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TITLE: *The Condom Conundrum: Barriers to Condom Use Among Commercial Sex Workers in Durban, South Africa*

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INTRODUCTION

This paper examines the dynamics of condom use among female commercial sex workers (CSWs) in Durban, a large coastal city in KwaZulu-Natal province. Our objectives were to explore the socio-behavioral determinants of condom use between CSWs and their partners, both in professional sexual relations with clients and in personal relationships with domestic partners. We also sought to examine the extent to which HIV/AIDS influences CSWs' condom use in these situations.

Reported here are the results from in-depth interviews with two groups of young black African CSWs. Our data illustrate the pivotal influence socio-cultural, conceptual, ideological, and economic factors have on condom use. These results also reinforce the necessity of considering such elements in the design - and ultimate success - of HIV intervention programs.

THE STATE OF HIV/AIDS IN SUB-SAHARAN AFRICA

Worldwide, an estimated 21.8 million individuals are currently living with HIV/AIDS[1]. The vast majority live in sub-Saharan Africa. HIV/AIDS figures for the region illustrate the situation in grim detail. By mid-1996, this region contained 63% (13.3 million individuals) of the total number of adult cases of HIV infection. Recent estimates suggest that 5.1% of sub-Saharan Africa's population is HIV positive. Moreover, the epidemic has not affected all members of the population equally; women account for more than half of all infected adults in Africa [1].

In recent years, South Africa has witnessed a dramatic increase in HIV infection rates. Between 1990 and 1995, the country's seroprevalence rate rose from 0.76% to 10.4% [2, 3]. In KwaZulu-Natal province, where this study was undertaken, the rate of increase is cause for even

greater concern. During the same period, provincial seroprevalence rates underwent an eleven-fold increase, from 1.6% to 18.2% [2, 3]. This most recent (1995) provincial figure (18.2% seropositivity) reflects a 27% increase over the previous year's figures (14.4 in 1994) [4]. Presently, KwaZulu-Natal has the highest (and rapidly increasing) prevalence of HIV infection in South Africa.

THE COMMERCIAL SEX INDUSTRY AND HIV/AIDS

The commercial sex industry has long been associated with disease. In the early 20th century, U.S. social reformers and physicians attributed the spread of sexually transmitted diseases (STDs) almost solely to prostitution, and prostitutes[1] were commonly known as "plague spots" [5, p.31]. The evidence used to support such claims was the high prevalence of STDs among women arrested for soliciting male clients. In addition to physical afflictions, prostitution was frequently associated with mental and social afflictions. In 1911, the Vice Commission of Chicago published a report describing prostitution as "a disease scattering misery...leaving in its wake sterility, insanity, paralysis, blinded eyes of babes, the twisted limbs of deformed children, degradation, physical rot, and mental decay" [5, p.32]. Moreover, it appears that many of prostitution's negative associations have persisted well into the present [5-12].

In medical and epidemiological research, CSWs are frequently targeted as a "high risk group" for STD and HIV acquisition and transmission. The picture portrayed is that of members of the commercial sex industry posing a significant public health threat through their professional (high risk) sexual behavior. This threatening image is enhanced by the frequency with which CSWs are referred to either as a "reservoir" of infection or as a potential "bridge of infectivity" for STDs and HIV/AIDS [6, 8, 11, 13-17].

What exactly is the general population's risk of HIV infection from the commercial sex industry? Two patterns of HIV infection among CSWs seem prevalent. In the developed world (North America, Europe, and parts of Latin America), studies have revealed low HIV seropositivity (<10%) among non-drug injecting CSWs [14, 15, 18-20]. This is consistent with the so-called Pattern I transmission of HIV/AIDS in which male homosexuals, intravenous drug users (IVDUs) and their sex partners are those most affected [21]. With Pattern I there is generally a low (though increasing) female to male seropositivity ratio, and relatively few cases of vertical transmission of HIV.

In contrast, CSWs in developing countries such as those in sub-Saharan Africa, the

[1] The terms "prostitute" and "prostitution" are used here for historical review purposes only.

Caribbean, and, most recently, Asia have demonstrated extremely high seroprevalence (>25%) [6, 20, 22-24]. These rates occur among CSWs who are *not* IVDUs and where intravenous drug use is uncommon in the general population. Such a profile conforms to Pattern II HIV/AIDS, characterized by heterosexual transmission, nearly equal sex ratio of infection (or slightly higher female to male ratio), and high frequency of pediatric HIV/AIDS [2].

