination. Commenting on the last phase of the new model, namely dissemination, Rothman and Thomas (1994:39-43) write that once the intervention has undergone all the other phases, it is ready to be disseminated to organisations and other audiences. The following activities make the process of dissemination and adaptation more successful:

- Preparing the product for dissemination.
- Identifying potential markets for the intervention.
- Creating a demand for the intervention.
- Encouraging appropriate adaptation.
- Providing technical support.

Dissemination of information took place through word of mouth, as the sex workers who participated in the study shared information with other people in their areas. The existence of the study created a demand for more intervention as more cases of sex workers who were using drugs were reported to the social services offices and more drugs were confiscated. In this regard, the sex workers who eventually educated others owned the intervention tool on how they could prevent and protect themselves from harm.

4.2.1.2 Section A: Pretesting the feasibility of the study (pilot study)

A pilot study was conducted during the information gathering and synthesis phase of the intervention research process, prior to the focus groups discussion with the sex workers. The purpose of the pilot study was to explore qualitative issues relating to sex work and the experiences and emotions evoked by sex work in communities where it existed. This was a supplementary study designed to pilot and adapt a

woman-focussed HIV prevention programme among women who were using cocaine in Pretoria. This programme targeted women to help them develop personal power through the reduction in drug use, strengthening negotiation skills for sexual protection, and increasing skills to prevent sexual violence on women.

To illustrate the risky sexual behaviour-substance abuse phenomenon among sex workers on individual and subpopulation level in particular, the extent of sexual risk and policy implication, presentation and analysis of the responses of the sample to the schedule administered in this study was done. This programme was adapted from the North Carolina (NC) Women's Co-Op instrument. The sample was selected from a population based in the Sunnyside suburb in Pretoria. The goal of the programme was to pilot and adapt a woman focussed HIV prevention programme on women who were using cocaine, in accordance with the study that was conducted by Wechsberg (2002:3) in the United States. This programme was subsequently administered on a sample of women sex workers in Pretoria. The study focussed on two groups, namely, the Standard Intervention Group (SIG) and the Woman-focused Intervention Group (WIG). The SIG was channelled towards awareness of HIV, drug use, sexual risk, and the risk reduction methods including the use of the female condom and assertive communication with a partner(s). The WIG was channelled towards the development of personal power through a reduction in drug use, strengthening negotiation skills for sexual protection, and increasing skills to prevent sexual violence on women.

A total of 93 women who were using cocaine and other substances were reached during this phase. A one-month follow-up was conducted after the baseline study had been conducted. The researchers observed positive changes in the participants' protective sexual behaviours, which indicated a reduction in their HIV risk behaviour. A substantially great increase in the proportion of women who reported using condoms with a boyfriend during the last sexual encounter was observed from the baseline and follow-up studies in the WIG. The qualitative data collected during the initial stages of the pilot study revealed that many women, who trade with sex in South Africa, do so, in order to survive economically. The researchers also found that these women abused alcohol and other drugs (AOD) as well, to help them overcome fear and shyness which may occur while they were doing their work. Many of these

women came from disadvantaged backgrounds, were poorly educated, and lacked skills that were necessary for formal or informal legal employment. Figure 1 below indicates the participants' use of a condom before and after the baseline study.

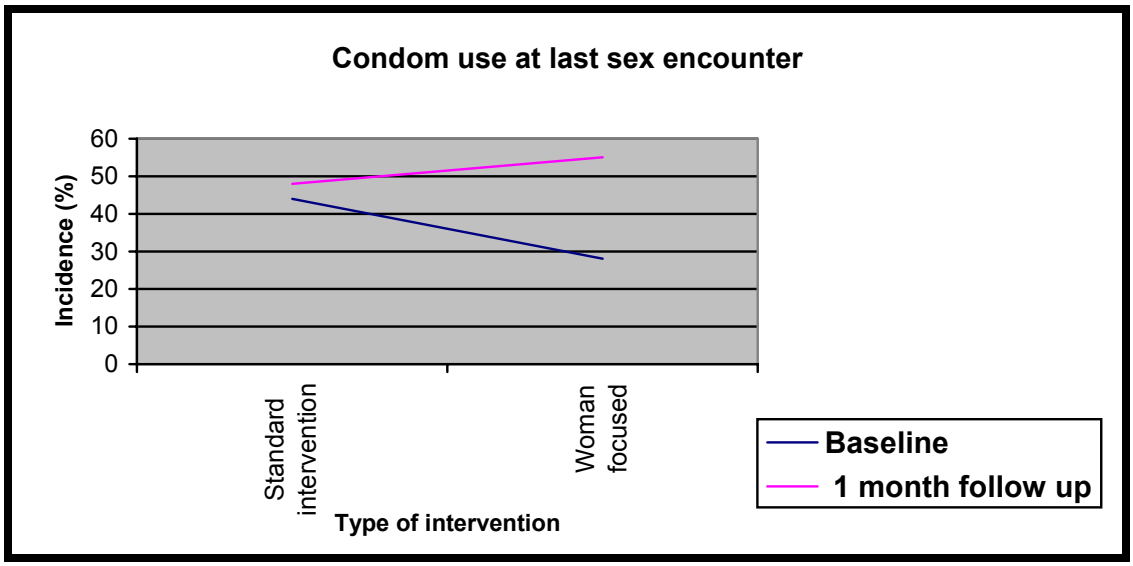


Fig. II

Figure 1 indicates that there was an increase in the proportion of women who reported using condoms with a boyfriend during the last sexual encounter. This observation was noticed from the baseline and the follow-up studies too. The results showed that in the WIG, condom use had increased from 28% to 55% whereas in the SIG, it increased from 44% to 48% in the one month period between the baseline study and the follow-up period.

With regard to reports on violence on the sex workers the following data were gathered during the one month follow-up study:

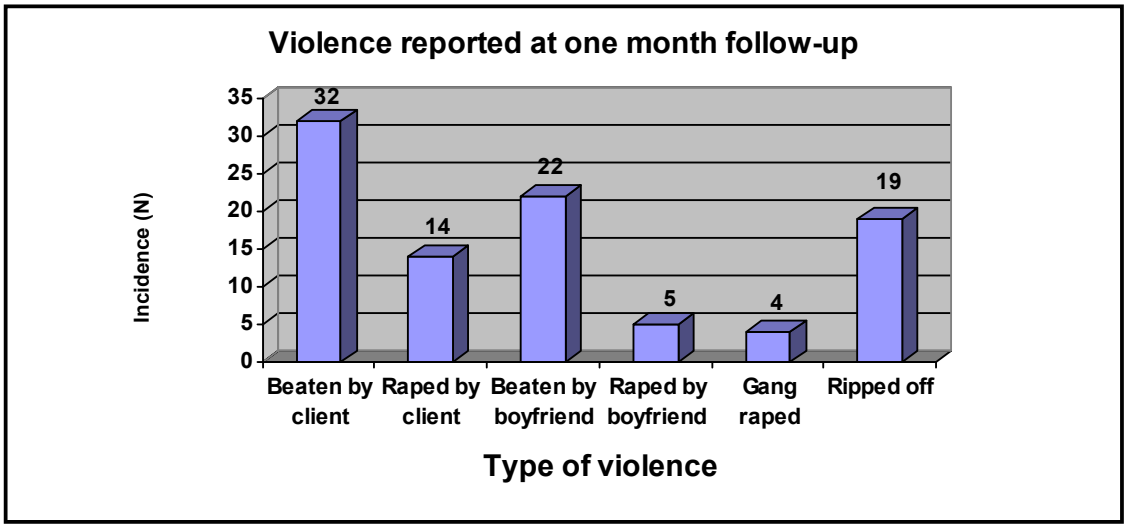


Fig. III

The researchers observed that in the follow up study, the participants reported an increase in the number of violations towards women sex workers. They reported that they had been beaten by clients (32%); raped by clients (14%), beaten by boyfriends (22%); raped by boy-friends (5%); gang raped (4%) and ripped off by clients (19%). The implication of these findings show that realities related to existing violence against sex workers, limited legal employment, education, and limited access to barrier protection and medical assistance to reduce future risk would undermine the successes that could be realized. In addition, a decrease was observed in the daily use of alcohol and cocaine from the baseline to follow-up studies. There was a slight decrease in the proportion of women who used alcohol daily, in the WIG from 15% to 5%, compared to a decrease in the proportion of women using alcohol daily in the SIG from 17% to 10%. These findings indicated that changes in alcohol, other drugs (AOD), and condom use could occur when the sex workers were involved in brief woman-focussed intervention programmes.

- **Early Development and Pilot Testing**

This phase of the study involved developing a preliminary intervention programme. In this process, sessions were held with sex workers to try and understand the problems that they were encountering and to engage them in developing the intervention technique, which would be suitable to them. This preliminary intervention consisted of cue cards that were used to assist the sex workers to avoid or prevent

problems. Thereafter, a pilot test was conducted with the participants. It is important to note that all phases of a model, whether in practice or research, can never be viewed as patterns, which follow each other rigidly (De Vos et al., 2002:409-412). Hence, in this study, the pilot study was conducted after the development of the intervention tool or technique.

- **Activity step 1: Developing a prototype or preliminary intervention (intervention techniques)**

In this step, the sex workers were targeted to help elicit information for the tool. The modes of delivery were the meetings held with the sex workers and experts who were known in the study as the Community Board Advisors (CBAs). These CBAs refined the tool. The intervention techniques (efforts of sex workers to protect themselves and their fellow sex workers) were developed and utilised to assist the sex workers with their work-related problems. These were in the form of cue cards, which facilitated discussions around issues specified in each card.

Card 1: Some reasons women are at risk in South Africa

- Women's position in society and in relationships is low.
- Women are often uninformed about choices and sexual risks.
- Women are often unable to negotiate the use of condoms.
- Women may not know that they have sexual rights.
- Social norms that accept or encourage many sexual partners.
- Labour patterns where men are working far away making multiple sexual partners more likely.
- Norms that keep women form discussing sexual matters and the acceptance of condom use.
- High incidences of violence, battery, and rape.

Card 2: Reduce the "chance" – negotiate

- Because men may feel they may control, dominate, or intimidate a woman into sex without protection should be prepared.

- Bargain for protection for both partners.
- Have condoms ready.
- Use a female condom if the man refuses to use one.
- Be prepared to use your whistle (that will be given to participants), scream for help, or get out of the situation.

Card 3: Stop being ripped off

- It is well-known that women are being raped, robbed, beaten up, cut, having guns and knives pulled on them, and suffer injuries because of this.
- Therefore, your life is at risk. Also, being raped can cause vaginal trauma that can put you at special risk for HIV and hepatitis.
- There are ways to reduce violence.
- If you find your-self in a bad situation, go along with him and wait for your chance to get away, and sweet talk him; sometimes that will change his mood
- Acting crazy or talking too much may change his mood – he might want to get away from you.
- Attract attention to yourself by screaming or using a whistle, and he may just not want to hang around.

Card 4: Dealing with a bad situation

- If you have to get out of a car: wait for a red light and get out.
- If the car is still moving, open the door and wait. Many times this will show your date you are serious and he will slow down or stop.
- It is hard to think quickly while you are high. Remember, stopping, reducing, or delaying your drug use keeps you in control.

Card 5: Power of women

- The free nation of South Africa is new.
- Women do not realize they are free to take charge of their lives and reduce risks, especially for those who may not have education or skills for a job.

- Women can insist on condom use or use female condoms.
- Women can avoid being victims.
- Women can own their lives and not give it away because of drug need and alcohol abuse.
- Women can protect themselves from HIV, violence, and drug use.
- It is a start towards a more positive, free, and safer life.

- **Activity Step 2: Conducting a pilot test**

Pilot tests are designed to determine whether the intervention will work, in other words “to see if the beast will fly”. Pilot tests are implemented in settings convenient for the researchers and are somewhat similar to ones in which the intervention will be used. They also help to determine the effectiveness of the intervention and to identify which elements of the preliminary programme may need to be revised (De Vos et al., 2002:410). In this study the cue cards were given to the WIG and not to the SIG. The difference of the outcome between the two groups was compared.

- **Activity step 3: Applying designs criteria to the preliminary intervention**

Rothman and Thomas (1994:37) in De Vos et al. (2002:411) state that this activity step has to do with developing guidelines for the intervention in order to guide the application of the programme according to the established criteria. In accordance with this, the study team developed the following guidelines for the current study’s programme. The guidelines were that the programmes should be:

- Effective and efficient.
- Replicable to typical end users.
- Simple to use.
- Practical.
- Adaptable to various contexts.
- Compatible with local customs and values.
- Empower the target group.
- Sustainable.
- Responsive to the needs of the target group.

The substance abuse and risk behaviour prevention programme was then implemented in the light of the information highlighted in the information gathering

and synthesis phase, the model design phase and the current phase. The cue cards as the tools for intervention were tested against the above-mentioned guidelines (See details in Appendix A (see 237)).

- **Evaluation and advanced development**

The “evaluation and advanced development” phase addressed the question of the effectiveness of an intervention model. The researchers concluded that evaluation methods in intervention research include much of the already established research methodology of the social and behavioural sciences, including quasi and true experimental designs, single-subject designs, as well as psychological and behavioural assessment. It is important to emphasise that the use of research methods in the evaluation phase of intervention research is not meant to provide programme appraisal for practice purposes, but to contribute further to programme design and development as necessary and proceed to adoption and widespread use ultimately (Thomas, 1989:587-589, in De Vos et al., 2002:412; King et al, 1987:32; Klitzner et al, 1994:57 and Mantell et al., 1997:27). The four major activity steps in this phase are the following:

- Selecting an experimental design.
- Collecting and analysing data.
- Replicating the intervention under field conditions.
- Refining the intervention.

In this phase, the participants were involved in refining the instrument, which was developed during the pilot study. The CBAs assisted with the refinement of the tool used to empower women. They also provided advice on how the sex workers could be helped and also on how their working conditions could be improved. The instrument would be tested later in the study, to teach some of the sex workers to negotiate safer sex with their clients and partners. The success of this phase would be assessed by the ability and willingness of the sample to feel empowered to take control of their lives. The evaluation of whether the women had gained from the study or not, would be verified by the key informants.

- **Dissemination**

De Vos et al. (2002:414) mentions that since diffusion and adoption are closely related and are generally carried out concurrently, they should be considered together as dissemination. Rothman and Thomas (1994:39-43) mention that once intervention has undergone all the other phases, it must be deemed ready to be disseminated to organisations and other audiences. Several operations or activity steps that make the process of dissemination and adaptation more successful are the following:

- Preparing the product for dissemination.
- Identifying potential markets.
- Creating a demand for intervention.
- Encouraging appropriate adaptation.
- Providing technical support.

In this study, dissemination took place through word of mouth. The participants in the study shared information with other sex workers in the areas where they were operating. A positive reaction was received and more people requested to be included in the study in order to gain more information. There was an increase in the number of requests for intervention in the plight of sex workers. Those who were using drugs were reported to the social services and more drugs were confiscated. In this regard the sex workers who eventually educated others owned the intervention tool on how they could prevent and protect themselves from harm.

4.2.1.3 Section B: In-depth interviews with key informants

- **The need for in-depth interviews**

The researcher deemed it necessary to conduct in-depth interviews among the gatekeepers as key informants, in order to complement the focus group results in the current study. The following facts about in-depth interviews have been confirmed by many researchers:

- Reality can be reconstructed from the world of the interviewee.

- An in-depth interview enables the interviewer to obtain an “insider view” of the social phenomenon under study.
- It enables the interviewer to explore other avenues of research emerging from the interview.
- It facilitates an open discussion on socially and personally sensitive topics, such as deviant behaviour, problems in relationships, sexual behaviour, and unemployment.
- It endows researchers with a better understanding of the world of the research subjects and puts them in a position that enables them to explore their subjects in more detail (De Vos et al., 2002:379; Denzin, 1978:6; Flay and Petraitis, 1991:368; Denzin and Lincoln, 1994:583; and Mouton and Marais, 1996:212-214).

The aim of the in-depth interview in this study was to provide a framework for the participant/ gatekeeper to speak freely and in his or her terms about a set of concerns, which the researcher had brought to the interaction. It also gave the gatekeepers leeway to freely introduce their own concerns and in this way provide a broader view of the problems of sex workers. Generally, the researchers had an idea of what basic issues they had wished to cover in the interview. Although free narration by the subjects was encouraged, such narration was guided by the focus of the study. The interviews and the data that were collected were limited only to data that contributed to the research objectives. During the interview the researchers endeavoured to assume a non-argumentative, supportive, and sympathetically understanding attitude. The procedure that was followed entailed first, establishing rapport with the gatekeepers and creating a warm and accepting atmosphere. Thereafter, the purpose of the interview was outlined, namely that the study intended to assist sex workers to reduce their substance abuse and risky sexual behaviour while executing the sex trade. Participants were also informed that the data would inform the creation of a policy to improve the working situations of sex workers. They were encouraged to communicate their own attitudes and feelings as well. This motivated them to lead the interview and to speak freely on the topic and issues which were of most concern to them (Mouton and Marais, 1996:212-213).

- **Designing in-depth interview's guide**

A schedule was designed which was adapted from Wechsberg, Zule, Lam, Hall, and Ellerson 2003:669–700). A total of eight in-depth interviews were conducted with gatekeepers. The researchers designed a questionnaire in such a way that it had direct relevance to the issues, which had been raised during the pilot study (appendix D: 244). The gatekeepers were asked the following questions:

- What do you remember about the Pilot women's coop study?
- What did people say about this study on women's health?
- How can we establish trust and credibility with women sex workers?
- How might our intervention help women sex workers?
- How can we best reach women sex workers who use alcohol and other drugs?
- What are some of the barriers to women's participation in the study?
- How can we help women stay in the study throughout all the follow-ups?
- How can we reach the sex workers' community without threatening their business?
- Have you ever noticed or heard about women sex workers who experience problems?
- Do you think that study participants who take steps to reduce their sexual and drug use risk behaviours will experience changes in the level of violence in their lives?
- What suggestions do you have for our intervention to help decrease the level of violence among sex workers?
- Have there been any changes in police activities directed towards women sex workers, harassment of the sex workers, or changes in clients' behaviours since our pilot study last year?
- How can this study help women to feel more in control and to achieve any personal goals?
- How do you feel about having former sex workers being part of the study staff?
- Do you have any suggestions for the study?

- **Implementing the in-depth guide**

Consent forms were explained to the gatekeepers before every interview was conducted. These were signed only when the interviewees had agreed to take part in the study. Permission of the interviewees was also sought to allow the researcher to use an audiotape during the interview. The preferred language of the interviewee was used during the interview process. The researcher used an interview guide when she interviewed the gatekeepers to stay focussed on the topic under discussion. Finally, the data from each interview were transcribed, analysed, and interpreted in order to find a solution to the problem of substance abuse and risky behaviour among sex workers.

- **Results of the in-depth interview with gatekeepers**

Prior to the presentation of the results, the researcher deemed it necessary to describe the demographic characteristics of the study sample in order to provide the background of the respondents. The following are the demographic characteristics of the gatekeepers:

Date of Interview	ID #	Gender	DOB	Age	5 or more sex workers	Offered housing to sex workers	Offered food to sex workers	Offered clothing to sex workers	Offered security to sex workers	Race
14/10/2003	6	Female	19/12/1954	49	yes	yes	yes	no	no	Black/African
15/10/2003	8	Male	18/12/1961	41	yes	yes	no	yes	yes	Black/African
15/10/2003	7	Female	24/10/1970	33	yes	yes	no	yes	no	Black/African
14/10/2003	5	Female	23/07/1981	21	yes	yes	yes	yes	yes	Black/African
10/10/2003	1	Female	12/3/1953	50	yes	yes	yes	yes	yes	Black/African
10/10/2003	2	Female	3/3/1964	39	yes	yes	yes	yes	yes	Black/African
11/10/2003	3	Male	27/08/1978	25	yes	no	no	no	yes	Black/African
11/10/2003	4	Male	8/5/1965	38	yes	yes	yes	yes	yes	Black/African

Table I

- **Activity Step 4: Identifying functional elements of successful models**

In this study, the primary data gathered from the focus group and in-depth interviews as well as the secondary data gathered from the literature survey, raised several issues that were crucial to the programme design and implementation. The prevention programme was proposed to be as follows:

- Be linked to the theory.
- Reflect real life situations.
- Be sensitive to the needs of women sex workers.
- Be monitored and evaluated periodically.
- Utilise the trained women sex workers to provide peer education.

- **Reviewing the pilot women's coop study**

Participants in the study started by reviewing the pilot women's coop study. They talked about the project team's task of transporting female sex workers to the project office where they were informed about the dangers of smoking. They expressed their wish to see the female sex workers terminating their habit of smoking. The study was seen as a facility that helped these female sex workers to care for themselves. The self-defence skills that the female sex workers had learnt were also reviewed. The participants had been informed on how to use a condom, how to deal with clients who are difficult, and, that the client must pay first and only after a cash payment could a service be provided.

The outcome of the study as reviewed by the women, was that it had helped them to stop smoking. The positive changes in the trainees, who had been abusing drugs, were attributed to the training provided in the intervention process. The participants mentioned the fact that some trainees had been empowered to the point that their lifestyles had changed. The reformed trainees were reported to have taken control of their lives and had voluntarily moved to Mamelodi Extension 7 where each owned an RDP house. However, some trainees who had not completely recovered, had left their RDP houses and had settled in Makulubani in Marabastadt. These trainees had lapsed to their drug-taking habits and were reported to be smoking dagga (commonly known as zol and easily accessible in Marabastadt). The participants implored the

project team to visit the area and observe the risky sexual behaviour that is practised in broad day-light in public toilets and on shop premises. They expressed concern and requested the researchers to provide intervention programmes which would redeem their mates.

Some of the male sex workers, who had heard about the study and had been impressed by its efforts to help drug-abusing female sex workers, approached the researcher and volunteered to participate in focus group discussions. They suggested that the researchers should concentrate on helping sex workers who were using drugs but had lost control of themselves. They commented on the fact that the study's success was in its approach, which did not force women to stop drugging but focussed on helping those who wanted to stop using drugs. They also pointed out that the study had succeeded to empower women who were operating under the protection of their boy-friends.

The male participants reported that the sex workers respected the researchers and regarded the study as important. They mentioned that none of their mates had ever talked negatively about the study on the street. They also reported that the female sex workers could be easily accessed if the study team negotiated with them with respect and explained to them about the dangers involved in the trade they were plying. The male participants reported that female sex workers do not listen to males and that every time the males were entrusted with the responsibility of enforcing rules in the premises where the sex workers were doing their business, the female sex workers defied them. They suggested that the study team should involve female security officers and female cleaners in the study as the female sex workers would listen to advice given by other females and would not feel threatened by them. The male participants also indicated that the study team must be diplomatic when they communicate with these sex workers. They advised the researchers to talk openly and honestly about their plans, show some respect for the female sex workers and visit them at their places of residence. The study team should never expose the sex workers nor reveal the kind of work they were doing to anyone, as this would be a breach of confidentiality and trust between the women and the study team.

- **Perception of people on the street about the study**

The women participants reported that sex workers liked the study very much. They hoped the study would help women with their personal problems. They perceived the study as a successful way of encouraging sex workers to realise that it was possible for them to stop using drugs. They appreciated the fact that the researcher's American partner (Dr Wechsberg) was genuinely concerned about them as women in distress. They were impressed that she had come all the way from the United States of America to help them while fellow South Africans did not seem to realise their plight. They expressed their gratitude that the researchers were concerned about their plight and were doing something to help them deal with the problems they were encountering in their work (particularly the drug abuse problem). The participants also reported that they had enjoyed participating in the study and that the programme had helped to change the lifestyles of quite a substantial number of sex workers who had gained knowledge on the HIV/AIDS pandemic. They regarded the research as successful as it had helped some sex workers to be more cautious in their work while others, however, continued with their old lifestyle unperturbed.

Quite a substantial number of women showed interest in the study, while others did not. Whereas some women requested help, others did not want help. Some women realised that many female sex workers who came to know about the study liked it, yet not all wanted to reveal themselves as sex workers. The women reported that many people commended the good work that the study team was doing. They acknowledged the high death rate due to AIDS and drug abuse among sex workers and they hoped that knowledge and empowerment that had been gained through the study would serve as a preventative measure and help to alleviate the AIDS pandemic.

- **Building trust and credibility with sex workers**

The women participants reported that the approach that had been used had enhanced their willingness to work with the study team. They regarded the approach as good and stated that it showed that trust had been established between them and the research team. They mentioned that if it were not for the positive approach, the participants would not have bothered to work with the study team. The participants

appreciated the gifts they had received which they showed to friends and other sex traders. They were happy with the gifts and the knowledge they had gained from the study. They felt confident that the study would help minimise their personal problems. They suggested that the study team should work with at least one of their handlers so that they could get support in their willingness to change some practices, which had negative effects on their health. They suggested that the study team should work with security and cleaning ladies too, as these would support them in their new ventures. They emphasised the participants' need for continued contact with the study team as they acknowledged the mutual benefit of the study to themselves as well as to the study team.

In order to build credibility with people such as the male security guards, the participants suggested that the study team should win the trust of the male security guards, because their task was to enforce rules that prohibit the use of drugs and smoking in the premises. Whereas some turned a blind eye to the drug trade, others meticulously carried out their tasks. To ensure that the security workers too could trust the study team, the participants proposed that the study team should have regular contact with them and inform them regularly on what they were doing, so as to enlist their support.

The female sex workers pleaded with the study team for support, respect, and acceptance. They asked not to be judged for trading in sex but to be treated with respect so that they should not resort to defensive behaviour, which would result in their becoming evasive, aggressive and dishonest and subsequently providing the researchers with unreliable data. The participants stated that trust between them and the study team could be established if the study team could provide them with guidance during discussions so that they could learn better ways of protecting themselves against infection from sexually transmitted diseases, including HIV. The women regarded self-protection as important. They mentioned that when the sex workers were infected with any sexually transmitted disease, they would in turn infect their clients and in this way, the virus would be transmitted to many people including the innocent wives of their clients. Both the male and female participants suggested that infected female sex workers should be placed at a secure setting where they would be treated for six months and should be discharged only after they had

recovered. All the participants concurred that the women sex workers needed to be visited by the researchers more often and to be taught skills that could boost their morale.

- **Building trust and credibility with gatekeepers**

All the participants reported that the study team had to communicate openly with the gatekeepers so that they would trust them and understand them.

- **Identity for sex workers (t-shirt, hat, and ID)**

Both the male and female participants indicated that it would be good if the female sex workers involved in the study could be identifiable. Specific t-shirts and hats were to be worn by the female sex workers and the study team. The use of some identity documents too, was suggested as well.

- **How intervention might benefit women sex workers**

The male participants suggested that the female sex workers in the study should be treated with the utmost care. They were to be interviewed at venues where interruptions from clients could be avoided. In addition, they were to be made to feel relaxed and comfortable while the research team ensured that they were not on the defensive and that they could trust the study team and provide them with reliable information. The study team was informed that women in the sex trade need acceptance and love as they experience severe pain in their job, and have to find ways of coping with the pain as they have to continue working since they do not have alternative income-generating jobs. The male participants in the pilot study indicated that the study team had to be readily available to access possible respondents at the right places. The female participants indicated their interest in being utilised in the study and in bringing in other females who would serve as female sex workers in the study. The female participants would readily provide places and times for other prospective female sex workers required in the study. They knew the female sex workers and understood their problems too and they could help in engaging them and ensuring them that the study team could be trusted. It was obvious that the prospective respondents operated under the control of the participants of the pilot study.

