The Right to Health Care:
Sex Workers' Experiences in South Africa

Student: Trish Kaseke

Student number: 16378017

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Centre for Human Rights

Faculty of Law

University of Pretoria

Supervisor: Busisiwe Deyi

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DECLARATION

I, **Trish Kaseke**, declare that this dissertation is my own original work. Where secondary material has been used (whether from a printed source, the internet or any other sources) this has been appropriately acknowledged and referenced in accordance with the requirements of the Centre for Human Rights, Faculty of Law, University of Pretoria.

Signed: _____ Date: 23 December 2020

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Abstract

While the Universal Declaration for Human Rights (UNDHR) guarantees rights as absolute and universal, the practical realisation and extension of these rights remain arguable in different countries. With regard to UNDHR Article 25, the right to healthcare, the South African Constitution guarantees the right to primary health care for all. This obligation is fulfilled, from a legislative perspective, by the National Health Act.

In the context of the HIV/AIDS pandemic, sex workers are a key population on account of both their vulnerability to infection and propensity to spread infection by virtue of the work they engage in. Their unrestricted access to healthcare services is critical in terms of the national response to the pandemic.

Various studies have highlighted how, despite the existence of a progressive Constitution and progressive health legislation, sex workers continue to experience significant challenges in accessing public healthcare services.

This study sought to provide an explanation for the contradictions between legislative provisions and the lived realities of sex workers. A multi-pronged theoretical approach was utilised that included a trans political and queer theoretical approach, complemented by an intersectionality perspective, as an analytical tool to explore the existence of invisible networks that create conditions for discrimination and exclusion.

The study revealed the existence of invisible networks that work to deter sex workers from seeking health care services and other rights-related services, leaving them to employ survival strategies that are mostly unorthodox and harmful. The report concludes with recommendations on factors to consider if the access to health care services is to be fully realised by this important sub-population group.

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1 INTRODUCTION AND STUDY RATIONALE

1.1 Introduction and background

It is often argued that 'sex work' or 'prostitution' has been in existence since the beginning of time, with sex workers often viewed as transgressors of cultural and social norms such as monogamy, thereby destroying the moral and social fibre of society.[1] It is for this and other reasons, including stigma, discrimination, violence, rape, extortion and degrading treatment,[2] that sex workers are rendered a vulnerable group in society. Subsequently, they become targets of violence and degrading treatment that compromises their right to life, health, dignity, non-discrimination, safety and security, bodily autonomy,[3] and socio-economic rights amongst numerous other rights.[4]

Sex worker is a term

> *coined by sex workers themselves to redefine commercial sex, not as the social or psychological characteristic of a class of women, but as an income-generating activity or form of employment for women and men. As such it can be considered along with other forms of economic activity*.'[5]

While 'prostitution' as a term is widely used, it remains derogatory and discriminatory. 'Sex work 'on the other hand, sets a neutral, value-free foundation of how sex work should be approached and as such this paper will adopt the term sex work. The World Health Organisation (WHO)[6] defines a sex worker as a

> *female, male and transgender adult aged over 18 years who sells consensual sexual services in return for cash or payment in kind, and who may sell sex formally or informally, regularly or occasionally.'*[7]

[1] 'The VAMP/SANGRAM Sex Worker's Movement in India's Southwest' (Hereafter Sex Worker's Movement)
[2] 'Sex work and the law the case for decriminalisation' (hereafter Sex work and the law)
[3] Bodily Autonomy refers to the concept that a person has control over who or what uses their body, for what, and for how long
[4] Sex work and the law (note 2 above) 2
[5] J Bindman, & J Doezema, J 'Redefining prostitution as sex work on the international agenda' (1997).
[6] World Health Organisation (hereafter WHO)
[7] WHO (note 6 above)

The right to healthcare is guaranteed for every human being in Article (25) of the Universal Declaration of Human Rights[8]. It is carried through in other subsequent legally binding human rights instruments such as Article (12) of the International Covenant on Economic, Social and Cultural Rights (CESCR),[9] Article (12) of the Convention on the Elimination of All Forms of Discrimination Against Women,[10] Article (16) of the African Charter on Human and Peoples' Rights[11] and Article (14) of the Protocol on the Rights of Women.[12] The Declaration was unanimously adopted as the guiding document setting out the basic human rights, and their minimum standards, to be guaranteed to all individuals by member states. It is currently ratified by 179 of the 193 member States. The Vienna Declaration and Programme of Action[13] proclaims all human rights contained in the UNDHR as "universal, indivisible, interdependent and interrelated." This mandates States to ensure that these rights are concurrently realised for all persons and at all times without any prejudice of political, social, economic and cultural difference.[14]

The UNDHR can be viewed as the blueprint for international human rights law and theoretically it plays a complementary and subsidiarity role to regional and national mechanisms in place to promote, protect and uphold human rights.[15] To a significant degree, these rights form the premise upon which signatory country constitutions are developed as a process of commitment to, compliance with, and domestication of some of these human rights instruments.

In fulfilment of its obligations to all these instruments, South Africa has the right to healthcare entrenched in section 27 of its Constitution[16], which it gives legislative effect through section 4 (3) of the National Health Act.[17] The National Health Act seeks to fulfil the constitutional

[8] Universal Declaration for Human Rights (hereafter UDHR)
[9] International Covenant on Economic, Social and Cultural Rights (hereafter CESCR)
[10] The Convention on the Elimination of All Forms of Discrimination Against Women (hereafter CEDAW)
[11] African Charter on Human and Peoples' Rights (hereafter ACHPR)
[12] Protocol on the Rights of Women (hereafter Maputo Protocol)
[13] Vienna Declaration and Programme of Action
[14] J Cantius Mubangizi 'The Constitutional Protection of Socio-Economic Rights in Selected African Countries: A Comparative Evaluation' (2006) 1 African journal of legal studies 2 at 1-19
[15] F Viljoen *International Human rights law in Africa* (2012)
[16] The Constitution of the Republic of South Africa 1996 (hereafter Constitution)
[17] National Health Act 61 of 2003(hereafter National Health Act)

mandate by making primary or basic healthcare services freely available to everyone at all government facilities.

Cognisance of sex workers as a key constituent in the spread of, and therefore the fight against HIV and AIDS, a South African National Sex Worker HIV Plan for 2016 – 2019[18] was also developed. The existence of this plan means that neither the fact that sex work is criminalised in South Africa nor society's sentiments towards sex work and those who work as sex workers, should curtail sex workers' access to their right to healthcare services. Unrestricted access to primary healthcare services by sex workers is also particularly important given that they are a 'vector' in the spread of HIV and AIDS and therefore a key constituent in the fight against HIV and AIDS.

The stigma and discrimination perpetuated by the sexual repression laws lead to the acceptance and normalisation of violence against sex workers, and their bodies and practices remain a site on which any form of violence, structural or otherwise, manifests itself.[19] Some violence experienced by sex workers is in the form of rape (and being told that sex workers cannot be raped), as well as arbitrary arrests and sexual abuse perpetrated by state officials such as the police.[20] The threat of violence alone compromises any vulnerable groups' ability to live freely as it destroys any sense of security. Against the background of the post 1994 South African transformative constitutionalism history and the importance of having the Bill of Rights, the inability to access, or denial of access to primary healthcare services should be viewed as a betrayal of the Constitution's democratic values of equality, human dignity and freedom.

