

## ORIGINAL RESEARCH ARTICLE

# “It is just a lot to deal with”: A qualitative study exploring the sexual and reproductive health needs of a sample of female sex workers in six locations in Southern Africa

DOI: 10.29063/ajrh2022/v26i5.8

Alexandra Spyrelis<sup>1\*</sup> and Latifat Ibisomi<sup>2,3</sup>

Independent researcher<sup>1</sup>; School of Public Health, Faculty of Health Sciences, University of the Witwatersrand<sup>2</sup>; Nigerian Institute of Medical Research<sup>3</sup>

\*For Correspondence: Email: [aspyrelis@gmail.com](mailto:aspyrelis@gmail.com)

## Abstract

The sexual and reproductive health of female sex workers in Southern Africa is particularly important, given the high prevalence of HIV among this population. This paper presents the results of a rapid assessment study conducted prior to the implementation of the “SRHR-HIV Knows No Borders” project in six Southern African countries. Trained interviewers interviewed 20 sex workers across 10 high migration communities. Data were analysed thematically. Participants were well informed about and were able to access preventive methods for STIs and pregnancy, although reports of condom failures were common. While sex workers found SRH services easily accessible, many reported experiences of stigma and discrimination when accessing them. Physical and sexual violence were common occurrences among participants, both from their clients and the police. In addition to addressing stigma within the healthcare and broader community, interventions could provide opportunities for those looking to exit the industry by providing skills training and microfinance support. (*Afr J Reprod Health* 2022; 26[5]: 72-80).

---

**Keywords:** Sex workers, SADC region, sexual reproductive health, stigma, healthcare

---

## Résumé

La santé sexuelle et reproductive des professionnelles du sexe en Afrique australe est particulièrement importante, compte tenu de la forte prévalence du VIH au sein de cette population. Cet article présente les résultats d'une étude d'évaluation rapide menée avant la mise en œuvre du projet «SRHR-HIV Knows No Borders» dans six pays d'Afrique australe. Des enquêteurs formés ont interrogé 20 professionnel(le)s du sexe dans 10 communautés à forte migration. Les données ont été analysées par thème. Les participants étaient bien informés et pouvaient accéder aux méthodes de prévention des IST et de la grossesse, bien que les rapports d'échecs de préservatifs soient fréquents. Alors que les professionnel(le)s du sexe ont trouvé les services de SSR facilement accessibles, beaucoup ont signalé des expériences de stigmatisation et de discrimination lors de leur accès. La violence physique et sexuelle était courante chez les participants, tant de la part de leurs clients que de la police. En plus de lutter contre la stigmatisation au sein de la communauté des soins de santé et au sens large, les interventions pourraient offrir des opportunités à ceux qui cherchent à quitter le secteur en offrant une formation professionnelle et un soutien à la microfinance. (*Afr J Reprod Health* 2022; 26[5]: 72-80).

---

**Mots-clés:** Professionnel(le)s du sexe, région de la SADC, santé reproductive sexuelle, stigmatisation, soins de santé

---

## Introduction

Female sex workers (FSWs) face a range of threats to their wellbeing stemming from multiple layers of vulnerability, including risks to their physical health, mental health, and safety<sup>1,2</sup>. The sexual and reproductive health (SRH) of FSWs is of particular concern given their high level of exposure to morbidities through multiple sexual partnerships and unprotected sex<sup>3</sup>. FSWs are at an increased risk of HIV infection, with an up to 30 times higher risk

of contracting the virus than the broader female population<sup>4,5</sup>. While HIV prevalence rates vary largely between countries in Africa, sex workers in the Southern African Development Community (SADC) region have some of the highest infection rates; as many as 70% of sex workers in Lesotho and 60% in Eswatini are living with HIV<sup>6</sup>. FSWs are also at increased risk for other sexually transmitted infections (STIs) and while prevalence data is scarce, existing evidence indicates a high STI burden in the region, with up to two thirds of

*African Journal of Reproductive Health* May 2022; 26 (5):72

FSWs infected with a curable STI at any given time<sup>1,7</sup>.