The male participants stated that female sex workers liked money and that they needed money and would do anything for money. They proposed that the study team should consider a programme of intervention which would help the women to stop using drugs. They suggested that the study team should visit the prospective respondents and speak to them about the dangers of drug abuse. They implored the study team to be very patient with the women, as drugs made them to have mood swings and they often behaved like children. An important fact that was reiterated by all participants in the pilot study was that the female sex workers were plying the sex trade because of poverty. It was reported that the female sex workers needed jobs in order to help themselves. The study team was implored to try to convince the female sex workers to seek alternative jobs, which would be less stressful than the sex trade. An additional opinion was expressed that the female sex workers should be taught to like themselves. They were to be encouraged to take care of themselves and whenever they felt sick, they should consult a doctor, as they might not know the extent of their ailments.

Both the male and female participants indicated that women sex workers need information on a daily basis. They regularly had to be taken to hospital to get proper treatment in order to clean the drugs out of their blood system. The participants were adamant that most drug dealers were foreigners from Nigeria, Tanzania and other countries and that these should be repatriated to their countries as they were ruthless and were also guilty of supplying sex workers with drugs. In response to the question: If women were to be provided with jobs and alternative skills would they stop plying the sex trade? all the participants indicated that jobs and skills would definitely make a difference in the women's lives. Sex work was described as abhorrent and that no one liked being a sex worker and having sex with up to twenty men in one night. The participants reported that sex workers have to go out to the streets at night irrespective of the weather conditions and that most of them often weep in the morning when they return from their escapades. They express remorse and often regret the previous night's experiences. They talk to each other and share their pain. Drug use is common among them as these help to relieve the traumatic experiences encountered in the sex trade.

The female sex workers reported that they felt severe pain in their work and that they would stop if they could get alternative jobs, which yield a high income. Although sex work offers a high income without any skills, most of the money gained is used to relieve the pain that comes with the job, hence the money is abused in buying drugs. The female sex workers stated that access to money and skills would keep them away from the streets. In response to the question: How can intervention make a difference?, the female participants indicated that intervention would help female sex workers to exit sex work, as they were not happy about what they were doing. When the participants were asked the question: What is the best way to reach female sex workers? All participants agreed that the best time to reach prospective respondents was any time after 20hours. The female sex workers could be found at affordable hotels. There were about seventy to eighty female sex workers at some hotels and quite a substantial number of them used alcohol while others used other drugs in addition to alcohol. The participants explained that female sex workers who use drugs preferred not to do so in the presence of their boy-friends or male sex partners.

Female sex workers mentioned that they could easily access other female sex workers and talk to them about the study. They indicated that it would not be easy for the study team to approach the female sex workers prior their briefing with them, about the study. This then made the issue of condom use difficult to measure, as the women do not use drugs in the company of their male sex partners. Seemingly, the women used drugs because they were too shy to talk to their clients.

Both the male and female participants indicated that Saturday was the best day to reach sex workers. They suggested that the best way to access sex workers was to visit their Mama, buy some cold drink, sit with the female sex workers, and observe what was happening. They informed the study team to watch out for some young men who buy drugs and hide these in their genitals and also for female sex workers who use cocaine that they obtain from foreigners. Many sex workers resided or hung out around Marabastadt, Devilliers Hof and the city centre (mainly on Struben Street and its vicinity in Pretoria). The sex workers could not be reached during the day because the drugs they used made them sleepy, so the best time to get hold of them was during the night. In Marabastadt, however, the women were easily accessible in the afternoon.

In response to the question: What are the best times at which women would be free to work with the study team, and how much do they make per night on the average? both the male and female participants reported that female sex workers who trade with sex make about R500 – R700 per night while those who abuse drugs spend most of their earnings on drugs. Participants voiced concern that sex workers needed help to stop them from abusing drugs. They mentioned that without help, it was difficult for any drug abuser to stop using drugs and to stay clean, as long as she lived in an environment where drugs were easily available. One gatekeeper cited an example of her own daughter who had been clean for 12 months but started reusing drugs when she resumed trading in sex. The gatekeeper stated that at one time, her daughter had R2000 and she had called an old friend, whom she hooked up with and they resumed their drug-taking habit. The influence of people one hangs out with is well illustrated in this example. The participants stated that it was good for the sex workers to stay in a house/home where they could be supervised by someone, rather than to stay with friends who might encourage them to go back to drug use and risky behaviour.

When asked about the barriers to females' free participation in the study, the participants gave different views regarding the issue of barriers to participation. Some women participants indicated that there were no barriers in their perceptions and they stated that their participation was their personal choice and that even the consent letters they had signed had given them free will and clearly did not force them to participate against their will, but rather allowed them to terminate participating whenever they wanted to, at any stage of the study. The female sex workers reported that there were no barriers to participation as most of the sex workers knew about the study and were keen to participate, as the study provided them with information and skills they previously did not have. They mentioned that if the study team were to select only a few participants and leave the others out of the study, those who had not been selected would be upset and would want to know the reasons for the discrimination against them. They also mentioned that the project team had negotiated successfully with the sex workers. They had treated the sex workers well and had communicated with them with respect. They suggested that the study team should empathise with the sex workers and try not to be judgemental towards them.

In some settings, there had been some interruptions as the sex workers came in and out of the gatekeepers' rooms to make enquiries and/or to get condoms. Some of the gatekeepers demonstrated their credibility by showing the study team a card of some specialist doctors, an obstetrician and gynaecologist, who operated locally and attended to the sex workers who needed medical help without being judgemental of them.

Most of the sex workers were from provinces other than Gauteng. They had come to Gauteng hoping, to be employed in the formal sector and had ended up doing sex work as they had failed to gain employment due to their limited education and skills. The Female sex workers anticipated that a major barrier to communication with the sex workers would be that they were wary of having their pictures taken by anybody (including the study team) as they feared that the pictures might be published and their relatives might be alerted to the work they did. While some of the participants had no objection to their pictures being taken, others were against it as they stated that they had had experience of photographers who had promised that they would not publish the pictures but had, however, failed to honour their promises.

The male participants in the study mentioned that a barrier to free participation might be incurred if the sizes of the focus groups were too large. They warned the researchers that large focus groups were often unmanageable, as some participants might feel threatened while others might not get an opportunity to express themselves freely in the group. They also suggested that the research team should pose as sex workers too, when they recruited respondents to the study, in order to allay suspicion that they might be journalists or might be working with the police.

The Focus group discussions also covered the following issues: What did women benefit from the study? Could money, food and other support or what they were taught have been the reason for participation in the study? The female sex workers stated that they had benefited from the lessons the study team had taught them. They had been willing to share the information they had received with others. Money, food, and other support that were provided by the research team were highly appreciated. The participants were unanimous that most women who trade with sex did not like what they were doing. Poverty had led the majority to leave their homes

of origin. They had come to Gauteng to seek for employment in the formal employment sector in order to help maintain their families. However, due to the lack of employment, they had ended up doing sex work. The participants were adamant that sex work did not provide job satisfaction hence many sex workers resorted to drug abuse, which is a very costly practice that hindered them from maintaining themselves and their families, as they were always in debt, despite their high earnings.

The male participants stated that the women were always in need of money, food, and all other forms of support. However, they blamed the sex workers for their plight, which emanated from their drug abuse. They stated that the women ill advised one another and that they were under the influence of drugs most of the time. They were inclined to be careless and to ignore hygienic practices, littered the premises, and had a tendency of throwing condoms all over the place, while some were foul of mouth and made it difficult for concerned people to advise and/or counsel them.

With regard to the questions: How can the women be helped to stay in the study? and did women have any concerns about being in the study? The female participants stated that the study team had to know where the sex workers were staying. The fact that the women did sex work in the evenings and they slept during the day, meant that there should be someone who would know exactly where they could be found and who might assist to wake them up if there were duties to be fulfilled during the day. The participants suggested that the study team should first build a relationship of trust with the sex workers and reassure them about the purpose of the study and of the confidentiality which would be maintained with the data gathered and about the participants. The sex workers also requested help with their personal problems. The study team was advised not to pounce on the female sex workers without notice. They were to make and honour appointments with the sex workers as this would help build trust between them and the respondents and would facilitate honest and free interaction. The research team was also advised to provide the female sex workers with transport, so that they would honour all appointments and not be hindered by lack of funds from reaching the venues where the focus group discussions were held. Photographs were not to be taken without the permission of the female sex workers and incentives in the form of meals and payment were to be provided to the

respondents. Some participants suggested that interviews should be held away from the areas where the sex workers were operating or using drugs to ensure that they could not easily access drugs during the interviews, as this would also teach them to refrain from drugs.

The male participants suggested that the handlers of the sex workers should be included in the study. They argued that the handlers endangered the lives of the sex workers as they provided them with accommodation only in a hotel for sex workers and when the workers took ill they were booted out as they were no longer of value to the handlers. The women perceived sex work as dangerous because the clients could injure them. In order to decrease violence, it was imperative that the sex workers should be taught how they could protect themselves.

The male respondents reported that their handlers who were also drug dealers tended to introduce the sex workers to drugs. The sex workers were supplied with drugs which they have to use before going out to meet clients as these give them courage and they, therefore, operate more effectively while they are under the influence of drugs. Drug abusing sex workers are always broke and are often unashamed to steal money, jewellery, and cell phones from their clients in order to support their addiction. The handlers/drug dealers exploit sex workers and force them to work hard even when they are ill.

In response to the question: Do you think that female sex workers who take steps to reduce their sexual and drug risk behaviours will experience changes in the level of violence in their lives? the females stated that eruption of violence was inevitable in the sex and drug trade. Sex workers however, might be exposed to less violence if they reduced their drug habits and became less confused and provocative. The female participants reported that female sex workers had to learn a number of skills, such as self-defence to ward off clients who wanted to throw them out of moving cars. Sex workers had to anticipate the eruption of violence from their partners or clients at the slightest provocation. The male participants reported that sex workers would experience changes if the female sex workers reduced their drug habits. The general opinion held was that those who did not use drugs did not steal. They made their money without stealing from their clients. Security officers preferred working with

drug-free sex workers. They open the gate for them and allow them to enter the premises with their clients as they are sober and interested only in business with their clients. When women are sober they also think more clearly. They work hard, maintain a positive relationship with their clients, and usually do not pose any problems, which may require the intervention of security officers.

- **Results of the one month follow-up study**

In the follow up study, when the participants were asked the question: **Has there been a decrease in the use of alcohol and crack over the past month?**, the female participants reported that a considerable number of sex workers who had participated in the study had reduced their alcohol use, but none had reduced the habit of smoking cigarettes as they were addicted and also regarded cigarette smoking as part of the pattern of sex work. All the sex workers who had been involved in the study had reportedly made an attempt at refraining from the use of substances but most of them had failed dismally to stop the substance abuse completely over the period of one month.

In response to the question: **Do women sex workers ever talk about the female condom?**, the participants reported that sex workers did not feel comfortable engaging in discussions about the female condom. They were reluctant to talk to other women about the female condom. The sex workers generally preferred the male condom above the female condom.

When the question: **Do you think women know how to properly use male condoms and are they using more than one male condom at a time?** was posed, the female participants stated that female sex workers were using more than one male condom at a time. They use about 2 or 3 condoms together. They go through a large number of condoms as these differ in quality and some are not of a good quality.

In response to the question: **What suggestions do you have for the intervention programme to help decrease the level of violence on sex workers?** the participants commented that tauting for clients on the streets was dangerous and

because sex workers were using this method, their lives would always be in danger. The female participants reported that the sex workers themselves should try to take steps towards reducing the level of violence on them. Sex workers should not conduct their business while under the influence of drugs as this would decrease confusion and provocative behaviour which angers the clients. The participants also suggested that sex workers should be taught communication and negotiation skills to enable them to talk to the clients, make them pay for services rendered, and avoid any form of behaviour that may result in them becoming victims of violence. All the participants concurred that women do not perceive violence in the same way and that it was, therefore, very difficult to point out what women should do to decrease the violence inflicted on them. Of importance was that women who were in the sex trade had to remain sober in order to take firm decisions so that violence on them could decrease.

The male participants commented that most sex workers usually start trading with sex work at an early age when they are still naïve, and are desperate to secure an income to support their families at any cost. The sex workers are often urged by their families to bring money home, hence they put their lives in danger to secure the required income. It was, therefore, necessary that awareness of the danger of sex work should be conveyed to family members and to enlist their empathy so that they may decrease the pressure they put on young sex workers. Some participants, however, reported that women sex workers do not get beaten up by their clients, but rather by their boy-friends when they dump them.

When the question: **Do you know women who have been raped by security guards?** was posed, the female participants responded with the exclamation: “Uhuh!”. They, however, defended the security guards as they maintained that they worked amicably with them (allowing them to pass through the gate with their clients) and readily intervene and protect them against violent clients. The participants also mentioned that in five of the venues where the sex workers were operating, there were security officers who protected them.

In response to the question: **Have there been any changes in police activities directed towards women sex workers since our pilot study last year**?, some of

the female participants reported that the police on a regular basis raped sex workers. They stated that some police raped women sex workers whenever the women sought their protection to report incidences of violence or when the officers found the sex workers soliciting for clients on the streets. The police often victimised sex workers. They seized the condoms that sex workers often keep ready for their clients and used these as exhibits in court. Some police officers pick up female sex workers from the streets and transport them to the police stations, where they demand money (a bribe) and those who do not have money are raped before they are released. Other participants, however, denied that the police had ever harassed them. The participants reported that at some hotels, the sex workers worked very well with police officers that regularly check on their safety. They stated that some police officers provided sex workers with their contact details so that the sex workers could contact them whenever they needed protection. They maintained that there was no police harassment, as they knew that some of the gatekeepers were trained to work with sex workers. In some incidents the gatekeepers would even produce their certificate of attendance. This indicated that some of the crisis intervention courses could be utilised by women to meet their ulterior motives and that the women needed to be taught how to deal with their clients.

The male participants reported that there had been some change in police activities so that there was subsequently some decrease in violence on sex workers. All the participants maintained that many young females (who were practically children) were often arrested for sex work but they were often released on the following day without being charged. They expressed concern that the police ought to arrest and prevent children from trading in sex, but should, however, allow the older women to earn a living from sex work.

Some women reported that there had been no changes in police activities. Some police officers had reassured women sex workers that they would not arrest them if they dressed up in long instead of short clothes and did not make noise when doing their business. They forbade sex workers from operating on Beckett Street but allowed them to operate on Johan Street as there is an Old Age Home on Beckett street and the residents would complain to the police if the sex workers became noisy.

With regard to the question: **How can this study help women feel more in control to achieve any personal goals?,** the participants suggested that a shelter should be established to accommodate sex workers who did not have their own places of accommodation. The major reason for this is that most women come from far and when they arrive in Gauteng to seek employment they struggle to get accommodation and fall victim to men who use them for sex work. Usually, women would seek accommodation at places where other sex workers dwell. As the handlers are not only pimps but drug traders as well, the new workers are told that unless they do drugs they cannot be given accommodation. Peer pressure too, plays a major role in negatively influencing the lives of the females. The females, however, mentioned that prayer helps them to be more in control and to achieve their personal goals. They stated that they sometimes request church people to visit and pray for them at the hotels where they live.

With regard to knowledge of organizations that were helping women in distress, all the participants were aware that sex workers are regularly checked for sexually transmitted infections every Wednesday. They knew that nurses from the STI clinic did home visits to do checks on the sex workers who were reluctant to attend the clinic voluntarily. Nurses also did the Pap smears and mammograms on the women. Although blood samples were taken regularly, the participants however, were not sure whether the STI check-ups included HIV tests as well.

The male participants suggested that the sex workers should be informed about the importance of their lives and future and also about the danger of sex work and substance abuse. They indicated that the sex workers could be referred to social workers for more information and counselling services. They suggested that the women should be provided with jobs and be trained in sewing and other manual skills that could help them generate an income to promote their standard of living. They insisted that sex workers must be provided with moral support as most of them had been driven to the street by problems that prevailed at their homes and they were desperate to earn some money. All the participants stated that sex workers basically were good people who could change their lifestyles if they were to find alternative ways of earning a substantial income. The female participants suggested that faith based organizations (FBOs or churches), the Department of Social Development

(social workers), and the Department of Health (clinics), should find ways of helping the women out of their plight.

Some of the male participants were ignorant of referral places where the female sex workers could obtain help. They suggested that the study team should provide sex workers with information on all social service agencies (Governmental, FBOs, and NGOs) that can provide services such as social relief, counselling, primary prevention, support, and any other form of service. They claimed that they had heard about treatment centres and rehabilitation centres, but they did not know where to find any of these.

When the question: **How do you feel about having former sex workers being part of the new study?** was posed to all the participants, they all stated that they had no objection and they commended the idea as good. The female participants reported that they would feel happy if former sex workers could be included in the study team, as they knew that some of the female sex workers were not happy with sex work and would gladly stop if they could find alternative jobs that could pay them substantially. The male participants stated that the inclusion of former sex workers in the study was a great idea, as the women understood the problems that assailed sex workers.

When the participants were asked if they would **be willing to refer women to the research team,** all of them answered in the affirmative. They would be willing to assist the study team as long as they were reassured that the respondents' names would not be recorded and some incentive would be given to the respondents.

When the question: **Would you be willing to go through the peer advocate training?** was asked, all the participants expressed willingness in peer advocate training. They mentioned that they too would like to have t-shirts to identify them. They also stated that they were concerned about the time the study would consume as they had other commitments too. On explaining that the study would consume four to five hours of their time, the women gatekeepers felt that their husbands/partners would not support that, as they were often jealous of them going outside their homes. Alternatively, it was agreed that the training could be provided at

the sex workers' places and some were satisfied with that although others were hesitant but promised to think it over and provide feedback at a later date.

In response to the question: **Do the sex workers who smoke also drink alcohol?** all the participants stated that sex workers generally use alcohol and other drugs. Varied estimates were given on the extent of substance use. Some participants estimated the extent of alcohol use as being high (about 60%) and that it could be equated to that of other drugs use too (60%). Other participants indicated that only about one half (50%) of the sex workers drink alcohol and do not use other drugs while the other half (50%) abused both alcohol and other drugs (particularly dagga). Another group, however, mentioned that all sex workers either drink alcohol or use some drugs: "Those who drink say beer is better than drugs. I don't know the percentages."

When the participants were asked: **Do you think sex workers have changed their behaviour since last year?** they all answered in the affirmative. They stated that the sex workers had generally changed after being included in the study: "I know sex workers who used to smoke and now they don't smoke anymore" and "I know those who drink beer now and they don't do drugs".

With regard to the **estimation of sex workers who operate in town**, all the participants reported that there were many sex workers who were operating in town. Some had gained weight after the study. Some had gone back to their homes and others had died. The participants reported that the mobility of sex workers was high and that at the time of the follow-up study, there were about 15 sex workers who regularly came to town only during weekends but stayed at their homes during the week. Some of the participants estimated the number of sex workers who resided at the hotels in town as twenty while others estimated the number at more than thirty.

They mentioned that: "The main building had forty rooms, the side building had eight rooms. On the other side there were nine rooms at the back and seven rooms in the house next door. The main building accommodates smokers and they pay R320 weekly (seven days). The other rooms are used for residential purposes and they pay R650 monthly for two people in a room, R870 for three people in a big room, R820 for a single room and the overall rent is inclusive of water and lights."

In response to the question: **Do you have any suggestions?** most of the female participants did not provide any future suggestions for the study. The participants were clearly afraid of their partners who had promptly entered the room before the end of the interview. As the participants had started fumbling and mumbling, the interview had to be terminated and they were asked to initial their receipts and collect their honorarium, which amounted to R60.00 each for the interview. The sex workers, however, found an opportunity to accompany the study team to their car in order to collect condoms and some toiletries.

Some women requested to be included in the study as they viewed it as an opportunity for employment. They mentioned that they were literate, trainable, and needed any job that they could be involved in and that they were currently in the sex trade because of a lack of employment. The male participants commended the study team and encouraged them to keep up the good work because sex workers were a difficult group to work with as they liked shouting and arguing and were uncontrollable most of the time.

4.3 SECTION C: FOCUS GROUP DISCUSSIONS WITH SEX WORKERS

Prior to the presentation of the results, the researcher deemed it necessary to describe the demographic characteristics of the study sample in order to provide the background of the respondents.

4.3.1 Demographic characteristics of the participants

- A total of 93 women who were engaged in sex work and were also using cocaine and/or other substances were selected for the study. The sample was a convenience sample based on respondents who had been recommended by the participants in the pilot study and other sex workers who had been reached earlier on by the study team. Eighty of these women subsequently returned for further interviews in a period of one month following the baseline study and again after three months, six months, and twelve months. Each of the women was interviewed five times. The interviews entailed pretesting first, whereby the women were screened; and subsequently a focus group discussion, which was held immediately thereafter to gather baseline information. The women were

further requested to report periodically after one month, three months, six months, and a year. The criteria used to select the sample were the following;

- Age: only participants whose ages ranged from 18 years and above would be selected.
- Gender – only females were required to participate in the study
- Sex work and drug abuse participants had to be active sex workers who had at some time or other abused some drug(s).
- Written consent - only participants who were willing to sign a letter of consent indicating their understanding of the purpose of the study and were able to provide verifiable locator information as they were going to be followed up (Wechsberg et al., 2003:2) would be selected.

It was interesting to note that all the respondents in the study reported that they were single women yet each had a steady boyfriend either at the home of origin or was currently living with the respondent. Most of the women had left their children at home, either in a township or in some rural village. Their sources of income were sex work or boyfriends. Their method of communication with their clients was the cellular phone. They did not openly declare their possession of cellular phones. Some indicated that the phones were for business only. They were reluctant to be contacted on their cellular phones by the study team.

Regarding the follow-up process, only eighty of the 93 respondents who had been selected, participated in all the sessions of the intervention programme. On the average, 45 respondents were always present at the venue for research, ready to participate in organized focus group discussions on the specified dates. It was difficult to retain respondents in the same discussion group due to the random character of the sample throughout the intervention study process and because of the problems experienced in tracing some of the respondents. Some respondents could not be found regularly at the places from which they had to be transported to the venue for the interviews. The reason for this was that sex workers are generally mobile and are inclined to constantly relocate without prior notice. The interview schedules were constantly changed to accommodate respondents who had missed scheduled appointments. Before the programme was completed, about five

respondents were reported to have died of AIDS, while others were prohibited from further participating in the study as they had relapsed back into drug use, whereas others were prevented from participating by their boy-friends, hotel owners, and drug dealers. The decrease in the sample size affected the composition of the original sample as reflected in Table III. Furthermore, the changes in the sample size did not prejudice the assessment of the impact of the intervention programme because the researcher used a list of those workers who met the criteria of the study. Hence, the pre-post and pre-follow up comparisons were not disturbed. The demographic factors of selected respondents were as follows:

- Age: About one half (50%) of the respondents were in the twenty-one to fifty years age group. The over-representation of respondents in this age group may be explained by the fact that generally, females in this group are regarded as adults. They can take decisions and be held accountable for their decisions. They can enter into marriage or cohabitation with partners of their choice. Coming of age is usually marked by a variety of ceremonies among the different ethnic groups in South Africa, regardless of whether the woman's family is in an urban or rural setting. The unequal age distribution of the female sex workers in the current study's sample was empirically valuable.
- Gender: The sex workers, who were selected for the intervention programme, were all females. Respondents in the study comprised of females and a limited number of males who served as key informants. Among these, there were male sex workers who had volunteered to participate in focus group discussions in order to provide the viewpoint of males on sex work and substance abuse. The overrepresentation of the female participants in this study is due to the fact that females are over represented in sex work as many of them are poor, uneducated, and lack skills to enter the open labour market (Farmer, 1996:25). According to the South African Census Report (2001:8), women are represented in all provinces as constituting 23 385 737. In contrast, men are represented as constituting 21 434 040. In the country as a whole and in all the provinces, except Gauteng, there is a larger proportion of females than males. For example, in the Limpopo Province, females constitute 55% of the population.

Sex	EC	FS	GP	KZN	Limpopo	MP	NC	NW	WC	SA
Male	2975 512	1297 605	4444 679	4409 091	2394 785	1497 333	4011 68	1821 547	2192 321	2143 4040
Male %	**46.2**	**47.9**	**50.7**	**46.8**	**45.4**	**47.9**	**48.8**	**49.6**	**48.5**	**47.8**
Female	3461 251	1409 170	4392 499	5016 925	2878 857	1625 658	4215 59	1847 803	2332 014	2338 5737
Female %	**53.8**	**52.1**	**49.7**	**53.2**	**54.6**	**52.1**	**51.2**	**50.4**	**51.5**	**52.2**
Total	**6436 763**	**2706 775**	**8937 178**	**9426 017**	**5273 642**	**3122 990**	**8227 27**	**3669 349**	**4524 335**	**4481 9778**

Table II: (Distribution of the South African population by province and sex)
Source: Census in brief-Census (2001:8-9) Statistics South Africa

- **Marital status:** Respondents in the intervention programme were all single women. Information givers, however included the big mamas who were married women, who, together with their husbands, served as pimps. The big mamas perceived their role as “care takers” who were looking after the “girls”, (the sex workers). It is assumed that those involved in sex work, indulged in substance abuse as well in order to forget the dire situation they find themselves in (Farmer, 1996:26). A number of researchers have confirmed that substances inhibit the perception of the abusers (De Miranda, 1996:1-8).
- **Ethnicity:** The respondents were all black South Africans who belonged to the Batswana, Bapedi, Basotho, Shangaan and Xhosa ethnic groups. While there were an almost equal number of respondents from the Batswana, Bapedi, Basotho, and Xhosa ethnic groups, the Shangaan respondents were in the minority. Only one Key informant was Afrikaans speaking and he belonged to the Coloured ethnic group.
- **Income level:** Participants in the intervention programme generally originated from a low socio-economic background. They stated that they did not have any other source of income and had resorted to sex work as the only possible means of generating income to support their significant others (children and siblings). Although these respondents generated a high income from sex work, most of it was spent on drugs and they were always in debt.

- **Educational level:** None of the female sex workers had any educational qualifications beyond a senior certificate (Grade 12). They reiterated that, if they could attain some skills, which would make them employable, they would gladly stop trading in sex. They expressed despair about their situation, which they regarded as hopeless due to their lack of education. They believed that no amount of training would help them earn a substantial income that would enable them to meet the needs of their large families who were dependent on them. They indicated that they would be contented to take any jobs that would provide them with a minimum of two thousand rand (R2000, 00) per month.
- **Community of origin:** Approximately 90 percent of the participants stated that they had been born and bred in the rural areas of the North West, Limpopo, Free State, and Eastern Cape Provinces. Those who had been born and bred in the urban areas stated that they came from Gauteng. The latter group resided in Mamelodi West (where residents from Marabastadt had been settled in RDP houses provided by the Tshwane Metropolitan Council). Table II below illustrates the respondents' demographic characteristics.

