Theatre for a Change Ghana:

Baseline report for the Peace and Love Club Project

Participants from the Peace and Love Club at a legislative theatre performance, February 2013

Written by Ruth Simister
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Abbreviations and acronyms

AIDS - Acquired Immunodeficiency Syndrome

SW - Sex Worker

HIV - Human Immunodeficiency Virus

RNPP – Regular Non-Paying Partners

STIs – Sexually Transmitted Infections

TfaC - Theatre for a Change

1. Introduction

Theatre for a Change (TfaC) is a registered non-governmental organization in Ghana which works to reduce the risk of HIV infection among marginalized and at risk groups through the use of interactive, participatory learning techniques. In September 2012 the organization mobilized a group of 10 female sex workers living and working in brothels in Old Fadama, Accra's largest illegal settlement, to form the Peace and Love Club. TfaC developed a programme incorporating a series of behavior change workshops, advocacy through legislative theatre, service provision and vocational skills training, in order to develop participants' abilities to protect and promote their health and to advocate for their rights to live without gender-based violence.

On 10 January 2013 a baseline survey was completed in a workshop, in order to measure and understand current levels of knowledge, experiences and practices among the participants on gender rights, sexual and reproductive health, HIV and AIDS and substance use. The report provides results and analysis on the following:

- Socio-demographic profile
- Knowledge of the prevention, transmission and treatment of HIV
- Knowledge of substance use
- Attitudes toward authorities
- Knowledge of relevant sexual offences legislation
- Knowledge of rights

2. Purpose

The baseline survey was carried out in order to measure and understand the levels and types of knowledge, attitudes and practices amongst participants in the Peace and Love Club on gender rights, sexual and reproductive health, HIV and AIDS and substance use. This report provides data which will inform programme implementation and which forms the basis for measuring the project's impact; it also provides an analysis and recommendations which aim to confirm future programming, monitoring and evaluation.

3. Methodology

The baseline survey was conducted at a regular workshop meeting of the Peace and Love Club in the Jamestown Community Centre in Old Fadama, Accra. All 10 members of the Club participated in the baseline survey voluntarily, with verbal consent obtained by the researchers. Structured questionnaires were administered as face-to-face interviews. The first part of this questionnaire asked about the participants' socio-demographic background, whilst the second part consisted of statements which participants identified as true or false, as well as a series of closed questions.

In order to aid analysis, the results from the baseline survey were triangulated against those from the 'Situational Analysis of the Lives of Female Sex Workers from Old Fadama', carried out in December 2012[1]. The situational analysis used a mixed methodology of face-to-face questionnaires, individual in-depth interviews, structured workshop exercises and key informant interviews. Participants were the same for both the situational analysis and the baseline survey, although 3 members of the Peace and Love Club did not take part in the questionnaire part of the situational analysis. The sensitive nature of the survey questions means that responses may have been distorted, with participants giving 'correct' answers rather than truthful or realistic ones. On-going trust building between researchers, facilitators and participants attempt to minimize such distortion.

Both quantitative and qualitative data are analysed in this report, with comparisons and contrasts drawn throughout. Literature is cited where relevant.

4. Results and analysis

4.1 Socio-demographic profile

The ten participants in the baseline survey were aged between 19-35 years. Education levels were basic, with eight participants having attended primary education, half of whom left before completing primary six, and two of whom continued to junior school, one of whom completed schooling. Seven participants had children, whilst one was pregnant. Seven participants identified as having a regular non-paying partner, whilst one was married, one single and one cohabiting.

These results highlight the importance of knowing their HIV status for the participants. As current and future mothers knowing their HIV status is imperative to reducing the risk of mother to baby transmission. That the majority of participants had children is of note for this project, as behaviours and practices concerning sexual and reproductive health and gender rights are likely to impinge on children, especially for those participants living with their children in brothel establishments. The age of participants is also an important factor in identifying and understanding behaviour trends with regard to sexual and reproductive health practices. For example, studies have indicated that younger women are both at higher risk of contracting STIs[2] and younger SWs are more likely to consistently use condoms[3].

The survey found that the majority of participants have regular non-paying partners (RNPPs), identifying a key stakeholder group for this project. The situational analysis of the lives of female SWs from Old Fadama carried out in December 2012 showed that participants' relationships with RNPPs was a

[1] Lorraway N, 'Situational Analysis of the Lives of Female Sex Workers from Old Fadama, Accra, Ghana', December 2012. Theatre for a Change. Further references to 'situational analysis' refer to this publication.
[2] Fitch J.T., Stine, C., Hager W.D., Mann, J., Adam M.B., & McIlhaney J. (2002). 'Condom Effectiveness: Factors that Influence Risk Re-duction', *Sexually Transmitted Diseases, 29(12), 811–817*
[3] See, for example, A Adu-Oppong, RM Grimes, MW Ross, J Risser, and G Kessie, 'Social and Behavioural Determinants of Consistent Condom Use Among Female Commercial Sex Workers in Ghana', 2007. *AIDS Education and Prevention*, 19(2): 160–172.

significant factor in sexual reproductive health practices, with 86% of participants responding that they never use condoms with an RNPP, a result which is consistent with previous studies[4].

