

THE HEALTH SEEKING BEHAVIOURS OF SEX WORKERS AT NGUNDU GROWTH POINT IN CHIVI DISTRICT, ZIMBABWE



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in partial fulfilment of the requirements for the degree of
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Dedication

“To the sisters, daughters and mothers in Zimbabwe making a living out of sex work. You are human beings just like everyone else and you are not animals, it is your right to live. I have a dream....that someday your voices will be heard....I have a dream....!”

-Thamsanqa Maphosa (inspired by Martin Luther King Jnr.)-

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List of Abbreviations

AIDS	-	Acquired Immunodeficiency Syndrome
ART	-	Antiretroviral Treatment
ARV	-	Antiretroviral
ASO	-	AIDS Service Organisation
BHASO	-	Batanai HIV/AIDS Service Organisation
CD4	-	Cluster of Differentiation 4
CeSHHAR	-	Centre for Sexual Health, HIV and AIDS Research
DMO	-	District Medical Officer
DNO	-	District Nursing Officer
FACT	-	Family AIDS Caring Trust
GAPR	-	Global AIDS Progress Report
HCPPC	-	Health and Child Welfare Parliamentary Portfolio Committee
HIV	-	Human Immunodeficiency Virus
IEC	-	Information, Education and Communication
IGP	-	Income Generating Project
MIPA	-	Meaningful Involvement of People with HIV/AIDS
MoEASC	-	Ministry of Education, Arts, Sports and Culture
MoHCW	-	Ministry of Health and Child Welfare
NAC	-	National AIDS Council
NGO	-	Non Governmental Organisation
OI	-	Opportunistic Infections
OVC	-	Orphans and Vulnerable Children
PLHIV	-	People Living with HIV
PLWHIV	-	People Living With HIV
SAMP	-	Southern Africa Migration Project
STI	-	Sexually Transmitted Infection
UNFPA	-	United Nations Population Fund
USAID	-	United States Agency for International Development
WHO	-	World Health Organisation
ZAPP	-	Zimbabwe AIDS Prevention Project
ZESN	-	Zimbabwe Election Support Network
ZLHR	-	Zimbabwe Lawyers for Human Rights
ZIMSTAT	-	Zimbabwe Statistics agency

Abstract

Chivi district has the highest HIV prevalence of 35% in Masvingo Province. The provincial rate is at 14%. Ngundu growth point which is part of Chivi South District recorded the highest number of sexually transmitted infections in the province in early 2013. The growth point is characterised by increased number of sex workers that operate in the area and the local clinic records revealed that Ngundu constituted the highest number of individuals treated for HIV and STI infections. FACT-Chiredzi, a local AIDS service organisation, wants to contribute to the reduction of HIV prevalence in the district by designing an appropriate intervention for sex workers in the district.

The goal of the study was to gather information on factors influencing sex workers behaviour in seeking HIV prevention and treatment services in order to facilitate the design of an appropriate intervention strategy. A qualitative approach to the study was based on the desk study of literature, a case study and a review of official documents. Data was collected from a total of 12 respondents which included 3 sex workers below 16 years, 3 sex workers between 17 and 40 years, 3 sex workers above 40 years, 1 health service provider and 2 local governing bodies. It was expected that the information obtained would be triangulated in order to identify factors influencing sex workers in accessing HIV prevention and treatment services.

Data analysis was guided by the relationships shown in the conceptual framework in order to identify and assess the factors categorised as external, internal and governing bodies' influences. The study identified external factors such as consistent drug shortages, expensive alternative health services and lack of coordination in health service provision. Internal factors identified included financial dependency, fear of dying and stigmatization. Governing bodies were also identified excluding sex work issues in their policy formulation which translated to exclusion of special needs for sex workers in health service provision.

Recommendations to FACT were based on the identified factors and they included the revision of the current sex work intervention. Also identified is need for the organisation to collaborate with strategic stakeholders in developing appropriate intervention strategies. Recommendations for governing bodies included the need to develop appropriate policies in order to ensure sex workers are not marginalised and have access to sexual health services.

Chapter 1: Introduction

1.1 Problem Background

Ngundu growth point is located along the busy Beitbridge-Harare highway which links countries such as Zambia, Malawi and the Democratic Republic of Congo to South Africa. The growth point is also an overnight resting place for long distance travellers such as haulage truck drivers and cross boarder traders who usually spend a lot of money at local bars and nightclubs. This has led to the main problem of increase of sex workers in the growth point, mostly women and young school going girls who compete for male clients seeking sexual services at the local bars and nightclubs. UNFPA (2010) defines sex workers as individuals who “...include female, male, transgender adults and young people and children who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not identify as sex workers”. For purposes of this research sex workers refer to older women, young women and school going girls who receive money for sexual favours at Ngundu growth point. According to the Demographic Health Survey (ZIMSTAT, 2012) and the Health and Child welfare Parliamentary Portfolio Committee report (HCPPC, 2013), the high level of commercial sexual activities at Ngundu growth point has contributed to Chivi South District recording the highest HIV prevalence rate of 35% within Masvingo province, which is above the provincial prevalence rate of 14%. Furthermore, Ngundu growth point recorded the highest number of Sexually Transmitted Infections (STI's) in the province which is an indicator that people are engaging in unprotected sex which facilitates the spread of HIV (HCPPC, 2013). The issue has also caught the attention of local media (Mtimba, 2013). This is a cause for concern for local leaders and AIDS service organisations such as FACT-Chiredzi which has the following mission “*To contribute towards to reduction in HIV prevalence while mitigating its impact in communities*” (FACT, 2013).

1.2 Problem Statement

FACT-Chiredzi wants to develop an intervention to reduce the spread of HIV among sex workers at Ngundu growth point in order to reduce HIV prevalence in Chivi South District. There are two reasons why the organisation is focussing on sex workers. Firstly, the acquisition of HIV and other STIs are major occupational hazards of sex work where clients can infect sex workers who may transmit infection to other clients, and from them to their sex partners. Secondly, by preventing infection among sex workers there is a potential to improve individual health of sex workers as well as slowing HIV transmission among the wider population. As a result, FACT-Chiredzi wants to conduct a baseline research on influencing factors that contribute to sex workers behaviour in seeking HIV prevention and treatment services at Ngundu growth point, that will provide the information needed to design the appropriate intervention.

1.3 Research Objective

The objective is to gather information on factors influencing sex workers' behaviour in seeking HIV prevention and treatment services in order to facilitate the design of an appropriate intervention strategy by FACT-Chiredzi.

1.4 Problem Owner

Family AIDS Caring Trust Chiredzi (FACT-Chiredzi)

1.5 Research Questions

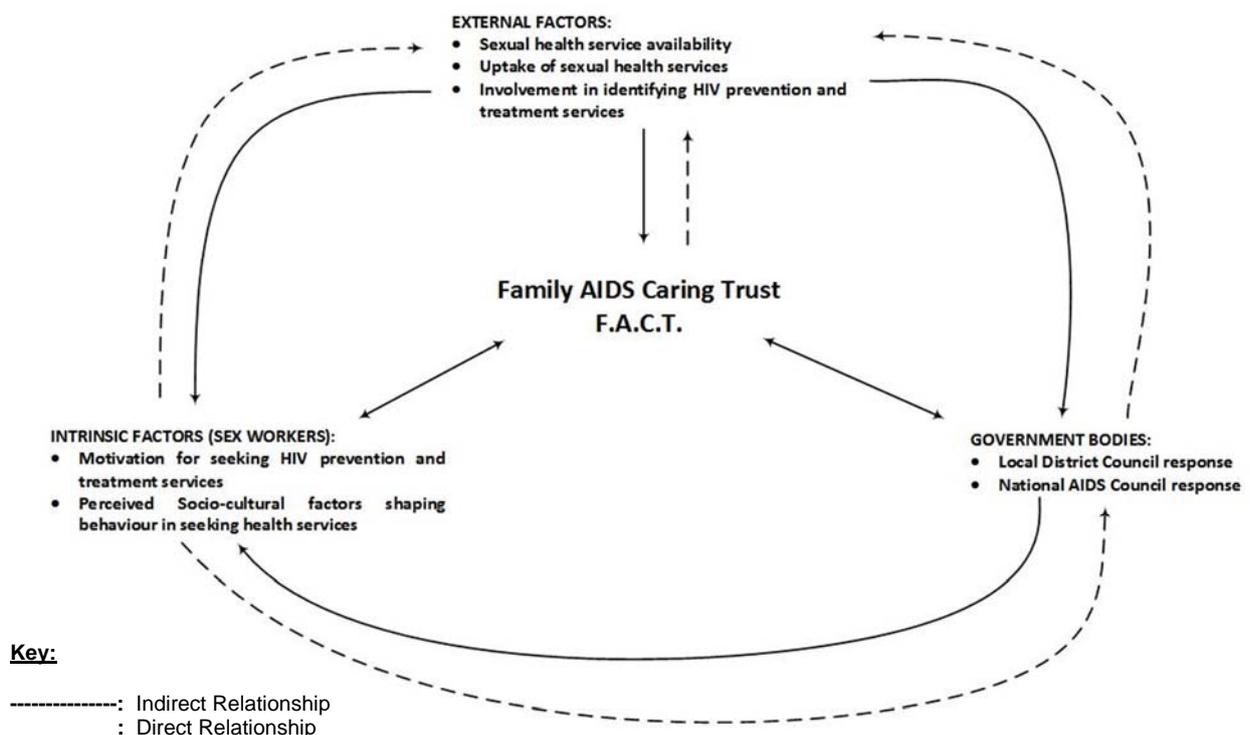
1. What are the external influencing factors that are influencing the sex workers behaviour in seeking HIV prevention and treatment services?
2. What are the intrinsic factors that influence the sex workers in seeking HIV prevention and treatment services?
3. What is the role of government bodies in contributing to the behaviour of sex workers in seeking HIV prevention and treatment services?

1.5.1 Sub questions

- 1.1. What are the health services available for sex workers which address their need for HIV prevention and treatment?
- 1.2. What are the conditions that influence the uptake of health services by the sex workers?
- 1.3. What is the involvement of sex workers in defining HIV prevention and treatment services that address their sexual health needs?
- 2.1. What are the personal and economic influences for sex workers that determine their actions in seeking HIV prevention and treatment services?
- 2.2. What are the socio-cultural reasons that shape the behaviour of sex workers in seeking HIV prevention and treatment services?
- 3.1. What measures has the local district council put in place in order to address the issue of sex workers within the growth point?
- 3.2. What is the national AIDS coordinating body, the National AIDS Council's (NAC) response in addressing the issue of HIV prevention and treatment services for sex workers?

1.6 The Conceptual Framework for Research

Figure 1: Conceptual Framework



Chapter 2: Background Review

2.1 Sex Work and Sex Workers

According to the UNFPA (2010), sex work is the provision of sexual services by one person to another in return for money or reward in the form of goods. UNFPA (2010) further defines sex workers as male, female or transgender people who receive either money or goods for sexual services. The exchange of sexual services is either on a regular or occasional basis and those receiving money or goods for sexual services may not identify as sex workers. For the purposes of this study, sex workers refer to both young and older females receiving money or goods in exchange for sexual services.

2.2 HIV/ AIDS and Sex Work in Zimbabwe

In Zimbabwe, the estimated HIV prevalence rate among adults 15 years and older in the year 2011 was at 13% in a projected population of approximately 13 million people according to the National HIV Estimates of 2010 (Global AIDS Progress Report, 2012). In 2010, Zimbabwe undertook the UNAIDS modes of transmission modelling through the National AIDS Council, and the results revealed that HIV transmission in the country remains predominantly sexually driven. The results also indicated that sexual transmission accounts for above 90% of new infections (GAPR, 2012). According to Baral et al (2012), there are higher levels of HIV among sex workers compared to all women of reproductive age in Sub-Saharan low income countries such as Zimbabwe. The authors' further note that sex workers in these countries are more than 12 times more likely to be HIV positive compared to all women in the country. A similar study by Luam et al (2012) confirms this finding by noting that HIV and STI prevalence among sex workers in the same region is likely to be more than 20 times higher than the HIV prevalence of the general population.

Data on HIV and sex workers in Zimbabwe is either undocumented or not available at all. Baral et al (2012) note that about two thirds of low income countries in Africa do not have current estimates on HIV among sex workers and this could be a result of social stigma and criminalization of sex work. This leads to reduction in research funding and low investor interest. In Zimbabwe, the unavailability of information is shown in the country's Global AIDS Progress Report of 2012 shown in table 1 below;

Table 1: HIV Indicators for Sex Workers in Zimbabwe

Indicators for sex workers

	2007	2009	2012
• Percentage of sex workers reached with HIV prevention programmes	Data not available	Data not available	Data not available
• Percentage of sex workers reporting use of condom with their most recent client	Data not available	38.3% (Women only) [NBCBS 2007/2008]	68.5% (Women Only) [ZAPP/RDS Sex Work Programme Database]
• Percentage of sex workers who have an HIV test in the past 12 months and know their results	Data not available	Data not available	58.8% (Women Only) [ZAPP/RDS Sex Work Programme Database]
• Percentage of sex workers who are living with HIV	Data not available	Data not available	50% (Women Only) [ZAPP/RDS Sex Work Programme Database]

Source: Government of Zimbabwe (2012)

Table 1 reflects a number of gaps in required data, notably for years 2007 and 2009. In Zimbabwe, there is no legal framework that supports the targeting of sex workers with prevention activities. The current National HIV and AIDS policy focuses on issues such as the prohibition of HIV screening for employment purposes, and is silent on protecting sub populations such as sex workers. The government has acknowledged that there is a need to put in place targeted programmes and special needs studies for sex workers in order to understand the nature of the epidemic among them (GAPR, 2012). This view is echoed by Scanlon and Vreeman (2013) who note that implementation research which investigates how health systems implement and deliver evidence based interventions is crucial for guiding governments and policy makers in developing appropriate HIV/AIDS interventions.