Demographic characteristics of respondents

Characteristics	Focus group	Pretest N () (%)	Post test (%) Woman Focused	Post test (%) Standard Intervention	Follow up (%) Woman Focused
Respondents Age					
21 yrs +below	2	0	0	0	0
22-26 yrs	26	15	15	10	15
27-31 yrs	28	25	25	20	25
32-36 yrs	26	30	5	5	5
37-41 yrs	3	10	0	0	0
42-51 yrs	2	0	0	0	0
Respondents Gender	93 Females	80 Females	45 Females	35 Females	45 Females
Marital status					
Single					
Married	93	80	45	35	45
Divorced					
Ethnic group					
Botswana	22	18	10	10	10
Bapedi	22	18	10	10	10
Basotho	22	20	10	3	10
Shangaan	2	2	2	2	2
Xhosa	25	22	13	10	13
Income Level					
None					
R999 or less	0	0	0	0	0
Educational level					
None					
Primary level					
Secondary	80%	80%	80%	80%	80%
High school	15%	15%	15%	15%	15%
Tertiary	5%	5%	5%	5%	5%
Community of origin					
Urban	20%	20%	20%	20%	20%
Rural	80%	80%	80%	80%	80%

Table: II

(Schematic presentation of demographic data of participants in the intervention programme)

4.3.2 Results of focus group discussions

Focus group interviews were conducted during the information gathering and synthesis phases of the activity step two of the intervention research process. This

was done, in order to determine the factors that were critical in the design and implementation of the programme on awareness of risky behaviour and obviating violence from clients and pimps.

The research team utilised a guide/schedule for analysing qualitative data as outlined by various researchers. Two techniques were used here. They are: encouraging-which targeted all members of the group to speak; and questioning which entailed asking follow-up questions or even probing. These techniques helped to elicit additional information whenever respondents' statements were vague or not understandable. The researcher utilised both the directive and non-directive approaches. The directive approach allowed for greater coverage of topics or more detailed coverage of specific topics of interest in the time available at the cost of group synergy and spontaneity, while the non-directive approach provided more opportunity for group interaction and discovery. The participants' views were placed at the fore of the discussion (Schurink, Schurink, and Poggenpoel, in De Vos et al., 2002:306-312). The researcher identified different themes/regularities/patterns, which captured the meaning of what the female sex workers were doing or saying, in their own vocabulary. She looked for underlying similarities between her own and the solutions provided by the respondents to the identified problems. The ultimate goal of the programme was to enable the researcher to make recommendations towards developing a policy to protect sex workers who operate in South Africa. In reality, recommendations would develop from the focus group discussion which followed empowerment of the respondents with information on drugs, condom use and self-protection from clients and pimps.

The sex workers remembered the following information and tips during intervention:

- Explanation about the drugs.
- Respect for oneself/themselves.
- Proper condom use.
- Use condoms regularly.
- Never forget to use a condom at every sexual encounter.
- Learning to stay clean and beating drug addiction.

- Not to sell their bodies for supporting the drug habit.
- Caring for their bodies.
- Must stop drug use.
- Must take control of their bodies when using drugs.
- Never allow people to sleep with them without protection.

Data were organized around twelve questions which had been posed in the focus group discussions (Appendix A: 244) and alluded to in Chapter Two. The data were analysed and recurrent themes were determined. The recurrent themes, which emerged in relation to each question, have been presented in the results and have been illustrated with selected direct quotations from the participants. Direct quotations were used to retain what Hall and Hall (1996: 150) refer to as the richness of the data as it allows the participants to speak for themselves. A discussion of focus groups has been presented separately from that of the key informants' in-depth interviews, as this will make interpretation understandable and easy to follow.

- **Safety precautions in commercial sex work**

The focus group participants perceived a need for a knowledge-based education programme designed to motivate the women to refrain from substance use prior to sexual intercourse and to remember to use a condom every time. The University of Cambridge Counselling Service (2004:3) warns that people may turn to drugs in an attempt to avoid confronting problems which may be linked with the use of drugs. Whereas this may work in the short term, it could however, have severe financial, social, legal, or physical consequences.

– **Condom use**

Respondents in the standard intervention group mentioned that the study had provided them with the necessary information regarding the dangers of indulging in substance abuse and sexual risky behaviour. The feelings of all the participants were aptly captured by one respondent who stated:

"Refuwe tsebo ka mosebetsi o re o etsang bosiu le motshehare, nako e kgolo le e nnyane le ka bohlokwa ba ho sebedisa Condom, ho salang ke hore motho o tlohele

ho rosha, hobane ha ho re ise kae kapa kae mo relabalabelang ho finyela teng". This is a Sesotho statement when literary translated means: "we have been provided with knowledge regarding the work that we do at night and during the day, when we have plenty time and when we don't have time. The importance of using a condom has been emphasised. What remains, is to stop prostituting, because, if we don't, we will never reach any goals that we want to achieve."

All the respondents expressed concern that condom use was no foolproof guarantee against STIs including HIV, as condoms were prone to burst. The respondents particularly singled out the male condoms that are supplied for free by the Department of Health. They preferred the condoms from the United States of America (especially the flavoured ones) that were supplied to them during the intervention programme. They stated that those were of a good quality. They liked the condoms that had strawberry, banana, mint, vanilla, peach and grape flavours.

- **The male condom**

The respondents mentioned that the male condom breaks easily. They reported that they knew that they did not have to use two condoms together but because of the low quality of the condoms that were available for free, they had resorted to using two or three condoms together as a precautionary measure against breakage. The following statement by one respondent, was supported with nods of approval by all participants: "One can never predict the day an accident may happen (that a condom may burst) and trouble that could have been avoided may occur." The following diagrams show samples of condoms: The respondents confirmed that they generally used only one condom at a time as the use of two condoms together would result in easy breakage, especially when the vagina was dry.

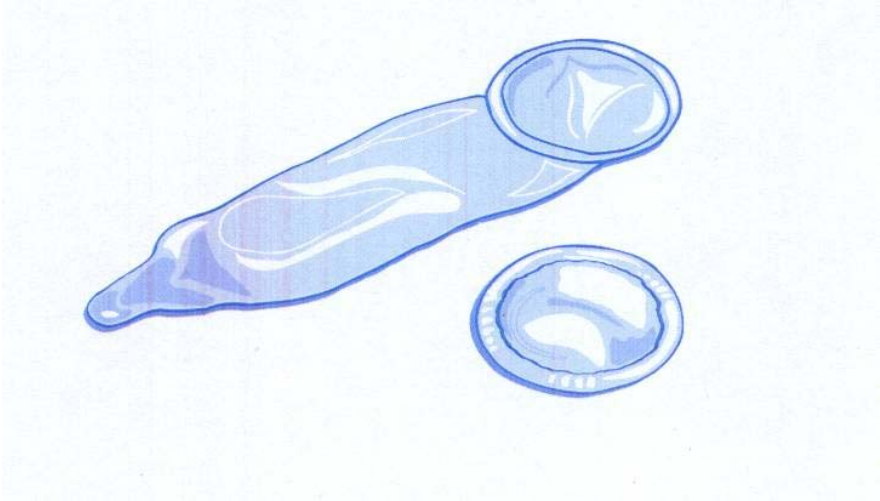


Figure IV: Male Condom

- **The female condom**

The respondents reported that female condoms were much better than male condoms in terms of quality. Female condoms were regarded as quite strong. The major problem with female condoms was cost (R39.99 per unit) and scarcity (not easily available in most chemists). Unlike male condoms, female condoms were not supplied for free. They were much stronger than the male condoms as they did not break easily. Respondents mentioned the major advantage of the female condom as the fact that a user can fit it in the uterus before going to the street to solicit clients and if she found a client that demanded a “flesh to flesh” service she could then oblige without revealing her secret. The client would be satisfied, as he might never discover the female condom. They reported that such clients offered more money for the job. A disadvantage of the female condom, however, was that it could be detected from the noise, which it made during intercourse. The respondents reported that the clients reacted to the noise in different ways. Whereas the noise irritated some clients, others were stimulated by it. The female condom fascinated most of the respondents and only an insignificant number indicated that they did not want to use the female condom at all.

Regarding washing of the female condom, the respondents were adamant that they would never use a female condom and wash it for reuse. Although it was explained to the respondents that in the United States of America and elsewhere around the world, women wash the female condom with soap and disinfectant and after drying it

properly reuse it as it is expensive and strong enough to sustain several washes, the respondents were adamant that they would not. One respondent speaking in isiXhosa aptly captured the sentiments of the respondents as she stated: *"Ngeke, andi phambananga*!" (Never, I'm not crazy!); while another said in Sesotho: "*Ha re hlanye rona*" ("We are not crazy!") and another exclaimed in Sepedi: "*Aowa! A rea gafa na?"* ("What? Are we crazy?"). This reaction almost drove the group out of control. On probing this reaction that nearly disrupted the group forever, the respondents explained that sperms sometimes smell terrible especially when they are mixed with blood and that they present a horrible sight which might make one to puke.

Whereas emphasis was laid in the importance of condom use in the programme, the respondents were implored never to use two or more condoms together and to remember that the male and the female condoms must never be used together. Demonstrations on fitting both the male and the female condoms were given and the respondents were informed that there must be no air inside the condom as this could result in breaking the condom.

By the end of the programme, however, some of the female sex workers stated that the programme had provided them with valuable information which they had not been aware of. Subsequently they would be willing to change their attitude about washing the female condom, as they understood the importance of doing so. Their sentiments were captured in the statement made by one respondent: "One day, you may find yourself in the desert far from accessible resources, having only one female condom. After using that single condom, the only sensible thing would be to wash it and in that way protect yourself against unforeseeable harm." The respondents, who had accepted the inevitability of washing a condom, urged others to change their minds too. The following diagrams illustrate the female condom.

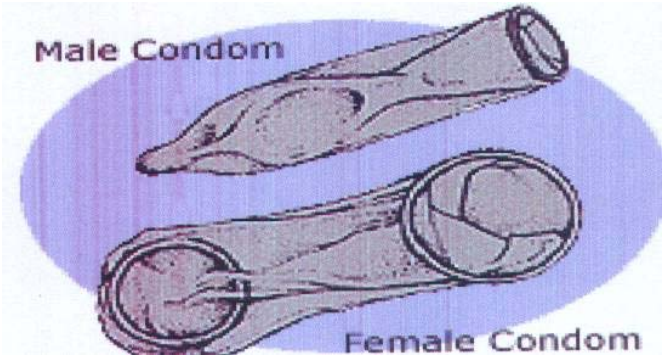


Figure: V: Male and Female Condom

- **The Oral Dam**

Women commended the oral dam and requested the project team to provide them with more supplies of the oral dam and flavoured condoms. The oral dam was seemingly a preferred barrier for reducing the risk of contracting sexually transmitted diseases that may occur during oral sex. The type that is currently on the market is the Sheer Glyde Dam. It is a thin sheet of rubber latex, which is in a rectangular shape. It comes in a variety of flavours, such as strawberry, vanilla, grape, mint, and banana. The respondents were knowledgeable about the oral dam's quality to prevent skin contact or contact between body fluids during oral sex and that it was easily available over the counter without a prescription. They stated that they used the oral dam when they performed cunnilingus (oral and, or vaginal sex) or rimming (oral and, or anal sex). The respondents knew that each oral dam could be used once only, when a couple switched from oral/anal to oral/vaginal sex. An oral dam serves to reduce the risk of infection from harmful anal germs. Advantages of the oral barrier are to help reduce the risk of catching sexually transmitted diseases. The disadvantage of the oral barrier is mainly that some people may be allergic to the rubber latex while it also reduces sensitivity. The following diagrams illustrate the Oral Dam that was supplied to the respondents during the process of the programme.

Fig. VI: Oral Dam

- **The impact of condom use on specific partners**

As the respondents maintained that they never used condoms with their lovers (boyfriends), but used them regularly with clients who did not offer a higher fee for service provided without, they provided the following explanations for their actions:

- A boyfriend is a person that one loves and has a stable relationship with. Faithfulness among lovers was a sine qua non hence the respondents stated that they usually would not use a condom when they indulged in sexual intercourse with their boyfriends (lovers).
- A client is someone with whom one has a casual relationship that entails charging him a fee for any services rendered during the time spent with him. Clients were not required to be faithful to any sex partner. They could exchange sex partners at will and choose whichever sex partner they desired at a particular time. Clients assumed that each of their clients had a relationship with a number of sex partners, hence it was essential that a condom should be used when indulging in sexual intercourse with a client in order to protect oneself from sexually transmitted diseases and pregnancy.
- The respondents described some clients as being ugly and dirty. They were adamant that one cannot risk her life with an ugly dirty client, hence it was essential to use a condom with men they did not love but simply required the money they were prepared to pay for sex.

- **Remembering to use condom**

In response to a hypothetical case that was presented to them, about whether, when one was drinking, drugging and smoking at around 4 a.m. could she remember to use a condom with a client? Respondents agreed that they could remember, as a condom was the first thing they had to use whether they were sober or stoned. They appeared amused and were laughing as everyone demonstrated how to fit a condom. A random check on whether they always carried condoms with them yielded poor results. When they were asked if any of them was carrying a condom at that particular time, it was found that only a few had, while the majority did not have. The explanation they gave was that they had not carried any condoms with them, as they had come specifically for the programme and knew that they would be supplied with some at the end of the programme before they went out to meet clients.

Initially in the early sessions of the programme, when the respondents were asked about the faithfulness of their boyfriends, all the respondents vehemently stated that their boyfriends did not have other girlfriends besides them; hence they did not use condoms when they indulged in sex with them. When the question was repeated in the later sessions some of the respondents mentioned that they perceived their boyfriends as a risk, as they did not know them well enough and they suspected that their boy-friends might be having other girlfriends besides them. Others, however, maintained that they did not think that their boyfriends were seeing other women besides them. Those who believed that their boyfriends were seeing other women too, stated that they used condoms regularly when indulging in sex whether with clients or their boyfriends; while those who believed that their boyfriends were faithful, maintained that there was no need to use a condom with their boyfriends hence they did not. All the respondents mentioned that with clients, one is forced to use a condom: “waya waya” (This is slang which means:” Always/ forever”).

- **Factors that prevent condom use and lead to unsafe sex**

The respondents explained that they were on the street to make money, and as clients offered them more money for unprotected sex, they were inclined to oblige. The risk of indulging in unsafe sex in order to raise a higher income was discussed at length as it clearly jeopardises the sex workers’ lives. However, the majority of

respondents were uncompromising. They emphasized their need for more money - a factor that seemingly placed them in a state of helplessness with no choice other than to take the risk. Finally, the respondents resolved to put on a female condom, whenever they go out to the street, so that should they meet clients who offered more money in exchange of unprotected sex they could oblige without endangering their lives.

- **Perception of the study by sex workers**

– **Talk on the street**

The respondents reported that word had gone round about the study in the taverns, brothels and the streets and that many people held misconceptions about the work done by the researchers. People who were not involved in the study did not trust the research team. There was a misconception that the research team members were sending sex workers for HIV and AIDS testing. This misconception puzzled the team members as the intervention programme they facilitated was only informative and had thus far entailed engaging the participants in discussions and supplying them with condoms. At no stage in the process of the study thus far had blood or saliva ever been drawn from the respondents. Another misconception that prevailed was that, the research team comprised of police informers: “Basadi ba maponesa” - a Sesotho word that refers either to female police officers or wives/girlfriends/lovers of policemen. The latter misconception perturbed the drug dealers in particular, as they feared that the research team might provide the police with information on their drug dealings - an issue that could lead to their being arrested.

– **Informed consent**

Only after the respondents had been provided with adequate information on condom use, drugs, and abuse were they included in a follow-up study which entailed an educational programme. At this stage, the respondents were asked if they would be willing to submit saliva or blood samples for testing for HIV/AIDS in the next phase of the study. They were informed that testing would be voluntary and no one would be forced to submit to the test. Those who would be willing to be tested would have to sign letters of consent which however, were not binding. These letters included a

clause that indicated that, should a signatory change her mind afterwards, she would not be coerced to proceed with the test. The results of the test would be kept confidential and would be disclosed only to the testee.

The researcher observed that although many of the respondents were visibly afraid of being tested, they all agreed that the idea of being tested for the HIV/AIDS was good. The respondents acknowledged that the HIV/AIDS test would help each person to know her HIV status. More than half of the respondents consented to be tested, on condition that the test would be administered free of charge. It was interesting to note that they exonerated their clients as they stated that, if the test results were to show that any of them had tested positive, that would be proof that their steady boyfriends had been cheating on them. They reported that they generally used condoms only with their clients and not with their steady/live-in boyfriends or husbands. They expressed mixed feelings regarding their HIV status. The feelings of the respondents were aptly expressed in the following idiomatic expression: "*Go ra gore re mo kotsing, ke Tshwane ya Mošate wa e gapa o molato wa e tlogela o molato".* This is a Sepedi idiomatic expression, which relates to a Catch 22 situation in which they found themselves: "This means that we are in trouble! Our situation compares to that of dealing with a strayed cow from the King's kraal. If the finder guides it to the kraal, he or she will be found guilty and if he or she ignores it, he or she will still be found guilty". What the respondents meant was that, as they were now informed about the danger of not using a condom, each respondent would always feel guilty whenever she indulged in sex without protection either for gaining a higher fee from a client or proving faithfulness to a lover. As both actions were part of their lifestyles, they would always be faced with guilt whenever they would have to choose between losing income (a client) or a lover or indulging in risky behaviour, which would expose them to sexually transmitted diseases.

- **Drug use and AIDS transmission**

The respondents explored the issue of drugs and the manner in which the use and abuse of drugs could result in their being infected with HIV/AIDS. They rationalised that:

- ❖ Any person can be infected with HIV/AIDS if he or she does not use a condom but indulges in unprotected sex;
- ❖ When a person uses drugs he or she might stop using a condom as he or she might not remember to use a condom, especially when he or she is with a client who offers more money and insists that a condom should not be used.

At the end of the programme, the respondents unanimously agreed to stop using drugs and to take control of their actions. They were aware and confirmed that doing business without being under the influence of drugs would enable them to take good decisions and refrain from taking risks that could otherwise not be avoided when they were under the influence of drugs.

– **How sex workers perceived drug dealers**

The respondents stated that drug dealers held a negative perception of the study, as they believed that the research team members were police informers who would soon have them arrested. They regarded the sex workers who participated in the intervention programme as troublemakers who would reveal them to the police so that they would be arrested, and their drugs seized. The respondents were aware that the drug dealers loathed the study team and got angry every time they saw the team transporting them to the venue where the discussions were held. They also mentioned that other people viewed the study in different ways. While some liked the study, others really hated it. Those who liked the study were under the impression that its main purpose was to supply sex workers with condoms; while the others thought that the research team was taking the respondents to venues where they could meet clients. The respondents' own view was that the study was highly informative. It had provided them with invaluable information and they had gained knowledge and insight on life skills. They felt empowered and enabled henceforth, to take decisions that would prevent their being abused in any way. They stated that they did not really mind what others said about them and the study. They emphasised that if they would hear people criticising them, they would use the opportunity to defend the study and to enlighten the critics about it so that they could correct the negative perceptions held about the study.

- **Reasons for encountering problems with other sex workers**

The respondents stated that sex workers, who had not been selected to participate in the study, were jealous and they believed that the respondents had been selected because they were all suffering from AIDS. The sex workers who had not been selected for the study were angry for not having met the criteria for the study, hence they were unhappy with the research team and the respondents.

4.4 ASSESSMENT OF THE CUE CARDS (INTERVENTION) INSTRUMENT

The respondents mentioned that the intervention instrument was good. They stated that the cue cards had helped them to gain information and to easily understand the skills taught to them. They expressed gratitude that they had gained knowledge and would in future be able to negotiate for condom use and to utilise skills to protect themselves from the harm they had sustained from violent clients. They stated that they had benefited from the lessons written on the cue cards and they felt confident that they would be able to apply the skills they had learned, as the information would be easy to recall. The cue cards had information on the following issues:

- **Women's position in society**

Women's position in society is low even in relationships. The respondents concurred that this statement aptly described the reality that prevails in society. They mentioned that they needed to elevate their position in society.

- **Violence and what can be done to improve the situation**

There is a high amount of violence towards and rape of women. The respondents agreed that they were experiencing a high rate of violence and rape. They felt that it was high time that they did something to defend themselves. The following statement aptly captures the sentiments expressed by respondents: "Ke tiisitse, ka sefapano! Banna ba re reipa tsatsi ka tsatsi, kabaka la gore ga ba batle go re patala." This statement, which had been uttered in Sesotho, simply means: "Honestly, I swear by Jesus' Cross! Day by day we are raped by clients who refuse to

pay us". The respondents indicated that only a day before that particular focus group discussion, some sex workers had reported having been raped by their clients. The respondents, however, were reluctant to provide more details on the incident, as they claimed that it pained them greatly to reflect on the incidence.

- **Reaction of a woman in case of a bad situation**

Reduce the chance to negotiate and scream for help. The respondents agreed that this advice was and would always be more effective when a woman faced a bad situation. They concurred that such situations could occur to any one and every worker had to anticipate it. Some of the respondents indicated that they always carried whistles, which they did not hesitate to blow, whenever they wanted to scare any man who wanted to harm them. Some women, however, were reluctant to heed the advice or even to discuss the issue.

- **Stop being ripped off**

Stop being ripped off: This cue card also illustrated that women's lives were at risk as rape might result in their being infected with HIV, Hepatitis, or STIs. Most of the respondents identified with the message on the card. They were familiar with the concept STD but not with the concept STI. They were aware of the prevalence of STD among sex workers. They were subsequently informed that the two concepts were sometimes used synonymously. STI refers to sexually transmitted infection. An infected person might sometimes not be aware of the infection, while STD refers to the actual disease and one is always aware of the ailment.

- **Power on condom**

The respondents understood this card to mean that condoms help to protect them against STIs and STDs and they agreed with this statement that implied that they should always insist that a condom be used in a sexual encounter.

- **What alternatives are there to sex work and life on the street? What skills can be taught to sex workers to help them refrain from using drugs?**

Most of the respondents were adamant that there were none. Generally, the respondents indicated their unwillingness to stop drugging as this might result in the reduction of clients they would serve. They associated sex work with drug use and they mentioned that although they were different individuals, none of them would change their drug use, as they were already addicted. Some mentioned that they had tried to refrain from drugs since the inception of the programme, but had failed. They reiterated that in their perception the problem of drug use among the respondents was already advanced as some of them made up to R500 per day but used it all on alcohol and drugs. They stated that the more money they got from their work, the more they spent it on drugs. They mentioned that they made more money in the business when they were under the influence of drugs as these removed inhibitions and enabled them to service more clients.

With regard to the question of what their reaction would be, if they were to be given alternative employment which required them to stop servicing clients and doing drugs, the respondents gave different views - some stated that they would rejoice at the offer, while others stated that they would still find it difficult to refrain from drug use. It was at this point that some mentioned that they would be willing to take any job that would pay them a wage not less than R2000 per month.

- **Identification of respondents**

The research team needed to be able to recognise the participants in the study and to distinguish them from other sex workers, so they supplied some T-shirts to them. The T-shirts issued to respondents were similar to those used by the team members.

- **T-Shirts**

The respondents' reactions varied from appreciation to disgust on having to wear a uniform. Although all were in agreement that the T-shirts helped them to be viewed as a group working together and helping each other, some stated that the uniform had caused conflict between them and the drug dealers. Some of the respondents mentioned that the label and letters of the Women's Coop which appeared on the T-shirts were admired by other sex workers who misunderstood the goals of the study as they had not been included in the study. As sex workers are generally perceived

as people who “sell their bodies”, people thought that the respondents were advertising themselves to clients with the T-shirts hence, other sex workers wanted to buy the T-shirts too.

With regard to whether T-shirts should be used in the next study or not, the respondents mentioned that for identity, T-shirts should be worn. They suggested that the label on the T– shirts should be changed to “Women’s Health Project”. Other suggestions, were that in future, the respondents should also be provided with water bottles, clean water, more toiletries, gift bags, and toiletry bags for carrying condoms.

- **Compensation for participating in the study**

Whereas some of the respondents regarded the amount of R60, 00 per session, that they received as very little and suggested that it should be raised to R100, 00 per session, the others were quite satisfied with the amount of R60.00 as they rationalised that it was supplemented by the meals that were regularly served to them.

- **Access to drug treatment programmes in South Africa**

A number of issues were explored in this regard and the reactions of the respondents subsequently recorded.

- **Drug Dependency Treatment in South Africa**

The respondents relayed accounts of their experiences to the research team. Some reported that they had been to the Magaliesoord Rehabilitation Centre but efforts to rehabilitate them from their drug abuse habits had failed. They reiterated that treatment did not work for them. They complained that drug abuse treatment which was meted out in the form of tablets (anti abuse drugs) had failed with them because anti abuse drugs made them feel tired all the time and had the same effect as that of missing to take the drugs that they were already addicted to. This effect lasted over one or two days.

- **Duration of the drug dependency program**

Concerning the duration of treatment in the treatment centre, the respondents stated that it varied from one centre to another. The treatment programme in some centres lasted over two weeks while in others it lasted over four weeks.

- **The physical and social environment of a drug dependent person**

Concerning the treatment programmes in South Africa, the respondents reported that treatment centres offered good programmes and the patients were treated with respect. They mentioned that they were treated humanely and were neither stigmatized nor discriminated against there. They appreciated taking a nap and getting recreation in the form of sports (basket ball and netball) at the treatment centres. Although patients were offered good meals at the treatment centre, it was the detoxification treatment that they were not happy with, as it left them tired and had the same effect as that of missing their daily dose of illicit drugs.

- **Assessment plan of drug dependent persons**

Regarding the assessment plan, the respondents remembered that there were short term and long-term goals for treatment. The short-term treatment programme was offered in Sunnyside where patients were allowed to attend together with their children and meals and accommodation were offered. The programme at Sunnyside was reportedly good as it made them feel secure and safe and enabled them to resist the urge to take drugs. The long-term treatment programme provided patients with life skills and training, which would enable them to get and sustain alternative jobs. The respondents, however, reported that the training was limited to low paying jobs which provided a pittance hence, they found it difficult to abandon sex work.

- **Future of women on the street who had been rehabilitated**

The respondents indicated that women on the street needed to be rehabilitated and to be reintegrated into society. The following sentiments, which were aptly articulated by one respondent, were expressed. “We cannot say that we need jobs like, for instance, office work, when we are aware that we have never been to school and we are not educated. We understand our limitations and we don’t need jobs that will pay plenty of money, as we know very well that we are not educated. We will be

comfortable to settle for jobs like cleaning premises. It is still okay, as we will be out of danger and harm that we experience on the street. When one is having a job that does not pay a fair wage but ensures her safety, it is still fine with us. Employment for us guarantees that we shall not be sleeping with ten men a day and still think we are normal. We are educable. We can be trained and we are ready to learn." Some of the respondents suggested that they should be trained to bake and/or to use computers and make a living out of that. They emphasised that gaining skills that would make them employable would keep them away from drugs. They maintained that jobs would keep most of them too occupied to think about drugs and only a few would continue to take drugs. They stated that the devil urged them to take drugs and they were in need of prayer to help them break the drug habit. They explained that it was difficult to stop the drug habit and addicts would not be deterred by jobs, but would continue with their drug habit as soon as they earned their wages. They maintained that addicts would do anything to get their daily dose of drugs. They would sell all their possessions or even pawn a car for drugs.

