“It’s All About Making a Life”: Young Female Sex Workers Vulnerability to HIV and Prevention Needs in Kumasi, Ghana
A Qualitative Study

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Executive Summary

Introduction
This report presents findings from a qualitative study examining the vulnerability to HIV of young female sex workers (FSW) in Kumasi, Ghana and their prevention needs. The study was conducted by Boston University’s Center for Global and Health and Development (CGHD) and the Kwame Nkrumah University of Science and Technology (KNUST) as part of the Project SEARCH Program funded by PEPFAR and the United States Agency for International Development Ghana.

The objectives of this study were to:
1) Investigate knowledge about and perceptions of HIV in young FSW in the Kumasi Metropolitan area,
2) Explore their risk behaviors, and
3) Identify their most urgent prevention needs.

A secondary objective was to provide foundational knowledge to inform the design of future studies of girls and young women engaging in sex work in Ghana.

Background and Rationale
Overall adult HIV prevalence in Ghana is 1.31% (1). Among women and girls selling sex, prevalence is estimated to be 12.9%, compared to 2.1% among pregnant women and 2.2% in the general female population (2,3). At 13% HIV prevalence among FSW, the Ashanti region mirrors the national median and has the second highest FSW prevalence following Accra (16.3%) (2). New recruits to sex work have increasingly been seen as a group highly vulnerable to HIV infection due to biological and behavioral risk factors. Asamoah-Adu et al. found in 2001 that one fourth of roamers, who work from bars and hotels and on the streets, and one half of seaters, who work from home, acquired HIV within the first six months of sex work (4).

The recent Integrated Biological and Behavioural Surveillance Survey (IBBSS) of Female Sex Workers and their Clients in Ghana has provided much needed quantitative regional and national data (3); however, little qualitative research has been published on sex workers in Kumasi. In general young people under age 18 who are selling sex have received little attention from researchers, donor agencies, and program implementers in the country (5). This qualitative look at girls and young women selling sex in Ghana’s second largest city attempts to fill this knowledge gap by documenting factors that drive them to sex work, their knowledge and perceptions about HIV risk, their own behaviours, and their overall vulnerability to violence and exploitation. We offer these findings within the context of current interventions for sex workers in Kumasi and make recommendations for targeting resources and programs at girls and young women age 8-18 entering sex work.
Methods
Female sex workers were recruited using a snowball sampling technique. Inclusion criteria for FSW participants included current involvement with sex work; age 18-20; involvement in sex work for at least two to four years; and fluency in English or Twi. Focus group discussions and in-depth interviews were conducted with 48 female sex workers. Ten key informant interviews were conducted with purposively sampled health care providers at youth-friendly clinics. The study was approved by institutional review boards (IRBs) at Boston University and KNUST. Study instruments were jointly developed by the research teams at CGHD and KNUST and were approved by both IRBs.

Results
The women we spoke with reported feeling little control over their entry into sex work. Analysis of push/pull factors causing young women to begin sex work revealed common trends. Push factors included: familial poverty, leaving school, and inherited sex work. Pull factors included: friends, financial need, and lure of economic opportunity in Kumasi. Having no option emerged as a recurring theme. Most said they would leave sex work if given the opportunity. The top reason given for staying in the trade was the unavailability of better paying work or another form of financial support.

Almost half of the women we spoke with entered sex work after turning 15, while 18% started between ages 12 and 14. The general consensus was that many girls start selling sex at age 12. Respondents reported that younger sex workers are more likely to engage in unprotected sex or be taken advantage of. Many described clients as difficult when it comes to getting them to wear a condom. FSW believed inexperience and poor negotiation skills increased the vulnerability of younger sex workers.

Study participants tended to talk about two categories of risk behavior, the first based on their own decisions and actions and the second being risks imposed on them by others. The most common risk taken by FSW was unprotected sex with boyfriends or regular partners. Of the 24 women interviewed, 22 reported having boyfriends in addition to their customers. Fifty percent of those with boyfriends (11 of 22) reported either never or only sometimes using condoms with their boyfriends.

Some of the biggest perceived risks reported by women related to the actions of others. The largest perceived risk was violence or rape at the hands of the clients. Three types of transactions were perceived to place FSW at heightened risk of violence: going to a client’s house, having an overnight session, and either of these things with a stranger. Condom breakage was also a concern. Women reported that this happened accidentally due to rough sex or intentional damage by clients. FSW also alluded to problems with police physically abusing and blackmauling them in exchange for sex.

Participants demonstrated a high level of HIV knowledge and accurate perceptions of the signs and symptoms of the disease. All participants reported being aware of their risk for becoming infected with HIV, and all knew that condom use prevented transmission.
Participants repeatedly also reported that their primary source of condoms and HIV information was “WAPCAS.” Participants reported receiving regular voluntary testing and counseling, discounted condoms, and treatment for minor ailments from WAPCAS. “WAPCAS” refers to the West African Project to Combat AIDS/STIs. This project was originally funded by the Canadian International Development Agency and focused on building capacity within government health centers to provide HIV and STI services across the country. Funding from CIDA ended in 2006. In Kumasi the Suntreso Hospital STI Clinic and the Maternal and Child Health (MCH) Hospital still run the model, supported by the Ghana Health Service. After CIDA funding ended, a non-governmental agency was created to continue services focused on HIV prevention. The current WAPCAS-NGO is an implementing partner in the USAID-Ghana Strengthening HIV/AIDS Response Partnership and Evidence-Based Response (SHARPER) project operated by FHI 360 in Kumasi, Accra and 90 additional districts across Ghana. Through SHARPER, WAPCAS-NGO has implemented a drop-in-center for sex workers in Kumasi. Respondents tended to use the term “WAPCAS” to describe services received both at the government-run Suntreso and MCH Hospitals and the WAPCAS-NGO drop-in-center (2).

In general, stigma emerged as a major barrier to seeking care at other clinics. Sex workers spoke about not feeling comfortable talking about their work at local health clinics, seeking out testing for STIs, and asking for condoms. Many of the health care providers interviewed made comments suggesting that there was significant stigma towards FSW in health facilities.

**Discussion and Recommendations**

Girls and young women who engage in sex work in Kumasi face multiple levels of vulnerability. Most of the young women we spoke with lacked education and income-earning opportunities and many perceived leaving school early as a significant turning point in their lives. When they arrived in Kumasi, they quickly fell in with other girls and young women already involved in sex work. Numerous factors and actors contributed to the processes and circumstances on their pathway into sex work. The ones who are fortunate and strategic earn a relatively high income, save money, and achieve financial stability. However, one-fifth of the women in this study started sex work between the ages of 12 and 14 (30% before age 15), and likely had little capability to think strategically about their actions.

Sex work can provide girls and young women with a path to greater financial stability than they may have found as *kayayei* transporting goods on their head (also known as “head porters”) or domestic workers. But that income comes at the cost of high risk of assault, pregnancy, STIs, and HIV/AIDS. Once these young recruits start selling sex, their most frequent and important contacts in Kumasi become other sex workers, boyfriends, clients, law enforcement officers, and health care providers. In order to be successful, an intervention strategy must take the contextual factors driving girls and young women to Kumasi and these stakeholders into account and build on existing programming and infrastructure.

To date, prevention education and condom campaigns seem to have been successful in that the young women we spoke with had a high level of knowledge about HIV/AIDS and how to avoid it. They also knew where to get condoms, and claimed to use them for most client transactions.
But avoiding HIV/AIDS is not the only concern of young women and girls selling sex. When they arrive in Kumasi they are worried about finding shelter, food, and friends. Once they are selling sex, they are also trying to avoid abuse from clients and police. They are also looking for love and to build a future, so they enter romantic relationships with young men who themselves may be at high risk for HIV, avoiding condoms to build intimacy. They also have babies who they send to the village or raise as single mothers. Outside of this sphere of human relationships, are the cultural, economic, and policy environments that can both facilitate and restrict efforts to help these young women stay safe within the profession or leave it.

In order to be successful, an intervention strategy must take the contextual factors driving girls and young women to Kumasi and these stakeholders into account and build on existing programming and infrastructure. Kumasi is well-positioned to implement effective HIV prevention strategies focused on young sex workers as it already has a strong network of critical key population-friendly service providers in place and some promising national reforms focused on reducing gender based violence and exploitation are in the works, including:

- The rapport that the WAPCAS-CIDA model government clinics has developed with female sex workers and the high level of knowledge regarding HIV infection are assets that can be built upon.
- The various components of the FHI 360 SHARPER project all have the potential to provide outreach, advocacy, and services to girls and young women selling sex, including an FSW drop-in center, peer educators, the “Text Me, Flash Me, Call Me” hotline, the key population-sensitive training for service providers, the strengthening of the health care and social welfare referral system, and the M Watchers advocacy network.
- The Ghana AIDS Commission and the Committee for Human Rights and Administrative Justice are also in the process of developing a gender-based violence reporting system that will also provide ongoing training to partner service provider.
- The Ghana Police Service is partnering with USAID, FHI 360, and Johns Hopkins University to develop and systematically implement an HIV/AIDS training curriculum with a special focus on working with key populations to be used in to train both current officers and new recruits.

Rather than adding new ideas to the substantial work already being done with sex workers in Kumasi, the following recommendations instead urge that these services and interventions sharpen their focus on girls, adolescents, and teens.

**Policy and Programmatic Recommendations:**

1. **Focus on Harm Reduction First**

We urge a harm reduction approach that focuses on improving outreach to girls newly entering sex work, recruitment and training for a cadre of adolescent and teenage peer educators comprised of both girls in sex work and their boyfriends and other non-paying partners, and training for health care workers, police, and other service providers to sensitize them to the special needs of this highly vulnerable age group.
2. Develop an Early Identification Response System & Recruit and Deploy a Cadre of Youth Peer Educators
The first days, weeks, and months when girls and teens enter sex work are arguably when they are at their most vulnerable and when intervention might have the greatest chances of success. The pathway into sex work may provide an opportunity to intervene. Given the integral role of friends in pulling girls into sex work, the existing peer educators who work through Suntreso clinic and the WAPCAS-NGO drop-in center may be aware of common processes and geographical pathways that lead to sex work for new arrivals to Kumasi. Girls and teens who are new to the business often do not think of themselves as sex workers and the youngest and greenest girls might also be less visible than those working high-traffic areas (5). Therefore an early identification and response system to identify girls just starting sex work and provide them safe sex education, condoms, condom negotiation training, alcohol and drug counseling, and more is necessary.

