Sex Workers' Network, Accra, Baseline Report

October 2016

A Theatre for a Change New Partnerships Project

Contents

Background

Theatre for a Change has been working with female sex workers from the Old Fadama Community in Accra, Ghana since 2012. In August 2015, based on the experience gained and through listening to the women, Theatre for a Change, in collaboration with Ghanaian facilitators, launched Ghana's first Sex Workers' Network. The Network brought together 20 women over a period of nine months in regular workshops focusing on sexual and reproductive health and rights (SRHR) and economic empowerment. The Network was led by a Project Officer and six facilitators, all of whom had previously taken part in Theatre for a Change activities in Old Fadama. In May 2016 the project carried out a pilot to assess the impact of the pilot year. Full results can be found here: http://www.tfacafrica.com/what-we-do/ghana/

Year one participants continue to be engaged through the Network through monthly saving group meetings. Participants are also invited to take part in the interactive theatre advocacy group, and in all HIV and medical testing and check-ups.

Over the summer 2016 the project team reflected with the participants on the progress made and the learning informed the focus and structure of work for the second year of the Network. This in turn has informed the scope of the baseline study.

Context

The project is focused on two geographical areas, Old Fadama and Jamestown. Old Fadama is an unofficial settlement in the heart of Accra. It is home to approximately 60,000 residents. Many of the residents originate from the North of Ghana and have come to the city to seek work. The slum is at the heart of political debate, and over the years has been subject to regular state sponsored demolitions. As a result of fire, flooding and a demolition process in 2015 many of our project participants are living in tents. There are few formal health, legal or educational services within Old Fadama. There is a small Police force, with whom the Network has a relationship. Within Old Fadama the project focuses on an area called Railways due to its high density of brothels. Jamestown is one of Accra's oldest neighbourhoods and is close to the Old Fadama slum. It is primarily a fishing community, and its high density of population has resulted in poor quality housing. Jamestown has several health clinics and schools; it also has a large Police station.

Sexual and reproductive health

The HIV prevalence rate among female sex workers in Ghana was 11.1% in 2011, much higher than the national HIV prevalence rate of 1.3% in 2013. Greater Accra presents the highest rate of prevalence (Ghana AIDS Commission). Female sex workers are identified in Ghana's National Strategy for HIV Prevention as a key target for support.

The main risks to sexual and reproductive health for female sex workers are:

- Vulnerability to violence from their clients, non-paying partners and from community members. Most female sex workers feel unable to report violence and many do not seek the medical support of qualified medical professionals.
- Low use of condoms, particularly with their non-paying partners.
- Alcohol and drug use.

Many female sex workers have children. Older school aged children are often sent to live out of Accra with family members whilst younger children often remain with their mothers.

Sex work

Sex work in Ghana is illegal and punishable through fines and prison sentences. In recent years there have been a number of calls from the NGO sector and from sex workers to relook at the law regarding sex work, however there has been no concrete evidence that this is a policy the Government wishes to pursue.

Sex workers report experiencing stigma from their communities and from duty bearers, including the Police and health services.

What we want to achieve

Project goal: To have a safe space and support structure for female sex workers to protect their human rights and respect their dignity

Outcome 1: Female sex workers from Railways (Old Fadama) and Jamestown have a reduced risk of HIV, STDs, unsafe abortion and unsafe pregnancies

Output 1.1: By May 2017 20 new female sex workers in Railways and Jamestown have knowledge, attitudes and skills to improve their SRHR

Output 1.2: By May 2017 40 female sex workers in *Railways and Jamestown* and 6 core group members access appropriate health services

Outcome 2: In Railways and Jamestown there is reduced stigma around HIV and there is access to ARVs and free condoms

Output 2.1: By May 2017 all members of the Network have access to free or affordable condoms

Output 2.2: By May 2017 Community members in Railways and Jamestown have reduced stigma around HIV and support access to ARVs

Outcome 3: Female sex workers from Railways and Jamestown are part of village saving and loan (VSL) groups that are registered with Accra's VSL Cooperative

Output 3.1: By May 2017 20 new female sex workers in Railways and Jamestown are able to collectively save their money improving their self-esteem, independence and dignity.