African sex workers have received considerable attention in connection with the HIV/AIDS epidemic. Many researchers emphasize the increased risk of HIV acquisition and transmission specifically among African CSWs, their clients, and others in their sexual networks [10, 19, 24, 25-29].[2] There appears to be a certain amount of justification for such claims. Studies with African CSWs have revealed some of the highest recorded seroprevalence rates anywhere in the world [23, 26, 33].

Regardless of such research findings, interpretation of variation in HIV patterns among CSWs must be undertaken cautiously. Lower seroprevalence rates in some areas may reflect the later introduction of HIV, not necessarily decreased risk for it [20]. In addition, many seroprevalence studies among CSWs are clinic-based, making them unlikely to be representative of the commercial sex industry as a whole. Plant cites research findings from work with European and Indian CSWs which defy expected trends, and question the strength of geographically based associations between intravenous drug use and HIV [6, p.11]. Moreover, Gillies and Parker [34, p.258] point out that HIV seroprevalence among non-drug injecting female CSWs is consistently higher than among childbearing women in the general population in *both* Pattern I and Pattern II areas. At the very least, this finding suggests that the link between HIV and commercial sex work must be explored more carefully among CSWs in Pattern I regions and who are not non-intravenous drug users.

Despite - and in some cases due to - variation in HIV seroprevalence patterns, there is ample reason for examining sexual behavior and sexuality-related issues among members of the commercial sex industry [14]. By definition, CSWs have multiple sex partners who may themselves have many partners. Commercial sex often takes place under risky circumstances (anally, without protection, in the presence of genital lesions, without access to adequate health care). Finally, it is well-known that the most common mode of HIV transmission is through

[2] The differences between Pattern I and II transmission have been attributed to various factors including lack of access to medical care and subsequent increased prevalence of untreated STDs in developing countries, population-specific biological differences, differences in virus sub-types, extreme poverty and poor material conditions, and African cultural patterns which emphasize fertility and sanction multiple sex partners [20-21, 24, 30-32].

sexual intercourse, responsible for 86% of HIV infections. The majority of these infections (71%) are through heterosexual relations [35].

Africa in particular appears to merit close attention in exploring the link between commercial sex work and HIV/AIDS. Not only does the continent bear the majority of HIV/AIDS cases worldwide, but its commercial sex industry appears to be strongly associated with HIV infection. In the South African context, KwaZulu-Natal has a potentially similar profile, with its skyrocketing HIV seroprevalence rates. Although prostitution is illegal in South Africa[3], those providing commercial sex services have by various means succeeded in circumventing the law, and a thriving industry exists throughout the country. For CSWs on the streets of Durban, extortion, incarceration, rape and other forms of violence from police is a daily threat. Most women in this study had been arrested or experienced violence from local law enforcement officers at some point during their working lives. However, such repercussions appear to provide little long-term deterrent for CSWs, who view it as a job hazzard. Thus, focus upon HIV/AIDS-related issues in Durban's commercial sex industry is certainly timely and necessary.

CONDOM USE PATTERNS AND CHANGING SEXUAL BEHAVIOR

With no cure on the horizon and ineffective therapeutic measures available against HIV/AIDS, emphasis on changing sexual behavior is one of the few potentially viable intervention options [36-38]. A major focus of many intervention efforts - both in the commercial sex industry and the general populace - has been promotion of condom use as an effective means of protection against HIV infection. Within the commercial sex industry, however, condom use is a complex issue, dictated by multiple - and often conflicting - factors.

The frequency of condom use among CSWs varies considerably, and appears to follow a largely geographically based pattern.[4] Recent research has revealed the highest condom use rates are among CSWs in European countries and the United States [6, 20, 23]. Studies in Scotland [10, 11], England [17, 39], Germany [40], the Netherlands [41], Greece [42], Italy [19] and the

[3] Presently, escort agencies and massage parlours are the only sector of the commercial sex industry operating legally in South Africa. These are classified as "entertainment facilities" and require the same permit as movie houses, theaters or night clubs. They are subject to periodic visits from health inspectors, and until recently could be raided without warrant by police if covert activities were suspected. Owners of such facilities rarely admit to supplying sex services on the premises, and claim that they have no control over employees during house calls or dates with clients.

[4] Research by Estebanez et al. [20, p.404], Campbell [28], and Jackson et al. [15] suggests CSWs' condom use with clients is positively related to the legalization or public toleration of commercial sex work.