1.2 Purpose

In theory, and certainly on paper, South Africa is in compliance with its obligations to the international human rights instruments that it has ratified. With regard to the right to health, the South African Constitution guarantees the right to primary healthcare for all, and the National Health Act fulfils this constitutional obligation. The magnitude of the HIV pandemic means that it is important to understand the experiences of key stakeholders in the South

[19] CK Butler and others 'Security Forces and Sexual Violence: A Cross-National Analysis of a Principal—Agent Argument' (2007) 44 *Journal of peace research* at 669

[20] 'Framework on rights of sex workers and CEDAW' (2017) at 41 (hereafter Framework on sex work)

African government's response to the pandemic. Sex workers, due to criminalisation, are largely perceived as vectors in the spread of HIV and AIDS, and as such, are a key stakeholder. The purpose of this study is to review the experiences of sex workers as they exercise their right to healthcare, and juxtapose this against what is contained in the Constitution, health policies and supporting legislation. Understanding the sex workers' experiences will help with the strengthening of interventions aimed at reducing the spread of the virus and any other related advocacy and litigation efforts.

1.3 Problem statement

Section 27 (1) (a) and 27 (3) of the South African Constitution read as follows:

> *(1) Everyone has the right to have access to*
>
> *(a) Health care services, including reproductive health care;*
>
> *(3) No one may be refused emergency medical treatment.*

At a minimum, Section 4 (3) of the complementary National Health Act[21] guarantees free primary or basic healthcare services for everyone at all government facilities, while progressive realisation of a comprehensive package is underway.[22] Sex workers, by virtue of the work they do and its potential contribution to the spread of HIV and AIDS, should be able to fully and freely access primary healthcare services at government healthcare facilities. South Africa continues, albeit slowly, to make some progress in doing away with some repressive colonial laws. Examples include sodomy laws, life sentence and execution as in the well-known case of *S v* a *Makwanyane*[23] and the case of the *Minister of Justice and Constitutional Development v Prince*[24] which led to the legislation of cannabis.

Despite some signs of progress in the protection of the rights of sex workers, as in the case of *Kylie v CCMA*,[25] which resulted in the recognition of employer/employee relationship between sex workers and "pimps"/ "brothels," and the case of *SWEAT vs Minister of Safety and Security and Others*,[26] which found that sex workers have the right not to be arrested without the

[21] National Health Act (note 17 above)
[22] 'Right to Health – Period: April 2000 - March 2002'
[23] *S v Makwanyane* 1995 (3) SA 391 (CC)
[24] *Minister of Justice and Constitutional Development v Prince* 2018 (6) SA 393 (CC)
[25] *Kylie v Commission for Conciliation Mediation and Arbitration and Others* 2010 (4) SA 383 (LAC) (Hereafter Kylie v CCMA)
[26] *SWEAT v Minister of Safety and Security and Others* 2009 (6) SA 513 (WCC)

potential for prosecution, sex work remains criminalised in South Africa. This creates a complex and challenging context for the full exercise of this right by sex workers.

The perceived limiting definition of a sex worker to mostly entail the sex workers who 'work the streets' and not exclusively capturing adult film actors, advent online sex-services and women and men who engage in regular transactional sex, which all carry health risks as well, is indicative of classism. It could therefore be argued that sex workers who 'work the streets' are particularly more vulnerable, made so on account of the secondary victimisation they suffer at the hands of the State, as it fails to ensure that sex workers fully exercise their right to access healthcare services. Given the stated importance of sex workers being able to access primary healthcare services, it becomes important to understand the relationship between the right to healthcare as it is legally defined and the experiences of sex workers as they access primary public healthcare services.

1.4 Research questions

This study sought to answer the following primary research question:

> What is the relationship between the right to healthcare as it is legally defined and the experiences of sex workers as they access primary public healthcare services?

The study also attempted to answer the following sub- questions:

1. What does the right to access healthcare entail?
2. What are the experiences of sex workers in South Africa as they exercise their right to primary public healthcare services?
3. Where challenges are experienced, what strategies do sex workers employ in order to obtain healthcare services?
4. What are the key drivers behind the challenges experienced by sex workers in exercising their right to access healthcare services?

1.5 Aim of the study

The broad aim of the study is to explore the experiences of sex workers in South Africa in relation to the provision in Section 27(1)(a) and 27 (3), and by so doing, gain an understanding

of the relationship between the legislative reality and the lived realities of sex workers. Given that sex workers are a vector in the spread of HIV and AIDS, the insights obtained from this study can be used in the design of non-discriminatory interventions aimed at curbing the spread of HIV and AIDS, and eliminating barriers to access. It will equip lawyers with an understanding of what else may be at at play in terms of how people can experience improved accessibility and equality. The law in itself does not translate to equality.

1.6 Objectives of the study

Given the main research question and the stated aim of the study, the specific objectives of the study were:

1. To ascertain the extent to which the right to access healthcare is exercised by sex workers through the public healthcare system, in a context in which sex work is criminalised and societal sentiments are not favourable towards sex workers

2. To understand the key strategies that sex workers employ in exercising their right to healthcare within the public healthcare system.

1.7 Rationale of the study

In the global fight against the HIV and AIDS epidemic, sex workers are a key constituent. As a key population, their access to healthcare services becomes more important. This is due to the nature of the work they do, which renders them both susceptible to becoming infected with HIV and AIDS and thus becoming a key factor group in the spread of the virus. Given that a significant portion of the South African government's response to HIV and AIDS is delivered through the public healthcare system, understanding the experiences of sex workers in exercising their right to healthcare through the public healthcare system is therefore important. Assuming the system is cis normative and heteronormative, the findings of this study could assist healthcare workers better understand the experiences of sex workers and in return, they will strengthen interventions aimed at improving healthcare seeking behaviour, which would ultimately contribute positively to the national management of the HIV and AIDS pandemic and to sex workers' rights being protected without prejudice and stigmatisation.

1.8 Literature Review

1.8.1 Understanding stigma and discrimination

In his early work, sociologist Erving Goffman defined stigma as

> *a social attribute or mark that separates individuals from others based on socially given judgments. Stigmas are deeply discrediting and reduce the bearer from a complete and accepted person to a tainted and discounted one.*"[27]

This often results in social exclusion and social isolation because of shame. In the case of sex workers, Benoit and others argue that the result is often the reluctance to use health services as the "sex worker" identity becomes the principal and magnified status, and even healthcare workers and facilities often fear "courtesy stigma" or "stigma by association", leading to attitudes and hostility when sex workers seek services.[28] Sex workers are thus 'othered', and consequently "routinely denied social rights enjoyed by other citizens,"[29] as what becomes overarching is their identities as "prostitutes", "deviant" and "criminals." These identities therefore evoke and incite whorephobia, transphobia and other intersecting stigma. For example, transgender sex workers' stigma may intersect on the basis of gender, sexuality and sex work. This deeply embedded stigma also fuels the structural stigma that sex workers experience as maintained in the laws and policies.[30] This also results in the normalisation of discrimination.