- **Types of drugs used by women**

Sex workers indicated that they used a variety of drugs, singularly or together. Respondents mentioned a prevalent use of the following substances:

- **Alcohol**

The respondents rated alcohol as a milder substance compared to other drugs. However, when alcohol is taken together with other drugs, the chances of getting addicted were higher. Some mentioned that alcoholism developed faster among those who used both alcohol and other drugs such as rock (cocaine). They joked that rock makes one to "shake, rattle, and roll."

- **Dagga (Cannabis)**

They regarded dagga as being more addictive than alcohol. They mentioned that the use of both dagga and alcohol led to alcoholism.

- **Other drugs**

* Besides alcohol and dagga, other drugs used were prioritised as follows:
* Rock (cocaine) was regarded as the most addictive drug. It was rated as number one.
* Thai white (heroine) was rated as number two.
* Dagga was rated as number three.
* Home brewed concoctions and/or dagga were both rated as number four.
* Ecstasy was rated as number five.

From the above, it was clear that solvents (benzine, glue, thinners) and other drugs like mandrax and wellconol were unknown to the respondents.

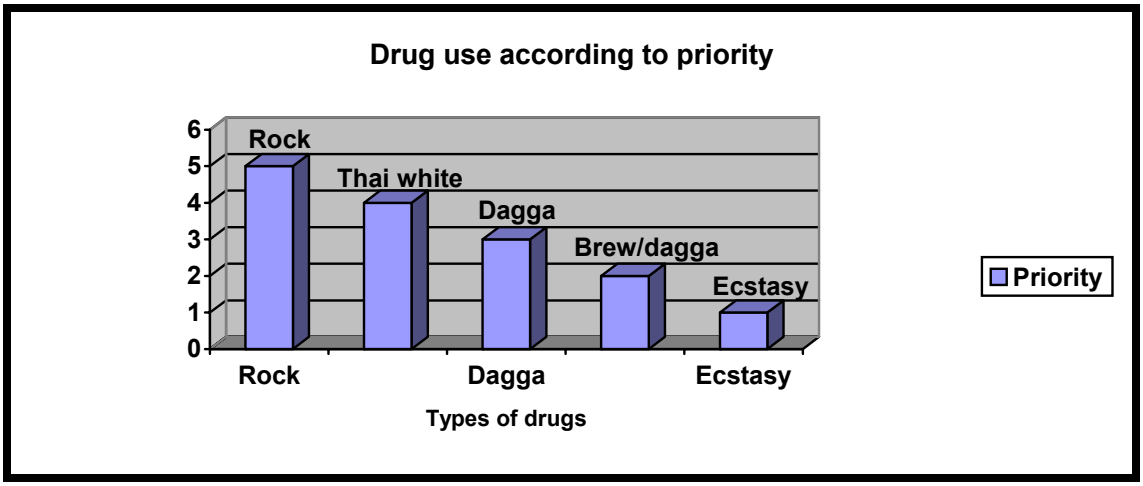


Figure.VII

Respondents were emphatic that alcohol was not a drug. They argued that a person could drink alcohol and still think clearly, whereas the same cannot be said with other drugs. They maintained that daily use of alcohol was common among sex workers in general. They reported that when they are high on drugs, they seize to discriminate and often crave for alcohol.

- **Entry into sex work**

The respondents reported that for one to enter their trade, the skill most required is the ability and experience to put a condom on the client before embarking on a

sexual encounter. Some respondents claimed that they could feel it when a condom had burst. The respondents raised a concern that a major challenge in their work was that if all women could insist that a condom be used in every sexual encounter, the HIV/AIDS pandemic would be greatly reduced. They were unanimous that to a large extent their clients were mostly responsible for the spread of the virus.

- **Resources That Are Available To Women Sex Workers**

Referral lists had been included in the packs that had condoms and other goodies, which had been offered to the respondents. When the respondents were asked if they had found the lists useful, they agreed and most of them mentioned that they were already utilising some of the resources mentioned in the lists. They reported that they had encountered problems in accessing most of the listed resources. They had found that it was not easy to be treated at hospital, as the institution followed some red tape, which necessitated referral by a clinic before one could be attended to. The respondents specifically mentioned that at the Skinner Street Clinic, as a patient had to queue from as early as 5H00 a.m. if she were to access a doctor who would assess her and subsequently refer her to the Pretoria Academic Hospital if necessary.

- **Needs of women in the study**

The respondents mentioned that sex workers needed health centres (clinics) that would attend to their specific needs without discriminating against and/or stigmatising them. They emphasised that they had learnt much from the programme. However, they would not be able to apply what they had learnt in practice, as there was a lack of adequate health facilities that accepted them and would neither discriminate against, nor stigmatise them.

The respondents were aware that they regularly needed check-ups. They argued that they needed to be checked for STDs including HIV/AIDS and as each used many condoms, they also needed to find out the damage that these might have caused. They mentioned that they were prone to infections, which might occur when a condom bursts. Some respondents reported that they had never ever douched, while

others expressed a wish that clinics should administer douches. It was apparent that the respondents in general, did not know this practice, hence the programme included educating respondents to douche using vinegar and water. They were implored to buy douche bags. The respondents found the information of using vinegar to douche amusing, as some believed that vinegar was not good for their business, as it would cause the vagina to be wide. The researcher, however, allayed their fears by informing them that they could substitute the vinegar with plain yoghurt. They were warned never to use flavoured yoghurt for douching.

During discussion, the respondents suggested that, douching should be done by clinic staff instead of it being self-administered. The reasons advanced were that the condoms supplied for free by the government, were oily and could damage their womanhood. Some respondents indicated that their vaginas emitted a foul odour and that clients too emitted a foul odour which could be harmful to them. The researchers advised the respondents to consult doctors and visit clinics about the odour and also to use Flagyl, an antibiotic that could help reduce the odour.

- **Health facilities that were utilised by sex workers**

When respondents were informed that they could go to Lerato House for Pap smears and STI tests they stated that they already had that information. They were aware that money for transport and food could also be provided at Lerato House. They knew about New Lock too. However, many were reluctant to use both facilities as they stated that New Lock was an extension of Lerato House which supports incarcerated women who have babies. On their own, the respondents stated additional facilities that they utilised, such as the Pretoria Academic Hospital, which they still referred to by its old name as the H F Verwoerd Hospital and also the Sammy Marks Clinic, which they referred to as a clinic that specialises in tuberculosis and other lung diseases. They complained of the long distance they have to travel to the Mamelodi Day Hospital and stated that for one to get there, she has to wake up at 5H00 a.m. in order to get into the queue for treatment. Another facility that was identified was the Skinner Street clinic but the respondents stated that this clinic referred did not provide service but referral to the Pretoria Academic hospital.

4.4.3 Focus group discussion results

Although the findings from the focus group discussions were seldom generalised, it was important to note that findings from the ten discussion groups that were involved in this study demonstrated a remarkable consensus among and between the groups and across divisions of age, ethnicity, and social background on all the issues under discussion. The participants raised five important issues or patterns that were taken into consideration when the current study's substance abuse and risk behaviour prevention programmes were designed. During the model design phase as well as the early development, pilot testing, and programme implementation phase of the intervention research process, the five issues/patterns/themes and regularities that were highlighted were the following:

- The extent of the problem of substance abuse- its incidence or prevalence
- Component aspects of the problem.
- Possible causal factors.
- Effects of the problem, including behavioural, social, and economic accompaniments.
- Intervention shortcomings on how the problematic condition was confronted.

– **The extent of the problem-its incidence or prevalence** - The focus group discussions highlighted that women sex workers work under difficult circumstances froth with violence instituted by clients, pimps and law enforcing officials. The respondents mentioned that they often get off-loaded from moving cars, get raped, are denied payment for services rendered, robbed of their money, get assaulted and/or be killed while on duty. The participants indicated that there was a need for a comprehensive policy and prevention programme to protect sex workers from violence and harm. They suggested that the policy and prevention programme should equip women involved in sex work with information about the dangers of using and abusing drugs and the resultant risk behaviour. This would enable the women to take informed decisions and get protection. In addition, the workers should be trained in communication, decision-making, and negotiation skills, to facilitate them to persuade all their

clients to use protective devices such as male or female condoms whenever they engage in sexual intercourse.

The empowerment of women with the above-mentioned skills would improve their personal and social competencies to resist the temptation to indulge in substance abuse and risky behaviour. Skills training programmes should be culturally and developmentally appropriate and should reflect real-life situations. Beck, Summons, and Matthews (1991:50) mention that a prevention programme can be effective only for a short while, if it is more theoretical and focuses on risk behaviour. Programme developers are, therefore, advised to try to integrate theory into practice and involve the subjects of the study in order to sustain the programme and make it relevant to the situation where intervention is practised.

- **The component aspect of the programme** - The second issue which was raised in the focus group discussions was the fact that the content for intervention should address the real and expressed ideas and feelings in order to bring change to the lives of the female sex workers involved in the sex trade. The participants suggested that ideas should be written on cue cards, which would provide information geared at helping participants and changing their lives. The researcher maintains that the method of conveying information is critical for the success of any prevention programme. In the current study the participants confirmed the findings of the researchers as they too, recommended that programmes should be delivered in an informal environment and not in the formal style, so as to encourage free interaction (Kaskutas et al 1998:43). The use of a natural setting for intervention proved to be effective for the sessions held with women.
- **Possible causal factors** - The third issue raised by the participants referred to the possible causal factors relating to substance abuse and risky behaviour. The participants mentioned factors such as emotional involvement, poverty, lack of income, low education, low self-esteem and low condom use compounded by offers of a higher fee if a sex worker agreed to permit a client not to use a condom. Most of these issues have been mentioned by other researchers such as Kim et al (1998:9). The participants suggested that an

effective strategy would be to train peer educators who would serve as models to other sex workers. The participants commended the programme that had been used with them and suggested that it should be used on peer educators too. In a study, which was conducted in 2001 in Thailand, it was found that HIV infection was reduced through peer involvement in education and training programmes. At a SWEAT workshop held in Cape Town in 1998, the participants recommended that sex workers should be involved in discussions geared at creating a policy that aims at protecting sex workers.

- **Effects of the problem, including behavioural, social, and economic accompaniments** – The participants suggested that substance abuse and risky behaviour prevention programmes should target women involved in the sex trade before they started using substances and engaging in risky behaviour, as this would delay the onset of the behaviour or prevent the possible development of the undesirable consequences. Klepp et al (1991:424) found that when prevention efforts were introduced to youth who had already engaged in substance abuse and risky behaviour, they were inclined to become unsuccessful. This could be attributed to the fact that the young people would have already learned inappropriate and health compromising behaviour which they found difficult to unlearn.

- **Intervention shortcomings in how the problematic condition was confronted** – The respondents were concerned that policies were often enacted without the involvement of the target population. Such policies were often not suitable and were viewed as undesirable. The participants felt that the intervention in the form of policy and programmes should protect all people as this is enshrined in the South African Constitution. A number of studies reveal that law enforcers ignore clients and target sex workers for arrest; yet the Sexual Offences Act, No.23/1957 criminalises all acts that are seen as related to the performance of sex work, including the keeping of a brothel, soliciting and "public indecency." Sex workers are arrested for allegedly committing criminal offences. Charges against them are usually not framed in terms of The Sexual Offences Act, No. 23/1957 but rather, they are framed in terms of the contravention of municipal by-laws, which prohibit "loitering", "causing a public disturbance" or related provisions. The reason for this is that, the enforcement

of The Sexual Offences Act, No 23/1957 section 20 (1) (aA), requires more intensive investigation methods, such as setting a "trap" with concomitant personnel. This requires elaborate supervision, which can be least afforded. The alternative charges are often based on municipal by-laws, which normally require little more than regular patrol activities (Combrink, 1999:1-2). Some researchers have also pointed out that stricter law enforcement, stiffer fines, and tougher laws were often ineffective as they attempt to prevent the action after it has occurred (Wilson, 1993:212). On the contrary, Brown and Caston (1995:485) state that a public policy in the form of customs and unwritten rules of behaviour can be effective in controlling the rate of undesirable behaviour such as substance abuse and risky behaviour.

Card 1: Some reasons women are at risk in South Africa

The following reasons were mentioned:

- Women's position is low in society and in relationships.
- Women are often uninformed about choices and sexual risks.
- Women are often unable to negotiate for the use of condoms.
- Women may not know that they have sexual rights.
- There are social norms that accept or encourage many sexual partners.
- There are Labour patterns, which make men to work far from their families thus leaving them vulnerable to engage in sex with multiple partners.
- There are norms that forbid women from discussing sexual matters including the acceptance of condom use.
- There are High incidences of violence against, barter, and rape of women.

Card 2: Reduce the "chance" – negotiate

The participants were taught the following skills:

- Preparedness-Because men may feel that they must control, dominate, or intimidate a woman into sex without protection, be prepared.
- Bargaining-Bargain for the protection of yourself and the sex partner.

- Insisting on condom use-Always have condoms ready, and use a female condom if the man refuses to use a male condom.
- Blowing the whistle-Be prepared to use a whistle, scream for help, or get out of the threatening situation.

Card 3: Stop being ripped off

Participants were trained to be alert, conscious and aware of imminent dangers that lurk in a sex workers' daily life. They were cautioned to be ready to escape or seek help when the situation calls for it.

- We know that women are raped, robbed, beaten up, cut, have guns and knives pulled on them, and suffer injuries because of this.
- Your life is at risk. Rape can cause vaginal trauma that can put you at special risk of HIV and/or hepatitis.
- There are ways to reduce violence.
- If you find yourself in a bad situation do the following:

– Go along with him and wait for your chance to get away.

– Sweet talk him; sometimes this will change his mood.

– Acting crazy or talking too much may change his mood – he might want to get away from you.

– Attract attention to yourself by screaming or using a whistle, and he may just not want to hang around.

Card 4: Dealing with a bad situation

Additional life skills were provided to the participants by teaching them escape techniques as follows:

- If you have to get out of a car:

– Wait for a red light and get out.

– If the car is still moving, open the door and wait. Many times this will show your date you are serious and he will slow down or stop.

- It is hard to think quickly while you are high. Remember, stopping, reducing, or delaying your drug use keeps you in control.

Card 5: Power of women

Empowering women with life skills would be incomplete without creating self-awareness and conscientizing them about the human rights which are entrenched in the South African Constitution, hence:

- The free nation of South Africa is new
- Women do not realize they are free to take charge of their lives and reduce risks, especially for those who may not have education or skills for a job.
- Women can insist on condom use or use female condoms.
- Women can avoid being victims.
- A woman can own her life and not give it away because of her need for drugs and/or alcohol.
- Women can protect themselves from HIV, violence, and drug use. This is a start towards a more positive, free, and safer life.

- **Activity Step 2: Conducting a pilot test**

Pilot tests are designed to determine whether the intervention will work, in other words “to see if the beast will fly”. Pilot tests are implemented in settings convenient for the researchers and are somewhat similar to ones in which the intervention will be used. They also help to determine the effectiveness of the intervention and identify which elements of the preliminary programme may need to be revised (De Vos et al., 2002:410). In this programme, only the WIGs were exposed to the cue cards while the SIGs were not. The difference in the outcome between the two groups was compared.

- **Activity step 3: Applying design criteria to the preliminary intervention**

Rothman and Thomas (1994:37) in De Vos (1998: 396) state that this activity step has to do with developing the guidelines of the intervention programme in order to guide its application in accordance with the established criteria. In accordance with

this, the study team developed guidelines for the current study's programme. In the guidelines the following criteria were stipulated, namely that the programmes should be:

- Effective and efficient.
- Replicable to typical end users.
- Simple to use.
- Practical.
- Adaptable to various contexts.
- Compatible with local customs and values.
- Empower the target group.
- Sustainable.
- Responsive to the needs of the target group.

The substance abuse and risk behaviour prevention programme was then implemented in the light of the information highlighted in the information gathering and synthesis phases, the model design phase, and the current phase. The cue cards as the tools for intervention were tested against the above-mentioned guidelines (see Appendix D).

4.5 SECTION D: EVALUATION AND ADVANCED DEVELOPMENT

The "evaluation and advanced development" phase addressed the question of the effectiveness of an intervention model. The researchers concluded that evaluation methods in intervention research include much of the already established research methodology of the social and behavioural sciences, including quasi and true experimental designs, single-subject designs, as well as psychological and behavioural assessment. It is important to emphasise that the use of research methods in the evaluation phase of intervention research is not meant to provide programme appraisal for practical purposes, but rather, to contribute further to the programme design and development as may be necessary and to proceed ultimately to adoption and widespread use of the programme (Thomas, 1989:587-589, in De Vos et al., 2002:412; King et al, 1987: 32; Klitzner et al, 1994:57; and Mantell et al., 1997:27). The four major activity steps in this phase are the following:

- Selecting an experimental design.
- Collecting and analysing data.
- Replicating the intervention under field conditions.
- Refining the intervention.

The application of this phase in this study entailed involving the participants in refining the instrument to be utilised during the intervention. Later the instrument was used to teach the women to negotiate safer sex with their clients and partners so that they would eventually be empowered to take control of their lives. This evaluation of whether the respondents had gained from the study or not, was verified by the key informants. In addition, the community board of advisers assisted with the refinement of the tool that had been used to empower the female sex workers. The key informants also advised on how the sex workers could be helped and also on how their working conditions could be improved.

4.5.1 Dissemination

De Vos et al. (2002: 414) explain that since diffusion and adoption are closely related and are generally carried out concurrently, they should be considered together as dissemination which the authors regard as the last phase in the intervention research. Rothman and Thomas (1994:39-43) state that, once intervention has undergone all the phases, it must be disseminated to different organisations and other audiences. Several operations or activity steps that make the process of dissemination and adaptation more successful are as follows:

- Preparing the product for dissemination.
- Identifying potential markets.
- Creating a demand for the intervention.
- Encouraging appropriate adaptation.

The dissemination of data took place through word of mouth, as the respondents shared information they had gained from the study with other sex workers in the areas where they operated and/or resided. The study created awareness, which subsequently led to a demand for more intervention as the sex workers started

reporting their drug-abusing peers to social service organizations and there was an increase in the drugs that were confiscated. Peer group education entailed that the sex workers (respondents) eventually educated their peers and in this way they owned the intervention tool on how they could prevent and protect themselves from harm.

4.6 CONCLUSION

The data that had been collected for the study have been presented, analysed and interpreted in a simple descriptive manner. Some tables, bar graphs, and pictures have been included for the reader to understand and increase insight into the field of study or phenomenon under investigation. The problem that was investigated (substance abuse and risky sexual behaviour among sex workers) is sensitive hence the researcher had to be skilful in communicating with the respondents who otherwise would have concealed information that they thought was not acceptable in society and in that way would have hindered the study. The prevention programme for an activity that contributes to the well-being and livelihood of the target population is often difficult to implement, as many sex workers are secretive about their means of livelihood and the subsequent problems that assail them. However, the methods that were utilised in this study enabled the researcher to reach the study goal and pose a challenge to social work practitioners. The next chapter is based on a restatement of the problem, aims and objectives, findings, and conclusions of the study as well as the recommendations.

CHAPTER 5
SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This study attempts to provide a framework to protect sex workers. The researcher has demonstrated that a programme on the prevention of substance abuse and risky behaviour administered to women in the sex industry can yield positive results. In this chapter, the problem statement, the aim and objectives as well as the assumption of the study have been restated. Findings and conclusions have been drawn from the data that were gathered through focus group discussions and in-depth interviews that were conducted with a number of sex workers and gatekeepers. In concluding the chapter, the researcher has made recommendations that will hopefully be considered by policy-makers when they review policy on sex work.

5.2 RESTATEMENT OF THE PROBLEM

Despite many incidences of prostitutes that have been found murdered in South Africa, research-involving prostitutes is scanty. While debates on whether to legalize prostitution or not are going on in parliament, the South African mass media thrive on stories about prostitution and the fact that it is an income generating trade which is currently untaxed, yet it is a means of livelihood for a significantly large number of people. Prostitutes, however, are assailed by numerous problems such as violence, clients' refusal to pay and sexually transmitted diseases including HIV/AIDS. In the current study, the researcher focussed on prostitution as a problem, and the extent to which substance abuse compounds problems that emanate from prostitution.

Prostitution and substance abuse are viewed as twin problems that affect public health. While a great deal of research has concentrated specifically on substance abuse, many researchers agree that substance abuse, directly or indirectly, is either the cause or the effect of many problems that assail humanity (Rocha Silva, 1996:1; The National Institute on Drug Abuse, 1999:48; The National Drug Master Plan, 1999:1; The Drug Trafficking Act, 1992 (Act 140 of 1992); The Prevention and Treatment of Drug Dependency Act 1992 (Act 20 of 1992).

At present, South African law regards the performance of sex work as a criminal offence in terms of section 20 (1) (aA) of the Sexual Offences Act. No. 23 of 1957. The fact that the sex work industry is criminalised, implies that sex workers are unable to make use of existing legal mechanisms when they are subjected to violence, for example in the form of sexual assault, while executing their work. In addition, sex workers are vulnerable to violations of human rights in the form of police harassment and unlawful arrest and detention (Combrink, 2004:1 and South African Law Commission, 2002:24)

Consequently, sex workers may also find it difficult to access public health services in respect to HIV and AIDS and other sexually transmitted diseases. In order to ensure that the legal and health systems are more accessible to sex workers, the researcher felt compelled to examine the policy that control the sex work industry in South Africa, for the purpose of attempting to ameliorate the situation.

Thousands of people in South Africa are victims of HIV and AIDS which are transmitted sexually, yet no research has as yet been conducted as to whether such people are directly involved in sex work, or whether they are victims who have been infected by sex workers. During the apartheid era, researchers in South Africa viewed problematic issues in isolation and never in combination, as they had to present results of the different ethnic groups - black, coloured, Asian, and white separately. Much research was accordingly presented as either the cause or effect of problems.

The female sex workers were trained in the above-mentioned areas so that their conditions could be improved. The trained female sex workers were classified as the intervention group, while those not trained were classified as the standard group. Both groups received male and female condoms and other benefits such as toiletries.

5.3 RESTATEMENT OF THE AIMS AND OBJECTIVES OF THE STUDY

5.3.1 Restatement of the aims of the study

The primary aims of the study have been to create awareness amongst sex workers that their lives are of value and they need to take precautions towards avoiding HIV

and AIDS over and above earning a means of livelihood. The study is also aimed at providing preliminary guidance to program planners and policy-makers regarding risky behaviours which are related to substance abuse and sex work preventive action and policy that would facilitate prevention efforts to be appropriately developed and targeted.

The secondary aims of the study were:

- To equip women sex workers with skills and knowledge to help them take decisions and create for themselves a more stable lifestyle.
- To develop a peer-educator model that could be replicated in other provinces where women manifest a high rate of risky sexual behaviour.
- To stimulate future research endeavours in new or under-researched areas within the drug abuse and sex work field.
- To broaden the knowledge base of social work by developing knowledge and skills for social work practice in the area of substance abuse and sex work.

5.3.2 Restatement of objectives of the study

To fulfil the aims outlined above, the following objectives were set:

- To conduct focus groups in order to gain insight into the substance abuse and sex work problem and thus assess appropriate forms of intervention which would yield success and also to gain an understanding of the extent of substance abuse and risky behaviour that is manifested by sex workers.

  This objective was achieved because five facilitators (the project team) held focus groups with sex workers from the women focused intervention group (WIG) and the standard intervention group (SIG). From the data gathered at the focus group discussions an intervention tool (programme) was developed, refined, and reviewed. The respondents gained information on preventing and protecting themselves from manifesting risky behaviour. Subsequently, many of the respondents reported success stories of reducing substance intake and having increased condom use. Out of this focus discussion a substance abuse and sexual risk behaviour prevention programme was developed and the

respondents (sex workers) served as the experts to (provide information and evaluate the programme). Focus group discussions had been conducted in small groups (each group had five members) and each member was able to participate actively in the group. The implementation of the tool by the women focussed intervention group was enabled as it reflected the real life situation of women in the sex work industry. The schedule used to guide the group discussions was interpreted and tested prior the implementation. (See Appendix C)

- To review the national and international literature on drug abuse and sex work theories and policies in order to gain a clear understanding of the issues raised and gaps created in this field.

  This objective was achieved as reflected in Chapters Two and Three. Chapter Two outlined a critical review of substance abuse and sex work as based on the findings of the experts (researchers). The problem of substance abuse among sex workers was found to be common. This study has demonstrated that it is a national and social problem of high magnitude and requires attention if the war on HIV/AIDS is to be won. In Chapter Three the researcher provided an overview of the link between substance abuse and sexual risky behaviour as based on other researchers' findings. She also alluded to policy implication towards controlling the problem.

- To develop, review and modify the guiding questions for use in the focus group discussions and in-depth interviews to suit the socio-cultural context of the participants.

  This objective was achieved. Twelve guiding questions were developed and used as themes in focus group discussions in order to obtain qualitative data from the respondents (See.4.2.2 and 4.10.2 respectively).

- To examine ways in which sex workers can protect themselves against harm, violence and HIV infection.

  This objective too was achieved. A tool to assist the respondents to protect themselves against harm, violence, and HIV infection was developed and subsequently utilised by the respondents. There was a noticeable change in

behaviour among the respondents in the WIG in contrast to those in the SIG (See.4.1 – 4.10.6).

- To develop, review, and modify the original intervention schedule from North Carolina Supplemental study through conducting a pilot study with sex workers to test the feasibility of the tool and to ensure clarity, comprehensibility, and simplicity.

  This objective was achieved as well. Focus group discussions were conducted with the sex workers and the results were analysed. The results were used in the base line study, which was subsequently followed by an intervention programme.

- To conduct process and impact evaluations of the HIV/AIDS and substance abuse prevention programme through the administration of a pilot study, post-test, and follow-up schedules.

  This objective was achieved. A pilot study was conducted and it was subsequently followed by the implementation of an intervention programme and a follow-up study (See Appendix, A, B, and C).

- To identify qualitative key contextual factors related to HIV risk behaviours among substance using female sex workers operating from hotels.

  This objective was achieved. Data were collected from the respondents and subsequently analysed, interpreted, and presented in Chapter Four of this study.

- Designing an intervention programme after being informed by the qualitative data that have taken these contextual factors into account.

  This objective was also achieved. A prevention programme (intervention tool) was developed and implemented to assist the sex workers to protect themselves and acquire skills to negotiate for condom use with their clients (See application of intervention method in Chapters One and Four).

- Identifying strategies that maximize subject recruitment and participation in such an intervention.

  This objective too was achieved. In-depth interviews with the gatekeepers were conducted in order to prepare for the smooth entry of the research team into the

field of sex work. There were a number of hurdles that the researchers had to pass before actual recruitment could be done successfully (See Chapter Four on In-depth interviews).

