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“You already drank my beer, I can decide anything”: Using structuration theory to explore the dynamics of alcohol use, gender-based violence, and HIV risk among female sex workers in Tanzania

Anna M. Leddy^{*,a,1}, Deanna Kerrigan^{a,2}, Caitlin Kennedy^b, Jessie Mbwambo^c, Samuel Likindikoki^c, and Carol Underwood^{a,d}

^aDepartment of Health, Behavior, and Society, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

^bDepartment of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, 21205 USA

^cMuhimbili University of Health and Allied Sciences, United Nations Rd., Dar es Salaam, Tanzania

^dCenter for Communication Programs, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

Abstract

Female sex workers experience high rates of gender-based violence (GBV) and HIV. Alcohol has been shown to facilitate women’s risk for both GBV and HIV; however, little research has qualitatively explored how aspects of the sex work environment shape this risk. Drawing on structuration theory, this study explored how social conduct is patterned across time and space within the sex work environment to influence alcohol consumption, GBV, and HIV risk among female sex workers. Qualitative in-depth interviews were conducted with 24 female sex workers enrolled in an ongoing community randomised controlled trial of a combination HIV prevention intervention in Iringa, Tanzania. Data were analysed using both inductive and deductive approaches. Findings reveal how routine interactions between female sex workers and their clients occur at three moments of time and space during the sex exchange process to facilitate alcohol consumption and increase women’s risk for GBV and HIV. Findings also highlight how sex workers mobilise their collective agency to address aspects of the sex work environment that place them at risk for alcohol abuse, GBV, and HIV. Implications for future interventions to prevent GBV and HIV among female sex workers in Tanzania and similar contexts are discussed.

Keywords

sub-Saharan Africa; female sex workers; gender-based violence; alcohol use; HIV

*Corresponding author: Anna Leddy, anna.leddy@ucsf.edu.

¹Division of Prevention Sciences, Department of Medicine, Center for AIDS Prevention Studies, University of California San Francisco, 550 16th Street 3rd Floor, San Francisco, CA, 94158 United States

²Department of Sociology, American University, Washington, DC, USA

Background

Globally, female sex workers are disproportionately affected by HIV and gender-based violence (GBV) (Beyrer et al. 2015; Decker et al. 2015). In Tanzania, the national HIV prevalence among female sex workers is 6.5 times higher than the HIV prevalence among women in the general population (National AIDS Commission 2014; Tanzania Commission for AIDS 2013). Female sex workers in Tanzania also report much higher rates of GBV than their female counterparts in the general population (Ministry of Health 2016; National AIDS Commission 2014). The national prevalence of physical and sexual violence among Tanzanian women in the past 12 months is 22% and 9% respectively (Ministry of Health 2016). In contrast, 50% of female sex workers in Tanzania have experienced physical violence and 37% experienced sexual violence in the past 6 months (National AIDS Commission 2014). Such disparities are influenced by structural factors including the criminalisation of sex work, stigma and discrimination towards sex workers, poverty, and gender inequity (Decker et al. 2015; Kerrigan et al. 2013; Beckham et al. 2015).

Alcohol use and abuse has also been shown to increase female sex workers' risk for both HIV and GBV in sub-Saharan Africa (SSA). Alcohol consumption is thought to increase sex workers' risk for HIV by limiting their ability to successfully negotiate and use condoms with their sexual partners (Mbonye et al. 2014; Muldoon 2015; Schulkind et al. 2016). Furthermore, alcohol use can increase women's risk for violence by limiting their ability to detect potentially dangerous situations, or by rendering them unconscious and unable to defend themselves against unwanted advances from clients or partners (Panchanadeswaran et al. 2008; Schulkind et al. 2016; Schwitters et al. 2015; Mbonye et al. 2013).

Prior research suggests that alcohol plays a central role in the sex work negotiation process in Tanzania. Clients typically purchase alcohol for sex workers in order to indicate that they are interested in securing their services (Research to Prevention 2013a). Thus, it is common for both sex workers and clients to engage in sex under the influence of alcohol. Previous studies have demonstrated not only how female sex workers' own alcohol consumption places them at risk for HIV and GBV (Wilson et al. 2015; Schwitters et al. 2015), but also how client intoxication is associated with increased violence perpetration (Panchanadeswaran et al. 2008) and reduced condom use (Madhivanan et al. 2005; Goodman-Meza et al. 2014).

