FEMALE SEX WORKERS' EXPERIENCES OF THE SEXUAL REPRODUCTIVE HEALTH (SRH) SERVICES ON THE EMERGING VOICES PROJECT IN CHIPATA DISTRICT IN ZAMBIA

BY

MASOZI BRIDGET MOYO

A Dissertation submitted to the University of Zambia, School of Public Health, in partial fulfilment of the requirements for award of Degree of Masters in Public Health – Health Promotion

The University of Zambia

Lusaka

2017

DECLARATION

I, Masozi Bridget Moyo declare that this dissertation submitted to the University of Zambia as partial fulfillment of the award of the degree of Master of Public Health (Health Promotion and Education) is my own work and has not been submitted either wholly or in part for another degree to this University or any other Institute of Higher Education.

Signed (Candidate)…… Date…….

Masozi Bridget Moyo

COPYRIGHT

All rights reserved. No part of this dissertation may be produced or transmitted in any manner without prior permission in writing from the researcher or the University of Zambia.

©2017, Masozi Bridget Moyo and The University of Zambia

CERTIFICATE OF APPROVAL

This dissertation by Masozi Bridget Moyo is approved as a partial fulfillment of the requirements for the award of the degree of Master of Public Health (MPH) by the University of Zambia.

Examiner: 1	**Dr. Alice Hazeemba**	Signature: ……..…	Date: ……
Examiner: 2	**Mrs. Doreen Sitali**	Signature: ……..…	Date: ……
Examiner: 3	**Mr. Chris Mweemba**	Signature: ……..…	Date: ……
Name:	**Mrs. Doreen Sitali** Department of Health Promotion and Education	Signature: ……..…	Date: ……

CERTIFICATE OF COMPLETION OF DISSERTATION

The undersigned certify that they have read the dissertation and are satisfied that it is the original work of the author under whose name it is being presented.

Signed (Supervisor)…… **Date…….**

Dr. Joseph M Zulu

Department of Health Promotion, School of Public Health

Signed (Co-supervisor) …… **Date……**

Dr. Oliver Mweemba

Department of Health Promotion, School of Public Health

Signed (Head of Department) …… **Date……**

Prof. Charles Michelo

Department of Health Promotion, School of Public Health

ABSTRACT

The number of people living with HIV and AIDS has continued to rise globally despite the significant effort and resources invested in prevention programmes worldwide.

Epidemiologically, majority of new HIV infections in Asia occur in individuals who are at high risk. This is so in many other parts of the world including Zambia. Although Female Sex Workers (FSW's) are among the most at risk, they are often deterred from seeking health services because of stigma associated with their work. The hostile legal environment concerning sex work in Zambia and the unfriendly and discriminatory health services provided discourage them from accessing Sexual Reproductive Health (SRH) services thereby increasing the risk of infections and re-infections of HIV/AIDS and Sexually Transmitted Infections(STI's) among them and their partners who may be the general population. The Southern African AIDS Trust (SAT Zambia) identified this gap in the fight against HIV/AIDS following a base line survey in 2013 which resulted in – The Emerging Voices Project in Chipata District. This study aimed at exploring the Female Sex Workers' lived experiences of the SRH services on the Emerging Voices Project in Chipata District – Zambia.

Using a Phenomenological study design, this study aimed to explore the Female Sex Workers' lived experiences and acceptability of the Sexual Reproductive Health (SRH) services on the project.

The study findings revealed that the FSWs had challenges accessing SRH services before the Emerging Voices Project. From their perspective, they shunned health facilities because of the experience of discriminatory and unfriendly health services. The barriers to their utilization of the SRH services included the cost of SRH services, a poor referral system, fear to test positive and lack of knowledge of SRH services. However, the Projects' creation of the Taskforce and Hubs, introduction of Peer Educators, facilitated the FSWs rights to health in the community and amongst the Health workers and improved the acceptability, adoption and utilization of SRH services in among the FSWs.

The lived experiences of the FSW's SRH needs highlighted in this study challenge the unfriendly and discriminatory health services in Chipata District prior to the Emerging Voices Project. The adoption and utilization of the SRH services now by FSW's inform policy on the importance of decriminalization of sex work in Zambia to ultimately promote good health seeking behaviors and reduce the HIV prevalence among the FSW and the general population. These study findings are of particular importance to re-focusing of HIV/AIDS prevention and treatment initiatives on targeted groups. It generates evidence for expansion and replication of similar impactful interventions in the HIV/AIDS fight.

Key terms: Sexual and Reproductive Health (SRH), Female Sex workers (FSW)

DEDICATION

I dedicate this study to my husband Matthew Ndhlovu, without your all-encompassing support, I would not have made it this far. My Son, Thokozani Matthew Ndhlovu and daughter, Thandiwe Amy Ndhlovu, your sweet hearts, love and encouragement always gave me the drive to work hard at school so that you could have a stepping stone to a bright future.

ACKNOWLEDGEMENT

Special thanks to my Lord Jesus Christ for the favour and grace thus far. Thank you most sincerely my supervisors Dr Joseph Zulu (Supervisor) and Dr Oliver Mweemba (Co-Supervisor) for all the support and encouragement you rendered to me throughout this study. I owe this to you, God bless you. I am very thankful to all the Lectures in the school of Public Health for the selfless effort of sharing and imparting Public Health knowledge in me that will go a long way in saving live. To my fellow MPH students and especially my study group – People of my Colour – I am so glad I belonged to this hardworking study group, it sharpened me. God bless each one of you. Specifically, Catherine Katentemuna Musonda, you held my hand all the way through our studies and we encouraged each other towards great achievements during our studies. Finally, I thank my beautiful family (hubby, T and T, my in-laws, parents and siblings) for your support throughout the period when I was in school. I love you all.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

DEFINITION OF KEY TERMS

Sexual and Reproductive Health and Rights (SRHR); encompass the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence.

SRH: Encompasses HIV and AIDS, as well as other SRH issues such as sexuality, reproductive health services and Sexually Transmitted Infection (STI) treatment.

Acceptability of the SRH services: is the consideration of SRH services to be socially OK or within the realm of what is appropriate, or something that is tolerable but not necessarily desired.

Adoption of SRH services: A ready taking up or utilization of the SRH services.

Key populations: These include sex workers and their clients, Men who have Sex with Men (MSM), lesbians, gays, Bi-sexual, Transgender and Injecting drug users, and their immediate long-term sex partners

Female Sex worker: Females who sells sex in exchange for money.

Legality of sex work

In Zambia, sex work is criminalized, its legality is not clearly stated in the Penal Code, what is clearly stated as illegal is:

- To live off the earnings of a prostitute (S 146 Penal Code)
- To procure a woman for prostitution (S 140)
- To keep premises for the purposes of prostitution (S 149)

Soliciting to sell sex is made illegal by the Public Order Act Chapter 87 of the Laws of Zambia, which bans nuisance, idling and disorderliness and carries jail sentences as well as fines.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
HIV	Human immunodeficiency virus
IEC	Information and education communication
VCT	Voluntary counseling and testing
WHO	World Health Organization
STI	Sexually Transmitted Infection
FSW	Female Sex Workers
SRH	Sexual and Reproductive Health Services
SAT Zambia	Southern African AIDS Trust Zambia
YHHS	Young, Happy, Healthy and Safe
CCP	Chisomo Community Project
FSW	Female Sex Workers

CHAPTER ONE

INTRODUCTION AND BACKGROUND

The number of people living with HIV and AIDS has continued to rise globally despite the significant effort and resources invested in prevention programmes worldwide to fight the epidemic (UNAIDS 2004). In Zambia, 13 percent of adults aged 15-49 are infected with HIV, (16.1 percent of women and 12.3 percent of men) and specifically, the HIV prevalence in Chipata District stands at 10.3 % with the women being more infected (CSO-Zambia 2014). Approximately, 80% of the HIV cases are transmitted sexually hence the increase in the number of Sexual and Reproductive Health (SRH) prevention and treatment programme interventions. Mainly these programmes include; HIV and ART services, family planning services, STI control, antenatal and delivery care and cervical cancer screening, (Askew & Berer, 2003).

Over the years, the focus of transmission of the HIV and other STIs globally was on heterosexual relationships and these were considered high risk of acquiring or transmitting HIV (Pisani et al 2003). However, this strategy has not reduced the prevalence and incidence of the infection and disease despite 20 years of experience with prevention programmes. Since the start of the epidemic, an estimated 78 million people have become infected with HIV and 35 million people have died of AIDS-related illnesses. (UNAIDS 2017). Epidemiologically, a vast majority of new HIV infections in Asia, as is the case in many other parts of the world including Africa and Zambia, occur in individuals who are at high risk. The populations that are at risk, also known as key populations which include sex workers and their clients (Dandona et al, 2005). This understanding has resulted in a shift in programming around Sexual Reproductive Health to include FWS's and several other risky populations such as sex workers and their clients, Men who have Sex with Men (MSM), lesbians, gays, Bi-sexual, Transgender and Injecting drug users, and their immediate long-term sex partners other than heterosexuals (Dandona et al, 2005). In China, as the case has been in Zambia, Sex workers and their clients appeared to play a significant role in the spread of STIs. Data from STI clinics suggest that the majority of male STI patients are infected through unprotected sexual contacts with sex workers. The high prevalence of STIs indicates the potential for the further spread of HIV (Van Den Hoek, A, et al, 2001)

In Cambodia, clinics established for the prevention and management of sexually transmitted infections (STIs) in women sex workers do not address other reproductive health services.

Access to comprehensive reproductive health care for women sex workers should be considered in the context of sexual and reproductive health and rights for all women (Delvaux. T, et al 2003). Family planning methods, other than condom use, are not widely discussed among female sex workers. Information on the different methods of family planning will help the FSW's, who are sexually active and are prone to getting pregnant, decide when and when not to get pregnant, to prevent unplanned pregnancies and prevent illegal abortions

HIV prevalence varies widely among Female Sex Workers (FSW) in different regions of the world. Higher prevalence's have been reported in sub-Saharan Africa (0.2% to 60.5%), followed by south and South-East Asia (0.0% to 26. 0%).In Latin America and the Caribbean, overall rates are lower than in other regions (0.0% to 14.0%),34 (Bautista et al. 2006). There is not much documentation on sex work in Zambia but unpublished data from National AIDS Council Library indicates that it is high especially along the line of rail, in the big cities and in Boarder areas (boundaries with other countries) (Corridors of Hope-Behavioural Surveillance Survey, 2009).