It was difficult to determine the scope of the connection between substance abuse and risky sexual behaviour due to the small-scale nature of this study.

The recruitment technique for sex workers was very difficult as the researcher had go out onto the streets were the sex workers do business from 22h00 onwards as they start operating at that time. On other occasions, the researcher had to be accompanied by the men who work with them.

5.4 RESTATEMENT OF THE ASSUMPTIONS OF THE STUDY

An exploratory study generates a hypothesis, which could be used to guide future research studies. In order to guide the researcher and provide direction to the study, the following hypothesis was formulated:

If prevention initiatives are introduced when sex workers are already practising their trade, the risk of being unsuccessful becomes high, because sex workers would already have learnt inappropriate and health compromising behaviour or sexual risk behaviour which they might find difficult to change.

This hypothesis is further supported by the following assumptions:

- Risky sexual behaviour is a complex phenomenon, which is impacted upon by a variety of factors that interact and influence one another.

  It is important that substance abuse and risk behaviour programmes be introduced, prior to the initiation of individuals into sex work. This assumption was supported by factors which were identified during the focus group discussions with the sex workers and in-depth interviews with the gatekeepers. For example, it was found that substance use and abuse and other risky behaviour such as not using a condom, were common practices among sex workers. The major problems encountered by the female sex workers were addiction to drugs, violence meted out to them by clients who are reluctant to pay for services, and a lack of education and skills to enable them to take alternative jobs. The sex workers generally engaged in risky behaviour, which

entailed a very low rate of condom use when they had sex with their lovers, and clients who offered a higher fee for service rendered; in spite of having knowledge about HIV and other STD infection. The evidence underlines the fact that the sex industry may involve a very high risk of HIV infection. In some cases, a notable proportion of sex workers admitted having used drugs intravenously and also being regular users of alcohol or other non-injected drugs. The heavy use of alcohol or other psychoactive drugs is often associated with unprotected sex (Plant and Plant, 1989:53-4; Ridlon, 1988:27-8; Stall, 1988:78; Connant, 1988149, Coutinho, Andel and Rysdyk, 1988:207-8).

- Sex workers need a comprehensive and integrated, culturally appropriate programme that would provide them with:

o Knowledge on substance abuse and risky behaviour prevention. This would help them to decrease the tendency to take risks and to be consistently conscious of the consequences of risky behaviour.

o A change of habit. They should be implored to increase stable relationships, which entail emotional attachments and the willingness to work in groups to be able to protect each other in violent situations.

The latter was achieved in the study. The respondents in the WIG moved in groups and they were provided with whistles, which they blew to alert one another whenever any of them found herself in a threatening situation.

o Adequate knowledge on risky behaviour in relation to the sex trade. This would help them to make informed decisions and to willingly act in ways that would lead to improvement in their lifestyles.

This assumption was achieved as the respondents in the WIG responded positively to the programme on the dangers of unprotected sex and what to do in bad situations. They subsequently reported a decrease in violence meted out by clients after they had started moving in groups and using whistles.

Research efforts that allow sex workers to participate will benefit them to be more informed and appropriate. When conducting interventions in the area of changing behaviour and, dealing with the actual problems encountered, the sex workers will provide first-hand information. This type of research will be in a position to provide

researchers with knowledge of new patterns and risks, trends, and the extent of drug use among sex workers.

Literature on sex work suggests that diversion programmes for those arrested early in their sex work career may be the paths that criminalisation proponents might consider. However, for those arrested later in their sex work career it is suggested that multiple criminal justice interventions, such as time in jail, probation, mandatory 12 step meetings, regular urine testing, when coupled with sanctions from child protection services and the individual's desire to leave sex work should be considered as these, did have an effect on women's motivation to leave the sex work business.

Decriminalisation activists may use this information on sex work stages to develop assessments and treatments that are congruent with specific stages. An assessment tool for health and social work professionals practising in the field could potentially be developed to enable workers to make appropriate assessments. Once the tools and capability to appropriately make assessments are complete, professionals will have the ability to make more appropriate referrals. This natural progression of knowledge building will illuminate gaps in services and precipitate the need to develop and expand existing services to accommodate new assessment information. Programme developers and advocates will be needed to create sex work specific programming in order to provide services to address particular needs according to such assessments. Social workers should therefore, be employed to fill the gaps between need and service, while serving their profession's mission of serving the poor, vulnerable, and oppressed

Free-choice proponents argue that legalisation will decrease the amount of violence and risk suffered as a result of the lack of societal protections afforded other professions. They argue that for sex workers, it is a matter of oppression and distorted perceptions. While others view the stages of sex work as the progression of problems and issues, free-choice advocates see sex work as a job. Entrance may be viewed as a choice while social adjustment may be seen as the time to learn one's role in a new, although dangerous, profession. They maintain that by regulating the profession and providing benefits and protections under the law, sex work will become a safer

enterprise. It is expected that social immersion may be perceived as nothing more than commitment toward obtaining the capitalistic fruits of a dedication to one's career, much like that of any other dedicated professional who seeks the fruits of his or her labour. The free-choice activists may view the "caught up" stage as a response to repeated violence, degradation and stigma, all of which are caused by environmental conditions that would be minimised with legislation. The position sex workers have is the right to prosecute to the full extent of the law any client who assaults them much like any other hard-working citizen.

It is clear that for several reasons, be it criminalisation, decriminalisation or legalisation of sex work, when a group is marginalized and locked out of the mainstream economy, its members are forced to participate in an underground economy. Although the implications for policy and practice approaches differ, the goal of both remains the same - to enable street sex workers to participate in mainstream society and become part of the solution to problems that have been identified by many citizens.

- **An increase in self-esteem.**

A life skills programme which included self-awareness and self-esteem, was provided to the respondents in the WIG. This programme had the effect of increasing the self-esteem of the respondents. After the respondents in the WIG had been exposed to the programme, the research team observed a change in their behaviour and they too reported an increase in self-esteem. In the follow-up study, the respondents stated that they had no difficulty in rejecting offers of a higher fee from clients who wanted sex without a condom. They mentioned that they always negotiated for condom use at every sex encounter.

- **Increase strong bonds with the family.**

The respondents were able to work and also to make time to visit their families. A significant number of those in the WIG reported that they had been able to send money home for the maintenance of their significant others and siblings.

- Developing a strong bond with institutions that promote appropriate norms and values that build society, such as the family, school, and religious organisations, and good social clubs that do not serve substances of abuse.

  The respondents were advised to love themselves and to avoid risky behaviour. Most of them reported that they were affiliated to some church. They requested that they be taught some skills to enable them to take alternative jobs. Some were even willing to serve as peer educators to other sex workers.

5.5 DEMONSTRATION OF HOW THE INITIAL PROPOSITIONS OF THE STUDY WERE ADDRESSED

The current section, the researcher reflects on whether the intervention research process, which was undertaken in the study, actually addressed the initial propositions of the study or not. It is important here to highlight the ethical considerations regarding research in substance abuse and risky sexual behaviour. A study of sexual behaviour implies that information about the most private intimate sphere of human life and the interest of the researcher might violate the individual right of respect and discretion. The more overt the research, the more likely it is to get socially desirable accounts, while the more covert the study, the more likely it is to detect the truth. In reality, there might be a legitimate interest to know about some hidden private behaviour in order to develop protective means for potential victims such as in cases of abuse, but this interest has to be balanced with the right of the individual of a protected sphere of privacy (Lee, 1993:7)

The growing need for research in the field of sexuality has created an awareness of the necessity to define ethical principles applicable in sexual behaviour research. The following principles also governing research with human subjects in other fields are equally applicable in sex-research:

- **Risk versus benefit**

Sexual behaviour research has to be critical about the question of whether the risk for an individual might be justified by the benefit for the community because it is easily suspected of voyeuristic motives. No survey should be organised without a service to the community under study. This study provided respondents with life skills

which served to protect them from violence. From its findings, a policy to protect sex workers and provide them with the services that could be friendly to them and also strengthen the voice of the sex workers could be developed. This means, a policy that recognises the human rights of a specialised group (sex workers) can be developed, to the benefit of the entire community.

- **No harm**

Research should not jeopardise the psychological well-being of an individual. There should be a critical analysis of the level of understanding and experience of the vulnerable group addressed. In this study the respondents (women sex workers) were taught self-protection and negotiation skills while no blood was drawn from the participants.

- **Confidentiality**

Interviews were conducted in a private context and the questionnaires were self-administered to guarantee the respect of privacy as individual behaviour or experiences were asked for. Confidentiality observed by all the interviewers (research team) and the assistants charged with data analysis. Sensitive data was handled with utmost care and professionalism. In this study, procedures of confidentiality were made explicit to the interviewees and discussions were held in secluded venues where there was no noise or interference from clients' handlers and friends. Maximum participation of all respondents was ensured by providing them with food, toiletries and condoms at all sessions.

- **Autonomy**

Autonomy refers to the respect of the individual, his or her right to consent or to withdraw. In this study, consenting implied that the individuals understood what they were asked for and that they were aware that they could withdraw participating at any stage of the research process. The different phases of the intervention research process were explained fully to the participants prior to their signing of the consent forms. Incentives were provided to compensate for business time that had been lost while the respondents were participating in the study (Ringheim, 1995:1691-1695 and Schoepf, 1991:749).

- **Ownership of the intervention programme**

De Koning (1996:10) points out that investigators have a moral obligation to give those involved in the research a chance to find out the results of the study by making these accessible to them. In this study a feedback workshop was organised to provide the respondents with the preliminary report and they expressed their appreciation for this process. The respondents were provided with an opportunity to gain information from the researchers and from one another (peers). A programme was developed together with them, to facilitate their participation in the development, refinement, and evaluation of the programme. The participants had an opportunity to reflect on their problems as well as on possible solutions to their problems. The participants provided information needed by the research while they gained knowledge from life skills programmes and focus group discussions.

The primary aims of the study were to create awareness amongst sex workers that their lives are of value and they need to take precautions towards avoiding HIV and AIDS over and above earning a means of livelihood and to provide preliminary guidance to programme planners and policy-makers regarding risk behaviours related to substance abuse and sex work preventive action and policy that would facilitate prevention efforts to be appropriately developed and targeted.

The secondary aims of the study were as follows:

- To equip women sex workers with the skills and knowledge to make decisions and create a more stable lifestyle.
- To develop a peer-educator model that could be replicated to other provinces with the high sexual risk behaviour.
- To stimulate future research endeavours in new or under-researched areas within a drug abuse and sex work field.
- To broaden the knowledge base of social work by developing knowledge and skills for social work practice in the area of substance abuse and sex work.

5.6 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

The following summary provides the of major findings from this study:

5.6.1 Pretesting the feasibility of the study (pilot study)

A pilot study was conducted during the information gathering and synthesis phase of the intervention research process, prior to the focus group discussions with the sex workers and the in-depth interviews with the gatekeepers. The purpose of the pilot study was to explore qualitative issues relating to sex work and the experience and emotions it evoked in communities where it existed. This study was adapted from the North Carolina Women's CoOp study tool that had been designed for the woman-focussed HIV prevention programme. This programme was used on women in Pretoria who were in the sex trade and also used cocaine. The study was organised around the development of personal power through the reduction in drug use, strengthening negotiation skills for sexual protection, and increasing skills to prevent sexual violence.

The qualitative data collected during the initial stages of the pilot study revealed that many women who are trading in sex in South Africa, do so in order to survive economically and that they also abuse alcohol and other drugs to help overcome fear and shyness in conducting their trade. The majority of female sex workers come from disadvantaged backgrounds, have little or no education and lack the skills that are necessary for formal or informal legal employment. A total of 93 women who used cocaine and other drugs participated in this study. A one month follow-up study was conducted after the baseline data had been gathered. Positive changes in the participants' protective sexual behaviours were observed. This was a confirmation of the possibility of reduction of the HIV infection as was later shown in that the number of respondents who reported having used a condom with a boyfriend and or partner during the last sexual encounter had increased for those in WIG from (28% to 55%) when compared to those in SIG (from 44% to 48%) (see Figure ll)

With regard to violence, at the one month follow-up study, the respondents reported that it had decreased remarkably as the following statistics indicate that participants were: beaten by a client (32%), raped by a client (14%), beaten by a boyfriend (22%), raped by a boyfriend (5%), gang raped (4%), and ripped off (19%). These findings show the reality of problems experienced by women in the sex trade. In addition to the violence meted out to them, the women lacked the necessary skills and

education to compete for alternative jobs and had limited access to institutions that might provide them with protection and/or medical assistance. The female sex workers are, therefore, vulnerable to taking risks, which endanger their lives and those of their clients as well as their spouses' and/ or any other person who has sexual contact with them.

A decrease was observed in the daily use of alcohol and cocaine from the results of the baseline to the follow up studies. Among the respondents in the WIG, there was a decrease from 15% to 5%, when compared to those in the SIG (from 17% to 10%) in the proportion of women who used alcohol daily. These findings show that the exposure of women who trade in sex while abusing substances, to life skills programmes, could result in a reduction of their substance abusing habit and subsequently they would take responsible decisions which would lead to an increase in condom use and a decrease in HIV infection. The use of programmes that target a high-risk group such as females who trade in sex could have the desired effect of harm-reduction, as the society in general would be protected from sexually transmitted diseases including HIV and AIDS.

5.6.2 In-Depth Interviews

The age of the respondents' ranged from 21–49 years. This is a critical development stage (young and middle adulthood), which comprises people who are still sexually active. Quite a significant number of people (males and females) in this age group are involved in the sex industry although women are in the majority. People in this trade interact actively and are inclined to be companions, hence male sex workers volunteered to participate in this study as they claimed that they knew and understood the activities of their peers very well.

- **Perception of gatekeepers**

The gatekeepers had played a major role of accompanying the research team to the venues where prospective respondents resided. They had also played a significant role in helping to choose the venue where focus group discussions could be held with a selected sample of respondents. In the initial phase, respondents were taught about the dangers of using drugs and had also been provided with gifts and flavoured

condoms, before discussions on their risky behaviours were discussed. Respondents were urged to quit smoking and doing drugs. Some gatekeepers perceived this as empowering sex workers with self-defence skills as respondents could take responsible decisions and refrain from risky behaviour that might endanger their lives when they were not under the influence of drugs. Gatekeepers evaluated the programme as successful. They reported that some respondents had been empowered by the programme and had subsequently quit doing drugs.

- **Perception of people on the street about the study**

People on the street observed that sex workers (respondents) liked the study very much and freely talked about the programme to their peers. They perceived the study as empowering to the women (respondents) as many of them had subsequently changed their lifestyles and had overcome some of their personal problems. The study was rated a success, as it had, according to observers, proved that it was possible for sex workers to stop drugging and to take control of their lives, instead of surrendering themselves to drug dealers who took most of their earnings. They mentioned that respondents were happy with the researchers' adherence to the principle of confidentiality and were ready to give honest responses to sensitive questions, as they were sure that their identities would not be revealed anywhere.

Hopes were expressed that all people (particularly the sex workers) who were victims of drug dealers could receive attention and be rescued from their plight. The role of the U S researcher was commended, as she was perceived to be representing the interests and empathy of Americans in general, towards South Africans who had drug problems. Concern about the HIV and AIDS pandemic in the country was also expressed by people on the street. They mentioned that many women (sex workers) were dying of HIV and AIDS related diseases. They hoped that the study would be the first of many others which would highlight the South African Government's attempts to help people who were vulnerable to HIV/AIDS infection. They hoped that the results of the study would serve as a resource, which would help the government towards developing policy toward alleviating problems that made women vulnerable to risky behaviour and HIV infection.

- **Establishing trust and credibility with sex workers**

The respondents mentioned that trust could be built through openness between two parties - the research team and themselves. They explained that credibility depended on mutual assistance. No party should feel threatened by the other and if one party should encounter problems, attempts should be made to solve these immediately. The manner in which the research team negotiated and eventually worked with the respondents increased trust between them and the sex workers. All the respondents honoured appointments and whenever they had an opportunity, they talked amongst themselves about the information they had gained at each session, the gifts they had received, and the impact these had on their lifestyles. The respondents suggested that the project team should contact them through persons who worked or lived at the places where they resided, in order to increase trust. They preferred that contact persons should be selected either from security guards and/or females who were cleaners at the residences. They suggested that contact persons should be women, as they said that women would be more empathic while men were only interested in enforcing rules at their work places. The respondents felt threatened by men and were more comfortable with female contact persons. They emphasised that the study team had to trust the contact persons as they were gatekeepers who were employed at the residences and their duties entailed minimising drug trafficking at the residences. Some gatekeepers were described as honest as they were Christians. The research team was implored to show respect, empathy, and support for the gatekeepers and not to be judgemental towards them, if they were to win their trust. The respondents were ensured that those who were found to be at an advanced stage of drug addiction would be taken care of – by being removed and placed where they would receive special treatment for a period of six months, away from the drug environment.

- **Identity for sex workers (T-shirt and ID)**

The research team and all the respondents were identifiable through a particular T-shirt and IDs.

- **Additional benefits to respondents**

The respondents who needed treatment were transported to treatment centres by the research team. This activity made them feel comfortable and provided them with an opportunity to confide in the research team. The respondents mentioned that they and all other women in the sex trade felt remorse about the manner in which they earned their livelihood. They had no choice but to opt for sex work, as they could not find alternative jobs to meet their responsibilities. They wished that this study would assist them to stop using drugs. They suggested that the research team should visit sex workers regularly and educate them about the dangers of using drugs. They implored the research team to be very patient when they work with sex workers as many of them had a drug problem and were inclined to act impulsively. They needed to be taught to love their bodies and to increase their self-esteem. They also proposed that they should be assisted with their personal problems - such as transportation for those who needed to go to hospital. The respondents mentioned that they did not know their HIV status but were aware that they were prone to STI and HIV infection. They reported that they often needed support to accomplish minor tasks.

Clearly, the sex workers used the opportunity offered by this exploratory study, to convert it into an intervention study that benefited them. They bargained for their needs to be met by the researcher in exchange for honest responses and data that the researchers required. This intervention study was carried through all the phases as suggested in De Vos et al (2002:394-418). The study was, therefore, effective as it focussed on the women's real situation. The women participated actively in designing the intervention programme and in turn learned some skills, which helped to reorient them to normal life tasks.

- **Exploring possibilities of the women taking alternative jobs to sex work**

The respondents affirmed that they would be happy if they were provided with jobs and skills as an alternative to sex work, which they associated with drugging. They stated that they would stop doing sex work and drugs If they were offered alternative jobs with a regular income and an opportunity to plan their future. They stressed that there was neither joy nor dignity in a job that sometimes entailed having sex with up

to twenty different men on the same day. According to them, sex workers walked the street at day and night time seemingly looking content with what they were doing, yet in the morning when they reached their residences, they felt pain and were ashamed of the things they had to do to secure an income and they wept in bitterness. They shared one another's pain, comforted one another and in vain, planned on how to get out of the trap they were finding themselves in. They reported that they got into the habit of abusing drugs as a means of finding solace and relief from the traumatic experiences that emanate from sex work.

It was apparent that the women definitely needed skills and ways of generating income without stress and the anticipation of violence. A life skills programme that would educate them and improve their lives through skills development would improve their situations.

- **The best way and times to reach sex workers for research purposes**

In terms of time, it was reported that the female sex workers could be contacted at about 20H:00 in the evening. Others proposed that the right time to reach the female sex workers was on Saturdays. The best location proposed was the Marabastadt area and the hotels that housed the female sex workers. They could also be contacted during the day, when they were sleeping and would then be sober, as they usually took drugs at night when they engaged in sex work. In the Marabastadt area, they could be contacted during the day and in the afternoon, as most of them lived in RDP houses in Mamelodi.

The participants stated that sex workers would respond positively, if they were approached with respect. The majority of these female sex workers were reported to be using alcohol and drugs. The drug habit was said to be a secret they kept from their spouses or boyfriends. Allegedly, they used drugs only before they met with clients and never in the presence of their boyfriends/spouses. They stated that safety in using a condom when engaging in sexual intercourse could not be totally guaranteed.

The respondents suggested that as part of their observation process, the study team should visit a particular gatekeeper where the sex workers resided. On their arrival they should buy something to drink. While they were sipping their drinks, they should watch the trafficking of drugs and the way the sex workers operated. They would see the female sex workers constantly going to the toilet, to have sex. They advised the team to go to the toilet for closer observation of the sex trade and trafficking of cocaine. They alleged that immigrants and the youth were the main suppliers of drugs to women sex workers who made between R500 and R700 per night, most of which was spent to support their drug habit. They alluded to the fact that drug abuse is very difficult to stop. They emphasised that the environment also contributes to drug use. They suggested that whoever wanted to stop using drugs should stay away from places where drugs were sold.

The research team visited the gatekeeper whose name had been provided. They were able to confirm the information that had been given to them and also secured assurance that the intervention programme would not be hindered. It was essential that the proposition that the sex workers should be placed under the supervision of a credible counsellor to assist them to stop using substances of abuse, should be taken seriously. The research team also took into consideration the suggestion that the prevention programme should target the social and physical environment where the sex workers resided, if the goal to help them to quit substance abuse and risky sexual behaviour was to be realised.

- **Problems encountered with sex workers who had not been selected for the study**

- Sex workers who did not meet the criteria of the study felt discriminated against when they were not selected. The study team always had to explain to the hopeful sex workers who thought the researchers might change their mind and include them in the study later on, each time they picked up the respondents for focus group discussions.
- The respondents insisted on keeping their identities secret. The main reason which was advanced for doing sex work by almost all of them was that they had families who depended solely on them for maintenance, so they had come to

Gauteng to get jobs with a high income as quickly as possible while they had no skills at all. Their dependents did not know that they were sex workers. The respondents stated that they were particularly afraid of photographers who might publish their pictures in newspapers that might be seen by their next of kin.

- The respondents preferred to confide in other sex workers who would be more empathic to their plight. The research team were thus advised to pretend to be sex workers too, so that they could win the trust of the respondents and not be seen as nosey people who were out to expose the sex workers and destroy the industry.
- The participants in the study reported that sex workers were providing one another with bad advice. They were accused of being careless and scattering used condoms all over the place. They neglected personal hygiene too.

The respondents clamoured for respect and acceptance. They preferred not to be judged as bad people but rather to be viewed as stranded people who did what they did to eke out a living.

- **Assessment of benefits of the study to the respondents**

The respondents reported that they had benefited knowledge and skills from the programme, while they had also been paid for their time and were further rewarded with gifts such as flavoured condoms that they had never been exposed to before. They also reported that other sex workers who had not been selected for the study envied them and this served to elevate their self-esteem and image among their peers.

From the focus group discussions, it was deduced that many sex workers were in danger of STIs as they did not always use a condom in their business. While they were aware of the existence of male condoms, their knowledge of condom use was low. For example, they sometimes used more than one condom together “as security against their bursting”, yet this practice was more dangerous than safer. The intervention programme had also created awareness of and interest in female

condoms, which were initially unknown to some while others were reluctant to use them.

- **Exploration of the feelings of the respondents and what was needed to sustain their participation**

The respondents demonstrated their willingness to cooperate with the researchers and their interest in the study as they suggested that the research team ought to visit them at their residences in order to have an idea of the conditions under which they were living; namely, in hotel rooms, which were rented in the drug dealers' names. Each dealer rented only three rooms, which had to be shared by the sex workers for sleeping and also for business as they worked at different times. They reported that the drug dealers catered for them only when they were well and were in a position to do business. However, anyone who took ill was immediately chased out of the accommodation. The researcher noted that female sex workers needed a shelter where they could operate more safely than on the street where they are exposed to various dangers. The women lacked accommodation and ended up being accommodated at places where they were introduced to sex work. Peer pressure also played a notable role towards the females using drugs.

The female sex workers plied their trade at different times. Some worked during the day, while others worked at night. They suggested that the research team should know each respondent's free time in order to appropriately schedule them for focus group discussions. They indicated that they would always be available during their free time and they did not mind being woken up for discussions when they were sleeping, as long as the researchers made them aware of when they were needed and provided them with transport to the appropriate venues for discussion.

The respondents were accordingly scheduled for focus group discussions in accordance to their free times. The fact that the dealers owned the accommodation where the sex workers lived and worked, made it necessary to empower them to negotiate their conditions of work and to distinguish between time for work and free time. The sex workers had to know their rights and not be at the mercy of their bosses for 24 hours each day.

- **Pattern of drug use**

The respondents used the concept “starter” to refer to the first intake of drugs, which they took before going to work. They admitted that the “starter” left them in a state of indifference, ready to do whatever was demanded of them in their job. They mentioned that the “starter” carried them through the entire shift. It made them crave for more drugs and at times, they got tempted to steal money and cell phones from their clients to acquire more drugs and to pay the dealers which they always owed for the drugs supplied to them.

The respondents reported that their addiction often led to stealing which always got them into trouble with the clients. They were often subjected to violence by angry clients and the drug lords, which they always owed some money. It became clear that the sex workers spent most of their earnings on drugs. A daily dose of the “starter” turned them into addicts and the suppliers of the drugs took most of their earnings. The drug dealers virtually controlled the sex workers as they supplied them with both accommodation and drugs and monitored all their movements. Attempts at treating sex workers for drug addiction would be futile as long as they were living and working in premises where drugs were accessible and supplied on tick; yet it was essential that they should reduce their drug taking in order to experience less violence. In the intervention programme, respondents were taught communication skills as a way of abating violence from clients. They were taught to talk politely to their clients and to avoid initiating fights. They had to avoid provoking their clients and their lovers into beating them up.

The intervention programme provided, the respondents with skills on protecting themselves from violent clients and to prevent being victimised by their clients. The respondents reported that the programme had given them an opportunity to rethink their positions and to realise that they could change their destinies hence some had made an effort at reducing their alcohol and crack intake. They claimed that while they found it easier to reduce their alcohol intake, it was not easy to stop using crack and they needed professional help to accomplish this.

The intervention programme targeted women sex workers and taught them to take control of their lives and to use a humane approach when they interacted with other people. They learnt to negotiate in an assertive way and to refrain from displaying aggression.

- **An analysis of relationships between security officers and sex workers**

The respondents mentioned that they usually had, a good relationship with security officers. They stated that while some police officers treated them well, some often mistreated them. Some demanded bribes and others raped sex workers and then released them without charging them. Security officers never mistreated or raped them and readily came to their rescue whenever they encountered problems. They were always ready to intervene and protect sex workers whenever there was conflict between them and violent clients. The respondents implored the research group to involve security officers in the intervention programme for peer educators.

5.6.3 Focus Group Study

All the participants were women sex workers whose ages ranged from 21 to 50 years. They were single and had reported to be having either a steady boyfriend or a live-in partner. There was an over-representation of women between 21 and 30 years. This could be attributed to the fact that at 21 years most women are regarded as mature enough to be able to fend for themselves. This age group attracted a wide spectrum of clients. The participants belonged to the following ethnic groups: Basotho, Batswana, Bapedi, Xhosa, and Shangaan. The participants all came from the lower socio-economic level and reported their source of income as their boyfriends or clients. None of them had any skills or schooling beyond a senior certificate, hence they did not qualify for any other job except domestic work. About 90% of the participants came from the Northwest, Free State, Eastern Cape, and Limpopo while only about 10% came from Gauteng, in particular, townships around Pretoria (Mamelodi and Atteridgeville). The majority of the participants, came from rural areas while a very low number came from historically disadvantaged townships in urban areas.

