

The devil in the details: A comparison of demographics and behaviours of female sex workers in Johannesburg and Pretoria

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Key populations at higher risk of acquiring HIV, such as female sex workers (FSWs), are not benefiting equally from the gains made by the global fight against HIV (1). Sex workers (SWs) have generally been overlooked and underserved by health and social services in South Africa. From 2010 onwards, efforts have focused on scaling up health services for SWs and more recently there has been a substantial increase in the availability of SW-specific programmes. These include programmes funded by the Global Fund, PEPFAR and the South African Government and that reach as many as 35 000 to 40 000 SWs.

FSWs face many barriers to accessing health care because of stigma and discrimination, which increase their vulnerability to acquiring HIV and hamper their right to access health care services (2). A number of recent studies have shown that the SW community is at a substantially higher risk of contracting HIV and that prevalence rates in this community are among the highest in the world. Research shows that HIV prevalence among SWs in South Africa ranges between 40% and 88%, which is much higher than the 14.4% among women in the general population (3). These high prevalence rates called for urgent steps to be taken and a national campaign to address the needs of SWs.

The South African National Sex worker HIV Plan, 2016-2019, which was launched in 2016, describes a standardised minimum package of services to be provided by all implementers of SW services in South Africa (4). The combination of services prescribed in the plan uses a peer-led approach and the core package has been designed to respond to the multi-faceted lives of SWs. The minimum package includes HIV prevention and treatment, psycho-social support, legal support and economic empowerment elements.

When taking a closer look at SWs in different settings, social and demographic factors vary considerably across and within settings. Adopting a standardised approach to SW programmes may therefore compromise the health outcomes of some sub-groups in local areas. In this study, SWs in inner-city Pretoria and inner-city Johannesburg (Hillbrow) - two cities merely 50 kilometres apart - were compared.

Diversity of sex workers and their varying needs

SWs in these two urban sites in Gauteng differ significantly in almost all demographic- and behavioural characteristics we studied (Table 1).

Table 1: Demographic and behavioural characteristics of sex workers in Johannesburg and Pretoria

	JOHANNESBURG N=1422 N(%)	PRETORIA N=408 N(%)	ODDS RATIO	P value
HIV positive* all	575/1364 (42.2)	211/399 (52.9)	0.6 (0.5-0.8)	<0.001**
<i>South Africans</i>	210/593 (35.4)	80/158 (50.6)		
<i>Zimbabweans</i>	286/589 (48.5)	123/229 (58.3)		
<i>Other origin</i>	79/181(43.6)	8/12 (66.7)		
Previous STI	630/1422 (44.3)	34/408 (8.3)	8.8 (6.0-13.0)	<0.001**
Use modern contraception, other than condoms	187/1422 (15.1)	62/408 (15.2)	0.9 (0.6-1.2)	0.288
No child dependents	281/1401 (20.1)	61 (399) (15.3)	1.4 (1.0-1.9)	0.032*
Age years				
<25	340/1422 (23.9)	43/404 (10.6)	2.6 (1.9-3.8)	<0.001**
25-29	517/1422 (36.4)	92/404 (22.8)	1.9 (1.5-2.5)	
30-34	369/1422 (26.0)	128/404 (31.7)	0.8 (0.6-1.0)	
35+	196/1422 (13.8)	141/404 (34.9)	0.3 (0.2-0.4)	

Age years; HIV-positive				
<25	77 (23.8)	9 (22.0)		
25-29	206 (41.6)	36 (40.5)		
30-34	182 (51.1)	73 (57.9)		
35+	110 (58.2)	90 (64.8)		
Education				
Primary	46/1414 (3.3)	61/406 (15.0)	0.2 (0.1-0.3)	<0.001**
Grade 8-10	490/1414 (34.7)	180/406 (44.3)	0.7 (0.5-0.8)	
Grade 11-12	808/1414 (57.1)	146/406 (36.0)	2.4 (1.9-3.0)	
Tertiary	70/1414 (5.0)	19/406 (4.7)	1.1 (0.6-1.9)	
Have a main partner	693/1422 (48.7)	221/406 (54.4)	0.8 (0.6-1.0)	0.043**
>1 child lives with sex worker	163/1233 (13.2)	101/408 (24.8)	0.5 (0.3-0.6)	<0.001***
>3 dependent adults	456/1398 (32.6)	153/400 (38.3)	0.8 (0.6-1.0)	0.036**
Country of birth				
South Africa	621/1422 (43.7)	234/408 (59.1)	0.6 (0.5-0.7)	<0.001**
Zimbabwe	610/1422 (42.9)	162/408 (39.7)	1.1 (0.9-1.4)	
Other	191/1422 (13.4)	12/408 (2.9)	5.1 (2.9-10.2)	
Alcohol use	977/1314 (74.4)	221/390 (56.7)	2.2 (1.7-2.8)	<0.001**
Marijuana use	92/1314 (7.0)	32/390 (8.2)	0.8 (0.5-1.3)	0.422
Years in sex work				
<2	496/939 (52.8)	298/407 (73.2)	0.4 (0.3-0.5)	<0.001**
2-5	311/939 (33.1)	71/407 (17.4)	2.3 (1.7-3.2)	
>5	132/939 (14.1)	38/407 (9.3)	1.6 (1.1-2.4)	
Sex encounters past 7 days				
0-10	515/1311 (39.3)	41/218 (18.8)	2.8 (2.0-4.1)	<0.001**
11-20	452/1311 (34.5)	72/218 (33.0)	1.1 (0.8-1.5)	
>20	344/1311 (26.2)	105/218 (48.2)	0.4 (0.3-0.5)	
Consistent condom use: main partner	201/1422 (14.1)	58/208 (27.9)	0.4 (0.3-0.6)	<0.001**
Consistent condom use: clients	1289/1302 (99.0)	359/382 (94.0)	6.4 (3.0-13.8)	<0.001**
Times moved house past year				
0	729/1422 (51.3)	336/408 (82.4)	0.2 (0.2-0.3)	<0.001**
1	415/1422 (29.2)	64/408 (15.7)	2.2 (1.6-3.0)	
2	278/1422 (19.6)	8/408 (2.0)	24.3 (9.3-90.3)	
Site receives services				
Hotel	1129/1328 (85.0)	329/408 (80.6)	1.4 (1.0-1.8)	<0.001**
Clinic	75/1328 (5.7)	2/408 (0.5)	12.2 (3.2-102.5)	
Mobile vans	124/1328 (9.3)	77/408 (18.9)	0.4 (0.3-0.6)	