United States [28, 43] have confirmed this trend.[5][6] Financial gain (particularly among those CSWs using drugs), client refusal and avoidance of physical abuse from clients appear to be the primary reasons for waiving condom use [10-11, 20, 39] .

By comparison, frequency of condom use between CSWs and their clients in developing countries is generally much lower[7]. Most studies from African countries reveal low condom use rates between sex workers and their partners. Abdool Karim et al. [24] discovered condom use to be a rarity among South African sex workers. Working with CSWs in Kinshasa, Zaire, Mann et al. [26] found that 2% of women reported "frequent" use of condoms with clients. Fischbacher and Njeru [46] reported a 23% use rate among CSWs in an intervention study in Kenya.

Wilson et al. [29] recorded low condom use rates among sex workers in Bulawayo. In another study among CSWs in Harare, they found just over half of the CSWs in the study reported consistent condom use with clients [27]. Finally, Pickering et al. [22] found varying condom use rates among Gambian CSWs (53%-80%). Primary reasons for CSWs engaging in unprotected sex with clients included limited access to condoms, financial incentive, clients' objections and physical abuse, and low self-perceived risk for HIV infection [22, 24, 27, 29, 46-47].

Patterns of condom use between CSWs and their personal partners appear far more uniform than in commercial sex situations. Those studies which have addressed this aspect of sex workers' sexual behavior have found a nearly universal avoidance of condoms [8, 10, 15, 19, 23, 28, 34, 39, 48]. The primary obstacles to condom use in personal sex situations appear to be perceived violation of trust and intimacy connected with requesting condom use, and sex workers' need to disassociate themselves with professional (i.e. protected) sexual behavior. Among African sex workers, little research has focused upon issues related to personal sex situations. Instead, available studies focus almost exclusively on CSWs' professional sexual behavior.

Intervention efforts frequently rely on education and heightened HIV/AIDS awareness as a means of effecting behavioral change among CSWs and their partners. The assumption

[5] See Gillies & Parker [34] for exceptions to this pattern in demonstrating high condom use rates among sex workers in Brazil and the Dominican Republic.

[6] Due to variations in methodology and reliability, comparison of reported use rates is problematic. However, nearly all the European and U.S. studies cited here reported use rates of 80% or higher. Note also that some studies have demonstrated questionable reliability of self-reported condom use, with sex workers over-reporting and clients under-reporting frequency of use [22-23, 27]

[7] See findings from research in India [44], Nicaragua [45], and Indonesia [16].

underlying such approaches appears to be that provision of information about HIV/AIDS and its consequences is sufficient in order for individuals to make informed, rational, and ultimately safe choices regarding their sexual behavior. Several studies cited here undertook surveys to establish a baseline of HIV/AIDS knowledge, or emphasized HIV/AIDS education as part of intervention strategies [11, 15-16, 27-28, 34, 39, 47]. In most cases, HIV/AIDS-related knowledge appeared to be quite sufficient regarding means of avoiding HIV infection and the health consequences of risky behavior. However, a common finding was a minimal relationship between HIV-AIDS awareness and CSWs' (high risk) sexual practices [8, 10, 16, 29, 39]. Condom use rates remained poor or erratic, particularly among African sex workers and in CSWs' personal sexual situations.

Though armed with the facts regarding HIV/AIDS risk, African CSWs in particular use condoms inconsistently, especially within personal sexual relationships. Two questions then arise: What factors *are* influencing CSWs' condom use? How - if at all - *does* HIV/AIDS fit into decisions concerning condom use? There is a pressing need for research aimed at answering such questions and at identifying contextual and socio-cultural factors which influence sexual behavior [48-54]. Such an approach may shed light on the dynamics influencing sex workers' decisions to use (or not use) condoms both on the job and in personal relationships. It may also be a crucial step toward sustainable AIDS interventions in the commercial sex industry.

AN ANTHROPOLOGICAL APPROACH

Anthropology offers an important alternative perspective in finding solutions to problematic HIV/AIDS-related issues such as condom use. An anthropological approach is significant for at least two distinct but inter-related reasons. First, it can provide an understanding of socio-cultural reactions to HIV/AIDS; that is, how societies conceptualize etiology, symptoms, and treatment, and these factors' potential impact upon behaviors surrounding HIV/AIDS. Research by Farmer [55-56] on Haitians' reactions to AIDS and AIDS victims, Green's work on African traditional healers' roles in dealing with AIDS-related issues and on local conceptions regarding STDs and AIDS [57-60], and research conducted by Schoepf [61] among Zairian women at high risk for HIV infection are only a few excellent examples in this regard [52, 62-64]. All these works illustrate the potential health impact of socio-cultural responses to HIV/AIDS.