FSWs are often deterred from seeking health services because of stigma associated with their work and in some cases due to hostile legal environments or unfriendly health service providers. Such community reaction discourages FSWs from accessing SRH services thereby increasing the risk of infection and re-infection due to untreated STIs (Lafort et al. 2010). This social stigma around FSWs limits their access to appropriate SRH information (Day, S. Et al. (1997) Education, empowerment, prevention, care, peer education, training in condom-negotiating skills, consistent and correct use of male and female condoms, family planning, antenatal care and a general need for specialist health services is important for the sex workers as these are likely to offer significant benefits in prevention, early diagnosis, and treatment of STIs such as Syphilis and cervical cancer and for effective disease control (Day, S. Et al. (1997).

1.1 The Emerging Voices Project – Chipata District

The Southern African AIDS Trust SAT Zambia (SAT Zambia), a non-profit making organization that promotes community systems for HIV and Sexual Reproductive Health and Rights in Zambia, identified the gap in accessibility and acceptability of SRH services by the FSWs following a baseline survey which was conducted in 2012. The survey showed that FSWs faced several problems such as death due to HIV/AIDS, STI's , they experienced physical violence and forced sex at the hands of police officers and stigmatization from health

workers which hindered their access to SRH services(Rheumatologica 2015). This situation placed the FSW at risk of HIV infection and placed the clients, and their partners in the general population at risk too, hence the urgent need to curb HIV by targeting the FSW in HIV prevention.

The survey findings facilitated the implementation of the two-year Emerging Voices Project (EVP) in 2013 by two NGOs: Young, Happy, Healthy and Safe (YHHS) and Chisomo Community Programme. The goal of this project was to Promote HIV Prevention by improving access to non-discriminatory HIV and SRH for FSWs aged 18–24 years in Chipata District. The objectives of the project focused on increasing access to and uptake of integrated SRH health services by the FSWs; Conducting outreach activities to FSWs; Referring FSWs to health care services; and linking stakeholders to each other to work together to fight HIV/ AIDS and STI in their community through these interventions (Rheumatologica 2015). The Project created a Task Force led by the community stakeholders, identified Peer Educators and Queen Mothers among the FSWs who implemented it with the two Implementing Partners; Chisomo Community Programme and Young Happy Healthy and Safe. According to the records from Chisomo Community Programme and Young Happy Healthy and Safe, over 600 FSW have registered on the Programme and 400 FSW are actively accessing the SRH Services provided under the project in |Chipata District.

This study explored the Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District. Specifically, the study aimed to describe FSW experiences on acceptability of SRH services, to describe the FSW experiences of their uptake of SRH services, to establish the facilitators and barriers to SRH services for FSW and to find out the meaning of SRH services to the FSW following their experience on the Emerging Voices Project Chipata District.

1.2 Statement of the Problem

The primary focus of the problem at hand remains the high prevalence of HIV and AIDS in Zambia and that it is specifically higher among females (16.1%) compared to males (12.3%) (RNASF 2014-2016). Consequently, HIV prevalence is higher among women who have had multiple and concurrent partners (40 percent) than among those who did not (34 percent). This population is referred to as key population because it is at higher risk of being infected or re infecting others with HIV and STIs (CSO-Zambia 2014). Sexually transmitted infections (STI) are widely recognized as major risk factors for HIV acquisition because they share the

same modes of transmission, and because ulcerogenic STIs such as syphilis and herpes increase HIV associated susceptibility and infectiousness (Bautista et al. 2006).

Female sex workers (FSWs) in Zambia and many other countries where Sex work is criminalized, experience high levels of sexual and reproductive health (SRH) violence, marginalization and discrimination by both the health workers in the health centers. This often inhibits sex workers' access health services in general but particularly SRH services(Rheumatologica 2015).

The FSW's who have been the key beneficiaries of the first intervention to improve access to non-discriminatory HIV and SRH for FSWs at district level through the Emerging Voices Project (EVP) were sampled to describe their experiences and meaning of the SRH services on the health of the FSW themselves. Reference was also made to the period before the project. Over 600 FSW have been registered on the Programme and are still accessing SRH information, HIV testing, ART, STI treatment, contraception, condoms. This project has been running since 2013, however, there was limited information on the experiences and the factors that shaped the adoption and acceptability of these SRH services by FSW. This research sought to address this knowledge gap to improve and inform policy on the effective Sex Worker SRH Programme interventions in fighting the HIV /AIDS epidemic.

1.3 Justification of the study

Although Sex Work is criminalized in Zambia and in many regions around the world, it is worth noting that every human being has equal rights to health services. The National Strategic Framework (NASF 2014 – 2016) acknowledges that Female sex workers are one of the most at-risk populations of contracting and transmitting HIV and STI's. Despite this fact, these women are deterred from seeking health services because of the hostile discriminatory environment. This situation increases the risk of infection and re-infection due to untreated HIV and STIs (Lafort et al. 2010). The most recent WHO guidelines on HIV and STI prevention and treatment for sex workers (2012) recommend that all health services, including primary health care, are made 'available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health'. Based on this precept, several interventions on SRH services have been implemented with and for FSW to fight this scourge. This research seeks to contribute to ensuring that FSW access SRH services that are acceptable by the FSW themselves and the community by exploring the Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services on the

Emerging Voices Project in Chipata District. Specifically, once the experiences are determined they will inform policy and contribute to evidence generation for expansion and replication of similar interventions among FSW in Zambia. This paper will ultimately contribute towards reaching the ambitious treatment target to help end the AIDS epidemic where it is hoped that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will attain viral suppression. (UNAIDS 2017) (UNAIDS 2017) by addressing the health needs of an unreached marginalized group in the community.

1.4 Aim

Research question

What are the lived experiences of FSW on the SRH services under the EVP and how can they inform SRH services?

1.5 General Objective

To explore the Female Sex Workers' lived experiences and acceptability of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District.

1.6 Specific Objectives

1. To describe the FSW experiences of their utilisation of SRH services on the Project.
2. To establish the facilitators and barriers to SRH services for FSWs provided by the project.
3. To Explore possible solutions of addressing SRH needs following the FSWs experiences on the Emerging Voices Project.

CHAPTER TWO

LITERATURE REVIEW

The section represents literature of different studies on the Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services globally. The literature brings out various experiences and understanding of FSW. These experiences will be classified into themes such as adoption, accessibility, utilization, barriers and facilitators of SRS services. The focus of this review is based on similar studies and their finding on FSW's experiences globally.

2.1 Understanding and use of HIV/STI preventions methods by FSW

A Qualitative study of the Female Sex workers' understanding and experiences of Male Circumcision (MC) and HIV and HIV risk in Zambia was conducted. In-depth interviews were conducted with twenty female sex workers (FSWs) in Lusaka to examine their understanding of MC and experiences with circumcised clients. Knowledge of MC was derived primarily through informal sources, with very few FSWs reporting exposure to MC educational campaigns. MC was not widely believed by the female respondents to be protective against HIV; however, it was viewed by some as protective against STIs. Three FSWs reported having sex with recently circumcised clients, and most reported that men often used their MC status to try to convince FSWs to forego condoms(Abbott et al. 2013).

The findings suggest that FSWs, already at high risk for HIV infection, may face additional pressure toward higher risk behavior because of MC. As MC services are expanded, programs should support FSWs' efforts to protect themselves by providing information about what MC can--and cannot--offer for HIV/STI infection prevention (Abbott et al. 2013).

A quantitative study in China (Zhang et al. 2011) was conducted to examine the predictors of condom use with clients during vaginal intercourse among FSWs based on the Information-Motivation-Behavioral Skills (IMB) model. A self-administered questionnaire was used to collect data. Structural equation modeling was used to assess the IMB model. A total of 427 (98.8%) participants completed their questionnaires. Condom use was significantly predicted by social referents support, experiences with and attitudes toward condoms, self-efficacy, and health behaviors and condom use skills. Significant indirect predictors of condom use mediated through behavioral skills included HIV knowledge, social referents support, and substance use. These results suggest that the IMB model could be used to predict condom use among Chinese FSWs. It can therefore be concluded that further research is warranted to

develop preventive interventions based on the IMB model to promote condom use among FSWs in China (Zhang et al. 2011).

2.2 Barriers to utilisation of SRH services by FSW

Despite high HIV prevalence rates among most-at-risk groups, utilization of HIV testing, treatment and care services was relatively low in Karnataka prior to 2008. A Research conducted by Beattie and other, 2012 aimed to understand the barriers to and identify potential solutions for improving HIV service utilization. Focus group discussions were carried out involving 302 participants among homogeneous groups of female sex workers, men who have sex with men and transgender, and Programme peer educators in six districts across Karnataka in March and April 2008. The results indicate that participants had good knowledge and understanding about HIV and HIV voluntary counseling and testing (VCT) services, but awareness of other HIV services was low. The participants indicated fear of the psychological impact of a positive HIV test result and the perceived repercussions of being seen accessing HIV services were key personal and interpersonal barriers to HIV service utilization. Previous experiences of discrimination at government healthcare services, coupled with discriminatory attitudes and behaviors by VCT staff, were key structural barriers to VCT service uptake among those who had not been HIV tested. Among those who had used government-managed prevention of parent to child transmission and antiretroviral treatment services, poor physical facilities, long waiting times, lack of available treatment, the need to give bribes to receive care and discriminatory attitudes of healthcare staff presented additional structural barriers(Beattie et al. 2012).