FSWs face unsafe working conditions, with frequent experiences of physical and sexual violence from their clients, the police, and intimate partners<sup>8,9</sup>. Experiences of emotional violence are equally common given the stigma associated with sex work, and the resulting discrimination and humiliation that sex workers face in society<sup>10</sup>. The trauma and stress associated with these working conditions negatively impact sex workers' mental health<sup>11,12</sup>. However, despite the disproportionate health burden borne by FSWs, their access to adequate healthcare and support services is often limited due to high mobility rates which limit healthcare access and interrupt antiretroviral treatment (ART), the criminalisation of sex work, the fear of stigma and discrimination from service providers, and linguistic barriers<sup>9,13-15</sup>. Access to SRH services among FSWs is further influenced by factors at an individual level, including their awareness and perceptions of SRH services, as well as their perceived need for them<sup>16</sup>.

This study sought to explore the SRH awareness, needs, and contexts of FSWs living in the towns targeted for a regional sexual and reproductive health and rights (SRHR) intervention called the "SRHR-HIV Knows No Borders" project.

## Methods

Data were obtained from a broader, exploratory rapid assessment study that was undertaken prior to the implementation of the project to ensure that the interventions were appropriately tailored to the needs of the target groups. The project was implemented in six Southern African Development Community (SADC) countries between 2016 and 2020, and aimed to improve SRH and HIV-related outcomes among youth, sex workers, and others living in high migration communities, given the associated health risks that mobility poses for people living in these spaces<sup>17</sup>. The intervention focused on creating awareness of and demand for SRHR-HIV services and facilitating the supply and accessibility of such<sup>18</sup>. The project was carried out by a consortium comprising of the International Organization for Migration (IOM), Save the Children Netherlands and the University of the Witwatersrand's School of Public Health (WSPH).

Prior to the start of the project, a qualitative rapid assessment was conducted to identify gaps in SRHR-HIV awareness and services and SRH needs among the target population, as well as to understand contextual factors. Data were collected in the 10 border towns and high migration areas in the six countries where the project was implemented, namely: Maputsoe in Lesotho; Mwanza and Mchinji in Malawi; Ressano Garcia and Cassacatiza in Mozambique; Nkomazi and Ekurhuleni in South Africa; Hhohho in Eswatini; and Katete and Chipata in Zambia. This paper reports on the results pertaining specifically to the female sex workers interviewed as part of the broader rapid assessment study.

The consortium was led by the WSPH who provided project management, technical oversight, and managed the data collection via country-based consultants. A total of six independent in-country consultants were recruited to oversee data collection (one per country), which was conducted by a team of trained data collectors experienced in working with vulnerable and hidden populations. The data collectors interviewed FSWs as key informants between April and December 2018. A qualitative method was employed as it allows for the description of human experience and meaning, and provides a rich description of the phenomenon being studied<sup>19</sup>. Purposive sampling was used to recruit FSWs aged 18 years and older who were working in the towns targeted by the project.

## Procedure

An interview guide consisting of open-ended questions and probes was developed for the study based on a broader policy and literature review conducted at the project's inception. The interview questions covered a range of themes around sex worker knowledge and preferences for STI preventive methods, and their experiences working in the sex trade.

Implementing partners in each site translated the interview guides into the local languages spoken in the target communities and trained fieldworkers in their use. The interview guides were piloted prior to the start of the study. Implementing partners worked with local sex worker organisations in the target communities wherever possible to gain access to sex workers hot spots. They also conducted a rapid mapping

exercise in each site. Sex workers were recruited from these hotspots using snowball sampling. Interviews were scheduled at convenient times for the respondents at accessible, private locations, were audio-recorded, and ranged between 30 and 45 minutes in length. Participants were provided with an information sheet about the study and were guided to provide signed informed consent for the study. The interviewers, together with other trained team members, transcribed the interviews verbatim and then translated them into English for analysis, working in teams to minimise translator subjectivity.