It is currently unclear whether sex worker peer educators are reaching out to new arrivals and youth specifically. Peer educators can be assigned to the bus station and other areas where young people newly arrived in Kumasi congregate. These educators can offer HIV prevention education, condoms and referrals to shelters and drop-in centers, other child protection organizations, and key population-friendly health care. This outreach is critical for girls and adolescents who are newly arrived and unaccompanied by a parent or guardian.

3. Strengthen Links with Social Welfare and Child Protection Services to Promote Sustained Individual-Level Intervention
Local NGOs working with vulnerable children and youth frequently provide lay case management to the extent that their resources allow, but are often unable to provide sustained individualized engagement. Stronger links to social welfare services, the Domestic Violence and Victim Support Unit (DOVVSU), and education/livelihood support services are a critical follow-on step to a peer counseling and early identification system. Social workers/case managers working at the local organizations that are a first point of contact can work with individual youth to assess their needs (for shelter, rape or assault services, returning home, enrolling in school, learning a skill for alternative income generation), and connect them with professionals in the Department of Social Welfare and other protection resources.

4. Engage Boyfriends and Other Regular Partners
The high proportion of young FSW who said that they had unprotected sex with their boyfriends or regular partners compared with the suspected high HIV prevalence of this group indicates that this practice is a large driver of HIV infection. New initiatives aimed at encouraging protected sex between intimate partners can be implemented through the existing network of service providers and peer educators. The boyfriends and other non-paying partners of FSW are already a priority population for the SHARPER project. Outreach to this population can be expanded to include teenage boys as well as men of all ages who are in cross-generational intimate relationships (6).
5. Improve Access to Condoms
Affordable condoms and lubricants are critical to prevention efforts. SW can buy condoms at shops, clinics, and through peer educators. But the young women who participated in our study still reported difficulty finding and buying affordable condoms, and they reported feeling ashamed to ask for condoms in shops and clinics. The peer educator distribution system seems like the most accessible way to get condoms to these girls and young women, yet none of them mentioned this system, leading us to conclude that it might not be well-known among youth SW. Therefore, the youth peer educator cadre that we propose above can also be tasked with selling inexpensive condoms as part of their scope of work. Finally, private sector pharmacies and licensed chemical shops are easily accessed and may be motivated to offer better customer service to FSW of all ages compared to government institutions which do not profit from selling condoms. The use of female condoms as a negotiation tool, as described by some of our respondents, also warrants further explorations.

6. Continue to Focus on Stigma Reduction in Health Care Settings
Stigma from health care providers remains a barrier to care for female sex workers. While the clinics at Suntreso and MCH Hospitals, provides FSW-friendly services, other clinics and hospitals do not. Professionalism with FSW and other key populations should be the norm. Health care providers should be given sensitivity training regarding work with female sex workers, and there should be reporting mechanisms in place to hold them accountable for instances of discrimination. The SHARPER M Friends and M Watchers programs are a critical platform for reducing stigma among health care workers. An enhanced focus on working with children and teenagers involved in sex work in a calm, non-reactive or judgmental way is critical.

7. Continue Building Partnerships with Police to Shift Emphasis from Punishment and Exploitation to Protection and Advocacy
The SHARPER M Watchers program and the Ghana Police Service HIV/AIDS training curriculum currently being developed by FHI 360, Johns Hopkins University, and USAID Ghana are both promising developments in terms of sensitizing police to the vulnerabilities faced by key populations and reducing the punitive approach and exploitation that, according to our respondents as well as other sources, still occur with some frequency. The curriculum should specifically highlight the vulnerabilities of children who arrive in Kumasi unaccompanied by adults as well as girls and teens involved in the sex trade and provide officers with training to provide appropriate support and referrals. The Domestic Violence and Victim Support Unit, which is part of the Police Service, has a clearly articulated mission to provide children involved with sex work with protection and advocacy services. The DVVSU can be directly engaged in any training or sensitization programs targeting police officers.

8. Learn More about the Vulnerability of Boys and Young Men Involved in Sex Work and Provide them with Similar Outreach and Protections Services
A 2009 United Nations Family Planning Agency Report has documented high levels of vulnerability among adolescent and teenage boys and young men who are involved sex work
(33), confirming reports from programs working with youth and key populations. The national Ghana Men’s Health Study (being undertaken by the University of San Francisco and the US Center for Disease Control in partnership with the Ghana AIDS Commission) and a qualitative study in Kumasi (undertaken by BU, KNUST, and FHI 360 as part of the Operations Research among Key Populations portfolio) will provide further information about their specific vulnerabilities and needs. All of the recommendations made here for girls and young women can be adapted for boys and young men.
1. Introduction
This report presents findings from a qualitative study examining the vulnerability to HIV of young female sex workers in Kumasi, Ghana and their prevention needs. The study is one of nine being conducted by Boston University’s Center for Global and Health and Development (CGHD) and the Kwame Nkrumah University of Science and Technology (KNUST) aimed at filling the knowledge gap regarding the HIV prevention needs of key populations in Kumasi. All studies are being conducted as part of the Project SEARCH Program funded by PEPFAR and the United States Agency for International Development.

This qualitative study was conducted as operations research to better understand the particular vulnerabilities identified by young FSW, and their current access to and unmet need for HIV prevention services in Kumasi. The objectives of this study were to:
1) Investigate knowledge about and perceptions of HIV of young FSW in the Kumasi Metropolitan area
2) Explore their risk behaviors
3) Identify their most urgent prevention needs
A secondary objective was to provide foundational knowledge to inform the design of future quantitative and in-depth qualitative studies of teenage girls and young women engaging in sex work in Ghana.

2. Background
In 2010, over 225,000 adults in Ghana were HIV-positive with an overall prevalence of 1.31% (1). The Ashanti region has the fourth highest prevalence at 3.1%. Because prevalence is over 1%, the epidemic is considered to be generalized but it is also concentrated within high risk populations. Among sex workers, 2011 prevalence was 12.9%, compared to 2.1% among pregnant women and 2.2% in the general female population (2,3). At 13% HIV prevalence among FSW, the Ashanti region mirrors the national median and has the second highest prevalence among FSW following Accra (16.3%) (3). Transactional sex plays a significant role in HIV transmission in Ghana, with 2.4% of sex workers, 13.2% of male clients, and 22.2% of clients’ partners contributing to new HIV infections in the country sex (2).

Female sex workers in Ghana tend to be categorized as seaters or roamers based on a foundational study conducted by Asamoah-Adu et al. in Accra in 2001 (4). Seaters work from their homes while roamers work in bars, brothels, hotels, the streets, and other such locations. Roamers tend to be younger and more mobile than seaters. In 2011, the average age of roamers was 25 compared to 34 for seaters; among young sex workers age 15-19, 23.2% identified as roamers and 3.9% as seaters (3). Forty-two percent of the 2012 FSW Integrated Biological and Behavioral Surveillance Study (IBBSS) respondents reported starting sex work prior to age 20 and 3.7 prior to age 15.

Knowledge of condoms and lubricant as a form of HIV prevention was relatively high at 81% in both groups, but HIV testing was much higher among seaters at 70.7% compared to 55% of
roamers. IBBSS findings on HIV and STI prevalence, condom use, and forced sex and physical violence for roamers, seaters, Ashanti Region, and Ghana overall are presented in Table 1. As Asamoah-Adu et al. found in 2001, seaters in 2011 still tended to have much higher HIV and STI prevalence than roamers, but roamers were more likely to experience forced sex (with or without a condom) and physical violence (3,4). Consistent condom use with paying clients was lower among roamers at 74.6% compared to roamers. Condom use with non-paying partners was low for both groups though higher among roamers (21.1%; 16.8% seaters). Both roamers and seaters reported relatively high levels of drug use: marijuana (17.3% roamers; 20.4% seaters) and sleeping pills (15.6%; 14%). Findings on alcohol use have not yet been reported (3).

Table 1: 2012 Female Sex Worker IBBSS Findings (3)

<table>
<thead>
<tr>
<th>Biological and Behavioral Indicators</th>
<th>Roamer</th>
<th>Seater</th>
<th>Ashanti</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Prevalence</td>
<td>6.6%</td>
<td>21.4%</td>
<td>13%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Syphilis Prevalence</td>
<td>4.7%</td>
<td>9.8%</td>
<td>7.6%</td>
<td>6.2%</td>
</tr>
<tr>
<td>HSV Prevalence</td>
<td>67.9%</td>
<td>86.7%</td>
<td>74.5%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Consistent Condom Use with Paying Clients</td>
<td>74.6%</td>
<td>80.8%</td>
<td>82.7%</td>
<td>79.2%</td>
</tr>
<tr>
<td>Condom Use with Non-Paying Partners</td>
<td>21.1%</td>
<td>16.8%</td>
<td>18.2%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Forced to have Sex without a Condom (last 3 months)</td>
<td>29.9%</td>
<td>16.9%</td>
<td>19.3%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Experienced Forced Sex (last 3 months)</td>
<td>15.2%</td>
<td>9.2%</td>
<td>12.2%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Experienced Physical Violence (last 12 months)</td>
<td>15.8%</td>
<td>13.6%</td>
<td>14.9%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Tested for HIV (ever and within last 12 months)</td>
<td>67.8%</td>
<td>71.1%</td>
<td>78%</td>
<td>68.9%</td>
</tr>
</tbody>
</table>

Seaters tend to be highly organized, live in specific urban enclaves socially centered around a “queen mother” figure (4). The extent to which this organization extends to roamers is unclear from the literature. But this organization among seaters arguably plays out in their higher levels of health seeking behavior. A 2006 SHARP (Strengthening HIV/AIDS Response Partnerships) study compared HIV related behavior in seaters and roamers in Kumasi and Accra (7). In both cities, significantly more seaters than roamers demonstrated health seeking behavior. In Kumasi, more seaters than roamers reported attending a HIV/AIDS meeting in the past year (80.1% vs. 56.7%) and ever attending a sex worker or STI clinic (65.9% vs. 31.5%). Roamers in
Kumasi were also the least likely to have been tested for HIV, with only 24.4% reporting to testing in the past 12 months compared to 38.7% of seaters in Kumasi and 41.1% and 43.7% of roamers and seaters in Accra, respectively. There was a strong association between attending HIV/AIDS meetings and going to a clinic, termed “program contacts”, and HIV testing rates. Among roamers in Kumasi, only 13.1% of those who had no program contacts had been tested for HIV in the last 12 months. Among those that had one program contact, 23.2% got tested, and among those that had two, 40.6% got tested (7).

