

LONDON
SCHOOL of
HYGIENE
& TROPICAL
MEDICINE



LSHTM Research Online

Mbonye, M; Nalukenge, W; Nakamanya, S; Nalusiba, B; King, R; Vandepitte, J; Seeley, J; (2012) Gender inequity in the lives of women involved in sex work in Kampala, Uganda. Journal of the International AIDS Society, 15. ISSN 1758-2652 DOI: <https://doi.org/10.7448/IAS.15.3.17365>

Downloaded from: <http://researchonline.lshtm.ac.uk/989816/>

DOI: <https://doi.org/10.7448/IAS.15.3.17365>

Usage Guidelines:

Please refer to usage guidelines at <https://researchonline.lshtm.ac.uk/policies.html> or alternatively contact researchonline@lshtm.ac.uk.

Available under license: <http://creativecommons.org/licenses/by/2.5/>

<https://researchonline.lshtm.ac.uk>

Research article

Gender inequity in the lives of women involved in sex work in Kampala, Uganda

Martin Mbonye^{1§}, Winifred Nalukenge¹, Sarah Nakamanya¹, Betty Nalusiba¹, Rachel King^{1,2,3}, Judith Vandepitte^{1,4} and Janet Seeley^{1,4,5}

§Corresponding author: P.O. Box 49, Entebbe, Uganda. Tel: +256 41320272 (martin.mbonye@mrcuganda.org)

Abstract

Background: Gender inequity is manifested in the social and economic burden women carry in relation to men. We investigate women's experiences of gender relations from childhood to adult life and how these may have led to and kept women in sex work.

Methods: Participants were drawn from an ongoing epidemiological cohort study of women working in high HIV/STI risk environments in Kampala. From over 1000 enrolled women, we selected 101 for a qualitative sub-study. This analysis focuses on 58 women who engaged in sex work either as a main job or as a side job. In-depth life history interviews were conducted to capture points of vulnerability that enhance gender inequity throughout their lives.

Results: Most participants were young, single parents, poorly educated, who occupied low skilled and poorly paying jobs. All women knew their HIV status and they disclosed this in the interview; 31 were uninfected while 27 said they were infected. Parental neglect in childhood was reported by many. Participants described experiences of violence while growing up sometimes perpetuated by relatives and teachers. Early unwanted pregnancies were common and for many led to leaving school. Some women stated a preference for multiple and short-term money-driven sexual relationships. Needing to earn money for child care was often the main reason for starting and persisting with sex work. Violence perpetrated by clients and the police was commonly reported. Alcohol and drug use was described as a necessary "evil" for courage and warmth, but sometimes this affected clear decision making. Many felt powerless to bargain for and maintain condom use. Leaving sex work was considered but rarely implemented.

Conclusions: Inequities in gender and power relations reduce economic and social opportunities for better lives among women and increase risky sexual behaviour. Interventions focused on these inequities that also target men are crucial in improving safer practices and reducing risk.

Received 12 January 2012; Revised 23 March 2012; Accepted 29 April 2012; Published 14 June 2012

Copyright: © 2012 Mbonye M et al; licensee International AIDS Society. This is an open access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Background

Over the past two decades, HIV prevention efforts in parts of Sub-Saharan Africa and Asia have often focused on female sex workers because of fears that these women act as a reservoir of infection [1,2]. In addition to providing condoms, efforts have been made to improve women's safer sex negotiation skills, with some success [3–5]. However, the prevalence and incidence of HIV among these women remains high in many different settings. For example, prevalence among sex workers was estimated at anywhere between 21% and 74% in West Africa compared to less than 10% in the general population [6], while recently in Uganda prevalence has ranged between 37% and 47% among different sub-populations of sex workers [7,8] compared to 8% of Ugandan women in general [9]. Among the reasons for the continuously high prevalence rates of HIV and other sexually transmitted infections is the social context in which sex workers operate and the unequal power dynamics between the women and their clients [10,11].

Work on structural drivers by Parker and colleagues [12] grouped the factors that facilitate HIV transmission in the developing world as (i) economic (under) development and poverty; (ii) mobility including migration, seasonal work and social disruption due to war or politics and (iii) gender inequalities. Gender inequalities and inequities in particular have affected women's social, economic and political opportunities keeping them in a more disadvantaged position than their male counterparts [13,14]. In many societies including Uganda, women have been socialized to offer sex at the behest of their male partners [14], putting them at a disadvantage in negotiating for safer sex [15]. Infertility is often blamed on women, while infidelity is almost sanctioned for men. A lack of voice arising from disempowerment has led to the United Nations including gender among the key targets in the millennium development goals. Goal number three aims at promoting gender equality and empowerment of women [16]. Economic strains and unstable relationships put many women in Africa at a disadvantage, as they seek to

finance children's needs as well as their own. Many lack help from their partners which can open the route for sex work as a readily available option [17].

It is widely recognized that young women in Sub-Saharan Africa have higher rates of HIV infection than young men [18,19]. While the reasons for this difference may partly be biological, social and cultural factors also play a part [20,21]. The broader context of women's lives and the structural factors which affect their position in society as well as individual behaviour need to be understood [10,22]. Understanding the vulnerability to HIV infection of female sex workers is particularly critical in order to inform workable interventions. Locating the position of gender inequality as a structural driver of HIV among female sex workers requires an understanding of how women become sex workers in the first place and under what conditions they work [23].