Enrisek et al (2010) further emphasise that such special needs studies need to utilize a multi-actor approach because if the social complexity of HIV/AIDS is ignored, and legitimate concerns of stakeholders such as sex workers are neglected, it leads to disruptions in policy making and decision making. These disruptions are also captured by Chambers (2005) in a discussion on the social complexity of HIV/AIDS *“governments and NGO’s in Sub-Saharan Africa will follow the same trajectory as the disease; they will get sicker and less effective until they finally die, with donors standing at a distance, blaming them for their own irresponsible behaviour”*.

2.3 Sex Workers and Sexual Health Services

Sex workers in Zimbabwe are noted to be experiencing challenges in seeking HIV and AIDS services. The challenges are related to the problems of disclosing their sexual orientation as a major barrier to obtaining accurate, appropriate and relevant treatment. The prevailing criminal laws and the resultant stigma prevent them from participating in professional bodies and organised associations that protect the rights of other professions. This makes it difficult to organise themselves as a profession that monitors and promotes their professional rights. There are also a number of widespread barriers in Zimbabwe that prevent sex workers from accessing sexual healthcare services and these include problems in seeking health services from government hospitals because the responsible medical personnel insist on the sex workers to bring their sexual partners for similar treatment, therefore refusing to offer them the required treatment (Maseko, 2013).

The other barrier is related to the criminalisation of sex work in Zimbabwe, which prevents sex workers from fully disclosing their profession and specific health needs such as inability to access treatment such as pap smears and breast screening. An article published by the Zimbabwe Lawyers for Human Rights highlighted that a total of 53 women were arrested in a single overnight raid by the police under the operation code named "*Operation Zvanyanya*" (It's too much), which was aimed at getting rid of sex workers off the streets and lodges. The women were assaulted by the police using baton sticks and are denied sanitary wear whilst under police custody (ZLHR, 2013). A local newspaper "The Standard", also published a similar article entitled "*Outcry over women's arrest*" in July 2013 (Mbanje, 2013). To further compound the sex workers situation, if they are found carrying condoms, the very condoms are used as evidence that they are engaging in sex work and this becomes a justifiable reason to arrest and detain the sex workers. As a result sex workers rights are often unreported in Zimbabwe and this makes it a challenge for organisations and researchers to collect accurate data about their experiences. The above arguments suggest a strong linkage between criminalization of sex work and increased access to sexual and reproductive health services for sex workers in Zimbabwe (Maseko, 2013).

2.4 HIV/ AIDS interventions and Health Seeking Behaviour

Skordal et al (2011) note that in Zimbabwe, emphasis has been placed on the importance of community mobilization in behaviour change efforts, including those of sex workers. Barnett and Whiteside (2006) note that the concept of a 'community' is not a static one and should be carefully defined in any development intervention. They argue that HIV/AIDS interventions have a tendency of looking at communities as resources in either prevention or impact mitigation. These communities are perceived as cohesive, interactive and mutually supportive entities. In reality there are various factors which determine how individuals interact which define whether they are a community or not, and this includes their history and cultural framework. As a result, Skordal et al (2011) criticise the current community based interventions in Zimbabwe by noting that health seeking behaviours are shaped by factors lying beyond the boundaries of local communities where AIDS affected people live and work. They highlight that there is a need to develop systematic accounts of social contexts that subsequently frame appropriate responses. In order to develop appropriate interventions for targeted groups in Zimbabwe, health seeking behaviour should be studied and understood as a process influenced by the material, relational and institutional contexts where health seekers live. Their motivation, participation and psychosocial responses to available sexual health services should be considered (Skordal et al, 2011).

Mackian (2003) notes that since the spread of HIV and STI's is 'social' in nature and reflects cultural beliefs around sexuality, virility and reproduction, it is recommended for solutions to be found through context specific research reflecting the cultural and social element. This

process can be achieved through an exploration of interrelationships of individuals within specific social systems, cultural norms and system constraints. The resultant behaviour should therefore be understood as a product of these interrelations (Mackian, 2003).

2.5 Factors affecting health seeking behaviour

There are several studies from around the world that have been conducted on factors affecting health seeking behaviours amongst sex workers in low income countries. Studies by Meheus et al (2008), Chakrapani et al (2009) and Ghimire (2009) present significant findings applicable to recommendations made by Skordal et al (2011) in a study on Zimbabwe. The studies identify factors that influence health seeking behaviours amongst sex workers in their respective countries in relation to HIV and STI prevention and treatment services.

Chakrapani et al (2009) classify these factors into three broad categories, namely, 'Social barriers' which include fear of adverse consequences as a result of disclosure of HIV positive status, lack of family support if found to be HIV positive, unmet basic needs to support their families, societal level stigma and discrimination of PLHIV. 'Healthcare programmatic barriers' include negative experiences with health care providers, lack of adequate counselling services at government centres and NGO outreach workers, biased treatment in favour of sex workers referred by NGO. Meheus et al (2008) also cite long distances from home to health facilities and lack of coordination across health services as some of the healthcare factors.

'Individual barriers' are the last category defined by Chakrapani et al (2009) and they relate to lack of adequate knowledge of sexual health services and perceived benefits of health services. Ghimire (2009) provides an elaboration on individual barriers to include sex workers hygiene, age, education level, duration of exposure to sex work, low living status and the ability to pay for health services as factors affecting health seeking behaviours among sex workers.

2.6 The Context of Health Seeking Behaviour

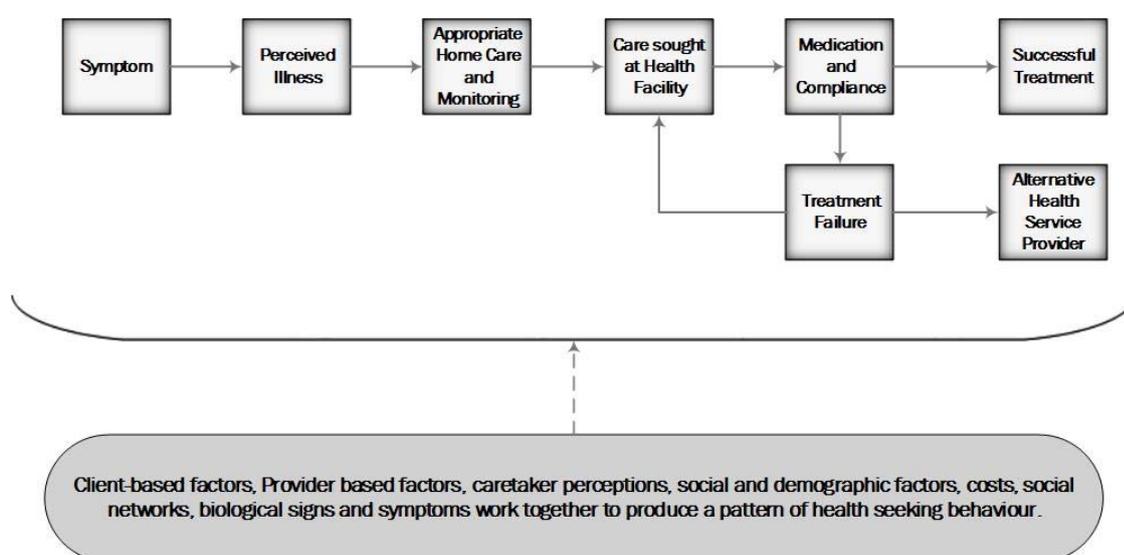
Health seeking behaviour is a concept that can be perceived from two perspectives. The one perceives health seeking behaviour as all behaviours associated with the establishment and retention of a healthy state of individuals and groups, and includes aspects of dealing with departure from a healthy state. This is the preventive aspect of health seeking behaviour, which focuses on planning health programmes and encourage the use of modern health care facilities (WHO, 1995).

Olenja (2003) perceives health seeking behaviour from another perspective as any action taken by an individual perceiving themselves to have a health problem or illness so that they find appropriate treatment for their ailment. This action does not occur as an impulsive and predictable response to the ailment, but is preceded by a process of decision making that is further governed by characteristics such as individual/ household behaviour, influence from the community such as norms and expectations, as well as the conditions set up by the health service providers as they interact with the community they serve.

For the purposes of this study, health seeking behaviour refers to both broader social aspects of planning health programmes together with the use of modern health facilities in combination with the individual actions governed by household, community, and health service provider terms and conditions.

There are external factors that influence the health seeking behaviour of an individual. These factors fall under what Olenja (2003) refers to as a “*contextual analysis of care seeking behaviour*”. The context referred to consists of the level of awareness of the services being provided, socio-cultural factors that influence the health seeking behaviour of the concerned individual, as well as the economic factors that determine the capacity of an individual seeking health services. The interplay that obtains from the interaction between the individual cognitive factors in the decision making process and the contextual environment where these decisions take place, leads to the development of health seeking behaviour as a non-homogenous entity. These means that health seeking behaviours vary between rural areas, growth points or big cities depending on the individual decisions made by the health seekers and the accompanying contextual environment.

Figure 2: Typical individual health seeking model and influencing factors



Source: Author’s construct adapted from Olenja (2003)

Olenja (2003) further notes that the health seeker’s perspective on the quality of health care that is experienced through client- provider encounters, play a major role in health seeking behaviour. The health seeker’s satisfaction with the health services provided is considered an essential factor in determining compliance with treatment and maintaining a relationship with the health service provider. Factors such as the nature of the interaction, health care provider attitude, the physical environment all have the potential to influence the health seeker’s perspective on the quality of services being offered, thereby influencing the subsequent health seeking behaviour (Olenja, 2003).

As a result, there is no single method that can be used to explain or establish any health seeking behaviour pattern due to its complexity. In summarising the non-homogenous nature and complexity of health seeking behaviour, Olenja (2003) notes that “*Health seeking behaviour is a reflection of the prevailing conditions, which interact synergistically to produce a pattern of care seeking but which remains fluid and therefore amenable to change*”. It is therefore necessary to study the issue of health and health seeking behaviour in wider socio-cultural and economic contexts rather than focussing only on individual behaviour.

2.7 FACT- Chiredzi: Organisational Background

Family AIDS Caring Trust (FACT) – Chiredzi is a Christian AIDS Service Organisation (ASO) based in Chiredzi, south-eastern of Zimbabwe. The mission of the organisation seeks to help reduce HIV prevalence in the areas of operation by facilitating community empowerment. Its initial activities focused on Orphan's and Vulnerable Children (OVC's), HIV prevention for youths, vulnerable adults and rural groups. This scenario has evolved and the organisation's current main HIV and AIDS programmes are focused on prevention through information, education, counselling, testing, care and support. The organisation also focuses on social enhancement and economic empowerment in rural and urban communities (FACT, 2011).

FACT is closely linked to key government line ministries and works closely with the Department of Social Welfare; Ministry of Education, Arts, Sports and Culture (MoEASC), Ministry of Health and Child Welfare (MoHCW) and the National AIDS Council (NAC). The organisation is pursuing a strategic approach targeted at facilitating institutional sustainability by empowering communities to own the development process. The organisation has a volunteer network with more than two thousand volunteers working in urban and rural areas as counsellors, carers, peer educators, and AIDS patrons (FACT, 2011).

Figure 3: Premises of FACT-Chiredzi in Chiredzi District, Masvingo Province



The organisation's premises are located in the local community, within the high-density residential area of Tsovani suburb.

2.8 FACT's sex work programming

The organisation is currently running the Adult Peer Education Programme which falls under its HIV prevention strategy. The beneficiaries of the programme are mostly women recruited from the local communities and trained to be peer educators. This Peer Education programme started off by recruiting 180 sex workers who were willing to make a change in their lives by stopping their involvement in the sex trade and offering them alternatives for income generation with do not involve using sex as a means of survival (FACT, 2013).

The Peer Education Co-ordinator with FACT-Chiredzi revealed that the peer education programme was mainly designed to curb the high levels of prostitution on Zimbabwe's highways, with reference to areas such as Gundu growth point in mind. The South African Migration Project (2005), had the previous opportunity to interview the FACT Peer Education Coordinator on the intervention which by 2005 when the interview was conducted, was already being implemented. The main objective of targeting sex workers to be peer educators is revealed by the Coordinator's words when she said "...*Instead of selling their bodies for money these former prostitutes now go into beer halls performing drama and teaching people about the dangers of HIV and AIDS. They also distribute condoms.*" (SAMP, 2005). The sex workers are not the only ones benefiting from the Peer Education intervention, the programme has evolved to include young mothers. Most of these young mothers are single mothers who are trained in issues related to domestic violence and women's rights (FACT, 2013).