### **Data analysis**

The interview data were analysed thematically, using a data-driven, inductive approach<sup>20</sup>. The researcher initially coded the transcripts in Atlas.ti v8, and then identified key concepts that best explained and summarised the experiences of the participants. An overarching conceptual framework was developed based on the initial codes, which guided the analysis and write-up of the remaining data.

### **Results**

A total of 20 female sex workers were interviewed across the six countries involved in the project, with at least one interview conducted per site and additional interviews conducted where more sex workers could be recruited (see Table 1). Given the exploratory and qualitative nature of the rapid assessment study, a small sample size was deemed sufficient. All but one of the sex workers were local citizens of the country, although many were living outside of their towns of origin. Several of the sex workers interviewed had children, and a few reported being either married or divorced. Further, several sex workers disclosed that they had HIV and were on antiretroviral treatment (ART) at the time of the interview.

#### **Awareness, preference, and use of prevention methods**

All of the sex workers were well informed about condoms and felt that they are the best preventive method against both STIs and pregnancy. They reported learning about condoms from a range of

sources, including sex education at school, from television and radio, and from healthcare workers at clinics and non-governmental organisations (NGOs). However, when asked to explain how condoms protect users from infection, only a few sex workers could do so. While all of the participants knew about both male and female condoms, few had personal experience using female condoms due to non-availability. All of the sex workers reported being able to access male condoms very easily, either freely from health facilities and taverns, or by buying them at a low cost from nearby shops. They reported keeping condoms on their person and in their rooms at all times, and no barriers to access for male condoms were reported. Given their accessibility, ease of use, and their protective benefits, male condoms were the preferred method for all participants.

*'There are (male) condoms in the stalls, in the police station, the hospital also, has in many places, in all corners we have condoms.'* (Sex worker, Ressano Garcia, Mozambique)

While all of the sex workers reported regular condom use, there were exceptions. A handful of sex workers reported that condom use depended on payment from clients, and that they would forgo condom use where clients paid a higher fee to do so. Other participants were much stricter about condom use and would refuse a client that did not want to use a condom.

*'It depends on clients - whether they want to use it or not because the client pays more if we don't use condoms.'* (Sex worker, Nkomazi, South Africa)

*'even if he comes with a lot of money and refuses to use maximum [condom brand], I refuse because I know what I am doing and I have children.'* (Sex worker, Katete, Zambia)

Sex workers identified various challenges associated with using condoms. Some complained of condoms bursting during sex, particularly the free condoms which they felt were of poorer quality. A few sex workers were also worried about clients piercing holes in condoms, which they felt clients did intentionally to infect them with HIV. Another reported drawback of condom use was that they reduced sexual pleasure, particularly for clients.

*'The problems we face is that when you use a condom with a client, sometimes accidentally a*

**Table 1:** Number of FSWs interviewed per country

	Country						Total
	Eswatini	Lesotho	Malawi	Mozambique	South Africa	Zambia	
Number of FSWs interviewed	2	1	5	4	4	4	20

*condom may burst.*’ (Sex worker, Mchinji, Malawi)  
*‘Sometimes they (clients) deliberately make a tiny whole at the condom’s tip, by the time you realize it becomes too late, you might have already been infected’* (Sex worker, Mchinji, Malawi)

While male condoms were the predominant prevention method used by the participants, with some reporting it was the only method they had ever used, the sex workers also reported using a number of other contraceptives. Some participants were also using the pill, injection, or implant to prevent pregnancy. Only one sex worker had used pre-exposure prophylaxis (PrEP) to avoid HIV infection and had only done so intermittently, when it was available at the clinic.

**Access to healthcare and experiences of stigma**

All but one of the participants reported accessing SRH services from government facilities. The services sex workers had sought included HIV testing, treatment for sexually transmitted infections (STIs), contraceptives, pregnancy tests, abortion, ART, and ART for prevention of mother to child transmission (PMTCT). They had also accessed routine health services at these facilities, such as general medical check-ups, and treatment for flu and malaria. The participants that were mothers had delivered their babies at government hospitals.