Previous studies have focused on reasons for entry into sex work as ranging from child abuse [24,25], pressure from pimps, drug use, economic necessity and peer pressure [26,24,27]. A review article by Harcourt and Donovan [28] categorized sex work as being either direct or indirect, with the latter group comprising of women who exchange sex for money, but do not perceive themselves as sex workers, reflecting the great diversity among women who offer sex for cash or material support.

This paper explores how gender inequities may have played a role in facilitating the entry of women into sex work by looking at the life histories of women who are at high risk of HIV infection because they engage in sex with multiple partners, with particular reference to those who identify as female sex workers.

Methods

This study was nested in an ongoing (since 2008) epidemiological cohort study of women involved in high-risk sexual behaviour in Kampala, Uganda. The aim of this cohort is to understand the dynamics of HIV/STI infection and to implement future HIV prevention trials in this core group in Uganda [7].

The study setting and sampling

The participants of the cohort study were recruited from two divisions of southern Kampala after "hot spots" were mapped. These hot spots were defined as clusters of bars, night clubs, local beer breweries, eating places, lodges, guest houses known to provide rooms for sex work or selected street spots often frequented by sex workers in search of clients [7]. The study catchment is a densely populated area of Kampala with small-scale retail shops on road sides selling general merchandise. Many of these turn into night time bars and compete with larger bars, night clubs and restaurants for customers as the sun sets. Some guest houses and lodges operate 24 hours a day and their presence reflects a booming sex industry. Vendors sell alcohol throughout the day and night. However, it should be noted that sex work is illegal in Uganda.

All 1027 women participating in the main cohort were eligible for this qualitative study. All women attended

the research clinic at three monthly intervals and received general and reproductive healthcare facilities, counselling and treatment for their biological children aged less than 5 years [7]. Our target sample was 100 of these women, but we interviewed 101 because one woman who had missed earlier appointments later returned and she was interviewed. In order to allow for as equal a chance as possible for all women, every third woman attending her clinic visit was invited to participate in the qualitative study until the sample size was attained. Three women refused to participate while three others who had agreed to attend never returned and all were replaced. This analysis focuses on the experiences of 58 women who self-identified as sex workers.

Data collection and analysis

Prior to data collection, we held group discussions with peer leaders of the women attending the clinic which helped us to design the topic guides and the checklist. Data were collected through in-depth life history interviews with repeat interviews to allow for rapport creation and for participants to remember some key events in their life stories. We used a checklist with women who self-identified as sex workers in order to capture the context-specific factors that are involved in their day-to-day lives and livelihoods. The checklist included topics such as: reasons for entry into sex work, early experiences in sex work, challenges faced, daily routines and future plans in order to capture lived experiences and to understand gender-related factors which influence their decision making. Women were interviewed at least two times on different days and further interviews were arranged on clinic visit days when needed. The interviews followed the women's life stories from birth to present day. We sought details on what participants perceived as points of vulnerability with particular reference to experiences of gender-related inequity.

Interviews were conducted by four female interviewers who had previously worked with similar populations. All interviews with a particular participant were conducted by the same interviewer who had initially made contact with them to encourage rapport. Tape recorders were not used because all participants had expressed discomfort about them fearing that recordings of their voices could be used in the media or with the police, despite assurances from the team. Therefore, notes were taken during the interviews and the accounts of the interviews written up immediately after the interview in Luganda. Debriefing sessions were then shared with research team members and any comments were used to help structure subsequent interviews. All interviews were conducted at the social science offices which were located in a separate building from the clinic setting but within the same compound, to allow for privacy. The social science team worked independently of the clinical team. Data collection started in March 2010 and ended in June 2011. Interviews lasted between one to one and a half hours and were almost always conducted in the local Luganda language which is the most widely used in the area. One participant unfamiliar with Luganda was interviewed in English. Participants were given 5000 shillings (about

\$2 USD), transport refunds and a bottle of soda during the interviews.

Data management was aided by the use of NVivo 8 qualitative software. The team leader and interviewers each read two different interview scripts to come up with ideas for the code book inductively. An initial code book capturing key thematic areas was created and coding then started with scripts being divided among the five social scientists using one master project. Weekly meetings were set to compare the coding and if a new node was found necessary, it was then included into a master project. This process continued moving from broad nodes to more specific nodes that captured areas of gender inequality/equity throughout the participants' lives and specifically in their lives as sex workers. Common themes emerging from participants' narratives were constantly compared pointing to both direct and indirect associations with gender inequities within the broad cultural context. Such themes included; experiences of violence, relationship history, family background and experiences in sex work. The different projects were then merged, and comparisons of inter-relationships between codes and categories were conducted leading to the themes presented in this paper.

Ethical clearance was secured from the Uganda Virus Research Institute's Science and Ethics Committee and the Uganda National Council for Science and Technology.