The General Comment No 20 defines discrimination as "any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of Covenant rights."[31] WHO argues that discrimination is the source of structural inequality in society, making the marginalised groups more vulnerable and to an extent bear disproportionate share of health problems.[32] This impact is compounded when an individual is exposed to more than one discrimination, for example on the basis of sex, work and race.

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[27] C Benoit & others 'Prostitution stigma and its effect on the working conditions, personal lives, and health of sex workers' (2018) 55.4-5 at *The Journal of Sex Research* at 457-471 (Hereafter Benoit and others)
[28] Benoit and others (note 26 above) 2
[29] Benoit and others (note 26 above) 3
[30] Benoit and others (note 26 above) 3
[31] CESCR General comments 20 (2009)
[32] WHO (note 6 above)

The justice system, aided by the media, often sustains the stigma as it presents sex workers in a sensationalised manner and as less worthy of the protection of the law.[33] Where laws and policies are favourable for sex work, the stigma is often concealed in a bid to abide by the law, however it does not remove the moral prejudice and disdain targeted at sex workers as they are viewed as disruptors of social order in communities. Thus, routinised stigma from all these angles and associated fear of judgement when seeking healthcare is a major factor that explains unmet healthcare needs of sex workers. Regardless of constitutional and statutory provisions, they are often humiliated and sometimes experience outright denial of healthcare services once their involvement in sex work is known. For example, in South Africa, police often buttress structural stigma, as they often rely on using condoms carried by sex works as evidence. To avoid falling victim, sex workers are then discouraged from carrying condoms, and consequently end up not using condoms in their encounters. These barriers are critical components of healthcare access and are important in the HIV epidemic control.[34] This is an illustration of how criminalisation reinforces stigma, and discrimination against sex workers.

1.8.2 The law and sex work

Given that most countries' laws were initially informed by the draconian laws and the precolonial Victorian ideas of morality, this resulted largely in prostitution being criminalised.[35] Since then, in the legal fraternity, three models have evolved around sex work, and these are: decriminalisation, criminalisation and legalisation. There has also been a conflation of global concern regarding human trafficking and sex exploitation. This has given rise to the development of various legal instruments and mechanisms in place to address these linked societal concerns. Among these are the 2000 United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, (also known as the 'Palermo Protocol') and the 2006 Migration Policy Framework for Africa which implores States to "condemn in very strong terms sexual tourism and prostitution in receiving States in order to discourage trafficking in women and children as well as paedophiles in source States."[36] Against this background, many States, in their diversities, have adopted varied

[33] Benoit and others (note 26 above)
[34] 'Why Sex Work Should be Decriminalised in South Africa' (hereafter why sex work should be decriminalised)
[35] J Scoular *The subject of prostitution: Sex work, law and social theory* (2015)
[36] African Union *The African Migration Policy Framework for Africa* (2006)

domestic legislative policies to address 'prostitution', and most of these policies do not appear to safeguard the rights of sex workers.[37]

Criminalisation of sex work, often with an intention to prohibit and abolish sex work, uses stringent criminal law as a deterrent to sex trade.[38] A case in point is South Africa. Since the passing of the Immorality Act, 1927,[39] later amended to Sexual Offenses Act, 1957,[40] and now the Sex Offenses Amendment Act, 2007,[41] sex work has remained one of the activities that is illegal. While the Sex Offenses Amendment Act carries through the illegality of selling of sex, owning brothels, living off or benefiting from the earnings of sex work and luring and alluring of people into sex work, it also now criminalises the buying of sex.[42] Sweden, Iceland and Norway partially criminalise sex work by criminalising the buyers and not those who offer the sex work services. The rationale behind it is to achieve its goal of ending sex work, and also as a way to protect female sex workers from being exploited.[43] This kind of sexual repression encourages the suppression and denial of those sexual impulses seen as illicit and immoral in a particular society or culture. This repression is likely to lead to shame, hopelessness and/or guilt, which is reinforced in many countries through culture, law and religion. Sexual repression includes the criminalisation of specific kinds of sexual expression and conduct such as sex work, as a way to prevent individuals in engaging in 'immoral' sexual acts.

Legalisation of sex work consists of acknowledging and recognising sex work on grounds of public health, and as work that contributes to economic output.[44] Very few countries globally have legalised sex work and among these are countries such as Austria, Germany, Greece, Senegal, the Netherlands, Switzerland and Turkey.[45] In the Netherlands, for example, they have legislative provisions incorporating sex work into the mainstream economy, public health and society through various societal sensitisation and integration programmes and regulations

[37] R Matthews *Prostitution, politics & policy* (2008)
[38] JG Raymond 'Ten reasons for not legalizing prostitution and a legal response to the demand for prostitution' (2004) 2 *Journal of Trauma Practice* at 315-332
[39] The Immorality Act 5 of 1927 (hereafter Immorality Act)
[40] The Sexual Offences Act 23 of 1957 (hereafter Sexual Offenses Act)
[41] The Sexual Offences Amendment Act 32 of 2007 (hereafter Sexual Offenses Act 2007)
[42] The Sexual Offences Act 2007 (note 40 above)
[43] 'Laws and Policies affecting sex work' (hereafter laws and policies)
[44] A Lutnick & D Cohan. 'Criminalization, legalization or decriminalization of sex work: what female sex workers say in San Francisco, USA' (2009) 17 no 34. *Reproductive Health Matters* at.38-46
[45] L Artz, & R Stefanie 'Criminal Law (Sexual and Related Matters) Amendment Act (No. 32 of 2007): emerging issues for the health sector: more about... women's health' (2009) 27(10) *CME: Your SA Journal of CPD* at 464-467.

such as health monitoring, registration and tax payments.[46] However, this is not necessarily indicative of it being a generally acceptable and tolerable phenomenon.[47] Sex workers have continued to be trivialised, objectified and reduced to sex and immoral deviants.[48] Even in such instances, however, while a societal positive attitude is not guaranteed, sex workers still have a better opportunity to fully and freely exercise their right to healthcare as encapsulated in the UNDHR and to have recourse when that right is violated.[49]

Decriminalisation of sex work is the removal or lifting of hefty criminal penalties such as imprisonment and criminal records associated with committing a crime.[50] This does not necessarily amount to legalisation but could rather warrant generally lesser charges or penalties enforceable through bylaws, at times while some aspects of sex work could still remain illegal.[51] New Zealand is known for its efforts and intent to decriminalize sex work and this has resulted in its Prostitution Reform Act of 2003.[52] The Act stipulates the need to decriminalise sex work for consenting adults over the age of 18 and to "safeguard the human rights of sex workers and protect them from exploitation."[53] In addition, it goes further to create a Prostitution Law Review Committee in an attempt to continually monitor and evaluate the impact of the law, including monitoring the number of sex workers in the country, and to ensure inclusivity, sex workers are part of the members of the Prostitution Law Review Committee.

While these legal models are important to note, they are not a focus of this paper. They do; however, help provide an understanding of the dynamics that law can produce, and it also dispels the idea that law alone can provide answers to a number of social justice issues. South Africa is currently pushing for decriminalisation of sex work. Granted that this may have some impact in allowing easier access to rights, as alluded to above, there remains questions regarding whether decriminalisation alone would sufficiently address the lack of access to rights at an intersectional level.