Second, qualitative anthropological studies are a vital complement to quantitative survey

methodologies often employed in research on health-related issues [65-66]. In many cases surveys provide a necessary descriptive baseline for understanding *WHAT* people know and do with regard to sexual relations. Anthropology can be instrumental in elucidating *WHY* people behave they way they do; and why adequate knowledge of potential negative health consequences appears to have little impact on reducing risky sexual behavior. Given its characteristic holistic and ecological approach to the study of the human condition, anthropology is ideally suited to this purpose [67-76]. In the case of HIV/AIDS, understanding the why's of human behavior could be the key to the difference between life and death.

Anthropological Studies of Condom Use

Anthropologists have recently begun exploring socio-cultural and ideological factors influencing condom use in the context of HIV/AIDS. Several recent studies have focused on condom use among American women considered at increased risk for HIV infection [48, 77-79]. Some research has also examined condom use in an African context [61, 80-83].

Sobo [77] explored risk denial for HIV infection and the self-perceived benefits of unprotected sex among impoverished urban African-American women. Women's avoidance of condoms was interpreted as a psycho-social and economic strategy to maintain self-esteem and domestic economic stability. By denying risk for HIV and shunning protected sex, women created both a public and personal image of monogamous, secure, trustworthy sexual relationships. Admission of the necessity for condoms would require acknowledgement of steady partners' infidelity, leading to women's personal humiliation and loss of dignity.

Studies by Worth [48], Sibthorpe [79], and Pivnik [78] with intravenous drug users revealed similar conceptual and socio-cultural obstacles to condom use. Despite acknowledgement of their high risk status for HIV infection, many women made a deliberate decision NOT to use condoms. Condoms threatened trust, intimacy, sexual satisfaction of both partners, and domestic and economic stability. Condom use also presented a barrier to fertility and childbearing; a practice contrary to the cultural value placed on motherhood [48, 78]. Due to these negative associations, protected sex was appropriate only in casual sex situations and strictly avoided with personal partners [79].

In Pivnick's study [78], the bonding associated with unprotected sex was so important that condoms were avoided even within relationships where one partner was a suspected or confirmed HIV carrier. Men and women judged the emotional benefits of unprotected sex more

important than the risk of infection. HIV was viewed as a potential, and in some cases unavoidable, cost incurred in entering into an intimate sexual relationship; risk was part of the commitment made in what the author described as "conjugal bonding" (p.443).

Anthropological studies have also begun to examine socio-cultural factors influencing condom use in an African setting. According to Taylor [80], Rwandan women's resistance to condom use was related to cultural notions of fulfilling personhood and social cohesion through (mixing) of bodily fluids. Condoms represented a polluting "blockage" to Rwandan men and women (p. 1027). Thus, protected sex was an obstacle to the reciprocity necessary to maintain social stability.

Schoepf [61]examined cultural barriers to condom use in Zaire. Among these were the value placed on fertility and polygyny, and men having multiple sex partners as a culturally sanctioned means of achieving status and gender superiority. In another study, Schoepf [81] examined the potential role of involving Zairian traditional healers in promotion of HIV awareness and safe sex practices. By virtue of their respected status in the community, and being "legitimate interpreters of customary rules of conduct", traditional healers' advocacy of condom use could be a culturally appropriate means of effecting behavior change [81, p.234].

In South Africa, anthropological research has revealed condoms to be a problematic aspect of sexual negotiation among adolescent sex partners [82, 83] Adolescent females avoided discussion or attempted use of condoms out of fear of emotional rejection or physical abuse from partners, or of being branded promiscuous or HIV positive [82]. Adolescent males refused condoms due to the belief that they interfere with male control in a relationship. The need for condoms was also seen as a reflection of the *female* partner's status: untrustworthy, uncommitted, "dirty" (promiscuous and a carrier of sexual diseases) [83]. These insights can be helpful in understanding the dynamics behind condom use among Durban commercial sex workers.