5.6.3.1 Safety precautions in commercial sex work

- **Condom use**

The respondents reported that they used condoms every time they had sex with clients except when they had sex with their boy-friends, or clients who offered a higher fee for sex without a condom. They were willing to take risks whenever a client offered them a higher fee for sex without a condom. They defined a boyfriend as a lover, who is true to his girlfriend as his only sex partner and, therefore, condom use was not necessary among lovers. The respondents mentioned that they trusted their lovers. A client was described as someone who exchanges sex for money and always had several girlfriends with whom he had sex, hence it was necessary to use a condom with him to protect themselves as the clients could not be trusted. The respondents also perceived a client as someone who is ugly, dirty, and they strongly felt that they could not risk their lives by not using a condom with such a person, yet they desperately needed his money.

They were not quite convinced about the reliability of male condoms, particularly the ones supplied for free at public institutions. They reported that these burst easily, as their quality was poor. They indicated that they constantly used two to three condoms together as a precautionary measure to prevent contracting any sexually transmitted infection. They did not realise that this practice was dangerous as it caused friction, which made the condoms more susceptible to bursting.

The respondents were exposed to the female condom for the first time in the study. They reported that female condoms were much stronger than male condoms, however, these were not as yet easily accessible. In addition, female condoms were expensive and scarce in the country. They were impressed by the fact that they could wear the female condom before going out to solicit clients and even when they met clients who offered a higher fee and insisted on “no condom”, they could oblige without the client realising that they were wearing a condom. Mixed feelings were expressed about the female condom. The respondents reported that the female condom made some noise when the user was walking. The noise was interpreted by some as part of the sexual pleasure while it was regarded as irritating, by others. Although the respondents stated that they disliked washing and reusing female

condoms as is the practice in other countries and also because it is reusable since it is much more expensive than the male condom, they resolved that in future, they would wear the condom before going out on business, in order to avoid infection.

The respondents were impressed by the quality and flavours of the male condoms that were supplied to them during the study. They appreciated the information they had been given on the care of female condoms and indicated that they would consider using them now that they had information on them. It was noted that condom use by women sex workers before the study, had been sporadic. The respondents mentioned that the study had provided them with essential information regarding the dangers of indulging in substance abuse and sexual risky behaviour, while they were plying the sex trade. Information supplied in the intervention programme and exposure to stronger and flavoured condoms would hopefully induce sex workers to realise the importance of constant condom use as an essential safety measure.

During a spot check, it was found that very few respondents had condoms with them, ready for use. The respondents were, however, honest in stating that they never remembered to use a condom with their clients when they were under the influence of substances (alcohol, dagga and/or other drugs). They acknowledged the fact that while they professed to trust their lovers, they could not guarantee that their lovers did not have sex with other women besides them.

- **The oral dam**

The women sex workers reported that they liked the oral dam as a barrier that reduces the risk of contracting sexually transmitted diseases when participating in oral sex. They were impressed by the fact that it comes in flavours, such as strawberry, mint, grape, vanilla, and banana. They indicated that the oral dam served as a major barrier in preventing skin contact or contact between body fluids when engaging in cunnilingus (oral/vaginal sex) and/or rimming (oral/anal sex). The unavailability of the oral dam in South Africa as yet, was noted.

With regard to the question on whether their boy-friends could pose a risk to them, they understood that, if the boy-friends were seeing other women they could pose a risk factor to them. The women had to do soul searching regarding their relationships with their boy-friends and concluded that they needed to use a condom with their boy-friends as they did with their clients, because they did not know whether they were seeing other women or not.

5.6.3.2 Perception of the study by people as reported by the sex workers

The study was popular in the sense that the respondents talked about it with the sex workers who had not been selected to participate in the study and also with other curious people about the Women's CoOp T-shirts they wore. In this way, misconceptions such as that the respondents were involved with HIV/AIDS testing, or that they were police informers or drug traffickers, were dispelled.

5.6.3.3. Benefits of the intervention programme to the respondents

The intervention programme helped the sex workers to take control of their lives. They were taught skills to protect themselves. They gained insight into their problems and ways of solving their problems such as the following:

- Knowing their status as women and striving to elevate it in society and to develop self-confidence.
- Working on how the respondents could protect themselves from violence and rape. In order to counteract this situation, they agreed to work in groups so that they could support each other.
- Reacting in the case of a bad situation. The respondents were taught to scream for help in order to scare off violent clients and to blow a whistle in case any man wanted to harm them.
- Stopping being ripped off. The respondents learnt that their lives were at risk and that rape places victims at special risk for HIV, hepatitis or STIs. They needed to protect their health, valuable lives and their earnings.
- Empowering the respondents with knowledge on the use of condoms. The respondents learnt that the consistent use of a condom would protect them from

STIs. They were worried that the condoms they were using were oily and the ointment could damage their womanhood. They mentioned that the vagina sometimes emitted an awful smell. They were advised that if they experienced any awful smell from the vagina, they could get antibiotics such as Flagyl from the doctor to treat the bacterial infection. The respondents got information on flavoured male condoms, female condoms, antiseptic gel, body lotion, food, and the oral dam.

- Learning skills to prepare them for jobs other than sex work. The respondents who were hooked on alcohol and drugs reported that they found it difficult to change their drugging habit. They stated that once they were addicted they spent all the money they gained from sex work to support their drug habit. They believed that when they were high, they became more daring and this got them more clients and more money.
- Information and referral lists on facilities, which sex workers could use whenever they encountered problems (See Appendix D).
- Training on douching. They could use vinegar and water. This practice had been unknown to the respondents and initially they believed that douching with vinegar could get them out of business, as vinegar would enlarge the vagina. They welcomed the idea that they could also douche with plain yoghurt. They proposed that the clinic too should provide douches.

The researcher observed that addicts found it difficult to stop their drug habit despite the fact that when they were high they took more risks and became more vulnerable to STIs.

5.6.3.4 Accessibility of drug treatment centres in South Africa

The respondents reported that they needed strong prayers to keep the devil from dragging them to use drugs. They were sceptical that drug treatment in specialised centres was not always successful. The symptoms experienced by the drug dependents were reported as discouraging patients to continue with treatment. The respondents reported that they needed a clinic where they would be treated with respect and not just be labelled as sex workers who deserved whatever problem they

had. They would be willing to be checked regularly for STI and HIV if they could be guaranteed respect by the clinic staff.

All the respondents claimed that they had experienced harsh treatment and a judgemental attitude at police stations and health centres. However, those who were willing, were given an opportunity to access some treatment centres. Clearly, the experience was good, as they got accommodation and were fed without any charge. The humane treatment they got at the treatment centres helped to restore their feelings of worthiness and to rethink their positions hence some respondents expressed willingness to be trained in skills which would enable them to take alternative jobs other than sex work after they had returned from the treatment centres. These respondents had been rehabilitated and they required re-integration into the community. Those with a low education were willing to accept jobs which offered lower wages, while others preferred to be provided with secretarial skills, which would help them get jobs with an adequate income. They were hopeful that God would provide them with the power not to go back to drugging and sex work. They believed that once they were employed they would function better than they did on the street.

5.6.3.5 Types of drugs used by sex workers

The respondents did not regard alcohol as a drug. They prioritised the drugs they were using as follows:

- Rock was prioritised as the most commonly used drug by women in the sex work trade
- Thai white was the second most used drug.
- Dagga was the third most used drug.
- Home brewed alcohol and dagga in combination were the fourth most commonly used drug.
- Female sex workers used ecstasy minimally.

- The Sex workers used alcohol and a variety of other drugs on a daily basis. The programmes targeting risky behaviour among sex workers must thus include drug education and rehabilitation.

5.7 POST TEST EVALUATION (EVALUATION OF QUALITATIVE RESEARCH AND PLAN FOR FUTURE RESEARCH)

After the intervention programme was completed, -Eight meetings were held to evaluate the programme, and to hear from the participants, suggestions on how the programme could be improved. The Community Advisory Board also provided regular evaluation reports on the progress of the study. The researcher recommends that community advisory board members and the sex workers themselves must be included as part of the evaluation team of the study. It is also important to indicate that the plan for the future in this study is to conduct full-scale surveys using the quantitative design methodology in Johannesburg, Pretoria and Cape Town cities in order to contain the spread of substance abuse and HIV and AIDS in these cities. A larger sample of respondents would be required to examine the extent of the dangers of sex work. Substance abuse and HIV/AIDS in these three cities. The qualitative design had to be added to the body of knowledge in the helping profession, and be complemented by quantitative design which help to reach more people and reveal the extent of the problems.

5.8 CONCLUSIONS

The incidences of substance abuse and sexual risk behaviour among sex workers in South Africa continue to escalate despite numerous prevention efforts that have been geared towards alleviating it, if not actually uprooting it. Substance abuse and risky sexual behaviour among the sex workers have become rooted as a social problem that forms a vicious cycle that warrants discussion and analysis on its own as it unfolds throughout all spheres of existence. Debates on whether to legalise prostitution or not are continuing in parliament, and the South African mass media are thriving on stories about prostitution and the fact that it is an income generating trade which is currently untaxed, yet it is a means of livelihood for a significant number of people. As a major national issue, the debate to review the Sexual Offences Act, No.23/1957 and other related legislations to regulate these

phenomena has not yet started. This social problem has not been accorded the attention that it deserves. More emphasis has been given to HIV and AIDS, yet there is sufficient research evidence that shows that there is a strong connection between HIV and AIDS and substance abuse. Other issues that are receiving attention in South Africa are poverty, unemployment, youth development and care, violence, crime, insufficient housing and other basic needs that could generate votes during national elections. It is important, however, to realise that substance abuse is a crosscutting element and it is either a cause or effect of the national issues that are receiving attention. Scientifically, it could be referred to as confounding for the following reasons:

- The connection between substance abuse, and risky sexual activities, which this study has attempted to address, could stem from a host of personal factors, including a reduction in sexual inhibitions because of the actual pharmacological effect of alcohol or drugs and cognitive impairment caused by drinking or drugging. An individual's personality or risk taking tendencies may also influence any risk behaviour he or she engages in. An assumption that alcohol or drugs would enhance a person's sexual attraction, behaviour, or performance could also have an impact.
- It has been proved that drugs and alcohol cloud judgement and increase the likelihood of unsafe activities such as having sex without a condom.
- Physical and social environments that support the use of alcohol and other drugs may also support the meeting of new sexual partners and new risk behaviours, which may explain the relationship between recent substance use and the likelihood of having multiple partners and poly drug use.
- If sexual risk taking is caused by lessened inhibitions due to substance use, then education might warn users about the potential consequences of such situations, such as the increased risk of STI and HIV transmission. Alternatively, if personality or other unique factors of individuals influence sexual risk-taking and substance use, then prevention efforts might be better focussed on particular groups of people with more specific messages to help them channel potentially destructive risk taking impulses into healthier activities.

- An introduction of awareness and intervention programmes on the dangers of sex work and drugging among disadvantaged communities is essential if the HIV pandemic is to be reduced.
- Follow-up sessions are essential in intervention studies, especially when they promote safe health and the well-being of the participants. In this study the researcher realised that sex workers trusted their boyfriends and did not use condoms with them, yet they too pose the same risk that clients pose as sexual partners.
- In this study, trust between the research team and the sex workers were developed and the sex workers spoke openly about their feelings, experiences, and behaviours. In informal focus group discussions, the respondents revealed information that would not have been explored with a quantitative design methodology. The qualitative design methodology proved to be more effective for conducting research on issues that are sensitive and are generally not talked about.

5.9 RECOMMENDATIONS

Based on the findings and conclusions drawn from the focus group discussions with the sex workers, the researcher recommends the following:

- In order to stop drug abuse, reduce the demand and interdict the flow of illegal narcotics, it is recommended that attempts should be made towards bringing drug users into treatment facilities.
- Substance abuse and sexual risk behaviour intervention programmes should target sex workers of all ages before they develop drug dependency. Intervention programme should be provided in an environment, which is free from elements that could encourage undesirable behaviour.
- Substance abuse and sexual risk behaviour intervention programmes should target the connection between the twin diseases (substance abuse and risky sexual behaviour) in order to effectively provide education and treatment.

- Substance abuse and risky sexual behaviour intervention programmes should be presented in the language appropriate to the participants and be based on real life experiences and realistic representations.
- Substance abuse and risky sexual behaviour intervention programme should be facilitated by peers.
- Substance abuse and risky sexual behaviour intervention programmes should be delivered in small, intimate and informal settings.
- The community need to be mobilised to sustain this community based project. All future studies in the field of risky behaviour and substance abuse should include a follow-up study as well, as this enables researchers to measure positive outcomes of their efforts.
- Stakeholders and service providers should increase their education, information and dissemination programmes to assist in preventing this problem.
- Protective factors to prevent substance abuse and instil good behaviour among young people should be introduced. Young people must be at the centre of strategies to curb substance abuse, HIV, and AIDS. Positive attitudes towards school and reduction in risk behaviours, such as substance abuse, are also benefits of constructive relationships with parents. Strong family relationships can help children develop confidence, withstand peer pressure, and behave responsibly when making decisions about smoking, drug use, violence, and sexual intercourse.
- More prevention efforts need to be based on the best practice model in order to utilise the lessons learned and implement effective programmes that have worked elsewhere.
- Substance abuse and risky sexual behaviour among sex workers must be prioritised and put on both political and public agendas, because if it is neglected it would explode at a later stage and hit the country hard, like HIV and AIDS have done in South Africa-where about 1 500 persons are infected by HIV daily.
- It is important to introduce drug awareness programmes that target substance abuse related problems such as risk behaviour during a tender age because the

long-term effects of the risk behaviour (unprotected sex) learned during these years, may be translated into a range of lifelong problems at a later stage. An informed person is able to make an informed decision.

- Substance abuse and risky sexual behaviour prevention programmes need to address the South African socio-economic realities, such as women sex workers from lower socio-economic backgrounds and associated problems such as lack of education, unemployment, and limited resources. Sex workers need negotiation skills and basic employment skills so that they could be placed in jobs after training and be counselled to stop sex work and live a more challenging life in the country that recognizes human rights and the dignity of all South Africans, without discrimination.

5.10 CHALLENGES FOR SOCIAL WORKERS

Substance abuse and risky sexual behaviour prevention among sex workers are collective responsibilities that require a concerted effort from every stakeholder in a variety of professions. Each profession has to position itself and still retain its own speciality. The findings and conclusions drawn from the study and the recommendations that have been presented here, provide three special challenges to social workers which entail that Social workers must:

- Adapt and refocus their knowledge, update their knowledge through training, seminars, workshops; and in-service training; assume new roles; and have a catalytic influence that is required to deal with contemporary social problems such as the connection between substance abuse and risky sexual behaviour among a high-risk group, such as sex workers.
- Conduct more intervention research in terms of the Rothman and Thomas (1994) model as exposed in De Vos (2002:397). In this way, a body of knowledge and practice skills that are valuable for this noble profession will be developed. Intervention research has triple task of gathering information while providing some service to the subjects and finally disseminating the information.
- Generally, every prevention programme developed out of research needs to be replicable, guided by the good practice model and be specific, measurable, achievable, and realistic and must have time frames (SMART).

- Data from this study reveal that sex workers use alcohol and other drugs on a regular daily basis. This compounds risks they take in the type of business they are involved in. It is thus imperative to note that epidemics of drug abuse, HIV and AIDS hit the poorest sector of society the hardest. Transmission of STIs including HIV is higher among heterosexual people as well.

5.11 CLOSING STATEMENT

In conclusion, it is important to restate the fact that despite many incidences of sex workers that have been found murdered in South Africa, research involving sex work is limited. Sex workers are assailed by numerous problems such as violence, clients' refusal to pay, and sexually transmitted diseases including HIV and AIDS. In this study the researcher focussed on prostitution as a social problem and the extent to which substance abuse compounds problems that emanate from prostitution. The issue of whether to legalise prostitution or not is continuing in parliament. The mass media are thrives on stories about prostitution mass media raises debates on issues like legalising sexual trade as an income generating trade, the legalisation of brothels, and trafficking of women and children for the purpose of practising prostitution as part of the organised crime syndicate. On the other hand, legislation to regulate and contain this problem is outdated and needs to be reviewed. The norms, standards, and policies to protect the health, human rights, and working conditions of the sex trade to operate smoothly, are still to be developed.

LIST OF REFERENCES

Books

Altman, D.A., 1999. **Practical statistics for Medical Research**. Washington, D.C. Chapman & Hall/CRC.

Babbie, E. & Halley, F. 1994. **Adventures in Social Research: Data Analysis using SPSS.** Thousand Oaks, California: Pine Rorge Press, Sage Publications Company.

Babbie, E. 1990. **Survey research methods.** Belmont: Wadsworth.

Barker, R.L. 1999. **The social work dictionary.** 4th ed. Washington, D.C.: NASW Press.

Bell, S. 1994. **Reading, Writing and rewriting the prostitute body**. Bloomington: Indiana University Press.

Benchhofer, F. 1992. **The research process.** In Worsley P. (ed). The New introducing sociology. Harmondsworth: Penguin.

Best, J. 1998. **Controlling vice: Regulating brothel prostitution in St. Paul**, 1865-1883. Columbus: The Ohio State University Press.

Biestek, F. 1957.**The Casework Relationship.** Great Britain: Loyola University

Blacker, J. & Zaba, B. 1997. HIV prevalence and the lifetime risk of dying from AIDS. Health Transition Review, (suppl.2): 45-62.

Bless, C. & Higson-Smith, C. 2000. **Fundamentals of social research methods: an African perspective.** 3rd ed**.** Cape Town**:** Juta & Co. Ltd.

Broomberg, J., Steinberg, M., Masobe, P., & Behr, G., 1991." **The Economic Impact of AIDS in South Africa" In AIDS in South Africa:** The Demographic and Economic Implications, The Centre for health Policy, Johannesburg: University of the Witwatersrand.

Cohen, B., & Alexander, P. 1987. **Deviant street networks: Prostitution in New York City,** Lexington: Lexington Books.

De Beer, F. & Swanepoel, H. 1998. **Community Development and beyond.** Pretoria: J.L. van Schaik Publishers.

De Miranda, S. 1996.**The South African Guide to Drugs and drug abuse**. Cresta, Johannesburg: Michael Collins, Publications.

De Vos, A.S. & Fouche, C.B. 1998. **Data analysis and interpretation: Univariate Analysis.** In De Vos, A.S.**;** Research at grassroots: A primer for the caring professions. Pretoria: J.L. Van Schaik Publishers.

De Vos, A.S. (Ed). 1998. **Research at grass roots: A primer for the caring professions.** Pretoria: J.L. van Schaik Academic

De Vos, A.S. (Ed). 2002. **Research at grass roots: For the Social Sciences and human service professions.** Pretoria: J.L. van Schaik Publishers.

De Vos, A.S. (Editor) 1998. **Intervention research.** Research at grassroots: A primer of the caring professions. Pretoria: J.L. Van Schaik Publishers, Pretoria.

De Vos, A.S. Strydom, H. & Fouché, C.B. 2002. **Research at grassroots. For the social sciences and human service professions**. Pretoria: Van Schaik Publishers.

Decarl, P., Alexander P. & Hsu H 1996. ***What Are Sex Workers' HIV Prevention Needs?*** Centre For Aids Prevention Studies University Of California San Francisco.

Delate, R. 1998. ***Report On The Global HIV/AIDS Epidemic*** Johannesburg: UNAIDS.

Denzin, N.K. 1970. **Sociological methods**. A Sourcebook, Chicago, Illinois: The University of Chicago Press.

Denzin, N.K. 1988. **The Research Act: A Theoretical Introduction to Sociological Methods.** 3rd Ed. New York: McGraw-Hill Book Company.

Denzin, N.K. & Lincoln, Y.S. 1998. **The landscape of qualitative Research: Theories and issues.** London: Sage Publications.

Dhlomo, O. 1994. **Salient elements in the transition from apartheid to democratic government.** In Rhoodie, N. & Liebenberg, I (eds). Democratic nation building in South Africa. Pretoria: HSRC Publishers, Pretoria.

Dunn, D.S. 1999. **The practical researcher: a student guide to conducting psychological research.** Boston: McGraw-Hill College.

Edmonds, L. & Wilcocks, L. 1995. **Teen drug scene, South Africa: A guide for parents and schools, 2nd edition.** Aspen Oak Associates, Pinegowrie.

Farmer, P. 1996. **Women. Poverty and AIDS.** In Farmer, P. Connors, M. & Simmons J. (Eds) **Women, Poverty and AIDS: Sex Drugs and Structural violence.** Maine, Monroe: Common courage Press.

Fawcett, S.B., Suarez-Balcazar, Y., Balcazar, F.E., White, G.W., Paine, A.L., Blanchard, K.A. & Embree, M.G. 1994. **Conducting intervention research: the design and development process.** In Rothman, J. & Thomas, E.J. (Eds). Intervention research: Design and development for human service. The Haworth Press, Inc. New York.

Feldman, M.J. 1995. **Strategies for interpreting qualitative data.** Qualitative research methods. Vol 33. California: SAGE Publications inc.

Fisher, A. A., & Foreit, J. R. 2002 **Designing HIV/AIDS Intervention Research**: An Operations Research Handbook. Washington, D.C.: Population Council Inc: (1-139).

Fouche, C.B. & De Vos, A.S. 1998. **Selection of a research design.** In De Vos, A.S. Research at grassroots: A primer for the caring professions. Pretoria: J.L. Van Schaik Publishers.

Flay, B.R. & Petraitis, J. 1991. **Methodological issues in drug use prevention research: Theoretical foundations.** Rockville: National Institute on Drug Abuse.

Global HIV/AIDS Epidemic Report (1998) Geneva: UNAIDS/WHO.

Goldstein, P. 1979:1-29. **Prostitution and Drugs.** Toronto: Lexington Books.

Gordis, L. 2000. **Epidemiology,** Philadelphia: W.B. Saunders Company.

Grinnell, Jr, R.M. & Williams, M. 1990. **Research in Social work: A primer.** Itasca, Illinois: F.E. Peacock Publishers, Inc.

Grinnell, Jr, R.M.; Rothery, M. & Thomlison, R.J. 1993. **Research in Social Work.** In Grinnell, R.M. Social work research and evaluation, 4th Ed. Itasca, Illinois: Peacock Publishers, Inc.

Gumede, V. 1995. **Alcohol Use And Abuse In South Africa**: A Socio-Medical Problem. Pietermaritzburg, South Africa: Reach Out Publishers.

Hall, D. & Hall, I. 1996. **Practical social research: Project work in the community**. London: Macmillan Press, Ltd.

Harding, S. 1991**. Whose Science? Whose knowledge? Thinking from women's lives**. Open University Press, Hartstock.

Hepworth, D.H. & Larsen, J.A. 1993. **Direct Social work practice: Theory and skills. Fourth edition**. California: Brooks/Cole Publishing Company.

Huysamen, G.K. 1994. **Methodology for the social and behavioural sciences**. Midrand, Johannesburg: Half way House Publisher.

Inciardi, J.A., Lockwood, D. & Pottieger, A.E. 1993. **Women and Crack Cocaine**. New York: Macmillan Publishing Company.

Inciardi, J.A., Tims, F.M., & Fletcher B.W. (ed) 1993. **Innovative approaches in the Treatment of Drug Abuse**. Westport, CT: Greenwood Press.

Jemmott, L.S. & Jemmott, J.B. 1991. Third Edition. Applying the theory of reasoned action to AIDS risk behaviour: Condom use among black women. **Nursing Res,** July-August; 40 (4) : 228-34.

King, J. A. Morris, L.L. & Fitz-Gibbon, C.T. 1987. **How to assess programme implementation.** SAGE Publications Inc. California: Thousand Oaks.

Krueger, R.A. 1994. **Focus groups: A practical guide for applied research.** Second Edition. SAGE Publications Inc., London: Thousand Oaks.

Lambert, E.Y.& Wiebel, W.W. 1990. **The Collection and Interpretation of Data from Hidden Populations**. US Department of Health and Human Services. National Institute on Drug Abuse, Rockville. NIDA Research Monograph Publisher. (98): 4

Latkin CA., Mandell W., Oziemkowska M., Celentano D.D., Vlahov D. & Ensminger M. 1995. Using Social Network Analysis To Study Patterns Of Drug Use Among Urban Drug Users At High Risk For HIV/AIDS. **Drug And Alcohol Dependency**. Baltimore: NIDA Research Publisher. (38:1-9)

Leedy, P.D. 1993. **Practical research: planning and design.** Fifth Edition. New York: Macmillan.

Leggett, T. 1998. **Drugs, Sex Work And HIV In Three South African Cities**. In NIDA (Eds.) Proceedings Of The 3rd Global Research Network Meeting On HIV Prevention In Drug Using Populations, Durban 2000.Washington, DC: U.S. Department Of Health And Human Services.

Lindlof, T.R. 1995. **Qualitative communication research methods**. California: Sage, Thousand Oaks.

MacBurney, D.H. 2001. **Research methods**. London: Wadsworth Thomson Learning

Magura, S., Rosenblum, A., & Rodriguez, E.M., (ed) 1998.: 71 – 90. **Changes in HIV Risk Behaviours Among Cocaine-Using Methadone Patients.** New York: The Haworth Press, Inc.

Maier, B., Gorgen, R., Kielmann, A. A. Diesfeld, H.J., & Korte, R. 1994. **Assessment of the district health system**, London: Thousand Oaks.

Mandanaro, J 1990. **Community Aids Prevention Interventions: Special Issues Of Based Women Intravenous Drug Users**. Monograph Series, National Institute On Drug Abuse, Pp. 68-82.

Mantell, J. E. Divittis, A. T. & Auer Bach, M.F. 1997. **AIDS Prevention and mental health: Evaluating HIV Prevention Interventions**. New York: Phenum Press.

Martins, J.H. Laubsor, M. & Van Wyk, H. de J. 1999. **Marketing research: a South African Approach.** Pretoria: UNISA Press.

Mazrui, Ali. A., 1986. **The Africans: A Triple Heritage.** Boston: Little Brown and Company.

McHugh, P.R. & Slavney, P.R. 1998. **The perspectives of psychiatry.** Second Edition. Baltimore, The John Hopkins University Press.

Miles, M.B. & Huberman, A.M. 1994. **Quantitative data analysis.** 2nd Ed. California: Sage, Thousand Oaks.

Mouton, J. & Marais, H.C. 1990. **Basic concepts in the methodology of the social sciences:** Pretoria Human Sciences Research Council sciences

Mouton, J. 1996a. **Understanding Social rese**arch. Pretoria: J.L. van Schaik.

Neequaye, A. 1993. "**Prostitution in Accra**" In Plant, M..A. (Ed) AIDS, Drugs and Prostitution, London, Routledge.

