



MIDLANDS STATE UNIVERSITY

**AN INVESTIGATION ON CONDOM UPTAKE AMONG COMMERCIAL SEX
WORKERS IN JACHA EPWORTH ZIMBABWE**

BY

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DEDICATION

This project is dedicated to my family especially my daughter Tadiswa Lannah. May this project be a source of inspiration to her

And

To all the strong, courageous and inspirational women, may we know them, may we be them and may we raise them

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TABLE OF CONTENTS

Dedication	i
Acknowledgements	ii
Abstract	iii
Chapter 1: The Research Problem	1
1.0 Introduction	1
1.1 Background to the study	1
1.2 Statement of the problem	2
1.3 Research questions	2
1.4 Significance of the study	3
1.5 Delimitations	3
1.6 Limitations	4
1.7 Summary	5
CHAPTER 2: Review of Related Literature	6
2.0 Introduction	6
2.1 Identification of relevant literature	6
critical interpretation and evaluation of	12
scholarly studies in relation to area of study	
2.2 Organisation of reviewed literature and	
linking it to the research problem	
2.3 Summary	14
Chapter 3: Research Methodology	15
3.0 Introduction	15
3.1 Research design	15
3.2 Population and sample	15
3.3 Instrumentation	16
3.4 Ethical considerations	17

TABLE OF CONTENTS

3.5 Data collection procedures	17
3.6 Data analysis plan	18
3.7 Summary	18
Chapter 4:Data Analysis,Presentation and Discussion	19
4.0 Introduction	19
4.1 Presentation and analysis of findings	19
4.2 Discussion	29
4.3 Summary	33
Chapter 5:Summary,Conclusions and Recommendations	34
5.0 Introduction	34
5.1 Summary	34
5.2 Conclusions	35
5.3 Recommendations	35
References	37
Appendix 1	41
Appendix 2	44

LIST OF TABLES AND FIGURES

Table 1:Distribution of the respondents by sex	19
Figure 1:Distribution of therespondants by age	19
Figure 2:Distribution of the respondents by marital status	20
Figure 3:Educational qualifications of the respondents	20
Table 2:Distribution of the respondents by knowledge of what condoms are	21
Table 3: Distribution of the respondents by whether they had used condoms before	21
Figure 4:Respondants awareness of the male condom’s protective functions	21
Figure 5:Respondants awareness of the female condom’s protective functions	22
Figure 6:Respondants source of awareness of the male condom’s protective functions	22
Figure 7:Respondants source of awareness of the female condom’s protective functions	23
Figure 8:Respondants consistent use of condoms	23
Figure 9:Respondants perceptions on the availability of condoms in Jacha	24
Figure 10:Respondants perceptions on the promotion of condoms in Jacha	24
Figure 11:Who initiated condom use in a sexual encounter	25
Figure 12:Could the respondents refuse sex where no condom was used	25
Figure 13:Distribution by sex of whether the respondents could refuse unsafe sex	26
Figure 14:Why the respondents could not refuse unprotected sex	26
Figure 15:Is condom use negotiable	27
Figure 16:Distribution by sex of whether the respondents could negotiate for safe sex	27
Table 4:Why the respondents could not negotiate for condom use	28

ABBREVIATIONS

AIDS	Acquired ImmunoDeficiency Syndrome
HIV	Human Immunodeficiency Virus
NGO	Non-governmental Organisation
STI	Sexually Transmitted Infection
WHO	World Health Organisation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund

ABSTRACT

The study was designed to investigate condom uptake among prostitutes in Jacha. The study attempted to fulfil the following objectives: ascertain what condoms are, establish the benefits or importance of using condoms, identify strategies to promote condom accessibility and acceptability in Jacha as well as ascertain who initiated condom use between sex workers and their clients. The rationale of this study lay in the fact that condoms have been proven to significantly prevent unwanted pregnancies, sexually transmitted infections and HIV but uptake of these protective devices is inconsistent even in risky sexual encounters. The study used the descriptive research design. Data were collected using a questionnaire and interview schedule. The data were collected from 200 respondents who were sampled using the random sampling technique. It was hoped that the results of the study would be generalised to the population of Jacha and interventions to promote condom uptake be implemented as recommended. The respondents knew what condoms were and what the condoms protective functions were but the majority cited inconsistent condom use due to a number of factors such as being offered more money for unprotected sex. It was also established in the course of the study that the respondents of either sex had difficulties in negotiating for safe sex. The female respondents cited fear of violent clients and competition among the sex workers while the male respondents cited patriarchal reasons for their inability to negotiate for condom use. Further research was recommended to reveal the determinants of low condom uptake and how they can be eradicated. Promoting condom use was also recommended with the Ministry of Health and local nurses at the forefront. It was also recommended that the government through the Ministry of Health construct a clinic to cater for the sexual and reproductive health needs of the sex workers in Jacha.

CHAPTER ONE

THE RESEARCH PROBLEM

1.0 INTRODUCTION

This chapter introduced the research problem which was the rate of condom uptake among commercial sex workers in Jacha Epworth. A background to the study was given citing why this topic was chosen followed by a statement of the problem which made the problem as explicit as possible. Research questions were formulated and these research questions sought to provide answers to the research problem. The significance of the study followed citing the beneficiaries of the research project. Delimitations of the study looked at the geography of the study location as well as the subject delimitation that is the province, district and ward of the study population. Limitations addressed constraints to the study such as time, finance, a polarised society and questionnaire complexity. Finally a summary of the chapter addressing all the above mentioned aspects was given.

1.1 BACKGROUND TO THE STUDY

The HIV/AIDS pandemic continues to take its toll in Zimbabwe. In the Zimbabwe National Behavioural Change Strategy 2006-2010 Minister of Health and Child Care Dr Parirenyatwa acknowledged that HIV transmission was predominantly sexually driven accounting for between 80-90% of new infections. UNAIDS in Napierala et al (2008) set the HIV prevalence rate in Zimbabwe at 20,1 % among 15-49 year olds with 21,1% being women and 14,5% being men.

The population of Epworth is comprised of poor Zimbabweans surviving mainly on informal trade such as vegetable vending. The Zimbabwean weekly paper The Sunday Mail dated 28 September 2014 reported that children as young as twelve were being roped into prostitution due to the gruelling effect of the failing economy. Poverty plays a major role in precipitating prostitution and subsequently negotiation for safe sex as it becomes a matter of take it or leave it.

Child prostitutes can find it difficult to negotiate for safe sex as most of their clients are older than them. Early sexual debut increases one's lifetime chances of being infected with HIV/AIDS. WHO, UNAIDS and UNFPA (2004) said prevention is the mainstay to the response of HIV/AIDS and condoms are an integral and essential component of comprehensive prevention and care programmes. These condoms can either be male or female.

The study population has low educational attainment and this includes both the sex workers and their clients. Education contributes to one's perceptions, accessibility and acceptability of condoms. Bukenya et al (2013) attributed inconsistent condom use to client preference.

Condoms especially female condoms can be female initiated thereby giving the commercial sex workers control over their reproductive and sexual health.

Commercial sex workers are viewed by the general population as the core group responsible for the transmission of HIV/AIDS. Steen et al (2015) said the clients infected the sex workers who in turn infected other clients, the sex workers regular partners/spouses and ultimately the general population. Men who have both commercial and non-commercial sexual partners bring the HIV infection into the general population. Correct and consistent use of condoms has been proven to reduce the transmission of HIV/AIDS, other sexually transmitted infections as well as unwanted pregnancies.

Bar owners may manipulate commercial sex workers to lure patrons to their establishments.

Places such as PaBooster in Overspill and Jacha are unassuming places during the day but at night they are a hive of activities of both commercial sex workers and their clients. Most sex workers claim that business is almost always good and recent reports claim that they charge as little as 50 cents which means anyone even a school child with half a dollar to spare has access to them. A high number of clients per day can contribute to inconsistent condom use.

Biological and cultural reasons increase women's vulnerability to HIV/AIDS. Cultural reasons also contribute to the perceptions, accessibility and acceptability of condoms among commercial sex workers. Women as they are socialised are taught to be passive and assume ignorance when it comes to their reproductive and sexual health.

Condoms are a successful public health strategy. Correct and consistent use has been proven to reduce the transmission of HIV/AIDS, other sexually transmitted infections and unwanted pregnancy.

Due to the above mentioned factors such as poverty, low educational attainment and a high number of clients per day, this study was chosen as these factors existed in the study population. These factors may or may not have influenced condom uptake among the study population but it was the goal of this study to determine the condom uptake in the presence of such factors.

1.2 STATEMENT OF THE PROBLEM

Condom use is a critical element in a comprehensive, effective and sustainable approach to HIV/AIDS prevention yet they are not always used correctly and consistently even in risky sexual encounters between commercial sex workers and their clients. Inconsistent condom use is high in many settings due to various reasons which may be connected with the ultimate decision whether to use or not use a condom in a sexual encounter.

1.3 RESEARCH QUESTIONS

1. What are condoms?
2. What are the benefits of using condoms?
3. Who should initiate condom use during a sexual encounter?
4. What can be done to promote condom accessibility and acceptability?

1.4 SIGNIFICANCE OF THE STUDY

The Ministry of Health and Child Care of Zimbabwe could use the results obtained from the study to plan and assess the efficacy of health promotion and education programmes in Jacha. Behaviour change strategies for HIV prevention such as accessible sexual health services, peer group health education, condom use promotion, condom marketing and distribution could be implemented in Jacha.

Reduced HIV/AIDS prevalence and incidence rates put less strain on the nation's health budget and social welfare budget for care of the sick and orphaned. A healthy and productive community increases the country's gross domestic product.

According to Jitta and Okello (2010) free vocational skill training was in great demand among commercial sex workers in Kampala and this created opportunities for alternative income. However lack of start up capital limited the sex workers. Local authorities hence need to put measures in place to curb child prostitution. Economic generating programmes such as poultry rearing and community gardens could be implemented to help the Jacha community.

Promotion of condom use among commercial sex workers could significantly reduce the transmission of HIV/AIDS, other sexually transmitted infections and unwanted pregnancies. Reduction of HIV/AIDS incidence and prevalence rates could help in poverty eradication through a productive, educated and healthy community. Poverty could also be eradicated through the elimination of unnecessary health costs and less strain is put on community social support structures for care of the sick, orphaned and elderly. If HIV infections were allowed to rise in Jacha, the informal settlement would be thrown into deeper and gruelling poverty with an increase in child headed families, school drop outs, deviant and delinquent behaviours and reduced parental guidance.

The study could be used as a foundation for more comprehensive and exhaustive studies by other researchers.

In carrying out this study the researcher's research skills as a scholar were sharpened and awareness of Jacha was greatly improved. The study also assisted the researcher to gather more knowledge on HIV/AIDS related issues.

1.5 DELIMITATIONS OF THE STUDY

Epworth is found in Mashonaland East province and the settlement lies 15 kilometres just outside Harare towards the east. The settlement was established in the late 1890s through the Methodist Church led by John White. The church transferred ownership of the settlement to The Ministry of Local Government in 1983 as they could not control the influx of people. Epworth is a high density dormitory town with an estimated population of 167 000 according to the 2012 Zimbabwe National Census. 70% of the 30 000 families stay in informal settlements with the remainder in formal areas.

Epworth is divided by a stream into two parts. The Balancing Rocks found in the northern approaches of the town are a national monument and were featured on all bank notes issued

by The Reserve Bank of Zimbabwe. The Epworth Profiling Report (2009) reported that there were eight wards in Epworth but their boundaries did not coincide with the areas which the community was familiar with. These areas are Chiremba (Maguta), Makomo, Domboramwari, Jacha, Chinamano, Overspill, Magada and Chizungu. Epworth is administered by a Local Board headed by a Town Secretary. This local board was established in 1987 by an Act of Parliament.

The study population came from Jacha. Jacha is located in ward one and is bordered to the west by Makomo and Chiremba and Jacha river to its east. This settlement was established in 1978 and is recognised by The Local Board though it is an unplanned site without any services. The houses are unplanned structures. There was water infrastructure in Jacha and residents drank water from natural springs and deep wells. There were no water-borne sewerage facilities and residents used pit latrines. There was no electricity and no planned roads. There were no schools in Jacha and the nearest school was in Chiremba. There was no clinic or community centre in Jacha.