High levels of HIV/AIDS awareness among Ghanaian sex workers have been reported in multiple studies dating as far back as 1996 (8,9). In 2011, 81% of sex workers participating in the IBBSS reported the importance of using condoms and lubricant to prevent HIV and other STIs; 74% noted the importance of HIV testing. However less than half reported STI screening and management (47.2%) and just over one-third reported partner reductions as a prevention strategy (3).

New recruits to sex work have increasingly been seen as a high risk group for HIV infection. Asamoah-Adu’s research team found that one fourth of roamers and one half of seaters acquired HIV within the first six months of sex work, leading them to recommend targeting younger and new sex workers for HIV prevention efforts (4). They outline multiple biological risks that may put young, newly initiated sex workers at a greater risk of acquiring HIV than their older, more experience counterparts.

New recruits may have higher rates of sexually transmitted infections (STIs) which can increase the probability of HIV transmission. This could be a result of a lack of acquired immunity to diseases like gonococcus and chlamydia and poor health seeking behaviour. The initial manifestation of genital herpes is open sores which increase risk of HIV infection. Subsequent outbreaks of genital herpes are frequent in the first few years after infection, after which immunity is built and outbreaks become infrequent or cease altogether. In addition, the high level of vaginal micro-abrasion that a young woman may experience in her first months of sex work may increase HIV transmission probability per contact with HIV-infected individuals (4).

In addition to these biological risk factors, behavioural risk factors may also put young, new recruits and young roamers at a higher risk for HIV infection. Young, new recruits are less experienced and are likely to have poor negotiation skills on condom use. They frequently have clients who are much older than themselves, introducing a power imbalance that can undermine their ability to negotiate. Traditional gender roles can also influence the power dynamic (9). It is also possible that there is a misconception by men that, because young FSW look healthy and have been in sex work for a shorter period of time, they are HIV negative. This may lead to greater insistence on risky behaviour on the part of male clients.

In a mixed epidemic such as Ghana’s, understanding the unique risk behaviours of key populations and providing appropriate services is critical. A 2011 conference focused on mixed epidemics in Accra sponsored by PEPFAR posed a critical question for Ghana and other countries facing mixed epidemics: is the right population being addressed, at sufficient scale,
with adequate services (11). Ghana has recognized and addressed this critical question, as demonstrated by the focus on services for key populations in the National HIV/AIDS Strategic Plan for Most-at-Risk Populations 2011-2015 (12).

While a fair amount is known about the HIV prevalence and behaviour of female sex workers in Accra, little research has been done in Kumasi. With a population of over 1.5 million, Kumasi is the second largest metropolitan area in Ghana. Furthermore, a 2006 SHARP study presented data suggesting roamers in Kumasi, mostly young FSW, may be at heightened risk due to lower rates of condom use and less health seeking behaviour. It is thus an important geographic area to understand in order to prevent HIV transmission. Likewise, the specific prevention needs of younger sex workers who are new to the trade have not been independently examined. Most of the available data focus on women of a wide age range and are not disaggregated below age 18. There is a need for focused research on young, newly entered FSW in order to create targeted services that will help them protect themselves and their partners.

The West African Project to Combat AIDS/STIs (WAPCAS)¹
From 1999 through 2006, the Canadian International Development Agency (CIDA) implemented the West African Project to Combat AIDS in 9 West African countries. In Ghana, some of these funds were used to implement programs targeting key populations, particularly sex workers. Programs were rolled out in 21 pre-existing government clinics across the country.

WAPCAS-CIDA programs in Ghana developed from the ground up, deploying workers into communities to identify and learn about existing sex worker communities before approaching government health facilities and district health offices about offering HIV/AIDS services to key populations in the area. Facility staff was then trained in STI/HIV care and in working with key populations, specifically FSW. Once training was complete, WAPCAS-CIDA staff identified a leader within the sex worker community and held meetings to spread awareness of the program. One FSW was identified from each community to act as a liaison with FSW community.

This foundation was built upon throughout the course of the program. Peer educators were trained and used to reach female sex workers and provide HIV/AIDS education. Routine HIV screening (every 3 months) was provided for FSW through the WAPCA-CIDA sponsored clinics. Monthly meetings were held with FSW to identify and help them address problems (for example, harassment by policemen). In Kumasi, a drop-in center was established to provide a communal space for FSW. Strong relationships between the FSW communities and the government WAPCAS-CIDA clinics were created. WAPCAS-CIDA directly involved the Ghanaian government in the implementation and monitoring of the program. Therefore the Ghana

¹ In order to reduce confusion around the name WAPCAS, all future references to the CIDA model will be referred to as “WAPCAS-CIDA” and references to the NGO will be referred to as “WAPCAS-NGO”. In accordance with terminology used by respondents, general references to FSW-specialized health services are referred to simply as “WAPCAS”.

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Health Service was able to take over the WAPCAS-CIDA project and has continued to support the key population-specific programs at designated clinics.

After CIDA funding ended in 2006, a non-governmental organization with the same name was created to continue services focused on HIV prevention. The current WAPCAS-NGO, in addition to receiving funding from numerous sources to provide HIV prevention services, is an implementing partner in the USAID-Ghana SHARPER project operated by FHI 360 in Kumasi, Accra and other sites with high SW density across Ghana. Through SHARPER, WAPCAS-NGO has implemented a drop-in-center for sex workers in Kumasi. This brief overview of WAPCAS-CIDA and the current WAPCAS-NGO is necessary for understanding findings presented here.

3. Methods
This study used a qualitative design. For data collection, in-depth interviews, focus group discussion, and key informant interviews were conducted with female sex workers and health care providers at youth friendly clinics in the Kumasi Metropolitan area.

Ethical Considerations
The study was approved by the institutional review boards (IRBs) at Boston University and KNUST. During the interviews, participants were reassured that taking part in the study was voluntary and that they could stop the interview at any time. Confidentiality was confirmed and maintained throughout the data collection process. Study instruments were jointly developed by the research teams at CGHD and KNUST and were approved by both IRBs.

Sampling and Selection of Study Participants
Female sex workers were recruited using a snowball sampling technique. This technique is implemented by having existing study subjects recruit future subjects from among their social networks. Snowball sampling is often used in qualitative research to find and recruit “hidden populations,” that is groups not easily accessible to researchers through other sampling strategies (13).

Health care providers were purposively sampled from clinics in Kumasi. A total of 10 participated in in-depth interviews. See Table 2 for a complete description of sample sizes.

Inclusion criteria
Inclusion criteria for FSW participants included:
• Current involvement with sex work
• Age 18-20 involved in sex work for at least 2-4 years
• Fluency in English or Twi

FSW respondents participated in either an in-depth interview (IDIs) or a focus group discussion (FGDs), but did not participate in both. In-depth interviews were conducted with 24 women. Four focus group discussions were held with a combined total of 24 FSW.
Training and Data Collection
Prior to data collection, research staff from KNUST and BU held a one-week training for all personnel involved in data collection and management. Training was provided on human subject’s protection, research ethics, and qualitative methods. Strict confidentiality practices were maintained throughout data collection. No identifying information was collected from participants. Consent was verbally obtained. Field notes were simultaneously translated from Twi into English during the interviews and FGDs by data collectors. Data collection occurred from August through October 2011.

Interviews with Health Care Providers
Interviews with health care providers and female sex workers were triangulated in order to understand ease of access to health services for female sex workers. Information about surrounding clinics was collected and themes were identified and explored.

Analysis
Inductive content analysis was performed on all transcripts. Two experienced researchers reviewed all transcripts and independently identified broad themes. These were compared and found to be corresponding. The transcripts were then imported into Nvivo9 where data was organized into broad themes and sub-topics. Coding was continuously rechecked and agreed upon by both researchers, who worked together to present results.

Study Limitations
The snowball sampling technique was useful in identifying FSW to participate in the study. However the nature of the snowball sampling technique naturally results in a sample that may have similar behavior patterns and social maps. Our age inclusion criterion of 18-20 years old is also an important limitation, particularly in light of the perception among participants that many girls start sex work around age 12 and some as young as 8. We attempted to include the experiences of these younger girls by requiring sex work for the past 2-4 years; nevertheless, we missed some significant perspectives by not speaking directly with younger teens, adolescents, and children. We also did not ask participants about their HIV status.

4. Results

Reasons for Starting Sex Work: Push/Pull Factors
The women we spoke with frequently reported feeling little control over their entry into sex work. Narratives from FSW revealed common factors pushing/pulling them into sex work. Many
grew up in rural Ghana and migrated to Kumasi due to a lack of financial support from their family. For example, dropping out of school played a critical role in their path to sex work. Once in Kumasi, most reported being influenced by friends to join sex work. A majority of participants claimed that they had no choice but to engage in sex work and, if given a better opportunity, they would leave the trade. There were a few exceptions who declared that sex work was their own autonomous choice. Overall, most respondents expressed discomfort with society’s moral disapproval of their work.

Analysis of push/pull factors causing girls and young women to join sex work revealed common trends. Push factors included: familial poverty (leading to dropping out of school due to a lack of support from parents), education level and inherited sex work. Pull factors included: friends, financial need, and lure of economic opportunity in Kumasi.

**Push factors: Familial Poverty and Leaving School**
The most common reason given for sex work was poverty. Some in-depth interview participants described selling sex in order to support themselves or to alleviate the impoverishment of their family. The following quotes illustrate this well:

“I had the interest to go to school. I also needed a job to raise some money to cater for myself. My parents could not also support me financially and that pushed me into this job.

Someone introduced me. I was in need of money and when I entered I can now pay my child’s school fees and buy my own cloth.