Conclusions Embedding some HIV care services within existing programmes for vulnerable populations, as well as improving service quality at government facilities, are suggested to help overcome the multiple barriers to service utilization. Increasing the uptake of HIV testing, treatment and care services is key to improving the quality and longevity of the lives of HIV-infected individuals and minimizes new infections (Beattie et al. 2012)

2.3 Sexual Reproductive Health needs of FSW

Little is known about the sexual and reproductive health care needs of female sex workers in Dhaka, Bangladesh. A survey was conducted on 354 hotel-based FSW and 323 street-based female sex workers. In addition, in-depth interviews were conducted with 20 female sex workers recruited from drop-in centres. The unmet need for family planning and examined fertility desires, use of condoms and other contraceptive methods, experiences with gender-based violence, sexual and reproductive health service needs, and preferences on where to receive services was calculated. The results indicate that the prevalence of unmet need was 25% among hotel-based female sex workers and 36% among street-based female sex workers(Katz et al., 2015). Almost all participants reported having used condoms in the past 30 days, and 44% of hotel-based sex workers and 30% of street-based sex workers reported dual method use during that period. Condom use was inconsistent, however, and condom breakage and non-use for extra money were common. Many women reported experiencing gender-based violence. Sexual and reproductive health services had been obtained by 64% of hotel-based and 89% of street-based sex workers in the past six months; drop-in centres were their preferred site for receiving health services. In conclusion, Female sex workers in Dhaka need family planning and other sexual and reproductive health services and prefer receiving them from drop-in centres(Katz et al., 2015).

2.4 Acceptability and adoption of SRH services by FSW

An ethnographic study investigated health-seeking strategies in relation to sexual health among a group of sex workers in Calcutta, India and it looked at the relationship between women's understandings of (sexual) health, treatment seeking and service utilization. According to Evans & Lambert, (1997) the study indicated that the sex workers exhibited initial patterns of seeking treatment at the health facilities but did not eventually comply with treatment. This was a cause for concern. The study highlighted that the cultural understanding of health and ill health and the social economic environments is important for the importance of both strategies for seeking treatment and interpretations of their effects. The research finding indicates that "'health" was not one of the sex workers' explicit priorities. This seems to be a common finding among the economically and socially marginalized. The alternative is to first meet their perceived needs priorities (which may appear to be unrelated to health) to buy their trust to subsequently improve receptiveness to the health intervention. With respect to sex workers, applied research and interventions that do not directly address the socio-

economic context of women's lives may succeed in reducing levels of HIV/AIDS, STDs, but they may have a questionable impact on improving women's health in the longer term (Evans, C. and Lambert, H., 1997). This study out rightly highlights the fact that the human being is whole and to address one aspect of their lives and omit what they perceive to be important will address the health issue only in the short term. Holistic interventions must be planned for the intended SRH programmes for FSW to succeed.

Some FSW's in Dominican felt that, despite evidence of the potential of the female condom as a method that effectively protects against sexually transmitted infections (STIs), HIV, and pregnancy, it is still not widely available (Lotfi et al, 2016). This was the experience of the Dominican Sex workers, their clients and their partners. An in-depth interview was conducted with 18 sex workers, to assess their experience of acceptability of the female condom. Many of the sex workers found the female condom acceptable and welcomed the option of a female controlled method. Clients and partners of the sex workers were also positive about the female condom and, particularly regarding pleasure; almost all preferred it to the male condom. These findings suggest that the female condom offers an acceptable option for protection against HIV, STIs, and pregnancy. The positive attitudes of women and men could be developed into messages in health education, marketing campaigns for the female condom, targeting not only vulnerable groups but also the general population.

From the analysis of the transcripts, it can be concluded that partner involvement plays a vital role in acceptability and adoption of these SRH services (van Dijk, M.G et al 2013).

CHAPTER THREE

METHODOLOGY

This was a qualitative study. Lived experiences were gathered of some of the Female Sex workers enrolled on the Emerging Voices who had adopted and were utilizing the SRH services. The research was guided by the research question seeking to explore lived experiences of FSW on the SRH services under the EVP in Chipata District with the hope of using these experiences to inform SRH services in Zambia.

3.1 Study Design

The study utilized a Phenomenological study design. This design was appropriate for this study population because it is a closed group and so to obtain the FSW's individual's daily life experience, the study included discovering, analyzing, clarifying and seeking patterns of certain phenomena. (Creswell 2007). In this study, emphasis was on describing the meaning of the FSW s individual's perceptions, feelings and lived experiences of their SRH needs and the health services made available to them following the introduction and existence of the Emerging Voices Project. The adoption and utilization of the SRH health services by FSW's could only be qualitatively analyzed for the study to have a deep understanding and meaning of the phenomena. This study design enabled the researcher to investigate and describe the situation as it existed amongst through direct interaction with the research participants who were the direct beneficiaries using In-depth Interviews (IDI), observation, notetaking and voice recording data collection methods which were convenient for the respondents.

3.2 Study Setting and study population

The study was conducted in Chipata District, Eastern Province of Zambia. The population of Chipata, as captured during the 2010 Census of Population and Housing was 455,783 with 50.6 % being female (Summary Census Wall E. Prov 2010). The HIV prevalence in Chipata stood at approximately 10.3% (CSO-Zambia 2014).

The participants were purposively selected from among the Female Sex Workers in Chipata from Navutika, Munga, Transembe, Kapata, Muchin, Kanjala, Dilika, and Msanga where sex work activity is highly concentrated. The Sex workers who were above 18 years old, peer educators and queen mothers of the FSW who were enrolled on the Emerging Voices Project were selected by the two Implementing Partners: Young Happy Healthy and Safe (YHHS)

and Chisomo Community Programme (CCP). The participants of the study are a hidden population, they could only be located and selected easily by their peers most of whom were also Peer Educators on the Programme. Hence Snowball sampling was used to select FSWs who have experienced the phenomenon.

The Study population was FSW, former FSW, FSWs who were Peer Educators and Queen Mothers on the EVP Programme in Chipata District aged 18 years and above (the young or old). This population also included those in formal employment, who had had lived experiences of the SRH services provided at the Health centers and other Community Service Organizations(CSO's) in Chipata in the period that the project was in existence. These diverse characteristics of the FSWs brought out varied experiences of the services.

3.3 Sampling methods, and sample size

Non-probability (Purposive) Snowball sampling was used in this study. The participants were purposively selected from the study population to ensure that the sample of participants collected was of Female Sex Workers previously enrolled on the Emerging Voices Project. Participants were selected using Snowball sampling of varied FSWs; 2 FSW from the Programme register, 2 Peer educators and 2 queen mothers were each asked to recruit 2 of their colleagues who had been enrolled on the EVP Programme. Of those recruited, 8 were also asked to each recruit 1of their colleagues on the EVP Programme. This way participant variation was guaranteed to provide the study with different experiences. Snowball sampling was used because this is a hard to reach group because of the nature, sensitivity and legality of the trade. Only FSW will know where and how to reach another. The snow balling method was the appropriate method to use because there is very no database containing FSW population.

A working Sample size of about 20 FSW which comprised of the following: about fourteen (14) FSW and three (3) FSW Peer Educators and three (3) queen mothers were selected. This selection considered the FSW's that were enrolled on the Emerging Voices Project young, (aged between 18 – 29), older (30 and above), those that were in formal employment FSW characteristics that were. Data was collected from each of participants until data saturation was reached, a point where no more new data was received from any new participant than had been given in the earlier interviews (Hancock et al, (2007). This principle determined the sample size of 20 of this study.

3.4 Inclusion and exclusion criteria

This research included; FSWs who are aged 18 and above, Peer educators and Queen mother's all who were enrolled on the EVP Project.

The research excluded the implementing partners of the Project Chisomo Community Programme (CCP) and Young Happy Healthy and Safe (YHHS) and health workers, the community leaders and members, underage sex workers (17 years and below), and all FSWs in Chipata District who were not enrolled on the Emerging Voices Project.

Table 1: Sample Size Characteristics and Data Collection Methods

Study Population	**FSW > 18 years on EVP**
Sampling and Sample size method:	Purposive-Snow ball sampling: EVP FSW 20 Participants (Applied – The Data Saturation Principle)
Characteristics of FSW	• FSW (Younger, older, employed.)14 • Peer Educators - 3 • Queen mother's -3
Data collection methods	• In-Depth Interviews (IDI). • Observation • Note taking and voice recording

3.5 Data Collection methods and tools

The data for this qualitative study was collected only in Chipata District. It was collected using In-Depth Interviews (IDI) using unstructured interview guides that were administered in English and interpreted in to Nyanja for the FSWs that were not fluent in English during the interviews. Observation, note taking and voice recording was conducted with the consent of the participants (Creswell et al 2007).

In-depth interview

According to the phenomenological approach, data was collected using in-depth interview (Zulu et al., 2014). The researcher with experience in conducting In-depth interviews began the interview by first reading the Consent Forms to the participants. They were read, understood and signed by each participant before each interview. The interviews were conducted on a one on one in a private and quiet place that was comfortable for the FSWs to freely express themselves. conducted all the interviews using a semi structured interview guide. The Interview guide was used to ask the FSW unstructured questions to determine their experiences on the EVP. This technique enabled the FSW share their lived experiences with the interviewer without limitations. The participants were free to respond in English and or Nyanja, which are commonly spoken languages in Chipata and specifically by the FSW.

With the consent of the participants, each of the Interviews were recorded using a digital audio recorder. In addition, the researcher was taking down some interview notes in an interview notebook to note some vital information that would not be recalled later.

Observations

Observations were conducted during the interviews. Techniques used included written descriptions of facial expressions, actions and passing comments that further explained the experiences of the FSW (Hancock et al. 2007).

3.6 Data Management and analysis

The audio records of data from the recorder and notes taken were collected during each interview, downloaded onto a computer and de-identified while the sources of the data remained anonymous. This information was stored safely on a password protected computer and the hard copies and records were stored under lock and key according to ethical procedures.

The recorded interviews were translated and transcribed verbatim. The data was then analysed manually using the Thematic Framework Analysis, here the Data was categorised in themes to establish meaningful patterns important in description of the phenomenon through coding in six phases; (Joffe and Yardley, 2004).