Output 3.2: By May 2017 20 female sex workers are registered with the VSL Cooperative

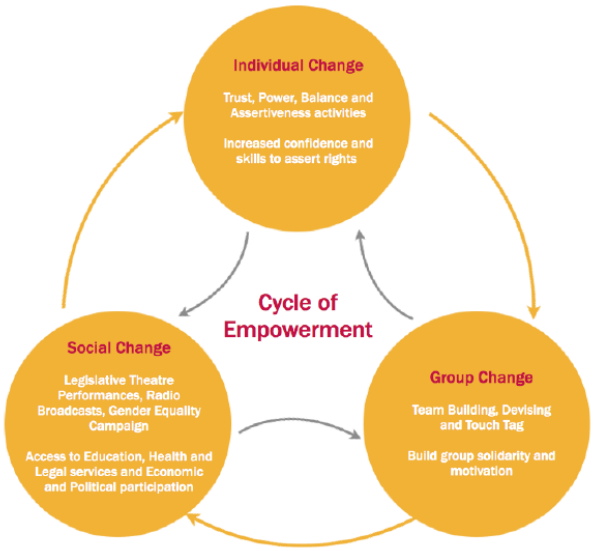
Outcome 4: The Network has increased capacity to be self-managed

Output 4.1: By August 2017 6 facilitators and 10 Network members can use Microsoft word and social media confidently

Output 4.2: By May 2017 6 core group members and 2 staff are trained to understand and implement Child Protection policies and procedures

Output 4.3: By May 2017 the Network is registered

The aim and the outcome of the project have been identified in collaboration with the project participants and they speak to our organisational theory of change, in which individual behavioural change is a necessary driver of group behavioural change, which in turn is a driver for social behavioural change. All three stages of change reinforce and strengthen each other.



The organisational Theory of Change

By aligning project outcomes to the theory of change, we are, from the outset concerned with developing a project that has greatest potential to achieve long lasting sustainable change for the most marginalised and vulnerable people who are at its heart.

The baseline

In order to check the assumptions of our outcomes and aim, and to understand the prioritisation and nuances of our activities, we devised a baseline that took place in September 2016 in the Jamestown Community Centre.

The baseline was facilitated by Project Officer, Susana Dartey and supported by six project facilitators and the newly appointed Project Assistant, Mariama Yussif.

The baseline was taken by 20 identified project participants. All participants were new to Theatre for a Change activities. All had been identified as potential participants between May and August 2016 and each participated in an interview with the Project Officer, ensuring they understand the aims and expectations of the Network and that their circumstances adhered to the project criteria (Annex 1).

All the participants were female and their ages ranged from 18-25. All participants self-identified as being engaged in transactional sex.

Two participants from the Railways group and six participants from the Jamestown group were identified as being literate. The baseline was conducted in English, Ga and Twi. Participants were not required to read or write during the baseline.

All baseline activities were active and participatory, using body and space, as well as voice to help us build a holistic understanding of the participants' needs.

The baseline will be repeated in June 2017 so that we will be able to assess the impact we have had.

The baseline results

1. Sexual and Reproductive Health and Rights knowledge, attitudes and practice

a) Knowledge and reported use of contraception

Approach

Facilitators led an open discussion with participants to elicit the different forms of contraceptives that they knew.

Participants then indicated the different contraceptive methods that they have used in the last month.

Results score card

Contraceptive method	**Number of participants who say they use this in the last month (Railways)**	**Number of participants who say they use this in the last month (Jamestown)**	**Total**
None	2	1	15%
Female condom	0	1	5%
Male condom	0	0	0%
Contraceptive implant	0	0	0%
Contraceptive injection	1	1	10%
Coil	0	0	0%
Contraceptive pill	2	4	30%
Diaphragm / Cap	0	0	0%
Natural family planning / calendar method	0	0	0%
Abstinence	0	0	0%
Female sterilisation	0	0	0%
Local preparation	3	0	15%
Emergency contraception	0	0	0%

Other	2	3	25%
TOTAL	10	10	100%

Summary of results:

Overall use of contraceptives is extremely poor, particularly bearing in mind the high risk of unintended pregnancy and contraction of HIV and STIs within a population who has sex with multiple partners on a regular basis.

Unlike the Network members in Year 1 of the project, these participants have very poor uptake of condoms with 0% using male condoms and 5% using the female condom in the last month. It would be useful to investigate why none of the women are using male condoms; has the context changed, for example are condoms now more expensive, or is this due to personal preference?