Anthony Giddens' work on the structuring of social conduct across time and space provides a lens through which we can explore how alcohol use, GBV, and HIV risk overlap to further increase risk for negative health outcomes and offers insight into potential avenues for intervention. According to structuration theory, by examining the routine interactions of certain populations across time and space, social scientists can gain insight into aspects of social systems that shape such practices (Giddens 1984). Furthermore, the theory posits that while social systems shape individual behaviours and routines, individuals also have the capacity to either reproduce or change social structures through their own agency (Giddens 1984). Thus, by exploring how social interactions occur across time and space in the sex exchange process, we can better understand the factors that place female sex workers at risk for GBV and HIV. This exploration can also provide insight into strategies sex workers can

use to mobilise their collective agency to shift social and structural factors to better improve health outcomes.

Although prior research has demonstrated the important role alcohol plays in increasing female sex workers' risk for both HIV and GBV, little research has examined how social interactions across time and space in the sex exchange process shape this risk. Further research is also needed to gain a more nuanced understanding of the dynamics that link alcohol to HIV and GBV among this population in order to shed light on potential pathways for intervention. We conducted a qualitative study with 24 female sex workers in Iringa, Tanzania in order to fill this gap in the literature.

Methods

Study Setting

Iringa is located in the Southern Highlands of Tanzania along the Tanzanian-Zambian highway, which brings truck drivers and seasonal migrant workers through the region, and increases the demand for sex work (Research to Prevention 2013b). The majority of female sex workers in this region are employed as barmaids in bars that line the highway and sell bottled and/or locally brewed alcohol to clientele. Barmaids in Iringa often engage in sex work to augment their low wages (Beckham et al. 2015). Alcohol use is common among female sex workers in Tanzania, and 65% of female sex workers in Iringa report alcohol consumption on a daily basis, which is one of the highest rates of daily alcohol consumption among this population in the country (National AIDS Commission 2014).

Description of Parent Study

This qualitative study was nested within an ongoing phase II community-randomised controlled trial of a community-based combination HIV prevention model for female sex workers in Iringa, Tanzania (Kerrigan et al. 2017). Project Shikamana (Kiswahili for 'stick together') consists of biomedical, behavioural, and structural intervention components and is informed by a community empowerment approach. Intervention components include (1) peer education, condom distribution, and HIV counselling and testing in entertainment venues; (2) peer navigation to facilitate HIV prevention as well as linkage to and retention in HIV care and treatment; (3) sensitivity training for HIV health care providers and police; (4) text messages to promote project awareness and adherence to HIV care and treatment; and (5) a community-based drop-in centre (DIC) where workshops are held to promote social cohesion among female sex workers and facilitate community mobilisation around issues such as stigma and discrimination, violence, and HIV prevention (Kerrigan et al. 2017).

The parent study established a cohort of 496 female sex workers, stratified by laboratory-confirmed HIV status, in the Iringa region of Tanzania. The cohort includes 252 participants from the intervention community and 143 participants from the control community. To be eligible to participate in the parent study, women must have met the following eligibility criteria: 18 years, report exchanging sex for money in the last month, and work at an identified sex work venue in one of the two study communities.

Sampling and Recruitment

We conducted a qualitative sub-study among 24 participants from the cohort of 252 female sex workers in the parent study's intervention community from August- October 2016. Using baseline data and intervention tracking information, participants were purposively sampled based on the following characteristics to facilitate analytic comparisons: laboratory confirmed HIV status (12 HIV infected & 12 HIV uninfected), work venue (12 modern bar & 12 traditional bar), and level of engagement in the intervention (12 low engagement & 12 high engagement). Laboratory confirmed HIV status was included as a sampling characteristic based on evidence suggesting that HIV-infected women are more likely to experience violence and less likely to use condoms consistently (Dunkle et al. 2005; Li et al. 2014). Fieldwork within the study population also suggested that female sex workers working in modern bars are slightly more mobile than those who work in traditional bars. Mobility may limit sex workers' ability to form strong social bonds with sex worker colleagues which could prevent them from accessing support for limiting their alcohol consumption, avoiding potentially violent clients and/or situations, and using condoms (Ramesh et al. 2012; Shannon et al. 2015). Finally, participants were stratified by level of participation in the intervention due to the fact that aspects of the project sought to address GBV, HIV, and alcohol use.