4.2 Sexual and Reproductive Health

The results show that all participants were aware of their risk to HIV infection and of the importance of knowing their HIV status as well as that of a partner. All 10 participants correctly identified that HIV risk increases with having many sexual partners and can be reduced by having sex with only one uninfected partner. The statement, 'You are safe from HIV if you cut your skin with a knife used by someone else who cut themselves', was recognized as false by 8 participants, demonstrating that the majority of participants understood that HIV is present in some bodily fluids and can be transmitted in non-sexual encounters. However, results also reveal some barriers to obtaining accurate knowledge of one's own HIV status and that of partners: half of participants agreed that 'All people who have HIV look sick' and 1 participant believing that if you get tested for HIV everyone will find out your status. The significance of this belief is highlighted by the situational analysis, in which participants reported that if a client requests unprotected sex the SW assesses whether the man 'looks infected' in order to make a decision. Despite knowledge about their risk to HIV infection, results of the situational analysis showed that only 71% of participants had been tested for HIV in their lifetime, with only 29% having been tested in the last 6 months. Similarly, whilst 8 participants correctly identified that vulnerability to HIV infection is increased by STI infection, the situational analysis revealed that 57% of participants had never been tested for STIs.

In measuring participants' knowledge of HIV transmission the survey revealed belief in widespread myths relating to HIV transmission (for example, 4 participants agreed that a person can contract HIV through witchcraft; half of participants agreed that HIV can be contracted from a mosquito bite; and 1 participant identified as true the statement, 'HIV can be transmitted by talking about it'). Regarding knowledge of condom use, only 7 participants agreed that the risk of contracting HIV can be reduced by using a condom every time they have sex. It must be remembered that knowledge of condom use does not necessarily mean correct usage (for example, the situational analysis showed that 83% of participants who correctly applied a condom during a workshop exercise did not thoroughly check the condom first).

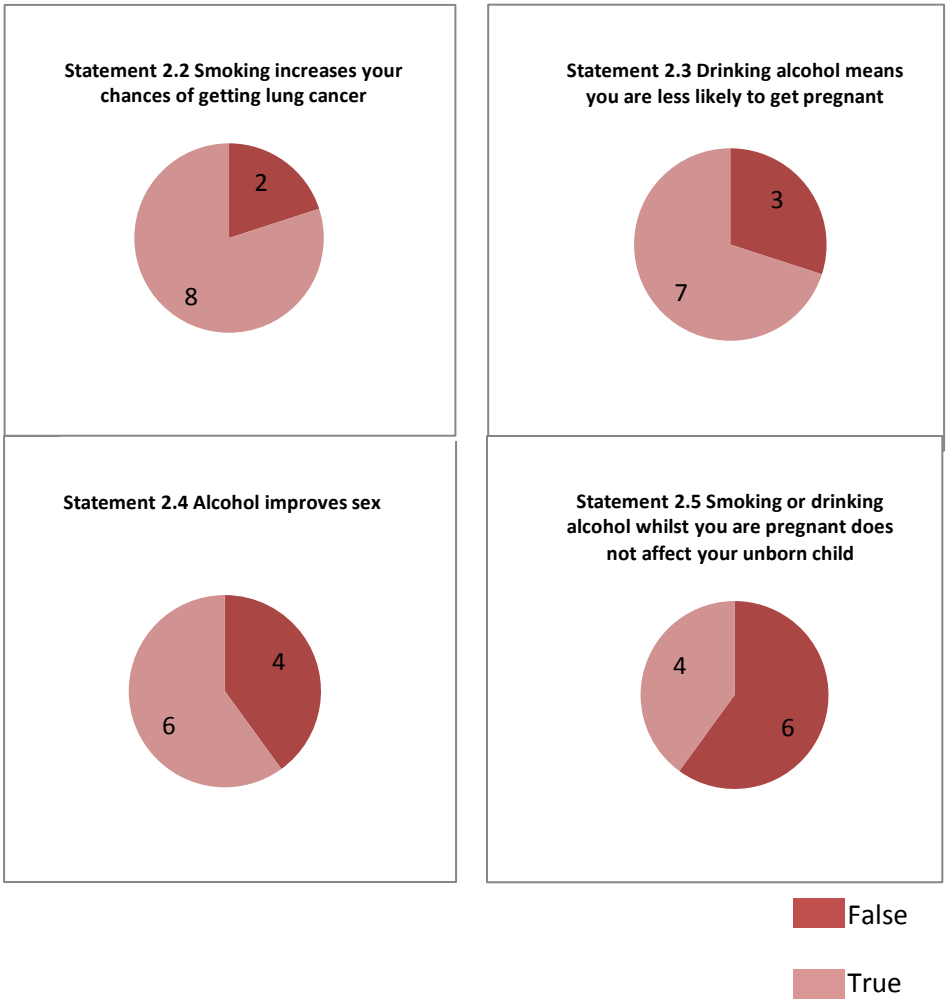
Only 2 participants identified that some medical drugs can prevent the transmission of HIV from mother to child, revealing a knowledge gap which could affect the participants' likelihood of accessing treatment (possibly compounded by the distrust of and discrimination among healthcare workers which was revealed in the situational analysis), increasing the risk of mother to child transmission. 8 participants identified as true the statement, 'some medical drugs will prolong the life of a HIV positive