Most of the participants were satisfied with the medical care and treatment they had received. However, experiences of stigma and discrimination were common. Some sex workers complained about nurses being rude to them, insulting them during clinic visits, and blaming them for contracting illnesses, especially STIs. One sex worker explained that she did not disclose her symptoms when seeking treatment out of fear of judgement.

*‘Yes, I have felt stigmatized. Sometimes when you are in the queue, the people in the line*

*laugh at you. Sometimes it is the nurses that shout at us before offering us medication. They would say that “we give you drugs and you still go back to sex trade and get STIs”. But we just stay until they help us since you know that you just want help.’* (Sex worker, Chipata, Zambia)

Further, some sex workers reported being turned away from government facilities or denied treatment as a result of the work they do. One sex worker reported solely seeking care at private facilities at her own cost in order to avoid the discriminatory treatment at public facilities.

*‘They refused to attend to me the second time I had STIs. They said very hurtful things and that I have been very careless with my life and doing things deliberately because I know I will get the service. I felt very bad and went to a traditional healer. After some time, I started experiencing problems on my private part and I went back to the hospital and begged the doctor and they helped me that time around.’* (Sex worker, Chipata, Zambia)

Despite such reports, experiences of stigma were not universal; some of the sex workers reported that the clinic staff treated them well and that they had never encountered stigma or discrimination when seeking care.

*‘We already have our nurse who treats us in a good way, so she is the one who has been assisting us when we go there and explain to her our sicknesses, give us pills, or stamp our booklets and tell us to go and get pills at the hospital. I think she is a person who truly understands us.’* (Sex worker, Ntfontjeni Hhohho, Eswatini)

**Stigma within the community**

Sex workers also reported experiencing stigma and discrimination from the broader community, including from the police and co-workers. One sex worker complained about the stigma they experienced from their very own clients. The lack of empathy experienced from others resulted in sex workers feeling dehumanised.

*'The other challenge I face is judgment, not only from clients and the society, but from the people I work with, because of my background. They judge me and try to put me down. They disregard my feelings. It is just a lot to deal with judgement from my co-workers, clients and from the society. Its emotionally damaging.'* (Sex worker, Ekurhuleni North, South Africa)

*'I would like the community and police officers to help us and see us as human beings too, we are doing this job because we are forced by situations of being in poverty.'* (Sex worker, Nkomazi, South Africa)

### **Violence and vulnerability**

Most of the participants had experienced some form of violence from their clients. The most common form of violence reported by the respondents was clients physically beating them and refusing to pay for their services. Some sex workers had been robbed by their clients who stole their cell phones, money, and other items after having sex with them. A few sex workers reported experiencing sexual violence at the hands of their clients, with two sex workers reporting having been raped. Sex workers felt that there was little they could do to protect themselves against violence as they also faced abuse from police when reporting these incidents.

*'The police arrested me. While in the cell one of them approached me and said he will release me but at night he will come to have sex with me, but I refused and told him that they should proceed with their case and when it is over, I will also open a case against them in court. The following day I was released without any charge.'* (Sex worker, Mwanza, Malawi)

*'He grabbed a condom from my hands, said that we should have unprotected sex, and forced me to have sex, beating me after sex and not paying me for my services. He told me that I will not leave the room and go elsewhere to do my business, then he raped me. I went to the police to report but I was answered very rudely that they do not handle sex workers cases.'* (Sex worker, Mchinji, Malawi)

These experiences happened in the context of a deeper sense of vulnerability among sex workers. They talked about how their work exposed them to a range of threats, including violence and risks to their health, but that there was little they could do

to avoid this. The sex workers explained that they do not know who their clients are, and do not know what diseases their clients may have, or how they will behave, which made them feel very vulnerable. This was linked to a broader sense of vulnerability experienced as a result of poverty, which had led them to sex work to earn an income. Many sex workers reported being mobile and working in different towns. One sex worker felt that due to the criminalisation of sex work, they could not report violence as they were criminals themselves. Another sex worker felt that the legalisation of sex work would offer better protection against the risks that they face.