1.6 LIMITATIONS

Time was a major constraint for both the research participants and the researcher. Time was money for the commercial sex workers. They were mostly accessible at night and they gave rushed answers as they tried to solicit for customers while the researcher was a full time employee for The Ministry of Health and Child Care.

Finance was also a major constraint. The respondents expected incentives for their participation in the study which was however impossible due to the unavailability of funds/sponsorship. The researcher was also limited by financial issues to visit the supervisor, print material required for the study especially the questionnaires and for travelling to Jacha to visit the study population. Money was also required to access the internet to research on the project topic.

The respondents were reluctant in disclosing their personal and intimate information because they were not sure where and how the information was going to be used. The respondents had the notion that someone somewhere wanted to source donor funds for their own enrichment at their own expense. The study itself was viewed as an intrusion into people's private and intimate lives.

The primary language of the questionnaire was English. The study population was comprised of respondents of low educational attainment though not completely illiterate. Language/communication became a barrier if the respondents could not read, write or interpret the correct context of the questions which led to distorted answers. There was danger of third parties being used to respond to the questionnaire if the respondent could not read, correctly decipher the question, write or was not interested. The questionnaire itself could also have been viewed as a cumbersome task wasting the respondents' time.

1.7 SUMMARY

This chapter discussed the background to the study, statement of the problem, research questions, significance of the study, delimitations and limitations of the study.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 INTRODUCTION

This chapter reviewed literature related to condom uptake among sex workers at international, continental, regional and local levels. The aim of this chapter was to establish any knowledge gaps in the available literature, avoid duplication as well as identify what other researchers have written on the topic. The literature reviewed in this chapter tried to answer the questions of what condoms are, benefits of using condoms, who should initiate condom use during a sexual encounter and finally strategies to promote condom accessibility and acceptability among sex workers and their clients.

2.1 IDENTIFICATION OF RELEVANT LITERATURE, CRITICAL INTERPRETATION AND EVALUATION OF SCHOLARY STUDIES IN RELATION TO AREA OF STUDY

WHO and UNAIDS (1998) defined a male condom as a sheath worn on the erect penis to prevent the exchange of body fluids during sexual intercourse. The condoms can either be latex rubber condoms and non-latex synthetic condoms. Laboratory studies confirmed that intact latex condoms formed an effective impermeable barrier to spermatozoa and pathogens including HIV, herpes virus, hepatitis B virus, cytomegalovirus, gonorrhoea and chlamydia trachomatis.

Shane (2006) defined a female condom as a soft and strong transparent polyurethane sheath about the same length as a male condom but with flexible rings at both ends. It can be inserted into the vagina several hours prior to sexual intercourse and can remain in place after ejaculation. It provides a protective barrier between the penis and the cervix, the vagina and parts of the external female genitalia. Polyurethane is a thin and odourless material that transfers heat better than latex. The female condom is prelubricated with a silicone based non-spermicidal lubricant and it has a shelf life of five years.

According to WHO and UNAIDS (1998), the reasons for technological improvement in manufacturing condoms are several but the most prominent is the threat of HIV/AIDS. As a contraceptive, the condom did not command a great deal of scientific attention. Condom breakage was mainly attributed to poor quality condoms that passed recognised standards of manufacturing and younger and less experienced condom users. WHO and UNAIDS (1998) also cited that human behaviour such as using the same condom twice, unrolling the condom before putting it on, using the condom inside out and using oil based lubricants contributed to condom breakage. Stringent quality control measures were put in place according to the International Organisation for Standardisation.

Jackson (2002) said quality male condoms have a laboratory efficacy rate of 99, 99%. Just one condom in 10,000 can be expected to break or let viral particles pass through. Reputable

manufacturers submit the condoms to high international standards of quality assurance. Good quality well packaged condoms can be stored in adverse conditions for over four years and still be stable. In the real world, the failure rate is greatly increased by human error and neglect such as use of long expired condoms, dry or rough sex and application of lubricants that damage the latex.

Jackson (2002) further said the latex does not naturally have any pores but studies show that manufacturing processes can lead to the presence of microscopic holes. However the risk of HIV is minute.

Albert et al (1995) carried out a study in Nevada brothels and reported that latex condoms can substantially reduce the risk of transmission of HIV and other sexually transmitted infections when used consistently and correctly though condoms may still break up or slip off and thereby expose users to potential infection and risk of pregnancy. The condom breakage rates ranged from 0, 5% to 6,7% and falling off ranged from 0, 6% to 5,4%.

The benefits of condom use according to WHO and UNAIDS (1998) are that condoms are an effective contraception which does not have systemic side effects and are an effective means of protection against sexually transmitted diseases including HIV which causes AIDS. Therefore natural rubber latex condoms are of prime importance in the fight to stop the spread of HIV.

According to Jackson (2002) consistent condom use is undoubtedly the most effective way to reduce the risk of HIV and other sexually transmitted infections in risky sexual encounters. At a population level, condom use can greatly slow down HIV spread which can assist in buying time for individuals to adopt safer strategies long term. Jackson (2002) further said strategic targeting of condom use should be done to those who have multiple sexual partners hence more likely to transmit the infection. In Thailand, a 100% Condom Programme was initiated in brothels and formal establishments where commercial sex workers are based. Consistent condom use was made compulsory and checks made for compliance. The result was increased condom use from less than 15% to over 90% and a dramatic decline of STIs and HIV prevalence over ten-fold from 1987 to 1996. Where the sex workers operated independently on the streets, they were harder to reach with effective awareness and prevention campaigns, condoms and care services than in the organised sex trade.

Moses et al (1991) cited in Jackson (2002) developed an HIV prevention programme among 500 sex workers in Nairobi raising their condom use from 10% to 80%. About 80% of the sex workers were already HIV positive. They calculated that this strategy averted 10 200 new infections a year, one third among the clients and two thirds among the client's other partners including their wives and babies.

WHO, UNAIDS and UNFPA (2004) acknowledged that condom use is a critical element in a comprehensive, effective and sustainable approach to HIV prevention and treatment. They said condom promotion should be accelerated to reduce HIV transmission. Condoms are the most efficient in addition to delayed sexual initiation, abstinence, being faithful to one partner and a reduced number of sexual partners. Condoms are impermeable, procured according to

quality assurance procedures established by WHO, UNAIDS and UNFPA and should be stored away from direct heat sources. Condoms should be accessible to those who need them, when they need them and people should have the skills and knowledge to use them correctly and consistently.

According to Shane (2006) some women like the female condom as it gives them greater control over safe sex negotiation, is effective for STI and pregnancy prevention, is easy to use, increases sexual pleasure and is a good option for men who do not like male condoms. However, other women reported dissatisfaction with the female condom because of discomfort during sex, the need to get a partner's consent, difficulties in use, aesthetic concerns, noise, sensitivity to polyurethane and or cost. Shane (2006) went on to say that female condoms are not substitutes for the male condom but are complimentary and contribute to increased use of both types of condoms. As the female condom covers more of the external genitalia than the male condom does, it may even be more effective at preventing genital ulcer diseases, all of which can increase HIV infection. Female partners of male condom users are less likely to get cervical cancer so it is plausible that the same protection is provided by female condoms. Shane (2006) further alluded to the fact that the STI prevalence rate in Madagascar declined by 13% among sex workers a year after female condoms were added to the distribution of male condoms. Consistent use of female condoms by women in America provided complete protection from trichomoniasis reinfection. In typical use, the female condom results in 80% reduction in HIV incidence. Shane (2006) however asserts that the uptake of the female condom is inadequate. In 2005 only 14 million female condoms were made available compared to 6 to 9 billion male condoms which were made available. According to Mativo (2010) absence of the female condom in the local market and high cost of female condoms influenced access among women of the reproductive age in Kiambaa district Kenya.

Jeffreys, Fawkes and Stardust (2012) reported that in Australia condom use approached 100% in Sydney and Perth brothels. Sex workers had low rates of HIV (less than 1%) and low rates of STIs than the non-sex working population. This phenomena was attributed to sex worker peer education and safer sex practices. Chersich et al (2012) also conformed to this phenomena when they reported that social networks may provide a strong foundation for sex worker health programmes and STI/HIV prevention services.

Vuylsteke et al (2012) said between 1991 and 1998 an increase in condom use among female sex workers led to a dramatic decline of HIV prevalence rate from 89% in 1992 to 33% in 1998. These female sex workers were attending the Clinique de Confiance in Abidjan Cote d'Ivoire. The success of this project called for expansion and scaling up of both community based HIV prevention activities for commercial sex workers in Cote d'Ivoire.

The question of who initiates condom use during a sexual encounter cannot be addressed adequately without first addressing the challenges which are faced by the commercial sex workers on a daily basis. Prostitution is not viewed as an occupation in many settings. The trade is criminalised and highly stigmatised by many societies.

UNAIDS (2000) reported that condoms were underused. In Zimbabwe men interviewed had sex with prostitutes an average of seven times a month but only used condoms in half the encounters. The men cited difficulties in finding or paying for condoms, embarrassment, lack of experience, difficulties in achieving/maintaining an erection due to older age or alcohol and a general resistance to condoms where culture portrayed men's need for sex as uncontrollable. UNAIDS (2000) further reported that a research conducted in Mexico revealed that men could not turn down sex even if they did not have a condom with them. These men cited loss of sensation as the reason for unprotected sex. Campaigns among South Africa migrant mine workers increased condom use from 18% to 26% in two years.

Jeal and Salisbury (2004) conducted a study on the health needs assessment of street based prostitutes in Great Britain and reported that the sex workers were at an increased risk of STIs which could be reduced by condoms. However, condom use was inconsistent as 97% of the prostitutes were offered more money for unprotected sex. Inconsistent condom use was also attributed to drug use, violence and young age.

Alcohol was found to independently affect decision making concerning sex, skills for negotiating condom use and their correct use according to a study carried out in sub-Saharan Africa by Chersich, Rees, Scorgie and Martin (2009).

Mack et al (2010) carried out a study on introducing female condoms to female sex workers in Central America (El Salvador and Nicaragua) and concluded that if provisions were made for instructing women on female condoms in places where they were not stigmatised and if supplies were easily and consistently available, uptake of the female condom among sex workers seemed likely.

Scorgie et al (2012) reported that female sex workers have limited economic options, many dependants, marital disruption, low education, work characterised by poverty, endemic violence, criminalisation, high mobility and hazardous alcohol use which results in low condom uptake.

Netzelman (2012) conducted a study in Bulgaria, Estonia, Germany, Poland, Latvia, Romania and Slovak Republic. More than 30% of commercial sex workers stated that none of their last 10 clients asked for unprotected sex, 30% stated that 2 to 4 of their last 10 clients demanded unprotected sex while 4,7% stated that almost each of their last 10 clients demanded unprotected sex. Intravenous drug abuse increased this risky behaviour.

In a study carried out in China by Zhao et al (2012), condom use was found to be affected by individual characteristics such as knowledge, beliefs, skills, self efficacy, drug and alcohol abuse, working conditions such as sexual partners, gatekeepers, the workplace, community and culture and finally socio-economic factors such as policy, health care systems, law enforcement and legislature.

Almodovar-Diaz et al (2013) said negotiation for condom use skills should be focused on both female sex workers and their clients. Clients make the final decision. Clients should not demand unprotected sex. Strategies to reduce demand for unprotected sex should include high

level government leadership supporting condom use in all penetrative sex acts, media campaigns to destigmatise condoms, workplace condom programs for potential clients and distribution of condoms in convenient places. Almodovar-Diaz (2013) also offered condom negotiation strategies such as taking money prior to a sexual encounter in case a client refuses to pay for protected sex, refuse the client sex if he will not use a condom and taking the client to a known sex work venue where the rule of the venue require use of condoms.

Bharat, Mahapatra, Roy and Saggurti (2013) conducted a study in four high HIV prevalence states in India to see if the sex workers could negotiate condom use. 60% reported ability to refuse unsafe sex. Less than a fifth reported the ability to successfully convince an unwilling client to use a condom or negotiate condom use in a new site. Those with more experience, alternative sources of income, programme exposure and those who purchased their own condoms refused unsafe sex and negotiated condom use to unwilling clients.