1. **Familiarization of data**; the researcher familiarized themselves with the data collected on experiences through reading and re-reading the same data and looking out for themes or patterns.

2. **Generating the initial codes;** The Generation of initial codes was done by documenting the patterns in the various categories. The data was summarized by labeling it to create categories for more efficient analysis. Here inferences on the meaning of the generated codes were done.

3. **Searching for themes among codes**; in this phase, the researcher combined codes into similar ideas, responses, comments and expressions by the FSWs that accurately depicted the data. The researcher ensured that the exact meaning of the themes being identified was maintained in the coding.

4. **Reviewing themes**, the researcher then critically looked at how the themes supported the collected data.

5. **Defining and naming themes;** Major themes and sub themes were identified. These themes were then defined and named.

6. **Finally producing the final report**; the report was written based on the data collected and the defined themes.

(Joffe and Yardley, 2004)

The data transcription was organised manually and this information was validated with the data that was collected in the field.

3.7 Reflexivity

This research focused on female Sex workers who are a hidden population. The researcher relied on the relationship that the Female Sex Workers had with the Implementing Partners (Chisomo Community Programme and Young Happy Healthy and Safe) to reach them. The researcher worked with SAT Zambia on the Emerging Voices Project for ten months providing technical support to the Implementing Partners of the project. During implementation of this Project, the researcher also interacted with the Female Sex Workers directly during site Mentoring, Monitoring and Taskforce meetings. The researcher was careful not to abuse this association formed to ethically disadvantage the participants of the

study but instead helped to calm the participants and enabled them to trust and be free with the researchers during the interviews. Research assistants were used in the study to ensure that the study was conducted objectively. The researcher followed the interview guide to avoid asking leading questions due to familiarity with the project. This ensured that their experiences and understanding of SRH were explored and captured without interference.

Although the questions had been constructed in simple language, they were carefully paraphrased to ensure that the participants responded appropriately. Although English had been used in the interview guide, translation of questions and responses from participants were carefully done to ensure no data was lost in the process.

Additionally, the participants were financially reimbursed to secure the interview with this hard to reach group and to compensate them for the time they spent participating in the study.

3.8 Ethical consideration

The researcher ensured that ethical issues were addressed to minimize the risk of potential ethical breach which could arise during the research process especially since the study participants were Female Sex Workers who are a marginalized group. The study focused on the Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District, thus being Sex workers, they could have felt uncomfortable to disclose personal information to the researcher. They probably could have also felt uncomfortable to participate in the study because sex work in Zambia is criminalized so all their concerns had to be addressed.

The data collection process of the study began with the researcher obtaining formal consent from the participants. All the participants each received an information sheet and a consent form containing the justification, data collection procedures, the participant's risks and benefits, the researchers' and University contact details of the study. The researcher ensured that every participant read and read out the same forms to them so that even those that are illiterate, clearly understood the purpose of the study and they each had to make an informed decision to participate and consent by signing or thumb printing on the same document before the study began. The information sheet also informed the participants that the study would be conducted with strict confidentiality to ensure privacy and security of the Female Sex Workers participation was upheld. The FSW (participants) identities were protected at every stage of the research documentation so the study used codes of the participants in the IDIs, the data was de-identified and the sources of the data remained anonymous.

The discussions and interviews were held behind closed doors and all information collected, written and audio documentation was treated with strict confidentiality and was securely locked. The participants were also being informed that participation was completely voluntary and that they are free to opt out of the study at any time and they could refuse to answer any questions which they did not wish to answer and would not be placed at risk. They were guaranteed a payment, transport refund whether they completed their participation in the study or not.

Researcher respected each individual FSW and did not use language or names that were discriminatory in nature and they ensured that their trustworthiness was maintained to the FSW. They also maximised transparency by availing the research findings to the participants to check how they will be represented in the study.

There were no direct benefits to the participant, except that the researcher would learn from each of them. The In-depth Interview would empower the participant to contribute towards the fight against HIV/AIDS by sharing their experiences that would be helpful in the development of practical interventions to address the SRH needs of FSW.

Permission from National AIDS Council, SAT Zambia, Population council was sought to use their data before the study began.

The study sought approval to conduct an ethical and non-exploitative research on this marginalised group from University of Zambia Biomedical Research Ethics Committee (UNZABREC).

CHAPTER FOUR

FINDINGS

This phenomenological study of the FSW's presents, qualitatively the experiences of the SRH services on the project in Chipata. The study generated four major themes and seven sub themes.

The Major Themes that emerged were:

- Understanding and use of HIV /STI Prevention methods by FSW
- Barriers to Utilization of SRH services by FSW
- Facilitators to utilization of SRH services by FSW
- Acceptability and adoption of SRH services by FSW

The table below shows the results of the study. Some common and unique experiences of the participants are discussed further:

Table 2: Major and Sub-themes

Objectives	Major themes	Sub- Themes
Objective 1: To describe the FSW experiences of their utilisation of SRH services on the Project.	Understanding and use of HIV /STI Prevention methods by FSW	FSW's Experience of SRH services before EVP • Unfriendly health workers • Lack of SRH information by FSW • Fear to access SRH services • FSWs having to buy medicines and pay for treatment • FSWs being asked to bring partners to facility to access treatment • Stigma and discrimination of health services FSW's Experiences of SRH services of the EVP • Health workers accepted FSW • FSW's awareness of SRH services raised • Increased use of SRH services • Reduced reported cases of disease or deaths of FSW related to SRH
Objective 2: To establish the facilitators and barriers to SRH services for FSWs provided by the project.	Barriers to utilization of SRH services by FSW	FSWs perception of barriers to accessing SRH services • Cost of SRH services • Distance to facility • Poor referral system • Fear to test positive • Lack of information on SRH services
	Facilitators to utilization of SRH services by FSW	FSW's facilitators to accessing SRH services • Introduction of the Taskforce • Easy accessibility to hubs (managed by Queen mothers and peer educators) • Availability of Peer Educators to give information on SRH issues. • Improved Health Facility referral system • Institutional support from the church, police and health workers to provide nondiscriminatory health services**.**
Objective 3: To Explore possible solutions of addressing SRH needs following the FSWs experiences on the Emerging Voices Project.	Acceptability and adoption of SRH services by FSW	Meaning of SRH services to FSW • Possible solutions to SRH needs of FSW • HIV Self-testing • Health Centre's that will provide services to FSW's other than health centers • Continuous supply of condoms in the community hubs • Continuation and Expansion of a similar project countrywide

4.1 Major theme: Understanding and use of HIV/STI Prevention methods by FSW

4.1.1 Sub theme: FSW's Experience of SRH services before EVP

4.1.1.1 Unfriendly health workers

All the participants interviewed described the life they lived as FSW's before the Emerging Voices Project with regards accessibility to Sexual Reproductive Health services. The health workers were very unfriendly to them. The health workers would skip the FSWs in a queue of patients to attend to other people and only get back to them much later if at all. They complained that they were treated inhumanly and as deserving of the diseases they were presenting at the health center so they would not consider them worth treating. For the majority who are on Antiretroviral Treatment would be told they are on treatment because of their miscellaneous behaviors. *A 23 year old sex worker who began sex work when she was in her 9th grade narrated the following…….*

……. whenever I got sick the hospital workers would always ask me why I keep getting sick n with such diseases of adults at such an age and keep frequenting the hospital with the same complaint. When they discover that I was a SW they stopped attending to me and giving me the attention a patient would need. They didn't know that we too have rights to health care services…

4.1.1.2 Fear of accessing SRH services

When treated once, the FSW were afraid to go back to the health facility for treatment soon after or as frequently as they got re-infected especially with STI's. The FSWs were at times chased from the health facility while being called names such as 'bitches' or 'whores' (hule's) who were terrorizing the women in community by sleeping with their men. This was very humiliating to the FSWs. Because of this open rebuke, the community would laugh at them whenever they saw them at the health Centre. Stigma was the order of the day and the SW's walked with shame and shunned the health Centre's and preferred to stay home with their diseases and many confessed infecting their clients and getting worse and nearly dying at home. Several FSWs mentioned that they lost to death a lot of their colleagues because they did not go back to the health facility for treatment and care. There was stigma, self-stigma and stigma from the community

4.1.1.3 Lack of SRH information

The study revealed that before the emerging Voices Project came into existence, the SW's had little or no knowledge of SRH information, it was difficult for the SW's, they used to conduct their business of selling sex anyhow. Condoms were not known. They were not scared of HIV/AIDS and all they wanted was money. So, they went anywhere just to get it. Most of these women did not know their HIV status and were afraid of testing.

Pregnancies, abortions and diseases were plenty and deaths were very common among the sex workers they said.

Most of the sex workers did not know how to use Family planning pills, condoms and mentioned that they frequently contracted STIs. They did not know where to go for treatment. They would conduct their work without knowing the consequences.

4.1.1.4 FSWs being asked to bring partners to facility to access treatment

Almost all the FSW reported that they were victimized whenever they went to the facility for treatment of STI's. The Health Care Workers would insist that they bring their partner so that both could be treated. The Challenge the FSWs face is to trace their client that infected them among the many sexual partners and convincing them to go to the facility with them for couple testing and treatment. The study revealed that the FSW felt sidelined and embarrassed because they were not married or did not have a steady partner they could freely go with for treatment. This unrealistic condition caused many of them to shun the health services or resort to unhealthy and deadly alternatives.

Some of the participants who had children and had been pregnant before the project shared the experiences they had with the health facility when accessing antenatal care. The health worker would insist that the all women including FSW, go with their partner to encourage male involvement in family planning and Prevention of Mother to Child Transmission(PMTCT). 35-year-old SW from Mchin who started SW in 1997in bars narrated the following:

…. when I got pregnant with my third child I went to the hospital to register for antenatal and then I was asked to come back with my husband to get treatment. They knew very well that I was a sex worker and that we don't have husbands neither do we get to know who the father of the children we carry is. The health worker still insisted that then I should go and get a letter from the chairman of Mchin indicating that I don't have a husband so that I could be attended to at the hospital. I went to the chairman and that was when I got the card for antenatal from the hospital. With no paper, no help. This happened to me on my child who is now 1yr 6. I almost even gave birth at home because of all this scorn. People would laugh at me.