30% of the women are using the contraceptive pill. It is unsurprising that uptake it higher in the Jamestown group as they have more access to service provision. However, the pill, unlike other contraceptives, rely on participants taking it regularly and attending clinics regularly to receive new prescriptions, which may be challenging for this group.

15% of the women use natural preparation, a herbal solution, and 25% of the women use other methods. These include “drinking of water after sex to push out the sperm”.

Participants in the baseline also expressed their belief that contraception was needed for family planning, “to stop pregnancy”, none referred to the need to use contraception to prevent HIV or STIs.

Implications for practice:

There is clear need for improved knowledge, attitudes and skills around contraception.

It is important that the participants understand the potential health benefits and risks of different forms of contraception that are available to them. It is important to emphasise the role of condoms in preventing HIV and STIs.

The facilitation team need to further investigate why participants are not using condoms; is the barrier financial, due to accessibility, related to self-esteem, ability to negotiate condom use etc. This understanding is crucial in order to develop suitable workshops.

It is important to investigate the current skills of the participants in using contraception. This includes details of storing and taking pills, and putting on condoms. It is important to ensure participants have the skills to ensure their sexual partners also use contraception.

It is vital that the facilitators help participants explore the myths around contraception, particularly in relation to alcohol and herbal preparation, which could have a severe detrimental impact on their health.

b) Knowledge of SRH and Sexual and Gender Rights

Knowledge of individual SRH and sexual and gender rights was explored through two activities.

Approach

The participants formed a circle with their backs to each other. They were asked to close their eyes. The facilitator read out a statement and participants were asked to step forwards if they believed the statement to be true.

Results score card

Statements	**Number of participants who think this is true (Railways)**	**Number of participants who think this is false (Railways)**	**Number of participants who think this is true (Jamestown)**	**Number of participants who think this is false (Jamestown)**	**Total of correct score**
A person can get HIV through witchcraft. CORRECT ANSWER IS FALSE	2	**8**	8	**2**	50%
All people who have HIV look sick. CORRECT ANSWER IS FALSE	8	**2**	6	**4**	30%
If you don't take drugs then HIV can kill you. CORRECT ANSWER IS TRUE	**4**	6	**8**	2	60%
Some medical drugs can prevent the	**7**	3	**4**	6	55%

transmission of HIV from mother to child. CORRECT ANSWER IS TRUE					
Condoms prevent you from getting HIV and STIs. CORRECT ANSWER IS TRUE	**8**	2	**8**	2	80%
Some STIs mean you will never be able to have children. CORRECT ANSWER IS TRUE	**7**	3	**3**	7	50%
If you wash after sex you won't get HIV or STIs. CORRECT ANSWER IS FALSE	6	**4**	6	**4**	40%
Women in sex work have fewer rights than other women. CORRECT ANSWER IS FALSE	6	**4**	4	**6**	50%
If a client beats you then you have the right to report it to the police. CORRECT ANSWER IS TRUE	**7**	3	**8**	2	75%
You should always use a condom with a client. CORRECT ANSWER IS TRUE	**5**	5	**8**	2	65%
You should always use a condom with a boyfriend. CORRECT ANSWER IS TRUE	**1**	9	**1**	9	10%

Please note, correct answers are highlighted in bold

Summary of results

Knowledge of HIV and STIs is patchy, and often poor. The greatest correct knowledge is around condom use with 80% of women identifying that condom use can prevent HIV and STIs. However, there is a clear gap between knowledge and behaviours with no women having used male condoms in the last month and only 65% and 10% believing that you should always use condoms with clients and boyfriends. We see again the myth around washing after sex preventing infection and in the Jamestown group a strong connection between HIV and witchcraft.

In this baseline we introduced some new questions focusing on women's rights. 50% of participants believe that women in sex work have fewer rights than other women. 75% believe they have the right to report abuse to the Police. Further investigation is needed to understand whether this knowledge translates into behaviours.

Implications for practice:

There is a clear need to improve knowledge around transmission, focusing on the ways HIV and STIs are contracted and confronting the myth around witchcraft.

There is also a need for further information about the symptoms and effects of HIV and STIs, including the potential impact on fertility.

There is need for improved knowledge about the efficacy of drugs for HIV and STIs. This needs to be delivered within a contextual understanding of the availability of different drugs for the participant group.