The majority of the women interviewed grew up outside of Kumasi. The move to Kumasi was motivated mostly by financial hardship, although some reported leaving their home areas due to strained familial relations. When asked about their background, many FSW mentioned dropping out of school as a critical step in the path that led them to Kumasi. Education levels among FSW interviewed reflected this narrative as they were generally low; 14.6% of participants reported no formal education. About 40% had below a primary education; 37.5% left school during or following completion of junior high. All those who dropped out of school

<table>
<thead>
<tr>
<th>Table 3: Demographic Information of FSW</th>
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<tbody>
<tr>
<td><strong>Descriptive Statistics of FSW sample</strong></td>
</tr>
<tr>
<td>Descriptive Variable</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Primary and Below</td>
</tr>
<tr>
<td>Some or all Junior High School</td>
</tr>
<tr>
<td>Some or all Senior High School</td>
</tr>
<tr>
<td><strong>Duration of Sex Work</strong> (yrs)</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
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<td>4</td>
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<td>6</td>
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<td>7</td>
</tr>
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</table>
cited a lack of financial support from their families as the cause. Many felt that, because of their lack of education, they had no marketable skills with which to support themselves.

Reasons for familial poverty often included the death of parent and parental unemployment. As a result, some young women traveled to Kumasi with the goal of getting a job to support their parents or younger siblings. The few who did not mention financial hardship reported that familial dispute drove them to Kumasi, such as quarrels about an early marriage or hostility from a new stepmother. Most of the girls/young women traveled to Kumasi alone. Quotes below demonstrate these narratives:

I was born in Wa in the Upper East Region of Ghana..... I had to stop schooling when my father died and my mum is very old and unemployed so she could not support me. So I decided to come to Kumasi with my friend.

I am from Somanya in the Eastern region but was born in Accra. I have some of my family members in Accra and others in Somanya. I am now residing in Kumasi due to financial constraints. I came purposely to work in order to raise money to support my parents financially.

I am from Volta Region and hail from Adidome. I separated myself from my family a long time ago about 2003. They gave me out for marriage and I didn’t agree to that so it led to a quarrel which ended up with me in Kumasi.

**Pull Factors: Friends and Money**
Some participants mentioned that they practice sex work in order to save money for future endeavors. One female sex worker explained:

Even though I am trading, my interest is in furthering my education and I wasn’t having any financial support from my parents. So I decided to enter this job and gather enough money to continue my education.

A large majority stated that they were trying to accrue capital to start a business.

Almost all of the subjects reported being introduced to sex work by friends. The details of how they entered differed. Some observed their friends bringing home money after engaging in sex work and asked to join. Others were invited into the business after a friend observed them struggling financially. The vast majority said that they started selling sex because they had no other option. One of the participants explained:

When I came to Kumasi, these friends that I met at the station, informed me about their work and what they do for a living. They asked my willingness to join and I agreed to it because I wasn’t having anyone to help and support my living. I was at the age of 14 years when I was introduced and started this work.
Only one respondent reported migrating to Kumasi with the intention of engaging in sex work. She was a pupil teacher who did not like the amount of money she was being paid. A friend of hers told her about sex work in Kumasi. She got interested, followed her friend to the city, and started selling sex.

The shared common background narrative of poverty puts young FSW in a desperate position upon arrival in Kumasi. Many reported migrating to Kumasi alone and quickly coming to rely on friends. If these friends were practicing sex work, they became exposed to its potential to bring in money. This may be the only option immediately available for economic survival. The quote below illustrate this scenario:

> When I came to stay with my friends, I found out that they go to some specific parts along some roadsides in the night to look out for money after sleeping with them. I therefore joined them in one of such activity. This is because I did not have any work to do.

**Push and Pull: Children Living in a Sex Work Environment**

Some FSW mentioned following their mothers into sex work; this push factor was further confirmed in focus group discussions where participants reported that girls are sometimes introduced by their mothers. This pattern was described as occurring among seaters, who come together in the Adum section of Kumasi. The daughter of a seater who was not directly introduced to sex work described the normalizing effect of growing up in that environment:

> I think it was as a result of where I grew up. Seeing a lot of women practicing it I got interested. Adum where I live is a red light area and I saw many friends and other women do that work so it was ok.

Thirty-seven percent of the women we interviewed had at least one child. Many women left their children with parents or extended family, but some had their children living with them. Children can be both push and pull factors in the decision to start sex work, and (as illustrated above) the children of sex workers can also be pulled into the business. We did not ask women who had children if they were born before starting sex work or after. But the young age at which many respondents started as reported in the following section, makes it likely that they become mothers after starting and possibly as a consequence of sex work.

**Early Debut into Sex Work**

Almost half of the women we spoke with entered sex work after turning 15, and 18% started between ages 12 and 14. In the focus groups the general consensus was that many girls start selling sex at age 12. As one participant explained, “*You could find some even below 12 years but it is dominant around 12 years.*” In one focus group, when asked the youngest age when a girl might begin to sell sex, all members agreed that some start as young as 8 years old. The discussion is illustrated below:
Table 4: Age of entry to sex work n=48

<table>
<thead>
<tr>
<th>Age of entry</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>3 (6.3)</td>
</tr>
<tr>
<td>13</td>
<td>2 (4.2)</td>
</tr>
<tr>
<td>14</td>
<td>4 (8.3)</td>
</tr>
<tr>
<td>15</td>
<td>6 (12.5)</td>
</tr>
<tr>
<td>16</td>
<td>11 (22.9)</td>
</tr>
<tr>
<td>17</td>
<td>14 (29.2)</td>
</tr>
<tr>
<td>18</td>
<td>8 (16.6)</td>
</tr>
</tbody>
</table>

Moderator: “What is the youngest age a girl might begin selling sex?”
FSW 1: “8-9 years”
FSW 2, 3, 4, 5: “8 years”
Moderator: “Can you show me someone who is 8 years and is into commercial sex work?”
Chorus: “We can show you now if you want.”

Tenure in sex work is as important as the age at which a girl starts. The length of time in which study participants were engaged in sex work is depicted in Table 3. Two respondents who were 20 years old had been involved for 8 years.

**Extreme Vulnerability of Girls and Adolescents Selling Sex**

In focus group discussions, all women reported that they knew of young girls practicing sex work. Among study participants, it was generally perceived that younger sex workers were more likely to engage in unprotected sex or be taken advantage of. While the women interviewed were relatively confident in their condom use, they shared their concern that younger girls are more likely to have unprotected sex with clients. This was because of inexperience and poor negotiation skills.

The inexperience of newcomers to sex work may preclude them from knowing standard practices of the trade. For example, many participating FSW reported using lubricating gel to minimize abrasion and prevent accidental condom breakage. They were concerned, however, that new recruits were often unaware of this practice. Inexperience may also lower the risk perceptions of HIV. Focus group participants explained:

*Those at ages 12-14 have greater risk because they may not be knowledgeable enough to use condoms and also avoid certain types such as anal.*

*The 20 year age group has more experience than the 12-14. They even accept raw sex while we don’t.*

*We are experienced enough to be using gel and condom, but the 12-14 may not know and will exposed themselves to a lot of risk.*

In both focus group discussion and interviews, the women expressed concern that young and inexperienced sex workers may naively grant unprotected sex for the large amounts of money offered by clients.

*Young ones only think about money so they can be enticed with money to do anything which puts them at risk, like not using condoms.*
Data revealed that discussion and negotiation with a client are critical points of the transaction pathway. Many respondents described clients as difficult when it comes to getting them to wear a condom. Decisions that may have a significant impact on the risk of a transaction are made quickly during this interaction. All FSW reported that price, meeting place, and duration of the session are discussed right away. Some reported including negotiations on condom use and style of sex in the initial interaction, but with most it was unclear whether this discussion happens upon meeting or at a later time. Study participants reported that clients regularly try to convince them to engage in unprotected sex. The women interviewed used their knowledge of HIV to support their negotiations. One even kept a flyer about HIV she received from WAPCAS on hand to show customers who refused to use a condom. Female condoms were also occasionally mentioned as useful negotiation and protection tools. One woman reported always having female condoms on hand as it ensured that she had the power to enforce condom use. She also used them as a negotiation tool, as she explained below:

*Clients usually prove difficult to use condom. But if they don’t agree I use female condom. If I use a female condom the style becomes one way that is lying on my back. So those who do not want me to lie on the back will be encouraged to use male condom. My female condoms are left with only three.*

It was a common opinion among study participants that younger teens and girls are more vulnerable to intimidation to have unprotected sex by clients who are often much older than them. The power dynamic of gender and age put them at a disadvantage. As explained by respondents, the inexperience of young FSW often translates to poor negotiation skills. Combined with potentially lower levels of knowledge regarding HIV transmission, this puts them at higher risk for agreeing to raw sex or putting themselves in dangerous situations.

*These girls are naïve so the men can always bully them, with the young girls you cannot guarantee their safety.*

**How Do Young FSW Perceive Their Work?**

Almost all women reported that they did not wish to engage in sex work. Having no option emerged as a recurring theme. As one female sex worker explained: “It is a difficult job but I have no option.” Many expressed concern about how their morality will be perceived by others. They were sensitive to the stigma and disrespect from those around them. Some seemed to pass harsh judgment upon themselves for their work, calling it “shameful”:

*We all practice commercial sex work at night, though it is a shameful work to do. We need the money.*

Many talked about a lack of respect from others. The following dialogue from a focus group discussion reveals the women’s insight into society’s perception of their work:

*Moderator: How would you describe sex work and women engaged in sex work?*

*A: People normally think of you as a bad person.*
A few women had come to terms with practicing sex work. They described their work as a lucrative means of support for themselves and their families. They were comfortable in the profession, and expressed skepticism that they would leave for another job because their income would not be able to match what they were currently making from sex work. Data on pricing revealed that most FSW charged under GHS 20 (~$11.00) for a “short” session, defined by most as less than 30 minutes. Three FSW reported that they charged GHS 50 (~$29.00) for a short session. Overnights varied from GHS 50 (~$29.) to GHS 120 (~$70.00). Other factors also considered in the price include the type of client and the type and or style of sex the client requests. Different sex positions and types of sex, such as oral or anal, were priced higher. The comments below highlight the profitability of sex work:

Yes I like the job very well. When [clients] come to me I am happy because they are helping me to get money.

We are comfortable in this work since, through it, we are able to cater for most of our needs such as food, clothing and even sometimes cater for our children.