*'I consciously put my life at risk of contracting HIV due to the clients that I meet. When the client has money, there is very little that you can do to try and convince them of the importance of your health. This is my job and customers are 'always right'.'* (Sex worker, Ekurhuleni North, South Africa)

*'I used to stay with my Aunt in Lusaka, my parents died a long time ago. We were not staying well and we were also suffering. That is how I came with my friend here in Chipata, that is how we found ourselves in this trade.'* (Sex worker, Chipata, Zambia)

*'Sometimes our agents do not really care about our security and the abuse that we are suffering from the clients, all they care about is the money. So, we do what we do to survive. I just cry it out, talk about it with the girls over a drink. I think if sex working was legalized it would be better. We wouldn't have to depend on agents or be controlled by anyone.'* (Sex worker, Ekurhuleni North, South Africa)

*'We have our own husbands and boyfriends but for steady and sustainable income, we resort to sex work because sometimes our husbands are not working and we have to take our children to school.'* (Sex worker, Maputsoe, Lesotho)

### **Awareness of and involvement in sex worker programmes**

About half of the participants were aware of sex-worker programmes in their communities. Most of the programmes were educational, teaching sex workers about SRH (including STIs, STI and pregnancy prevention methods, and cervical cancer) and distributing condoms and lubricant,

while others provided medical screening to participants (including pap smears) and medical care for their children via mobile clinics. These programmes were typically offered by NGO's in partnership with local government hospitals. The sex workers that had accessed these programmes felt that they had been valuable in teaching them how to protect themselves against STIs and pregnancy. Further, a few of the sex workers interviewed were members of FSW advocacy and support groups, that ranged in function from advocating for sex worker rights and decriminalisation of sex work, to general support groups providing emotional support.

*'We have a programme with a mobile clinic here at the soup kitchen and they strictly help sex workers here. They do screening, pap smears, they test us for HIV, they help us with family planning and they help our children too. It helped us a lot because we are open and can talk about anything.'* (Sex worker, Ntfontjeni Hhohho, Eswatini)

### **Programmatic needs**

Some of the sex workers interviewed indicated that they would be able to exit the industry if they had an alternative, viable source of income. They suggested that interventions should be designed to provide microloans or capital to help them start their own businesses. Others felt that programmes should assist them to go back to school or to learn a trade or skill that would help them to secure a sustainable income.

*'These programmes can be improved by empowering us economically. Personally, if I had capital, I could stop doing this. It is not a good thing. I could start my own business. I would like programmes that can economically empower us, like taking us to schools where we learn a trade.'* (Sex worker, Chipata, Zambia)

Beyond helping them to exit the industry, sex workers felt that interventions should expand SRH sensitisation and prevention campaigns among their clients, who were often truck or taxi drivers and have multiple sexual partners. They also felt that the quality of free condoms should be improved to prevent breakages. Finally, sex workers indicated that awareness programmes should be offered

within their communities to sensitise others in an effort to minimise stigma.

*'They can improve these programs by continuously sensitizing people, especially the truck drivers and taxi drivers who are our main clients. They do not want to have safe sex.'* (Sex worker, Chipata, Zambia).

### **Discussion**

Female sex workers' reports were similar across the six countries, with no clear distinctions by country or site. The study found high levels of condom awareness and access among FSWs in the target sites, whether obtained freely from clinics or purchased cheaply at local shops; higher than access levels reported among FSWs elsewhere in Africa<sup>5,21</sup>. Despite broad accessibility to condoms, some sex workers reported forgoing condom use when this fetched higher prices, which is consistent with findings from the broader continent<sup>10,22,23</sup>. Very few FSWs reported use of female condoms due to their lack of availability, which has been identified as an issue in many African countries<sup>24</sup>. While male condoms were the preferred STI and pregnancy prevention method, sex workers complained about condom failures (a particular concern about freely available condoms). The sex workers also shared their concerns about their clients puncturing condoms to purposefully infect them with HIV. Both condom failure and condom tampering are common issues reported among sex workers in other studies<sup>25,26</sup>.