The Adult Peer Education programme is currently the only intervention that involves sex workers in its programming. The goal of this programme is to have dynamic community owned HIV and AIDS prevention programmes which lead to a reduction in new HIV infections and sustainable behaviour change among youth and adults. Programme objectives are focussed on promoting behaviour change through provision of sustainable projects such as Income Generating Projects (IGP's) that are implemented and managed by the sex workers (FACT, 2013).

The following is a summary of current activities that involve sex workers under the Adult Peer Education Programme (FACT, 2013):

- Provision of seed fund for micro-finance to Peer Educators in 12 sites in 5 districts.
- HIV/AIDS drama, songs, role plays and prompt speech competitions among Adult Peer Educators.
- Provision of sewing machines to Adult Peer Educators in Chiredzi urban, growth points and business centres.
- Training of disabled adult peer educators.
- Pass-on goat project to adult peer educators in 5 districts.
- Training of workplace and church adult peer educators on ART, OI and Treatment Literacy on behaviour change strategies.
- Production, summarise, translation and distribution of IEC materials on changing trends on HIV and AIDS.
- Provision of uniforms, props and monthly incentives to Adult Peer Educators.
- Distribution of condoms to 12 sites and road shows at growth points, popular business centres and border posts.

Figure 4: Vegetable gardening IGP - Tshaka-Maoko project site



Figure 4 shows one of the income generating projects being run by FACT peer educators at the Tshaka-Maoko project site. This is one of the interventions by FACT meant to persuade sex workers to find alternative sources of income compared to being involved in sex work.

2.9 Ngundu Growth Point, Chivi District

According to Wekwete (1988), in Zimbabwe the term 'growth point' is used to denote settlements designated or earmarked for physical and economic development. They are rural centres designed to serve rural communities by providing them with commercial, industrial and administrative functions. They also provide a market for manufactured items, agricultural and rural products.

Residents of Chivi district and Masvingo province in general are known for being well educated and draw their income from formal employment. The economic collapse of more than ten years since 2000 and the proximity of the Chivi district to South Africa encouraged local residents to engage in cross boarder trading and seek employment opportunities in the neighbouring South Africa (ZESN, 2008).

The Beitbridge – Harare highway that passes along Ngundu growth point is a busy road, with long distance buses and heavy duty long distance trucks plying the route every day, thereby providing a ready market for informal traders and local business owners at Ngundu Business Centre.

Figure 5: Ngundu stopping area along national highway to South Africa



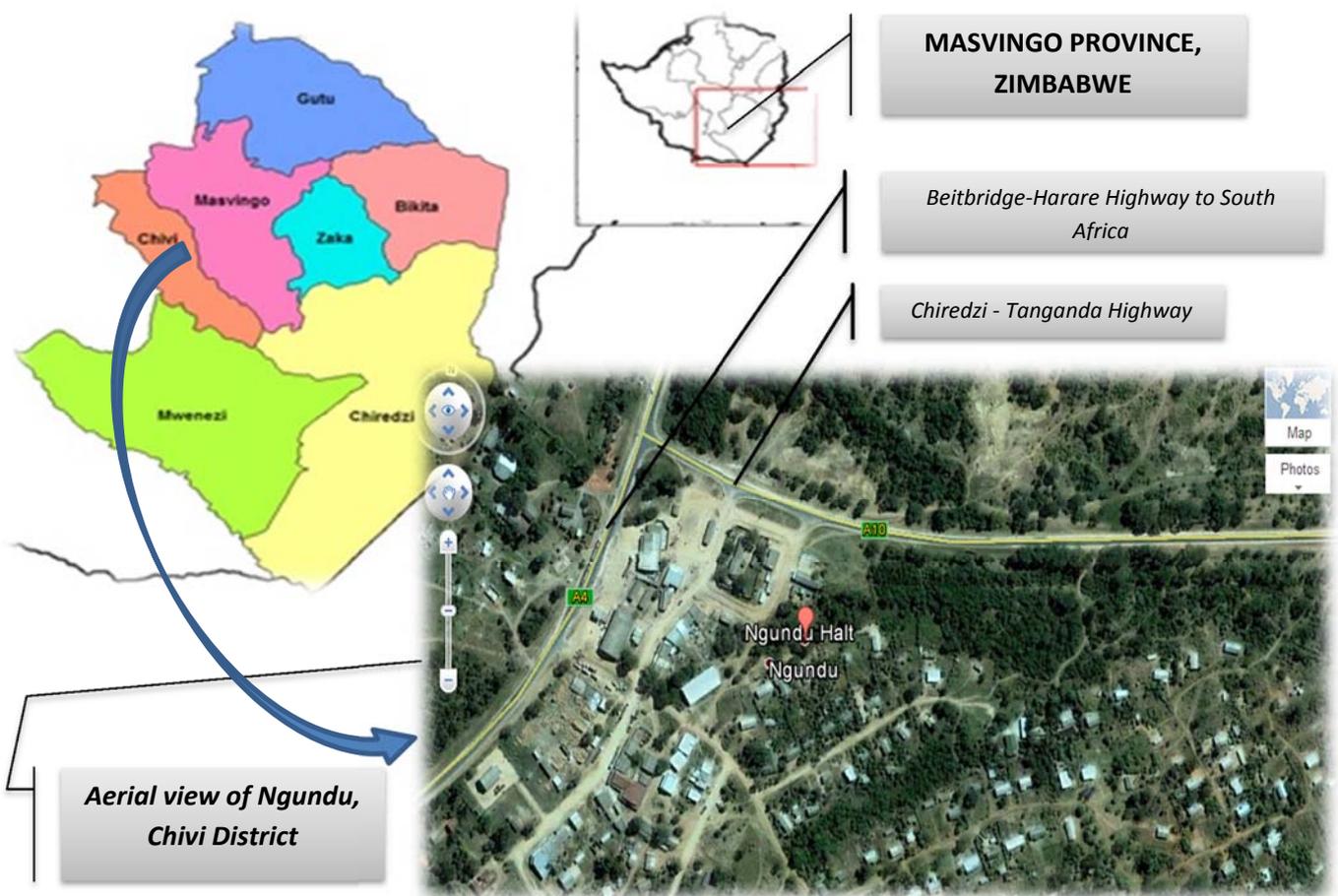
In terms of services, the growth point has got one rural health centre, a single police station which is located at Ngundu Business Centre. The district local government administration is run by local councillors. Therefore Ngundu can be described as a small growth point characterised by high mobility and temporary residents as a result of its proximity to the busy national highway (Government of Zimbabwe, 2011).

Chapter 3: Methodology

3.1 Study Area

The study was conducted at Ngundu growth point, Chivi district, Masvingo province in Zimbabwe. The growth point is situated along the intersection between the Beitbridge – Harare national highway and the Chiredzi – Tanganda. (See Figure 6 below).

Figure 6: Ngundu Growth Point, Chivi District - Zimbabwe



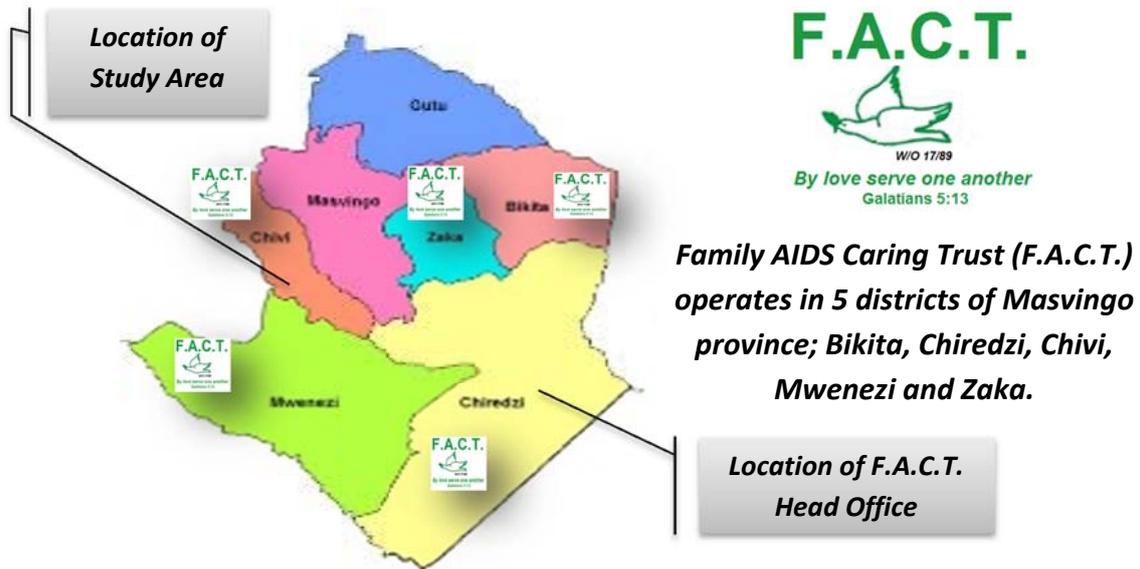
Source: Adapted from Government of Zimbabwe (2011) and Google Maps (2013)

Chivi district is mainly a rural area with a population of approximately 62100 inhabitants (Government of Zimbabwe, 2011).

3.2 FACT's geographical scope

The organisation's operational area coverage besides Chiredzi includes Zaka, Bikita, Chivi and Mwenezi Districts in the province of Masvingo. The majority of the organisation's operational areas are located in the drought prone Region 5, an area supporting irrigation based agriculture. The areas of operation have a close proximity to the South African boarder, and this has resulted in high cross boarder mobility as well and the presence transient populations who provide seasonal labour to the sugar plantations within Chiredzi district. The organisation operates in a multicultural environment which comprises of the Shangaan, Ndebele and Shona speaking people.

Figure 7: Location of study area in relation to area of operation by FACT-Chiredzi



Source: Adapted from Government of Zimbabwe (2011) and FACT-Chiredzi (2013).

Figure 7 shows that FACT covers five out of a total of seven districts in Masvingo province including the area of study which falls under Chivi district.

3.3 Research Design

The research used a qualitative approach through a desk study of literature on the context of the development of health seeking behaviour, the context of sex work and sex workers in Zimbabwe and a review of current interventions by FACT. A case study was also used for the chosen study area and a review of official documents from health provider and FACT was done.

- i. Desk Study: The desk study was used to gain an understanding on the meaning of health seeking behaviour, the conditions that influence health seeking behaviour and the resultant variations. Literature was also used to gain an understanding into the context of sex work in Zimbabwe and how sex workers end up benefiting or being excluded from services meant for Zimbabwean citizens.
- ii. Case Study: A case study was used to gain an insight into factors that either encourage or discourage sex workers to seek sexual health services which include HIV/AIDS and STI prevention and treatment services. Individual interviews with relevant stakeholders and a focus group discussion with sex workers were conducted.
- iii. Review of official documents: Documents for FACT-Chiredzi were obtained from the organisations Adult Peer Education department which is responsible for the implementation and management of all interventions related to sex workers. The organisation's current interventions were reviewed in order to assess the effectiveness of the interventions and identify potential intervention areas based on findings from relevant stakeholders. Documents from the health service provider were used to provide an insight on the utilisation of prevention and treatment services by health seekers, and were also used to gain insight into frequency of STI infections and HIV status of the population seeking treatment at the facility.

3.4 Data Collection

Sex Workers

Sex work in Ngundu is characterised by women being the providers of sexual services and men being the seekers of sexual services. As a result of the sensitive nature of the sex work and the difficulties in identifying and interviewing willing sex workers, the study focussed on sex workers already working with the problem owner of this study, which is FACT- Chiredzi through its adult peer education programme office. Since the sex workers are not a homogenous entity, for the purposes of this study the sex workers were categorised into three groups in order to gain an understanding into different factors that affect them.

- The first group of sex workers is categorised as '*Young girls below the age of 16 years*'. For the purposes of this research 3 girls who are expected to be school-going and those who are not at school for various reasons were identified. The identification of these school girls was through being referred by the sex workers already working with FACT – Chiredzi in the adult peer education programme. In Zimbabwe the legal age of sexual consent is above 16 years, girls below 16 years are considered minors.
- The second group of sex workers are categorised as '*Women between the ages of 17 and 40 years*'. This group was identified because it had most young women who are expected to be mobile, belong to the most productive age group and generally more active. Three respondents for this group were identified from a group of sex workers who are peer educators in the FACT Adult Peer Education Programme.
- The third group of respondents is categorised as '*Women aged 41 years and above*'. This classification was developed on the assumption that the women are more experienced and have different factors affecting them compared to the other two groups of younger women and girls.
- A focus group discussion was conducted with sex workers and they were all drawn from the above-mention subgroups excluding young girls below the age of 16. The focus group discussion was meant to provide additional information which could not be obtained from the individual interviews.

Health Service Providers

The Head Nurse from the clinic was selected to be the respondent since he is responsible for running the facility and well positioned to provide a detailed overview. Ngundu Rural District Clinic is the sole government health service provider at Ngundu that has a working relationship with FACT Chiredzi. The clinic was selected on the basis that it is well positioned to have a record of the health status of the local population that seeks its services. The clinic was also selected with the expectation that it will provide an insight into factors that are beyond sex workers which influence them to either seek or not seek prevention and treatment services from health service providers.

Governing Bodies

Two representatives were chosen from the local governing authorities. The first representative is the Community Services Officer based at Chivi Rural District Council, which is responsible for the administration of Ngundu growth point. The community service office was chosen on the basis that it is familiar with all activities that occur within the local community, ranging from challenges faced to development activities that are taking place. The office was expected to provide information related to the development policies and actions taken that are directed at addressing sex work and sex workers at Ngundu. Another reason is that the local authority has a working relationship with FACT- Chiredzi.