Bukenya et al (2013) reported that in Uganda 40% of inconsistent condom use was attributed to client preference. Factors such as sexual debut before 14 years, alcohol, pregnancy and confidence interval increased inconsistent condom use while marriage and an increased number of sexual partners reduced risk of inconsistent condom use.

The Gap Report (2014) stated that sex workers are vulnerable to HIV because of violence, criminalisation of their work, stigma and discrimination which limited the availability, access and uptake of HIV prevention, treatment, care and support.

Nyembe et al (2014) reported that in South Africa, sex workers were exposed to more sexual partners, threat of violence, riskier sex, criminalisation of their work and use of drugs and alcohol which limited their access to health care services such as condoms. The sex workers also faced prejudice from health care workers and sexual abuse from the police.

Moore et al (2014) stated that sex worker marginalisation and criminalised working environment in sub-Saharan Africa limited the sex workers ability to mitigate the impact of their occupational hazards such as multiple sex partners, difficulties in negotiating condoms and a high HIV prevalence rate.

Bhattachargee et al (2015) said high levels of physical and sexual violence from clients and arrest or violence from law enforcement agencies compromised condom uptake among female commercial sex workers.

Grosso et al (2015) reported that in The Gambia, sex workers found it easy to negotiate condom use if they have been tested for HIV and if they had bought their own condoms.

Hail-Jares et al (2015) concluded that violence led to psychosocial distress which led to decreased condom use and engaging in risky sexual behaviour after an investigation they made on intimate partner and client initiated violence among sex workers in China. Criminalisation and stigma worsened the violence.

A study by Communication for Healthy Communities (2015) in Busia district Uganda stated that sex workers faced coercion or violence from clients. Sex workers with condoms were

considered careful and safe hence clients negotiated for unsafe sex. Sex workers faced barriers such as the allure for more money, competing financial responsibilities, fear of pregnancy and not HIV, alcohol consumption, lack of legal support if coerced, religious beliefs against condoms and no customer for some time in their bid to negotiate for safe sex.

Maher et al (2015) reported that repressive laws undermine HIV prevention efforts. In 2008 Cambodia introduced anti-trafficking legislation designed to suppress human trafficking and sexual exploitation. Following this law sex workers were displaced to the streets impacting their ability to negotiate for safe sex. Violation of the sex workers rights has adverse public health outcomes, promotes stigma and discrimination and impedes condom uptake and increases infections.

Gay, Croce-Galis and Hardee (2016) said criminalisation of sex work prevents access to health services and affects negotiation for condom use. Non-establishment based sex work is more prone to unsafe sex as compared to establishment based sex work. Without money to eat, health becomes the lowest priority.

Initiation of condom use is therefore affected by many factors on both the part of the clients and sex workers. Measures therefore need to be put in place to encourage condom acceptability and accessibility.

According to Jackson (2002) obstacles to condom use need to be overcome in order to promote condom use in Africa. Obstacles cited included societal, cultural, religious disapproval, lack of awareness, lack of control over condom use and implications for trust about fidelity in stable relationships especially marriage. To these obstacles effective responses were suggested and these included stressing cultural and social benefits of condoms in preventing HIV, creating multiple strategies for information sharing and correcting misconceptions about condoms, promoting negotiation skills, destigmatising condoms, social marketing and free government condom distribution in shops, hotels, bars, markets and workplaces, marketing condoms as trendy and responsible and enforcing strict guidelines for condom production and quality control.

WHO, UNAIDS and UNFPA (2004) said condoms should be readily available, universally free or at a low cost and promoted in ways that help overcome social and personal obstacles to their use. Condoms should be accessible to everyone, women, young people, sex workers and their clients, drug users as well as homosexuals. Challenges of complex gender and cultural factors should be overcome. Reduced HIV infections encourage safe sex behaviour. A perceived low risk increases complacency leading to unsafe sex hence there should be increased access to anti-retroviral therapy and an opportunity for accelerated condom uptake should be created.

Shane (2006) said the female condom should be included on the WHO essential drug list. Greater political and social support for the female condom should be created at local, national and international levels. There should also be increased scaling up of female condom promotion and increased public and private sector investment in female condoms.

Dittmore (2009) said sex workers should be included in the decision making and provided with information on self organisation, access to health care, education and safe sex materials. Safe and good working conditions should also be provided for the sex workers.

Almodovar-Diaz et al (2013) cited that condom programming should occupy a central place in any package of HIV and STI prevention, care and treatment for sex workers. Programs should establish accessible male and female condoms, multi-level promotion of condoms and lubricants, creating an enabling environment for condom programming through partnerships of national and local governments, local NGOs, sex worker led organisations and sex worker communities. Programs should also advocate for decriminalisation of sex work and improved living and working conditions for the sex workers in order to promote condom use. Condoms should be destigmatised and viewed as sexual health tools not tools for risky sex. Media campaigns should promote condom use and reduce demand for unprotected sex. Consistent complimentary messages on condom use should be delivered at workplaces, entertainment centres, health centres and sex work venues. Condoms should be provided at all strategic places such as shops close to sex work venues, hotel rooms and proper disposal locations should be provided.

Nyembe et al (2014) advocated for decriminalisation of sex work in order to increase the uptake of condoms among sex workers.

Chow et al (2015) said condom use increased in a group of female sex workers who had been tested for HIV in the past 12 months. Armstrong et al (2013) also alluded to this fact when they said that increased condom use and HIV testing had a strong association.

Gay, Croce-Galis and Hardee (2016) advocated for peer education, medical services and support groups to enable sex workers to adopt safer sex practices. Outreach workers can also be used to effect condom use among sex workers. Empowerment of the sex workers and targeting the male clients can also increase condom use. Decriminalisation of sex work and policies that involve the sex workers, brothel owners and clients can increase condom uptake.

Patel et al (2016) said there should be community led approaches in addressing sex worker financial vulnerability thereby providing alternative sources of income or increasing condom uptake through safe sex negotiations.

2.1.1 CRITICAL INTERPRETATION OF SCHOLARY STUDIES IN RELATION TO AREA OF STUDY

Condoms have been proven to have an efficacy rate of 99,99% and are fundamental to the reduction of HIV and STI prevalence rates worldwide if used correctly and consistently. Although this literature and evidence exist to support this claim for example the success of The Thailand 100% Condom Programme, sex workers are generally more afraid of pregnancy than HIV or STIs hence they prefer post exposure prophylaxis to condom use. The main reason being that unprotected sex pays more than protected sex. Jeal and Salisbury (2004) reported that 97% of sex workers were offered more money for unprotected sex. Bukenya et al (2013) attributed inconsistent condom use to client preference.

Due to the failing economy, sex work has become the major source of income in Jacha and competition for clients is rife. According to a study carried out in the Busia district Uganda (2015) failure to have a client for some time affected the sex workers condom negotiation skills especially if faced with dire need for money to pay rent or buy food.

Formal establishments have been shown to increase condom use for example The Thailand 100% Condom Programme became a success due to the establishment of brothels and sex work venues. Almodovar-Diaz et al (2013) also advocated for sex work venues stocked with condoms to ensure accessibility. Gay, Croce-Galis and Hardee (2016) reported that destruction of red light districts in India led to fewer clients and sex workers were more likely to engage in unsafe sex. Sex workers in Jacha operate from undesignated points such as tower lights.

Nyembe et al (2014) called for decriminalisation of sex work in South Africa to increase condom uptake. In Zimbabwe sex work has been decriminalised and condoms are no longer confiscated by the police to be used as evidence of sex work. However this concept of decriminalisation for increased condom uptake seems to be affected by other factors such as young age, client preference and level of education.

Although sex work has been decriminalised in Zimbabwe, stigma and discrimination still exist among the general population. Maticka-Tyndale and Lewis (1999) said sex workers should be part of the mainstream society rather than marginalised. Work conditions should be structured to minimise risks to safety and well being. Health and social services should be available that are sensitised to the needs of sex workers. There is no clinic in Jacha to cater for the health needs of sex workers. Nyembe et al (2014) said there was prejudice among health care workers which acted as a barrier to quality health care and education.

Decriminalisation of sex work may not increase condom uptake due to other co-existing factors such as young age and alcohol intoxication which affect condom negotiation skills.

According to Gay, Croce-Galis and Hardee (2016) peer education, medical services and support groups enable sex workers to practise safe sex. Church groups have been shown to make donations especially food and clothing to sex workers in Epworth. However, what these sex workers really need is self empowerment through alternative sources of income. Bharat, Mahapatra, Roy and Saggurti (2013) reported that sex workers with an alternative source of income refused unsafe sex.

Dhana et al (2014) said sex work programmes in Africa have limited coverage and a narrow scope of services and are poorly coordinated with broader HIV and sexual and reproductive health services. Sex workers in Jacha need access to HIV prevention programmes such as access to condoms and regular testing as well as anti retroviral therapy if they are already infected. However, Steen et al (2015) said that even if interventions were implemented, sustaining them was a great challenge due to declining global resources.

Dittmore (2009) advocated for sex-workers led organisations were they are able to make their own decisions. They should also be able to make inputs into the agenda of external organisations. The decisions should be made with them rather than for them. Sex worker

organisations are non-existent in Jacha with the sex workers in competition with each other rather than supporting each other. Jeffreys, Fawkes and Stardust (2012) reported that condom use approached 100% in Sydney and Perth brothels due to sex-worker peer education and safer sex practises.

Violence is rife in Epworth though the cases go unreported. Hail-Jares (2015) concluded that intimate partner and client initiated violence among sex workers led to psychosocial distress and risky sexual behaviours. Dittmore (2009) advocated for anti-violence campaigns and removal of sex workers from harm done by the police and military. In a study carried out in Busia district Uganda (2015), it was reported that sex workers lacked legal support if coerced or if they faced violence from clients. Maher (2015) said violation of sex worker human rights has adverse public health outcomes. The sex workers need to be protected. Sex workers in Jacha lack legal services and support.

In Epworth there is illicit alcohol smuggled from countries such as Mozambique and it is favoured by many in the study population as it is cheap and has a higher alcohol content. Scorgie et al (2012) reported that hazardous alcohol use lowered condom use. Chersich, Rees, Scorgie and Martin (2009) said alcohol independently affected decision making concerning sex especially skills for negotiating condoms and their correct use in sub-Saharan Africa. In Busia, alcohol consumption was also found to impair condom negotiation skills.

Girls as young as twelve engage in sex work in Jacha. Sexual debut before fourteen years increases inconsistent condom use. The likelihood of these girls dropping out of school is very high. Low education contributes to low condom use according to Scorgie et al (2012).

Almodovar-Diaz et al (2013) called for the inclusion of both sex workers and their clients in condom campaign programs. Clients are a highly dispersed group and very much part of the general population. Sex workers in Jacha have an assortment of clients which include local Zimbabwean men and Chinese men. These clients need to be educated on the benefits of condom use.

All the studies carried out on condom use agreed that condom use is effected or affected by other co-existing factors which may influence or hinder their uptake.

2.3 SUMMARY

This chapter reviewed literature related to condom uptake among sex workers at local, regional and international settings. The literature was related to the research questions such as what are condoms, benefits of using condoms, who should initiate condom use during a sexual encounter and what can be done to promote condom acceptability and accessibility. Critical interpretation and evaluation of scholarly studies in relation to the area of study was also done.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 INTRODUCTION

This chapter discussed the research design, population and sample, instrumentation, ethical considerations, data collection procedures and the data analysis plan. Finally a summary was given.

3.1 RESEARCH DESIGN

According to Creswell (2009), a research design is a plan and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis. The overall decision on which design to use is informed by the worldview assumptions the researcher brings to the study, procedures of inquiry and specific methods of data collection, analysis and interpretation. The selection of the research design is also based on the nature of the of the problem, the researcher's personal experiences and the audiences of the study.

De Vaus (2001) notes that the research design is the overall strategy chosen to integrate the different components of a study in a coherent and logical manner to effectively address the research problem. It has a blueprint for the collection, measurement and analysis of data. The research problem determines the type of design.