The sex workers in this study made regular use of government health facilities for both SRH, HIV and routine healthcare services. While they were satisfied with the medical treatment received, experiences of stigma and discrimination from healthcare workers was relatively common, although not true for everyone. Sex workers also reported frequent stigma and dehumanising treatment within their communities. Stigma and discrimination towards FSWs is widespread and commonly reported in the literature, and has been found to hinder HIV prevention efforts<sup>9,27,28</sup>. The criminalisation of sex work in the countries involved in the study, and across most of the African continent, makes interventions to address stigma difficult given the resulting marginalisation of this population.

This study also revealed frequent incidents of violence against FSWs by their clients and from law enforcement officers, with sex workers feeling that there was little they could do to protect themselves. The inability or unwillingness to report experiences of violence to the police given the illegality of their work, and the fear of harassment or abuse, intensifies sex workers' vulnerability. Indeed, HIV and other risks among sex workers are exacerbated by its criminalisation, given the resulting impact on service delivery, legal protection, and inclusion within societal structures<sup>29,30</sup>. The call for a human rights-based approach to policy making and legislation around sex work has gained momentum in recent years in an effort to both reduce HIV risk and broader vulnerability, as well as to protect sex workers and address stigma in society<sup>15</sup>. The decriminalisation of sex work in the region would improve the support and protection available to FSWs, as well as improve access to care.

The sex workers sampled were well informed about preventive methods for STIs and pregnancy and could access such with relative ease, which may in part be due to their participation in sex worker-specific programmes available within their communities. While these NGO-led programmes were not available in all sites, there were indications that they were of great value among sex workers that could access them. Despite the availability of such programming, the unmet needs highlighted by the sex workers still need to be considered in future interventions. For instance, in addition to sensitisation campaigns among sex workers' clients and the broader community to address stigma, some of the sex workers expressed a strong desire to exit the industry, which they envisaged would only be possible through the reception of microloans and skills training to secure an alternative and sustainable income. This finding echoes recommendations made elsewhere and warrants further exploration via pilot interventions<sup>3,15</sup>. In Tanzania, greater financial security achieved through community savings groups was found to reduce sexual risk behaviour among sex workers and help them to achieve socioeconomic inclusion<sup>31</sup>. In designing interventions, AIDSFONDS<sup>10</sup> and UNAIDS<sup>15</sup> stress the importance of approaches that empower sex workers to make informed choices about their own lives and that avoid a focus on 'rescue or rehabilitation'. The findings from this study

provided important insights that were used to inform the implementation of the "SRHR-HIV Knows No Borders" project. The findings highlighted that FSWs experienced similar challenges, even when residing in different countries with unique contextual factors. The findings also reveal critical gaps in SRH and HIV service delivery for FSWs in the SADC region, particularly the need for equitable care within public health facilities and law enforcement agencies, as well as the provision of tailored support for victims of violence.

## Limitations

Some of the sites included in this study already had extensive coverage of sex worker-specific programming, which limits the ability to generalise the findings to FSWs in poorly serviced areas. In addition, the use of snowball sampling is subject to various biases, including volunteer bias whereby sex workers that were more visible and willing to participate in the study may not represent the broader FSW population. While efforts were taken to maximise sex workers' comfort in sharing their true experiences and views, they may have withheld such for fear of judgement or other consequences. Anecdotal evidence from this study indicated a certain frustration among sex workers who were often requested to participate in research to inform intervention design, but felt that they rarely benefitted from such participation and that promises made by researchers were not fulfilled. The study sample mostly comprised of a combination of internal migrants and local sex workers, who may experience different challenges to foreign migrants. Finally, the nuances of spoken local languages can be lost during the translation process, which may have affected the interpretation of study results.