Results

Characteristics of study participants

Most of the participants were Ugandans with the majority originating from the Baganda ethnic group ($N=39$). Three women originated from neighbouring countries like Rwanda, Sudan and Democratic Republic of Congo. We found that although 20 out of 58 women had migrated from outside Kampala city, their life stories reflected a similar background of gender-based inequities to those who did not migrate. Their stories also reflected similar reasons for entering sex work. The majority of participants had attended only primary school although one reported having been at university. The women were aged between 16 and 46 years. Forty-two women reported sex work as their main income-generating activity while 16 reported that they did other work as well as sex work. Reasons for joining sex work were similar across a number of demographic characteristics like age, ethnic backgrounds or religious orientation. Women with longer periods of exposure in sex work charged more for their services than the new women because they knew the trade more and had a bigger clientele. However, older women (40 years or older) often found it harder to get clients and coped by charging less. So at the beginning and end of sex work careers prices were lower.

Two participants were childless, while all others had at least one child with 28 women supporting three or more children. Only one woman said that she was officially married, most women said they were separated. Three women were either single or had never married before. Twenty-seven women said that they were HIV positive (and voluntarily disclosed their status to the interviewer, who had been blinded to their status). Participants were

aware of their HIV status as they were all tested at the clinic; however, we did not seek verification from the clinic records until after data collection was completed. Interestingly the HIV prevalence from our qualitative sample ($N=101$) was very close to that found in the main cohort study at 37% [7].

A life story

Jackie (not real name) is 39 years old. She grew up with her paternal aunt in Eastern Uganda, about 80 km from Kampala. Her parents had separated and her father being a soldier was never home. When her father later retired from the army and became a commercial farmer, Jackie lived with him together with her stepmother. She was made to work on her father's farm. She left school without completing primary school, because her stepmother opposed spending resources on her education. At the age of 15, she was married off without her consent to an older man who had children Jackie's age. This older man had given her parents some money in exchange for her hand in marriage. After 3 years, she left the marriage with two children she had had with her husband and went to live with her mother. She had retraced her mother after a long time. She worked on other people's farms to sustain her two children. She got another partner in 1992 and moved with him to Kampala. They separated in 2000 after having four children. Most of the child care burden remained with her with sporadic support from her husband. She started selling sweet bananas and it is while doing this job that sympathetic friends introduced her to sex work. She started sex work in 2004 at a rather advanced age compared to other women in our study. At the time of the study she doubled as a part time waitress at a restaurant in a Kampala suburb. She also sold *waragi* (popular local gin) in her home and had a pipe smoking business which earned her extra money alongside sex work. (Pipe smoking is an increasingly popular business among women such as these who hope to improve economic prospects by making a wish to the ancestors while smoking. For example they could wish for more generous clients.) Younger sex workers teased her for continuing with the work, even though she was almost 40 years old. She has a new partner whom she considers her regular partner and does not use condoms with him. She hopes to leave sex work if she can raise capital for another business, something that is proving elusive.

Definitions of sexual relationships

Jackie's story introduces some of the complexity of the lives of women in our study. Some of the terms women used to define relationships require careful definition. For example "marriage" did not necessarily refer to a formal arrangement, but stretched as far as including magnitude of support both financial and other forms of assistance from a partner, having a child with a partner, feeling emotionally attached to someone and cohabiting, such as Jackie's regular partner. Most women were content to maintain extra-relationships as long as they brought material benefit even when they were aware that some of these partners were married or committed to other women. "Clients" were those men whose relationship with a woman was based on agreed prices (usually before sex) in exchange for sex and such

relationships ended after the sex. However, repeat clients were called regular clients and they could easily turn into regular partners (“husbands”) in which case the condoms might be discontinued and cohabitation considered. Women described clients as being any man who could afford their services. Specifically they mentioned married men, business men, commercial motor cycle riders locally known as Boda-Boda, foreign visitors and in some rare cases policemen and government officers. The complex and unstable nature of these relationships also meant that there was no exclusivity, with clients moving between women depending on need and availability.

Early sexual and relationship experiences

Starting sex during their teenage years was common in the life stories of the participants and in many cases this resulted in unplanned pregnancies. The earliest age of sex reported was 13 years but almost two in three women had reported sexual debut between 15 and 19 years. Early sexual experiences were dominated by stories of pain and suffering, and in many cases a lack of consent to sex. As a result many of these women had children whose fathers gave limited or no financial support.

Ironically despite previous negative experiences in what they had hoped would be stable relationships, some women retained the expectation of getting a man to settle down with as the condition for leaving sex work. The few that reported having left sex work said it was because they believed that they had found that kind of man. Many women in this study reported having multiple regular partners as well as having paying clients.

A 26-year-old HIV-positive sex worker who had not disclosed her HIV status to her newly acquired husband said that:

... Yes, the man knows I am a sex worker and he says I will spend two months at his home and come back to sell sex for three weeks; he told me he will tell his relatives that I have business that I run in Kampala ... I will be in [a Kampala suburb] for sex work from Wednesdays and go back on Saturdays like that up to when the man sets up a business for me as we agreed.