Orubuloye, I.O., Caldwell, J.C., & Caldwell, P. 1990.: 283-302. **Sexual networking and the risk of AIDS in South West Nigeria**. In Sexual Behaviour and Networking: Anthropological and Socio-cultural Studies on the Transmission of HIV. Ed. Dyson, T. Lige: Ordina Editions

Parry, C, Bennets, A. 1999. Country Profile On Alcohol In South Africa. **Alcohol And Public Health In 8 Developing Countries**. 139 - 160. Geneva, Switzerland: World Health Organisation.

Parry, C. Bennets, A. 1998. **Alcohol Policy And Public Health In South Africa**. Cape Town, South Africa: Oxford University Press.

Perlman, H.H. 1968. **Social Role and Personality.** Chicago: University of Chicago Press

Plant, M. & Plant, M. 1992. **Risk-takers: Alcohol, drugs, sex and youth**. London: Routledge & Kegan Paul.

Plant, M.A. 1990. **Conclusions and Strategies**. In M Plant (Ed): **AIDS, Drugs and Prostitution**. London and New York: Tavistock/Routledge.

Plant, M.A. (ed) 1993. **AIDS, drugs and prostitution**. London and New York: Routledge.

Plant, M.A. 1993. **Alcohol, AIDS and sex**. In Sherr, L. (ed), AIDS and the heterosexual population. Switzerland: Harwood academic Publishers.

Poggenpoel, M. 1998. **Data analysis in qualitative research.** In De Vos, A.S. (ed) Research at grassroots: A primer for the caring professions. Pretoria: J.L. Van Schaik Publishers.

Preston-Whyte, E.M. 1992a. **Halfway there: perspectives on the use of qualitative methods in intervention oriented AIDS research in South Africa.** Paper prepared for presentation at "Science and Vision" Pretoria: HSRC Publishers.

Preston-Whyte, E.M. 1992b. **The use of anthropological methods in AIDS-research,** a discussion paper prepared for presentation at the AIDS and Anthropology, working group held at the University of Amsterdam; University of Natal, Durban.

Ramos, R., 1990. **Chicano Intravenous Drug Users**. National Institute on Drug Abuse. Research Monograph series. Rockville, MD.128: NIDA Publications.

Reid, W.J. 1995. **Research Overview**. In Encyclopaedia Of Social Work, 19th Ed. Washington, DC: National Association Of Social Workers, 2040 - 2054.

Riley, L. & Marshal, M. (Eds) 1999. **Alcohol and public health in eight developing countries**. Geneva: World Health Organization.

Rocha Silva, L. 1993. **HIV Infection/AIDS Related Knowledge, Attitudes and Practices: Alcohol/Drug Users** (including Intravenous Drug Users) Receiving Treatment in selected Centres in the RSA. Pretoria: Human Sciences Research Council.

Rocha Silva, L. de Miranda, S and Erasmus, R. 1996. **Alcohol, Tobacco and other drug Use among Black Youth.** Pretoria: Human Sciences Research Council.

Rondi, A 1998. "**Decriminalising Sex Work**: A Summary Literature Review", Unpublished Paper, Institute of Criminology, University Of Cape Town.

Rootman I & Moser J. 1984. **Guidelines For Investigating Alcohol Problems And Developing Appropriate Responses**. Geneva, Switzerland: World Health Organisation.

Rothman, J. & Thomas, E. J. 1994. **Intervention research: design and development for human service.** New York: The Harworth Press Inc.

Rubin, A. & Babbie, E, 1997. **Research methods for social work**, Fourth Edition. Pacific Grove: Brooks/Cole Publishing Company.

Sarantakos, S.2000. **Social research**. Sydney: Macmillan

Schoepf, B.G. 1993. **AIDS, sex and condoms: African healers and the reinvention of tradition in Zaire**. In Bolton R & Singer, M. (eds), Rethinking AIDS prevention: Cultural approaches. USA: Gordon and Breach Science publishers.

Schrire, R, 1990. **Critical Choices for South Africa**: An Agenda for the 1990s

Schurink, E.M. & Strydom, H. 1998. **The nature of research in the caring professions.** In De Vos, A.S. Research at grassroots: A primer for the caring professions. Pretoria: J.L. Van Schaik Publishers.

Schurink, W.J.; Schurink, E.M. Poggenpoel, M. 1998. **Focus group interviewing and audio-visual methodology in qualitative research.** In De Vos, A.S; Research at grassroots: A primer for the caring professions. Pretoria: J.L. Van Schaik Publishers.

Slovic 1992. **Perception of risk: reflections on the psychometric paradigm**. In Krimsky, S. and Golding, D. (Eds) Social Theories of Risk. Westport, CT: Praeger.

Smit, G.J.1995. **Research guidelines for planning and documentation.** Johannesburg, Southern Book, Halfway House Publishers

Stall, R. 1988. "**The prevention of HIV infection associated with drug and alcohol use during sexual activity**" in Segal (ed) AIDS and substance abuse, New York: Harrington Park Press, pp.73-88.

Stewart, D. W. & Shamdasani, P.N. 1990. **Focus groups: Theory and Practice.** California: Thousand Oaks, Sage Publications.

Strathdee S.A., Patrick, D.M., Archibald, C., Ofner, M. Craib, K.J.P., Cornelisse, P.G.A., Eades, D., Schechter, M.T., Rekart, M. & O'shaughnessy, M.V. 1996. **Social Determinants Predict Needle Sharing Behaviour Among Injection Drug Users In Vancouver** XI International Conference On Aids (Abstract No MO.D. 363).

Strydom, H. 2002. **Single System Design.** In De Vos, A.S. (Editor), Strydom, H., Fouche, C.B., & Delport, C.S.L. 2002. **Research at grassroots: For the Social Sciences and Human Services professionals.** 4th Ed. Pretoria: J.L. Van Schaik Publishers.

Swanepoel, H. 1997**. Community Development: putting plans into action**, 3rd Edition. Cape Town: Rustica Press (Pty) Ltd.

Terborg-Penn, R. & Rushing, A.B. 1996. **Women In Africa And The African Diaspora.** Washington, D.C.: Howard University Press.

Van der Burgh, C.1975. **Drugs and South African youth**. Pretoria: Human Sciences Research Council.

Warren, B.E., Capozuca, J., Pols, B. & Otto, B. 1996. "**Aids Prevention For Trans-Gender And Transsexual Persons:** A Collaborative Community Based Program". XI International Conference On AIDS (Abstract No MO.D. 601).

Warren, P. 1994. **The Development Of Community Based Media For Aids Education And Prevention In South Africa***:* Towards An Action Based Participatory Research Model. Durban: University Of Natal Press.

Webb, D. 1997. **HIV And Aids In Africa** Pietermaritzburg: University Of Natal Press.

Wechsberg, W.M. Zule, M. & Burroughs, A.R. 2003. **Contextual factors and other correlates of sexual risk of HIV among African-American crack abusing women**. North Carolina, Chapel Hill, Research Triangle Institute.

Wilson, F. & Ramphele M, 1989. **Uprooting Poverty**. Cape Town: Oxford University Press.

World Bank. 1999. **Confronting AIDS: Public priorities in a global epidemic**. Washington D.C.: Oxford University Press.

Wynne, B. 1992. **Risk and social learning: reification to engagement**. In Krimsky, S. and Golding, D. (Eds) Social Theories of Risk. Westport, CT: Praeger.

Zastrow, C. 1992. **The practice of social work.** 4th edition. California: Wadworth Publishing Company, Inc. California.

Journals

Aktan, G.B. 1995. Organisational frameworks of a substance use prevention programme. **The international journal of the addictions**, 30 (2): 185-201.

Atkin, C., Smith, S., & Bang, H.K. 1994. How young viewers respond to televised drinking and driving messages. **Alcohol, drugs and driving.** 10 (3-4): 263-275.

Beck, K.H. Summons, T.G. & Matthews, M.P. 1991. Monitoring parental concerns about teenage drinking and driving: A focus group interview approach. **Journal of Alcohol and Drug Education,** 37 (1): 46-57.

Blacker, J. Zaba, B. 1997. HIV prevalence and the lifetime risk of dying from AIDS. Health Transition Review, (Suppl.2): 45-62.

Brents, B.G., & Hausbeck, K. 2005. Violence and Legalised Brothel Prostitution in Nevada. **Sage Publications**. 20 (3): 270-295.

Brents, B.G. & Hausbeck, K. 2001. State sanctioned sex: Negotiating informal and formal regulatory practices in Nevada brothels. **Sociological Perspectives**, 44 (3). 307-332.

Brock, D. 1989. Prostitutes Are Scapegoats in the AIDS Panic. **Resources for Feminist Research**. 18 (2): 13-16.

Brown, J.H. & Caston, M. 1995. On becoming "At risk" through drug education: How symbolic policies and their practices affect students. **Evaluation review,** 19 (4): 451-491.

Caldwell, J., C., Caldwell, P., & Quiggin, P. 1989 The Social context of AIDS in Sub Saharan Africa**. Population and Development Review**; 15 (2) 185-236

Caldwell, J.C., Orubuloye, I.O., & Caldwell, P. 1993. The destabilization of the Traditional Yoruba Sexual System. **Population and Development Review** 17:229-262

Campbell, C.A., 1998. Women and AIDS. **Social Sciences in Medicine** 30 (4): 411.

Celentano, D. Vlahov, D. Menon, A.S. & Polk, B.F. 1991. HIV Knowledge And Attitudes Among Intravenous Drug Users: Comparison To The U.S. Population And By Drug Use Behaviours. **Journal Of Drug Issues**, 21: 635-649.

Cohen, E., Navaline, H., & Metzger. 1994. High Risk Behaviours for HIV: a comparison between crack-abusing and opioid abusing African-American women. **Journal of Psychoactive Drugs**. 26 (3) 233-241

Connors, M. 1992**.** Risk perception, risk taking and risk management among intravenous drug users: Implications for AIDS preventio**n, Social Science and Medicine**, 34, 591-601

Coutinho, R.A. van Andel, R.L.M. & Rysdyk, T.J.1988. Role of male prostitutes in spread of sexually transmitted disease and human immunodeficiency virus**,** **Genitourinary Medicine** 64:207-8.

Cummings, S. 1997. An empowerment model for collegiate substance abuse prevention and education programs. **Journal of alcohol and drug education**, 43 (1): 46-62.

De Vos, A. 1989. Last Word. The Social Work Practitioner**-Researcher**, 2 (4): 44

Des Jarlais D.C., Friedman S.R. & Ward T.P. 1993. Harm Reduction: A Public Health response to the AIDS epidemic among Injecting Drug Users. **Annual Review of Public Health**. 87: 405-416.

Des Jarlais, D.C. & Friedman, S.R. 1989. The Psychology Of Preventing Aids Among The Intravenous Drug Users**. Journal of American Psychology***,* 43: 865-870.

Des Jarlais, D.C., Chamberlain, M., Yancovitz, S., Weinberg, P., & Friedman, S., 1984. Heterosexual Partners: A Large Risk Group For Aids**. *Lancet*,** 2 (8415): 1346-1374.

Development update. 2000. Youth in post apartheid South Africa**. Quarterly Journal of the South African NGO Coalition and INTERFUND**, 3 (2): 1-131

Elford, J. Bolding, G., Maguire, M., & Sherr, L., 2000. Combination Therapies for HIV and Sexual risk behaviour among gay men. **Journal of acquired Immune Deficiency Syndrome**, 23, 266-271.

Ellis, G.A. & Corum, P. 1994. Removing the motivator: A holistic solution to substance abuse. Alcoholism Treatment **Quarterly,** 11 (3-4): 271-298.

Flisher, A.J., Chalton, D.O. 2001. Adolescent Contraceptive Non-Use And Covariation Among Risk Behaviours. **Journal Of Adolescent Health**. 28(3): 235 - 241.

Flisher, A.J., Parry, C.D.H., Evans, J., Muller, M., Lombard, C. 2002. Substance Use By Adolescents In Cape Town: Prevalence And Correlates. **Journal Of Adolescent Health** (In Press).

Flisher, A.J., Ziervogel, C.F., Chalton, D.O., Leger, P.H., Robertson, B.A. 1993a. Risk Taking Behaviour Of Cape Peninsula High School Students. Part 1. Introduction and Methods. **South African Medical Journal.** 83(7): 469-473.

Flisher, A.J., Ziervogel, C.F., Chalton, D.O., Leger, P.H., Robertson, B.A. 1993b. Risk Taking Behaviour Of Cape Peninsula High School Students. Part Iv. Alcohol Use**. South African Medical Journal.** 83(7): 480-482.

Flisher, A.J., Ziervogel, C.F., Chalton, D.O., Leger, P.H., Robertson, B.A. 1996a. Risk Taking Behaviour Of Cape Peninsula High School Students. Part Ix: Evidence For A Syndrome Of Adolescent Risk Behaviour**. South African Medical Journal**. September 86(9): 1090-1098.

Flisher, A.J., Ziervogel, C.F., Chalton, D.O., Leger, P.H., Robertson, B.A. 1996b. Risk Taking Behaviour Of Cape Peninsula High School Students. Part X: Multivariate Relationships Among Behaviou**r**. **South African Medical Journal**. September 86(9): 1094-1098.

Gilgen, D. Williams, B.G., Macphail, C., Van Dam, C.J., Campbell, C., Ballard, R.C., Taljaard, D. 2001. The Natural History Of HIV/AIDS In A Major Gold Mining Centre In South Africa: Results Of A Biomedical And Social Survey. **South African Journal Of Science**. 97: 387 - 392.

Goldberg, D.J., Green, S.T., Kingdom, J.C.**P.** 1988. HIV infection among female drug abusing prostitutes in Greater Glasgow, **Communicable Diseases** (Scotland), Bulletin 88/12: 1-3.

Gorgen, R., Marx, M.,Yansane, M., & Millimounou, D. 1998. Sexual behaviour, partner choice, risk of premarital pregnancies and HIV/STD infections in unmarried urban youth in Guinea, West Africa**, International family Planning**; Vol. 27, No.3, 155-167)

Gottheil, E. & Stimmel, B. 1988. Effects of substance abuse treatment on AIDS risk behaviours. **Journal Addictive Diseases**. 17(4) 5

Gottheil, E. Lundy, A. Weinstein, S.P. Sterling R.C. 1988. Does Intensive Outpatient Cocaine Treatment reduce AIDS Risky Behaviours? **Journal of Addiction Disorders** 17 (4): 61-69.

Gray, M. 1996. Towards an understanding of developmental social work**. Social work Practice**, March. 9-13

Haverkos, H.W. 1998. HIV/AIDS and Drug Abuse: Epidemiology and Prevention. **Journal of Addictive Diseases.** 17 (4) 91-103)

Howard, J. 1997. Psychoactive substance use and adolescence prevention**. Journal of substance misuse,** 2 (1): 17-23.

Inciardi, J.A. Lockwood, D. & Quilan, J.A. 1993. Drug Use in prison: Patterns, Process and implications for treatment**. The Journal of Drug Issues,** 23 (1): 119-129.

Isiugo-Abanihe, Uche C. 1994. Extramarital relations and perceptions of HIV/AIDS in Nigeria. **Health Transition Review** 4, 1994, 111 –125

Karim, Q.A. Karim, S. S. A. Sodan, K. & Zondi, M. 1995. Reducing the risk of HIV infection among South African sex workers: Socio-economic and gender barriers. **American Journal of Public Health**, 85 (11): 886-9.

Karim, Q. A. & Karim, S. S.A. 1999. Epidemiology of HIV Infection in South Africa. **IAS Newsletter,** 12 (April),: 4-7.

Kaskutas, L. Marsh, D. & Kohn, A. 1998. Didactic and Experiential Education in Substance Abuse Programmes. **Journal of Substance Abuse Treatment**, 15 (10): 43-53

Kim, S. Crutchfield, C. Williams, C. & Hepler, N. 1998. Toward a new paradigm in substance abuse and other problem behaviour prevention for youth: Youth development and empowerment approach. **Journal of Drug Education**, 28 (1) 1-17.

Klepp, K. I. & Halper, A. & Perry, C.L. 1986. The efficacy of peer leaders in drug abuse prevention. **Journal of school Health**, 56 (9): 407-411.

Klepp, K.I. Perry, C.L. & Jacobs, D.R. 1991. Etiology of drinking and driving among adolescents: Implications for primary prevention. **Health Education Quarterly,** 18 (4): 415-427.

Klitzner, M. Greenwald, P.J. Bamberger, E. & Rossiter, E. 1994. A quasi-experimental evaluation of students against driving drunk. **American Journal of Drug and Alcohol Abuse,** 20 (1): 57-74.

Koblin, B.A., Holte, S., Lenderking, B., & Heagerty, P. 2000. Readiness for HIV vaccine trials: changes in willingness and knowledge among high-risk populations in the HIV network for prevention trials. The HIV/NET Vaccine Preparedness Study Protocol Team. **Journal. Of Acquired Immune Deficiency Syndrome**, 24: 451-7

Latkin, C., Mandell, W., Vlahov, D., Oziemkowska, M., Knowlton, A., Celentano, D. 1994. My Place, your place, and no place: behaviour setting as a risk factor for HIV related drug injection practices of drug users in Baltimore, Maryland**. American Journal of Community Psychiatry**, (22): 415-430.

Latkin, C.A., Mandell. W., Vlahov. D., Oziemkowska, M. & Celentano, D.D. 1996. The Long Term Outcome Of A Personal Network Oriented HIV Prevention Intervention For Injection Drug Users**:** The Safe Study. **AMJ Community Psychology**, (24): 341-364.

MacDonald, D. 1995. Harm reduction strategies for working with problem drug users: A new paradigm for a new South Africa? CHASA **Journal of comprehensive Health**, 6 (4) 194-198.

MacDonald, D. 1996. Drugs in Southern Africa: An overview**. Drugs, education, prevention and policy**, 3 (2) 127-143.

Meares, P.A. 1995. Applications of qualitative research: Let the work begin. **Social work research**, 19 (1): 7

Molamu, L. & MacDonald, D. 1996. Alcohol Abuse among the Basarwa of the Kgalagadi and Ghanzi Districts in Botswana**. Drugs, education, prevention and pol**icy, 3 (2): 145-152.

Morojele, N.K., Parry, C.D.H., Ziervogel, C.F., & Robertson, B.A. 2000. Prediction Of Binge Drinking Intentions Of Female School-Leavers In Cape Town, South Africa, Using The Theory Of Planned Behaviour. **Journal Of Substance Use**; 5:240 - 251.

Orubuloye, I.O., Caldwell, J.C., & Caldwell, C. 1992. Diffusion and focus in sexual networking: Identifying partners and partners' partners. **Studies in Family Planning**; 23 (6) 343-351.

Orubuloye, I.O., Caldwell, J.C., & Caldwell, P. 1991. Sexual networking and the risk of AIDS in the Ekiti District of Nigeria **Studies in Family planning** 22: 61-73.

Orubuloye, I.O., Caldwell, P., & Caldwell, J.C.. 1993. The role of high-risk occupations in the spread of AIDS: truck drivers and itinerant market women in Nigeria. **International Family Planning Perspectives** 17: 43-48

Padian, N. 1988. Prostitute Women and AIDS: Epidemiology. **AIDS**. 2: 413-419

Parry, C.D.H., Bhana, A., Myers, B., Pluddemann, A., Flisher, A.J., Peden, M. & Morojele, N.K. 2002. Alcohol Use In South Africa: Findings From The South African Community Epidemiology Network On Drug Use (SACENDU) Project. **Journal Of Studies On Alcoho**l; In Press.

Pauw, I. & Brener, L. 1997. Naming the dangers of working on the street. **Agenda**, 36: 80-83

Plant, M.L., Plant, M.A., Peck, D.F. & Setters, J. 1989. "The sex industry, alcohol and illicit drugs: Implications for the spread of HIV infection", **British Journal of Addiction** 84: 53-9.

Plant, M.A., 1990b. "Alcohol, Sex and AIDS", **Alcohol and Alcoholism**, 25, 293-301 London and New York: Tavistock/Routledge

Pedian, M. & Van der Spuy, J. 1996. Substance Abuse and Trauma-Related Injuries. **Trauma Review**, 4 (3): 8-9.

Perkins, R. 1991. AIDS Preventative Practices among Prostitutes in New South Wales. (Australian) **National AIDS Bulletin,** September 1991:28.

Peltzer K, Phaswana N. 1999 **Substance Use Among South African University Students**: A Quantitative And Qualitative Study. Urban Health And Development Bulletin; March, 2 (1); 63 - 68.

Rahman, A. 1986. Economic Development and Science Technology Policy in the Third World. June, 9:2.

Ramjee, G. Karim, S.S.A. & Sturm, A..W. 1998. Sexually transmitted infections among the sex workers in Kwazulu Natal, South Africa. **Sex Transmission Disease** 25: 346 – 349.

Rhodes, T. 1997. Risk theory in epidemic times: sex, drugs and the social organisation of 'risk behaviour'. **Journal of Sociology of Health & Illness** Vol.19 No.2 1997: 208-227. Blackwell, Publishers, Oxford, UK.

Ross, M. W. Stowe, A. Wodak, A. & Gold, J. 1995. Reliability of interview responses of injecting drug users. **Journal of Addiction Disease,** 14 (2): 1-12.

Schoepf, B.G. 1991. Ethical, Methodological and political issues of AIDS research in Central Africa**. Social science and medicine** 33, 749

Schoofs M (1999) **All That Glitters: How HIV Caught Up Fire In South Africa** Ivoice *Report April 28-May.*

Schoofs M (1999) **Sex And The Migrant Miner** Ivoice Report April28-May 4.

Stewart, D.W. & Shamdasani, P.N. 1998. Focus group research: Exploration and Discovery. In Stimson, G.V. & Thom, B. Reducing drug and alcohol related harm. **Drug education, prevention and policy,** 4 (1): 3-6.

Strathdee, S.A., Paplepu, A., C., Cornelisse, P.G.A., Eades, D., Schechter, M.T., Rekart, M. & O'shaughnessy, M.V. 1999. Barriers To Use Of Free Antiretroviral Therapy In Injecting Drug Use. ***Jama*****.** 280 (6): 547-549.

Suligoi, B., Wagner, TM. Ciccozzi, M., and Rezza, G. 2005. The epidemiological contribution to the preparation of field trials for HIV and STI vaccines: objectives and methods of feasibility. **Vaccine** (23) pp1437-1445

Terblanche, S.S. & Tshiwula, L. 1996. Development Social Welfare and Development Social Work. **Social service review,** (December):18-24.

Thomas, E.J. 1989. Advances in developmental research. **Social service review,** (December): 578-597.

Van de Perre, P. Jacobs, D. & Sprecher-Goldberger, S. 1987. The latex condom, an efficient barrier against sexual transmission of AIDS-related viruses. **AIDS,** 1:49-52.

Van Der Spuy, J.W. 1991. Alcohol-related trauma. **Continuing Medical Education,** 9 (7): 859-868.

Van Rooyen, C.A.J. & Bennett, T.R. 1995. Entry into communities: an exploratory review. **Social work practice**, July: 17-22.

Varga, C.A. 1997. The condom conundrum: barriers to condom use among commercial sex workers in Durban, South Africa, **African Journal of Reproductive Health**, 1 (1): 77-88

Visser, M. & Moleko, A.G. 1999. High Risk behaviours of primary school learners. **Urban Health Development Bulletin** 2 (1): 69-77.

Warren, M. 1997. Condom use in South Africa: Facts and Fant**asies**. **AIDS** Scan, (3), 4-6.

Williams, B.G. MacPhail, C. Campbell, C. Taljaard, D. Gouws, E. Moema, S. Mzaidume, Z. and Rasego, B. 2000.The Carletonville-Mothusimpilo Project: Limiting transmission of HIV through community based intervention**s**. **South African Journal of Science** 96: No 6.

Williams, B.G.; Ansell, S.M. and Milne, F.J. 1997. Illicit intravenous drug use in Johannesburg-Medical complications and prevalence of HIV infection. **South African Medical Journal** 87: 889-891.

Wilson, R.J. 1993. Drinking and driving: In search of solutions to an international problem. **Alcohol, Health and Research world,** 17 (3) 212-220.

Wojcicki, J.M. & Malala, J. 2001. Condom use, power and HIV/AIDS risk: Sex workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. **Social Science and Medicine,** 53 (1): 32-37.

Zule, W.A. 1992. Risk and reciprocity: HIV and injection drug user, **Journal of psychoactive Drugs**, 24, 243-249.

Publications Of The State And Authorities

Department of Health Report, 2001. 2000 **national HIV sero-prevalence survey** of women attending public antenatal clinics in South Africa. Pretoria: Department of Health.

Department of Health Report, 2002. 2001 **national HIV sero-prevalence survey** of women attending public antenatal clinics in South Africa. Pretoria: Department of Health.

Human Sciences Research Council Survey, 2002

IML, 2001

Department of Transport. **White paper on the Road Accident Fund**, 1998. Pretoria: Vol. 392, No. 18658

Department of Social Development. **White paper on Welfare**, 1996. Pretoria: No.108

National Youth Commission. **White Paper on Youth,** 14th August 1999. Pretoria

Parliament of the South Africa. **White Paper on Reconstruction and Development**, 1994. Pretoria: Vol. 353. Publication No. 16085

Posel, D. 1993. The sex market in the inner city of Durban: the economic and social effects of criminalizing sex work and the search for alternatives, **occasional paper**, No. 28. Economic Research Unit, Durban, University of natal.

Sex Worker Education And Advocacy Taskforce **"**Environmental Factors on Cape Town Sex Workers", **Internal Discussion Paper**, Cape Town, 1999

Slamah (Khartini) D. 1996. Developing Effective HIV/AIDS Programs For Transsexuals Working As Sex Workers **" Conference Paper" XI International Conference On Aids (Abstract No 603).**

South African Law Commission 2002, Sexual Offences: Adult prostitution, **Issue Paper, 19, Project 107**, December.

The Reconstruction and Development Programme. **A policy framework.** 1994. Johannesburg: Umanyano Publications.

The Ministry of Education. **National Plan for Higher education**, February 2001, Pretoria.

The Ministry of Health. **White Paper for the transformation of the Health System in South Africa,** 1997. Pretoria.

The Ministry of Transport, **White Paper on National Transport Policy**, 20th August 1996. Pretoria.

The Ministry of Welfare and Population Development. **White Paper for Social Welfare**, 1997. Pretoria. Vol. 386. No. 18166.

United Nations Office for Drug Control and Crime Prevention. 2000**. World drug report 2000**.Oxford: Oxford University Press.

United Nations Office on Drugs and Crime. 2002. **South Africa. Country profile on drugs and crime**. Pretoria: Regional Office for Southern Africa.

US Department of Health and Human Services. 1996**. Epidemiologic trends in drug abuse. Community Epidemiology Work group.** Volume II: Proceedings, January. Rockville.

United Nations World Economic and Social Survey, 2002. Trends and policies in the world economy, New York.

World Health Organization. 2000b. **Guide to drug abuse epidemiology.** Geneva

World Health Organization. 2002b. **Sex RAR guide**. Geneva.

Acts

Aliens Control Act, No. 96 of 1991

Child Care Act No 74 of 1983

Correctional Services and supervision Matters Amendment Act, No. 122 of 1992

Criminal Law (Sexual Offences) Amendment Bill. Govt Gazette No. 25282 of 30 July 2003.