[4] C.f. Cote AM, Sobela F, Dzokoto A, Nzambi K, Asamoah-Adu C, Labbe AC, Masse B, Mensah J, Frost E, and Pepin J, 'Transactional sex is the driving force in the dynamics of HIV in Accra, Ghana'. 2004. *AIDS* 18: 917-925. C.f.f. Walden V.M., Mwangulube K., and Makhumula-Nkhoma P., 'Measuring the impact of behaviour change intervention for commercial sex workers and their potential clients in Malawi,' 1999. *Health Education Research* 14**:** 545-554.

person'; however, the barriers to regular testing and to accessing healthcare service mentioned above may mitigate the use of this knowledge.

4.3 Alcohol, Nicotine and Substance use

Key results about participants' knowledge and experience of alcohol consumption and smoking are shown by the charts below:



Alcohol consumption increases the likelihood of risk behaviours and, thus, compounds the vulnerability of SWs to violence and harm. The results of the baseline survey show low levels of knowledge about the

effects of alcohol, with 7 participants responding that alcohol consumption reduces the chances of becoming pregnant and 4 participants answering that drinking whilst pregnant has no effect on a child. 6 participants agreed with the statement 'alcohol improves sex'. Whilst the nature of the experienced improvement was not explored and rates of alcohol consumption were not measured, this is consistent with studies which show widespread use of alcohol among SWs. One study in Western Kenya found that 60% of SWs who participated in a World Health Organisation Alcohol Use Disorders Identification Test presented scores indicating alcohol dependence[5]. A study in South Africa found that 82% of participants had abused or been dependent upon alcohol in the previous year[6]. Reasons for alcohol use among SWs include aiding to being more assertive with clients[7] and reduce feelings of embarrassment[8] relating to sex work, as well as use as a contraceptive, painkiller and abortive[9]. As well as the health risks associated with high levels of alcohol use, SWs experience particular sexual and reproductive health risks as a consequence of alcohol consumption, notably reduced ability to negotiate condom use, which must be considered in conjunction with the data collected on condom use.

Greater knowledge about the health risks associated with smoking is demonstrated by the results, with 9 participants identifying that smoking increases the chance of lung cancer; we can therefore conclude that there is some understanding of the causal effect of substance use and health risks among the majority of participants.

4.4 Violence

Data relating to participants' experiences of violence is illustrated in the chart below:

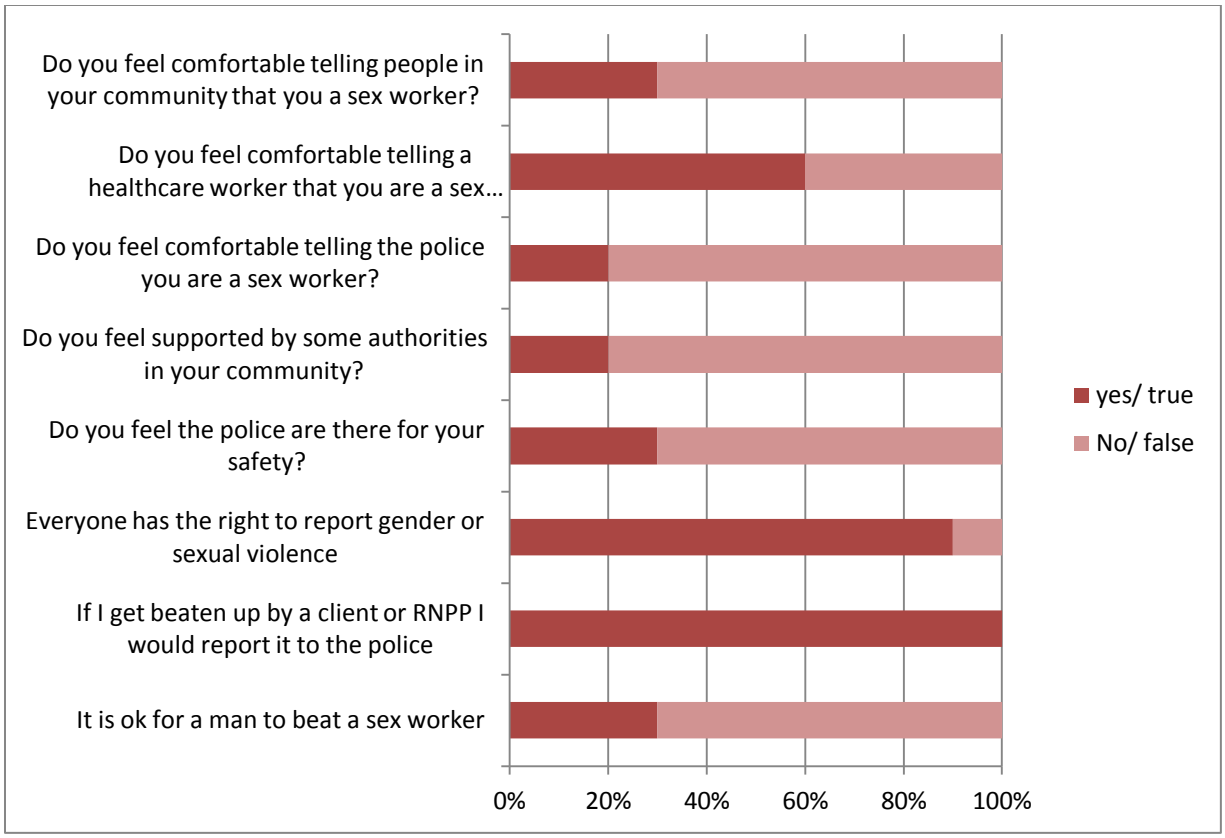
[5] Langat LC, Karanja G, Muraga R, 'Assessment of alcohol use among female sex workers in western Kenya,' 19th International AIDS Conference: Abstract no. WEPE293. Accessed 15 February 2013 at http://www.iasociety.org/Abstracts/A200744671.aspx.

[6] Chersich MF, Luchters S, I Ntaganira, A Gerbase, Y Lo, F Scorgie, and R Steen, 'Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services,' 2013. *Journal of the International AIDS Society* 16 (1): 17980, Table 4.

[7] Wechsberg WM, Luseno WK, Lam WK, 'Violence against substance-abusing South African sex workers: intersection with culture and HIV risk,' 2005. *AIDS Care*. 17 Suppl 1:S55-64

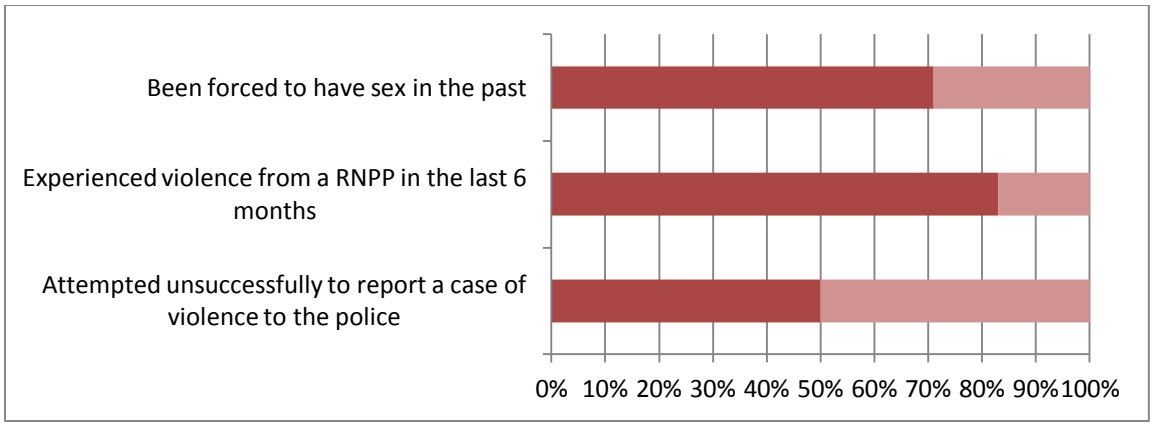
[8] Wendee M Wechsberg, Li-Tzy Wu, William A Zule, Charles D Parry, Felicia A Browne, Winnie K Luseno, Tracy Kline, and Amanda Gentry, 'Substance abuse, treatment needs and access among female sex workers and non-sex workers in Pretoria, South Africa', 2009. *Substance Abuse Treatment Prevention Policy*, 4: 11.

[9] '"I expect to be abused and I have fear": Sex workers' experiences of human rights violations and barriers to accessing healthcare in four African countries', April 2011. African Sex Worker Alliance, p.9; 51.