METHODS

Study Sites

Fieldwork was undertaken in two sites. The first was an inner city section of Durban known to be frequented by commercial sex workers. The area was near the central business district, recreational areas and hotels on the beach front and Durban harbor.

The second venue was an industrialized suburb approximately 15 kilometers from the city center. The area is characterized by a large truck depot, serving as the endpoint and way-

station for truck routes from throughout southern Africa. Near the truck depot were several hotels and bars frequented by locals, truckers, and CSWs.

Participants

Participants were black African female self-identified CSWs. The majority were Zulu or Xhosa-speakers. All women worked independently, either on the street, or frequenting bars or nightclubs. The snowballing technique was used for selection of study participants.[8]

Data Collection

Data were gathered using in-depth interviews (45), semi-structured questionnaires (100; 50 per venue)[9], focus groups (2), and participant observation. Questionnaire topics included HIV/AIDS-related knowledge and attitudes, and frequency of condom use. In-depth interviews and focus groups concerned issues related to condom use in professional and personal sexual relationships.

Study objectives were explained to each prospective participant and verbal consent obtained before enrollment. Questionnaires and interviews were conducted in Zulu or Xhosa with the aid of a young black African male fieldworker.

Data Analysis

Analysis of questionnaire data was undertaken using D-base and Epi-Info 6 statistical programs. Transcripts from in-depth interviews and fieldnotes were examined and interpreted.

RESULTS[10]

Socio-Demographic Characteristics

One hundred women participated in the study (50 per venue). Mean subject age was 25.5 years. In the central city group, 73.% were Zulu, and 26% Xhosa-speakers. In the suburban group, 56% were Zulu, and 36% Xhosa-speakers.[11]

Study participants had a mean of 6.4 years of schooling. Among central city CSWs, 90.2% identified sex work as their main income source. Seventy-six percent of suburban CSWs

[8] Due to the sensitive nature of the subject matter, random sampling was not possible.
[9] Questionnaire results are reported here selectively, only as they pertain to condom-related topics addressed in in-depth interviews.
[10] Questionnaire results will be reported as a combined figure from the two field sites unless otherwise noted.
[11] Significant difference (p.<.000)

derived their income from sex work.[12] Mean daily income was 148 Rand ($32.30) for central city CSWs, and 96 Rand ($21.00) for suburban CSWs.[13]

HIV-AIDS Awareness and Risk Behavior

All study participants knew of HIV/AIDS and were well-versed in means of acquisition, transmission, and prevention. Unprotected sexual intercourse was most frequently cited as a behavior likely to facilitate HIV infection. Significantly, the vast majority (87%) of CSWs described AIDS as lethal, incurable, and preventable.

Subjects had a mean of 2.7 clients per day. Eighty-six percent of CSWs described themselves as involved in monogamous non-commercial relationships. Nearly the same number (85%) suspected or had proof that their steady boyfriend had multiple sex partners.[14] Intravenous drug use was not practiced by any study participants[15]

Condom Dynamics and Symbolism

Data analysis revealed several trends in the dynamics and symbolism of condoms in CSWs' sex lives. They can be organized into the following themes:

1. Condom use with clients preferred but not always feasible

Most CSWs in both venues viewed condom use as a rule to be enforced whenever possible. Several CSWs noted their personal partners encouraged and even monitored their condom use with clients. One central city CSW described how her boyfriend counted the number of condoms missing from her purse and the amount of money brought home each night in an attempt to control the consistency with which she used condoms during working hours.

Structured questionnaire data revealed low condom use rates among both groups. Among central city CSWs 29% described themselves as "always" using condoms with clients; 14% of suburban CSWs responded this way. A further 71% of central city and 80% of suburban sex workers "usually" used condoms with paying partners.[16]

[12] Significant difference (p.< .002)
[13] Significant difference (p<.002); 1USD=R4.58
[14] Confidential interviews with several boyfriends confirmed this. In the course of this research, 35 personal partners and clients (mostly truckers) were interviewed. These data are currently being analysed.
[15] Interviews with local police and drug enforcement agents confirm that injectable drugs are currently a rarity in the communities where this research was undertaken.
[16] Significant differences (p.<.000)

Obstacles to Condom Use with Clients

Several obstacles to consistent condom use were articulated in structured questionnaires. These included: threat of physical violence from clients (4%), clean and trustworthy appearance of prospective clients (8%), and financial incentives for unprotected sex (67%).