For the purposes of this study, participants' engagement in the intervention was evaluated by the number of DIC workshops they attended and whether or not they accepted peer navigation services, because these were the only intervention components that addressed the intersection of HIV, GBV, and alcohol. High engagement in the intervention was defined as accepting peer navigation services and attending at least two DIC workshops. Women who did not meet the criteria for high engagement were deemed to be minimally engaged in the intervention. Participants were contacted by phone and asked if they were interested in participating in the qualitative sub-study. To ensure confidentiality and safety of the participants, recruiters framed the study as one that was focused on participants' health and life experiences (WHO 2001).

Data Collection

The interview guide consisted of broad, open-ended questions meant to elicit women's thoughts and perspectives on the role alcohol use plays in the sex work environment, and how alcohol use is related to experiences with violence and HIV prevention behaviours. Additionally, the guide included questions that explored the strategies female sex workers employ to address factors in the sex work environment that increase their risk for GBV and HIV. Questions in the guide were informed by prior research as well as social behavioural theory, including the constructs of social cohesion and structuration theory. The interview guide was written in English, translated into Kiswahili, back translated, and piloted to ensure questions made sense to participants.

All interviews were conducted in a private room in the DIC affiliated with the parent study and lasted 60–90 minutes. Participants provided informed consent before starting the interview and were compensated 5,000 Tanzanian Shillings (Tsh) (~\$2 US dollars) for their time. Two female interviewers conducted in-depth interviews utilising the semi-structured

interview guide. To ensure participant confidentiality, both interviewers completed an extensive human subjects training. This training emphasised the importance of maintaining the confidentiality of each participant, and the protocols and procedures in place to achieve this goal such as finding a private location to conduct all interviews, and how to seamlessly change the subject should the interview be interrupted (WHO 2001). Additionally, we assigned pseudonyms to participants to protect their confidentiality.

Data analysis

All interviews were audio-recorded, transcribed and translated into English, and entered into Atlas.ti (Proprietary Software 2016) software for coding. Qualitative analysis was conducted using the framework approach. This approach was developed for applied research, in which the objectives of a qualitative study are established in advance and driven by the need to inform the development of health programs (Pope, Ziebland and Mays 2000). This approach was chosen because it enabled a more direct analytic process, allowing us to hone in on questions of interest.

Analysis was facilitated by immersion in the data, through multiple readings of the transcripts and memo writing to highlight emergent themes and insights. Drawing on the framework approach, the first author developed an initial coding schema based on *a priori* codes (i.e. informed by the key research questions), which were iteratively revised by adding new codes that reflected additional themes, topics and frames that emerged from the data. The first author then systematically applied the codes across all the transcripts, using memos to elaborate upon the codes and their application. Next, data were organised into a chart format, with a chart for each key theme and summaries of different perspectives and experiences from several participants. This method allowed data to be compared and contrasted across different themes and perspectives, and facilitated the identification of associations between themes, which can provide explanations for the findings (Pope, Ziebland and Mays 2000).

We adopted several strategies to improve the likelihood that the data we collected, and our interpretations of that data stayed true to participants' lived experiences. Both the interviewers and the first author wrote detailed memos throughout the research process to reflect upon the ways their experiences, values, and beliefs may have influenced the data received, and their interpretation of that data (Sandelowski 1986). Additionally, interviewers and the first author debriefed after each interview to discuss the main themes that emerged in the interview, the tone of the interview, and any concerns that arose during the interview. These debriefing notes served as a check to ensure that the tone of the interview and the main themes were captured in the transcription and translation (Reissman 2008 Lincoln and Guba 1985). This study received human subjects research approval from the Institutional Review Boards of the Johns Hopkins Bloomberg School of Public Health, the Muhimbili University of Health and Allied Sciences Directorate of Research and Publications, and the National Institute for Medical Research of Tanzania.