The majority of our participants had experienced a history of relationship disappointments and had come to mistrust stable relationships preferring to have multiple, concurrent, short-term Money-driven partnerships, although desiring a more secure relationship. One 20-year-old HIV-positive sex worker described with sadness:

I currently have a partner whom I consider as a boyfriend but am aware that he is a married man. I mostly see this partner on Sundays and even during the week but after work. He normally calls me when his wife is away. His wife travels a lot though I do not know the purpose of her travels. My partner has 2 children. I have recently disclosed my HIV-positive status to this man [two weeks before a follow-up interview] and since then this man has not returned my calls.

Another 33-year-old sex worker had a partner who was once a client but had become a regular partner, visiting her house and sometimes going to the lodge to have sex. He was a married man and knew she was involved in sex work. He wanted her to stop sex work, but he felt that he would not be able to meet her many financial needs. Less than ten women reported that they had become regular partners of men who had been their clients before after these men had proposed relationships. However, these relationships were always short lived as women already used to sex work could not stop and concentrate on one man while the men could not afford to maintain the pay that women got on the streets.

Gender division of labour

Almost all the participants reported being born into lives where they found themselves doing gender-prescribed roles. They were engaged in looking after children, cooking family meals, fetching water from long distances and tilling the land; all tasks that had to be combined with school responsibilities. This type of work is described with a conviction that as girls, society expected them to have these types of jobs. For some of the participants who moved into Kampala in later years, they were met with similar tasks and many reported working as domestic house staff under difficult conditions. They were usually miserably paid, faced harassment including sexual abuse from men in those homes and accepted these disadvantages arguing that there was no better option, until they were introduced to sex work.

Other female-specific jobs that were mentioned included; food vending, massaging, karaoke singing and waitressing in bars. Most of the women who took up other work roles often used these jobs as a disguise in order to cover up for their sex work activities. These occupations especially bar work exposed women to constant harassment by male customers and in many instances the employers seemed to benefit from this, as it led to more male customers and therefore better chances for selling their alcohol and other products. Those who were uncomfortable with the harassment were usually asked to leave, but they said that they had nowhere to go and quietly endured the conditions until a way out was found through securing some better financial prospects elsewhere as the path to sex work begun. Some women blamed these conditions and experiences on poor education which meant they could not compete for better jobs or negotiate better pay and quite often payment was not honoured by employers some of whom felt they were doing these women a favour by giving them food and shelter. It is these poor conditions that sometimes forced women to seek better prospects in sex work. A recurring feature that demonstrated the burden women carried was the un-assisted duty of taking care of children. Financial requirements were the main factor in driving women into sex work. The narrative below illustrates the pressure that women endured in order to perform these gender roles amidst deprivation and poverty:

I resumed sex work when my baby made 3 months. And one day when my mother visited from the village, she found me with so many debts; unpaid house rent, lack of baby's milk. For those months

that I did not work, house rent money accumulated to 4 months. I would leave the baby alone in the house at night and go to do sex work. . . . When my baby was 5 months, my mother took it because I used to lock it in the house alone at night when going to work. (HIV-positive, exclusive sex worker, 26 years)

Obstacles to education

Life histories indicated that almost all these women faced numerous obstacles in their childhoods, which prevented them from developing skills that would improve their chances in searching for education and employment. There were competing forces that affected education. For example, it was typical for many of the participants to first take part in domestic work before they left for school. As a result many lagged behind or lost interest in education altogether and for some the situation was not improved by sexual and physical abuse while at school by teachers and male students. A few participants reported disruptions from parents/guardians who did not see the value of educating them, arguing that they were destined for marriage and therefore it was a waste of time investing in education even when they could afford:

When I completed primary four, my father told me to stop there and start learning domestic work. It was not because of money but my father said that girls should get married, they do not need much education. . . . (HIV-positive sex worker, 32 years)

Normative aspects of violence

Eighteen out of 58 participants described experiences of violence while growing up.

As children they reported having experienced mistreatment from step parents and other relatives including rape and severe beatings. Some participants reported growing up in other relatives' homes with many of them experiencing hardships. One woman was raped by her uncle who was supposed to be caring for her and she was threatened with death if she talked. Another woman was tortured by her cousin and forced to do punitive domestic work. A typical scenario is illustrated below about childhood and adult experiences of one of the participants:

My paternal grandmother [where she grew up] had grandchildren who used to beat me when I was young. They [grand children] never allowed me to remove jiggers [small insects that lay eggs under a person or animal's skin, causing painful areas on the skin] from my toes and I could not walk properly, and time came when I wanted to poison myself. . . . I escaped and started to work as a house girl. My male boss tried to rape me when I was about 15 years old. (HIV negative, 24-year-old sex worker)

She later left this place and after trying out other odd jobs ended up in sex work.

In some cases violence from male sex partners coupled with neglect of parental responsibilities by these same partners complicated the situation and made women

desperate to find some source of income. One HIV-negative, 33-year-old woman described how she ended up in sex work:

. . . the man [partner] used to beat me saying that I had become old and he never wanted to see me anymore, that is why I decided to leave him with my children; If this had not been the case then I would not even have done sex work because I liked my marriage so much.