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[46] C Warnock and N Wheen 'Sex work in New Zealand: The re-importation of moral majoritarianism in regulating a decriminalized industry' (2012) 24(2) at *Canadian Journal of Women and the Law* at 416
[47] Sex work and the law (note 2 above)
[48] Sex work and the law (note 2 above) 2
[49] UNDHR (note 8 above)
[50] Laws and policies (note 42 above) 5
[51] Laws and policies (note 42 above) 5
[52] Laws and policies (note 42 above) 5
[53] Laws and policies (note 42 above) 5

1.8.3 Broader society and sex work

Experiences of sex workers are dependent on prevailing societal attitudes that are informed by interlocking religious, political and cultural fundamentalisms, and which among others, are key factors in the heightened sexual repression of people.[54] The religious institutions and their underpinnings have been instrumental in the stigmatisation of sex workers and their being viewed as 'sinners'[55]. For example, the Christian beliefs and mentality that emphasizes that sex only in marriage is permissible, fuel attitudes that make sex work immoral by definition.

'Prostitution' contravenes socially constructed norms and beliefs regarding women's bodies and behaviour. These include norms and beliefs against having sex with multiple partners and strangers, having sex for money, having sex for pleasure and as such, these practices are unacceptable.[56] Society is presumably heteronormative, with disciplinary and population management codes, enforced by the State through State institutions put in place to deal with any deviances.[57] Community collective policing and upholding of socially constructed norms, socialised through various institutions such as religion, family and education, find their way into the "administrative systems that govern the distribution of life chances such as housing, education, healthcare, identity documentation and records, employment, and public facilities."[58] For example, most medical schools are sites of regulation, where the narrative of cis normative able bodied and acceptable sexual behavior is perpetuated. This is evident in how stigma continues in healthcare facilities for anyone who presents differently, and access is easily available for those who conform to the narrative.[59] This is best captured as follows;

> *The hidden curriculum—a term used to describe the implicit, often highly gendered, and discriminatory values that are taught to students in institutionalized education settings—plays a crucial role in teaching students about institutional values, institutional climate, and implicit assumptions about worth within the healthcare and medical education system.*[60]

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[54] Framework on sex work (note 19 above) 48
[55] MC Chiu '(Han-) Chinese cultural appropriation of sexual legal politics: Postcolonial discourse on law controlling sex work in Hong Kong' (2006) 34(4). *Asian Journal of Social Science at* 547-572
[56] G Pheterson 'The whore stigma: Female dishonor and male unworthiness'. (1993) 37 *Social Text* at 39-64
[57] D Spade *Normal life: Administrative violence, critical trans politics, and the limits of law* (2015) (hereafter Spade)
[58] Spade (note 56 above)
[59] A Muller 'Health for All? Sexual Orientation, Gender Identity, and the Implementation of the Right to Access to Health Care in South Africa' (2016) *18 Health and Human Rights* at 204 (hereafter Muller)
[60] Muller (note 58 above) 204

All these together form societies and therefore it is no surprise how it impacts access. In any given society there are conformists and non-conformists, there are two extreme attitudes towards sex work, those who embrace and accept it and those who disapprove of it.

Where the societal oppression paradigm view is dominant, the State, its representatives and the wider society, resist the perceived transgressions through systematic violence of discrimination, arbitrary arrests, rape, corrective cultural practices such as forced marriage, stigmatisation, and isolation from family.[61] Any perceived or real deviation from what society deems as acceptable conduct, of which sex work qualifies, is often met with harsh consequences. Some of the reported incidences experienced by sex workers include, but are not limited to, police brutality, [62] arbitrary arrests, confiscation of condoms, rape, unwanted pregnancies, murders, continuous exposure to STIs and HIV, ostracism, invasive tests, forced tests, lack of maternal care, extortion, torture, deportation threats and secondary victimisation by service providers which in some instances leads to substance abuse, unsafe abortions and depression.[63]

Emanating from these societal attitudes, various feminist theoretical approaches emerged to try and understand the relationship between sex work, the State and its continued criminalised regulation. Understandably, the subject remains contentious amongst academics both at a macro and micro level.[64]. While macro level theories put an emphasis on structural causations of sex work, the micro level theories focus on the individual relations.[65] Their commonality lies in both seeking to understand causes of sex work, and to understand the entry and exit processes of sex work.[66]

[61] Sex work and the law (note 2 above) 7
[62] Framework on sex work (note 19 above) 41
[63] F Scorgie and others 'We are despised in the hospitals': sex workers' experiences of accessing health care in four African countries' 2013 15(4) *Culture, health & sexuality* at 450-465 (hereafter Scorgie and others)
[64] L Gerassi 'A Heated Debate: Theoretical Perspectives of Sexual Exploitation and Sex Work' (2015) 42 *J Sociol Soc Welf* at 79 (hereafter Gerassi)
[65] Gerassi (note 63 above) 8
[66] Gerassi (note 63 above) 11

Feminism, as a macro theory, attempts to offer an all-encompassing theoretical explanation on both structural and individual levels. The neo-abolitionists[67] feminists, inclusive of radical and Marxist feminists, regards sex work as a form of structural or systematic imposed violence[68] and condemn all forms of prostitution, be it voluntary or involuntary, because they associate prostitution with oppression against women. In addition, they hold the view that sex work can never be consensual and highlight how sexual commerce provides a patriarchal latitude to access women's bodies, and therefore perpetuates women's subordination.[69]

The sex positivists, inclusive of sex radical and liberal feminists, largely depict sex work in a positive manner, categorising it as work that comes with flexible working conditions; work chosen out of agency and work that could improve an individual's socio-economic status.[70] They argue that a woman should have bodily autonomy and that it is her right to choose prostitution and other forms of sex work as a career.[71] This perspective advocates for women's rights to their autonomous choice of sex work and believes that sexuality, even in its paid form, is consensual many a time.[72] It puts emphasis on the idea that women should be given that opportunity to choose their line of work and that dictating women's choice of work is in actual fact dangerous and patriarchal.

With the rate of unemployment in South Africa over 27 percent,[73] Over 4 in 10 individuals are surviving on less than $2.00 a day, poverty becomes a basis of social exclusion and ill-health.[74] This degree of poverty is the context and reality in which radical feminists base their argument that the vast majority of sex workers are impoverished and living under these conditions. The radical feminists hold the view that sex workers are victims in need of help to exit the trade, and also that their engagement in sex work is as a result of systematic or structural reasons,

[67] Neo-abolitionists view voluntary and involuntary sex work as forms of oppression against women and advance that sex work can never be entirely consensual. "Radical and Marxist feminism serve as the roots of current day, neo-abolitionist perspectives with regard to sexual exploitation of women and girls" (Gerassi note 63 above)
[68] Gerassi (note 63 above) 2
[69] RE Dobash & R Dobash. '*Violence against wives: A case against the patriarchy'* (1979). at 179-206
[70] R.Weitzer 'Sociology of Sex Work' (2009) 35 *The Annual review of Sociology* at 214 (hereafter Weitzer)
[71] S Loue *Intimate partner violence: Societal, medical, legal and individual responses* (2001)
[72] M Farley 'Bad for the body, bad for the heart: Prostitution harms women even if legalized or decriminalized' (2004) 10 (10) *Violence against women* 1087-1125
[73] S Writer 'South Africa's unemployment rate climbs to 27.6%' *Businesstech* (Johannesburg*)* 14 May 2020 online)
[74] T Pogge 'World Poverty and Human Rights'. (2005) 19 Ethics & International Affair at 1

including patriarchal gender relations, class, and race.[75] The liberal feminists, on the other hand, contend that sex workers could be engaging in sex work from an empowered position which involves agency in choosing and viewing sex work as a source of income or profession.[76] While there are merits in radical feminist arguments in terms of poverty, context and the reality that people live in, they differ with liberal feminists in their denial of choice and agency for those who choose sex work.