4.1.1.5 Stigma and discrimination of health services

The FSWs reported experiencing Stigma and discrimination at the health facilities. The minute the health workers learnt that that one is a FSW either by the fact that they were accessing SRH services more frequently than others, they would be shouted at publicly for living recklessly, skipped to attend to others who they decided deserved the limited supplies, medication and time from the health facilities. They said other patients were genuinely sick and not out of their own free will. The FSWs also reported in the study that they would also stigmatize against themselves and feel unworthy to access treatment and services at the health facility hence they would stay home deteriorating in health to the point of death for some.

4.1.2 Sub Theme: FSW's Experiences of SRH services of the EVP

4.1.2.1 Health workers accepted FSW

Emerging Voices project initiated change in social interactions among the FSW's and the community and stake holders; workshops were being held with the with police, health personnel on SRH issues concerning the SWs to create an enabling environment which is non-discriminatory health services. All the sex workers spoken too said that now they are regarded as human beings just like other patients. The clinic is open and they are free to access SRH services. They are now free to talk to the same Doctors and Nurses and they are now kind, friendly and helpful. Medical help is abundant for SW's and they have access to Free condoms and medication. They now know their rights.

4.1.2.2 FSW's awareness of SRH services raised

Some Sex workers spoken to said they now know how to go and have their blood tested and are free to talk about their treatment and their status and they can freely drink medicines in public because they know the importance of disclosure. Self-stigma has reduced tremendously. It helps them remember to take their medication and to encourage their colleagues to go and get tested and know that they can still live a normal life when tested HIV positive and they will be helped at the hospital.

FSW's now know about Family Planning and there are very few unplanned pregnancies among the SW's. In addition, some of these mentioned that the project taught them not to get too drunk or intoxicated so they may make sound judgement in their work. This has improved these women's wellbeing, others have even gone back to school because of the project. The EVP has provided linkages to the Health Centers for the SW's. Peer educators have been trained and they also go and train and hold meetings with their fellow SW on SRH topics. One sex worker who is also a peer educator said the following:

> *.....I used to go out on the streets, drink strong alcohol and have sex with even six men in one night with no condoms. I get pregnant several times and I aborted them all. I had STIs every so often but I would just use traditional herbs to treat myself. One day I got very sick and nearly died, my friend rushed me to the hospital…*

4.1.2.3 Increased use of SRH services

Most of the participants indicated that they have been trained by EVP, on correct and consistent condom use to prevent diseases, on their rights to decide on condom use when doing sex work. One Sex worker who is 35 years old and has been in the trade since 1997 and is peer educator said the following:

.... I prefer female condoms because I put it on myself before I meet my client. I don't trust these men, they are clever, they can say they have worn the condom and then they pull it off and then they infect me with all sorts of STI's. With our work, we need to take care of ourselves so that we are in good health. It is Better to use condoms to have long life….

4.1.2.4 Reduced reported cases of disease or deaths of FSW related to SRH

The study revealed that the changes in the provision of health services towards the FSW, the increase in awareness of SRH services amongst the FSWs on the project has created a raise in the usage of these services and this has ultimately reduced their frequent visits to the health facility for treatment of STI's or attempted abortions. The number of cases/ colleagues that they as peer Educators and queen Mothers would personally refer to the health facility for treatment also reduced tremendously after the Emerging Voices Project was introduced. Most of the FSWs noted that fewer and probably none of the FSWs now die from deaths related to SRH. One female sex worker said:

….. now things are good and I don't get diseases and I get help. I now know that I can go to the hospital when I am sick and if I am tested HIV positive I will start treatment.

4.2 Major Theme: Barriers to Utilisation of SRH Services by FSW

4.2.2 Sub theme: FSW's perception of barriers to accessing SRH services

4.2.2.1 Cost of SRH services

Queuing for long hours for drugs or tests and results when one was unwell or feeling uncomfortable being identified as a sex worker or prostitute, as they would be called, forced some of the FSWs to opt to buy their drugs or go to private laboratories as many times as they needed to. Sometimes they had to buy the medication because the health workers would complain that the FSW were frequenting the facility with the same illness yet the drugs are limited. They would be told to go and buy from the money they make and leave the other drugs for the innocent many who deserved to be treated. This treatment would force them to buy drugs and self-medicate.

4.2.2.2 Distance to facility

The FSW complained about the early reporting to the facility to queue up for services. They reported that they only go home from their work usually after midnight and are expected to be at the health facility as early as 04:00am. They walk long distances because the public buses are not in operation at that time. One FSW narrated as follows:

> *…. I was punished several times to be attended to last for getting to the health facility late(08:00 am) so that the health personnel and all other patients could see me as being late to get to the clinic because I was out all night working as a prostitute….*

4.2.2.3 Poor referral system

The health system at the facility is so bad. Five of the FSW revealed that they must queue up as early as 04:00am in the morning and then only be attended to at 08:00am. The patient would then be referred to the lab where they will go and queue for hours on end. The services are scattered I the facility and the patient who is not well is only done with all the important referral points in the late afternoon of that day. This referral system discourages the FSW who must contend with the reception of different health workers and suffer ridicule.

4.2.2.4 Fear to test positive

One FSW reported that fear of being found pregnant, HIV positive or testing positive for an STI, generally the fear of knowing and sharing their status is a big barrier to accessing these SRH services. Others just fear taking medication while others fear that the health workers will talk and shout at them. One FSW reported that they would prefer to stay at home than be seen at the hospital where she thought everyone knew what treatment she was there for.

4.2.2.5 Lack of information on SRH services

Lack of information on SRH issues was the biggest barrier for most of the FSWs. They reported having very little or no knowledge of SRH and had nowhere to go to be informed on the services being provide and why it was important to access these services as a sex worker. The health workers did not see the need to share this information to help the FSWs avoid recurring STI's or unplanned pregnancies. They would opt for advice from the fellow FSW who would give even bad advice

4.3 Major Theme: Facilitators to utilisation of SRH services by FSW

4.3.1 Sub Theme: FSW'S facilitators to accessing SRH services

SRH Services ever utilized by SW's

All the Sex workers interviewed specifically mentioned that they have utilized Family Planning services, HIV counselling and testing and STI diagnosis and treatment. The Programme also trained and educated the Sex Workers on SRH issues. They confirmed that the knowledge was very beneficial and life saving for them, their families and the community. Many of the SW's have also been for cervical cancer screening organized through the project office where they would team up and the implementing partners would set up appointments for them to be screened at Chipata General Hospital. This motivated the women because they were assured that they would be attended to unlike if they went alone.

FSW's have so far referred many from among them to the Health Centre to access medical care so that they too could be treated. They all vehemently said they will continue to utilize the services and refer others. The community is not left out on awareness campaigns, they are also educated on safe sex practices and this makes the sex worker negotiate and succeed to use a condom easily with an informed client said one sex worker. One sex worker who got married early, had 3 children in a troubled marriage, opted to started sex work in 2012 narrated the following:

> *.....I thank God for Family Planning services because I would have had 6 children by now. I got pregnant for the 4th time but because I had an STI at the same time, the pregnancy aborted itself. I was rushed to the hospital and even though I was a sex worker, I was treated. Soon after that I was given an Injection but it was making me sick so I went back to the FP corner and I was put on another pill".*
>
> *At the same time, I didn't know my HIV status so I was encouraged to test. I tested positive and I am now on medication and I am well.*

The study revealed some of the facilitators to FSW's accessing SRH services:

4.3.1.1 Introduction of the Taskforce

Some of the FSWs said that the formation of the Taskforce which looked at SRH issues affecting the FSWs on the EVP was the best thing that has ever happened in the city of Chipata. One of the Sex workers who was also a queen mother sat on that taskforce as the representative of the sex workers. Others on the taskforce included the Zambia police, health care worker, teacher, the Drug Enforcement commission, a pastor, the District AIDS Coordinating Advisor (DACA) and several other NGO's that were providing HIV/AIDS services in the District. According to the FSW who was a member of the Taskforce, this changed the perception of many of its members and that of the sex workers on FWs and their profession. It was now being seen as a public health problem. It made them feel and know that they too are human beings who have SRH need and rights more so because of their profession. The taskforce shared information which gave its members an understanding of the challenges the FSWs were encountering in accessing health services and the effort and progress reports from the various stakeholders to help us the FSWs access health services easily she said.

4.3.1.2 Easy accessibility to hubs (managed by Queen mothers and peer educators)

The study was informed about the hubs that were formed in the community and were managed by the Queen mother and peer educator. The FSW shared how they received SRH information at the hub. Information on correct and consistent use of condoms, the importance of testing and timely treatment of HIV and STI's, and Family planning. The hubs also distributed free condoms and was the place the FSWs could run to for advice and guidance on their health because it was nearest and within the community and was being managed by trained FSWs who understood them. It was a referral point for the FSW. Here the community members or fellow FSWs would report or bring a FSW that was ill and they would be assisted to get to the hospital. One of the peer educators, a FSW, who managed one of the hubs said the following:

> *……We would escort our colleagues with referral letters from the hub to the clinic and wait for them until they are attended to …so they don't get discouraged and leave without services.*

4.3.1.3 Availability of Peer Educators to give information on SRH issues

Most of the FSWs interviewed informed the researcher that they first had an encounter with the Peer Educators who either sensitized them on the SRH services or encouraged them to go and access health services. Their experience as peer educators was to be role models to their fellow FSWs by ensuring that they did what they preached and encouraged others from their life stories as they trade in their profession with regards to their health. One FSW interviewed said that the peer educators were the community health workers who were their liaison with the health facility amongst the FSWs. A peer educator reported the following:

> *I use myself as example. I got so very sick and I used to mess my bed, I even show them photos of how I was when I was sick and I got hep in 2011. Now I am fine. They get encouraged and come with me to the hospital for help.*

4.3.1.4 Improved Health Facility referral system

The reports from the study highlight improved health facilities that accommodate the FSWs and encourage them to receive services. Health workers are trained to manage Key populations. Confidentiality is now ensured in the facility and the referral system is well coordinated they are guided well on the processes and referral points so that the patient is prepared or attended to as deserving the medical help. The improved referral system motivates them to go and seek medical help: One FSW had this to say about the fact that a FSW-queen mother who offered herself to assist the health workers identify her colleagues and assist them so that their SRH needs are addressed.