Results

Sample demographics

All 24 participants were purposively recruited from the intervention community in Iringa, Tanzania so that half of the sample (n=12) was HIV-infected, half worked in a modern bar, and half were highly engaged in the intervention. The age of participants ranged from 19 to 47 years, with a mean age of 29 years. Less than half (n=9) of the participants earned more than 120,000 Tsh per month (~ \$54 USD). The majority of participants (n=21) reported hazardous or harmful alcohol use, as defined the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001). One-quarter (n=6) reported consistent condom use with all clients in the past 30 days. Finally, over half (n=13) reported experiencing any violence (physical or sexual) in the past 6 months.

Findings

Women described engaging with their clients in routine patterns of behaviour at three specific moments during the sex exchange process, which facilitate alcohol consumption, GBV, and unprotected sex. These moments of time and space include: 1) attracting and meeting clients in the bar, 2) negotiating the terms of the sex exchange and moving from the bar to the room, and 3) engaging in sex in a room. These moments of time-space are depicted in Figure 1 as circles, each with an arrow representing the repetition of routine interactions and practices at that moment. Our results also shed light on strategies female sex workers use to shift the trajectory of the sex exchange process at each moment of time-space to limit alcohol consumption and prevent GBV and HIV. These strategies are illustrated on the right-hand side of Figure 1, with arrows pointing towards the moments of time-space to suggest their interruption of the routine behaviour in each moment.

Attracting and meeting clients in the bar

Women described consuming alcohol during sex work for a number of reasons, including for pleasure, as a coping mechanism to ‘forget’ the hardships of life such as poverty, and to attract clients. Here, we focus on alcohol as a strategy women use to attract clients. As the following quote illustrates, women recounted drinking alcohol to give them courage to initiate conversations with clients and appear ‘happy’ and ‘excited’ to interact with clients:

When you drink alcohol, it can attract a client to sit and drink at your place. If you haven’t drunk [alcohol]... he sees you are not excited. Clients want to find a person [who] is excited, laughing, happy...If he finds you angry he can’t come to your place. (Margaret, 23 years, traditional bar, HIV-uninfected)

Alcohol consumption is further facilitated by the routinised social practice of clients purchasing alcohol for female sex workers to signal their interest in securing the women’s services. This practice was revealed by women regardless of their sampling characteristics (i.e. HIV status, their work environment and their level of engagement in the intervention). Linda noted:

[Clients] can’t just come from nowhere [and say] ‘you lady, I want to go and sleep with you.’ No! So, he uses a certain way to get you attracted. [He tells a barmaid],

‘give that lady over there a beer.’ After you have already drank, he gives you an offer. He tells [the barmaid], ‘please call for me that lady I want to talk to her.’ You go and talk to him. He tells you, ‘I want you for today, maybe can we go [have sex]?’ (Linda, 23 years, modern bar, HIV-uninfected).

Most women supported this statement, maintaining that they know they are supposed to have sex with a client once he purchases an alcoholic beverage for them. The narratives around this practice suggest that by consuming alcohol purchased by a client, female sex workers essentially assent to a social contract (Pateman 1988), or an implicit agreement, that commits them to have sex with that client. For example, one woman stated, ‘when you take [a man’s] alcohol, it means you are ready to go with him [to have sex]’ (Hanifa, 34 years, traditional bar, HIV-infected).

Women argued that it is very difficult to engage in sex work without drinking alcohol. Some participants stated that if they refuse alcohol purchased by a potential client, they will lose business from that client. Since the vast majority of female sex workers rely on sex work for their income, they are often forced to accept and consume client-purchased alcohol, even if they do not want to. Again, this sentiment was expressed by women regardless of their sampling characteristics.