Violence continued to be a feature of women's lives as they became sex workers and experienced mistreatment from clients and the police. Sometimes police used the illegality of sex work to demand bribes from sex workers and those who did not have money ended up being beaten or arrested while those who paid were set free. One participant experienced this:

On the fourth day after starting sex work, the police men attacked our location and arrested many women from the street including myself. One of my friends had some money and she paid 5000 shillings [about \$2 USD] and was released but I and others were taken to a local police post and the next day to prison where I spent two months. (27-year-old, HIV-negative sex worker)

Of the 58 women who self-identified as sex workers, about half reported a history of violence from both their families and sexual partners. An HIV-negative, 27-year-old sex worker got pregnant after she was forced into sex and explained that it was her own sister who had set her up with the man who proceeded to rape her. She was eventually forced by her grandmother to move in with the man since he was now the father of her child. He initially provided money for child care but later turned his attention to other women:

He forced himself on me and by the time he left I was bleeding and crying but my sister just laughed and told me to keep quiet that nothing was going to happen . . . My grandmother was the one who saw that I was pregnant and she told my mother . . . later on mother asked me who the owner was [responsible for the pregnancy] and I said I do not know.

Exposure to violence obviously increased the risk of HIV for many of these women and they generally felt powerless against it. In some cases women simply felt that violence was a part of their lives and work and there was little they could do about it. However, two participants reported positive experiences with the police including receiving advice on better prospects in life or getting protection from aggressive clients. One 25-year-old, HIV-negative woman illustrates this in the quote below:

Some police men understand what the sex workers go through while on the street. They even come to chat asking how things are, and always advise us to save money so that we can start a new life or anything that will lead us off street life saying that staying on the street is not good at all. They advise us to start a decent life that is respectable.

Inconsistency in condom use

Participants reported that violent clients and those who paid more money coupled with the inability to insist on condoms or knowing how to initiate use complicated condom negotiation. Some women also reported being financially desperate and thus failed to insist on condoms even when they wanted to use them especially when clients became regular partners. More than 10 women reported having had clients turn into regular partners over time and in all cases condom use was discontinued after this transition. Although many sex workers said that they always used condoms with their clients, some admitted that it was almost impossible to sustain condom use over time since each client presented a different challenge. An HIV-positive sex worker aged 29 illustrated:

... When I separated with my partner, I started the street, I conceived but I aborted because I did not know the owner [father], how would I know him since I used to have sex with many men who sometimes refused condoms ... because they paid much money I could do nothing ...

Another 20-year-old, HIV-positive sex worker who had been in sex work since she was 14 years was more forthright arguing that the lure of extra money was enough for her to forget about condom use:

... But for me I don't give unprotected sex at five thousand shillings, he can promise seven thousand shillings and I also say that is little money and he gives me ten thousand shillings. For me a condom is not an issue when I get the money I want.

Alcohol and illicit drug use

Alcohol use was common and women combined it with the use of illicit drugs like marijuana. The reasons for use ranged from gaining courage to negotiating better deals including insisting on condoms although the irony was that many actually admitted that alcohol instead made them easily make risky decisions. Others wanted to protect themselves from the night cold. One participant's experience reflects what many went through:

... We would take alcohol and even forget to ask for money. I used to take too much of it and it was up to the man to put on the condom ...that alcohol eliminates shyness and you become bold. It gives you happiness and you forget about all your worries. (HIV-negative sex worker, 34 years)

Another HIV-negative, 37-year-old woman who struggled to believe her results after testing several times continued to practice unsafe sex and blamed alcohol for some of her mishaps. She argued that it was hard to maintain consistent condom use in sex work especially when the clients themselves are not interested:

... in sex work, there is no way one can keep the rule of using condoms every time they have sex ... Sometimes the man can caress you and because you

are under the influence of alcohol you fail to insist on condom use. Some men do not accept condom use at all and would do anything not to use it. I doubt being HIV negative.

Reasons for leaving and taking breaks from sex work

Leaving sex work was considered by most participants but for many the quest for an alternative sustainable livelihood, when faced with a financial burden that often included their children and other family members, was complex. However, six women reported that they had completely left sex work. Some opted out on receiving an HIV-negative test result after thinking that they might be positive. One of these was encouraged to leave by her regular partner who had been a regular client while another had started a business hoping that this would keep her negative since she would be away from the regular sexual episodes that characterize sex work.

The counselling that they received at the GHWP clinic was also credited for the decision to leave sex work:

I had no HIV virus or any other sexually transmitted diseases and I was very happy, they [counsellors] even told me to go back to the clinic whenever I get any health problem to get free treatment. After testing HIV negative I stopped going to the street completely (former sex worker, 31 years)

HIV-related illness on the other hand also prompted some to leave sex work as they could no longer cope with sex work demands. Others left because they had started relationships in which their male partners were providing for their basic needs. However, some of these could not guarantee that they would not return to the street especially as this situation was always changing. One 20-year-old HIV-negative former sex worker said:

... if this [current partner] man leaves me, I will return to my work [sex work]. "And yet in that work, a man could trick me with alcohol and infect me [with HIV]".

Participants also reported taking temporary leave from sex work when they were pregnant, ill, tired, when they went to visit family or when family members came to stay with them or when they were nursing very young children. These breaks ranged from a few days to about six months. Much as taking temporary leave from work is not unique to these women, we found that there was a lot of pressure for these women to continue with this work even when they needed to rest. This was especially true for those women who solely depended on sex work for any income. For these women, being away from sex work meant there was no money nor were there any savings to fall back to.