For the purposes of this report an expansive understanding of violence is employed which includes stigma and discrimination as forms of violence as well as sexual and physical violence. Violence in its multifarious forms exacerbates sexual and reproductive health risks, and the stigma, both perceived and enacted, associated with sex work is one of the most significant barriers to effective HIV/AIDS prevention.

The baseline survey results show low levels of trust and confidence among participants towards the police, authorities, healthcare workers and wider community as protectors and promoters of the health and wellbeing of SWs. Whilst 7 participants responded that it is not ok for a man to beat a SW, and all participants said that they would report it to the police if they were beaten by a client or RNPP, triangulation of these results with the findings of the situational analysis reveals a gap between participants' understanding of their rights to live free from violence and to report incidents of violence, and their lived experience of violence and impunity. The chart below details data gathered during an observational workshop which explored participants' experience of violence:



The discrepancy between the findings of the baseline survey and of the situational analysis may be attributed to the differing methodologies employed (structured questionnaire administered in face-to-face interview versus an observational workshop). The discrepancy also highlights the difference between measuring and assessing knowledge of violence and rights, on the one hand, and the experience of violence and rights, on the other; this triangulation indicates an important area of work for the TfaC programme.

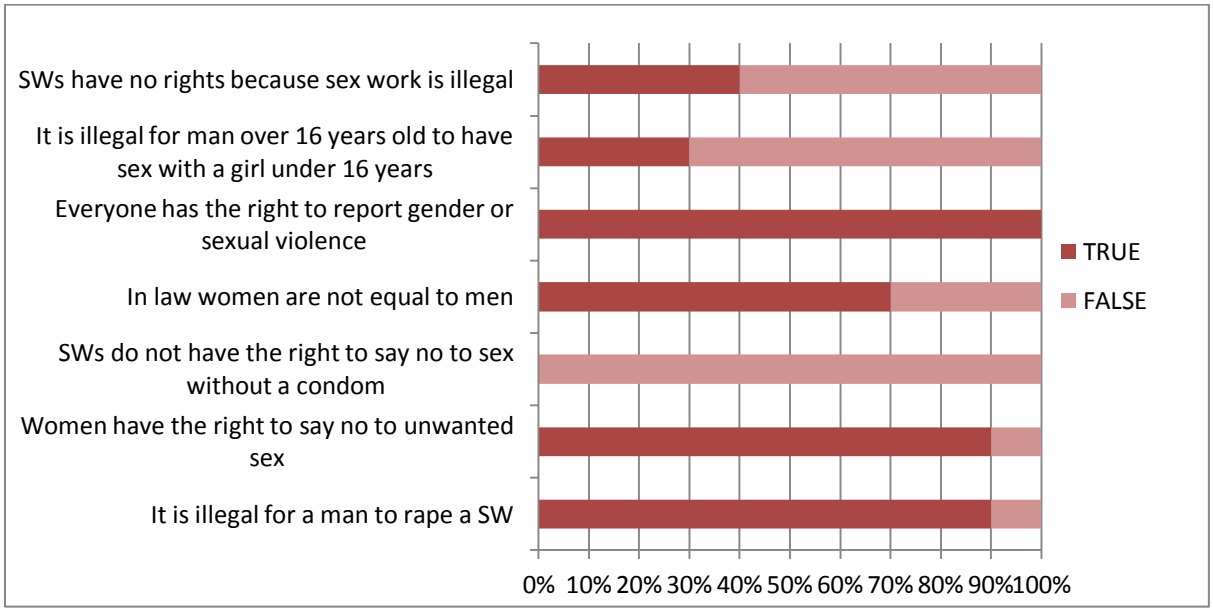
The baseline results indicated significant rates of felt stigma[10] among participants, with many demonstrating reluctance to make their work known to the police (8), healthcare providers (4), or members of the wider community (7). Results highlight the way in which that perceived stigma can prevent SWs accessing appropriate healthcare services, with 7 participants responding negatively to the question, 'Do you feel comfortable telling a healthcare worker that you are a sex worker?' There was also one positive response to the statement 'If you get tested for HIV, everyone will find out your status'. These results indicate distrust of healthcare workers and fear that stigma and discrimination will be augmented by accessing SRH services, findings which are corroborated by those of the situational analysis. A mapping exercise for the situational analysis revealed that 67% of participants would prefer to use alternatives to the hospital or health clinic if they felt unwell (50% said that they would go to a pharmacy or drug store; 17% said they would go to a local herbalist). The baseline survey focused on perceived stigma rather than enacted stigma, which is concerned with discriminatory treatment and practices. However, conversation during a workshop for the situational analysis revealed experiences of enacted stigma when some participants said that they had been discriminated against by healthcare staff. Widespread discriminatory treatment among healthcare providers is also attested to by numerous studies, such as a 2011 African Sex Workers Alliance report in which SWs from 4 countries spoke about