Finally, women reported that both modern and traditional bars are the primary locations where sex workers experience violence. Participants attributed this to the fact that male clients routinely drink to the point of intoxication. Women said that clients who are drunk are more likely to become violent. Participants described situations where they would get into arguments with a client over his payment for alcohol or for sex work, and because the client was drunk, he would become physically violent. Participants argued that such behaviours would occur less frequently if clients were sober.

Collective Agency.—Female sex workers who were highly engaged in the intervention described using strategies to avoid becoming intoxicated during sex work. For example, a few participants described arranging with the barmaid working behind the bar to fill their beer bottles with water, thereby creating the illusion that they are consuming the alcohol their client purchased for them. As Joyce describes below, not only does this strategy allow women to remain sober during sex work, it also allows them to earn additional money because they keep the money the client pays for the beer they never consume.

If [a client] tells me, ‘drink,’ I [order] a beer that is sold at 3,500 Tsh... the [beer] can doesn’t show what is inside. So, you take that can, [and] you just put water [in it]. You just tell the barmaid, like you just talk with your fellow [who] you have a good relationship [with], ‘make sure everything that is coming to me is a can with water.’ You [can] drink even ten of those. If you calculate 3,500 Tsh times ten, you just find you have a good amount of money. (Joyce, 29 years, modern bar, HIV-infected)

Furthermore, to mitigate violence that occurs in bars, some participants reported joining forces to intervene and stop violence perpetrated against their colleagues. Other participants said they seek help from the bar manager or other male clients to stop violence against their

sex worker colleagues in the bar. Participants who reported engaging in these practices were primarily those who were highly engaged in the intervention.

Transitional/Negotiation space

After consuming alcohol purchased by clients, female sex workers and their clients negotiate the terms of sex. These terms include the price and type of sex (vaginal or anal), and whether or not a condom will be used. Participants described negotiating these terms with their clients at the table where they are drinking in the bar, or as they are making their way from the bar to a guesthouse where they will have sex. The majority of women contended that violence often occurs if a woman refuses to have sex with a client after consuming the alcohol he purchased for her. In such situations women often experience physical violence, especially if the client is already drunk:

He can buy me two, three beers and want to leave with me (to go have sex), [if] I don't want [sex], he decides to beat me...Those things happen a lot. When clients get drunk in the bar, that is when they do that. (Irene, 30 years, modern bar, HIV-infected)

Aisha shared a similar story when asked by the interviewer what causes violence against sex workers in the bar: 'You may say, "let me drink alcohol from this person but I will not sleep with him." That is when problems (violence) happen' (Aisha, 33 years, HIV-uninfected, traditional bar).

Narratives around violence in these situations often cast blame on sex workers for revoking the social contract, which was set in motion when they consumed alcohol purchased by a client. When asked why female sex workers experienced violence from clients, a number of participants suggested that sex workers do not experience violence 'for no reason.' Instead, many suggested that the woman 'must have eaten his money' (drank his beers) and not provided sex in return.

Women also argued that negotiating condom use becomes particularly difficult when clients are drunk. In general, women said that the majority of clients do not want to use condoms because they feel that condoms do not allow them to 'taste' sex, meaning that sex with condoms is not as pleasurable as unprotected sex. However, women noted that when clients are drunk it becomes even more difficult to convince them to use condoms because alcohol makes clients 'stubborn' and many refuse to use condoms. Again, this finding was echoed by women regardless of their sampling characteristics.

Women explained that if they refuse to have unprotected sex with a client, the client could find another woman to have unprotected sex with. Therefore, in order to avoid losing business, women often feel as if they have to accept unprotected sex with a client, even if they prefer to use condoms.