Many stated that they would leave if they raised enough money to start businesses, but kept working even when these targeted amounts were raised treating the new businesses as extra income rather than substitute work.

Discussion

Gender inequity

Most of the women in this study came from very disadvantaged backgrounds. Many did not receive any parental, emotional and material support as children or were subjected to abuse and violence when growing up. With no skills to cope in the big city of Kampala and poor pay for those who managed to get work, they were introduced into sex work. Some said that at that point for once in their lives they could control their livelihoods, so potential risks seemed worthwhile. Life stories suggest that women's lived experiences are a tangled web of failed social and financial support. Structural forces of poverty and gender inequity heavily weigh against them in key areas like education where they failed to reach levels that would give them a competitive chance for formal jobs. In Uganda, women in the general population had a 22% primary school dropout rate compared to about 80% in our sample who had never enrolled for secondary education [29]. These women often carried the burden of nurturing children even when their partners had pressured them to have these children in the first place. Results from this study echo those in other studies where women have reported being at a disadvantage in sexual and reproductive health leading to a multiplicity of challenges with little hope of a sustained income to cope with what society has thrown at them [30,24]. In some studies sex work has been reported as an avenue of gaining some form of financial independence for marginalized women [31]. Dependence on men was manifested in how these women responded to reproductive issues. Having children was a cultural status symbol for a woman but at the same time a burden as men seemed to take advantage of this by demanding unprotected sex while promising stability when the child came, only for women to be abandoned after delivery.

Early sexual debut was common among women in this study with almost a third reporting initiating sex between 15 and 19 years. While the age at first sex has been increasing in Uganda rising from 16.7 to 17.1 years since 2001 [9], our population seems to defy this trend suggesting that some women face more structural barriers in attempting to achieve prevention goals. Most women in our study had resorted to short term multiple relationships with different men after they had experienced a history of failed monogamous relationships. The main motivating factor seemed to be material needs as women appeared to avoid forming an emotional attachment with clients as a coping mechanism. Like in other parts of Africa where sex workers have been studied, most of our participants were either separated, divorced or never married [32].

Male clients who started regular sexual relationships with women sex workers tended to abandon condom use with the women and this raised implications for safety. In one study, male partners of female sex workers had managed to consistently use condoms if their peers indicated that they used them with sex workers [33]. Our findings suggest that there is less inclination for men to use condoms once their relationships with sex workers became regular suggesting an opportunity for an intervention in this area by

engaging men further. Studies show that while sex workers may successfully insist on condom use with clients, this power disappears when they start emotional relationships with such clients [34].

Disguising sex work

There was stigma around the work of selling sex and many women disguised their income activities in public as fast food vendors, Karaoke singers, and bar workers, for example. Others went to great pains to ensure their loved ones never knew about the work that they were doing. Although a few women left sex work, those who persisted were the majority and they justified their continuing by stating that the conditions that had driven them into sex work still existed. Even those who had set targets to leave continued in this trade. Some women seemed to have gained a new identity and an acceptance and position among other women performing the same work, a status which they had lacked throughout their lives. Where they lacked agency in other spheres of life, many of the women reported feeling more independent than they had ever felt in their lives and this new found independence and self sustainability was a reason that kept many women in sex work.

Complexity of gender-based violence

Violence was an ever looming danger for these women as they engaged in sex work. Our results contribute to existing literature which highlights an association between violence and HIV risk [35,28,36]. Gender-based violence seems to be a crucial aspect of lives of these women especially as violence in various forms starts early for many and continues into adult life. Studies in other contexts seem to show an association between early sexual debut and violence in childhood [37,24]. The role of the police in this is not straightforward. Far from always being an enemy, some studies have pointed out that there is a potential for the police to be persuaded to promote safety for sex workers [38–40]. The narratives of the two women in our study who reported positively about the police indicate that this kind of intervention is possible in our setting.

Gender inequity is played out at three structural levels: sexual division of power, sexual division of labour and the affective component of relationships. These play a crucial role in subjugating women into positions of vulnerability which push them into risky income generating activities such as sex work [10].

The social and cultural context affected an individual's ability to take decisions about safe sex or even to save money earned from sex work. This could be attributed to the strong cultural influence that positions women in subordinate positions but also encourages male domination even in sexuality. Despite women feeling uncomfortable with sex work, they persevered since there were no better sustainable livelihoods open to them [41]. Risk reduction is compromised by the gains they get from charging higher rates for unsafe sex a finding corroborated in other studies [42].

This study has some limitations which need to be taken into account while interpreting these results. It was based on a sample of women who self identified as high risk. We are aware that many women may not be willing to be

identified as such. Therefore we could have missed out on the experiences of other women with similar experiences but not willing to self identify as sex workers. However, the experiences that are highlighted in this paper are pertinent and therefore they provide an avenue to understand one important structural driver of gender inequity and its role in enhancing risk for HIV in both direct and indirect ways.