**P<0.001; *P<0.05

Women in Johannesburg had lower levels of HIV infection, but the proportion of reported symptomatic sexually transmitted infections (STIs) was much higher compared with women in Pretoria. They also reported higher condom use with clients, while they were less likely to use condoms with their non-paying customers. For programming purposes, this suggests that women in Johannesburg were more exposed to STI infection from their romantic partners among which reported condom use is low, and that this should be a focus area for intervention. It is, however, important to note the difference in condom use between clients and main partners in both sites. Programmers often overlook the 'home life' behaviours of SWs, focusing only on 'work life' behaviours.

FSWs in Johannesburg were younger, better educated, and were more likely to come from outside South Africa than those in Pretoria. This is in line with the reputation of Hillbrow, an inner-city area in Johannesburg, which is renowned for commercial sex work and being a haven for immigrants, whereas Pretoria is not. This difference is also reflected in the findings on the domestic front: the women in Johannesburg were less likely to have a main partner, less likely to have child dependents, less likely to have children living with them, and more mobile (more likely to have moved house in the last year). A focus on childcare services and child welfare would therefore be a higher priority in Pretoria than in Johannesburg.

The difference between the two sites is also reflected in behaviour: Johannesburg women were twice as likely to drink alcohol, had less sex encounters in the last seven days, and had been in sex work for longer than their colleagues in Pretoria. These findings could be ascribed to several factors and was observed in other research (5). Firstly, sex-for-money exchange in Pretoria may be understood as a way to survive financially and not viewed as formal 'sex work' (6). It is therefore possible that women in Pretoria are less likely to report intermittent periods of 'sex-for-money to survive' as time doing sex work. Secondly, the majority of women in Johannesburg migrated from outside South Africa, often at a young age, some lacking official documentation. This in combination with xenophobic-related stigma influences their employment opportunities in the formal sector (7,8). Support with obtaining official documentation and assistance with alcohol abuse would therefore rank higher in Johannesburg than in Pretoria, as reduced mobility will promote retention in programmes, continuity of care within services and improve access to health services.

In both sites, SWs were more open to accessing healthcare if these were delivered at their place of work (9). Whether services are delivered from the clinic, mobile or hotel has important implications for both the accessibility of services and the training of healthcare workers. SWs served by the mobile vans are usually street-based and might be more exposed to violence from clients, police arrest, and have less access to condoms and healthcare than their colleagues in the hotels and brothels (10). Also, homeless women might not have a place to store their medication, even if they were to access treatment.

In conclusion, this study clearly shows the diversity of SWs and their varying HIV treatment needs in the workplace and at home. Standard treatment guidelines could therefore fall short of their intention to reduce vulnerability to poor health outcomes if a non-differentiated approach to care is followed. Trained staff who are sensitised to the local medical, emotional and legal needs of SWs

are able to create user friendly services that encourage these vulnerable women to utilise services.

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References:

1. UNAIDS. On the Fast-Track to end AIDS, 2016-2021 Strategy. Geneva: UNAIDS; 2016.
2. Scambler G, Paoli F. Health work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions. *Social Science & Medicine*. 2008;66(8):1848–1862.
3. Wits RHI; ANOVA Health Institute; UCSF; CDC. South African Health Monitoring Survey (SAHMS): An Integrated Biological and Behavioural Survey among Female Sex Workers, South Africa 2013 – 2014. Pretoria; 2016.
4. SANAC. The South African National Sex Worker HIV Plan, 2016 – 2019. Pretoria: SANAC; 2016.
5. Lafort Y, Lessitala F, Candrinho B, et al. Barriers to HIV and sexual and reproductive health care for female sex workers in Tete, Mozambique: results from a cross-sectional survey and focus group discussions. *BMC Public Health*. 2016;16(1):608.
6. Wojcicki JM. Commercial sex work or ukuphanda? Sex-for-money exchange in Soweto and Hammanskraal area, South Africa. *Culture, Medicine, and Psychiatry*. 2002;26(2000):339–370.
7. Hao C, Liu H, Sherman SG, et al. Typology of older female sex workers and sexual risk for HIV infection in China: a qualitative study. *Culture, Health and Sexuality*. 2014;16(1):47–60.
8. Richter M, Chersich M, Vearey J, et al. Migration status, work conditions and health utilization of female sex workers in three South African cities. *Journal of Immigrant & Minority Health*. 2015;16:7–17.
9. Stadler J, Delany S. The “healthy brothel”: The context of clinical services for sex workers in Hillbrow, South Africa. *Culture, Health and Sexuality*. 2006;8(5):451–464.
10. Scheibe A, Richter M, Vearey J. Sex work and South Africa’s health system: addressing the needs of the underserved. In: A. Padarath J, King J, Mackie E, Casciola J (Eds.). *South African Health Review* (pp. 165–178). Pretoria: Health Systems Trust; 2016.