> *……. Having a sex worker like us based at the clinic has helped us receive help without stigma (Queen mother)*

4.3.1.5 Institutional support from the church, police and health workers to provide non-discriminatory health services.

The institutional support from the church, police and health workers springs from the taskforce. These stakeholders sit on the taskforce and are educated through workshops and dissemination meetings on the HIV/AIDS pandemic and the efforts to fight the disease at community level. This has opened the understanding that the FSWs are human beings and are very prone to HIV and AIDS by nature of their profession but they ultimately interact with and place at risk the general population at risk. Addressing the FSW's health needs addresses the health needs of the general population who are the community. The police have become

friendly and the FSWs say they are now free to approach them for help. A Sex worker shared an experience:

> ……. *Early in 2015 one time, the police were patrolling the town in the evenings and locking up people that they would find loitering in the street to ensure security. I was found on the street waiting for a client and this policeman stopped me and gently advised me to get back home to safety. He escorted me home and went back without asking me to sleep with him for free or go to a jail cell.*

Objective 3: To Explore possible solutions of addressing SRH needs following the FSWs experiences on the Emerging Voices Project.

4.4 Major Theme: Acceptability and Adoption of SRH Services by FSW

4.4.1 Sub-Theme: Meaning of SRH services to FSW

The FSWs interviewed all reported that they are happy that they too know where to access health services. They are free to access non -discriminatory health services. They all acknowledge that had it not been for these services, many of them would have died a long time ago. Their lives have been prolonged, for many because they now know their HIV statuses, had STI's and they were diagnosed and treated early. Others tested HIV +ve and are now on treatment and are experiencing good health and they can enjoy raising their children and working because they have good health. Some of the FSW reported that they are now knowledgeable about SRH issues and know the correct and consistent use of condoms to reduce infections, use of Family planning to prevent unplanned pregnancies resulting in children who they will fail to raise. According to the participant, this job is difficult when one has little children. The knowledge obtained from the EVP on SRH goes beyond the FSW on the project and extends to their family members, their colleagues and the community at large. Two FSW reported the following on the meaning of SRH services to them:

……It means good health to me. It gives me happiness that I have good health, strength and confidence that I will live on because my health needs are met. My 3 children know about my health (HIV status). They are happy I am well.

……I have learnt a lot from the project on SRH issues. I teach all the girls on my community without fear on Sexual Reproductive Health because I have a girl child and I want her to make informed decisions.

4.4.1.1 Possible solutions to SRH needs of FSW

The study identified the gaps of the EVP and proposed some solutions to SRH needs of the FSW which included training the Peer educators to be testing the FSWs in the hubs or in the community, HIV Self-testing, opening of Health Centers that will provide services to FSW's other than the few government health facilities, Continuous supply of condoms the community hubs and Continuation and Expansion of a similar project countrywide.

4.4.1.2 HIV Self-testing

HIV self-testing was proposed by some of the FSWs as a solution to the stigma of going to test at the health facility every so often by the FSWs. They felt if this service could be made available, it would reduce the cost of frequently travelling to the health facility and they would only go to the hub for referral if they tested HIV +ve.

4.4.1.3 Health Centre's that will provide services to FSW's other than health centres

The study observed that the FSWs received health care from Corridors of Hope(NGO) and the Kapata Clinic – a government facility. Corridors of Hope had very friendly services for the FSWs and processed their laboratory tests such as HIV, STI's pregnancy tests within recommended turnaround times. The organization also treated some of the STI's. Services from this facility decongested the government facility and ensured that the diagnosis was given the urgency it deserved and the treatment or referral was given as quickly as possible. This facility was well stocked with supplies. One sex worker said that with Corridors of Hope, diagnosing and treatment was guaranteed the same day. The facility was open for longer hours than the government facilities to accommodate the FSWs programmes. All the participants commended this supplemental effort of the NGO to the government.

4.4.1.4 Continuous supply of condoms the community hubs

FSW reported in the study that condom supply was erratic especially at peak times. They said that the hubs would run out of condoms and so would the District Health Office that was the main supplier. They complained about the cost of buying condoms and narrated that sometimes they do not have money to even buy condoms. They would pass the cost to the client but if that client did not like using condoms they would use it as an excuse to demand unprotected sex. So, they advised that they preferred to be well stocked especially that they are now knowledgeable on the importance of consistence and correct use. A peer educator complained that sex workers are many in bars and the condoms are few.

4.4.1.5 Continuation and Expansion of a similar project countrywide

The EVP is only in Chipata District of Eastern Province but FSWs are countrywide. The study revealed that the benefits of the project on the health of the FSWs is evident in the community where they live hence their request for expansion of the Programme so that all FSWs are eventually targeted to curb the infections and re-infections of HIV and ultimately fight the disease.

CHAPTER FIVE

DISCUSSION OF FINDINGS

This study aimed to explore the Female Sex Workers' lived experiences and acceptability of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District. This chapter will discuss the findings of the study in relation to other similar studies in literature.

5.1 Understanding and use of HIV/STI Prevention methods by FSW

According to (Zhang et al. 2011), condom use among the FSW in China was significantly predicted by social referents support, experiences with and attitudes toward condoms, self-efficacy, and health behaviors and condom use skills. Significant indirect predictors of condom use mediated through behavioral skills included HIV knowledge, social referents support, and substance use. These finding on condom and SRH services use agrees with this study findings. Before the EVP Project most of the FSWs reported that they used to have unprotected sex or use and reuse the same condom with many different clients and the had no knowledge of HIV and STI's. Free condoms were not readily available and most of the FSWs could not afford to buy them. The project raised the knowledge of correct and consistent condom use and raised their awareness on HIV. This has changed the FSWs attitude towards condom use. This social support was provided by the project who gave information through peer educators and distributed condoms at meetings and at the hubs for easy access. However, some confessed that they sometimes give in to difficult clients who prefer unprotected sex but compensate for the risk by charging the client more. A few reported that they would decline to have unprotected sex and would forgo the money for their safety. All the FSWs interviewed reported that information of SRH issues always advised them to be low on substance use to be sober enough to remember to use a condom correctly every time they had sex. Two FSWs shared experiences when they were raped because they were too drunk on alcohol and drugs and did not know how many people raped them n if they used condoms or not.

5.2 Barriers to utilization of SRH services by FSWs

FSWs experienced a lot of challenges with the health workers attitude towards them. This was mainly being pegged on the kind of lifestyles they lead. From the findings, the FSWs reported that they would be skipped in queues, and the health workers would attend to other patients and only get back to them much later if at all. For the majority who reported to be on

Antiretroviral Treatment or suffering from STI's they would be told they are on treatment because of their miscellaneous behaviors. They were stigmatized and discriminated against because of their profession hence they shunned the health facilities. The FSWs also identified as barriers the long waiting hours at the health facilities in various departments due to poor and tedious referral systems

The discriminatory attitude from health workers is noted from other authors as well; despite high HIV prevalence rates among most-at-risk groups, utilization of HIV testing, treatment and care services was relatively low in Karnataka prior to 2008. A Research conducted by Beattie et al. 2012 aimed to understand the barriers to and identify potential solutions for improving HIV service utilization. Focus group discussions were carried out and the results indicate that Participants had good knowledge and understanding about HIV and HIV voluntary counseling and testing (VCT) services, but awareness of other HIV services was low. The participants indicated fear of the psychological impact of a positive HIV test result and the perceived repercussions of being seen accessing HIV services were key personal and interpersonal barriers to HIV service utilization. Previous experiences of discrimination at government healthcare services, coupled with discriminatory attitudes and behaviors by VCT staff, were key structural barriers to VCT service uptake among those who had not been HIV tested. Among those who had used government-managed Prevention of Parent to Child Transmission and Antiretroviral Treatment services, poor physical facilities, long waiting times, lack of available treatment, the need to give bribes to receive care and discriminatory attitudes of healthcare staff presented additional structural barriers(Beattie et al. 2012).

According to literature the FSW's experiences with Male Circumcision (MC) is that when the MC services are expanded, programs should support FSWs' efforts to protect themselves by providing information about what MC can--and cannot--offer for HIV/STI infection prevention (Abbott et al. 2013). This is contrary to this study findings, the FSW's on the project had information about MC and that it does not provide total protection against HIV/STI's so they said they would not allow a client to cheat them into having unprotected sex because they are circumcised.

5.3 Facilitators to utilization of SRH services by FSW

A community-based qualitative investigation was conducted using focus groups to understand experiences of stigma and discrimination and coping methods among HIV-positive women from marginalized communities. 15 focus groups were conducted with HIV-positive women in five cities across Ontario, Canada. Data were analyzed using thematic analysis to enhance understanding of the lived experiences of diverse HIV-positive women. Participants across focus groups attributed experiences of stigma and discrimination to: HIV-related stigma, sexism and gender discrimination, racism, homophobia and transphobia, and involvement in sex work. Coping strategies included resilience, social networks and support groups, and challenging stigma. Understanding the deleterious effects of stigma and discrimination on HIV risk, mental health, and access to care among HIV-positive women can inform health care provision, stigma reduction interventions, and public health policy (Logie CH, et.al, 2011).

The findings of the facilitators of utilization to SRH services in the qualitative investigation above agrees with the findings of this study, the Emerging Voices Project strengthened the community systems to improve service provision of SRH services by engaging the FSWs, the stakeholders and the community through the creation of the Taskforce and Hubs, introduction of Peer Educators to give information of SRH issues to the fellow FSWs though meetings. This understanding facilitated the understanding of FSWs rights to health in the community and amongst the Health workers and improved the utilization of SRH services in among the FSWs.