According to Anastas (1999) a descriptive design helps provide answers to questions of who, what, how and where associated with a research problem. However it cannot conclusively ascertain answers to why. This type of design is used to obtain information concerning the current status of the phenomena and to describe what exists with respect to variables in a situation. Anastas (1999) further said the subject is observed in a completely natural and unchanged environment in a descriptive research design. True experiments whilst giving analysable data often influence the normal behaviour of the subject (Heisenberg effect whereby measurements of certain systems cannot be made without affecting the systems). Descriptive research is often used as a precursor to quantitative research designs and if limitations are understood, they can be a useful tool in developing a more focused study. Descriptive designs collect a large amount of data for detailed analysis that lead to important recommendations in practice. However, results from a descriptive research cannot be used to formulate a definitive answer and neither can they be replicated as they utilise observational methods. The descriptive design is also greatly dependant on instrumentation for measurement and observation. Due to the above mentioned reasons, a descriptive research design was chosen for this investigation.

3.2 POPULATION AND SAMPLE

3.2.1 POPULATION

According to Kombo and Tromp (2011), a population is a group of individuals, objects or items from which a sample will be extracted for a research project. Chiromo (2006) goes on to say, population refers to all the individuals, units, objects or events that will be considered in a research project. The target population contains members of a group that a researcher is interested in studying and to which the study results will be generalised. The population of Jacha was estimated at 2000 informal residents.

3.2.2 SAMPLE

A sample consists of a subset of a population. According to Chiromo (2006) a sample is a smaller group or subset of the population selected from the entire population. Cohen and Manion cited in Kombo and Tromp (2011) said a sample is a number of individuals or objects from a population of which the selected group contains elements representative of the characteristics found in the entire group.

Out of the total population of 2000 people, a sample size of 200 research participants was chosen. Probability sampling/random sampling technique was used to select the population sample. According to Kothari (2004), under random sampling every element of the research of the study population has a chance of inclusion in the sample. Individual units are picked up from the whole group by some mechanical process and not deliberately. Kothari (2004) further says random sampling gives each element in the population an equal probability of getting into the sample and all choices are independent on one another. Random sampling also gives each sample combination an equal probability of being chosen. There is no bias in selection.

3.3 INSTRUMENTATION

Instruments are tools used to collect data. Questionnaire and interviews were used to collect data in this investigation. Cohen, Manion and Morrison (2005) define a questionnaire as a means of obtaining attitudes, feelings, perceptions and beliefs of a sample of individuals. They can be structured or unstructured. A questionnaire is also a concise preplanned set of questions designed to yield information about a pertinent research question. A questionnaire was chosen for this study because it was less expensive in terms of money and time. Questionnaires were also a great asset to the study due to the sensitivity of the research topic as they offered a sense of anonymity. This tool was also uniform and standard for all the respondents and was not influenced in any way by the mood of the interviewer. Questionnaires cover large geographical areas thereby ensuring large samples and compensate for the expected loss of subjects. The questionnaires were hand-delivered which offered the researcher an opportunity to interact with the respondents and explain face to face the issues involved in the study. The researcher was also able to check if all questions were responded to and if not, immediately asked the respondent to answer the questions. Finally the respondents did not feel pressured to provide immediate answers as compared to face to face interviews which were used to compliment the questionnaires.

The questionnaire was standardised to ensure the questions provided the desired answers thereby ensure validity. Reliability was guaranteed through competent and proper administration of the questionnaire.

According to Kothari (2004), interviews involve presentation of oral-verbal stimuli and response in terms of oral-verbal responses. Structured interviews were used, using predetermined questions and standardised recording technique. The interviews were used to elicit more information from the respondents and misunderstood questions were clarified. Interviews were useful when the researcher was faced with individuals who could not read and understand a written questionnaire. Interviews also enabled the researcher to observe the verbal and non-verbal responses of the respondents. Interviews ensured that all the questions were answered.

A pilot study was carried out in Overspill by randomly selecting a few respondents with the desired characteristics. This was done to obtain information for improving the study, assess its feasibility as well as assess the adequacy of the measurement instruments.

3.4 ETHICAL CONSIDERATIONS

According to Encyclopaedia Britannica (2007) ethics are the discipline concerned with what is morally good and bad, right and wrong. Ethics refer to the principles and guidelines that help a profession determine and uphold what is morally justifiable.

An informed verbal consent was obtained from the respondents before commencement of the study. The consent was voluntary and no deception, threats or coercion were used.

The respondents were guaranteed anonymity as no names or identifying markers were used during the study.

Confidentiality/privacy was also guaranteed. The information obtained from the study was not to be divulged to the public other than through professional channels as promised in the consent.

The respondents were protected from harm through enforcing voluntary informed verbal consent, anonymity and confidentiality. The researcher did not put the respondents' lives at risk from the community.

Due to the sensitivity of the research topic, respondents were protected from embarrassment and stigmatisation within the community of Jacha.

The researcher upheld her integrity through honest reporting of collected data. She ensured data were collected from the sampled population on site, reported and analysed the data as accurately as possible to allow for generalisation of the findings on the targeted population and also allow for implementation of interventions as outlined in the recommendations.

3.5 DATA COLLECTION PROCEDURES

The researcher formulated questionnaire and interview questions which were going to be used during the study and submitted them for approval from her supervisor. An introductory letter was then obtained from the Midlands State University, Faculty of Education, Department of Adult Education chairperson. This introductory letter was used to apply for permission from the Epworth Local Board Secretary. The letter highlighted that the study was in partial fulfilment of the researcher's studies at the university. Approval was granted by the Secretary and an approval letter was given to the researcher.

3.6 DATA ANALYSIS PLAN

Column graphs, tables and pie charts were used to analyse the data. The demographics and condom use behaviours and perceptions by the respondents were also analysed by descriptive methods.

3.7 SUMMARY

This chapter discussed the research design, population and sample, instrumentation, ethical considerations, data collection procedures and data analysis plan.

CHAPTER 4

DATA ANALYSIS, PRESENTATION AND DISCUSSION

4.0 INTRODUCTION

This chapter was devoted to data analysis, presentation and discussion of the investigation's findings.

4.1 PRESENTATION AND ANALYSIS OF FINDINGS

4.1.1 Demographic characteristics

Sex, age, marital status and educational qualifications were the characteristics analysed.

4.1.1.1 Sex of the respondents

Table 1 shows that out of the 200 respondents 78 (39%) were male and 122 (61%) were female.

sex	actual number of respondents	possible number of respondents	percentage
male	78	200	39%
female	122	200	61%

Table 1: Showing the distribution of the respondents by sex

4.1.1.2 Age of the respondents

37 (18, 5%) of the respondents were aged between 10-15 years, 50 (25%) fell in the 16-20 age group, 69 (34, 5%) were in the 21-30 age group while 44 (22%) were aged above 31 years.

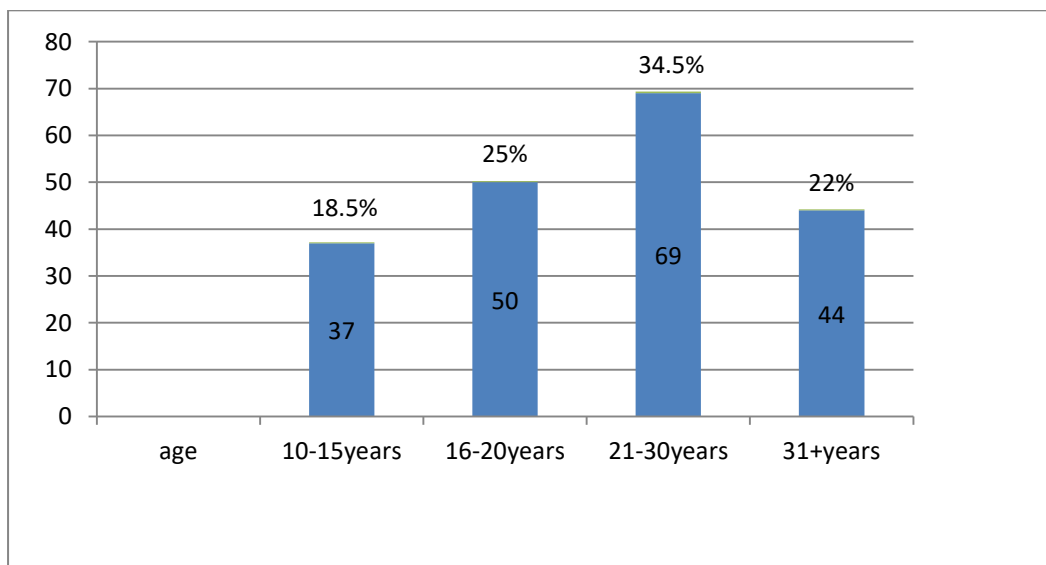


Figure 1: Column graph showing distribution of the respondents by age

4.1.1.3 Marital status of the respondents

64 (32%) of the respondents were single, 48 (24%) were married, 34 (17%) were co-habiting while 54 (27%) were divorced.

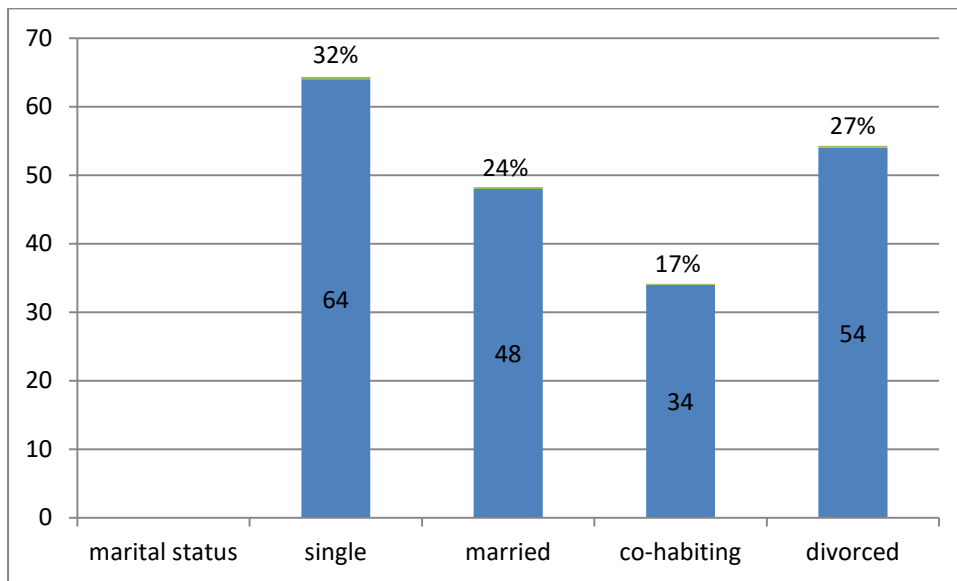


Figure 2: Column graph showing distribution of the respondents by marital status

4.1.1.4 Educational qualifications of the respondents

Of the participants, 27 (13, 5%) had primary school education, 160 (80%) had secondary school education while 13 (6,5%) had diplomas. None of the respondents had either a bachelor’s degree or master’s degree.

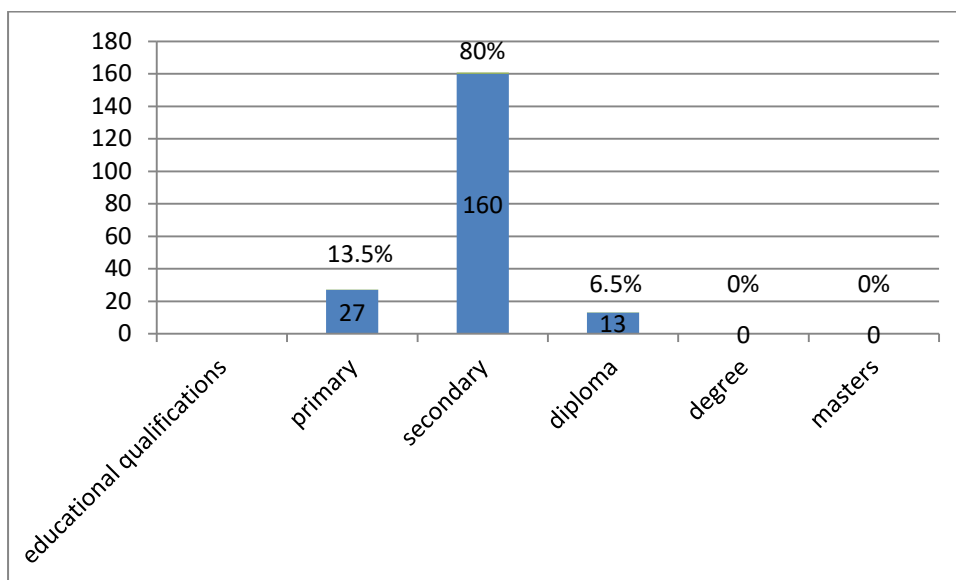


Figure 3: Column graph showing the educational qualifications of the respondents

4.1.2 Knowledge section

The respondents knowledge and perceptions about condoms as well as their sexual behaviours were analysed in this section.