In both groups, financial problems appeared to be the primary reason for waiving the condom rule[17]. Most CSWs calculated daily earnings, and many aspects of their finances - food, rent or transportation - were dependent upon making a certain quota each evening. In the course of a night's work, a sex worker might become increasingly likely to accept an offer of extra payment for unprotected sex if the financial quota had not been achieved. Several women also described steady clients with whom they did not insist upon condom use in fear of losing the regular income.

Finally, in focus groups and in-depth interviews, many women identified high alcohol consumption and frequent use of *dagga* (marijuana) or mandrax as a significant impediment in their decision-making and ability to enforce condom use with clients. Questionnaire responses revealed that 98% of sex workers in the study used alcohol (usually beer) on a regular basis, with an average 7.7 drinks consumsed daily. Twenty percent of study participants reported regular (daily or weekly) use of *dagga* or mandrax. CSWs who used drugs and alcohol described substance use as necessary in order to muster courage to solicit clients and face other unpleasant working conditions.

2. Condom use with personal partners rejected

Unlike professional sexual relationships, sex workers adamantly rejected condom use with personal partners. Nearly all (96%) of study participants reported never using condoms in private sex situations. Avoidance was due both to CSWs' own dislike of condoms and partners' objections.

3. Condoms Divide Professional from Personal Life

Sex workers viewed condoms as a means of maintaining the ideological barrier between professional sex with clients and personal sex with private partners. Most women described the conceptual necessity of dividing work and personal life, and of reaffirming their membership in

[17] Poverty was also the primary reason these women became involved in commercial sex work. Poverty and other reasons related to material circumstances accounted for nearly one half (48%) of study participants becoming involved in the commercial industry.

conventional society outside of working hours. Condoms were seen as being in direct opposition to this, and associated with impersonal, professional, and usually unpleasant sexual interactions. A central city sex worker described condom use in the following way:

"When I sleep with a client I use a condom because then I am not an ordinary person but a professional sex worker. There are no feelings or love involved and you don't expect to get any pleasure out of it. The pleasure is when you get money. That is fucking; when you fuck a client you are not a full human being. But you cannot be a sex object 24 hours a day. You have to become a full, emotional, loving girlfriend... You have to make love ".

Sex workers from the suburban group reaffirmed this viewpoint. One woman noted, "Condoms were made to keep flesh apart that isn't supposed to mingle". The use of condoms as a symbolic divider between personal and professional life among suburban CSWs was illustrated in yet another way. Many suburban sex workers described becoming personally involved with long-time trucker clients. The transition from client to personal partner was marked by a lapse in condom use. In respect to this, a suburban sex worker whose boyfriend had at one time been her client said, "Once he became my lover, I forgot to use condoms. I felt at home and safe....".

4. Condoms are symbolic of filth, disease, infidelity, lack of trust, and promiscuity

The negative symbolism of condoms was clearly demonstrated in reasons provided for the necessity of condom use with clients. Clients were considered "dirty", "untrustworthy", "promiscuous", and suspected carriers of "diseases" (AIDS or STDs). Professional sex was viewed as undesirable for both personal and health reasons. Clients were assumed to have had multiple sex partners and as a result to harbor STDs or HIV. In addition, the professional sex act was viewed by CSWs as an impersonal and even morally repugnant one. Thus CSWs felt it imperative to use condoms as a means of physical and emotional protection against intercourse with clients.[18]

Condoms' negative images were also demonstrated in reasons CSWs provided for the rejection of protected sex in personal relationships. Personal partners were viewed as "clean"[19]

[18] Note one reason provided for *waiving* condom use was a client's clean and trustworthy appearance.

[19] Connotations of "clean" and "dirty" refer both to physical appearance (dress and smell) and disease status (sores on genitals or appearing ill or wasted), and to a more symbolic notion of trustworthiness, intimacy and

and "trustworthy". Condoms were also seen as a threat to intimacy and commitment, in that requesting protected sex would introduce an element of distrust and suspicion into partner dynamics. Regarding condom use, the association between love, trust, cleanliness and unprotected intercourse was cited in nearly half (46%) of CSWs' questionnaire responses and all in-depth interviews.

Trust in a personal partner was also the primary reason for not fearing AIDS from unprotected sex with personal partners. When asked about the degree to which HIV/AIDS influenced her choice of personal partners, a CSW retorted, "I only sleep with guys who are clean and trustworthy. So why should I be afraid of AIDS?" Such views are also articulated as follows:

> "Condoms take the trust away. How do I say to my boyfriend that I do not trust him? How would I feel if he didn't trust me?"