[10] Scambler and Paoli describe felt stigma as denoting '(1) an internalized sense of shame and blame, respectively, and (2) a frequently disruptive and sometimes disabling fear of being discriminated against.' in Scambler, G. & Paoli, F., 'Health Work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions', 2009. *Social Science & Medicine,* 66**:** 1824-1862.

selective and discriminatory treatment from healthcare providers[11]. Perceived and enacted stigma puts SWs at increased risk since individuals are less likely to access health services; healthcare workers are less likely to be able to give full assessments and appropriate treatment to patients without knowing the nature of their work; and individuals are less likely to receive prompt, appropriate and fair treatment.

4.5 Knowledge of the legal and rights framework

Participants' knowledge of the legal framework for sex work, sexual offences, gender-based violence and human rights was assessed by the baseline survey. Some questions specifically address the legality/illegality of behavior, whilst others questioned participants' knowledge of their rights, legal, natural or otherwise. The chart below illustrates the responses to statements regarding the legal and human rights framework.



The results show mixed levels of knowledge about the legal and human rights framework among participants. Only 3 participants correctly identified that it is illegal for a man over 16 years old to have sex with a girl under 16, suggesting poor knowledge about consent. Whilst all of the participants were over 16 years old, this may be of indicative of a lack of knowledge about child protection or issues of consent in general. The response of 7 participants that women are not equal to men in Ghanaian law

[11] African Sex Workers' Alliance, '"I expect to be abused and I have fear": Sex workers' experiences of human rights violations and barriers to accessing healthcare in four African countries,' April 2011, pp.51-52.

further demonstrates a lack of awareness of legislation[12]; when considered in the context of other results, it suggests an alienation from or distrust of the legal system.

4 participants agreed with the statement 'Sex workers have no rights because sex work is illegal'. The statement did not specify what was meant by 'rights', leaving it open for participants to consider a range of rights affecting their lives, such as the right to decent working conditions, the right to live free from violence, the right to protection from the law, and so on. The response of 4 participants that they have no rights due to the illegal status of their work must be considered in conjunction with other results which show high levels of awareness of rights. 9 participants identified as true the statements, 'Everyone has the right to report gender or sexual violence', 'Women have the right to say no to unwanted sex', and, 'It is illegal for a man to rape a sex worker'; all 10 participants disagreed that 'Women in sex work do not have the right to say no to sex without a condom'. These results demonstrate that the majority of the participants identified the right of both women in general and SWs in particular to choose when and with whom to have sex, to ensure that contraception is used, and to report violence. However, the perception of 6 participants that the illegal status of sex work in Ghana means that SWs have no rights brings into question to what extent participants feel able to exercise the rights they identified.

3 participants agreed with the statement, 'Women in sex work are worth less than other women'. This result reveals a low level of self-worth which is likely to have a significant effect on participants' abilities to exercise and fulfill their rights, and, ultimately, to promote and protect their safety and health.

5. Recommendations

Analysis of the baseline results has prompted the following recommendations for future programming of the Peace and Love Club project:

- TfaC Ghana would benefit from developing a definition of the term 'violence', and violence in its multifarious forms should be addressed in programming. Since violence can be difficult to identify at the outset of the project or to address directly, it should be under constant review and analysis. One strong point of the Peace and Love Club project is its recognition of the inextricable link between violence and increased sexual and reproductive health risk; this should be fully incorporated in programming.

- Whilst it received little attention in the baseline survey, triangulation of results with those from the situational analysis indicates that programming must include work on and/or with RNPPs.

- Results from the baseline survey highlighted low feelings of self-worth and a belief among 7 participants that women's inequality with men is established in law. Programming should

[12] Whilst the broader context of gender relations and rights in Ghana must be considered, and there are significant gaps in Ghanaian legislation (e.g. rape within marriage is not recognized as a crime), the law treats men and women equally.

include wider discussion about wellbeing and happiness in terms of participants' whole lives and not just one aspect of their lives.

- Triangulation of results from the baseline survey and situational analysis identifies a gap between participants' knowledge of rights and their experience of rights. For example, all participants knew that they are entitled to report an act of violence, but many expressed reluctance to do this and recalled unsuccessful past attempts. This gap highlights a lack of empowerment among participants and must be forefront in programming.

- Inclusion of education about the law relevant to SWs and legal mechanisms available could help to address the knowledge gaps revealed by the baseline results. Ignorance of law and legal entitlements can allow police and others to exploit this insecurity. Explication of legal rights versus human rights might also be relevant to programming. In order to inform education about the law and legal mechanisms TfaC may benefit from further work into how the current legal and policy framework affects the health and wellbeing of SWs in Ghana.