4.1.2.1 Respondants knowledge on what condoms are

198 (99%) of the respondents knew what condoms were while only 2 (1%) did not know what they were.

do you know what condoms are	actual number of respondents	possible number of respondents	percentage
yes	198	200	99%
no	2	200	1%

Table 2: Showing distribution of the respondents by knowledge of what condoms are

4.1.2.2 Have the respondents ever used condoms before

175 (87, 5%) of the respondents had used condoms before while 25 (12.5%) had not.

have you ever used condoms before	actual number of respondents	possible number of respondents	percentage
Yes	175	200	87.5%
No	25	200	12.5%

Table 3: Showing distribution of the respondents by whether they had used condoms before or not

4.1.2.3 Respondants awareness of the male condom's protective functions

188 (94%) of the respondents knew the protective functions of the male condoms while 12 (6%) did not.

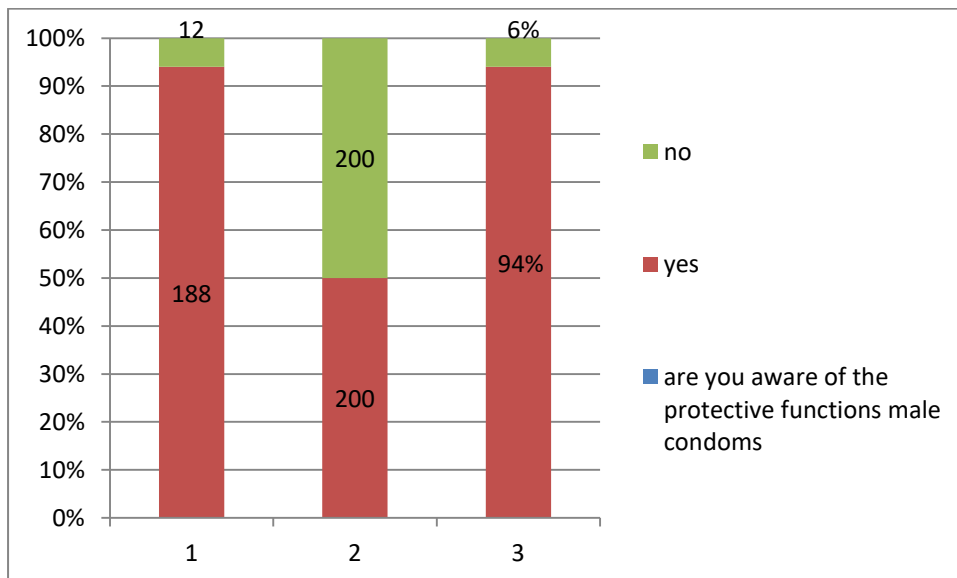


Figure 4: Column graph showing the respondents awareness of the male condom's protective functions.

4.1.2.4 Respondants awareness of the female condom's protective functions

183 (91,5%) of the respondents were aware of the female condom's protective functions while 17 (8,5%) were not.

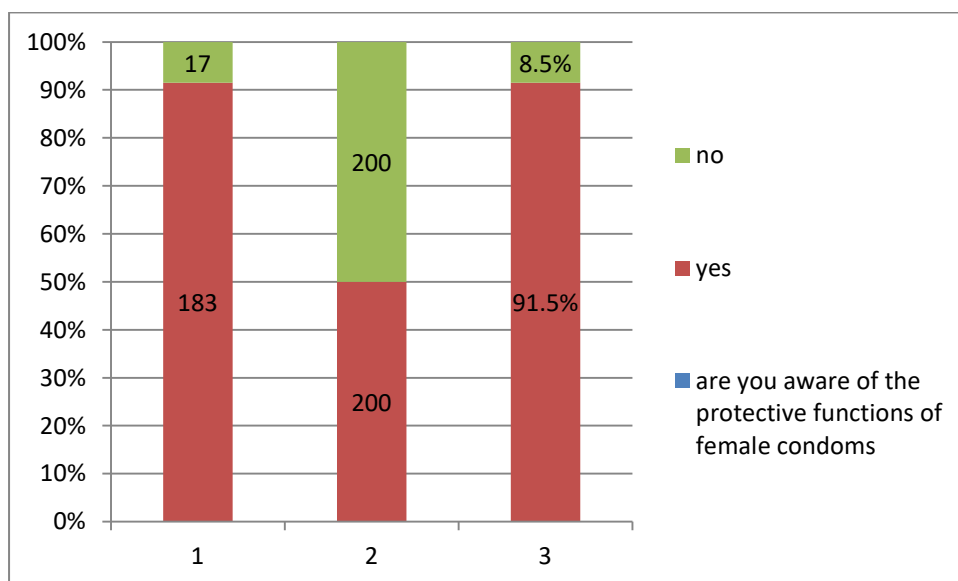


Figure 5: Column graph showing the respondents awareness of the female condom's protective functions.

4.1.2.5 Source of awareness of the male condom's protective functions

63 of the respondents (31,5%) had heard about the male condom's protective functions from a sexual partner, 47 (23,5%) heard from a friend, 25 (12,5%) from a local clinic, 26 (13%) from NGOs while 39 (19,5%) heard from the media.

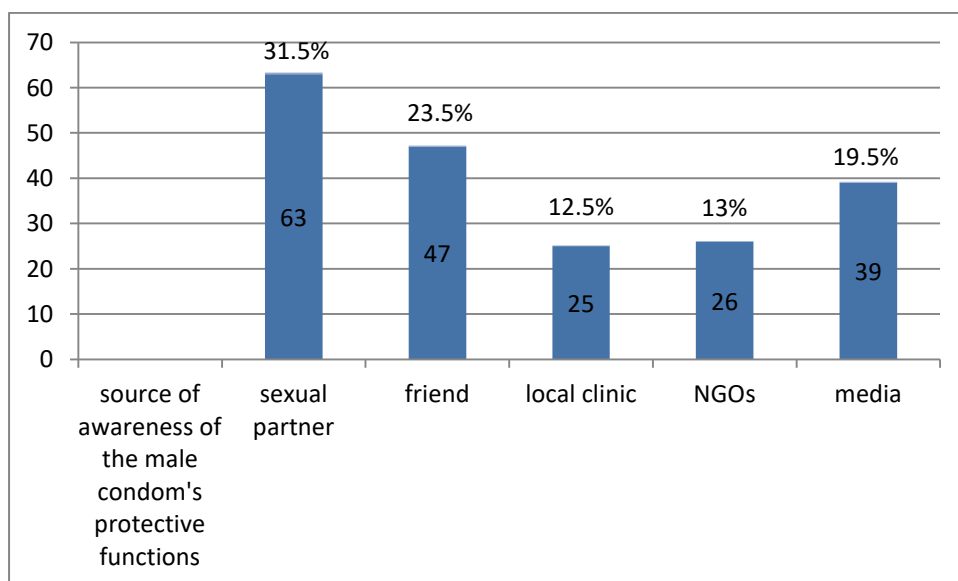


Figure 6: Column graph showing the respondents source of awareness of the male condom's protective functions.

4.1.2.6 Source of awareness of the female condom's protective functions

9 (4,5%) respondents heard from a sexual partner,81 (40,5%) from a friend,30 (15%)from a local clinic,49 (24,5%)from a NGO while 31(15,5%) heard from the media.

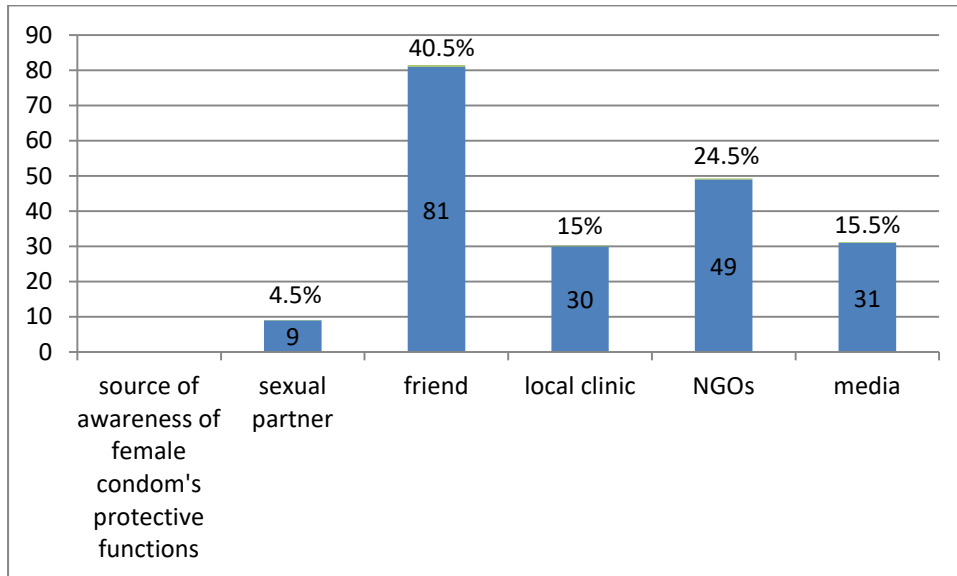


Figure 7: Column graph showing the respondents source of awareness of the female condom's protective functions.

4.1.2.7 Do you use condoms each time you have sex

79 (39,5%) of the respondents said they used condoms each time they had sex while 121 (60,5%) said they did not use them each time they had sex.

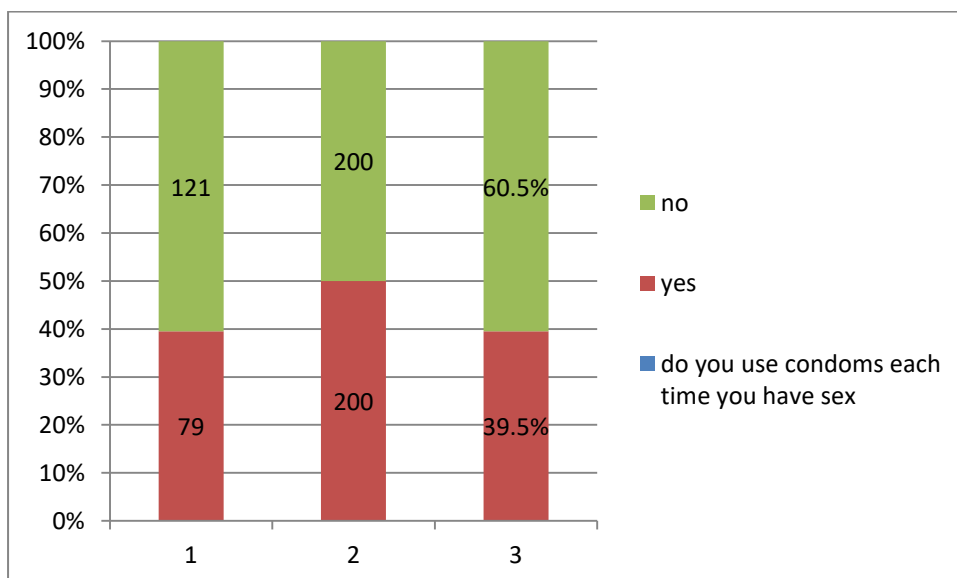


Figure 8: Column graph showing whether the respondents used condoms each time they had sex.

4.1.2.8 Condoms are readily and conveniently available in Jacha

77 (38, 5%) of the respondents agreed that condoms were readily available in Jacha,75 (37,5%) were neutral,37 (18,5%)disagreed while 11(5,5%) strongly disagreed.