5.4 Acceptability and adoption of SRH services by FSW

This study's findings contradict those of the ethnographic study in literature which investigated health-seeking strategies in relation to sexual health among a group of sex workers in Calcutta, India, which looked at the relationship between women's understandings of (sexual) health, treatment seeking and service utilization. According to Evans & Lambert, (1997) the study indicated that the sex workers exhibited initial patterns of seeking treatment at the health facilities but did not eventually comply with treatment. This study out rightly highlights the fact that the human being is whole and to address one aspect of their lives and omit what they perceive to be important will address the health issue only in the short term. Holistic interventions must be planned for the intended SRH programmes for FSW to succeed. To the contrary, this study highlights the acceptability and adoption of the SRH services by the FSWs following the implementation of strategies of the Emerging Voices Project to ensure non-discriminatory SRH services which were accessible and acceptable to FSWs as their right to

health. The lived experiences of the FSW and their understanding of the meaning of the SRH services brings out the aspect of inner happiness and appreciation of the services that have prolonged and improved the quality of their health. The researcher conducted the study a year after the project had ended but it was clear that the knowledge gained by the FSW on the SRH issues has not only impacted their lives but also those of their families, friends, fellow SWs and the community at large. They also reported that they are free to share information on SRH issues with their others including their partners and refer them to the health facilities knowing well that they too will receive friendly health services. The FSWs accepted and adopted the SRH services at the health facilities and in the community following the implementations of the strategies by the EVP.

CHAPTER SIX

CONCLUSION

In summary, in the quest to combat HIV and AIDS in Zambia, Public Health Specialists globally must have a targeted approach of focusing on high risk groups and not only on heterosexual couples as the case has been the case in the past. This study has focused on the FSW's who by nature of their work are at a higher risk of getting infected and infecting their partners with HIV/AIDS and STIs. The Emerging Voices Project (EVP) rose to this challenge to partner with the FSW's the community and the stakeholders which included the health care workers under the Ministry of Health to ensure service provision of SRH to this group of people contribute towards the achievement of the UNAIDS Fast Track goals of 90:90:90. This is an ambitious treatment target to help end the AIDS epidemic where it is hoped that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will attain viral suppression. (UNAIDS 2017). This research highlights the various challenges experienced by the FSWs to access SRH services in Zambia as well as the world over through the various literal works that have been cited. Some of the highlighted challenges that were faced were; fear to access health services due to unfriendly health workers, stigma and discriminatory health services, low awareness of SRH despite being in a vulnerable profession. These challenges were partly addressed by the EVP, which brought about the inclusion of the FSWs and the Chipata Community and stakeholders into the knowhow of the FSWs SRH rights as well as helped them have more access to non-discriminatory services offered at health facilities which included VCT, ART to those who were reactive to the HIV and AIDS virus, screening and treatment of STI's and family planning services. The paper further highlights the acceptability and adoption of the SRH services by the meaning and understanding attached to each of the participants lives. Further, the paper mentions the FSW's best workable solutions to help ensure that FSWs SRH needs are met and lastly recommendations are offered on how to best help the FSWs access SRH services just like any other human being in any form of profession.

6.1 Recommendation

The study recommends that policy makers regard sex work as a public health concern and that deliberate expansion and replication of similar impactful interventions among FSW in Zambia be considered urgent in the fight against HIV/AIDS.

The Female Sex Workers' experiences of the SRH services on the Project show through this study that there is improved access to non-discriminatory health care services by Female Sex Workers and healthier and knowledgeable FSWs and their partners with responsible lifestyles in SRH issues and ultimately a healthier community.

6.2 Implication

This study should inform policy to strengthen systems that promote equal rights to health services for the benefit of the Sex Workers who do not have a voice and are ignored when they speak out on their experience in accessing SRH services. It is worth noting that FSWs are human beings and deserve access to non-discriminatory SRH services.

The acknowledgment of the National Strategic Framework (NASF 2014 – 2016) that Female sex workers are one of the most at-risk population with regards to contracting and transmitting HIV and STI's. This acknowledgment means that that the barriers to utilization of these services will be eliminated by the policy makers through carefully designed policies and guidelines that promote and facilitate friendly and non-discriminatory SRH services to treat and mitigate infections and re- infections of HIV and STI's in this population and ultimately the general population of Zambia.

Having explored the detailed accounts of the Female Sex Workers' experiences and perceptions of accessing Sexual Reproductive Health (SRH) services before and on the Emerging Voices Project in Chipata District, this research has allowed for a critical analysis of the relationship between the way services are provided and how the FSW access and adopt the same services. The barriers and facilitators to utilization of these services were clearly identified. This study seeks to contribute to ensuring that the policy makers develop or alter policies to ensure provision of humanitarian health services and SRH services that are acceptable by the FSW themselves and the community. The FSWs and their family and friends have continued accessing and utilizing the friendly and non-discriminatory health services that were introduced by the project which from their perspective has improved the quality of their lives. This evidence generated should inform policy makers in Zambia of the

urgent need for expansion and replication of similar impactful interventions among FSW countrywide.

This paper should ultimately contribute towards reaching the 2020 target of the 90: 90: 90 This is an ambitious treatment target to help end the AIDS epidemic where it is hoped that by 2020, 90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will attain viral suppression. (UNAIDS 2017) by addressing the health needs of an unreached marginalized groups in the community.

6.3 Dissemination plan

The researcher will release copies of the report of the study to University of Zambia Public Health Department. According to ethical procedures, participants and stake holders will be informed on the research findings. The findings will also be disseminated through Academic research audiences using journal publications for future research and to the public and to Policymaker audiences through media, national and regional conferences and workshops.

6.4 Limitation of the Study

The population of this study was limited to Female Sex Workers aged 18 – 24 years who had ever been enrolled on the EVP. This means that the study may have missed out valid information from other FSW, not enrolled on the EVP, who have had an experience with SRH services in Chipata District that would have enriched the study findings.

The study did not include the data from the health care facilities because patient information is confidential. Information collected was one sided. This information would have contributed greatly to understanding the acceptability and adoption experiences of the SRH services of the FSW in the district from the service provision end.

Most importantly, sex work is criminalized in Zambia so this marginalized group cannot be accessed fully or freely.

REFERENCES

Abbott SA, Haberland NA, Mulenga DM, Hewett PC (2013) Female Sex Workers, Male Circumcision and HIV: A Qualitative Study of Their Understanding, Experience, and HIV Risk in Zambia. PLoS ONE8(1): e53809. https://doi.org/10.1371/journal.pone.0053809

Bautista, C. T, Sanchez, J. L., Montano, S. M., Laguna-Torres, A., Suarez, L., Sanchez, J., … Carr, J. K. 2006. Seroprevalence of and risk factors for HIV-1 infection among female commercial sex workers in South America. *Sexually transmitted infections*, 82(4), pp.311–6. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2564717&tool=pmcentrez&rendertype=abstract.

Beattie, T.S.H, Bhattacharjee . P, Suresh.M, Isac. S, Ramesh. B. M, Stephen Moses . 2012. Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Karnataka state, South India. *Journal of epidemiology and community health*, 66 Suppl 2, pp.ii42–48.

CH Logie, LL James, W Tharao, MR Loutfy - PLoS medicine. 2011 - HIV, gender, race, sexual orientation, and sex work: a qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada journals.plos.org, journal.pmed.1001124

Corridors of Hope-Behavioural Surveillance Survey, 2009

Creswell, J.W. 2007. *QUALITATIVE Choosing Among Five Approaches*, Available at: https://is.vsfs.cz/el/6410/zima2013/B_KV/um/Creswell_2007_Qualitative_I.

Central Statistical Office (CSO) Zambia, Ministry of Health, M. of H. & ICF International.2014.

Dandona, R, Dandona . L, Gutierre. J .P, Kumar. A. G, McPherson. S, Samuels. F, Bertozzi S. M and the ASCI FPP Study Team. 2005. High risk of HIV in non-brothel based female sex workers in India. *BMC public health*, 5(1), p.87. Available at: http://www.biomedcentral.com/1471-2458/5/87.

Day, S. and Ward, H., 1997. Sex workers and the control of sexually transmitted disease. *Genitourinary medicine*, *73*(3), pp.161-168

Delvaux, T., Crabbe, F., Seng, S. and Laga, M.2003. The need for family planning and safe abortion services among women sex workers seeking STI care in Cambodia. *Reproductive health matters*, *11*(21), pp.88-95.

Evans, C. & Lambert, H.1997. Health-seeking strategies and sexual health among female sex workers in urban India: Implications for research and service provision. *Social Science & Medicine*, 44(12), pp.1791–1803. Available at: http://www.sciencedirect.com/science/article/pii/S0277953696002882.

Lafort, Y. Geelhoed.D, Cumba.L, Lázaro.C.D M, Delva.W, Luchters.S and Temmerman..M.2010. Reproductive health services for populations at high risk of HIV: Performance of a night clinic in Tete province, Mozambique. *BMC health services research*, 10, p.144.

Lotfi, R., Tehrani, F.R., Salehifar, D. and Dworkin, S.L.2016. Predictors of Condom Use Among Iranian Women at Risk of HIV. *Archives of sexual behavior*, *45*(2), pp.429-437.

Pisani, E., Garnett, G.P., Grassly, N.C., Brown, T., Stover, J., Hankins, C., Walker, N. and Ghys, P.D.,(2003). Back to basics in HIV prevention: focus on exposure. *Bmj*, *326*(7403), pp.1384-1387.

Revised National AIDS Strategic Framework RNASF 2014-2016

Rheumatologica, A., (2015). iMedPub Journals Integrating friendly sexual and reproductive health services for young female sex workers into the health system at district level in Zambia : perspectives of stakeholders Abstract. , 2(1), pp.1–8.

Sharma, A., Bukusi, E., Posner, S., Feldman, D., Ngugi, E. and Cohen, C.R.2006. Sex preparation and diaphragm acceptability in sex work in Nairobi, Kenya. *Sexual health*, *3*(4), pp.261-268.

UNAIDS, (2004). 2004 report on the global HIV/AIDS epidemic: 4th global report. , pp.1–236.