> "It would be better to die of AIDS from someone you love than lose a loving guy for the sake of a condom."

Another prevalent theme was that requests for condom use with domestic partners suggest infidelity or the possibility of carrying HIV/AIDS. One young central city CSW noted:

> "Because I am a CSW if I asked my boyfriend to start using condoms he would accuse me of having had unprotected sex with clients and say that I have AIDS. Or he might think that I suspect him of having it [AIDS]."

5. HIV/AIDS Awareness has Limited Impact on CSWs' Sexual Practices

CSW study participants were aware of HIV/AIDS, high risk sexual practices associated with it, and the potential consequences of HIV infection. However, this appeared to have limited impact upon sex workers' condom use, particularly in personal sex situations.

In both professional and private sex situations women were resigned to the risk of HIV infection from unprotected sex. The priority in personal sexual relationships was to maintain

purity. They are also related to the manner in which CSWs view their jobs (distasteful, abnormal, sinful, dirty) vs. their personal lives (removed from sex work, conventional, and pure).

closeness and domestic stability. A popular sentiment was that the risk of AIDS is a responsibility which must be shouldered in a personal relationship. The cost of HIV risk did not outweigh the benefits of personal intimacy gained through unprotected sex.

Regarding professional sex situations, immediate concerns, such as financial gain, appeared to override any fear of contracting HIV/AIDS. Also, the threat of infection may not have been taken seriously due to the virus' long period of dormancy and AIDS' current lack of visibility in South Africa[20]. The following are comments by central city CSWs in this regard:

"I would rather die of AIDS in ten years' time than die of hunger next week..."

"Why should I care about a sickness [AIDS] that will only attack me years in the future? By that time I will be too old to do sex work anyway."

DISCUSSION

This research illustrates the complex dynamic involved in these South African sex workers' condom use, and the critical role socio-cultural and economic factors play in determining their sexual behavior. Thus, we may begin formulating answers to questions surrounding sex workers' condom-related decision-making and the role of HIV/AIDS in this process.

What factors were influencing Durban CSWs' condom use? In professional sex situations, study participants preferred protected sex. The primary barriers to CSWs' condom use with clients were practical and economic ones. Poverty, and thus the financial incentive to engage in unprotected sex, appeared to be the greatest obstacle. In addition, threat of physical abuse from clients and the debilitating effects of substance use were also factors hindering sex workers' ability to successfully negotiate condom use with clients.

Barriers to CSWs' condom use in personal relationships were much more complex. In this context, conceptual and symbolic issues determined (un)safe sex practices. Condoms' ugly connotations were an overwhelming component in women's decisions to avoid condoms. The negative symbolism of condoms was a significant deterrent to their use, and stood in direct opposition to what these women sought from personal sexual relationships. Condoms were

[20]In South Africa, the epidemic has yet to reach the point at which full blown AIDS cases are a visible (and thus recognized) public phenomenon.

associated with disease, infidelity, and impersonal, illicit, professional sexual acts. In stark opposition to such imagery, women looked to personal sex for purification, trust, intimacy, and affirmation of love. Thus, by definition, condoms were excluded from personal sexual relations.

Condom use was also conditioned by the conceptual categories into which sex workers placed their partners. Clients were seen as dirty, illicit and impersonal. Such interactions warranted protection of a condom from unwanted and potentially dangerous contact. Personal partners were viewed as clean, intimate, trustworthy, and offering invited physical acts of love and affection. In these situations condoms were anathema. Within such a conceptual framework it is unsurprising that condoms were used as a logical divider between professional and personal life.[21] Lack of skin contact might make the impersonal, unclean professional sex act physically, conceptually, and emotionally invisible.

What role did HIV/AIDS play in Durban CSWs' condom-related decision-making? In both personal and professional sex the risk of HIV/AIDS appeared to have little bearing on women's condom use, but for very different reasons. In personal situations, sex workers looked to their relationships to fulfill personal needs crucial in maintaining successfull equilibrium between professional and personal life. So strong were these needs, that study participants preferred to overlook personal partners' high risk behavior and maintain their relationships. Given their stressful life circumstances, potentially life-threatening personal sex was a rational cost-benefit analysis for Durban CSWs; the emotional benefits of unprotected sex outweighed the risks of HIV infection[22].