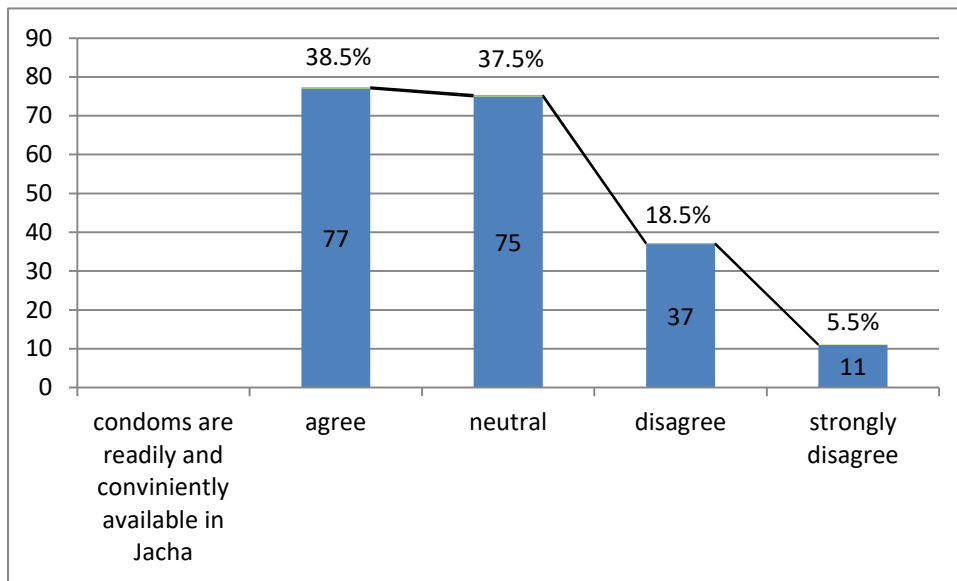


Figure 9: Column graph showing the respondents perceptions on the availability of condoms in Jacha

4.1.2.9 Condoms are well promoted in Jacha

46 (23%) of the respondents agreed that condoms were well promoted in Jacha,57 (28,5%) were neutral,73 disagreed (36,5%) and 24 (12%) strongly disagreed.

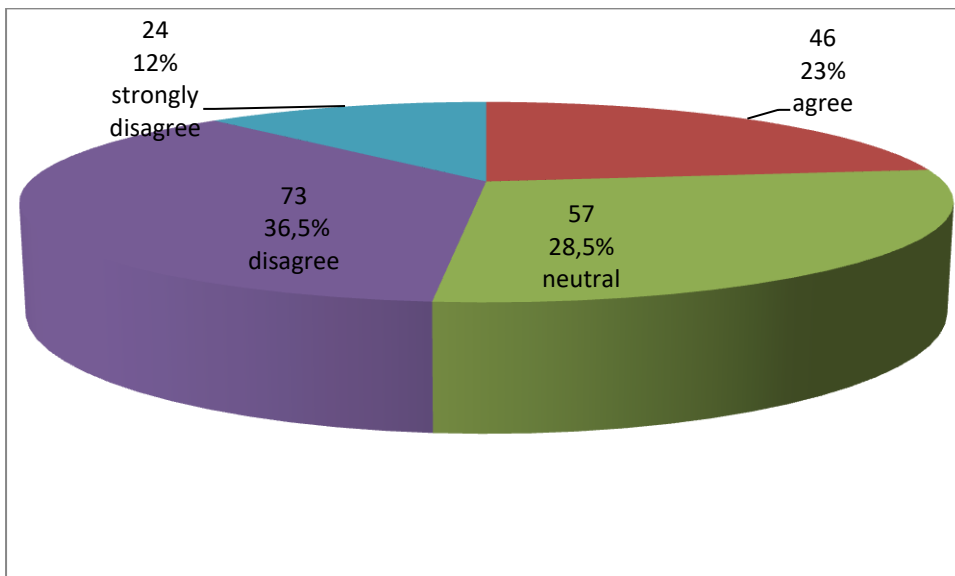


Figure 10:Pie chart showing the respondents perception on the promotion of condoms in Jacha

4.1.2.10 Who initiates condom use in a sexual encounter

124 (62%) of the respondents said condom use was initiated by the commercial sex worker while 76 (38%) said condom use was initiated by the client.

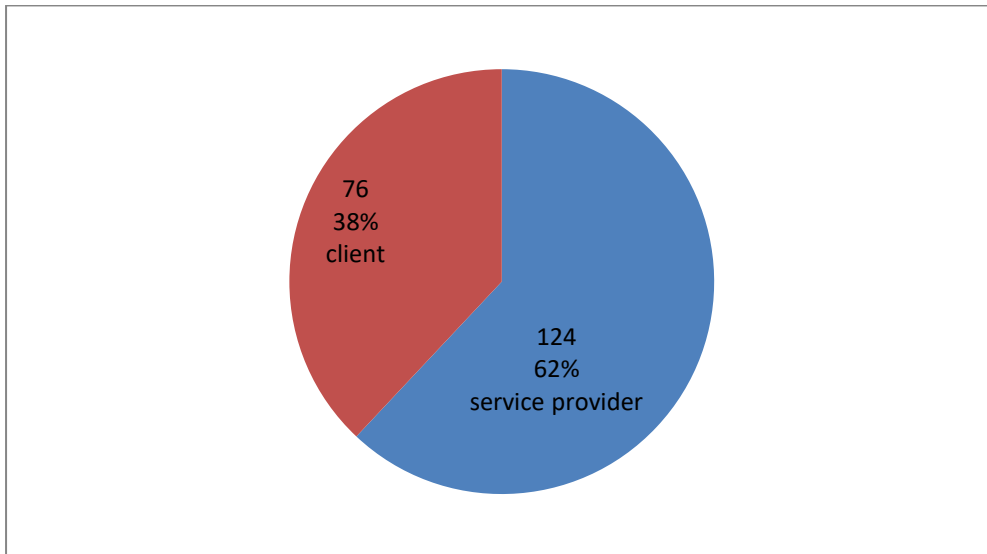


Figure 11: Pie chart showing who initiated condom use between a service provider and client.

4.1.2.11 Can you refuse sex where no condom is used

29 (14, 5%) of the respondents said they could refuse a sexual encounter where either client or service provider would not use a condom while 171 (85,5%) said they could not.

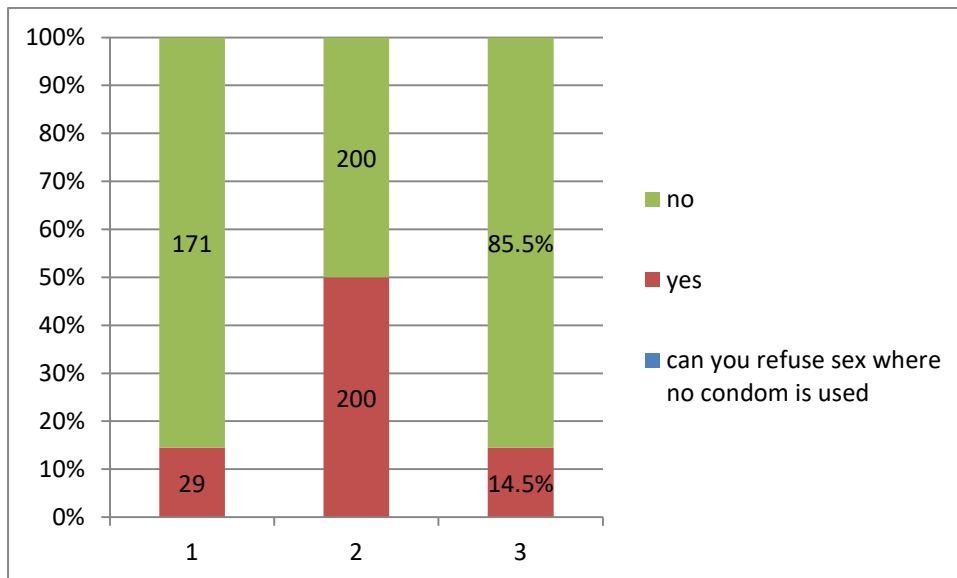


Figure 12: Column graph showing whether the respondents could refuse sex where no condom was used.

Out of the respondents who said they could refuse sex where no condom was used, 17 were men while 12 were women. Out of the respondents who said they could not refuse sex where no condom was used, 61 were men while 110 were women.

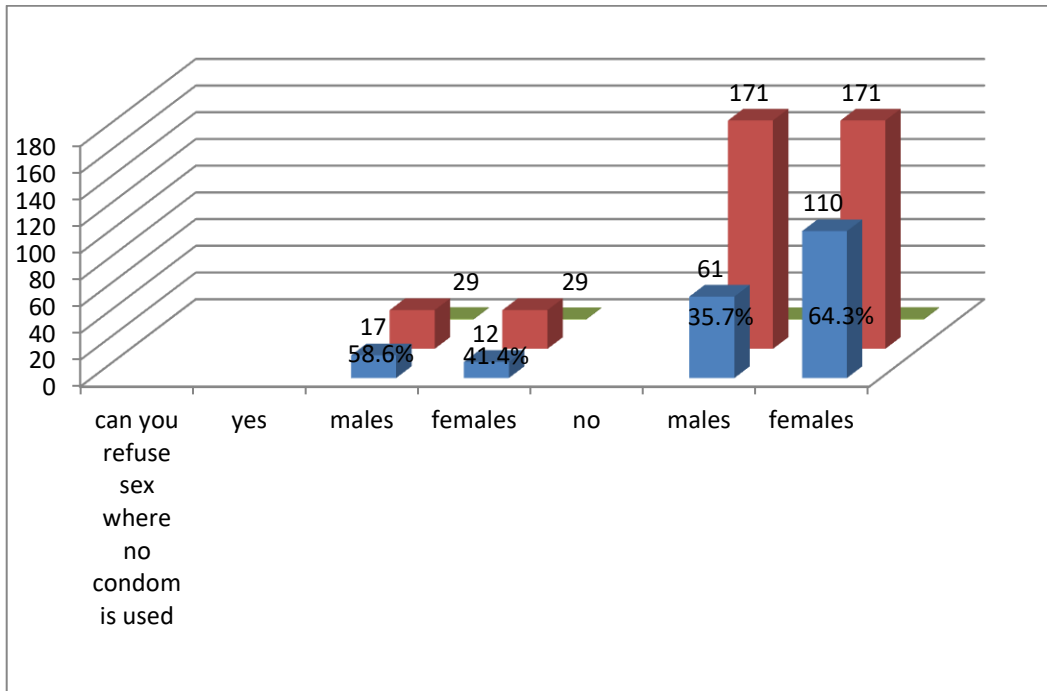


Figure 13: Column graph showing the distribution by sex of whether the respondents could refuse sex where no condom was used.

4.1.2.12 Why the respondents could not refuse sex where no condom was used

All the female respondents (64,3%) to this question cited that the rate of payment for unprotected sex was higher than the rate paid for protected sex. The male respondents (35,7%) did not want to be viewed as cowards by their peers.

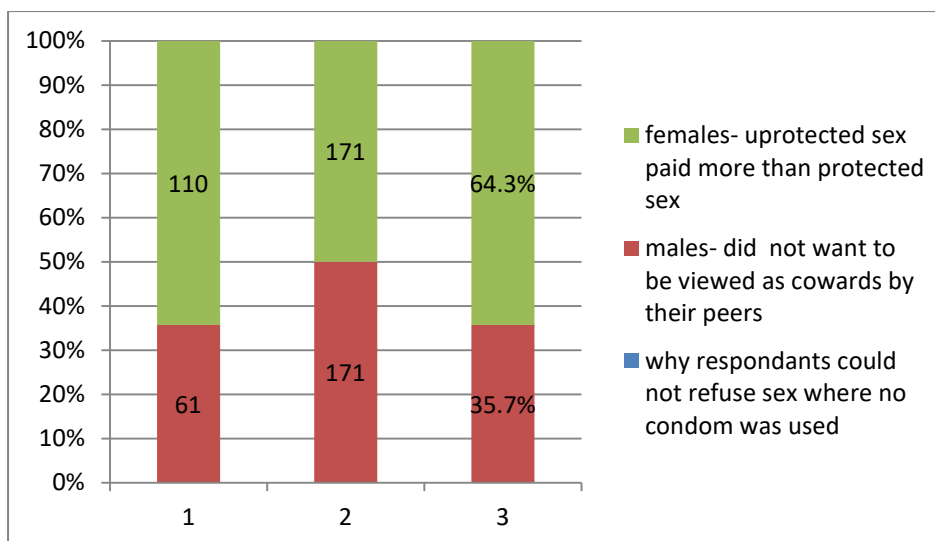


Figure 14: Column graph showing why the respondents could not refuse sex where no condom was used

4.1.2.13 Is condom use negotiable

73(36,5%) of the respondents said they could negotiate for condom use while 127 (63,5%) said they were not able to negotiate for condom use.