Collective Agency.—To prevent the violence that typically occurs when a sex worker refuses to have sex with a client after consuming the alcohol he purchased her, some women reported paying the client back for the drink(s) he bought her. As Esther articulates in the

following quote, if a sex worker does not have enough money to pay her client back, her colleagues will lend her money to help her avoid violence:

If you have used his money and beers, [and] if you refuse [to have sex with him], then he will ask for his money back. In that situation we can help our fellow working woman (sex worker). If they agreed before and later, she changes her mind and the man panics then we shall find a way to return his money back. (Esther, 28 years, modern bar, HIV-uninfected)

To ensure condom use, some women who were highly engaged in the intervention reported secretly inserting female condoms before leaving with their client to have sex. This often occurs after a woman tries to negotiate condom use with a client who adamantly refuses. As the following quote illustrates, women who employ this strategy go to the restroom to put on the female condom before they leave with their client:

You know [when] men are drunk, he tells [you] 'I don't use condom.' So, if he insists [on unprotected sex], I ask to visit [the] toilet. Then I put on my lady condom [and] then I come back. He will think that I have agreed to sex without condoms. Meanwhile I know what I have done. (Faith, 27 years, traditional bar, HIV-uninfected)

Room/Sex exchange space

The majority of female sex workers in Iringa exchange sex in guesthouses near the bars where they meet their clients. Typically, they and their clients leave the bar after agreeing to the terms of the sex exchange and arrive at a nearby guesthouse, where the client will pay to rent a room for a couple hours or the night, depending on the agreement made with the sex worker. Sex work can also occur in rooms in the back of modern bars, which double as living quarters for female sex workers who work as barmaids in these bars.

Many participants reported that, when women drink to the point where they lose consciousness, clients sexually assault them. Women recounted stories of cases in which they or their friends had become unconscious from excessive drinking, were taken to a room by a client, and were either raped (vaginally or anally), gang raped, and/or forced to have sex without a condom. Participants also described instances when clients attempted to get female sex workers drunk to facilitate sexual assault. Again, this finding did not differ by sampling characteristics.

There was a certain friend of mine... she drank the beers of people who arranged to rape her after she was drunk... She was very drunk, to the extent that she could not move. So, they raped her... They raped her both sides (vaginally and anally). When she got her mind (when she became conscious) she said there were like five men. (Hanifa, 34 years, traditional bar, HIV-infected)

Women also described cases of clients agreeing to engage in a certain type of sex during the negotiation process, only to change their minds when they get into the room. As Linda explains in the following quote, if a woman consumes alcohol purchased by the client and refuses to acquiesce to the clients' new demands, she is beaten or raped.

First, he (client) told her ‘I want to go with you.’ She agreed... but she told him clearly ‘I want us to use condom.’ The client agreed but inside [the room], the client turned [and said], ‘you can’t tell me to use condom while you have already drunk my beers, I can decide anything.’ She refused [to have unprotected sex] and that is when she was beaten. (Linda, 23 years, modern bar, HIV-uninfected)

Participants explained that alcohol can make them ‘forget’ to negotiate condom use, which results in unprotected sex. In this context, women revealed that it is often left up to them to negotiate condom use because clients prefer unprotected sex. Thus, when a woman forgets to ask her client to use a condom, they end up having unprotected sex. Finally, women also noted that alcohol greatly increases their sexual desire, and that this makes them reluctant to use condoms because they consider protected sex less pleasurable than unprotected sex.

Collective Agency.—To prevent violence, participants recalled covering shifts for colleagues who become too intoxicated to work. They also reported bringing their fellow sex workers home to rest when they become unconscious from excessive drinking. Such strategies prevent their colleagues from being exploited by clients. Participants also mentioned advising colleagues who frequently become intoxicated to reduce their alcohol consumption.

Some women who experienced violence in private rooms while conscious scream or yell for help from their sex worker colleagues. As part of Project Shikamana, women were given whistles and advised to take the phone numbers of their sex worker colleagues to call for help when they are in danger of violence. Women who were highly engaged in the intervention reported utilising these strategies and effectively mobilising their fellow sex workers to stop violence being perpetrated against them.