But these women were the exception; most women interviewed said they would leave sex work if they had the opportunity. The top reason given for staying in the trade was the unavailability of legitimate work or another form of financial support. One interview participant explained: “I will stop if I get a job and have someone to care for me. If I have a place to lodge. This job has no respect.” Some pointed out that a low level of education prevented them from securing regular income that pays as well as selling sex. Some women interviewed made it clear that they planned on leaving sex work. As one woman explained:

If I had the opportunity I would leave this business simply because of the many risks associated with it. One cannot do this job for life. Before I entered into the job I made up my mind that I will by all means stop.

**Perceived Risks**

Study participants tended to talk about two categories of risk, the first based on their own decisions and actions and the second being risks imposed on them by others. Figure 1 provides an overview of the risks reported under each category.
Risks Taken by Women

Unprotected Sex with Boyfriends

By far the most common form of unprotected sex was with boyfriends or regular partners. Of the 24 women interviewed, 22 reported having boyfriends in addition to their customers. Some also reported having regular customers, but often the distinction between boyfriends and regular customers was unclear. Fifty percent of those with boyfriends (11 of 22) reported either never or only sometimes using condoms with their boyfriends. Comments suggested this was a social norm. Status as a boyfriend seems to warrant unprotected sex:

- *I don’t use condom with my boyfriend because I have taken him as my serious boyfriend.*

- *I don’t use a condom because I have taken him as my boyfriend. He will even beat me up if I ask him to use a condom.*

The characteristics of boyfriends varied considerably. Some were previous customers, “bar boys” who were known for drinking and gambling, or “helpers” of the FSW. The women who reported using condoms consistently with their boyfriends had varying reasons, including distrust of their significant others, a hope for future marriage, and the need for family planning. One woman explained her reasons for using condoms with her boyfriend:

- *I use condoms because he knows the type of work I am doing. We do not trust each other so we have decided to use condom till we are ready to live together then we will all go for a checkup before.*

Only one woman reported not having access to condoms as a reason for unprotected sex.
Unprotected Sex with Clients

All the women who were interviewed claimed high rates of condom use with clients. However, 29% (7 of 24 IDIs) noted that there are certain circumstances that might cause them to agree to unprotected sex with a client. This was ascertained by two separate questions on the qualitative instrument. The first question read: Do you always use condoms with clients? Followed by: Under what conditions would you have unprotected sex with a client?

From this triangulation, a critical contradiction emerged as 6 of the 7 women who spoke of conditions under which they would have unprotected sex in response to the second question replied that they always used condoms with a client in response to the first question. The following exchange demonstrates this pattern:

*Interviewer*: Do you use always condoms with your clients?
*I insist on condom always.*

*Interviewer*: Under what conditions would you have unprotected sex with a client?
*I will only agree to unprotected sex if the clients agree to give me more money.*

The two most commonly mentioned contributing factors to unprotected sex were: 1) the influence of drugs and alcohol, and 2) being offered large sums of money. These were also the two influencing factors identified in focus group discussions.

The influence of drugs or alcohol was perceived to affect reasoning. One woman explained: “Some of my colleagues drink alcohol or smoke marijuana before engaging in the act and therefore affect their reasoning and judgment. They can’t even know whether their client use condom or not.” One of the participants who admitted to occasional unprotected sex said that she “could be convinced” with large amounts of money under the influence of drugs and alcohol. Another justified having unprotected sex “when the money is so big to the extent that it can be used for hospital treatment in case you get some sickness out of that.”

The perception that alcohol increases the chances of being convinced, coerced, or tricked into having unprotected sex led some women to refuse taking alcohol while working:

*I do not mix alcohol and sex. The combination makes you vulnerable to men.*

The 7 women who admitted to circumstances in which they would forgo the use of a condom with a client showed no deficit in their knowledge of HIV transmission.

Going to Client’s Home and Overnight Sessions

FSW also reported making decisions that may heighten their risk for harm at the hands of clients. Three types of transactions emerged as placing them at heightened risk: going to a client’s house, staying overnight at a client’s house and either of these things with a stranger.

Going to a client’s house was the most frequently mentioned high risk behavior. The women interviewed made multiple references to the danger inherent in going alone with a client to their place of residence as this is unknown territory with no surrounding supports. They clearly
saw themselves as more vulnerable in this setting. Some reported refusing these sessions, while others accepted but charged their clients more. Despite the heightened risk, client’s homes were still one of the most common meeting locations mentioned.

You must be careful when somebody decides to take you to their house. Alone, they may not use condoms, or can harm you.

The risk I perceive is that something can happen to me since I have been going to their houses.

I don’t go for overnights or sleeping sessions because I am afraid....A friend of mine died in a client’s house when she went for a full night session.

Respondents also expressed concerns that overnight sessions increase their vulnerability. This could be because they often take place at clients’ houses. It is also possible that the prolonged amount of time out of contact with a support network or falling asleep while with a client (i.e., letting one’s guard down) increase vulnerability to violence.

Risks Imposed by Others

Risks Imposed by Clients
Some of the biggest perceived risks reported by women related to the actions of the client. The largest perceived risk was violence or rape at the hands of a client. Infection with HIV as a result of rape was also mentioned as a concern of the women interviewed. Women also reported their belief that clients intentionally damage condoms in order to infect them with STIs.

Violence/Rape/Homicide
Fear of violence was universal among study participants. Most female sex workers claimed that the key risk of the job was harm from clients. Many times, the motivation was theft. Participants explained that many clients are armed robbers who forcefully steal money and cell phones from them following the transaction. Some clients became violent when it was time to pay, if money was not collected beforehand, or would steal their money back. One woman recounted this story:

Some clients could be very violent. Some may even refuse to pay you your fee after sex. There was a time during argument after sex on a fee a client stabbed me. It could really get serious sometimes.

Women also reported that refusing unprotected sex can anger clients and drive them to violence:

I had an experience where a client wanted to have sex with me without condom. I refused and he got angry so there was exchange of words and some people came to my rescue when he threatened to beat me up. So there are risks involved.
Forced sex without a condom was also a key theme emerging from both interviews and focus groups. One study participant explained that “Some clients are very strong and can forcefully sleep with you without condom. So they are the main challenge.”

There was a pervasive fear of death at the hands of the client. A few women had stories of friends being killed. A common motivation cited for homicide was a need for body parts or blood for “juju” activities. Respondents explained that sometimes people posed as clients only to lure FSW into privacy in order to kill or mutilate them:

For instance, a sad incident occurred some time ago to one of our friends who was killed by a supposedly client of hers. The police reported that the lady was killed by the man who needed human blood for his juju activities after he had lured our friend to a hotel room. We got to know this the following day after the incident occurred. Our work therefore can be become dangerous sometimes.

Condom Rupture

Condom breakage was also a concern. Women reported that this happened accidentally due to rough sex or intentional damage to condoms. Accidental condom breakage was perceived to occur when a client engaged in rough sex or was too big for the condom. Many sex workers reported that they always used gel to help prevent this from happening. Lubricating “gel” was considered a critical prevention tool. A few women suggested that younger and more inexperienced FSW may not be aware of the protective properties of gel, and that further education should take place.

It was also commonly mentioned that clients sometimes intentionally damage condoms prior to use. According to the sex workers interviewed, the motive behind this was to infect FSW with STIs or HIV:

Some HIV victims knowingly try to infect prostitutes just because they don’t want to die alone. They may intentionally damage the condom before coming so that during sex it breaks.

Others described condom tampering as a tactic used to achieve unprotected sex. This was mentioned as the reason many women insisted on using their own condoms rather than those offered by a client. One participant told interviewers that her fellow sex workers only used condoms straight from WAPCAS:

Sometimes some of them will agree to condom use but during foreplay he will intentionally tear the condom and have sex with the torn condom or they forced us to have sex without using condom. It is so disturbing but being a woman I cannot do anything about it.
**Risks Imposed by Police**

Harassment from the police also emerged as a critical risk, and was mentioned in all four focus group discussions and 4 of 24 IDIs. The Ahodwo roundabout and Bompata were two areas specifically mentioned as places where sex workers come into frequent contact with police. FSW alluded to problems with the police ‘beating them’ and blackmailing them in exchange for sex. FGD participants explain:

*The police may even sleep with you in a car and even refuse to pay after the act. They often will sleep with you without a condom and if you refuse he will threaten you with arrest.*

*I was once arrested by the police for smoking (wee) marijuana. He took all the money I had (GH¢70) and he threatened to send me to the police station if I don’t have sex with him, I had no option but to agree. I could not complain because no one would listen to me. I have since stopped smoking wee.*

*The police are worrying us a lot and if you complain then they ask for sex in exchange for our freedom. A lot of these police men have sex with us because they know we are vulnerable. Often they do not use condoms.*

As sex work is illegal, respondents felt they were unable to report this abuse to any legal body. Of note, one focus group participant mentioned that WAPCAS had intervened on their behalf and that abuse had decreased:

*Formerly the policemen use to come after us but now WAPCAS is intervening for them to leave us alone.*

In addition, many FSW expressed feeling unsafe in their homes because police could eject them at any time. This came mostly from FSW who reported living in the Bompata railway area and sleeping in a kiosk or outside.

**Knowledge and Perceptions of HIV**

Participants demonstrated a high level of HIV knowledge and accurate perceptions of the signs and symptoms of the disease.

**Knowledge of HIV/AIDS**

Knowledge of the biological nature of HIV and modes of transmission were highly accurate among the FSW in the sample. Participants had a solid understanding of the biological properties of HIV. They referred to it as a “germ” and knew that it existed in blood and mucus. One FSW explained that it damaged your immune system:

*HIV/AIDS are germs that fight against the body immune system and it can be acquired by having unprotected sex with someone who has the disease.*
They were aware that HIV develops into AIDS and that there were medicines that you could take to slow this progression. They also knew that it was ultimately lethal.

Awareness of transmission pathways was also generally accurate. Of central importance to this study, all FSW interviewed knew that HIV could be contracted through unprotected sex and that condoms prevented transmission. Many mentioned that anal intercourse was higher risk than vaginal intercourse. Mother-to-child transmission and transmission through shared razor blades and contaminated sharp objects were also commonly mentioned. Most knew that medications were available to help prevent mother-to-child transmission.