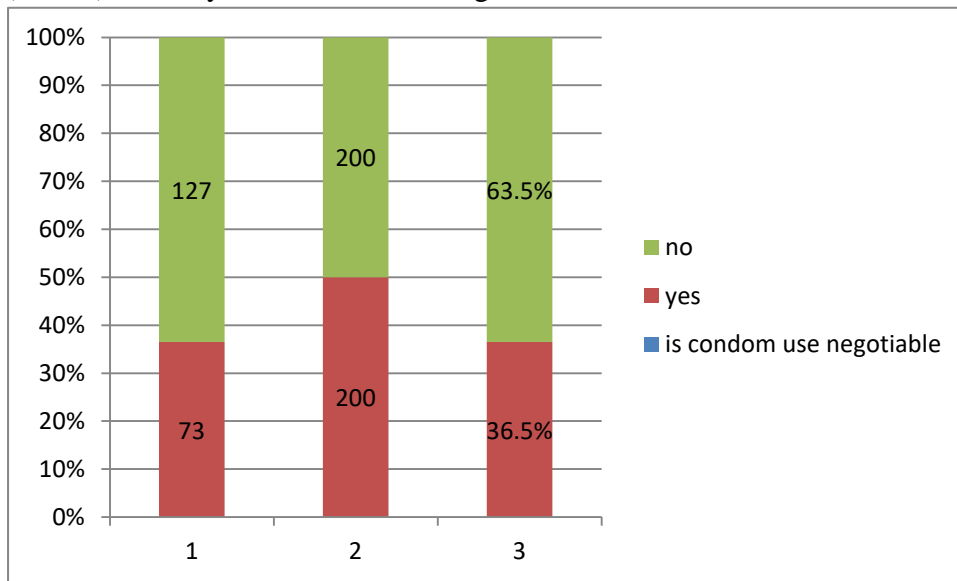


Figure 15: Column graph showing whether the respondents could negotiate for condom use or not

Out of the respondents who could not negotiate for condom use 105(82,7%) were women, 22 (17,3%) were men. Out of the respondents who could negotiate for condom use 17(23,3%) were women while 56(76,7%) were men.

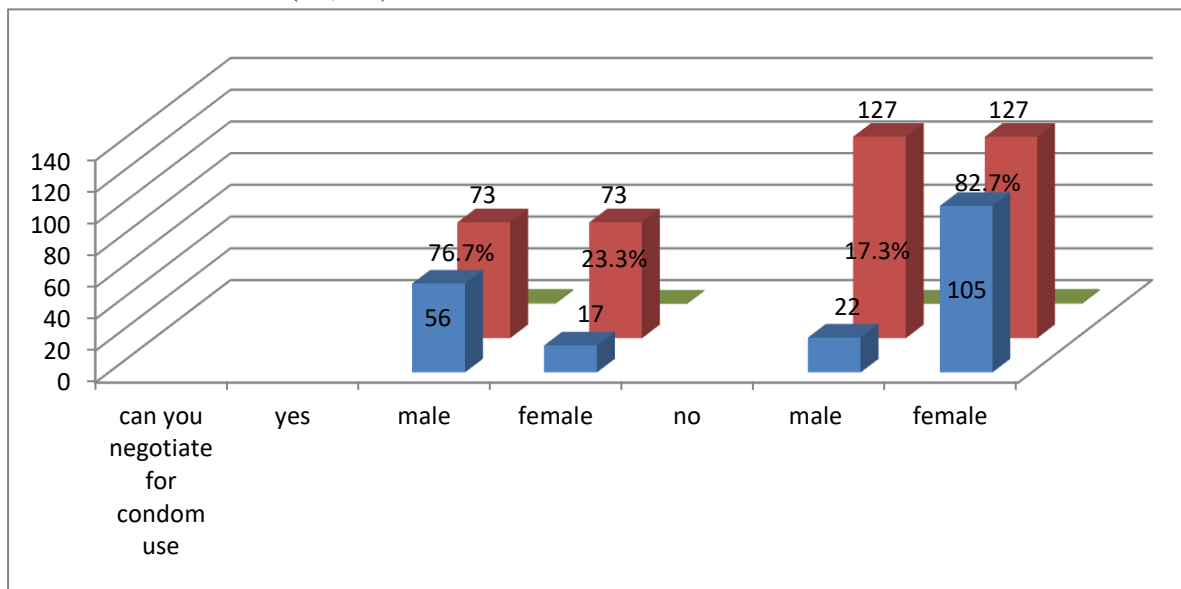


Figure 16: Column graph showing distribution by sex of whether the respondents could negotiate for condom use or not.

4.1.2.14 Why the respondents could not negotiate for condom use

The female respondents who could not negotiate for condom use said there was stiff competition among the sex workers and they could not afford to lose a client over the issue of condom use hence they ended up complying with the clients demands while others said most of the clients ended up being violent if they insisted on condom use. The male respondents said they had the final say over the sexual encounter since they would be paying for the services. If the commercial sex worker insisted on condom use, the client would easily find another sex worker who would have unprotected sex with him so negotiating for condom use would be a waste of time.

why the respondents could not negotiate for condom use	females 82,7%	males 17,3%
	stiff competition among the sex workers	they had the final say as they would be paying for the services
	violent clients	they could easily find another sex worker who would not use a condom

Table 4: Showing why the respondents could not negotiate for condom use

4.1.2.15 What do you want done to promote condom use in your area

The respondents said free condoms should be provided for them in Jacha at strategic points such as paBooster. They bemoaned the failing economy which brought about poverty which in turn pushed them into prostitution. This poverty affected their condom negotiation skills as they were desperate hence they wanted alternative sources of income such as poultry rearing projects. The respondents also said a clinic should be set up specifically for them where they could access free reproductive health services and where they would meet as commercial sex workers to share experiences, support and encourage each other on condom use without anyone judging them. They also said peer educators and counsellors who were familiar with their daily challenges and tribulations should be used to educate and counsel the commercial sex workers especially the young girls and these peers educators and counsellors should be drawn from the pool of sex workers or should be former sex workers rather than external people. The commercial sex workers also said their clients and partners/spouses as well as the young sex workers needed to be educated on the advantages of condom use so as to promote condom use. Others wanted to be able to report clients who resorted to violence when the issue of condom use was brought up to law enforcers.

4.1.2.16 Who should do it and why

The respondents said that it was the responsibility of those they elected into power in collaboration with non- governmental organisations to ensure that condom use was promoted in Jacha as they had the financial, material and human resources. They said poverty was the root cause of the problem so it was the government's issue to address. Some respondents said nurses from the local clinic should take time to teach them on the advantages of condom use and how to use them as the nurses were more knowledgeable than them.

4.2 DISCUSSION

This section presented a detailed discussion of the findings on the demographic characteristics and knowledge as well as perceptions about condoms by the respondents.

4.2.1 DEMOGRAPHIC CHARACTERISTICS

4.2.1.1 Sex

The majority of the respondents were females who constituted 61% of the study group while only 39% were males.

4.2.1.2 Age

Most of the respondents were aged between 21 to 30 years (34, 5%) followed by those aged between 16 to 20 years (25%).According to WHO (2011) the average age of sex workers in Africa was between 25 to 30 years while in a study carried out among sex workers in South Africa, Thailand, Turkey, America and Zambia by Farley, Baral, Kiremire and Sezgin (1998), the average age was 28 years. The findings from these studies corresponded with the study results.

4.2.1.3 Marital Status

59% of the respondents were not married while 17% were cohabiting. Marital status influence the composition of both sex workers and clients. Edlund and Korn (2001) argued that a woman cannot be both a sex worker and a wife. She had to be either a sex worker only or a wife only not both. Monto (2000) said sex worker clients were less likely to report being currently married and more likely to report never having been married. Gaffey et al (2011) further said unmarried men were far more likely than married men to use commercial sex workers.

4.2.1.4 Educational qualifications of the respondents

The majority of the respondents had attained secondary school education (80%) followed by those who only had primary school education (13,5%). In a study carried out by Ochere and Nanewortor (2011), educational level was not found to have a significant influence on prostitution behaviours. However socio-economic status, level of education and vocational skills/professional qualifications were found to interact significantly to influence the prostitution behaviours of sex workers. Scorgie et al (2012) linked low education and other factors such as poverty, endemic violence and work characterised by poverty to low condom use.

4.2.2 KNOWLEDGE AND PERCEPTIONS ON CONDOMS

4.2.2.1 Knowledge of what condoms are

99% of the respondents knew what condoms were. In a study carried out by Akpan, Ekott and Udo (2013), all the respondents knew what condoms were. Tran, Nguyen, Nguyen and Phan

(2013) reported that 94% of sex workers knew using condoms prevented HIV. However, this did not influence correct and consistent use of the condoms due to inadequate knowledge, misconceptions about HIV transmission routes, low perceived risk of HIV and low voluntary testing and counselling uptake.

4.2.2.2 Have you ever used condoms before

87,5% of the respondents had used condoms before while 12,5% had not. Akpan, Ekott and Udo (2013) reported that the main reason for using male condoms was for prevention of sexually transmitted diseases. Zellner (2003) said for most women in Cote d'Ivoire the condom was the widely known method of contraception. So for one reason or the other the respondents in Jacha had used condoms before.

4.2.2.3 Are you aware of the protective functions of the male condom

94% of the respondents were aware of the protective functions of the male condom. According to Mbizvo, Siziya, Olanyika and Adamcahk (1997), the majority of Zimbabwean men knew the protective functions of male condoms.

4.2.2.4 Are you aware of the protective functions of the female condom

91,5% of the respondents were aware of the protective functions of the female condoms while only 8,5% was not. Valens and Ntagaria (2013) reported that 79% of study respondents were aware of the female condom but only 24% knew how to use them. 78% believed it could prevent unwanted pregnancy while 81% believed it could prevent STIs. Thus it shows the female condom is comparable to the male condom.

4.2.2.5 Source of awareness of both condoms protective functions

The local clinic contributed to 25% male condom sensitisation and 15% female condom sensitisation. Nyembe et al (2014) called for the eradication of prejudice among health care workers as it acted as a barrier to quality health care and education. Akpan, Ekott and Udo (2013) alluded that only 14% of study respondents were sensitised about the male condom from the hospital. These results show that health services providers are not at the forefront in sensitising communities on the advantages of condom use. Population Services International resorted to distributing and marketing condoms in seemingly unorthodox places such as hair salons in Zimbabwe. Maticka-Tyndale and Lewis (1999) called for health and social services that are sensitive to the needs of sex workers.

4.2.2.6 Do you use condoms each time you have sex

60,5% of the respondents reported inconsistent condom use. UNAIDS (2000) reported that Zimbabwean men used condoms inconsistently due to difficulties in finding or paying for a condom, embarrassment, lack of experience, culture (need for sex is uncontrollable) or alcohol. Ng and Wong (2016) said adolescents reported inconsistent condom use thereby serving as a bridge of STI transmission to the community.

4.2.2.7 Condoms are readily and conveniently available in Jacha

76% of the respondents believed that condoms were readily and conveniently available in Jacha. Hoke (2007) found that the availability of female condoms was associated with increased condom use. However in Jacha despite the availability of condoms, they were not being utilised as the sex workers were offered more money for unprotected sex.