## Ethical consideration

Ethical approval for the rapid assessment study was obtained from research councils in each of the six countries where the project was implemented. Approvals were also sought from provincial authorities, ministries of education and health, and health service delivery points in each of the countries to conduct the studies at the selected project sites. Interviewers were trained on the study

objectives, procedures, and related ethical considerations. Respondents were informed about their rights within the study. Interviews were conducted at locations that maximised participant safety and confidentiality, and referral procedures were established for respondents that became distressed or required further care.

## Competing interests

We declare no competing interests.

## Acknowledgements

The needs assessment and baseline survey for the SRHR-HIV Knows No Borders Project were implemented by Wits School of Public Health in collaboration with Consortium members - the International Organisation for Migration (IOM) and Save the Children Netherlands (SC). The funding for this study was provided by the Government of the Kingdom of Netherlands. We are sincerely grateful to the sex workers who participated in the study. It is only through their willingness to share their sensitive personal experiences that we can understand the SRH needs of this population.

## References

- World Health Organization (WHO). Preventing HIV among sex workers in sub-Saharan Africa: A literature review 2011. Geneva, World Health Organization.
- World Health Organization (WHO). Violence Against Women and HIV/AIDS: Critical Intersections, Violence against sex workers and HIV prevention 2005. Geneva, World Health Organization.
- Scorgie F, Chersich MF, Ntaganira I, Gerbase A, Lule F and Lo YR. Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-Saharan Africa: A systematic review. *AIDS and Behavior* 2012; 16(4): 920–933.
- Baral S, Beyrer C, Muessig K, Potat T, Wirtz AL, Decker MR, Sherman SG and Kerrigan D. Burden of HIV among female sex workers in low-income and middle-income countries: A systematic review and meta-analysis. *The Lancet Infectious Diseases* 2012; 12(7): 538–549.
- Shannon K, Strathdee SA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, Reza-Paul S, Lau J, Deering K, Pickles MR and Boily MC. Global epidemiology of HIV among female sex workers: Influence of structural determinants. *The Lancet* 2015; 385(9962): 55–71.
- UNAIDS. *AIDSinfo* 2019. <http://aidsinfo.unaids.org/>
- Yah C, Tambo E, Adeagbo O and Magida A. HIV and sexually transmitted co-infections among sex workers in the Southern African economic region. *Annals of Tropical Medicine and Public Health* 2017; 10(5), 1128.
- Deering KN, Amin A, Shoveller J, Nesbitt A, Garcia-Moreno C, Duff P, Argento E and Shannon K. A systematic review of the correlates of violence against sex workers. *American Journal of Public Health* 2014; 104(5), e42
- Scorgie F, Nakato D, Harper E, Richter M, Maseko S, Nare P, Smit J and Chersich M. "We are despised in the hospitals": Sex workers' experiences of accessing health care in four African countries. *Culture, Health and Sexuality* 2013; 15(4), 450–465.
- AIDSFONDS Project. Sex work & violence in Southern Africa: A participatory research in Botswana, Mozambique, Namibia, South Africa and Zimbabwe 2018. <http://www.sweat.org.za/wp-content/uploads/2019/09/Sex-work-and-violence-in-Southern-Africa-participatory-research-1-1.pdf>
- Coetzee J, Buckley J, Otwombe K, Milovanovic M, Gray GE and Jewkes R. Depression and Post Traumatic Stress amongst female sex workers in Soweto, South Africa: A cross sectional, respondent driven sample. *PLOS ONE* 2018; 13(7), e0196759.
- Poliah V and Paruk S. Depression, anxiety symptoms and substance use amongst sex workers attending a non-governmental organisation in KwaZulu-Natal, South Africa. *South African Family Practice* 2017; 59(3), 116–122.
- Davey C, Cowan F and Hargreaves J. The effect of mobility on HIV-related healthcare access and use for female sex workers: A systematic review. *Social Science & Medicine* 2018; 211, 261–273.
- Scheibe A, Drame FM and Shannon K. HIV prevention among female sex workers in Africa. *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 2012; 9(3).
- UNAIDS. (2009). *UNAIDS Guidance Note on HIV and Sex Work*. [https://www.unaids.org/sites/default/files/sub\\_landi ng/files/JC2306\\_UNAIDS-guidance-note-HIV-sex-work\\_en.pdf](https://www.unaids.org/sites/default/files/sub_landi ng/files/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf)
- Nnko S, Kuringe E, Nyato D, Drake M, Casalini C, Shao A, Komba A, Baral S, Wambura M and Changalucha J. Determinants of access to HIV testing and counselling services among female sex workers in sub-Saharan Africa: A systematic review. *BMC Public Health* 2019; 19(1).
- Davies A, Basten A and Frattini C. *Migration: A Social Determinant of the Health of Migrants*. Geneva, International Organization for Migration (IOM), 2006.
- International Organization for Migration. (2016). "SRHR-HIV Knows No Borders: Improving SRHR-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa 2016 - 2020". Accessed June 10 2020. <https://southafrica.iom.int/programmes/migration-and-health>
- Polkinghorne DE. *Phenomenological Research Methods. In Existential-Phenomenological Perspectives in Psychology* (pp. 41–60). Springer US, 1989.