UNAIDS 2017 'Ending AIDS: Progress towards the 90-90-90 targets',http://www.unaids.org/en/resources/documents/2017/20170720_Global_AIDS_update_2017.

Van Den Hoek, A., Yuliang, F., Dukers, N.H., Zhiheng, C., Jiangting, F., Lina, Z. and Xiuxing, Z.2001. High prevalence of syphilis and other sexually transmitted diseases among sex workers in China: potential for fast spread of HIV. *Aids*, *15*(6), pp.753-759.

Van Dijk, M.G., Pineda, D.L., Grossman, D., Sorhaindo, A. and García, S.G.2013. The female condom: a promising but unavailable method for Dominican sex workers, their clients, and their partners. *Journal of the Association of Nurses in AIDS Care*, *24*(6), pp.521-529.

Ying, W.A.N.G., Jing-Bin, P.A.N., Xiao-Feng, W.A.N.G., Bing, L.I., Henderson, G., Emrick, C.B., Sengupta, S. and Cohen, M.2010. Reported willingness and associated factors related to utilization of voluntary counseling and testing services by female sex workers in Shandong Province, China. *Biomedical and Environmental Sciences*, *23*(6), pp.466-472.

Demographic and Health Survey 2013-14. , p.518.

Zhang, H. et al. 2011. Predictors of consistent condom use based on the Information-Motivation-Behavioral Skills (IMB) model among female sex workers in Jinan, China. *BMC public health*, 11, p.113. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3056744&tool=pmcentrez&rendertype=abstract.

ZULU, J. M., KINSMAN, J., MICHELO, C. & HURTIG, A.-K. 2014. Hope and despair: community health assistants' experiences of working in a rural district in Zambia. *Hum Res Health,* 12**,** 10.1186.

2010 mary Census Wall Chart - Eastern Province, p.253468.

APPENDICES

Appendix 1: Information sheet

Reading level: 10.8

INFORMATION SHEET FOR THE STUDY PARTICIPANT

THE UNIVERSITY OF ZAMBIA, SCHOOL OF MEDICINE

Department of Public Health

Title of the Study: Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District in Zambia.

Location: Chipata District, Eastern Province, Zambia

Principle investigator: Masozi Bridget Moyo

Cell: +260977764422

Email address: masozindhlovu@gmail.com

Introduction

I am a Master of Public Health (MPH) student at the University of Zambia-Ridgeway campus. I also worked for the Southern African AIDS Trust (SAT) Zambia in Lusaka. I am doing a research on the Adoption and acceptability of Sexual Reproductive Health (SRH) services by the Female Sex Workers in Chipata District.

Purpose of research project

The aim of the study is to understand the Female Sex Workers' lived experiences of the SRH needs, how and why they have adopted and are utilizing the SRH services in the health centres reintroduced by the Emerging Voices Project in partnership with the health care centers. The information that will be obtained from the study will generate data for future SRH programming and to inform policy around key populations in combating HIV AIDS epidemic. The researcher will conduct In-depth Interviews (IDI) a working Sample size of about 20. This sample will comprise of about fourteen (14) FSW and about three (3) peer educators and three (3) queen mothers. This selection will consider the young, older and employed FSW characteristics that were enrolled on the Emerging Voices Project. I am asking for your participation in this study.

Why you are being asked to participate in the In-depth Interview

You are being invited to take part in this research because I feel that your experience will bring out the gaps in the community and health care system and will inform policy and help in the development of practical interventions that may be replicated in other geographical locations other than Chipata district which cater for the FSW's SRH needs.

Procedures

We will ask you to take part in a discussion that will take about 1-2 hours. It will be done in a private place. We will tape record the discussion to help us write down exactly what you will say. If there is some information you feel should not be recorded, feel free to say so. If you allow us to record, the information from the tape or notes will be typed in full to help us fully understand what you have said. No name will be included in the tape recording and the typed documents.

Benefits

If you agree to participate in this In-depth Interview, we will pay you a sum of ZMW 50.00 to compensate you for the time you will spend. Apart from this, there are no direct benefits to you, except that what we will learn from you in this In-depth Interview will empower you to contribute towards the fight against HIV/AIDS by sharing your experiences that will be helpful in the development of practical interventions that will effectively address the SRH needs of FSW.

Risks/discomforts

We do not expect you to have any problems because of your participation in this In-depth Interview. However, some information we may learn from you may be personal and emotional. We would like to assure you that the information we will get from you will not be shared with anyone outside the research team, and all the In-depth Interview participants will be asked to keep whatever is said in the group confidential.

Protecting data confidentiality

We have put up steps to protect the information we will get from you. First, only members of the study team will be able to see the information. Second, we will not put names on any information. Instead, we will use numbers. The list of numbers and the information will be locked separately. The information you will provide will be strictly confidential and your identity will be protected. Third, we will destroy all tapes within 3 years after typing the information. We will keep copies of typed information on CDs in case we have a problem with the computer. All this information will be kept on a secure computer and in a secure room. This study has been approved by the University of Zambia Biomedical Ethics Research Committee (UNZABREC) and permission has been obtained from National AIDS Council, Southern African AIDS Trust and The University of Zambia Facility authorities. Should you have any questions or want clarification about the study, do not hesitate to get in touch directly with me. For any questions and concerns, you can call me on phone number, 0977-764422.

What happens if you do not want to participate or decide to leave the discussion early?

You are free to decide whether you want to take part in this In-depth Interview, and you are free to leave at any point during the discussion. You are also free not to answer any questions that you are not comfortable with and this will not bring any problem to you. Whether you decide to leave early, we will still pay you for your time.

Whom do I call if I have questions or problems regarding the study?

You can call the Principal Investigator, Masozi B Moyo

The University of Zambia, Department of Public Health
Cell: +260977764422

You may also contact
BIOMEDICAL RESEARCH ETHICS COMMITTEE (UNZABREC)
Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia
Telephone: 260-1-256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
E-mail: unzarec@zamtel.zm

Appendix 2: Consent Form

Reading Level: 11:1

CONSENT FORM FOR THE STUDY PARTICIPANT

THE UNIVERSITY OF ZAMBIA, SCHOOL OF MEDICINE

Department of Public Health

Title of the Study: Female Sex Workers' experiences of the Sexual Reproductive Health (SRH) services on the Emerging Voices Project in Chipata District in Zambia.

Location: Chipata District, Eastern Province, Zambia

Principle investigator: Masozi Bridget Moyo

Cell: +260977764422

Email address: masozindhlovu@gmail.com

The purpose of this study has been explained to me and I understand the purpose, the benefits, risks and confidentiality of the study. I further understand that, if I agree to take part in this study, I can withdraw at any time without having to give an explanation and taking part in this study is purely voluntary.

I.....
(Names)

Agree to take part in this study designed to understand the lived experiences of FSW, how and why they have adopted and are utilizing the SRH services in the health centers reintroduced by the Emerging Voices Project in partnership with the health care centers.

Signed/Thumbprint.....Date.....
(Participant)

Signed/Thumbprint.....Date.....
(Witness)

For more information you may contact

Principal Investigator, Masozi B M Ndhlovu. The University of Zambia, Department of Public Health

Cell: +260977764422

You may also contact

BIOMEDICAL RESEARCH ETHICS COMMITTEE (UNZABREC), Ridgeway Campus, P.O. Box 50110, Lusaka, Zambia. Telephone: 260-1-256067, Telegrams: UNZA, LUSAKA, Telex: UNZALU ZA 44370, Fax: + 260-1-250753, E-mail: unzarec@zamtel.zm

_____	_____	_____
Name of a researcher	Signature of a researcher	Date

Appendix 3: In-depth Interview Guide

SECTION A

In depth guide about experiences of Female Sex Workers (FSW) Sexual Reproductive Health (SRH) services by the on the Emerging Voices Project (EVP) in Chipata District

The Researcher has selected four themes for the study

- Understanding and use of HIV/STI preventions methods by FSW
- Barriers to utilisation of SRH services by FSW
- Sexual Reproductive Health needs of FSW
- Acceptability and adoption of SRH services by FSW

Date of interview……/……/…….

Place/Community ……

INSTRUCTIONS FOR THE INTERVIEWER

Consent form to be read, understood and signed before the interview. Use only this interview guide to conduct the interview.

Before starting the interview, the following should be read to the respondent.

a) Now that you have signed the consent form, are you ready for the interview?
……
b) Are you comfortable to be recorded?
……

SECTION B

Theme: Understanding and use of HIV/STI preventions methods by FSW

Exploring the experiences of the FSW's SRH services on the EVP.

- Can you tell me briefly about yourself?
- What are your experiences of SRH services before the Emerging Voices Project?
- What are your experiences of SRH services of the Emerging Voices Project?

Have you already used any of these services?
o Family planning services
o STI diagnosis and treatment
o HIV testing
o [Include any other relevant service that is available]

- What do you think about these services? Would you consider using these Services again? Why?

If yes:
o Can you tell me about your experience with [type of service]? What happened when you went to [type of service]?
o Was this a good experience? Or a difficult experience? Why? (Probe: what happened that makes you say this?)

SECTION C

Theme: Sexual Reproductive Health needs of FSW

What do sex workers perceive as gaps in current SRH services being offered?

- What are your views of the gaps in the EVP SRH services?
  - How did you manage these difficulties or gaps?
  - Mention two or three things that should be changed to improve this service, or even just one thing that they could improve to better meet your needs?

SECTION D

Theme: Barriers to utilisation of SRH services by FSW

What do sex workers perceive to be barriers and facilitators to their accessing of SRH?

- Have you encountered any difficulties or barriers in using these services?
- What were the main difficulties or barriers?
- What are the facilitators in using the SRH services?
- What services or issues attract one to access SRH services?
  - Based on your experience, would you recommend that other women should go to [type of service]? Why?

SECTION E

Theme: Acceptability and adoption of SRH services by FSW

What do you understand as the meaning of SRH services following your experience on the Emerging Voices Project?

- What do SRH services mean to you and your wellbeing?

SECTION F

Closing remarks

- Do you have anything that you would like to tell me?
- Do you have any questions?

Thank you for your participation.