But they also had some inaccurate information. A re-occurring theme was concern about deep kissing and oral sex as modes of infection. Many, though not all, claimed to avoid these activities completely with clients. Transmission through witchcraft was infrequently mentioned. Some participants stated that they believed in this mode of transmission before their HIV education. One woman said “I also know a woman whose rival bewitched her with AIDS.” Other anomalies included belief in transmission by unclean pedicures and mosquito bites.

“WAPCAS” was by far the most commonly mentioned source of information; references to WAPCAS seemed to be referring to both the government-run Suntreso and MCH Hospitals originally sponsored by WAPCAS-CIDA as well as the drop-in center for FSW currently operated in Kumasi by the NGO WAPCAS through the USAID SHARPER project. Respondents noted that most of their information was received through peer educators. Many participants expressed the desire that government agencies would engage in HIV/AIDS education campaigns to reach young girls entering the trade and potential clients. Other sources of HIV information which were mentioned include friends, television, and radio.

Perceptions of HIV/AIDS
All participants reported that they were aware of their risk for becoming infected with HIV. One FSW stated “with this type of work, I know I can contract diseases such as HIV/AIDS.” Some explicitly mentioned that they believed their clients could be infected:

I believe my clients can also transmit the HIV/AIDS because those who have it look very plump and fine.

Study participants generally had accurate perceptions of the signs and symptoms of HIV/AIDS. Many mentioned that you could not recognize HIV infection in clients or know if you were infected without a test. One FSW plainly stated “HIV is not written on their faces.” Many were also familiar with the symptoms of AIDS, mentioning weight loss, skin lesions, and diarrhea. The following quotes exemplify FSW perceptions of HIV/AIDS symptoms:

I know HIV is a virus and AIDS is a disease. If you have HIV you will not know unless you have a test. When you have AIDS there are signs like boils and shingles on your body.

When you contract HIV you will become fat and after some time grow lean. You may also experience diarrhea and vomiting which will eventually lead to death.
I know when you get AIDS, you grow lean. It is a killer disease too.

It is a dangerous disease. I know someone who had one before. It is characterized by diarrhea and vomiting.

In a few interviews, study participants seemed to confuse the symptoms of AIDS for those of HIV, but these were a small minority. All perceived HIV/AIDS to be fatal in the long run, and many expressed awareness that there was some kind of treatment that could help prolong life but was not guaranteed to prevent death.

A few respondents seemed to view HIV as a disease that primarily infected young girls who were flirtatious or “slept around.” Others expressed the feeling that HIV was everybody’s problem and felt that more education regarding HIV was needed for the general public.

Girls of today like love making. They make love of all kinds such as allowing their breast to be sucked etc. which will lead to all kinds of diseases.

Everyone has her own life. Some ladies like flirting with boys and have sex without using condoms. Some customers may ask for unprotected sex so if the woman is not smart she can be infected easily.

Access to Health Services

**Clinics with HIV/AIDS-Related Services**

HIV-related services available at area clinics can be seen in Table 5. Of particular interest are the clinics that offer specialized FSW services, namely the Maternal and Child Health and Suntreso Hospitals (both of which received support from WAPCAS-CIDA from 2001-2006 to expand HIV prevention services and conduct outreach directly to key populations).

According to the health care providers interviewed, the Maternal and Child Health Hospital partnered with the original WAPCAS-CIDA to train outreach workers and FSW peer educators. The health care providers (HCPs) interviewed saw this as a highly successful strategy to engage FSW with health care services. One HCP explained their outreach method:

I do go to their communities for health talks on risky behaviors and because they also know me from WAPCAS center, they feel safe obeying my directives when I invite them through their own peers. What we did earlier on was to identify some few ones and trained them as peer educators who later on became the medium of getting access to majority of them.
Table 5: Select services at local clinics

<table>
<thead>
<tr>
<th>Service</th>
<th>VCT</th>
<th>ART</th>
<th>Specialized FSW services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal and Child Health Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Suame Young and Wise Center</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manyhia District Hospital</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kumasi South Government Hospital</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Suntreso Hospital</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

While the Maternal and Child Health Hospital was only directly mentioned by one woman interviewed, a couple mentioned going with WAPCAS-NGO staff to the clinic. It is quite possible that this was referring to this partnership. When FSW visit the Maternal and Child Health Hospital they are able to jump the queue for expedited service. The voluntary counseling and testing (VCT) center has also distributed identification cards to female sex workers that are only known to counseling staff.

The general clinic at Suntreso Hospital operates an open day for FSW and reports keeping an open environment. The HCP interviewed at Kumasi South Hospital also reported keeping an open and non-judgmental environment, although there were not specialized services for FSW. They are seen as part of the general patient population.

Interviewees and discussion participants repeatedly reported that their primary source of condoms and HIV information was “WAPCAS” using the acronym to describe services received both at the government-run Suntreso and Maternal and Child Health Hospitals and the WAPCAS-NGO drop-in-center. Participants reported receiving regular voluntary testing and counseling, discounted condoms, and treatment for minor ailments from WAPCAS. They had only positive comments to share about WAPCAS and a couple claimed that they faced no challenges in accessing health care due to the services of the clinic.

Condom Access

Most of the women interviewed reported getting their condoms from WAPCAS. A couple of FSW expressed a desire for free condoms, but the majority simply mentioned that they get them at highly discounted prices from WAPCAS. Access seemed to be relatively reliable.

Comments from some women revealed internal organization among some FSW in Kumasi:

“We as FSW meet at Ahodwo monthly. We have our woman leader who talks to us about our charges so that it will be uniform. Some of us charge as low as GH¢3.00 ($1.76) for short time instead of 10.00 or 20.00. She may not use condom too. So the woman discusses some these issues with us. She also sells condom to us and make profit out of it. She collects the condoms from WAPCAS office adds a little profit and sells to us. She even goes to the extent of searching
our bag for condom. Those who do not have are given by force to buy but as to whether they use them when they get into the room is left to the individual.

The leader here resembles the “queen mother” described by Asamoah-Adu et al. (4)

Barriers to procuring condoms included price and stigma. Even though WAPCAS-NGO drop-in center and the Suntreso Hospital HIV/AIDS/STI Clinic distribute them at a discounted rate, there is still an upfront cost and a few mentioned affordability as a barrier. Participants also explained that requesting condoms from other health clinics was difficult.

F: We can’t ask for condoms at health facilities.
B: Yes, even at Family planning facilities asking for a condom being a woman is difficult. Condoms are for men only.

Stigma as a Barrier to Seeking Care

Many of the health care providers interviewed made comments suggesting that significant stigma toward FSW continues in health facilities. There are also distinctions made between clinics that have designated themselves FSW-friendly, versus those that have not. Clinics such as the Maternal and Child Health Hospital have specialized services for FSW, such as peer educators trained through WAPCAS-CIDA or designated clinic days for FSW. In comparison, the key informant from Kumasi South Central Hospital reported that FSW are seen just as other patients, and no effort is made to identify or better serve FSW. Workers interviewed from the centers with FSW specific services spoke directly about the needs they see among these patients and the care they provide. In comparison, workers from other clinics reported that in general they could not identify which of their patients were FSW. This may indicate that FSW do not feel comfortable disclosing their work to staff in these clinics for fear of discrimination.

Sex workers also spoke about experiencing stigma and discrimination from health care workers, not feeling comfortable talking about their work, seeking out testing for STIs, and asking for condoms. Health care providers also described their own need to proceed carefully when talking to women who they think might be sex workers. One of the health care providers from a major health care facility explained:

Please, it is not like they do not reveal their identity to us but we do not ask them specifically if they are FSW because our mandate here is the general public and not some special group such as FSW. The patient may feel very embarrassed if I should suggest through my line of questioning that she is FSW. I don’t think that will be fair.

5. Discussion

Young female sex workers in Kumasi are not living and working in isolation. Most of the young women we spoke with lacked education and income-earning opportunities and many perceived leaving school early as a significant turning point in their lives. When they arrived in Kumasi, they quickly fell in with other girls and young women already involved in sex work. Numerous
factors and actors contributed to the processes and circumstances on their pathway into sex work. The ones who are fortunate and strategic earn a relatively high income, save money, and achieve financial stability. However, one-fifth of the women in this study started sex work between the ages of 12 and 14 (30% before age 15), and likely had little capability to think strategically about their actions.

Sex work provides girls and young women with a path to greater financial stability than they may have found as kayayei transporting goods on their heads (also known as “head porters”) or domestic workers. But that income comes at the cost of high risk of assault, pregnancy, STIs, and HIV/AIDS. Once these young recruits start selling sex, their most frequent and important contacts in Kumasi become other sex workers, boyfriends, clients, law enforcement officers, and health care providers. In order to be successful, an intervention strategy must take the contextual factors driving girls and young women to Kumasi and these stakeholders into account and build on existing programming and infrastructure.

To date, prevention education and condom campaigns seem to have been successful in that the young women we spoke with had a high level of knowledge about HIV/AIDS and how to avoid it. They also knew where to get condoms, and claimed to use them for most client transactions. But avoiding HIV/AIDS is not the only concern of young women and girls selling sex. When they arrive in Kumasi they are worried about finding shelter, food, and friends. Once they are selling sex, they are also trying to avoid abuse from clients and police. They are also looking for love and to build a future, so they enter romantic relationships with boys and men who themselves may be at high risk for HIV, avoiding condoms to build intimacy. They also have babies who they send to the village or raise as single mothers. The following discussion analyzes the role these actors play in contributing to the risks faced by girls and young women who sell sex. Outside of this sphere of human relationships, are the cultural, economic and policy environments that can both facilitate and restrict efforts to help these young women stay safe within the profession or leave it.

Girls and young women who engage in sex work in Kumasi face multiple levels of vulnerability. The following analysis uses a multi-level framework for understanding vulnerability. As depicted in Figure 2, vulnerability starts at the macro level with structural determinants of vulnerability (socioeconomic factors, legal/policy factors, and programs) and then focuses in on the micro individual level (situation, behavior, and biology) (14).
The following discussion places the findings from young women selling sex in Kumasi into the larger structural context of socioeconomic factors, legal/policy environment, and programs. At the individual level, we focus on behavior, placing our findings in the broader research context.

**Socioeconomic Factors**
Young women and girls are pushed to leave the village due to poverty, poor options for staying in school, and lack of income generating and professional opportunities.