As opposing feminist theories, both neo abolitionists and sex positivist schools of thought are essentialist, subjective, and generalist in nature, and therefore lack the multifaceted and holistic approach necessary to fully understand sex workers' experiences.[77] An appreciation of both schools of thought and the need to move beyond a one-dimensional approach is necessary if the objectives of this study are to be achieved. A polymorphous approach enables this. Weitzer describes a polymorphous paradigm as one that "is sensitive to complexities and to the structural conditions shaping the uneven distribution of agency, subordination and job satisfaction."[78] In this case, a multifaceted approach inclusive of trans politics, queer theory, post-modernist, and critical race theory allows for an enriched examination of the experiences of sex workers through the integration of elements from both schools of thought.

1.8.4 Sex work and HIV/AIDS

The HIV/AIDS pandemic has remained a global concern for decades. In 2018, the estimated number of people living with HIV globally was 37.9 million, while the HIV/AIDS related deaths amounted to 770 000 and the number of new infections were 1.7 million.[79] South Africa's challenge with the pandemic is understandably a major local healthcare concern. Of the global estimated number of people living with HIV in 2018 (37.9 million), 68.18 percent (25.84 million) were in Africa and the Middle East. Of these, 29.80 percent (7.7 million) were in South Africa. Stated another way, 20.32 percent of the number of all people living with HIV/AIDS in the world were in South Africa.[80]

[75] Weitzer (note 69 above) 214
[76] Weitzer (note 69 above) 215
[77] Weitzer (note 69 above) 214
[78] Weitzer (note 69 above) 215
[79] UNAIDS *DATA 2019* (hereafter UNAIDS DATA)
[80] World Health Organisation *South Africa HIV country profile 2019(*hereafter WHO SA country profile)

Out of the global estimated new infections in 2018, (1.7 million), 64.70 percent were in Africa and Middle East. Of those, 21.82 percent (240 000) were in South Africa. This equates to 14.18 percent of estimated global new infections in 2018 taking place in South Africa.[81]
This pattern is also visible with regard to the number of HIV/AIDS related deaths. In 2018, of the estimated 770 000 deaths globally,71.95 percent (554 000) were in Africa and the Middle East. Of these, 12.82 percent (71 000) were in South Africa. Stated in relation to the global number, 9.22 percent of all people who died from HIV/AIDS related illnesses in 2018 were in South Africa.[82]

While an estimated 13.32 percent of the SA population is living with HIV/AIDS, the prevalence amongst sex workers is estimated at 58 percent.[83] This represents a more than four-fold higher prevalence rate among sex workers compared to the national prevalence rate. As a key sub-group that is vulnerable both from a point of contracting and spreading by virtue of the nature of the work engaged in, full inclusion in the national HIV/AIDS response is key.

Assuming that criminalisation is a proxy indicator of people's perceptions regarding sex work, that the law actually perceives sex work as a criminal act presents a dilemma, not only in terms of access to services but also in terms of recourse in cases of violation of rights. As a result, sex workers live in fear of the law, society, family and friends, and in many cases the fear is internalised and it cripples their willpower to challenge poor healthcare service provision or their ability to seek healthcare services at all.[84] An understanding of sex workers' experiences in engaging the public healthcare system is an important part of trying to assess to what extent they feel included.

These numbers shared above show how South Africa is disproportionately burdened by the HIV/AIDS pandemic. The need for the South African government to effectively fight the pandemic is clear, given the wide-ranging nature and magnitude of the adverse economic and social implications of HIV/AIDS in South Africa, such as the reduced life expectancy of

[81] WHO SA country profile (note 79 above)
[82] WHO SA country profile (note 79 above)
[83] WHO SA country profile (note 79 above)
[84] Framework on sex work (note 19 above) 14

economically productive people,[85] orphaned and child-headed families, deepened poverty, an overburdened welfare and healthcare system, gender inequality and sex work.[86]

South Africa's government has a comprehensive HIV/AIDS framework. A significant part of its HIV/AIDS response in terms of prevention, treatment and sexual reproductive services is delivered through the public healthcare system. In light of the magnitude of South Africa's share of the burden of the pandemic, and the indiscriminate nature of the disease, non-discriminatory access to healthcare as captured in the right to healthcare is vital in the effort to combat the spread of this disease.

1.8.5 Coping strategies

Studies show that despite the different challenges experienced by sex workers, there seems to be a sense of resilience, bodily autonomy and assertiveness amongst some sex workers as they find ways to navigate and access basic healthcare services.[87] These strategies range from misrepresenting the full nature of health issues to service providers, to not disclosing sex work as their profession, to forging relationships with specific service providers, to using alternative healthcare service systems such as NGO facilities, and to relying on other sex workers for some medication, contraception and barrier methods.[88]. In addition to this, some have reported violation cases to human rights organisations for litigation and representation.

Given the literature above, it is therefore important to understand how these factors interplay in South Africa and explore if there are any other factors contributing to the experiences of sex workers in exercising their right to healthcare in South Africa.

1.9 Theoretical framework

This study adopts a multi-pronged theoretical approach that includes a trans political and queer theoretical approach as outlined by Dean Spade, who provides a critique and analysis tool for transformative interventions. Amalgamated with post-modernist and critical race theory, this provides a more rigorous research product. Complementary to these, an intersectionality

[85] JR Youde *AIDS, South Africa, and the Politics of Knowledge* (2016) 9
[86] P Fourie and M Meyer *The Politics of AIDS Denialism: South Africa's Failure to Respond* (2016) at 6
[87] Scorgie and others (note 62 above) 456
[88] Scorgie and others (note 62 above) 458

perspective is overlayed as an analytical tool. Developed by Kimberle Crenshaw and expanded by Patricia Hill Collins, intersectionality suggests that oppressions, situations and experiences are influenced by various intertwined factors which act simultaneously.[89] In this regard, Kimberle Crenshaw argues that the position of women, particularly Black women and minorities, such as homosexuals and sex workers, and their experiences, cannot be fully understood without understanding the intersection between issues of race, class, gender and sexual orientation.[90] For the purposes of this study, and to the extent that application was possible, intersectionality as a tool of analysis enabled an enriched understanding of sex workers' experiences in exercising their right to health. It helped with assessing the interplay of different social power dynamics in relation to access, strategies and experiences of sex workers as they exercise their right to health.

1.10 Research design

1.10.1 Research methodology and data collection

Given the overarching aims of this study is to understand the experiences of sex workers as they exercise their right to healthcare services relative to the legal provisions in the country, this research is carried out within an interpretivist research paradigm. A qualitative research design is thus used. Data collection is exclusively carried out through a document review methodology. A review and analysis of content from textbooks, journals, articles, case law, statutes, conventions and other policies relating to sex work, right to healthcare and empirical evidence and theoretical frameworks on sex work and access to health is used in this study.