20. Braun V and Clarke V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 2006; 3(2), 77–101.
21. Morris CN, Morris SR and Ferguson AG. Sexual Behavior of Female Sex Workers and Access to Condoms in Kenya and Uganda on the trans-Africa Highway. *AIDS and Behavior* 2008; 13(5), 860–865.
22. Elmes J, Nhongo K, Ward H, Hallett T, Nyamukapa C, White PJ and Gregson S. The price of sex: condom use and the determinants of the price of sex among female sex workers in eastern Zimbabwe. *Journal of Infectious Diseases* 2014; 210(Suppl 2).
23. Ntumbanzondo M, Dubrow R, Nicolai LM, Mwandagalirwa K and Merson MH. Unprotected intercourse for extra money among commercial sex workers in Kinshasa, Democratic Republic of Congo. *AIDS Care* 2006; 18(7), 777–785.
24. Dhana A, Luchters S, Moore L, Lafort Y, Roy A, Scorgie F and Chersich M. Systematic review of facility-based sexual and reproductive health services for female sex workers in Africa. *Globalization and Health* 2014; 10(1), 46.
25. Bradburn CK, Wanje G, Pfeiffer J, Jaoko W, Kurth AE and McClelland RS. (2017). Risky Business: condom failures as experienced by female sex workers in Mombasa, Kenya. *Culture, Health and Sexuality* 2017; 19(3), 395–404.
26. Mukumbang FC. Actions of female sex workers who experience male condom failure during penetrative sexual encounters with clients in Cape Town: Implications for HIV prevention strategies. *Southern African Journal of HIV Medicine* 2017; 18(1).
27. Lafort Y, Lessitala F, Candrinho B, Greener L, Greener R, Beksinska M, Smit JA, Chersich M and Delva W. Barriers to HIV and sexual and reproductive health care for female sex workers in Tete, Mozambique: Results from a cross-sectional survey and focus group discussions. *BMC Public Health* 2016; 16(1), 608.
28. Stangl AL, Lloyd JK, Brady LM, Holland C and Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: How far have we come? *Journal of the International AIDS Society* 2013; 16.
29. Platt L, Grenfell P, Meiksin R, Elmes J, Sherman SG, Sanders T, Mwangi P and Crago AL. (2018). Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies. *PLoS Medicine* 2018; 15(12).
30. Scorgie F, Vasey K, Harper E, Richter M, Nare P, Maseko S and Chersich MF. Human rights abuses and collective resilience among sex workers in four African countries: A qualitative study. *Globalization and Health* 2013; 9(1).
31. Mantsios A, Shembilu C, Mbwambo J, Likindikoki S, Sherman S, Kennedy C and Kerrigan D. "That's how we help each other": Community savings groups, economic empowerment and HIV risk among female sex workers in Iringa, Tanzania. *PLoS ONE* 2018; 13(7).