The second local governing authority identified is the National AIDS Council (NAC). The District AIDS Coordinator from NAC was identified as a respondent because the office is responsible for co-ordinating all HIV/AIDS interventions in the district through a multi-stakeholder approach. NAC was expected to provide information on policies and actions that affect local service provision in the district from a policy level, and initiatives that have been done or yet to be done by relevant stakeholders with a focus on sex workers within the district. NAC was also chosen on the basis that it is a strategic stakeholder for FACT Chiredzi.

The table below provides a summary on the selection of respondents.

Table 2: Selection of Respondents for data collection

SEX WORKERS			TOTAL
<i>School Going Girls</i> 3	<i>Young Women</i> 3	<i>Older Women</i> 3	9
HEALTH SERVICE PROVIDER			
<i>Rural District Clinic</i> 1			1
GOVERNMENT BODIES			
<i>Local District Council</i> 1	<i>National AIDS Council</i> 1		2
TOTAL INTERVIEWEES			12

Table 2 shows that a total of 9 sex workers, 1 health service provider and 2 governing bodies were interviewed. The case study has a total of 12 interviewees.

The data collection process was a continuous process which involved alternating visits between all the 12 stakeholders. In relation to the sex workers, the formal introduction of the researcher by FACT to the sex workers opened an avenue to visit the identified sex workers at their homes and conducted interviews through informal discussions but guided by the checklist. Visits to the sex workers homes were informal and continuous depending on their availability. Each sex worker was visited at an average of three visits per respondent. The reason being that they were busy with their home and market activities such as attending to customers by the mini grocery stall outside their homes. Interviews had to be postponed either for a later time in the afternoon or the following day.

The focus group discussion was conducted with six sex workers at FACT premises. The six sex workers were the same sex workers that were identified for the individual interviews. Their number could not be increased to 9 or 10 because some of the sex workers invited did not respond to the request for participation made through the organisation, and some indicated being busy with other personal activities.

Data collection from the health service provider was done in three phases, the first one involved a verbal interview with the Head Nurse at the clinic. The second phase involved sifting through official documents on health information and the final phase involved observing the regular health service delivery processes which included the ARV drug distribution process.

At the local district council, an interview was conducted with the Community Services Officer within a day. The same applies to NAC where an interview was conducted on a separate occasion with the District AIDS Officer.

A checklist was used (See Annex 1 and 2, for checklist and guiding questions) to triangulate information from the main stakeholders in the study which include the sex workers, the local

health service provider and the local governing authorities. A single checklist was applied to all stakeholders and open ended questions were used to obtain relevant information from each stakeholder, thereby enabling the researcher to triangulate the information.

3.5 Ethical considerations

Respondents were assured that the information obtained was going to be used for academic purposes. Participation in the study was on a voluntary basis among the sex workers. The health service provider and FACT were assured that the information obtained would be used for academic purposes and would be considered highly confidential. They were further assured that none of the information obtained would be used to identify any individuals or groups other than for study purposes. One sex worker agreed to have her picture used in this study to reflect the individual interview conducted at her house.

3.6 Data Analysis

Data analysis is guided by the relationships outlined in the conceptual framework. The main focus is on the implications of the findings on FACT sex work programming to enable the organisation to identify and develop an appropriate intervention. The factors influencing the health seeking behaviour of sex workers are divided into three categories outlined as follows:

Table 3: Outline for data analysis of influencing factors

<i>Influencing Factors</i>	<i>Level of analysis</i>	<i>Components for data analysis per each level</i>	<i>Research sub-questions applied</i>
<i>External</i>	1. Young girls 2. Older Women 3. Focus Group Discussion	- Health availability and delivery - Conditions affecting actual use of services - Sex worker inclusiveness of available services	- 1.1; 1.2 and 1.3
<i>Internal</i>	1. Young Girls 2. Older Women	- Personal and economic reasons - Perceived socio-cultural reasons	- 2.1 and 2.2
<i>Local Governing Authorities</i>	Rural District Council	- Implications of policies and actions on sex workers health seeking behaviour	- 1.3; 2.2; 3.1 and 3.2
	National AIDS Council	- Implications of actions and service delivery on sex workers health seeking behaviour	- 1.3; 2.2; 3.1 and 3.2

3.7 Constraints and limitations

At the inception of the data collection process Zimbabwe was preparing for the 2013 national elections, which included Presidential, Parliamentary and Local Government Authority Elections all being conducted on the same day set on the 31st of July 2013. The prevailing elections atmosphere led to delays in securing interviews with the local government authorities at Chivi Rural District Council. Most staff members were actively involved in the

preparation of the national elections and also the council premises were also used as a polling station. As a result, the scheduled interview with the representative of the local government authority had to be continuously postponed.

Securing individual interviews and focus group discussion with sex workers that are actively involved in FACT's Peer Education Programme was also initially negatively affected by the prevailing mood of national elections preparations. FACT intervened by calling the sex workers individually to encourage them to participate. This intervention was done with a background that FACT was closing its offices for one week prior to the national elections, and this coincided with the days that the sex workers were meant to convene at FACT offices for their regular programme activities. Most of the sex workers were reluctant to cooperate prior to the national elections being conducted.

The interview with the local health service provider presented its own challenges related to gaining access to official health records and being granted an interview with the relevant representative at the local clinic. Following the established protocol for gaining access and being granted an interview was not a problem, but the location where authority had to be obtained presented a challenge for the researcher. Authority had to be obtained from the District Medical Officer (DMO) stationed at Chivi District Hospital, stationed approximately 80 km from Ngundu. The researcher did not manage to personally meet the DMO as he was away from the growth point on regular work duties. The remaining staff, which included the District Nursing Officer (DNO) expressed their willingness to help but firmly highlighted that it was not their responsibility to grant permission. Direct communication could not be established with the DMO. Through persistence by the researcher, authority was finally granted after three days when the DNO finally managed to contact the colleagues in the company of the DMO at the time of his field visits. The DMO confirmed over the phone to the DNO to give the researcher authority to conduct research at the rural health centre in Ngundu.

Chapter 4: Results

4.1 Health Service Availability

Girls aged 16 years and below:

All three girls interviewed indicated that they are aware of the sexual health services offered at the clinic. They identified Ngundu clinic as a treatment centre. Chiredzi district hospital and Chivi district hospital are other areas identified by the respondents. Reference was also made to the private health practitioners, who are noted to offer expensive services. The girls highlighted that Ngundu clinic is characterised with queues and that most people seek treatment there.

Women aged between 17 and 40 years:

All three women interviewed indicated that they are aware of the services being offered at the clinic. They indicated that at times they prefer not to receive ARV treatment at the clinic due to inconsistency in terms of availability of required medication at the clinic. Two respondents indicated that at times they prefer being treated at Lundi, 10 km from Ngundu. They indicated that Chiredzi district hospital and Chivi district hospital are quite far and will be more expensive to travel there. They also made reference to an NGO that treats sex workers once every month. 2 of the 3 respondents indicated that at times the organisation comes when they are out of growth point, and they do miss out on the services.

Women aged 41 years and above:

All respondents indicated that they are aware of the sexual health services being offered at Ngundu rural district clinic. They indicated that they prefer ARV treatment at Ngundu clinic to avoid travelling long distances. They also made reference to the organisation which comes once a month to treat sex workers at the growth point which they indicated that is more favourable for them since there will be reduced queues compared to the clinic services that cater for the general population.

Ngundu Rural District Clinic and sexual health services offered:

The following is a picture of Ngundu Rural District Clinic, the sexual health services being offered at the clinic and the outcome on the usage of STI and HIV services. According to the health service provider, the services are meant for the general population and are not designed specifically for a particular group of beneficiaries. Both sex workers and the rest of the general population are beneficiaries of the services offered at the rural district clinic.

Figure 8: Ngundu Rural Clinic

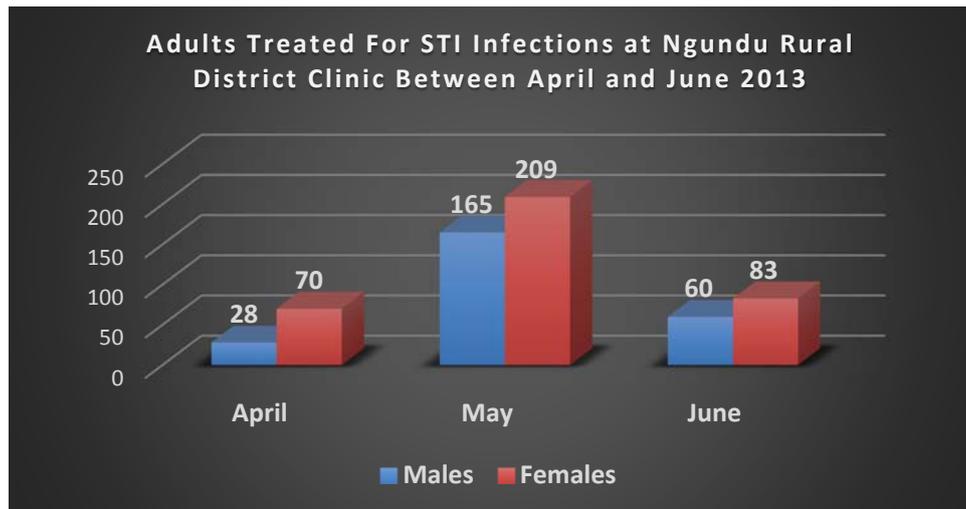


Services related to sexual health offered at Ngundu Rural Clinic were as follows:

- STI testing and treatment
- HIV testing and counselling
- ARV treatment therapy
- ARV drug distribution
- Male and female condom distribution

Outcome on the usage of STI and HIV testing services:

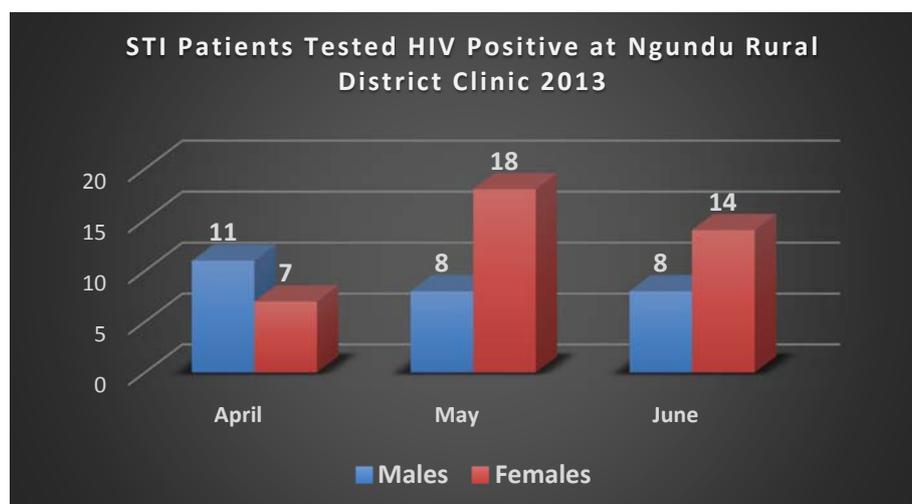
Figure 9: STI Treatment at Ngundu Rural Clinic



Source: Ngundu Rural Clinic Health Statistics (2013)

Figure 9 shows that between the months of April and June 2013, more women were treated for STI infections compared to men. The significantly high figure of individuals treated in May 2013 is attributed to more availability of STI treatment drugs at the clinic. The months of April and June have lower figures as a result of unavailability of drugs at the clinic.

Figure 10: STI patients who tested HIV positive at Ngundu Rural Clinic



Source: Ngundu Rural Health Clinic Health Statistics (2013)

Figure 10 shows that between the months of April and June 2013 more females tested HIV positive compared to men. The month of April had slightly more males who tested positive, but as May and June the figures for females were higher compared to those of males.

Funding and Costs for sexual health services at Ngundu Rural District Clinic:

The interview with the Head Nurse revealed that the clinic is funded by the Government of Zimbabwe under the Ministry of Health and Child Welfare (MoHCW). Expenses related to the purchase of drugs and salaries for paying the health personnel at the clinic fall under the national budget allocated to the MoHCW and administered through the district medical office based at Chivi growth point. Availability of drugs at the clinic is determined by the allocations made under the national budget through the district medical office based at Chivi District Hospital.

The Head Nurse indicated that there is a shortage of drugs at the clinic, and supply has been infrequent. There is a large number of people who are in need of drugs that are related to STI and HIV treatment. Drug shortages and demand are inversely related, as there is more demand for drugs compared to their availability. As a result, whenever there is a distribution of ARV drugs as an example, a large number of people come to the clinic and it takes approximately two to three hours before a single person is served (*See picture below*).

Figure 11: ARV drug distribution at Ngundu Clinic



Figure 11 shows people awaiting their turn to receive drugs from the clinic officials. Some people resorted to sitting down whilst other stood with holding their waists as a sign of a long time they have to wait before receiving their drugs.