1.10.2 Data analysis

A multi-pronged theoretical approach that includes a trans political and queer theoretical approach as outlined by Dean Spade is used to critique and analyse the findings. This was amalgamated with Martha Fineman's vulnerability theory[91], as well as post-modernist and critical race theory understanding. The researched lived experiences of sex workers as they exercise their right to healthcare are juxtaposed with both the policy and legal provisions

[89] A Gouws 'Feminist intersectionality and the matrix of domination in South Africa. Agenda' (2017) 31 *Agenda* at 20

[90] S Satapathy 'Intersections of Disability, Gender and Violence45' (2019) 4 *Training Manual for Legal Empowerment of Women and Girls with Physical Disabili es in India* 4

[91] MA Fineman 'Vulnerability and inevitable inequality' (2017) 4(03) *Oslo Law Review* at 133-149. (hereafter Fineman)

governing the right to health, as well as the practical imperatives of unrestricted access for sex workers within the context of the fight against the HIV and AIDS pandemic.

2 LEGAL AND POLICY FRAMEWORK

2.1 Introduction

This chapter examines and engages with the normative content of existing legal and policy frameworks that seek to respect, protect, promote and fulfil access to healthcare services and the implications for sex workers. The central argument advanced in this chapter is that the lack of access to healthcare services by sex workers is not due to a lack of appropriate protective legislative frameworks, but rather, the invisible networks, including law, stigma and discrimination, that deter sex workers from fully accessing these services.

Ideally, law is regarded as a protection and regulatory tool for instilling social order in any given society. It is also often a proxy indicator of societal attitude and perceptions towards acceptable and unacceptable behaviour.[92] As perhaps an unintended result, law can perpetuate and sustain the marginalisation of minorities in its bid to uphold society's moral values as informed by class, religion, culture and tradition.[93]

Legislative frameworks and policies are embedded in a patriarchal system that creates a perceived acceptable imbalance and inequality in a society through socialisation of stereotypes in what roles and responsibilities men or women can perform.[94] This existence of socially constructed 'gender' therefore provides a limited binary narrative of acceptable performances and categories of female and male, including acceptable relationships and sexual behavior[95] rooted in patriarchal power and hierarchy.[96] This invariably often finds its way, through implicit assumptions, into the development of laws and regulations, resulting in gendered laws and invisible networks that prevent protection and access to marginalised minorities.

[92] EG & 7 others v Attorney General; DKM & 9 others (Interested Parties); Katiba Institute & another (Amicus Curiae) Available at http://kenyalaw.org/caselaw/cases/view/173946/ (hereafter EG & others)
[93] EG & others (note 91 above) 35
[94] R Morrell & others. 'Hegemonic masculinity/masculinities in South Africa: Culture, power, and gender politics' (2012) 15. *Men and Masculinities* at 11-30
[95] S De Beauvoir *The Second Sex.* (2014)
[96] Z Magubane 'Spectacles and scholarship: Caster Semenya, intersex studies, and the problem of race in feminist theory' (2014) 39 *Signs: Journal of Women in Culture and Society* at761-785

2.2 The right to healthcare: International jurisprudence

The origins of the right to healthcare in South Africa, as encapsulated in the National Health Act[97], lie in a number of complementary global and regional human rights instruments. The WHO's 1946 Constitution defines the right to healthcare in its preamble as, "a *state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."*[98] Article (25) of the UNDHR articulates that:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*."[99] Article (12) of CESCR outlines that "*The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."*[100]

While it carries through this right, Article 2(1) of the CESCR[101] acknowledges the States' resource limitations by adding the element of progressive realisation. CEDAW[102] Article (12) and Maputo Protocol[103] Article (14), while focusing specifically on women and placing an emphasis on sexual and reproductive health, both emphasise the right of everyone to healthcare. South Africa has ratified all these instruments.

The right to health consists of both freedoms and entitlements.[104] It encapsulates the four elements of access to healthcare services which are; availability, affordability, acceptability and quality.[105] For example, the right, or freedom, to bodily autonomy with regards to controlling one's reproductive health, freedom from coerced and non-consensual treatment and the right, or entitlement, to a healthcare system.[106] The normative content of the right to

[97] National Health Act (note 17 above)
[98] 'WHO The Right to Health Fact Sheet No.31' (hereafter Right to health fact sheet No.31)
[99] UNDHR (note 8 above)
[100] CESCR (note 9 above)
[101] CESCR (note 9 above)
[102] CEDAW (note 10 above)
[103] Maputo Protocol (note 12 above)
[104] United Nations Office of the High Commissioner for Human Rights *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)* (hereafter CESCR General Comment 14) para 7-8.
[105] CESCR General comment (note 104 above)
[106] CESCR General Comment (note 104 above) para 8.

healthcare is best interpreted in the General Comment, which outlines the State's negative and positive obligations in respect thereto.[107] The negative obligation dictates that States desist from any action that could violate the right to health and this includes putting in place measures that guard against third party infringement.[108] In respect of its positive obligations, the State must take measures to ensure the accessibility and enjoyment of the right to health in practice by deploying its maximum available resources.[109]

The right to health mandates States to institute and avail quality public healthcare systems and facilities that are accessible to everyone without discrimination.[110] In this regard, accessibility entails economic or affordability, geographic and physical aspects. The General Comment places an emphasis on economic accessibility and articulates that an individual's inability to afford medical care should not be grounds for discrimination to receiving healthcare.[111]

As enshrined in the CESCR, the right to healthcare is a qualified right. In Article 12, States are obliged to provide the 'highest attainable standard' of physical and mental health. The quality and standard of healthcare system to be provided by the State is therefore subject to the State's circumstances and availability of financial resources. Be that as it may, the right to health remains legally binding and an obligation upon State Parties to the CESCR. This is to say the lack of resources would not absolve a State from its mandate to provide a degree of quality healthcare services to both citizens and immigrants.

In order to fully appreciate the normative content pertaining to sexual and reproductive healthcare as a human right, it is essential to first consider the distinction between sexual and reproductive health. The elements of sexual health comprise, first, protection from sexually transmitted infections (STIs), harmful practices and violence;[112] Second, control over sexual access and enjoyment;[113] Third, the imparting of information relating to sexuality. [114]

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[107] T Murphy *Human Rights Law in Perspective: Health and Human Rights* (2013) 23. (hereafter Murphy)
[108] Murphy (note 106 above) 43.
[109] Murphy (note 106 above) 43-44.
[110] CESCR General Comment (note 103 above) para 12.
[111] CESCR General Comment 14 (note 103 above) para 12.
[112] E Durojaye & LN Murungi 'The African Women's Protocol and Sexual Rights' (2014) *18 International Journal of Human Rights* 885. African Union, *Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa* (hereafter Durojaye & Murungi)
[113] Durojaye & Murungi (note 111 above) 885
[114] Durojaye & Murungi (note 111 above) 885

Reproductive health, on the other hand, includes the safe and effective protection from, as well as the termination of, unwanted pregnancies, treatment of infertility, contraception, safe pregnancy related procedures and education.[115] Despite this distinction, the two remain closely related, even if only from a theoretical point of view. They also are amongst the most sought-after services by sex workers at primary healthcare facilities.