- The perception of 4 participants that they have no rights due to the illegal status of their work indicates a potential focus area for advocacy work. The links between the criminalization of sex work and increased risk of both HIV/AIDS and violence are well documented. Studies have consistently demonstrated that the criminalization of sex work decreases SWs' negotiating power, likelihood to report violence, ability to organize and likelihood of accessing healthcare. Criminalization of sex work increases stigmatization and discrimination and risk to HIV. For example, the US Department of State Ghana 2008 Human Rights Report cites research findings that 15% of police personnel who were involved in arrests of SWs in 2008 demanded sex in return for not turning those arrested over for prosecution[13].

6. Conclusion

Participants in the TfaC Ghana Peace and Love Club have mixed levels of knowledge about sexual and reproductive health, alcohol and nicotine use, legislation, rights and legal mechanisms available to them. Whilst participants demonstrated some awareness about the transmission of HIV through sexual encounters, knowledge about preventative measures and treatments was generally poor. Consistent with the situational analysis, the baseline survey found that belief in myths about the transmission of HIV/AIDS is widespread among participants. Results also reveal beliefs about alcohol consumption which could exacerbate the risk of SWs to HIV, STIs and violence.

The survey results show a gap between participants' knowledge of their rights to live life free from violence and to secure justice, and their actual experiences of violence and impunity. Stigma was found to be a significant factor in the lives of participants, and few expressed feeling supported by authorities,

[13] U.S. Department of State: Bureau of Democracy, Human Rights, and Labor, '2008 Human Rights Report: Ghana.' Accessed 15 February 2013, http://www.state.gov/j/drl/rls/hrrpt/2008/af/119004.htm

healthcare providers or the wider community. Low levels of self-worth among participants and the perception that they possess no rights due to the nature of their work constitute significant barriers to promoting and protecting SWs' safety, health and wellbeing.

The triangulation of results from the baseline survey and situational analysis highlighted the necessity of employing both qualitative and quantitative methods to understand and analyse both the knowledge and the experiences of participants. The limited number of participants represents a challenge for identifying patterns and trends; however, triangulation with the situational analysis and reference to related studies provided a context for this report and facilitated deeper analysis.

Appendix 1 – The Baseline Survey

Education

When the participants were asked about their educational background, 8 respondents said they had attended primary education, with 4 respondents dropping out before primary six. Of the 4 who completed primary education, 2 continued to Junior High level. However, 1 respondent dropped out before completion. None of the respondents attended post-secondary education.

Relationship Status

1 respondent identified as married; 7 respondents as in a relationship; 1 respondent as single; 1 respondent who was in a relationship said that she was cohabiting.

How many children do you have currently?

3 respondents said they had 1 child; 2 respondents said they had 2 children; 1 respondent said she had 3 children; 1 respondent said she had more than 3 children. 1 respondent said she was pregnant and finally 2 respondents had had no children at the time of the survey.

Statement 1.1 **A person can reduce their risk of getting HIV by using a condom every time they have sex**

In response to this question, 7 participants believed this statement to be true; 3 believed it to be false.

Statement 1.2 **A person can get HIV through witchcraft**

4 participants answered true and 6 said this statement was false.

Question 1.3 **All people who have HIV look sick**

5 respondents said true and the remaining 5 said this statement was false.

Statement 1.4 **You can get HIV from a mosquito bite**

5 participants answered that HIV can be contracted by a mosquito bite; the other 5 said this statement was false.

Statement 1.5 **The risk of HIV transmission can be reduced by having sex with only one uninfected partner**

All 10 respondents agreed that the chances of contracting HIV are decreased when you have sex with only one uninfected partner.

Statement 1.6 **Having a sexually transmitted infection increases your likelihood of getting infected by HIV**

8 participants identified this statement as true and the remaining 2 said this statement was false.

Statement 1.7 **If you get tested for HIV, everyone will find out your status**

9 participants said this statement was false and only 1 said this statement was true.

Statement 1.8 **Some medical drugs will prolong the life of a HIV positive person**

8 respondents agreed with this statement and 2 disagreed.

Statement 1.9 **You are safe if you cut your skin with a knife used by someone else who cut themselves**

2 participants said this statement was true and the remaining 8 said this statement was false.

Statement 2.0 **The risk of HIV increases if you have many sexual partners**

All 10 participants said this statement was true.

Statement 2.1 **Some medical drugs can prevent the transmission of HIV from mother to child**

2 participants said this statement was true and 8 believed it to be false.

Statement 2.2 **Smoking increases your chances of getting lung cancer**

9 participants said this statement was true and 1 believed it to be false.

Statement 2.3 **Drinking alcohol means you are less likely to get pregnant.**

7 participants said this statement was true; the remaining 3 said this statement was false.