Infrastructure and personnel for managing the services:

The clinic has a staff compliment of 9 nurses. 4 of them are male and 5 are female. The Head Nurse indicated that the staff is adequate to handle the demands expected from them in executing their duties. In terms of infrastructure, the clinic is able to handle smaller

services such as diagnosis and treatments. For cases requiring major attention, they are referred to the much bigger Chivi District Hospital located at Chivi growth point.

4.2 Conditions influencing health service uptake

Girls aged 16 years and below:

All three respondents indicated that they find it difficult to go to the clinic and be tested for HIV. All of them indicated that they do not know their HIV status and do not want to know. They highlighted chances of being verbally abused by the clinic staff who accuse them of being sexually active at young ages. They also indicated that in order to be treated at the clinic they need to be in the company of a guardian or relative who needs to confirm their ailment. One of the girls expressed herself in the following statement:

“It is not cool to be seen at the clinic saying you have come to be treated for an STI or want an AIDS test! You will lose all your boyfriends, after all I am too young to die!”

One of the respondents that whenever she develops rash in her pelvic and pubic area, her sister whom she stays with often gives her some powder and cream to use. She has never gone with her to the clinic or hospital.

Results from the focus group discussion revealed that Sex workers below the age of 16 years that are school going are tested for HIV at schools but are not offered proper counselling services if found HIV positive. Some young girls end up committing suicide due to lack of proper counselling and advice on treatment.

Women aged between 17 to 40 years:

The women indicated that they do not identify themselves as sex workers whenever they go and seek sexual health services at the local clinic at Ngundu. All three women indicated that they are HIV positive and they are on ARV treatment. They are also beneficiaries of the ARV drug distribution service at Ngundu clinic and they all highlighted that during the time of the research ARV drugs were now a problem at the clinic as they are not readily available. In case of STI treatment, they indicated that to wait in line for more than 2 hours to be treated for STI for them it consumes most of their productive time. Two respondents indicated that they do meet up with some of their clients at the clinic, which is not good for their business is they are to remain “..a viable commodity..” that is according to her words.

The respondents indicated that private doctors charge expensive fees and “*kunoenda vanezvinhu zvavo*”, meaning those who go to the private doctors are more wealthy. They all indicated that the service at Ngundu clinic is strategically located, but their problem is there are too many people seeking similar service, and they are not patient enough to spend the whole day there waiting for treatment and drugs. They indicated that their most preferred service is the one from a private organisation that treats sex workers, the problem is they are only available once a month. One of the sex workers indicated:

“Just attend a drug distribution and count the numbers of people seeking treatment! Some of them are sex workers like me, but you can’t tell by looking. There are a number with STI’s but if we are treated once a month it does not make sense, all of us don’t get sick with STI once a month!..”

Women aged 41 years and above:

All three respondents indicated that sexual health services are free to those seeking treatment, and all of them were HIV positive. They highlighted that members of staff at the clinic treat them well. They also highlighted the problem of drugs unavailability which at times forces them to travel to other government health centres seeking the drugs. One of the

women indicated that the major challenge one gets was related to the requirement of undergoing lessons on ARV therapy before being given the drugs. This is not done in a single day, they have to wait for the following day for the lessons to continue. The lessons disrupt their schedule for taking drugs, and they do not have money for private medical treatment.

Focus group discussion:

The discussion revealed that government service providers such as Ngundu Clinic, Chiredzi District Hospital and Chivi Rural District Hospital used to provide mobile services where they will travel deep into rural areas offering drug distribution and testing services. When the services were stopped combined with the shortage of drugs, the situation led to the pressure on health facilities like Ngundu clinic where drug distributions are always characterised by a large number of people.

The focus group discussion confirmed that sex workers were forced to travel long distances such as 60 km from their homes in search of ARV drugs, if they come across a mobile clinic, they are first advised to attend a New Life counselling session before being given the drugs, and the whole process does not end in a single day. For those coming from far places, they are forced to look for alternative places to sleep and some resort to soliciting for sex so that they get money for food and transportation.

The researcher also found out that Ngundu is almost centrally located between the two district hospitals that are both approximately 110km apart from Ngundu. Transport costs range between US\$3 and US\$5 per single trip and travellers sometimes have to hitchhike and it is more expensive.

Figure 12: Interview with one of the sex workers who is also a peer educator



Figure 12 shows an interview with one of the sex workers above 41 years. She highlighted that she does not have any problem for people to know that she is HIV positive and that she is on ARV therapy.

Health service provider conditions:

Clinic fees and other charges for sexual health services:

The clinic does not charge any fees for sexual health services that are being offered. Services such as STI testing and treatment, HIV prevention methods and treatment services and also counselling services are offered free of charge.

Location of sexual health services centre (clinic) in relation to distances travelled by beneficiaries:

The clinic is located at the centre of the growth point next to the central business area, which is closely located to the residential area. In terms of accessibility, individuals seeking sexual health services do not have to travel long distances in order to get to the clinic. The distance from the central business area is approximately 5 to 10 minutes by walking. Local residents, which include sex workers at the growth point therefore walk short distances in order to access the services at the clinic.

Privacy, confidentiality, fear of recognition and discriminatory practices between clinic staff and sex workers:

The Head Nurse at the clinic noted that sex workers do not want to be seen and identified as sex workers in relation to them seeking medical treatment from the clinic. One of the reasons include shying away from the clinic staff because they find it difficult to approach the staff, especially male staff when they want to be treated for STI infections. The reasons are that some sex workers perceive the male staff at the clinic as potential clients for their sexual services therefore approaching them and asking to be treated for an STI infection would cause them to shy away and avoid treatment. The Head Nurse believes that the fact that the clinic only has 4 male staff, this must should not be a deterrent for seeking services.

Sex workers do not want to stay long in queues when they come for STI treatment. Ngundu clinic is usually busy with a large number of people always seeking its services. The 3 to 4 hours that one has to endure before being treated for STI infection or receiving HIV therapy is believed to deter local and known sex workers from seeking treatment at the clinic, as they prefer to be served quickly and go without being noticed much that they were at the clinic. Health staff at the clinic believe that most of the sex workers prefer going to a private organisation that comes to Ngundu once every month from the city of Bulawayo (*approximately 400km from Ngundu*), to provide STI and HIV prevention and treatment services, and also other sexual health services related to family planning specifically for sex workers.

The Head Nurse noted that there had been previous incidences where some sex workers had altercations with some of the female staff at the clinic, accusing them of stealing their husbands and spending their money. Such scenarios are not frequent by they do occur. The health staff believes such scenarios have led the sex workers not coming to request free condoms that the clinic is distributing, the first reason being that sex workers do not want to be seen to come and ask for 'tools of their trade', and also not wanting to meet up with their clients at the treatment centre.

Other reasons that the Head Nurse identified are that sex workers in Ngundu do not want to be treated by someone who stays with them in the community. This is believed to have led to some sex workers going to seek medical treatment at Lundi, another business centre located approximately 10 kilometres away from Ngundu along the Beitbridge - South African highway. The health staff also believes that some sex workers who reside in Lundi also come for their medical treatment at Ngundu for the same reasons of not wanting to be seen at their local clinic since health staff members are local community members, who also can be their clients.

Alternative health service providers in the area:

There is a private organisation, the name could not be established (possibly CeSHHAR), which is based in Bulawayo and provides sexual health services specifically for sex workers. This organisation comes to Ngundu growth point once every month to provide HIV and STI testing, treatment and counselling specifically for sex workers. The organisation uses Ngundu clinic health facilities where the clinic provides beds for the organisation to conduct testing and treatment services.

The Head Nurse at Ngundu clinic noted with concern that “...it will be an advantage for the affected sex workers to go for treatment to this organisation if they happen to be around when the organisation comes to Ngundu...” Treatment for sex workers would therefore depend on whether they are aware that the organisation is coming or not. If not aware and also waiting to be treated by the organisation per once per month, sex workers will continue to spread the STI's whilst awaiting the private organisation to come and treat them. The clinic health staff noted that most sex workers cannot afford to travel to bigger towns such as Masvingo and Chiredzi to access pharmacies, and also do not openly come for treatment services at the clinic due to irregular supply of drugs and not wanting to be seen by the local health staff.

The health staff at the clinic revealed that private doctors and pharmacies that are located far from Ngundu usually charge US\$5 – US\$10 for medication related to STI and HIV treatment. The costs of travelling to Ngundu and Masvingo are the same which is between US\$3 and US\$4. Transport costs and cost of medication has been identified as deterrents for sex workers to seek treatment from private medical facilities and pharmacies. The Nurse Noted that “...to show that money is a problem for these women, they would prefer to be ‘serviced’ and be given a dollar or ‘mpondo’ (US\$2) and be content with that. This ‘mpondo’ will be for ‘short time’ only, they would rather buy something to eat instead of spending it on transport and expensive medication, they can’t afford that!...”

4.3 Involvement in identifying sexual health services

Girls aged 16 years and below:

All three respondents indicated that they are not involved in any programme activities where they are able to work with any organisation and identify sexual health needs that best suit them. Two of the respondents identified a local NGO Regai Dzive Shiri as one of the organisations they once participated in their activities. The respondents indicated that they are not accessing any mobile community outreach programmes and services related to sexual health care. One of the respondents expressed herself in the following statement:

“These services are for adults...and it’s not always cool to be seen ‘nemaface’ (by boyfriends) looking for condoms or STI treatment! It’s not my responsibility to worry about this..”

Women aged between 17 to 40 years, and those 41 years and above:

All 6 respondents are peer educators at FACT- Chiredzi. They indicated that the only initiative they have is to design and act out drama and song for the community outreach activities where they perform in public places such as bars. They highlighted that through such activities they distribute condoms provided by FACT. In relation to programming issues, they indicated that FACT has been having challenges in terms of donor funding, and this has affected the nature of the interventions and the influence they can exert. At the moment, their level of participation is based on them fulfilling their roles and commitment in a programme, which can be difficult to maintain because the rewards for the commitment are few. They highlighted that if more funding is availed for their programmes, and they commence activities where they go into the community working with other sex workers who

do not have the time to attend FACT activities, they might be in a position to influence or initiate activities that address their sexual health needs.

Focus group discussion:

The discussion confirmed that the current intervention by FACT designed to address the needs for sex workers is not comprehensive enough to assist sex workers to either stop sex work or help seek appropriate sexual health services. The revolving fund project from FACT, where they are given US\$300 to share amongst 15 individuals and expected to pay back the money in 3 months is not effective. Sex workers highlighted that they share the money equally, that is US\$20 per individual, and buy household goods or use it to seek medication. They highlighted that trainings they receive from the organisations are quite good, but what to do with the trainings is not appropriately transferred and managed.

Health Service Provider Initiative:

Ngundu rural district clinic has 2 focal persons that live in the community and are involved in condom distribution. The Head Nurse from the clinic noted that the uptake of the clinic condoms has been very low as there are questions as to whether intended beneficiaries are not content with the quality of condoms distributed and prefer the ones being distributed in taverns and other local bars in the local business centre.

Through STI treatment services being provided by the clinic, those treated for STI infections are observed to be reluctant to take condoms being distributed by the clinic. But after extensive counselling, they usually take condoms with them, but the health staff is concerned whether they will be actually used or not.

4.4 Personal and economic reasons

Girls below the age of 16:

All three respondents were not employed, out of school and were dependents. One of the girls is an orphan staying with her self-employed uncle who often travels into rural areas and involved in petty trading. The second respondent was staying with her sister who works at a local salon as a hairdresser, and the third one was staying with her mother who operates a vegetable stall at the local bus termini. Two of the respondents indicated that they would like to work as housemaids so that they can have a more stable source of income. All of them indicated that their guardians are not able to always meet their health care needs, and they always find it difficult to come out in the open when they have problems that require medical attention related to sexual health care.

Condom use during sexual intercourse has been identified as inconsistent to no existent by the three respondents. The following statement by one of the respondents highlights the challenges they face with their clients:

“Ndoda kurova nyoro, iwe wakabatana, uri fresh meat...”

The statement translated means “I want to have sex with you skin to skin, you have a nice tight body and you are fresh meat”. The researcher observed that when the respondent was mentioning the statement she appeared to delight in it and further probing revealed that if men always refer to her as ‘fresh meat’ then it translates to more clients and money. All three highlighted that it is not always the case that their business is good, 2 respondents indicated that clients promise to pay US\$20 to US\$30 for unprotected sex. After intercourse some turn violent and pay between US\$3 and \$5 and others do not pay at all. The amount of money made at the end is too little and cannot afford off shelf medication combined with fear of being tested at the clinic. All three indicated that their female friends offer them medication that has worked for them for similar symptoms.

Figure 13: Local residential area where one of the young sex workers stays



Figure 13 portrays the living conditions for one of the young sex workers aged below 16.

Women aged between 17 to 40 years and those above 41 years:

None of the women interviewed are engaged in formal employment. Three of the respondents are vendors, 1 owns a house which she sub rents some of the rooms to her tenants and the other two are dependent on their sexual partners for financial support.

Table 4: Respondent ages and sources of financial support

Respondent	Age	Source of financial support
1	27	Vending
2	38	Dependent on partner
3	34	Vending
4	47	Vending
5	44	Dependent on partner
6	48	Own house

All six respondents highlighted that as peer educators, they are aware of the importance of condom use during sexual intercourse and also adherence to ARV drugs. They highlighted factors they come across that offset the recommended ways of prevention and treatment. All six respondents highlighted that financial instability is one of the main reason they experience problems in prevention and treatment. For those dependent on their partners for financial support one of the respondents expressed herself in the following statement:

“I keep my ARV’s inside a small pocket in my panties because I don’t want my boyfriends to see them whenever they come. I try to stick to the schedule by going to the toilet to take medicine. If they spend the whole night it’s difficult to stick to the schedule so I end up not taking them. After all, I am very fit and you cannot even tell yourself. If they know, I would lose them and the money too.”