There is a clear need to root the workshops within a rights based approach to health and gender, ensuring that participants feel supported by a wider framework of rights; and gradually start to develop the skills they need to be more confident at asserting their own individual and group rights. As part of this work it is clear to support participants to understand that the legal status of sex work does not denigrate their own rights to health and protection.

Approach

Participants were asked to find a quiet space in the room and handed four slips of paper. The facilitator asked them four questions and for each they indicated whether their answer was 'Yes' or 'No'. Participants then folded their slips of paper and handed them in. The exercise was devised to prevent unwanted disclosure and maintain privacy.

Results score card

Question number	Yes (Railways)	No (Railways)	Yes (Jamestown)	No (Jamestown)
1 Have you taken an HIV test in the last six months?	2	8	2	8
2 Have you taken an STI test in the last six months?	1	9	0	10
3 Would you tell someone if you were HIV positive?	7	3	2	8
4 Have you ever had an abortion?	4	6	6	4

Summary of results

These results were given privately by each participant. However these are sensitive topics and not all participants may have felt comfortable in revealing the truth.

20% of participants have taken an HIV test within the last six months, and only 5% of participants have taken an STI test. 5 participants said that they had taken an HIV test but had not waiting for the results, citing length of time, fear, and embarrassment at being at the testing clinic, as reasons for not staying.

Surprisingly bearing in mind that stigma around HIV is common, 9 participants (45%) said they would tell someone if they were HIV positive. There was a clear discrepancy in attitude between the group from Railways and the group from Jamestown, suggesting there may be a difference, or a perceived difference in stigma in these geographical areas. However, whilst higher than expected it is still important to note that 55% would not disclose a positive status.

50% of the women have had an abortion.

Implications for practice

HIV and STI testing are known as key drivers of reduced risk behaviours. As such they are an important step to take with a participant group vulnerable to infection. The results show that levels of fear around disclosure remain, and whilst the results show the fear of disclosure is not preventing testing for all, it may impact on participants seeking regular testing and from finding out their results. Fear of disclosure from participants may also put

the sexual partners of the participants at greater risk of HIV. As such the workshops need to focus on mitigating fear of testing and results and explaining in detail the positive health and personal outcomes of being tested.

It is clear that it is preferable to support participants to take HIV tests within a private clinical setting where they are able to access good quality HIV counselling. It may well be that participants within the project will gain support from each other to attend testing, and in this case we should use and encourage this group solidarity. However, we should make sure that participants are afforded privacy and are not expected to test in the vicinity of community members who are not part of the project, unless of course they specifically wish to. We should also ensure that the person conducting the test is a qualified professional who the participants feel comfortable with. It may be that participants feel more comfortable with a nurse / tester who is from a different community to their own in order to further safeguard their privacy.

Abortion was not a focus of the project in 2015, but during the year it became apparent that it was a subject that needed attention. In order to check this assumption we included this as a question in this baseline and with 50% of participants having had an abortion, it is clear that this is an area of the women's SRH that needs support. As this is a new area for us, it is important that all project facilitators have a good understanding of the physical, emotional and legal implications of having an abortion in Ghana, and are able to offer appropriate guidance and support. In addition the project must map a range of quality service providers, including counselling, that they can confidently recommend.

c) Attitudes to abortion

Approach

The facilitator brought the participants together in a circle and explained she wanted them to share their advice about a difficult situation. She asked them to imagine that their friend, who is also a female sex worker, has come to them and she is pregnant. The friend thinks the baby is from a client, not her boyfriend and she wants an abortion. The facilitator asked the participants to share the advice they would give to their friend. Whilst she facilitated the discussion, project facilitators noted down the different responses.

Summary of results

Railways group: Participants were confident and keen to give advice. Several participants said they would encourage their friend to go to the clinic for the abortion, although when probed none were able to name a clinic that she could attend. It was suggested that the friend could collects money from the clients to pay for an abortion. It was also suggested

that she discuss the pregnancy with the boyfriend or with a client she likes to avoid an abortion. One participant raised the danger of abortion, saying it was life threatening to the mother.

Jamestown group: Participants were confident and keen to give advice. Several participants advised their friend to go to the hospital, although again there was a lack of knowledge about which hospital they would recommend she visit. It was also suggested that the friend could tell her boyfriend that it was his baby, and there was another suggestion that she should give birth.

Implications for practice

Despite 50% of the participants saying they have had an abortion, none were able to name an official health service which they would recommend, suggesting that their abortions may have taken place in unlicensed environments. A clear recommendation from this would be to ensure participants know where to go to have safe abortions, and the law regarding abortion in Ghana.