Our fellow [sex worker] agreed to have sex with a customer. After getting inside [the room] she found two clients. Because she was already educated by then (participated in the intervention) ...she blew the whistle. After she blew the whistle there are some women who went there and some ... were called through phones. After been called, we as [female sex workers], we ran there. [When we arrived] that customer ran...we went to report [the violence] to the police station. (Grace, 25 years, traditional bar, HIV-uninfected)

Discussion

Findings from this study reveal that routine social interactions between female sex workers and their clients occur at different moments of time and space across the sex exchange process to facilitate alcohol consumption and increase women’s risk for GBV and unprotected sex. Our findings also shed light on how sex workers are already mobilising their collective agency to intervene upon these routine interactions to limit alcohol consumption and prevent GBV and HIV. These results have implications for future interventions that seek to address the intersecting epidemics of alcohol use, violence, and HIV among female sex workers in Tanzania and similar contexts.

Participants in this study described how their need to attract potential clients, and client expectations of alcohol consumption as a first step in the sex exchange process, facilitate high levels of alcohol use during sex work. Our findings support results from other studies in SSA, which document purchasing alcohol as a means to initiate the sex exchange process (Research to Prevention 2013a; Mbonye et al. 2014; Schulkind et al. 2016). They add to this past research by highlighting that accepting alcohol purchased by a client signals sex workers' implicit assent to a social contract signifying that they will eventually have sex with that client, and that abrogating this contract, by refusing to have sex after drinking client-purchased alcohol, often results in physical violence.

Here, the term 'social contract' is used to describe the implicit agreement between the client and the sex worker, which is initiated when the woman consumes client-purchased alcohol, and obligates her to have sex with the client (Pateman 1988). Findings from this study also suggest that this social contract can be understood to go beyond just an agreement to engage in sex. In some instances, the social contract also entails sex workers relinquishing their power or control over the timing and terms of sex. This was demonstrated by participants' stories of clients who, upon entering a private room, would abrogate the previously agreed upon terms of sex. In such instances, if a sex worker had consumed client-purchased alcohol, but did not agree to the new terms, she would experience physical or sexual violence.

Drawing on structuration theory, we can begin to understand how clients' violent reactions to female sex workers nullifying the social contract of sex work reflect larger social and structural forces at play (Giddens 1984). Hegemonic masculine norms, which value male virility and dominance over women, are hypothesised to perpetuate gender inequality and sanction violence against women (Jakobsen 2014; Connell and Messerschmidt 2005). Violence is seen as a way that men are able to exert control over women and confirm their masculinity (Jakobsen 2014; Jewkes and Morrell 2010). The narratives outlined by participants suggest that clients assume a sense of 'ownership' and control over women once a woman consumes alcohol they purchase. It is possible that clients feel as though their authority is challenged when a sex worker who has consumed alcohol they purchased for her refuses to have sex or a certain type of sex with them. In such instances, violence can be seen as a strategy men use to exert their power and control over 'disobedient' women.

Violence against female sex workers in the situations described above can also be understood (at least in part) as a result of stigma and discrimination towards sex workers. Sex work is criminalised in Tanzania, as in many other African countries, which fosters an environment of stigma and discrimination towards female sex workers, and can limit their ability to access justice for violence perpetrated against them (Decker et al. 2015). In such contexts, violence against sex workers is often a form of enacted sex work stigma, and regularly occurs with impunity (Decker et al. 2015). It is possible that such dynamics facilitate violence against FSWs in this setting.

Public Health Implications

As described earlier, structuration theory posits that while structure influences individual agency, individuals also have the capacity to use their agency to maintain or adapt structures. This theory has implications for how female sex workers can mobilise their collective

agency to interrupt the routinised interactions within the sex exchange process that promote alcohol abuse and increase their risk for GBV and HIV. Community empowerment approaches, which facilitate opportunities for sex workers to come together as a community, in partnership with key stakeholders, to mobilise their collective agency to challenge social systems and structures and demand their rights, have proven successful in increasing condom use and preventing violence among sex workers in other regions of the world (Kerrigan et al. 2015). However, few, if any, community empowerment approaches have addressed the overlapping epidemics of GBV, HIV, and alcohol use among female sex workers, and none have done so in SSA (Kerrigan et al. 2015). It is possible that such an approach would serve useful in addressing the role alcohol consumption plays in increasing women's risk for GBV and HIV in this context. Indeed, findings from this study suggest that women who are highly engaged in Project Shikamana, which adopts such an approach, are already mobilising their collective agency to limit alcohol consumption, prevent and respond to GBV, and improve condom use within the bar environment.