The respondents aged 41 years and above indicated that the responsibilities they are facing at home such as school fees for children, daily food needs and health requirements for their dependants force them to go to the bars in the evenings to ‘catch men’ and so they can provide for their dependents. They highlighted that because of their ages now, it is embarrassing for them to compete for men with young girls old enough to be their daughters

and the result is they cannot negotiate condom use with clients on two reasons, the first being the competition imposed by young sex workers who 'catch most men' and the need to provide for their dependants. One of the respondents noted that they accept US\$10 for unprotected sex as they will afford to buy maize-meal for food at home.

One of the respondents, aged 48 and owns a house, indicated that engaging in sex work and practising unprotected sex for her was not any easy option. She highlighted that when she tested HIV positive, her husband left their matrimonial home and deserted her and the immediate family. Relatives also deserted her, and leaving her with the burden of meeting financial demands alone at home. Her reason for engaging in sex work and practicing unprotected sex is related to increased financial demands of taking care of a family alone at home.

Focus group discussion:

The discussion revealed that sex workers operating in public spaces at Ngundu have a hierarchy and sex work is divided into two groups. There are those who solicit for travellers such as truck drivers and those who solicit within the community. Working as a sex worker at Ngundu is not freely open, the most senior sex workers require the new sex workers to work for a maximum of two months paying all their proceeds to the senior members. Some new sex workers end up giving up as they cannot work for two months without having to use any of the money they are working for. This leads to opportunities of new infections and inability to seek alternative health service providers.

Figure 14: The house where one of the older sex worker stays



Figure 14 shows one of the houses where one of the older sex workers stay. Financial challenges lead her to go and compete with younger sex workers for male clients at the local bar.

The respondents noted that being dependent on vending and sex partners for income combined with them being not as 'marketable' compared to young girls lead to them not affording alternative health services from private doctors and pharmacies which were

expensive for them. The inconsistency in drug availability at Ngundu clinic makes it difficult for them to seek and adhere prevention and treatment services.

4.5 Social and cultural reasons

Girls aged below 16 years:

All three respondents highlighted the difficulty of going to the clinic to ask for condoms because the perceived fear of being found sexually active at their ages. They highlighted that the clinic officials would expect them to be at school and not at the clinic looking for condoms and seeking STI treatment. One of the respondents highlighted that staff at the clinic have a tendency of not treating you if not in the company of guardians and older relative. They indicated that if there were to be treated, they do not want their guardians or relatives to be involved.

Two respondents highlighted that name calling and stigmatisation by local community members contribute to them not being interested in seeking prevention and treatment services. One of the respondents highlighted that at the local church she once visited, she was openly told by one of its members to stop associating with her daughter as she is of bad influence to other children.

The young girls believed the current sexual health services are for adults and married people only. They find it uncomfortable to be seen in the same queues with adults seeking treatment and preventive measure on sex related issues. The respondents highlighted that their boyfriends will leave them if they are always seen at the clinic.

All respondents highlighted that they are not aware of anything called 'legal protection'. They indicated that some police officers promise to offer protection in return for sexual favours when they are found soliciting in bars. They do not receive the promised protection.

Women aged between 17 to 40 years, and those above 41 years:

The respondents indicated that they have good relations with the clinic staff. They highlighted that the main problem they experience is when they fall seriously ill. None of the community members such as neighbours want to be involved in helping them go to the clinic. They highlighted that staying with a lot of dependants is unaffordable, but their help is needed when they fall sick or very ill.

One respondent highlighted that in order to secure the help of community members in times of sickness, she always behaves as if she is collecting ARV drugs for a very sick relative in her rural village. Since the treatment improves her health, people do not immediately suspect that she is HIV positive. Responses from the respondents indicate that community expectations and perceptions contribute to sex workers not to live openly about their HIV status, which negatively affects how they decide to utilise the available health services.

All respondents indicated that law enforcement officers usually ask for sexual favours. When they are found soliciting in the bars, they are sometimes beaten by button sticks and verbally assaulted. Whenever they are taken to a local police station, some respondents indicated that they cannot afford the fines imposed on them and sometimes asked for sexual favours in order to secure their release.

Focus group discussion:

The discussion also revealed that some sex workers on ARV treatment go to some local churches and get prayed for their health. Their growth in religious faith leads to them stopping their regular ARV treatment. They end up falling sick again, losing their faith and some die as a result of lost hope.

4.6 Measures by local district council

Policies on sex work, HIV and health of the local community:

The Community Services officer based at Chivi Rural District Council which governs the Ngundu area highlighted that the district council does not have any policy related to the issues of HIV/AIDS that are meant to address the health of the local community at Ngundu. The council also does not have a specific policy related to the issue of sex work and sex workers at Ngundu growth point, although acknowledged that is problem of high magnitude that has negatively affected the local community in terms of the spread of HIV.

The officer also highlighted that there were previous attempts by the council to first develop a workplace HIV/AIDS policy before developing an external policy focused on the local community. This exercise of developing the policies was started in partnership with FACT Chiredzi and the process stalled and discontinued along the way. The lack of expert knowledge and experience by the council on issues related to HIV and AIDS has translated to no policy on the related issues such as the development of health care services for sex workers and addressing HIV/AIDS in the district. The following image shows the premises of Chivi Rural District Council:

Figure 15: Chivi Rural District Council



Action on addressing sex work at Ngundu:

The council closed its guest houses at Ngundu growth point because it believed they were being turned into brothels by most of its guests. The Community Services Officer noted that there was now a tendency of the guest houses being used as venues for 'short time' sex and 'overnight sex' thereby encouraging sex workers to operate around the guests houses. As a result, the council closed the facilities so as to discourage the use of council facilities as brothels and also discourage the spread of HIV through the same facilities. There is no intervention by the council that is aimed at addressing the health status of sex workers or encouraging them to use available health services.

Strategic partners in HIV/AIDS interventions:

The local council works in partnership with FACT Chiredzi, Batanai AIDS Service Organisation (BHASO) and *Regai Dzive Shiri* Project. FACT is the only organisation that is located approximately 180 km away from the Chivi Rural District Council, and the Community Services Officer highlighted that this could be one of the problems related to coordination of the efforts between the organisation and the council. Two organisations, *Regai Dzive Shiri* and BHASO are physically located at the council offices and they have HIV/AIDS interventions as part of their programming. The response given by the officer on why these AIDS organisations have not helped the council develop internal and external mainstreaming HIV/AIDS policies was "...we give them space to rent in our premises. They come with their programmes and implement what they want to do in the area. We do not have control over their programme and we are usually invited to the workshops they hold. When their work is done, they go away..."

Challenges and future resolutions:

The Community Services Officer highlighted that the main challenge is the lack of expertise knowledge and funding for interventions. If there is no support on issues related to capacity building and funding for future interventions then the local authority will depend on the activities of AIDS organisations who come with their own mandate, let them operate in the district and when they are done they will be no option but to watch them go without continuity in the programmes initiated.

4.7 National AIDS Councils response

Measures by the National AIDS Council (NAC):

The District Coordinator highlighted that NAC does not have a specific role in developing programmes that address the sex workers and their sexual health needs. Its role is to coordinate HIV and AIDS programmes, and at district level coordinate HIV and AIDS efforts by organisations operating within the district. It does not have any control over their operations, but relies on the information given by the organisations operating at grassroots level. According to the coordinator, NAC has the responsibility of coordinating HIV and AIDS programmes through a multi-sectoral approach where all stakeholders within the district come together to plan, implement, monitor and evaluate HIV and AIDS programmes.

Initiatives by NAC on sex worker sexual health:

According to the district coordinator, the response is not entirely focused on sex workers but the general population. Highlighted is that sex workers are as individuals are part of the population therefore the initiatives are also meant to benefit them. As a result, NAC has sought to promote antiretroviral treatment among the general population. It has also made efforts to equip the district hospital and clinics with equipment such as CD4 count machines, chemistry analyses, haematology machines, viral load machines and related agents. This equipment is meant to benefit the community including the sex workers and the NAC can only promote the uptake of such services through advertisements and community gatherings such as the district agricultural show.

NAC's programme implementation challenges:

NAC acknowledged that it has received numerous grievances from groups, individuals and organisations outlining grievances related to shortage of drugs and exorbitant user fees charged by some health service providers. Ngundu district clinic and Chivi district hospital are noted as some government institutions affected by the shortage of ARV drugs. NAC revealed that the ARV's being distributed to district hospitals and clinics are donor funded by donors such as Global Fund and USAID, NAC contributes a certain percentage in the procurement. Between January and July, there was a delay in disbursing funding from Global Fund and the result was a reduction in drug stock levels at district hospitals and

clinics which led to people being given drug supply for one or two months, instead of the usual three months of drugs supply.

NAC also highlighted through the grievances they receive they have noted that user fees that are being charged by health service providers are affecting antiretroviral treatment therapy adherence. These user fees are being charged to cater for administration costs at the clinics and hospitals, and NAC does not have the authority to determine user fees at health institutions. With regards to the mandate that NAC has, the coordinator highlighted that NAC can only lobby together with appropriate government departments in order to ensure access to treatment and care services for People Living With HIV (PLWHIV).

NAC's current and future strategic initiatives:

The Coordinator highlighted that currently the organisation is currently increasing the involvement of PLWHIV in implementation, monitoring and evaluation of HIV/AIDS interventions. The organisation has established a MIPA unit (Meaningful Involvement of People living with AIDS) which through its Community Monitoring Team have the task of travelling through communities, monitoring whether intended beneficiaries of services are actually accessing the related HIV related health services in public institutions. The findings of MIPA are thereby used to strengthen and review NAC's systems.

In response to how can NAC ensure that these services indeed benefit sex workers in a growth point like Ngundu, NAC first emphasised that its vision is "*No HIV Transmission, Universal Access To HIV and AIDS Services*". The coordinator emphasised that this can only be realised if NAC's needs for internal and external funding are addressed so as to ensure accessibility of HIV prevention, treatment and care services to everyone without discrimination. NAC further noted that the organisation strongly upholds human rights in implementing HIV and AIDS services. In response to how they are achieving this the HIV District Coordinator said the organisation is currently working with organisations such as the Zimbabwe Lawyers for Human Rights (ZHLR) to ensure that sex workers do have access to HIV prevention and treatment services without any form of discrimination.

Chapter 5 Discussion of Findings

5.1 External Factors

5.1.1 Health Service Availability

Findings from the study revealed that both young and older sex workers are aware of the sexual health services at Ngundu. Ngundu clinic is noted to be inconsistent in terms of sexual health services provided due to drug shortages. This has led to the sex workers accessing its services to stop adhering to the recommended ARV therapy. The alternative private health service providers also deter sex workers in seeking their services due to high prohibitive costs that they are charging. Private health services were noted to be more commercialised in their delivery compared to the ones offered at Ngundu clinic which are for free.

The distance from Ngundu to alternative service providers such as Chivi District Hospital and Chiredzi District Hospital proved to be another impediment for sex workers access to sexual health services. The reason being that sex workers find transport costs prohibitive. The sex workers indicated that it was too costly for them in terms of money and time to use public transport and spend the whole day waiting for treatment at the health centres. This prevented them from accessing alternative health services. The above-mentioned findings are similar to those made by Ghimire (2009) and Chakrapani (2009) in Asia, which indicates that it is a common problem amongst sex workers.

Scalon (2013) emphasises the need for implementation research to investigate how health systems implement and deliver evidence based interventions appropriate for intended beneficiaries. In this study this was found to be lacking in assessing how the organisation of health services contributed to the health seeking behaviour of the sex workers. The private NGO that offers sexual health services strictly to sex workers was identified as an appropriate service. The fact that its services are only available once a month to sex workers frustrates the prevention and treatment efforts by the intended beneficiaries. Some sex workers were not available in time for treatment due to lack of coordination of services by the provider. The treatment process therefore becomes less effective and the resources invested in service provision end up not achieving their objective.

The manifestation of inconsistency in service provision is reflected in health care records at Ngundu clinic which indicate high incidences of STI and HIV infections. The records show that in a period of three months, there is an average number of 103 people being treated for STI's per month at Ngundu clinic. Out of the 103 treated for STI's, an average number of 22 people are found to be HIV positive per month. This information is based on records of individuals who actually go and seek treatment at the clinic and can be argued to be the tip of the iceberg of the health scenario prevalent at Ngundu growth point. The study showed that the large number of people that attend ARV drug distributions also deter sex workers who are not patient enough to wait the whole day in order to access prevention and treatment services. This concurs with findings of Chakrapani (2009) in the discussion on healthcare programmatic barriers, where health seekers lose satisfaction in health services provided and either avoid further treatment or seek alternative health service providers.

5.1.2 Conditions Influencing Health Service Uptake

Young Sex Workers:

Chakrapani (2009) notes that the fear of adverse consequences if found HIV positive and lack of family support deters sex workers from seeking health services. This study revealed that the conditions set up by the service provider where the young girls are expected to bring guardians or older relatives for HIV and STI treatment does not encourage health seeking behaviour. This is compounded by the expectations that young girls below sixteen are expected to be at school and not be seen in sexual health centres accessing sexual health services.