It is however, reassuring to note that the strongest advice from both groups was for the 'friend' to go to a clinic or a hospital, suggesting there is recognition that an official health care service is the safest place to have for an abortion.

Participants engaged well with this exercise and felt confident about talking about their own experiences, as well as suggesting advice. This gives the Network an opportunity to talk further to the women about the subject. However, it is necessary to further explore the likely gap between advice and actual behaviours.

2. Community status

Approach

The facilitator asked six participants to volunteer and give them each one of the following roles:

1. Nurse
2. Female sex worker
3. Boyfriend
4. Police man
5. Chief / community leader
6. Child

She then asked the other four participants to order them in line with the most important person standing at one end of the line and the least important at the other end.

Results score card

Participant role	Place in line (0 – least important, 5 – most important) (Railways)	Place in line (0 – least important, 5 – most important) (Jamestown)
Nurse	3	5
Female sex worker	2	1
Boyfriend	1	2
Police man	4	3
Chief / community leader	5	4
Child	0	0

Summary of results

In both groups the child was regarded as the least important person in the community, with female sex worker and boyfriend next. In Railways, the participants regarded the female sex worker as being more important than the boyfriend, whereas in Jamestown it was the other way around. The Railways group regarded the Chief as the most important person, whereas the Jamestown group believed the Nurse was the most important community member.

Implications for practice

The power dynamic between a female sex worker and her boyfriend plays an important role in the health and happiness of each, so this exercise could be further interrogated in the workshops to better understand the participants' own experience with their boyfriends and develop an awareness of healthy and unhealthy power relationships.

It is interesting that the Nurse held such a high status for one group. This potentially could prove to be an advantage, as it suggests the group may listen carefully to the advice given by a Nurse; on the other hand, this status could be alienating and prevent participants from seeking health care support. It is important that we take both possibilities into account as we consider how to enable participants to access health care during the project. This finding

should be followed up further to increase understanding through semi-structured interviews.

3. Savings ability and practice

a) Current and desired spending habits

Approach

The facilitator laid out sheets of paper with different items that participants could spend their money on. Participants were then asked to stand on the item which they currently spend the majority of their money on; this number was recorded. Participants were then asked to stand on the items which they would like to spend the majority of their money on; this number was recorded.

Results score card

Item	**Number of participants who stand on it in 1st exercise (current situation) (Railways)**	**Number of participants who stand on it in 2nd exercise (desired situation) (Railways)**	**Number of participants who stand on it in 1st exercise (current situation) (Jamestown)**	**Number of participants who stand on it in 2nd exercise (desired situation) (Jamestown)**
Rent	2	1	0	0
Clothes	2	0	2	0
Hair	1	0	1	0
Food	2	1	2	0
Savings	0	5	0	5
Items to sell	0	2	1	2
Business	0	0	0	0
Medicine	2	1	1	1

School fees	1	0	1	2
Money to give someone else	0	0	0	0
Money for police	0	0	2	0
TOTAL	10	10	10	10

Summary of results

Currently participants spend the highest proportion of their money on clothes and food, followed by medicine. It would be interesting to learn more about medical costs and what these entail. An important revelation is that two participants spent money on the police last week. This is likely to have been payment to resist arrest or to pay fines, a common occurrence for women working in sex work. Unlike in the year 1 baseline rent was not the biggest expense. This is likely due to many participants saying they do not currently pay rent due to staying with friends, or staying in informal accommodation and tents. It would be interesting to learn more about the safety of these options for participants.

Participants would overwhelmingly like to save their money, with 50% saying this is their highest priority. In addition participants from the Railways group told the baseline facilitators that "learning to save" was their biggest motivator to joining the Network. Four participants would like to spend their money on items to sell.

Implications for practice

The participants desire to save bodes well for our project. It may be that this desire was biased by their expectations of the project. It is important that we continue to be transparent about the savings group system, so that participants have a realistic expectation of how the savings group model works and the levels of savings and loans that might be achieved.

It is important for us to understand more about the reasons why participants are paying money to police, and examine the legality of this. Past experience working in Old Fadama has revealed that participants are often pressured to pay money to police. We need to ensure that participants are aware of their rights and know who to turn to if their rights are abused.