**Vulnerability: Rural Poverty and Migration to Kumasi**
The impact of poverty on women who sell sex in Kumasi can be examined as a two part process: rural poverty and migration to Kumasi. Rural poverty drove these girls and young women to leave their communities and travel to Kumasi, the regional metropolis. Young women reported various reasons for migrating to Kumasi. The majority came from an impoverished background. Many women spoke of dropping out of school or coming to Kumasi looking for work to support their families. Upon arrival in Kumasi, they may look for other jobs such as being head porters or domestic workers but many turn to sex work as a more profitable way to first survive and then, in some cases, get ahead.

Compounding the influence of these vulnerabilities is the confirmation in our findings that these processes often occur at a young age. As reported by study participants, girls can enter sex work as early as age 8 but more typically between ages 12-15. Underage and newly entering sex workers face unique vulnerabilities. In addition to the vulnerability due to poverty, young sex workers have additional biological and perceived behavioral risk factors. Poor negotiation skills may enable girls and young women new to the business to be bullied by clients, a power dynamic that has its roots in age, gender, and culture. These girls and young women may also not be able to bargain for higher prices for protected sex, and thus are at risk of being cheated.
financially by clients, increasing the number of men they need to sleep with. Inexperienced may lead young and newly entering FSW to forgo the use of lubricating gel, a tool that older FSW report using regularly to prevent condom breakage (3). These behavioral risk factors are exacerbated by biological risk factors (3,4). These include potentially higher rates of STIs including primary herpes outbreaks, and high rates of micro-abrasion of the vaginal walls.

**FSW as Mothers and Their Children**
Thirty-seven percent of the young women who participated in our study had one or more children. The vulnerabilities of women who sell sex can be compounded by having children. The added responsibility to provide for children increases pressure to either stay in sex work or to start. In addition, the children of sex workers can be at an increased risk for entering sex work themselves, as described by some of our respondents. This can create a cycle of inherited sex work in which children of sex workers (who may have been conceived through sex work) can both force the continuation of their mother’s involvement in the trade and subsequently increase the risk that they themselves will one day enter the trade (15). Only one respondent who grew up in the Adum section of Kumasi attributed her decision to start sex work to her mother’s involvement in the profession. Nevertheless, the children of our study subjects represent a sizable proportion who may be at risk of joining the profession themselves.

**Legal/Policy Environment**
Sex work is illegal in Ghana, leaving those who are arrested for selling sex or exploited by law enforcement little legal recourse. And young sex workers face a triple jeopardy: they are breaking the law by having sex as minors and having sex for money, and they sometimes cannot receive health care services without the consent of their legal guardian.

Ghana has universal education, broad rights to health care for all, and an expansive vision for rural development. Ghana is a signatory to the Convention on the Rights of the Child, and child protection is documented in the Constitution as well as the Criminal Code Act (1998), the Children’s Act (1998), Child Rights Regulations (2002), and the Juvenile Justice Act (2003). Attention to better understanding and meeting the needs of key populations (including young female sex workers) is a high priority for government and has had a strong influence on the current work of the Ghana AIDS Commission.

The Government of Ghana has also identified the need to stem the tide of rural-urban migration. The vision and policies exist to develop the agricultural sector and rural infrastructure but limited resources have created barriers to implementation and increased importation of rice and other food staples from foreign sources has further weakened internal agricultural markets. Likewise, all children in Ghana have the constitutional right to free primary education, but rural school facilities are poor; therefore, young people continue to leave rural areas at a rapid pace because there is nothing keeping them at home or in school.

The gap between policy and implementation remains wide, largely due to lack of adequate public funding. Rural-urban migration remains a problem. Likewise, implementation of the policies and enforcement of child protection laws has been a consistent challenge.
Programs
The WAPCAS-CIDA programming model was frequently referred to by study participants as their source for education, condoms, and health care. Suntreso and MCH Hospitals developed FSW-specific services under WAPCAS-CIDA project and still provide government-funded services to sex workers and other key populations. They have undertaken a number of important initiatives over the years including community outreach by nurses, peer education, and training for and collaboration with law enforcement. Much of this programming has continued to be funded by government and been successfully diffused beyond Kumasi within the Ashanti Region, but financing lags significantly behind need. For instance the nurse community outreach program is no longer funded.

The USAID SHARPER project, which is being implemented by FHI 360 in partnership with local organizations such as the NGO WAPCAS, runs a drop-in center and peer education programs devoted to the sex worker population in Kumasi and other parts of the country. These services primarily target adult sex workers and do not have specialized outreach for girls and adolescents, particularly those in the 8-18 age group who might just be starting sex work. The network of services, referral, and support provided through the SHARPER network provide a programmatic foundation upon which to build child and adolescent-focused FSW services.

Access to Health Care and Condoms
Stigma was identified as a major barrier to care for female sex workers. Both FSW and health care providers who were interviewed acknowledged the existence of stigma within major health care facilities in Kumasi. However, within facilities that offered specialized FSW services, HCP were identified who had a rapport with FSW. The lesson to be taken from these findings is that specialized services for FSW are not necessarily the determining factor of health care access for this population; rather, the increased awareness and stigma reduction that comes along with these services is what matters. Reducing stigma was reported by the women and health care providers in our study as the number one priority that will improve access to health services.

Even though all the study participants knew where to get condoms, they nevertheless reported that condoms can be difficult to come by, especially for women who do not use the WAPCAS-CIDA clinic or the WAPCAS-NGO drop-in center. They reported that simply asking for condoms was difficult at some clinics, even if they were available there. This is as much a matter of cultural mores as it is stigma. In Ghanaian culture, women are not supposed to ask for or purchase condoms (16). So the woman who wants them may have a hard time bringing herself to make the request or the purchase, and the health care worker or shop clerk who has them to give away or sell may, intentionally or not, increase this embarrassment by refusing or asking unnecessary questions. This embarrassment and difficulty are likely compounded for youth attempting to purchase condoms.
Police Exploitation

Exploitation and sexual abuse by the police were frequently mentioned by the women who participated in our study; their reports echo findings from a 2011 study conducted by the Human Rights Advocacy Centre on police exploitation of women involved in sex work in Ghana (17).

Suntreso Hospital has an active partnership with the local police and has been engaged with them for many years in providing training about HIV/AIDS. These discussions also cover the importance of dealing more gently with key populations (including sex workers). Sex work, illicit drug use, and sodomy are illegal in Ghana, so the focus of this training has been on sensitizing law enforcement officials to the vulnerabilities faced by these groups, the resources in the community available to help them reduce their vulnerabilities, and the importance of treating them with compassion and fairness. One goal of the conversations has been a sort of informal decriminalization, in which police may pick up women and refer them to the clinic or, in the case of adolescents and girls, referring them to child support shelters.

Direct collaboration between advocates, service providers, and law enforcement officials can create informal internal accountability when official protection policies are unenforced or absent (18,19). The SHARPER project is in the process of implementing a program called M Friends, a network of advocates in positions of power who can be called on to provide assistance in specific cases of abuse or exploitation and who are engaged more generally in sensitizing those with power in multiple sectors to the multi-level vulnerabilities of sex workers. M Friends include law enforcement as well as legal advisors and members of the judiciary.

Likewise, USAID Ghana is also working directly with the Police Service to design and systematically implement a key population sensitization curriculum for both in-service officers and new recruits. Both programs hold great promise, but are still in their infancy or planning phase. The Human Rights Advocacy Centre study makes comprehensive, detailed recommendations that reinforce the police training already being planned, and also calls for improving the awareness of sex workers about their rights as well as constitutional protections and assistance available from the Commission on Human Rights and Administrative Justice (Act 456 of 1993) and the Legal Aid Scheme (Act 524 of 1997), as well as domestic violence resources (17).

Behavior

Multiple studies in the African region conclude that boyfriends and regular partners are critical group in HIV transmission (10,20–22). Some evidence suggests that unprotected sex with boyfriends and regular partners may contribute more to HIV transmission than sex with clients (20,21,23). In Cote’s study of clients and boyfriends of FSW in Accra, boyfriends were significantly less likely than clients to have used a condom in their last intercourse with a sex worker (23). Similar results were found in a study in Kenya conducted by Voeten and colleagues. The team found that condom use with clients was around 75%, compared to less than 40 % with regular partners (21). In Accra, Cote et al. (2003) found that HIV prevalence among boyfriends (32.1%) was twice that of the clients of seaters (15.8%) and six times that of
clients of roamers (4.9%) (23). The men with whom female sex workers regularly have unprotected sex are the men who are most likely to be infected with HIV.

In a study of sex workers in Madagascar, Stoebenau (2009) and colleagues examined relationship definitions used by sex workers and commented on the ambiguity and fluidity of such relations (10). Although there are obvious and substantial geographic and cultural differences between Madagascar and Ghana, their findings provide valuable insights into FSW perceptions of relationships and condom use that maybe applicable in Ghana. They found that paying and non-paying customers were not always distinct categories, but instead changed over time. Many boyfriends were in fact old customers who became boyfriends or regular partners. Some provided constant financial support. This appears to be similar to the relationships described in Kumasi. While financial support arrangements were inconsistent, many young FSW in our study reported receiving money from their boyfriends and extra money from their regular partners. Even the distinction between regular partner and boyfriend was ambiguous. It is unclear at what point one goes from a repeat customer, to a regular client, to a serious boyfriend. The line between transactional sex and sex with an intimate partner is often blurry, as a relationship between a regular customer and a sex worker can resemble an intimate relationship of love.

The expectation of financial support for sexual rights goes back into pre-colonial African culture. In the Ashanti region, pre-colonial concepts of marriage relied heavily on a man’s financial support of his wife. A woman could legitimately leave her husband if he failed to provide for her and, according to ethnographic studies of this time, this frequently happened. It wasn’t until colonialism that Western notions of marriage and relationships were, as many Ashanti woman reported, forced upon their culture (24–27).