The fear of losing support of friends and sexual partners is one of the conditions identified in the study. It is evident from the perceptions of the young sex workers that community perceptions exert influence and shapes their health seeking behaviour. The available health facilities do not have appropriate counselling services to address their needs and concerns. This is reflected in the consequences of testing school children for HIV and not providing appropriate counselling services afterwards. The study revealed that some of the school going girls when tested HIV positive they end up committing suicide. This is a reflection of inappropriate targeting by the service providers and the biomedical approach that informs their service provision. Other related consequences identified in the study are use of inappropriate medicine and drugs acquired from non-medical sources, which further poses a danger to the already compromised health status of the young sex workers.

Women above the age of 17:

Long waiting hours at the health centre have been found to be a deterrent for sex workers in seeking prevention and treatment services. This is further compounded by the possibility of meeting with their potential clients at the health centre. Two factors therefore emerge at this point, the first one is related to the organisation of health services by the provider and the second one being the fear of being recognised so that they do not lose their clients who contribute to their sources of income. The study suggests that sex workers do not want to be seen and if they are to receive treatment they need to be served quickly and leave without being noticed. The long hours deter sex workers in spending time at the clinic, especially when they do not have visible signs that indicate their illness. This further encourages the spread of HIV and STI infections amongst and through sex workers.

Chambers (2005) notes that governments and NGO's if they neglect the social complexity of HIV/AIDS they will also get sicker and less effective like the progression of HIV to AIDS, and finally lose donor funding and forced to end their projects. The findings identified that resources being invested in sexual health services for sex workers by the NGO from Bulawayo are not achieving their purpose because there is no coordination between intended beneficiaries and health service provider. It can be argued that such an arrangement leads to donors withdrawing their funding because of failure by the service provider to consider all factors that affect the health seekers. An example from the study is the issue of mobility amongst sex workers which causes them to miss treatment dates and have to wait for a month or more to be treated. The result is they will continue to spread the infections until they get the next opportunity to be treated, which could be a month or more, and provided they are well informed on the next treatment dates. This concurs with Chambers (2005) assertion on the social complexity of HIV/AIDS.

Other barriers are the stipulated conditions of attending ARV therapy lessons before being given the drugs. The study revealed that sex workers do not have the time and patience to spend the whole day attending to lessons whilst they are more concerned about where and when they are going to make the next dollar. The ARV lessons are perceived to be time consuming, repetitive and unproductive for the sex workers, whom this study has already shown that they are aware of the available health services and how to use them. These

lessons deter sex workers from seeking treatment services and further facilitates the spread of infections.

This study has also shown that the withdrawal of mobile health services by the government health institutions has contributed to the sex workers not accessing sexual health services, especially those who cannot afford to travel long distances. The services used to subsidize the transport costs for health seekers and contributed to the reduction in pressure on health facilities at Ngundu clinic. This withdrawal of mobile services has led to people travelling distances more than 60 km away to access treatment at Ngundu, who in turn contribute to the increased numbers of people seeking treatment at the clinic thereby deterring sex workers in spending long hours queuing for drugs.

Olenja (2003) notes that the nature of interaction and provider attitude have the potential to influence the health seeking behaviour of health seekers and this seen at Ngundu. Some sex workers are believed to have sexual relations with male staff members at the clinic. As a result they do not seek treatment at the facilities and prefer alternative places. Also identified in this study is that female staff at the clinic at times do have personal conflicts with sex workers accusing them of providing sexual services to their husbands. Such conflicts prohibit sex workers from seeking further treatment at Ngundu clinic. As a result they are not comfortable being treated by health staff who are also community members because of issues related to violation of their privacy and personal conflicts that would have developed between them and the female staff.

5.1.3 Involvement In identifying sexual heal services

Young sex workers:

This study revealed that there are no specific interventions designed to address the sexual health needs for sex workers below the age of 16. Interventions available are for the benefit of the general adult population. According to the findings of this study, this is manifested in the young sex workers lack of involvement in any activity that they can influence in terms of defining their sexual health needs without any fear of repercussions. Lack of appropriate services for this age group has led to them distancing themselves from any services being provided. This leaves them vulnerable in terms of their inability to access treatment and prevention services based on their needs and also leaves them vulnerable as a result of lack of appropriate knowledge on how to further protect themselves in current and future sexual encounters.

Older sex workers:

Condom distribution has been identified in this study as the dominant form of prevention of STI and HIV infection amongst older sex workers. Although the condom approach is of value if properly used, the problem is it is dependent on male compliance in order for it to be successful. Therefore targeting sex workers as the ones responsible for the distribution of condoms to their male clients indicates a weakness in the approach. The approach itself is medical in its orientation because it perceives the individual as the problem, and fails to consider the power dynamics between the individual expected to distribute the condom and the one expected to wear the condom. The lack of donor funding at FACT has led to reduced participation in intervention programmes by sex workers including condom distribution to their peer and clients. This lack of participation by other sex workers is a result of unavailability of strong incentives to capture their interest in the intervention because sexual health services for them are not only defined by the use of the male condom.

This is also manifested in the approach taken by Ngundu clinic which has only two focal persons in the community responsible for distributing condoms. Evident from the study is that there is less investment in approaches that consider the specific health needs of the

sexual workers, and there is no direct involvement of the sex workers in defining what really works for them. The approaches adopted by the FACT and the health service provider are bio-medical in orientation. The increased uptake of condoms on paper does not reflect that they are being used at all. This explains the sustained levels of high HIV and STI infections at Ngundu growth point.

Mackian (2003) notes that since the spread of HIV and STI's is social in nature, reflecting cultural beliefs around sexuality, virility and reproduction, solutions should be found through context specific research that reflects the social and cultural element. And the above findings indicate a need to adopt Mckian's recommendations.

5.2 Intrinsic Factors

Olenja (2003) notes that "*health seeking behaviour is a reflection of the prevailing conditions, which synergistically interact to produce a pattern of care seeking, but which remain fluid and amenable to change*". This statements reflects the findings related to sex workers personal and economic reasons influencing their health seeking behaviour, with an emphasis that it can be changed.

5.2.1 Personal and economic reasons

Young sex workers:

This study revealed that most young sex workers are out of school, they are socially and financially dependent and do not have any source of income. As a result, this leaves them vulnerable to the prying behaviour of adult males who seek to exploit their vulnerability and dependence by either offering them high amounts of money for unprotected sexual intercourse. These male clients are perceived to take advantage of the levels of immaturity by the young girls where they tell them that they are more beautiful and attractive in order to lure them into unprotected sex. Their objectives are further achieved by offering the girls more money for unprotected sex, in which the girls fail to resist in light of the background that they are unemployed and dependent for economic support.

As a result, the girls have little negotiating power when it comes to condom use with their clients. Also related is that the girls do not want to lose these clients by avoiding any public places that offer HIV and STI treatment services so that they are not seen to be sick or suffering from a sexually related ailment. The consequences are that they end up establishing unseen barriers to health seeking behaviour, founded on their perceptions and beliefs. The study also revealed that the girls are afraid of dying if they are to be diagnosed HIV positive. As a result, they end up avoiding going for treatment and prevention services offered by the health service providers.

Older sex workers:

Sex workers at Ngundu do not have formal sources of income and are either dependent on informal sources such as vending or totally dependent on their sexual partners. This financial dependency on multiple sexual partners has led them to adopt risky sexual practices such as unprotected sex which leaves the vulnerable to infection and re-infections of STI and HIV. The study revealed that the sex workers do not want to lose these partners and are prepared to comply with the conditions set by their clients. As a result of this dependency, they do not have any negotiating power with their male clients and are prepared to engage in unprotected sex.

To further compound the situation, the study found out that some of the sex workers do not tell their partners that they are on ARV therapy with a fear that the discovery will lead to

them losing their partners, and consequently losing their sources of income. This is evidenced by one sex worker who was abandoned by her husband the moment she disclosed her HIV status to him. He left their matrimonial home and all the responsibilities at her disposal. As a result, total dependence on partner support and lack of formal employment, compounded by the fear of losing the available partners have led sex workers to adopt risky sexual behaviours and publicly avoid seeking medical treatment and prevention services from health service providers.

It can be argued at this point that negative perceptions associated with HIV and STI and the lack of sustained financial support for sex workers prevent them from seeking sexual health services and living openly about their HIV status. Another barrier for sex workers is at Ngundu growth point, the sex workers operating in public spaces have a hierarchy in terms of how they are meant to operate and incorporate new sex workers. The idea that new sex workers are required to earn their right to operate at Ngundu places pressure on them to raise the amounts required to pay the senior sex workers who control the area. As a result they engage in unprotected sexual practices with multiple clients increasing their chances of being infected and re-infecting others. This also leads them to avoid spending time travelling seeking sexual health services or spending time at the clinic waiting for treatment.

5.2.2 Social and cultural reasons

Young sex workers:

Community based interventions have been identified as problematic in terms of their approach and implementation (Skordal et al, 2011). The reasons are related to who defines what a community is and what is expected from the identified community. Results from this study revealed that the young sex workers are stigmatised by the people who are supposed to intervene and contribute in alleviating their situation. One respondent from this study revealed that at a church she once attended, some church members openly told her to stop associating with their children because she was promiscuous. As a result, going for treatment and prevention services is a sign of promiscuity to other members of the community, in which these young girls struggle to gain approval from. This leads to them to totally avoid treatment and prevention services. The results show that any future interventions by the health service providers and NGO's need to properly define who their community is in order to develop appropriate interventions.

Older sex workers:

Results from this study show that local community members tend to avoid the sex workers whenever they fall ill. This is dependent on whether these community members are aware that they are involved in sex work or not. This has led some sex workers not openly disclosing their status in public, and also whenever they seek treatment they claim that the medication is not theirs. Such perceptions further deepen the view of HIV, AIDS and STIs as a something very evil which automatically leads to death. This leads sex workers not to be open about their status and also contributes to them avoiding treatment even if it is openly available for them.

Maseko (2013) notes that the prevailing criminal laws and subsequent stigma on sex workers prevent them from participating in professional bodies and associations that protect the rights of their profession. The findings of this study confirm this assertion when interviewees highlighted that sex workers arrested in public places experience physical and sexual violence in custody of the police members who accuse them of spreading infections and loitering. As a result, sex workers do not find any incentive to claim their rights to access sexual health services on professional grounds because they will not be listened to. Therefore, they continue their conflict with the police and engage in more risky sexual activities to make up for the fines they pay to the police. The costs of seeking treatment

further deters them in engaging in ARV therapy. The above mentioned findings are a reflection of how sex workers are regarded in Zimbabwe, and this is reflected in articles published by Mbanje (2013) and ZLHR (2013) where sex workers were detained at police stations and made to pay exorbitant fines.

5.3 Local governing bodies

5.3.1 Measures by district council

This study revealed that the local district council does not have any policy related to HIV/AIDS and sex workers in particular. There is no investment by the council in activities that are related to HIV and AIDS. The findings revealed that any HIV and AIDS initiative is delegated to the NGOs that are operating in the area, and the council does not have any authority over their mandate. It can be argued that the council has left the administration of health issues related to HIV and AIDS to central government which does not have direct contact with the community concerned, and also the NGO's which have their own specific mandate in relation to their operations.

The only action the council managed to take was to close its accommodation facilities at the growth point which were now being used as brothels. As a local governing body, the lack of expertise and appropriate knowledge on sex work, sex workers behaviour and their health implications on HIV AIDS in the community has led to the unavailability of information that can help develop appropriate interventions for the sex workers. This is also acknowledged at national level (GAPR, 2012). Although the district council houses two AIDS service organisations, it appears there is no effort made to tap into their expertise and contribute to the capacity building of the council in the area of HIV and AIDS amongst sex workers.

It can further be argued that the council cannot support or initiate prevention and treatment efforts to contribute in assisting sex workers to have access to sexual health services. This is because they have no understanding of the specific dynamics that the sex workers are experiencing. Although findings indicate that the local authority needs funding for such activities, the stance taken in this report is that the authority needs to first engage in capacity building with available NGOs at their disposal, so that when funds are available appropriate interventions can be developed.

These findings reflect the scenario at national level and is evidenced in the Zimbabwe's Global AIDS Report (2012) where information on sex workers in Zimbabwe is very sparse and not sufficient for informing appropriate decision making processes.

5.3.2 National AIDS Councils response

The national coordinating body does not have a specific policy that addresses the sexual health needs for sex workers in general. Information from the study reveals that the district office is not conversant with the specific needs related to HIV/AIDS, STI's treatment and prevention efforts for sex workers. Since this governing body relies on information provided by the stakeholders operating on the ground, the approaches being implemented by the stakeholders emerge important in advising NAC so that appropriate sexual health policies can be developed and implemented to benefit the sex workers as well.