The normative content of Articles 14(1) and 14(2) is best considered in light of the General Comments.[116] The provision of access to sexual and reproductive healthcare falls under the specific obligation imparted on Member States.[117] Access to sexual and reproductive healthcare is interpreted as access to family planning, contraception and safe abortion services. [118] The General Comment emphasises availability, accessibility, acceptability and quality as characteristics of these healthcare services.[119] Furthermore, State Parties should ensure that such services are comprehensive, integrated, rights-based, and sensitive to the reality of all women.[120] In addition, the delivery of such services must be free from any coercion, discrimination and violence.[121] The last qualification made in this regard is that such services must be connected to other services including the treatment of HIV and other Sexually Transmitted Infections.[122]

Complementary to the frameworks already discussed, the WHO 'Building Blocks' Systems Framework offers guidelines on which elements States should focus on in order to achieve universal health access for all.[123] The 'Building Blocks' elements are; leadership/governance, healthcare financing, health workforce, medical products, technologies, information and research, and service delivery.[124] In essence, the right to healthcare entails adopting measures to ensure that actions conform to human rights standards. States should adopt legislative and

[115] Durojaye & Murungi (note 111 above) 885
[116] African Commission on Human and Peoples' Rights *General Comment No. 2 on Article 14. 1 (a) (b) (c) and (f) and Article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* Adopted at the Fifty-fifth Ordinary Session on 12 May 2014 (hereafter ACPHR General comment)
[117] ACPHR General Comment (n 115 above) para 53-54.
[118] ACPHR General Comment (note 115 above) para 53-54.
[119] ACPHR General Comment (note 115 above) para 53-54.
[120] ACPHR General Comment (note 115 above) para 53-54.
[121] ACPHR General Comment (note 115 above) para 53-54.
[122] ACPHR General Comment (note 115 above) para 53-54.
[123] A Scheibe & others 'Sex work and South Africa's health system: addressing the needs of the underserved' (2016) 1 *South African health review* at 165-178. (hereafter Scheibe and others)
[124] Scheibe and others (note 122 above)

other requisite measures to ensure equal access to healthcare facilities, especially the ones provided by third parties so that they do not constitute a threat to availability, acceptability, and quality of services provided. States are also supposed to disseminate appropriate information, foster research and support their populaces to make informed decisions. The obligation to fulfil requires States adopt legislative, administrative, judicial, promotional and other measures for full realisation of the right to healthcare. No State, as already argued, should use resource constraints as an excuse to curtail the right to healthcare[125]. This position was affirmed in the *Soobramoney v Minister of Health* case,[126] where the South African Constitutional Court argued that the scarcity of resources available to the States could not be a constraint to the enjoyment of the right to healthcare by the appellant. In the case of *Government of the Republic of South Africa and Others v Grootboom and Others*[127] the courts also found that measures that do not include meeting the needs of the most vulnerable groups in society were unreasonable.

2.3 The right to healthcare in South Africa

By virtue of being a party to all of these international human rights instruments, South Africa is mandated to guarantee and protect the rights of everyone, including those of sex-workers. The right to healthcare is articulated in the South African Constitution[128]. Sections 27 (1) (a) and 27 (3) guarantee everyone access to healthcare services, including the right to reproductive healthcare. Fulfilment of the right to healthcare requires the fulfillment of other related rights, such as the right to food, water, adequate housing and decent working conditions.[129] The realisation of the right to health is thus comprised of a range of rights and factors that must be satisfied in order to enjoy a healthy lifestyle.[130] At its core, the right to health, as guaranteed by the above various human rights instruments and ratified by States, embraces the principles of freedom, equality and dignity of all persons regardless of political, social, cultural and economic contexts.[131] The Constitution makes it clear that everyone is equal before the law and that everyone has the right to equal protection, which equality and protection include the full

[125] Right to health fact sheet No.31 (note 97 above)
[126] *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC)
[127] *Government of the Republic of South Africa and Others v Grootboom and* Others 2001 (1) SA 46
[128] Constitution (note 16 above)
[129] A Garson Jr., and CL Engelhard *Health Care Half-Truths: Too Many Myths, Not Enough Reality* (2008) 3. (hereafter Garson)
[130] Garson (note 128 above) 3.
[131] Framework on sex work (note 19 above)

and equal enjoyment of all rights and freedoms.[132] The Constitution mandates the State to respect, protect and fulfil the right to healthcare as articulated in General Comment No 14,[133] hence the enactment of the National Health Act.[134]

Premised on the principles of the Constitution and the Bill of Rights, the National Health Act is intended to be non- discriminatory and encapsulates the four elements of access to healthcare services, which are; availability, affordability, acceptability and quality.[135]

2.4 Sex work in South Africa

Buying and selling sex work is illegal in South Africa[136] and it has remained so since the enactment of the Immoral Act, 1927.[137] The illegality of sex work is subsequently and substantively carried through in the criminal law amended acts; the Sexual Offences Act, 1957,[138] and the current Sex Offences Amendment Act, 2007.[139] The current provisions in section 11 of the current Act are as follows:

A person

(A) who unlawfully and intentionally engages the services of a person 18 years or older

(B) for financial or other reward, favour or compensation to B or to a third part

(C)-

(a) For the purposes of engaging in a sexual act with Both B, irrespective of whether the sexual act is committed or not

(b) By committing a sexual act with B, is guilty of the offence of engaging the sexual services of a person 18 years or older

In addition, the owning and running of brothels, living off or benefiting from the earnings of sex work and luring and alluring of people into sex work are criminalised.[140]

[132] Constitution (note 16 above)
[133] CESCR General comments 14 (note 103 above)
[134] National Health Act (note 17 above)
[135] CESCR General comments (note 103 above)
[136] Scheibe and others (note 122 above)
[137] Immorality Act (note 38 above)
[138] Sexual Offences Act (note 39 above)
[139] Sexual Offences Act 2007 (note 40 above)
[140] Sexual Offences Act 2007 (note 40 above)

The complexity and intricacies of the Sexual Offences Act and invisibilised violation of human rights can be illustrated in two legal cases. In *Kylie v Commission for Conciliation Mediation and Arbitration and Others*,[141] while the court recognised the constitutional right to fair labour practices as stipulated in section 23, it found that the clause does not extended to 'illegal' employment, referring to protection of sex work activities. Doing so would encourage illegal activities, and thereby trample on the Constitutional value to uphold the rule of law.