4.2.2.8 Condoms are well promoted in Jacha

48,5% of the respondents believed that condoms were not well promoted in Jacha. Egger et al said condom promotion through education, counselling and advertising encouraged the use of condoms. Condom distribution makes condoms readily available. Condom promotion and distribution are effective in the fight against HIV, AIDS.

4.2.2.9 Who initiates condom use

62% of the respondents said condom use was initiated by the sex workers while 38% said clients initiated condom use. Bukenya et al (2013) attributed inconsistent condom use to client preference.

4.2.2.10 Can you refuse where no condom is used

85,5% of the respondents said they were not able to refuse unprotected sex. Female respondents said they were paid more for unprotected sex. Jeal and Salisbury (2004) reported that 97% of sex workers in Britain were offered more money for unprotected sex. Male respondents did not want to be viewed as cowards by their peers. Zellner (2003) said patriarchy, polygamy and extramarital relationships affected men's decisions on condom use in Africa.

4.2.2.11 Can you negotiate for condom use

63,5% of the respondents could not negotiate for safe sex. Moore et al (2014) said social marginalisation and criminalisation of prostitution affected the sex workers condom negotiation skills. Zellner (2003) reported that African men controlled much of the decision making regarding sexual encounters and also these men sought prostitutes who did not insist on condom use. This conforms with the study results where the men said they would find another sex worker who would not use a condom.

4.2.2.12 What do you want done to promote condom use in Jacha

The respondents said they wanted free condoms, alternative sources of income and a clinic dedicated solely to sex workers. They also called for peer educators and counsellors to help them cope with the nature of their work and working environment. According to Tucker et al (2011) peer interventions, condom promotion and STI screening reduced HIV exposure and transmission among sex workers. Respondents called for the health education of their clients, partners, spouses and sex workers on condoms. They also said the police should arrest clients who resorted to violence when asked to use a condom.

4.2.2.12 Who should do it and why

The respondents said condom promotion should be carried out by the government in collaboration with the NGOs and health workers as they had the human, material and financial resources. However, the respondents left out a crucial element in condom promotion which was themselves though they advocated for peer educators. Dittmore (2009) said sex workers should be included in decision and policy making. Dittmore (2009) also said sex workers should self organise and drive the agenda of organisations.

4.2.3 CHALLENGES ENCOUNTERED

The researcher did not experience any major challenges from the study planning through report writing. One notable limitation was gaining access to the respondents especially the male respondents due to the stigmatisation, marginalisation and discrimination of sex workers and their clients. The sex workers were also highly mobile in their search for clients.

Time and money for incentives were also major constraints for the researcher but overallly the researcher was grateful to the respondents who shared their intimate and private details with a total stranger. The study opened the researcher's eyes to the poverty and financial desperation of the study population. It was hard to believe the informal settlement was under a local board which had been established in 1987. Almost three decades later the settlement still lacks proper infrastructure, basic social utilities and planned residential structures.

It can be deduced from the study and available literature that condoms have protective functions and most people are aware of these protective functions. It can also be agreed that all sex workers face stigma, discrimination, criminalisation and social marginalisation by their respective communities which do not condone sex work as a form of employment though the sex workers are paid for the services they provide. The general population distances itself from the sex workers (them and us) but it is important to note that the commercial sex workers' clients come from the general population. Ultimately sex worker issues should be addressed encompassing both the sex workers and the general population. The two groups cannot have separate interventions.

Sex workers across all borders are offered more money for unprotected sex. The level of financial desperation in the different settings determine the ultimate answer to this offer. It can be argued that sex workers in Jacha need the money for basic human needs such as food and shelter while those in developed countries need the money for recreation for example alcohol and drugs.

The studies carried out in most developed countries such as Australia where condom use was close to 100% cannot be comparable with Jacha, as these areas were independent of co-existing factors such as gruelling poverty, low education and early sexual debut which exist in Jacha. Attaching the success of these findings to Jacha would be impractical.

Establishment of sex work venues such as in Thailand to promote condom use is also not feasible in Jacha where both the national and local governments have failed to establish basic social amenities such as schools, clinics, housing, water and electricity so formal sex work venues would be the least of their priorities.

4.3 SUMMARY

This chapter discussed data analysis, presentation and outlined a detailed discussion of the research findings. Demographic characteristics and knowledge as well as perceptions on condoms were analysed, presented and discussed.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 INTRODUCTION

This chapter gave a summary, conclusions and recommendations of the study.

5.1 SUMMARY

Chapter one dealt with the research problem, chapter two reviewed related literature, chapter three dealt with the research methodology and chapter four was concerned with data analysis. The study was on condom uptake among commercial sex workers in Jacha Epworth. The population of Jacha was comprised mainly of poor Zimbabweans surviving on informal trade. Child prostitutes are rife in Epworth and these children could find it difficult to negotiate for safe sex if faced with older clients. The population had low educational attainment and charged as little as half a dollar for sexual services. Condoms are a successful public health strategy. Correct and consistent use reduced unwanted pregnancies and STIs. However, inconsistent use was high in many settings. The study sought to answer what condoms are, benefits of using condoms, what could be done to promote condom accessibility and acceptability and who should initiate condom use during a sexual encounter. The study results would help the government plan health education and promotion programmes. The study results would help the local government implement alternative sources of income. Promotion of condom use could also reduce STIs, unwanted pregnancies and AIDS in Jacha. Jacha is an informal settlement located in ward one Epworth. It has unplanned houses and no basic utilities although it is recognised by the local board. Time, finance, respondent cooperation and questionnaire complexity were the study limitations. Condoms are protective devices used to prevent the exchange of body fluids during sexual intercourse thereby prevent unwanted pregnancy, STIs and HIV/AIDS. Condom use among sex workers was affected by factors such as being offered more money for unprotected sex, alcohol/drug abuse and poverty. A descriptive research design was chosen for the study. The population of Jacha was estimated at 2000 residents and a sample size of 200 respondents was chosen using random sampling. Questionnaires and interview schedules were used to collect data. Ethical considerations such as an informed verbal consent, anonymity, confidentiality and protection from harm were guaranteed to the respondents. Column graphs, pie charts and tables were used to present and analyse data on the research findings. The majority of the respondents were females and the majority of the respondents were aged between 21-30. 59% were unmarried. The greater portion had only secondary school education. 99% of the respondents knew what condoms were and 8,5% had used them before. Over 90% of the respondents were aware of the condoms protective functions. The majority of respondents had obtained their awareness of the condoms protective functions from other sources such as friends or sexual partners rather than from health workers. Condoms were readily available in Jacha though not well promoted. Over 50% of condom use was initiated by the sex workers. However 85,5% of the respondents could not refuse unprotected sex and 63,5% could not negotiate for safe sex. The respondents wanted free condoms and a clinic in

Jacha. They also called for multi-stakeholder collaboration on condom education, promotion and distribution.

5.2 CONCLUSIONS

The study revealed that condom uptake among commercial sex workers in Jacha was low with 60,5% of the respondents reporting inconsistent condom use and another 85,5% of the respondents said they could not refuse unprotected sex. 63,5% of the respondents could not negotiate for condom use. 78% were below the age of 30. This young age could have affected their condom negotiation skills. 59% were not married. Marriage according to Bukonya et al (2013) reduced the risk of inconsistent condom use. Low educational attainment could affect condom negotiation skills. The commercial sex workers would not be empowered to negotiate for condom use as they do not know the rationale and long time benefits of safe sex. The majority of the respondents knew what condoms were, had used them before and were aware of the condoms protective functions but still reported low uptake. This uptake could be attributed to poverty, young age and alcohol which could impair judgement. Sex workers reported that unprotected sex paid more than protected sex hence contributing to the low condom uptake. Health care workers and the media were not playing their part in informing the community about condoms which could also have affected their rate of uptake in Jacha. In Jacha there is no electricity to play televisions or radios so the print media should be utilised in condom campaigns. NGOs, friends and sexual partners were useful in raising condom protective functions awareness in sex workers. Condoms were available at a fee in Jacha but were not well promoted. 62% of the sex workers initiated condom use. Initiating condom use did not however obligate them to use the condoms if the client refused as the majority of sex workers claimed unprotected sex paid more than protected sex, stiff competition hindered condom negotiation skills and the clients became violent if the sex worker insisted on condom use. The majority of sex workers and their clients in Jacha could not negotiate for condom use. The respondents gave their opinion on what they thought should be done to promote condom use in Jacha but they put the burden of turning their lives around on other people rather than taking full charge and ownership of their lives and problems and turning them around for the better.

5.3 RECOMMENDATIONS

Need for further researcher

The study established that the respondents knew what condoms were as well as their protective functions but condom uptake was low. Further research needs to be carried out to reveal the determinants of low condom uptake and how these could be eradicated.

Promoting condom use

The Ministry of Health and Child Care through nurses should educate the sex workers and the community on the importance of condom use and how to use them.

The Ministry of Health and Child Care in collaboration with NGOs, the Epworth local board and the local clinic should organise workshops to teach sex workers and the Jacha community on the importance of condom use.

The Ministry of Health and Child Care through the local board should distribute flyers and pamphlets as well as put up banners and billboards in Jacha promoting the use of condoms.

The Ministry of Health and Child Care through the local clinic nurses should provide free condoms in Jacha.

The Ministry of Health and Child Care in collaboration with the mass media such as radios, newspapers and television stations should disseminate information on the importance of condom use.

Clinic in Jacha

The government through the Ministry of Health and Child Care should construct a clinic in Jacha to cater for the sex workers sexual and reproductive health services. If a permanent structure is not possible to construct, a mobile clinic should be availed to the community. Regular STI and HIV/AIDS screening should be offered to the community. Testing negative would encourage the sex workers to use condoms.

Sex worker organisations

The Jacha councillor and Member of Parliament should assist the sex workers form an organisation to put their challenges and tribulations into perspective. The sex worker's organisation would help them work as allies rather than competitors. This could also assist enforcing whatever resolutions they come up with for example all of them insisting on condom use and refusing unsafe sex even when offered more money for unprotected sex.

Peer educators and counsellors

Sex workers, former sex workers, professional counsellors, church leaders and other respectable members of the community like the councillor should teach the sex workers and their clients on condom negotiation skills and the advantages of condom use.

Alternative sources of income

The Epworth Local Board should implement income generating projects such as poultry projects, community gardens and dressmaking to supplement or even replace commercial sex work.

Social services and social welfare

The government through the Ministry of Social Welfare should pay the young girls school fees so that they can quit prostitution, attain better education and improve their livelihoods.

NGOs could also provide food to the needy so that the girls do not have to resort to sex work for this basic human need.

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APPENDIX 1

My name is Lindiwe Loice Maarira. I am a student at Midlands State University undertaking an **UNDERGRADUATE DIPLOMA IN ADULT EDUCATION**. I am carrying out an investigation on condom uptake among commercial sex workers in Jacha. I kindly ask you to participate in the investigation by answering questions with reliable, honest and up to date information. The answers are for academic purposes only. Your contributions will be greatly appreciated.

The confidentiality of your responses is guaranteed.

Please tick the appropriate box.

SECTION A: DEMOGRAPHIC SECTION

1. Sex

male

female

2. Age

10-15

16-20

21-30

31+

3. Marital Status

single

married

co-habiting

divorced

4. Educational Qualifications

primary

secondary

diploma

degree

masters

SECTION B: KNOWLEDGE SECTION

5. Do you know what condoms are

yes

no

6. Have you ever used them before

yes

no

7. Are you aware of the protective functions of male condoms

yes

no

8. Are you aware of the protective functions of female condoms yes no

9. Source of awareness of the male condom's protective functions

sexual partner friend local clinic NGOs media

10. Source of awareness of the female condom's protective functions

sexual partner friend local clinic NGOs media

11. Do you use condoms each time you have sex

yes no

12. Condoms are readily and conveniently available in Jacha

Agree neutral disagree strongly disagree

13. Condoms are well promoted in Jacha

Agree neutral disagree strongly disagree

14. Who initiates condom use in a sexual encounter

service provider client

SECTION C:INTERVIEW QUESTIONS

1. Can you refuse sex where no condom is used

yes	no

2. If no why

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.....

.....

3. Is condom use negotiable

yes	no

4. If no why

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5. What do you want done to promote condom use in Jacha

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6. Who should do it and why

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APPENDIX 2