Stoebenau et al. argue that Western notions of when it is appropriate versus inappropriate to use condoms have led women to use unprotected sex as a way to develop intimacy. Unprotected sex has become, from this perspective, a symbol of trust (10). For an impoverished woman, continued financial support from a boyfriend, regular partner, or husband is often desired as they strive to create lasting and meaningful relationships. Offering unprotected sex can be a means to create a sense of intimacy. The theme of trust was also found in Voeten’s study of sex workers in the Nyanza region of Kenya (21). The majority of sexual interactions with regular partners were unprotected because the woman and man trusted each other (although the definition of trust varied greatly between respondents). For some, trust seemed to be tied to financial support. The concept of trust was also brought up by the young sex workers in Kumasi. Almost all the participants in our study said they wanted to leave sex work; finding and keeping a man who could support them and their children was described as one potential pathway out.
6. Policy and Programmatic Recommendations

The following recommendations focus on mitigating the risk faced by girls and young women at the individual and community level as they enter and stay in sex work. Certainly, primary prevention in the form of hastening rural development, improving rural schools, and ensuring universal enrolment and attendance through primary and secondary school will be critical to the long-term strategy for keeping children and teens out of sex work and preventing HIV and STIs. However, that agenda will take many years to come to fruition. In the meantime, there are a number of programs and protections that can be expanded or put in place to help girls and young women engaged in sex work to reduce their vulnerability and improve the access to services.

Kumasi is well-positioned to implement effective HIV prevention strategies focused on young adolescent sex workers as it already has a strong network of critical key population-friendly service providers in place:

- The rapport that Suntreso government clinic has developed with female sex workers and the high level of knowledge regarding HIV infection are assets that can be built upon.
- The various components of the FHI 360 SHARPER project all have the potential to provide outreach, advocacy, and services to girls and young women selling sex, including an FSW drop-in center, peer educators, the “Text Me, Flash Me, Call Me” hotline, the key population-sensitive training for service providers, the strengthening of the health care and social welfare referral system, and the M Watchers advocacy network.

Some promising national reforms focused on reducing gender-based violence and exploitation are in the works, including:

- The Ghana AIDS Commission and the Committee for Human Rights and Administrative Justice are developing a gender-based violence reporting system that will provide ongoing training to partner service providers.
- The Ghana Police Service is partnering with USAID, FHI 360, and Johns Hopkins University to develop and systematically implement an HIV/AIDS training curriculum with a special focus on working with key populations to be used in to train both current officers and new recruits.

Rather than adding new ideas to the substantial work already being done with sex workers in Kumasi, these six recommendations instead urge that these services and interventions sharpen their focus on girls, adolescents, and teens.

1. Focus on Harm Reduction First

As noted in the US Department of State 2011 Human Rights Report for Ghana, “girls under 18 were among the most vulnerable child laborers, as many also engaged in prostitution or were sexually exploited in exchange for protection while living in the streets” (28). While a focus on enforcing child protection laws against defilement by adults may be part of the answer, a legal enforcement approach heightens the vulnerability of the girls involved who are themselves breaking the law. Therefore, we urge a harm reduction approach that focuses on improving outreach to girls newly entering sex work, recruitment and training for a cadre of adolescent...
and teenage peer educators comprised of both girls in sex work and their boyfriends and other non-paying partners, and training for health care workers, police, and other service providers to sensitize them to the special needs of this highly vulnerable age group (5).

2. Develop Early Identification Response System & Recruit and Deploy a Cadre of Youth Peer Educators

The general consensus from our interviews and focus group discussions was that girls and young women do not migrate to Kumasi from their villages in order to be sex workers. The more likely scenario is that they leave for the city with dreams about earning a decent income as domestic worker and gradually making their way to financial stability. When they reach the Kumasi bus station reality sets in as they find they have nowhere to go and no one to help them.

The first days, weeks, and months when girls and teens enter sex work are arguably when they are at their most vulnerable and when intervention might have the greatest chances of success. The pathway into sex work may provide an opportunity to intervene. Given the integral role of friends in pulling girls into sex work, the existing peer educators who work through Suntreso clinic and the WAPCAS-NGO drop-in center may be aware of common processes and geographical pathways that lead to sex work for new arrivals to Kumasi. Girls and teens who are new to the business often do not think of themselves as sex workers and the youngest, most naive and, therefore, vulnerable girls might also be less visible than those working high-traffic areas (5). An early identification and response system to identify girls just starting sex work and provide them with safe sex education, condoms, condom negotiation training, alcohol and drug counseling, and more is necessary.

Collaboration between the overall SHARPER project, the WAPCAS-NGO drop-in center, and local organizations that provide support to children and adolescents living in the Bompata bus station and other areas frequented by head porters and other children on the streets will be a useful first step to identifying these groups of friends involved in sex work, building relationships and trust, training peer educators, and building an overall rapid response system. Both roamers and seaters seem to have some form of organized initiation into the business. We learned that groups of girls will sometimes make new girls pay a fee to work in their area. This seems to be a less formal system than that of “queen mothers” who organize the seaters in Adum, giving them advice, regulating rates, etc. or the “aunties” who travel to Nigeria to bring girls to Ghana to join the business who then must pay a large fee to be autonomous (4). Strong connections between SW service providers and queen mothers have already been established in Kumasi; therefore, identifying and connecting with aunties and networks of friends can be a first step toward building a child and teen focused support and education system.

It is currently unclear whether peer educators have contact with new arrivals to Kumasi specifically. Peer educators can be assigned to the bus station and other areas where young people newly arrived in Kumasi congregate. These educators can offer HIV prevention education, condoms and referrals to shelters and drop-in centers, other child protection
organizations, and key population-friendly health care. This outreach is critical for girls and adolescents who are newly arrived and unaccompanied by a parent or guardian (5,29,30).

3. **Strengthen Links with Social Welfare and Child Protection Services to Promote Sustained Individual-Level Intervention**

Local NGOs working with vulnerable children and youth frequently provide lay case management to the extent that their resources allow, but are often unable to provide sustained individualized engagement. Stronger links to social welfare services, the Domestic Violence and Victim Support Unit (DOVVSU), and education/livelihood support services are a critical follow-on step to a peer counseling and early identification system. Social workers/case managers working at the local organizations that are a first point of contact can work with individual youth to assess their needs (for shelter, rape or assault services, returning home, enrolling in school, learning a skill for alternative income generation), and connect them with professionals in the Department of Social Welfare and other protection resources.

4. **Engage Boyfriends and Other Non-Paying Partners**

Addressing the behavioral norm of having unprotected sex with boyfriends and regular clients is the number one prevention need for this subset of sex workers. The high proportion of FSW who said that they had unprotected sex with their boyfriends or regular partners compared with the suspected high HIV prevalence of this group indicates that this practice is a large driver of HIV infection among FSW. New initiatives aimed at encouraging protected sex between intimate partners sex can be implemented through the existing network of service providers and peer educators. The boyfriends and other non-paying partners of FSW are a priority population for the SHARPER project. Outreach to this population can be expanded to include teenage boys as well as men of all ages who are involved intimately with girls under age 18 (5,6).

5. **Improve Access to Condoms**

Affordable condoms and lubricants are critical to prevention efforts. The peer educator distribution system seems like the most accessible way to get condoms to these girls and young women, yet none of them mentioned this system, leading us to conclude that it might not be well-known among youth SW. Therefore, the youth peer educator cadre that we propose above can also be tasked with selling inexpensive condoms as part of their scope of work. Finally, private sector pharmacies and licensed chemical shops are easily accessed and may be motivated to offer better customer service to FSW of all ages compared to government institutions which do not profit from selling condoms.

Female condoms, although not widely used, should be available for those who use them. While there has been a hesitancy to promote female condoms due to questions regarding their acceptability, we found that they work for some FSW and should not be disregarded (31). The use of female condoms as a negotiation tool warrants further exploration.
6. Continue to Focus on Stigma Reduction in Health Care Settings

Stigma from health care providers remains a barrier to care for female sex workers. While the clinics at Suntreso and MCH Hospitals, provides FSW-friendly services, other clinics and hospitals do not. Professionalism with FSW and other key populations should be the norm. Health care providers should be given sensitivity training regarding work with female sex workers, and there should be reporting mechanisms in place to hold them accountable for instances of discrimination. Interestingly, perceived HIV status seemed to be less of a cause of external and internal stigma than their profession. Some of the health care workers interviewed for this study noted the catch 22 they often find themselves in: women engaged in sex work reported being wary about bringing their work up; likewise, health care workers reported being wary about asking because they do not want to offend. The SHARPER M Friends and M Watchers programs are a critical platform for reducing stigma among health care workers.

An enhanced focus on working with youth involved in sex work in a calm, non-reactive or judgmental way is critical. Training for health care workers can provide guidance on how they can talk with youth selling sex about their work, and sexual health with a focus on providing harm reduction as well as psychosocial support appropriate to their maturity level (5). They can also work with the M Watchers network to inform them about girls at particular risk and potential for other interventions.

7. Continue Building Partnerships with Police to Shift Emphasis from Punishment and Exploitation to Protection and Advocacy

The SHARPER M Watchers program and the Ghana Police Service HIV/AIDS training curriculum currently being developed by FHI 360, Johns Hopkins University, and USAID Ghana are both promising developments in terms of sensitizing police to the vulnerabilities faced by key populations and reducing the punitive approach and exploitation that, according to our respondents as well as other sources, still occur frequently (17). The curriculum should specifically highlight the vulnerabilities of children who arrive in Kumasi unaccompanied by adults as well as girls and teens involved in the sex trade and provide officers with training to provide appropriate support and referrals. And M Watchers associated with the Police Service should also be trained to understand and advocate for the special needs of girls working as head porters or doing other jobs in the informal sector who seem to be at particularly high risk for drifting into sex work. The Domestic Violence and Victim Support Unit, which is part of the Police Service, has a clearly articulated mission to provide children involved with sex work with protection and advocacy services (32). The DVVSU can be directly engaged in any training or sensitzation programs targeting police officers.

8. Learn More about the Vulnerability of Boys and Young Men Involved in Sex Work and Provide them with Similar Outreach and Protections Services

A 2009 United Nations Family Planning Agency Report has documented high levels of vulnerability among adolescent and teenage boys and young men who are involved sex work (33), confirming reports from programs working with youth and key populations. The national Ghana Men’s Health Study (being undertaken by the University of San Francisco and the US
Center for Disease Control in partnership with the Ghana AIDS Commission) and a qualitative study in Kumasi (undertaken by BU, KNUST, and FHI 360 as part of the Operations Research among Key Populations portfolio) will provide further information about their specific vulnerabilities and needs. All of the recommendations made here for girls and young women can be adapted for boys and young men.
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