Criminal Procedure Act 1977 (Act 51 of 1977) with special reference to the Witness Protection Programme established in terms of 185A of 1992.

Criminal Procedure Act, No. 51 of 1977

Criminal Procedure amendment Act N. 5 0f 1991

Domestic Violence Act, No. 116 of 1998

Drug and Drug Trafficking Act 1992 (Act 140 of 1992)

Film and Publication Act. No 65 of 1996

Health Act, No 63 of 1977

Immorality Act No. 1987

Immorality and Prohibition of Mixed Marriages Amendment Act, N. 72 of 1985.

National Roads Act No. 54 of `1971

Prevention and Treatment of Drug Dependency Act, No. 20 of 1992 (With effect from 30 April 1993)

Prevention and Treatment of Drug Dependency Amendment Act, No 14 of 1999 (For the purpose of establishing Central Drug Authority)

Prevention of Family Violence Act, 1994.

Road Transportation Act 1977, (Act 74 of 1977)

Special Courts for Blacks Abolition Act, No. 34 of 1986 (With effect from 1 August 1986)

The Constitution of South Africa, Act 108 of 1996

The Extradition Act 1962 (act 101 of 1965)

The Extradition Amendment Act 1996 (Act 1977 of 1996)

The international Co-operation in Criminal Matters Act (Act 75 of 1996)

The Proceeds of Crime Act 1996 (Act 76 of 1996)

The Social Skills Development Act (Act. No. 97 of 1999)

Reports

Alexander P, Highleyman L & La Croix C 1996. Occupational Safety And Health Regulations As An HIV/AIDS Prevention Strategy In The Context Of Sex Wor**k**. **XI International Conference On HIV/AIDS (Abstract Number WE.C. 3602).**

British Broadcasting Corporation (BBC) **Documentary Report on prostitution**, 2000

Centers for Disease Control and Prevention (1999) **Increases in unsafe and rectal gonorrhoea among men who have sex with men-**San Francisco, California, 1994-1997 Morbidity and Mortality Weekly Report, 48, 45-48.

Centers for Disease Control, Prevention, (C. D. C.), 1998. **Guidelines for the use of antiretroviral agents in HIV infected adults and adolescents**. MMWR 47 (RR-5) 43-82.

Centers for Disease Control: **HIV/AIDS Surveillance Report**, Vol 6, 2. Washington, DC, Department of Health and Human Services: Fall 1995

Combrink H. In Community Law Center. **Gender Project.** 2002. University of Western Cape.

Deamant, C., Cohen M, Barkan S., Richardson J, Fitzgerald G, Young M, Holman, S, Anastos K, Cohen J, & Melnick S 1996. Prevalence Of Domestic And Childhood

Abuse Among Women With HIV And High Risk Uninfected Women. **XITH International Conference On Aids (Abstract Number Mo.C.224)**

Department Of Health **National Framework For Contraceptive Services.** First Draft Document For Discussion; 1998 Pretoria, South Africa: Directorate Of Maternal, Child And Women Health, Department Of Health.

Department Of Health, Medical Research Council, Macro International, South African **Demographic And Health Survey 1998. Preliminary Report**, 1999. Pretoria, South Africa: Department Of Health.

Department Of Health, National HIV/ AIDS & Std: **Strategic Plan For South Africa 2000-2005.** Pretoria, South Africa: Department Of Health, 2000.

Department of Social Development: **Annual report 2002/2003**. RSA

Drug Advisory Board.(Now Central Drug Authority) **National Drug Master Plan, 1999-2004**. RSA

Hammett, M.T. 1995. Patterns of Project Interaction With Clients In Three Sexual Partners/Prostitutes Sites. Community Based Aids Prevention Among Intravenous Drug Users And Their Sexual Partners. **A Paper presented at the annual NADR.**

ILO Report: HIV/AIDS: **A Threat to Decent Work, Productivity and Development**, June 2000:12-18.

Jacobs L, Shih A & Robbs P. (1999) **UNAIDS Report**.

Kaiser Family Foundation, 1999. Programs For Health And Development In South Africa 2000. **Daily Reports**.

Latkin, C.A. 1998. Outreach In Natural Settings: The Use Of Peer Leaders For HIV Prevention Among Injecting Drug Users' Networks. **Public Health Report,** June, 113: 151-159.

Leclerc-Madlala S. 2001. HIV/AIDS, Youth And The Disabling Sexual Context**. Paper Presented At The Aids In Context Conference**, University Of The Witwatersrand, Johannesburg, 4 - 7 April.

Mnguni, G.N. 1998. **"**Community Based Home Based Care For People Living with AIDS (PWAS) As A Policy Option: The Experience Of A South African NGO Initiative." **International Conference On Aids 1998; 12:99 (Abstract No 12427).**

Morojele, N. K. Parry, C. D.H. Ziervogel, C.F. Reddy, P. & Lombard, C.J. 2001. Adolescents, HIV And Drug Abuse In South Africa. In NIDA (Eds.) **Proceedings**

Of The 3rd Global Research Network Meeting On HIV Prevention In Drug-Using Populations, Durban 2000. Washington, DC: U.S. Department Of Health And Human Services.

National **Crime Prevention Strategy** March 1996

National Institute of Health. 1997. **Assessing drug abuse within and across communities.** Division of Epidemiology and Prevention research. Rockville. Maryland

National Institute On Drug Abuse, 1999. Global Research Network Meeting On HIV Prevention In Drug Using Populations**.** Second Annual Meeting Report: August 26 - 28, Atlanta, Georgia.

National Institute on Drug Abuse .2002. **Strategies to improve the Replicability, sustainability and durability of HIV Prevention Interventions for drug Users**-Meeting Proceedings May 6-7, 2002. Washington D.C.

National **Substance abuse strategy** 1996 in a White paper on Welfare

Network, spring, 1998, Vol.18.No 3:1

Rakgoadi, S. "**Policing Sex Work In South Africa**" Conference Paper, 1994.

Parry, C. Karim, Q.A. 1999. Country Report: Substance Abuse And HIV/AIDS In South Africa. **Proceedings of 2nd Global Research Network Meeting On HIV Prevention Drug-Using Populations,** Atlanta; 1999: 81 - 88. Washington, Dc: Us Department Of Health Systems Trust.

SANCA. 1993. **Fact sheet: Alcohol other drug use, abuse and related problems**. Johannesburg.

South African **Year Book**, 1989-1990 Government Printers Pretoria

Statistics South Africa. 1998. **Road traffic collisions**. Statistical Release, (2): 7161. Government Printers, Pretoria.

The White House. 2000. **The National Drug Control Strategy**. United States

UNAIDS ***Epidemiological Report On South Africa*** (1998; 1999; 2000).

UNAIDS, December 2001: 2, **AIDS Epidemic Update**

United Nations **Convention Against Illicit Drug Trafficking in Narcotic Drugs and Psychotropic Substances 1988**

United Nations Office on Drug and Crime Prevention **Report**, 2001:1

United Nations Research Institute For Social Development. 1994. **Illicit Drugs: Social Implications And Policy Responses.** UNRISD Briefing Paper, Series 2.Geneva: United Nations Research Institute For Social Development.

Varga, C. A. 1998. Commercial sex workers' partners: perspectives on relationships and HIV risk**. Reproductive Health Priorities Confe**rence, August 18-21.

World Health Organization, 1990. **Aids Surveillance In Europe**: Quarterly Report. Geneva.

World Bank **Brief on South Africa**, 1999.

World Health Organisation **Report on Drug Abuse**, 1998:3

World Health Organisation. 1995. **Programme on Substance abuse**. Mentor Foundation, Geneva, Switzerland.

PERIODICALS

Sources From Magazines And Newspapers

Bhengu, C, 2002. HIV prostitute wants to start anew. **Sowetan.** 21 February: page 6

Sunday Sun June 23, 2003: 23

Daily Sun, 19 October, 2004: 16

Sunday Times, 2001. Red lights flash as South Africa ponders next step:5 August, 1-2

Sources From The Media

Patta, D 2005. Third Degree programme. ETV. May 23.

Patta, D. 2002. Third Degree programme. ETV. January 23

Pauw, J. 2004. Special Assignment. SABC 3. October 19

Sources From Internet

http://www.icon.co.za

http://www.mrc.ac.za

http://www.rebirth.co.za

http://www.hri.ca/partners/alp

http://www.hst.org.za/research/hivsupp.htm

http://www.up.ac.za/academic/centre-study-aids

http://www.cosatu.org.za

http://www.africa.com/health

http://www.tarsc.org/punlist1.html

http://www.iclinic.co.za

http://www.undp.org.za/docs/pubs

http://www.health.gov..za

http://www.socdev.gov.za

http://www.medguide.org.zm/aids

http://www.hiv-e.com

http://www.healthforall.net/grmhss
http://www.healthnet.org/programs
http://www.redribbon.co.za
http://www.ratn.org
http://www.securethefuture.com
http://www.uct.ac.za/depts/mmi
http://www.polity.org/govdocs
http://www.nida.org

Dissertation For A Research Master's Degree

Makhubele, J.C. 2004. The Impact of culture on the prevention and treatment of HIV/AIDS Amongst People in low-resourced areas: A Social Work Perspective. Polokwane: University of the North. (Dissertation)

Thesis For A Doctorate

Phaswana-Nuntsu, M.R.N. 2002. The development, implementation and evaluation of a drinking and driving primary prevention programme among students drivers at the University of the North. Pietersburg: University of the North. (Thesis)

APPENDIX A: INFORMED CONSENT

The study and its purpose: We are as asking you to take part in a discussion group of the South African initiative study, an add-on to the North Carolina Woman's CoOp. The South African initiative is a research study being run and supported by the Research Triangle Institute (RTI), a not-for-profit research organisation. The study is funded by a grant from the United States' National Institute on Drug Abuse (NIDA/NIH). The goal of this discussion group is: 1) to give you a chance to talk in a small group of women (5-8/10) that will help increase our understanding of South African women's lives; and 2) to develop a culturally appropriate woman-focused study for South African substance abusing women at risk for getting HIV. Only staff connected with RTI will lead this group.

Being in this study is completely voluntary. You do not have to answer any questions, and you do not have to be in any part of this study. You can drop out of the study at any time. If you drop out, it will not affect your relations with any community services.

What we are asking of you: We are now asking you to answer some questions that will take about 60 minutes. These questions are about substance abuse and risky sexual behaviour and the possibility of having a woman-focused HIV risk-reduction study with South African women. We are asking you to share what you have seen others experience and your general opinions, you do not have to tell us about personal experiences.

We would also like to ask your permission to audiotape the discussion group/individual interview. The purpose of taping the group is to make sure that the interviewers are asking the right questions and the recorder is collecting the responses accurately. Agreeing to be audio taped is completely voluntary. If you don't want to be taped, you can still take part in the study.

We may also contact you again by mail or by phone to ask for your help in planning the community study. At no time during our contact will we reveal that this is a study on substance abuse and risky sexual behaviour, including HIV prevention.

Confidentiality: The information you provide will be kept private with this staff. We ask that you do not share the things that we talked about in this group/individual interview or who you knew in this group/individual interview with any one else. The researchers running this study will not tell your name to anyone and your name will never be connected with the responses you give during the group/ individual interview. However, if you say in the group/individual interview that you were about to hurt yourself, or that you were hurting or neglecting a child, and then we would have to report that information.

Any tapes connected with the discussion group/individual interview will only be used for review by study staff. Your name will not be used on the tape. The tape will only contain an ID number. The tapes will be kept in a locked cabinet and destroyed after the summary of the group/individual interview is written.

After each group/individual interview, a summary will be written that contains information from all participants but it will be impossible to identify who said what during a group discussion/individual interview. The information you give us will always be grouped with other answers so that no one person is known and no names will ever be on any reports or other information from the study. This general information may be shared in with local health agencies. The goal of this discussion group/individual interviews is to give you a chance to talk about issues within a small group of other participants that will help us understand the lives of South African women and the possibility of doing this study.

Compensation: To thank you for taking part in this project we will pay you R24 ($3) for one hour or R30.00 ($3.75) for one and a half hours, depending on the length of time of the group/individual. Taking part in this discussion group/individual interview is voluntary, which means you do not have to answer any question or talk about any topic discussion.

Who to contact with questions: If you have questions about any part of this study, about your rights or anyone else's rights as a study participant, you can call Dr. Pundy Pillay at 012 342 5318, who will serve as the South African contact for Wendy Visscher, head of RTI Internal Review Board. Or Evodia Mabuza-Mokoko, Associate

Investigator and Community Advisory Board member in South Africa, at 012 312 7558.Or you can contact Dr. Wendy Wechsberg, Principal Investigator, at:

Research Triangle Institute
P.O. Box 12194
Research Triangle Park, NC 27709

This project has been approved by committees that are concerned with the rights of people involved in research.

Do you have any questions?

Signature indicates consent: Your initials indicate that we have described the study procedures to you, asked you to participate, and given you the chance to ask questions.

Participant's Initials	Signature of Person Obtaining Consent	Date

Your initials indicate that you agree to participate in the study and have not been forced in any way to do so.

Participant's Initials	Signature of Person Obtaining Consent	Date

Your initials indicate that you agree to be audio taped (If not offer to do a face to face Interview)

Participant's Initials	Signature of Person Obtaining Consent	Date

APPENDIX B: IN-DEPTH SCHEDULE

Questions were asked to the gatekeepers:

- What do you remember about the Pilot women's coop study?
- What did people say about this study on women's health?
- How can we build trust and credibility with women sex workers?
- How might our intervention help women sex workers?
- How can we best reach women sex workers who use alcohol and other drugs?
- What are some of the barrier to women's participation in the study?
- How can we help women stay and the study throughout all the follow-ups?
- How can we reach sex workers' community without threatening their business?
- Did you notice or hear about women sex workers experiencing problems?
- Do you think that study participants who take steps to reduce their sexual and drug use risk behaviours will experience changes in the level of violence in their lives?
- What suggestions do you have for our intervention to help decrease the level of violence in sex workers?
- Have there been any changes in police activities directed toward women sex workers, harassment of sex workers or changes in client's behaviours since our pilot study last year?
- How can this study help women feel more in control to achieve any personal goals?
- How do you feel about having former sex workers being part of the study staff?
- Do you have any suggestions for the study?

APPENDIX C: FOCUS GROUP DISCUSSIONS SCHEDULE

Questions were asked to the Sex workers:

- What do you remember about the Pilot women's coop study?
- What did people say about his study on women's health?
- How can we build trust and credibility with women sex workers?
- How might our intervention help women sex workers?
- How can we best reach women sex workers who use alcohol and other drugs?
- What are some of the barrier to women's participation in the study?
- How can we help women stay and the study throughout all the follow-ups?
- How can we reach sex workers' community without threatening their business?
- Did you notice or hear about women sex workers experiencing problems?
- Do you think that study participants who take steps to reduce their sexual and drug use risk behaviours will experience changes in the level of violence in their lives?
- What suggestions do you have for our intervention to help decrease the level of violence in sex workers?
- Have there been any changes in police activities directed toward women sex workers, harassment of sex workers or changes in client's behaviours since our pilot study last year?
- How can this study help women feel more in control to achieve any personal goals?
- How do you feel about having former sex workers being part of the study staff?
- Do you have any suggestions for the study?

APPENDIX D: INTERVENTION TOOL

Card 1: Some reasons women are at risk in South Africa

- Women's position in society is low and low in relationships
- Women are often uninformed about choices and their sexual risks
- Women are often unable to negotiate use of condoms
- Women may not know they have sexual rights
- Social norms that accept or encourage many sexual partners
- Labour patterns where men are working far away making multiple sexual partners more likely
- Norms that keep women form discussing sexual matters and acceptance of condom use
- High incidences of violence, battery and rape

Card 2: Reduce the "chance" – negotiate

- Because men may feel they may control, dominate, or intimidate you into sex without protection be prepared-
- Bargain for protection for both of you
- Have condoms ready
- Use a female condom if the man refuses
- Be prepared to use your whistle that we will give you, scream for help, or get out of the situation

Card 3: Stop being ripped off

- We know that women are being raped, robbed, beaten up, cut, having guns and knives pulled on them, and suffering injuries because of this
- Therefore, your life is at risk. Also, being raped can cause vaginal trauma that can put you at special risk for HIV and Hepatitis
- There are ways to reduce violence

- If you find your self in a bad situation
- Go along with him and wait for your chance to get away.
- Sweet talk him; sometimes that will change his mood
- Acting crazy or talking too much may change his mood – he might want to get away from you
- Attract attention to yourself by screaming or using a whistle, and he may just not want to hang around

Card 4: Dealing with a bad situation

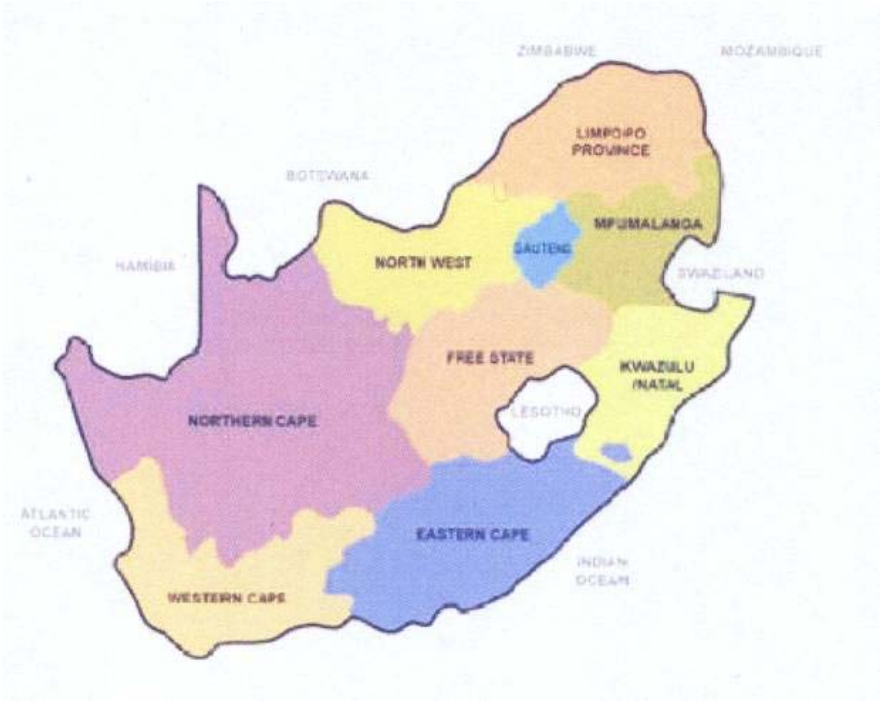
- If you have to get out of a car:
- Wait for a red light and get out
- If the car is still moving, open the door and wait. Many times this will show your date you are serious and he will slow down or stop
- It is hard to think quickly while you are high. Remember, stopping, reducing, or delaying your drug use keeps you in control

Card 5: Power of women

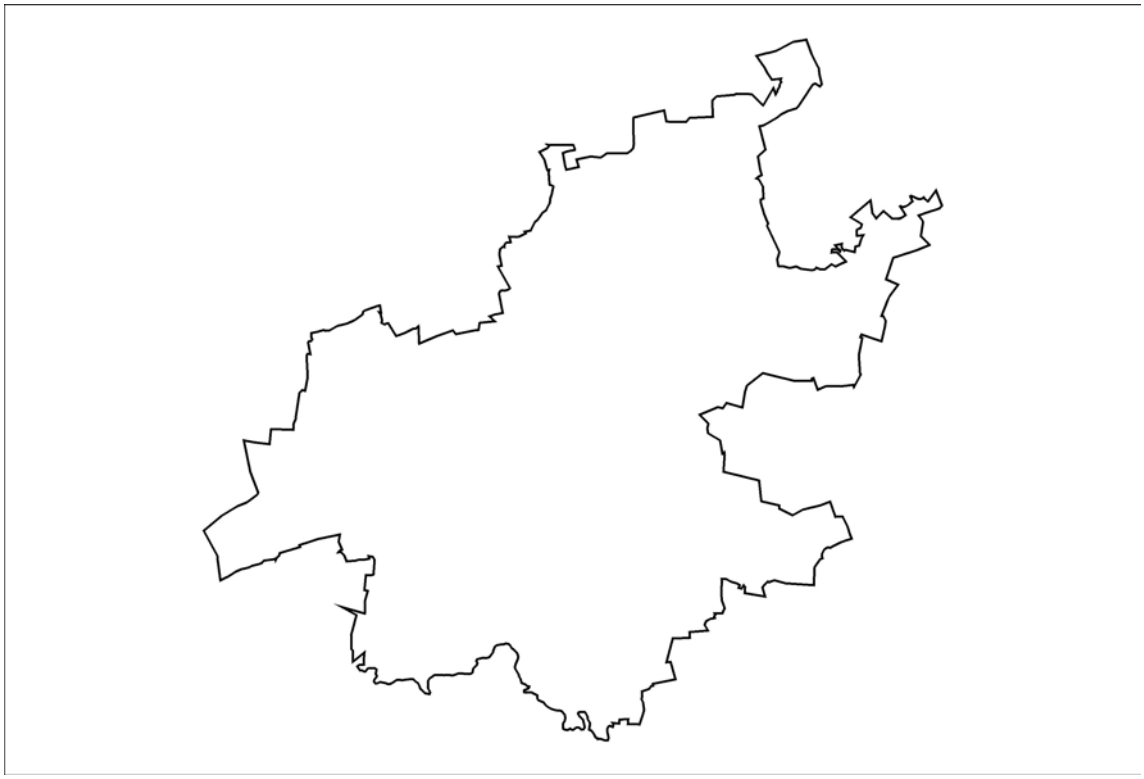
- The free nation of South Africa is new
- Women don't realize they are free to take charge of their life and reduce risks, especially for those who may not have education or skills for a job.
- Women can insist on condom use or use female condoms
- Women can avoid being victims
- Women can own their lives and not give it away because of drug need and alcohol abuse
- Women can protect themselves form HIV, violence and drug use
- It is a start toward a more positive, free, and safer life

APPENDIX E : SOUTH AFRICAN MAP

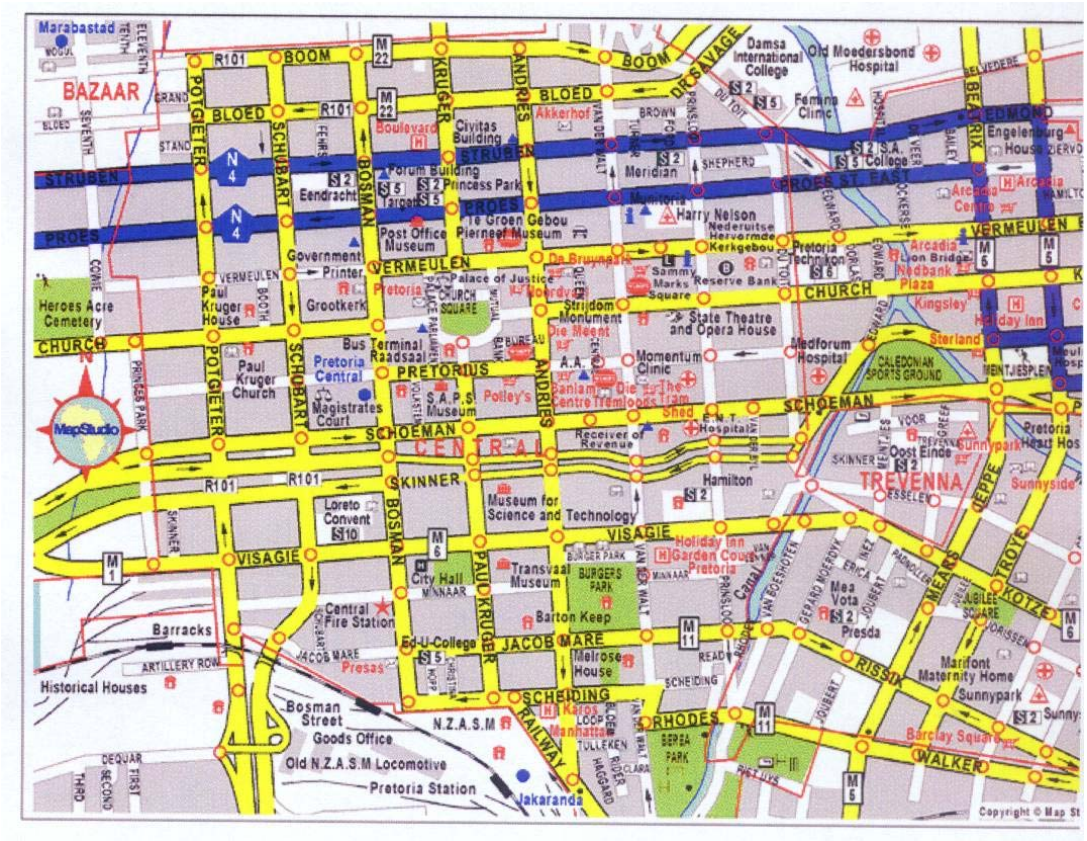
South Africa Map



GAUTENG PROVINCE MAP



TSHWANE/PRETORIA MAP



APPENDIX F: QUICK FIELD SCREENER

Identifying Information

Staff ID:……

Staff ID: ……..

Date: ……

Hello, my name is …….. I'm working on a study of drug use and health in permission to ask you some questions. It will take less than 3 minutes to find out if you might be eligible. Your answers will be kept strictly confidential and you do not need to give me your name.

A. SCREENER

A1. [FROM OBSERVATION IF POSSIBLE] (Are you male or female?)

Male: 1

Female: 2 Female ….

A2. What is your date of birth……..

a) And how old are you now?……. 18+

A3. Do you consider yourself to be Black, Colored, a White South African, or another race or ethnic group?

Black……..1 Black South African……..

Colored…….2

Asian/Indian……..3

White ……4

Other (Specify)……99

v……

A4. Where do you currently live? ……..Province and city

A5. Have you ever:

	No	Yes
a. Used crack cocaine	0	1
b. Used heroin	0	1
c. Used Marijuana	0	1
d. Used alcohol	0	1
e. Injected any drugs	0	1
f. DK/Unsure		7
g. Refused		8

A6. Have you used crack cocaine in the past 90 days?……..**Yes**……..

01 Yes 00 No

A7. Have you ever traded sex for drugs?……..**Yes**……..

01 Yes 00 No

A8. Have you had multiple sex partners?……**Yes……..**

01 Yes 00 No

A9. Where were you born?

_____

Town/city/Province/Rural

A10. Are you a South African citizen?……**Yes**…

01 Yes 00 No –What country are you a citizen of?

END OF SREENER

[IF ANY BOXES ( ) NOT TICKED, READ:]

Those are all the questions I have for you. Thank you very much for your time and participation. Let me assure you that all of the information you have provided will be kept confidential.

[IF ALL BOXES ( ) TICKED, READ:]

Based on your answers, you may be eligible to participate in focus groups or interviews we are conducting to try and slow the spread of AIDS and other health problems among drug users who are not in treatment. If you have a moment now, I would like to tell you a little more about that study.