In contrast, Durban sex workers' views on condom use and HIV/AIDS in professional sex situations were tied to poverty and powerlessness. Despite women's fears of infection from clients, and their desire to use condoms during professional intercourse, dire financial circumstances rendered them unable to enforce condom use. As a result of their dependence on sex work as a means of income generation, women approached the risk of HIV infection from professional sex somewhat fatalistically. It was considered an unavoidable job-related hazzard, and the risk of infection was subsumed by day-to-day worries. In view of their immediate concerns and constraints, Durban sex workers saw HIV/AIDS as a remote danger which had little bearing on their daily professional or personal lives.

[21] Jesson et al. [39] have also suggested CSWs' reluctance to use condoms in personal sex is tied to the need to "confirm the demarcation between sex as work and sex as pleasure" (p.8).

[22] In this respect, our findings confirm those of Worth [48], Sibthorpe [79], Sobo [77],and Pivnick [78] among American drug users, and of Nataraj [44] among Indian sex workers.

The fact that sex workers were unwilling to use condoms in personal sex relationships has significant ramifications for the progression of the HIV epidemic. It suggests that sex workers are at potentially greater risk for HIV infection from personal sexual behavior than professional intercourse. The HIV-related risks of sex workers' personal sexual behavior have been suggested elsewhere [8, 11, 15, 19, 28, 34, 39 41]. However, this study appears to be among the first to explore the differences between sex workers' personal and professional condom use, and the dynamics behind such contrasting behavior, in an African context. Most published works concerning African CSWs focus exclusively on HIV risks surrounding sex worker - client relationships [9, 26-27, 29, 47].

CONCLUSION

The differences between sex workers' professional and personal sexual relationships have significant ramifications for the structuring of HIV/AIDS intervention efforts focused on the commercial sex industry. In commercial sex, barriers to condom use are practical, environmental ones; external to sex workers' motivation to practice safe sex. Their preferences for condom use and the modifiable nature of barriers to protected sex are important characteristics to be considered in intervention frameworks. Women need not be convinced about the necessity of safe sex with clients, they need only be enabled to practice it. Environmental (political, legal, economic) change is the key.

Condom-related dynamics in sex workers' personal sex lives presents a very different scenario. With intimate partners, barriers to condom use are deep-seated socio-cultural and ideological issues. Such obstacles to safe sex practices are likely to be more difficult to overcome than those in professional sex situations. Unprotected intercourse serves an important function both emotionally and in terms of self-esteem; condoms symbolize everything that is the opposite. For the women in this study, the well-being they derived from intimate unprotected sex actually allowed them to function more successfully in their commercial sex roles.

Given the HIV-related implications of sex workers' condom use with personal partners, intervention programs must begin focusing on the broader aspects of their lives. This means centering upon women's personal lives and personal partners. Men (both clients and personal partners) are frequently overlooked in HIV/AIDS intervention programs targeting the

commercial sex industry.[23] Moreover, intervention efforts taking into consideration CSWs' personal situations must adopt an approach centered upon socio-cultural and ideological factors, not only practical, environmental ones.

This study among South African commercial sex workers illustrates the importance of examining socio-cultural, ideological, and economic factors influencing sexual dynamics and condom use. The work also demonstrates the significance of an anthropological approach in unraveling the inconsistencies between HIV-related knowledge, attitudes and behavior. Given that Africa bears the burden of the HIV epidemic, more qualitative work is needed to identify intervention strategies which reach beyond education and awareness to touch deep-seated socio-cultural and economic factors that influence sexual decision-making.

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[23] Results of data collected in this study among male partners (boyfriends and clients) will be available by mid-year 1997.

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ABSTRACT

We examined socio-cultural and economic determinants of condom use among 100 female South African commercial sex workers. The symbolism and dynamics of condom use between sex workers and their clientele were explored. These issues were also investigated when sex workers negotiated sex with their personal partners. An additional focus was the extent to which HIV/AIDS influences women's condom use in these situations. Results demonstrate considerable contrast between factors influencing condom use in professional versus private sex situations. With clients, practical issues such as financial strain were the major obstacles to condom use. With personal sex partners, sex workers avoided condoms due to their negative symbolism. Condoms were seen as suggestive of filth, disease, infidelity and mistrust. HIV/AIDS awareness had minimal impact on condom use. HIV/AIDS was viewed as a remote threat, overridden by immediate practical and emotional concerns. The intervention implications of condom symbolism and differential barriers to condom use are discussed.