Statement 2.4 **Alcohol improves sex**

6 respondents said this statement was true and the 4 said it was false.

Statement 2.5 **Smoking or drinking alcohol whilst you are pregnant does not affect your unborn child**

4 participants believed this statement to be true; 6 believed this statement to be false.

Statement 2.6 **HIV can be transmitted by talking about it**

9 participants responded that this statement was false; 1 participant said this statement was true.

Question 2.7 **Do you feel comfortable telling people in your community that you are a woman in sex work?**

3 participants responded ‘yes’, the remaining 7 said ‘no’.

Question 2.8 **Do you feel comfortable telling a health-care worker you are a sex worker?**

When this question was asked, 6 participants said yes and the remaining 4 said no.

Question 2.9 **Do you feel comfortable telling the police you are a woman in sex work?**

2 participants said ‘yes; and the remaining 8 said they would not feel comfortable telling the police they are a sex worker.

Question 3.0 **Do you feel supported by some authorities in your community?**

2 women said ‘yes’, the remaining 8 said ‘no’.

Question 3.1 **Do you feel the police are there for your safety?**

To this question, 3 respondents said ‘yes’ and 7 women said ‘no’.

Statement 3.2 **A man over 16 years having sex with a girl under 16 years is illegal**

7 participants correctly identified this statement as true; the remaining 3 said this statement was false.

Statement 3.3 **Everyone has the right to report gender or sexual violence**

9 participants said this statement was true and 1 said it was false.

Statement 3.4 **It is ok for a man to beat a woman who is a sex worker**

3 respondents agreed with this statement, 7 disagreed.

Statement 3.5 **Sex workers have no rights because sex work is illegal**

4 participants believed this statement to be true and 6 said this statement was false.

Statement 3.6 **Women have the right to say no to unwanted sex**

9 women said this statement was true and 1 said it was false.

Statement 3.7 **If I get beaten up by a client or boyfriend, I would report it to the police**

When this statement was asked, all 10 participants said this statement was true.

Statement 3.8 **It is illegal for a man to rape a woman in sex work**

9 participants identified this statement as true, with 1 answering that it was false.

Statement 3.9 **Women in sex work do not have the right to say no to sex without a condom**

All 10 participants said this statement was false.

Statement 4.0 **In law, women are not equal to men**

7 participants identified this statement as true, 3 as false

Statement 4.1 **Women in sex work are worth less than other women**

3 participants said this statement was true and 7 said this statement was false.

Bibliography

Adu-Oppong A, Grimes RM, Ross MW, Risser J, and Kessie G, 'Social and Behavioural Determinants of Consistent Condom Use Among Female Commercial Sex Workers in Ghana', 2007. AIDS Education and Prevention, 19(2), 160–172.

African Sex Worker Alliance, '"I expect to be abused and I have fear": Sex workers' experiences of human rights violations and barriers to accessing healthcare in four African countries', April 2011. African Sex Worker Alliance.

Chersich MF, Luchters S, Ntaganira I, Gerbase A, Lo Y-R, Scorgie F, and Steen R, 'Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services', 2013. Journal of the International AIDS Society 16 (1): 17980.

Cote AM, Sobela F, Dzokoto A, Nzambi K, Asamoah-Adu C, Labbe AC, Masse B, Mensah J, Frost E, and Pepin J, 'Transactional sex is the driving force in the dynamics of HIV in Accra, Ghana'. 2004. *AIDS* 18: 917-925.

Langat LC, Karanja G, Muraga R, 'Assessment of alcohol use among female sex workers in western Kenya: 19th International AIDS Conference: Abstract no. WEPE293.' Accessed 15 February 2013, http://www.iasociety.org/Abstracts/A200744671.aspx

Lorraway N, 'Situational Analysis of the Lives of Female Sex Workers from Old Fadama, Accra, Ghana', December 2012. Theatre for a Change.

U.S. Department of State: Bureau of Democracy, Human Rights, and Labor, '2008 Human Rights Report: Ghana.' Accessed 15 February 2013, http://www.state.gov/j/drl/rls/hrrpt/2008/af/119004.htm

Walden VM, Mwangulube K, and Makhumula-Nkhoma P, 'Measuring the impact of behaviour change intervention for commercial sex workers and their potential clients in Malawi,' 1999. Health Education Research, 14, 545-554.

Wechsberg WM, Luseno WK, Lam WK, 'Violence against substance-abusing South African sex workers: intersection with culture and HIV risk,' 2005. AIDS Care, 17 Suppl 1:S55-64

Wechsberg WM, Wu L-T, Zule WA, Parry CD, Browne FA, Luseno WK, Kline T, and Gentry A, 'Substance abuse, treatment needs and access among female sex workers and non-sex workers in Pretoria', 2009. South Africa Substance Abuse Treatment and Prevention Policy 4: 11.