It would be useful to discover more about medical costs and consider whether we could support participants to access Ghana Health Insurance cards to alleviate this burden, as well as better ensure the quality of the medication they are accessing. As we further explore behaviours around condom use, it will be important to determine how much cost influences this behaviour as reflect on the Network's role in ensuring contraception, and in particular, condoms, are affordable.

b) Current savings practice

Approach

Participants were asked to stand along a measuring line, created on the floor, to show how much money they saved in the last week.

Results score card

Amount saved last week	**Number of participants (Railways)**	**Number of participants (Jamestown)**	**Total**
0 – 20 cedis	2	0	10%
20 – 40 cedis	2	6	40%
40 – 60 cedis	0	0	0%
60 – 80 cedis	0	0	0%
80 – 100 cedis	0	0	0%
More than 100 cedis	0	0	0%
Other	6	4	50%
Don't wish to take part	0	0	0%

Summary of results

50% of participants were able to save between 0 and 40 cedis (£0 and £7.5). 50% of the participants said 'other', and all stated this is because they are not able to save at all. It

appears that the Jamestown participants are able to save more than the Railways participants.

It is important to consider whether participants were honest in their disclosure of their savings as this is potentially a very personal subject. However, the baseline facilitator reported that participants seemed comfortable taking part in this activity and she believed were responding honestly.

Implications for practice

This information should be used to establish the cost per share of the savings group, and the differentiation of the groups, suggests that it would be worth investigating a different share price for each group. With 50% of participants not currently saving it is likely that the saving groups will need increased facilitator support, as we are asking participants to make a clear behavioural change. It is also worth noting that some participants may not be in the financial position to be able to save, in which case we need to ensure they are supported on a case by case basis so they do not feel excluded from the project.

Conclusion

The baseline has helped establish clear vulnerabilities of participants. There is a lack of knowledge and healthy behaviours around key sexual and reproductive health areas and participants are at high risk of damaging their own health and the health of their clients and boyfriends. The lack of condom use from both groups is particularly concerning, as is the high number of participants who have had an abortion.

Currently, participants struggle to save money, limiting their ability to make informed financial choices and to have increased financial independence.

However, there are also opportunities here. Participants from the Jamestown group asked that “they learn more about the female body and the changes it goes through,” providing a clear opening for discussion around the body and health in the Network. Some participants are accessing contraception, and their experience can be shared with their peers. Participants in the Railways groups saw themselves as more important than their boyfriends, which shows a level of confidence which can be encouraged, and an opportunity for further exploration about these key power dynamics. Participants are keen to save, and some are already achieving this; again we can harness this experience and use it to encourage peer to peer learning and support.

The introduction of questions regarding rights has further highlighted an important learning point that emerged during the pilot; namely the importance to ensure the Network activities are rooted within a rights based approach. All Network activities should be

underpinned by the central tenet that participants have rights, and that their profession does not negate these rights. It is also clear that the Network needs to play a strong role in advocating for attitudinal change at a community level, and systemic change at a district and national level to ensure these rights are upheld by key power holders. It is vital that project staff, and facilitators, are able to confidently negotiate between the challenges of dealing with the legal framework regarding sex work and abortion, whilst still endorsing the protection of the fundamental rights of the Network participants.

Finally it is worth noting that all participants took a full and active part in the baseline. This shows a commendable level of engagement with the project approach, and most importantly, it displays the commitment of the participants to address the challenges they face in their lives.

Thank you to all the participants, facilitators and Susana Dartey for conducting this baseline

Annex 1 – Selection Criteria

- Participants must self-identify as female sex worker (main income source)
- Participants must be a seaters rather than roamers. Seaters are women working from their home / brothel. Roamers are women working from the streets / bars. HIV prevalence in Accra is considerably higher in seaters rather than roamers. A 2011 study by the IOM recorded HIV prevalence of 6.6% among roamers and 21.4% among seaters.[1] This prevalence ratio was also found in a study that took place in 2001.[2]
- Participants must be between the ages of 18-25 years.
- Participants must have been living within the community of Railways or Jamestown for at least 6 months.
- Participants must be able to give us their name, date of birth, phone number and address.
- Participants must show a high level of interest in the project and express a strong desire to take part.

[1] http://www.iom.int/news/hiv-vulnerability-among-female-sex-workers-ghana-iom-study
[2] http://www.ncbi.nlm.nih.gov/pubmed/11707673