Conclusions

Gender inequities expose women to social and economic hardships denying them a source of income from early on in their lives and setting them up for a life of high risk earning alternatives like sex work. This exposes them to a high risk of HIV/STI infections and physical harm through violence from clients, partners and relatives throughout their lives. Harm reduction even within sex work needs to be emphasised and those women who would like to leave sex work ought to be assisted in order for this to be sustainable. Interventions that focus on preventive measures for sex workers or alternative livelihoods need to take into account the structural factors that drive their decisions to begin and continue in sex work. In the absence of changes in gender relations, these women require broader support to have safer sex and be protected from violence. Existing attempts at promoting gender equality including affirmative action in education, extending access to credit facilities and enacting laws that are gender sensitive while encouraging, seem to be falling short of removing the structural barriers. Interventions could use a harm-reduction approach to engage men more effectively in ensuring the safety of women in sex work. Men play a central role in shaping the efforts towards gender equity especially in settings such as this one with deeply entrenched cultural beliefs that widen rather than narrow the gender gap.

Authors' affiliations

¹MRC/UVRI Uganda Research Unit on AIDS, Entebbe, Uganda; ²University of California, San Francisco, CA, USA; ³Karolinska Institute, Stockholm, Sweden; ⁴London School of Hygiene and Tropical Medicine, London, UK; ⁵University of East Anglia, Norwich, UK

Competing interests

The authors declare that there are no competing interests.

Authors' contributions

MM and JS participated in the conception, design and implementation of the study, analysis, interpretation of data and drafting of the manuscript. RK participated in interpretation of data and the drafting of the manuscript. WN, SN and BN participated in the data collection and coding of the data. JV participated in interpretation of the manuscript. All authors read and approved the final manuscript.

Acknowledgements

We would like to thank all the study participants and the interviewers who recruited and conducted life history interviews throughout the data collection.

This study was funded by the MRC/UVRI Uganda research unit on AIDS in Uganda.

References

1. Simonsen JN, Plummer FA, Ngugi EN, Black C, Kreiss JK, Gakinya MN, et al. HIV infection among lower socioeconomic strata prostitutes in Nairobi. *AIDS*. 1990;4(2):139–44.
2. Nzila N, Laga M, Thiam MA, Mayimona K, Edidi B, Van Dyck E, et al. HIV and other sexually transmitted diseases among female prostitutes in Kinshasa. *AIDS*. 1991;5(6):715–21.

3. Karim QA, Karim SS, Soldan K, Zondi M. Reducing the risk of HIV infection among South African sex workers: socioeconomic and gender barriers. *Am J Public Health*. 1995;85(11):1521–5.
4. Cohen J. HIV/AIDS in India. Sonagachi sex workers stymie HIV. *Science*. 2004;304(5670):506.
5. Ghose T, Swendeman D, George S, Chowdhury D. Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: the boundaries, 21 consciousness, negotiation framework. *Soc Sci Med*. 2008;67(2):311–20.
6. Cote' A-M, Sobela F, Dzokoto A, Nzambia K, Asamoah-Adu C, Labbe' A-C, et al. Transactional sex is the driving force in the dynamics of HIV in Accra, Ghana. *AIDS*. 2004;18:917–25.
7. Vandepitte J, Bukonya J, Weiss HA, Nakubulwa S, Francis SC, Hughes P, et al. HIV and other sexually transmitted infections in a cohort of women involved in high-risk sexual behaviour in Kampala, Uganda. *Sex Transm Dis*. 2011;38(4):316–23.
8. Kissling E, Allison EH, Seeley JA, Russell S, Bachmann M, Musgrave SD, et al. Fisherfolk are among groups most at risk of HIV: cross-country analysis of prevalence and numbers infected. *AIDS*. 2005;19(17):1939–46.
9. Ministry of Health (MOH) and ORC Macro. Uganda HIV/AIDS sero behavioural survey 2004–2005. Calverton, Maryland, USA: Ministry of Health and ORC Macro; 2006.
10. Connell RW. *Gender and power*. Stanford CA: Stanford University Press; 1987.
11. Busch N, Bell H, Hotaling N, Monto M. Male customers of prostituted women: exploring the perceptions of entitlement to power and control and implications for violent behavior toward women. *Violence Against Women*. 2002;8(9):1093–112.
12. Parker RG, Easton D, Klein CH. Structural barriers and facilitators in HIV prevention: a review of international research. *AIDS*. 2000;14(Suppl 1):S22–32.
13. Aikman S, Unterhalter E, Boler T. Gender equality, HIV and AIDS. A challenge for the education sector. Oxford: Oxfam; 2008.
14. Koenig MA, Lutalo T, Zhao F, Nalugoda F, Kiwanuka N, Wabwire-Mangen F, et al. Coercive sex in rural Uganda: prevalence and associated risk factors. *Soc Sci Med*. 2004;58(4):787–98.
15. Jewkes RK, Levin JB, Penn-Kekana LA. Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study. *Soc Sci Med*. 2003;56(1):125–34.
16. Sachs JD, McArthur JW. The Millennium Project: a plan for meeting the Millennium Development Goals. *Lancet*. 2005;365:347–53.
17. O'Leary A, Martins P. Structural factors affecting women's HIV risk: a life-course example. *AIDS*. 2000;14(Suppl 1):S68–72.
18. Auerbach JD, Parkhurst JO, Caceres CF. Addressing social drivers of HIV/AIDS for the long-term response: conceptual and methodological considerations. *Glob Public Health*. 2011;6(Suppl 3):S293–S309.
19. UNAIDS. *AIDS epidemic update 2009*. Geneva: UNAIDS; 2009.
20. MacPhail C, Williams BG, Campbell C. Relative risk of HIV infection among young men and women in a South African township. *Int J STD AIDS*. 2002;13(5):331–42.
21. MacPhail LA, Komaroff E, Alves ME, Navazesh M, Phelan JA, Redford M. Differences in risk factors among clinical types of oral candidiasis in the Women's Interagency HIV Study. *Oral Surg Oral Med Oral Pathol Oral Radiol Endod*. 2002;93(1):45–55.
22. Munoz J, Adedimeji A, Alawode O. They bring AIDS to us and say we give it to them': socio-structural context of female sex workers' vulnerability to HIV infection in Ibadan, Nigeria. *SAHARA J*. 2010;7(2):52–61.
23. Gupta GR, Parkhurst JO, Ogden JA, Aggleton P, Mahal A. Structural approaches to HIV prevention. *Lancet*. 2008;372:764–75.
24. Vanwesenbeeck I. Another decade of social scientific work on sex work: a review of research 1990–2000. *Annu Rev Sex Res*. 2001;12:242–89.
25. Weitzer R. Sociology of sex work. *Annu Rev Sociol*. 2009;35:213–34.
26. Pickering H, Todd J, Dunn D, Pepin J, Wilkins A. Prostitutes and their clients: a Gambian survey. *Soc Sci Med*. 1992;34:75–88.
27. Wamoyi J, Wight D, Plummer M, Mshana GH, Ross D. Transactional sex amongst young people in rural northern Tanzania: an ethnography of young women's motivations and negotiation. *Reprod Health*. 2010; doi:10.1186/1742-4755-7-2.
28. Harcourt C, Donovan B. The many faces of sex work. *Sex Transm Infect*. 2005;81(3):201–6.
29. Ministry of Finance, Planning and Economic Development (MoFPED): *Gender inequality in Uganda: the status, causes and effects*. 2006 (Discussion paper II).