However, it is important to acknowledge that female sex workers may face considerable constraints in shifting the structural environment due to their marginalised status in society. As such, community empowerment approaches should seek to provide opportunities for sex workers to garner the support from bar managers/owners to address aspects of the sex work environment that facilitate alcohol consumption and increase women's risk for GBV and HIV. Evidence suggests that significant advances could be made through workshops where bar owners/managers and sex workers learn about the human and labour rights of sex workers and form a collective sense of solidarity and commitment to ensure sex workers' safety within the workplace (Ghose, Swendeman and George 2011). In this vein, Project Shikamana plans to conduct sensitisation training with bar managers/owners to inform them of the relationship between alcohol consumption, violence, and HIV among female sex workers, and bring them together with sex workers to strategise ways to limit alcohol consumption, prevent violence and promote condom use within the bar. This plan emerged as a result of a dissemination meeting held in Spring 2017 with female sex workers in the intervention community, where the first author shared the findings presented in this manuscript and provided a space for women to brainstorm strategies to address aspects of the sex work environment that facilitate alcohol consumption, violence, and unprotected sex.

Specifically, sex workers articulated that the sensitisation workshops with bar managers/owners should stress that women have the right to refuse sex from a client even after consuming alcohol purchased for them. These workshops will also emphasise that any violence against sex workers is a human rights violation, and perpetrators of such violence should be prosecuted. It is hoped that by highlighting these important points in the sensitisation trainings with bar managers/owners, female sex workers will be able to redefine the social contract of sex work and end the routine practice of clients becoming violent towards women if they refuse to have sex with clients after drinking the alcohol purchased for them. Prior work has demonstrated the utility of sex workers and bar managers/owners signing a literal social contract agreeing to promote the health and wellbeing of sex workers within each establishment (Kerrigan et al. 2004). The social contract in this context will articulate that managers and other sex workers should intervene and press charges against clients who become violent towards a woman, even if she consumed the client's alcohol and

refused to have sex with him. Such an approach might serve useful to other community empowerment approaches seeking to address the intersecting epidemics of alcohol use, violence, and HIV among female sex workers in other settings across SSA. However, keeping in mind that a fundamental aspect of any community empowerment approach is sex workers taking collective ownership over the programs and developing solutions to address their specific needs (World Health Organization (WHO) et al. 2013), the strategies outlined in this paper should be taken into consideration but adapted to meet the needs of female sex workers in each specific context.

Limitations

While our study provides important insights into the ways in which alcohol use increases female sex workers' risk for GBV and HIV, it is not without limitations. Specifically, given the sensitive nature of our research questions, it is possible that some women withheld information regarding their personal experiences with alcohol use, violence and unprotected sex. In order to address this potential limitation, both interviewers were trained to establish rapport with participants before beginning all interviews and received in-depth sensitivity trainings related to sex work and GBV.

It is also possible that participants' engagement in the ongoing intervention, which seeks to facilitate community mobilisation, may have influenced their responses during the interviews. Specifically, participants may have exaggerated the extent to which they come together with their sex worker colleagues to address factors that place them at risk for GBV and unprotected sex. To address this potential limitation, we purposively sampled female sex workers with both high and low engagement in the intervention. Importantly, the majority of our findings emerged from the narratives of both participants who were highly engaged in the intervention and those who had limited engagement.

Conclusions

The results from this study reveal how routine interactions between female sex workers and their clients occur at specific moments across the sex exchange process and promote alcohol consumption and increase women's risk for GBV and HIV. Additionally, our findings highlight the strategies sex workers can use to mobilise their collective agency in partnership with bar managers/owners to address aspects of the sex work environment that place them at increased risk for alcohol abuse, GBV, and HIV in this context. We argue that findings support and inform the need for community empowerment responses among female sex workers to address the role alcohol consumption plays in increasing women's risk for GBV and HIV in Tanzania and similar contexts.

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Figure 1.
Intersection of alcohol use, gender-based violence, and unprotected sex across time-space.