The bio-medical approach to sexual health provision being promoted by NAC is evidenced by the interventions they are encouraging service providers to adopt. Findings show that

NAC has invested in equipment and drugs such as CD4 count machines and chemicals used in treatment services. The focus by the organisation is on drug acquisition and distribution. There is no further analysis on how these benefits are being distributed among the beneficiaries. Ignorance of the social and cultural elements in health service provision has led to the manifestations at community levels where in Ngundu the sex workers are not fully benefiting from the sexual health services being provided. Although NAC aims at promoting a multi stakeholder approach to HIV/AIDS, the specific health needs for the sex workers have been neglected. This concern is echoed by Enrisek et al (2005) where they emphasise that special needs studies need to be conducted and use a multi-stakeholder approach, in this case, sex workers should be part of the stakeholders. They argue that if the social complexity of HIV/AIDS is ignored and legitimate concerns of stakeholders neglected there will be problems in policy and decision making.

The findings from this study indicate that the organisation has made attempts to involve people living with HIV and AIDS in its activities, who go into the communities and monitor whether the services are being used by intended beneficiaries. Barnett and Whiteside (2006) note that communities are not static, and should be properly defined. Therefore the NAC MIPA committees that travel into communities need to include sex workers as part of the communities. The problem with this approach is sex workers are not represented in the committee, and findings which are used for policy recommendations are not inclusive enough to address sexual health needs for sex workers. NAC indicated that they are making efforts to work with the Zimbabwe Lawyers for Human Rights so that they can incorporate sex workers concerns in their programming, an effort that is awaited to be seen in terms of the results expected.

Chapter 6 Conclusion and Recommendations

6.1 Conclusion

Sex workers were aware of the sexual health services available to them, but those on ARV's had challenges adhering to the treatment as a result of drug shortages at Ngundu clinic. The prohibitive costs of services by private health services providers contributed to sex workers not seeking their sexual health services. Long distances from Ngundu to alternative health service providers were other barriers to sexual health service availability for the sex workers. The costs of transport and delays that characterised in service provision at health centres contributed to the sex workers at Ngundu to avoid seeking HIV and STI treatment and prevention services.

The organisation responsible for providing sexual health services strictly to sex workers at Ngundu is not locally based and its extension services available at the growth point once every month. This has led to some of the sex workers missing out on its services. Sex workers were left with an option of accessing similar services at Ngundu clinic, which was struggling to meet the demands for its services. The statistics obtained from the clinic records indicated that a large number of clients were seeking its services and the average figures per month were 103 individuals with STI infections and 22 individuals found HIV positive. Individuals already tested and those with new infections most of them sought treatment at Ngundu and the large numbers deterred the sex workers from seeking similar services at the clinic.

Young sex workers found the available services designed for adults and they were not comfortable accessing them. They attributed the reasons to the expectations that as young girls they were not supposed to be seen seeking services related to sexual health care. They also indicated that the requirement of being accompanied by an adult to the clinic served as another deterrent because they preferred their sexual health status to remain private. This was as a result of fear that if they were found HIV positive they could be abandoned by friends and relatives. This was compounded by the idea that other young girls committed suicide after discovering their HIV positive status.

Older sex workers did not want to spend longer hours at the clinic for fear of being seen by potential and regular clients. They wanted to be served early and quickly leave the premises. This behaviour also explained the lack of coordination of services by the NGO offering sexual health services to sex workers where the intended beneficiaries missed treatment and possibly continued spreading the infection and being re-infected themselves. The compulsory attendance of ARV lessons prior to being given the ARV drugs presented an impediment for sex workers as they did not have the time to attend the lessons.

The unavailability of appropriate sexual health services for young sex workers led them to distance themselves from similar interventions. This was caused by fear of perceived negative consequences associated with such involvement. Older sex workers were actively involved in FACT's adult peer education programme, which was characterised by condom distribution by sex workers. Some sex workers lost interest in the programme as a result of lack of incentives to encourage them to continue involvement in the programme.

Young sex workers were found to be socially and economically dependent on their guardians and male sexual partners. This left them vulnerable to further exploitation by the older male clients who provided large sums of money for unprotected sex. The fear of being seen seeking sexual health services by their lucrative clients led them to avoid any form of prevention and treatment methods and preferred medicine from their female friends. Older sex workers were identified to be dependent on their informal sources of income and their

sexual partners for financial support. This led to them adopting risky sexual practices and not being open about their sexual health status, which also contributed to them not adhering to ARV treatment.

Social reasons that prevented young sex workers from seeking sexual health services included reaction from community members who did not want their children to associate with them. The criminalisation of sex work by the local law enforcement deterred sex workers from standing for their rights as a professional body. Sex workers suffered physical and sexual abuse in police custody and therefore the negative stigma associated with sex work and being labelled as criminals deterred them to officially stand for their rights.

The local district council did not have any policy on HIV and AIDS and could not do anything to address the interests of sex workers and health services related to HIV/AIDS in the community. This contributed to the unavailability of information on sex workers in the district to assist in the development of context specific policies and decision making. As a result the district council could not develop and initiate any appropriate intervention for sex workers because it did not have the expertise and capacity to do so. They need to first undergo a capacity building program before they can develop any intervention related to HIV and AIDS.

NAC did not have any specific policy that addressed the sexual health needs of the sex workers. As coordinating body, the interventions they promoted were informed by unavailable data on sex workers from district to national level as evidenced in the 2012 Zimbabwe Global AIDS report. This led to the promotion of interventions which excluded sex workers in their programming. The organisations reportedly made efforts to collaborate with the Zimbabwe Lawyers for Human rights in order to promote sexual health care needs for the sex workers. The efforts of the collaboration are yet to bear any results.

6.2 Recommendations

6.2.1 For FACT Programming:

- There is need to revisit the target group for the sex work intervention to include young girls below 16 years, and develop interventions that specifically meet their needs as sex workers. The intervention should not be labelled as a sex worker project so as to avoid contributing to the stigmatisation of the target group.
- The organisation needs to revisit the curriculum of the adult peer education programme and separate the peer education component from the sex work component. Research findings indicate that people are aware of the spread of HIV being promoted under the peer education programme. There is a need to develop new innovative interventions on evidence based research. The current sex work intervention has been in place since 2001, but the conditions that affect sex workers have evolved over the past 12 years.
- FACT needs to collaborate with the NGO from Bulawayo in order to promote sexual health services for sex workers at Ngundu. This is necessary to avoid the organisation travelling from Bulawayo, which is 500 km from Ngundu, to provide services that FACT has the capacity to implement. The inconsistency in terms of sexual health service provision for sex workers would be avoided since FACT is already established in the community.

- There is a need to review the current income generating project and compliment it with other strategies that would enable the sex workers to meet demands for their daily sustenance such as household food and transportation needs.

6.2.2 Initiative by Chivi Rural District Council:

- The council's community services department needs to initiate the development of an HIV/AIDS policy for both in internal and external mainstreaming purposes. They should focus first on developing their own internal policy and build their own expertise though capacity building exercises.
- With approximately three AIDS service organisations at its disposal, the council needs to tap into the expertise of the organisations to help develop its own structures and policies related to HIV/AIDS interventions.

6.2.3 Initiative by National AIDS Council:

- The organisation needs to facilitate working relationships between community based AIDS service organisations like FACT and the Zimbabwe Lawyers for Human Rights in order to promote rights based interventions to health.
- NAC needs to incorporate sex workers in its MIPA committee so that policy recommendations for the organisation include special needs for sex workers.
- To work with relevant stakeholders such as Zimbabwe Lawyers for Human Rights and AIDS organisations in advocating for the decriminalisation of sex work in order to promote appropriate HIV/AIDS interventions among sex workers.

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Appendices

Appendix 1 – Checklist for data collection

Sub-question 1.1

- Type of sexual health services and usage outcome
- Cost of sexual health services
- Funding of health services
- Awareness on the availability of the services
- Qualified health personnel for implementing the services
- Technical resources and infrastructure required to administer the sexual health services

Sub-question 1.2

- Charges and fees
- Physical location of the services
- Discrimination by service providers
- Confidentiality and privacy
- Fear of Recognition and subsequent stigma
- Perceived satisfaction of treatment services
- Alternative options available in terms of sexual health service providers

Sub-question 1.3

- Outreach programmes on sexual health services for the sex workers
- Peer support groups to encourage sex workers to seek sexual health services
- Advocacy for HIV prevention and treatment

Sub-question 2.1

- Income status
- Negotiation of safe sex
- Perceptions on illness
- Condom use
- Education and employment opportunities

Sub-question 2.2

- Perception of health service providers
- Perception of community reaction in relation to being involved in sex work
- Beliefs in recommended health care
- Legal protection and law enforcement

Sub-question 3.1

- Policies and regulations on sex workers and sex work in the district
- Impact of sex work on the local community in terms of public health
- Action taken in addressing the issue of sexual health of sex workers in the district
- Resources for addressing the issue of sex workers and sex work in the district
- Partnership and collaboration with other stakeholders in addressing the issue of sex workers and sex work in the district

Sub-question 3.2

- Policies and policies for addressing the issues of sex work and HIV within the district
- Past and present interventions in working with sex workers and HIV issues
- Challenges experienced in interventions
- Future plan of action
- Strategic stakeholders to help in addressing the issue

Appendix 2 – Guiding questions

Sex Workers:

- Are they aware of any sexual health services? **(1.1)**
- What experiences do they have in form of discrimination from the health service providers? **(1.2)**
- Are there any violations of their privacy during treatment seeking? **(1.2)**
- Is there any fear that they will be recognised and stigmatised during treatment seeking? **(1.2)**
- How satisfied are they with the sexual health services if they are any available? **(1.2)**
- What are the alternative health services providers that they go to? **(1.2)**
- Are there any outreach sexual health services that they are currently accessing? **(1.3)**
- Are they involved in any support group to encourage sex workers to seek sexual health services? **(1.3)**
- Are there any efforts that they are making as individuals or groups to ensure that they have access to sexual health services? **(1.3)**
- What are their perceptions and actions taken in the event they fall ill or acquire HIV or STI? **(2.1)**
- What is their income status? **(2.1)**
- What are their experiences in terms of condom use during their sexual encounters? **(2.1)**
- What are their educational levels and their employment opportunities? **(2.1)**
- What are their perceptions on the charges and fees for sexual health services at local health services providers? **(2.1)**
- What are the distances that they have to travel in order to access sexual health services? **(2.1)**
- What are their perceptions regarding available health service providers? **(2.2)**
- What are their perceptions in relation to the reaction of the local community in their involvement in sex work? **(2.2)**
- What are their personal beliefs with regards to recommended sexual health care? **(2.2)**
- What are their experiences with regards to any legal protection or law enforcement authorities in the district? **(2.2)**

Rural Health Clinic and Private Health Service Provider:

- What are the sexual health services that are being offered and what has been the subsequent outcome in terms of usage? **(1.1)**
- What are the costs of running the sexual health services? **(1.1)**
- Where does the funding for health services come from? **(1.1)**
- Are the intended beneficiaries aware of the services? **(1.1)**
- Does the service provider have any qualified personnel for managing the services? **(1.1)**
- Does the service provider have any appropriate technical resources and infrastructure to administer the sexual health services? **(1.1)**
- What are the charges and fees for the services? **(1.2)**
- What is the location of the sexual health services in relation to the distances to be travelled by intended beneficiaries? **(1.2)**
- What is the observation amongst staff members in terms of discriminatory and stigmatising practices directed towards suspected sex workers seeking sexual health services? **(1.2)**
- What is the health service provider's positions with regards to privacy and confidentiality in relation to clients seeking sexual health services? **(1.2)**

- What are the observations made by the service provider in relation to the issue of fear of being recognised by women seeking sexual health services? **(1.2)**
- What are the indicators of satisfaction by health seekers of sexual health services being offered? **(1.2)**
- What are the alternative service providers available within the district? **(1.2)**
- What are any other initiatives being implemented with regards to sexual health services for sex workers? **(1.3)**
- What are established peer support groups that the health service provider has to encourage sex workers to seek sexual health services? **(1.3)**
- What are the initiatives done by the health institution in advocating for the realisation of health rights for sex workers to access sexual health services? **(1.3)**

Local Governing Bodies:

- What are any other initiatives being implemented with regards to sexual health services for sex workers? **(1.3)**
- What are established peer support groups that the governing body has to encourage sex workers to seek sexual health services? **(1.3)**
- What are the initiatives done by the governing body in advocating for the realisation of health rights for sex workers to access sexual health services? **(1.3)**
- What is their observation on sexual health service provision by the local health service providers? **(2.2)**
- What is their observation of the local community's reaction to sex workers and sex work being conducted within the district? **(2.2)**
- What is the governing body's position on sexual health services for sex workers in the district? **(2.2)**
- What is the governing body's position with regards to legal protection and law enforcement in relation to sex workers within the district? **(2.2)**
- What are the organisational policies and regulations regarding sex workers and sex work within the district? **(3.1)**
- What has been the observed impact of sex work on public health in the district? **(3.1)**
- What action has the organisation taken in addressing the issue of the sexual health of sex workers within the district? **(3.1)**
- What partnerships and collaborations does the organisation have with other stakeholders in the district in addressing the issue of the sexual health of sex workers? **(3.1)**
- What policies and programmes does the organisation have in relation to the issues of sex work, sexual health care and HIV within the district? **(3.2)**
- What are the past and present initiatives in addressing the issues of sex workers and sexual health care in the district? **(3.2)**
- What are the challenges experiences experienced in the current interventions?
- What are the future plans of action? **(3.2)**
- Are there any strategic stakeholders in the district to help in addressing the issue of sexual health for sex workers? **(3.2)**