30. Green G, Pool R, Harrison S, Hart GJ, Wilkinson J, Nyanzi S, et al. Female control of sexuality: illusion or reality? Use of vaginal products in south west Uganda. *Soc Sci Med.* 2001;52(4):585–98.
31. Bandali S. Exchange of sex for resources: HIV risk and gender norms in Cabo Delgado, Mozambique. *Cult Health Sex.* 2011;13(5):575–88.
32. Morison L, Weiss HA, Buve A, Carael M, Abega SC, Kaona F, et al. Commercial sex and the spread of HIV in four cities in sub-Saharan Africa. *AIDS.* 2001;15(Suppl 4):S61–9.
33. Barrington C, Latkin C, Sweat MD, Moreno L, Ellen J, Kerrigan D. Talking the talk, walking the walk: social network norms, communication patterns, and condom use among the male partners of female sex workers in La Romana, Dominican Republic. *Soc Sci Med.* 2009;68:2037–44.
34. Marcus R. Gender and HIV/AIDS in Sub-Saharan Africa: the cases of Uganda and Malawi. University College Swansea: Centre for Development Studies; 1993. Report No.: 13.
35. Dunkle KL, Jewkes R, Nduna M, Jama N, Levin J, Sikweyiya Y, et al. Transactional sex with casual and main partners among young South African men in the rural Eastern Cape: prevalence, predictors, and associations with gender-based violence. *Soc Sci Med.* 2007;65(6):1235–48.
36. Baral S, Beyrer C, Muessig K, Poteat T, Wirtz AL, Decker MR et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *Lancet Infect Dis.* 2012;10.1016/S1473-3099(12)70066-X. published online March 15.
37. Cluver L, Gardner F. Risk and protective factors for psychological well-being of children orphaned by AIDS in Cape Town: a qualitative study of children and caregivers' perspectives. *AIDS Care.* 2007;19(3):318–25.
38. Rekart ML. Sex-work harm reduction. *Lancet.* 2005;366:2123–34.
39. Biradavolu MR, Burris S, George A, Jena A, Blankenship KM. Can sex workers regulate police? Learning from an HIV prevention project for sex workers in southern India. *Soc Sci Med.* 2009;68(8):1541–7.
40. Shannon K, Kerr T, Strathdee SA, Shoveller J, Montaner JS, Tyndall MW. Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. *BMJ.* 2009;339:b2939.
41. Manopaiboon C, Bunnell RE, Kilmarx PH, Chaikummao S, Limpakarnjanarat K, Supawitkul S, et al. Leaving sex work: barriers, facilitating factors and consequences for female sex workers in northern Thailand. *AIDS Care.* 2003; 15(1):39–52.
42. Wawer MJ, Podhisita C, Kanungkasem U, Pramualratana A, McNamara R. Origins and working conditions of female sex workers in urban Thailand: consequences of social context for HIV transmission. *Soc Sci Med.* 1996;42(3):453–62.