In *S v Jordan and Others (Sex Workers Education and Advocacy Task Force and Others*,[142] the law on 'prostitution' was challenged and the argument brought forward was on the basis that the law violated the right to equality, privacy, human dignity and the pursuit of livelihood. The court upheld the constitutionality of the law prohibiting brothel keeping and sex work as outlined in Section 20 (1) of the Sexual Offences Act[143]

The position taken by the court in *Kylie v CCMA* case is also supported with a view that was taken in the *S v Jordan* case, where the judge found that—

> *Nothing illustrates the conflict of the objective of the right to a fair dismissal and the objecting of the Sexual Offences Act more than the issues of reinstatement. An order of reinstatement is the primary remedy for an unfair dismissal. Reinstating a person in illegal employment would not only sanction illegal activity but may constitute an order on the employer to commit a crime.*

The judgment confirmed the illegality of sex work in South Africa. The judge was of the view that while the Labour Relations Act 66 of 1995 is fairly comprehensive, Section 185 (a) which provides for protection against unfair dismal was not encompassing of sex workers, as this would be in contravention with highly regarded common law practices in South Africa. In addition, the judge made reference to the Sexual Offences Act citing the practice of brothel keeping as a criminal offence. Using the principle of *ex turpi causa non oritur actio,* the court regarded the contract as illegal, hence unenforceable. From the judgment extract above, it can be argued that the court clearly established that although reinstatement is a remedy for unfair

[141] *Kylie v CCMA* (note 24 above)
[142] S v Jordan and Others (Sex Workers Education and Advocacy Task Force and Others 2002 (6) SA 642 (hereafter S v Jordan)
[143] Sexual Offences Act 2007 (note 40 above)

dismissal, it was not warranted in this case as it would be regarded as constituting an order on the employer to defy the law, rendering the employer into committing a crime. The court found against this, citing its custodian mandate to uphold the rule of law and ensure that such activities are not encouraged. It should be noted, however, that such a judgment does not mean that the State, its agents or anyone, can violate the rights of sex workers because of the work they do or their identity. This position was affirmed in *S v Jordan*.

In *S v Jordan*, on gender discrimination and the unconstitutionality of the Sexual Offences Act, the central issue was to determine whether or not Section 20 (1) unfairly discriminated against sex workers. The court established that it was not discriminatory to the prostitute and the customer, as the law applied equally between the buyer and the seller. However, the applicants had contended that it does and was discriminatory. The court affirmed the illegality of sex work, regardless of gender. It indicated that if discrimination existed, such discrimination could hardly be said to be unfair as this was reflective of the social attitudes and not necessarily of the law. This judgment was upheld by the High Court when the case was taken on appeal. While the fact remains that sex work and associated activities outlined above are criminalised, this criminalisation is argued to have adverse implications on the lives of sex workers. Human Rights Watch report[144] argues that this continued criminalisation has made sex work to be very unsafe, and undermined access to justice even for some violations that are committed against sex workers.

2.5 Inclusion of sex workers in HIV/AIDS national response

Key to South African policies on access to healthcare is the National Strategic Plan (NSP). The one currently in force, though under review, is the 4th National Strategic Plan.[145] Important to this study are goals 3,4 and 5 as outlined in the NSP. Goal 3 aims to reach out to key and vulnerable populations, inclusive of sex workers, with customised and targeted interventions in line with the with global efforts leaning towards realising the UN Agenda 2030.[146] The Agenda aims to ensure that no one is left behind in the fight against HIV/AIDS. Goal 4 seeks to address the social and structural drivers of HIV, TB and STI using the equal treatment and social justice approach. Goal 5 seeks to ensure that the national HIV response is grounded in

[144] Why sex work should be decriminalised (note 33 above)
[145] South African National AIDS Council. "The South African National Sex Worker HIV Plan, 2016-2019." (2016) (hereafter NSP 2016)
[146] UNAIDS DATA (note 78 above)

the human rights approach and principles, thus ensuring that stigma is eliminated, along with discrimination and punitive laws that increase the burden on key and vulnerable populations. During the implementation of the National Strategic Plan 2007 – 2011, an investigation was carried in order to better understand the plight of sex workers.[147] While the findings of the investigation did not support that sex workers suffered isolated discrimination, they acknowledged the heightened exposure and vulnerability of sex workers to HIV.[148] In its bid to accommodate this identified vulnerability, the South African National AIDS Council confirmed sex workers as a key population that needed special and tailored interventions, and also recommended the decriminalisation of sex work.[149] This resulted in an improved and more comprehensive National Strategic Plan of 2012-2016.[150]

As already established, South Africa has an estimated 7.1 Million people living with HIV, with sex workers, as a sub-population group, suffering a significantly higher prevalence and transmission rate.[151] Due to this recognised vulnerability, the NSP is based on the idea that the plight of sex workers should be addressed by way of a multi-department and multi-sectoral approach.[152] Despite this, Scheibe and others[153] and Human Rights Watch report[154] argue that although the NSP seeks to adhere to the principle of the protection of the human rights of sex workers and the non-discrimination principle in general, criminalisation of sex work wards off efforts to access healthcare services pertaining to HIV prevention, treatment, care and support.

The draft 2012 NSP recognised sex workers as key populations and included references regarding the decriminalisation of sex work, but the latter aspect was removed by Cabinet before the NSP was launched.[155] Due to pressure from civil society's advocacy efforts, a separate specific NSP for sex workers was drafted. It was never launched.

[147] M Richter 'Sex work, reform initiatives and HIV/AIDS in inner-city Johannesburg' (2008) 7. *Afr J AIDS Res*.at:323–333 (hereafter Richter)
[148] Richter (note 146 above)
[149] Richter (note 146 above)
[150] South African National AIDS Council. *National strategic plan on HIV, STIs and TB, 2012-2016*. South African National AIDS Council, 2012 (hereafter NSP 12).
[151] UNAIDS DATA (note 78 above)
[152] A Hassim and others *The National Health Act 61 of 2003: A Guide*. *SECTION27* (2008) (Hereafter Hassim and others)
[153] Scheibe and others (note 122 above)
[154] Why sex work should be decriminalised (note 33 above)
[155] Richter (note 146 above)

The lack of political will and continued criminalisation continue to compound the issues. Paradoxically, while the existing frameworks and initiatives are commendable in theory, certain elements run counter to these efforts. For example, one of the biggest funders on HIV work, the U.S.' President's Emergency Plan For AIDS Relief (PEPFAR) has an "anti-prostitution'' pledge which disallows their grantees to promote or advocate for decriminalisation or legalisation of sex work, as this will be in contravention of the pledge.[156] Financing for sex work HIV prevention is also minimal globally, as only 1% is dedicated towards it.[157] Because of this opposing sentiment and practice, UNAIDS recommends that all sex work programs should be based on commitment to achieve universal access, a supportive environment and realisation of sex worker involvement.[158]

[156] Scheibe and others (note 122 above)
[157] Scheibe and others (note 122 above)
[158] UNAIDS DATA (note 78 above)

3 CRITIQUE OF LEGISLATIVE AND POLICY FRAMEWORK

3.1 Introduction

This chapter looks at the findings from the review of literature and discusses these in light of the theoretical frameworks highlighted earlier.

Identified themes revolve around sub-optimal services, barriers to basic access, as well as service uptake. Notable as an overarching finding is the disparity between policy in theory and policy in practice. This is due to barriers experienced by sex workers on the ground, such as stigma, stereotypes, discrimination and laws that criminalise sex work. That this discord is present in an environment where a human rights framework exists, but is being violated poses questions about the realistic impact that proposed mechanisms such as law reform may bring in the long run, when there are 'invisible networks' that can trammel the impact thereof.

Martha Fineman's model espouses how in humanity there is a 'constancy' and 'universality' degree of vulnerability for everyone due to institutions that regulate everyday life and mortality of human beings.[159] Consequently, this enables at least enunciating that sex workers maybe just an example of a 'most' vulnerable group, especially when in need of accessing healthcare services. Addressing institutions that regulate, promote and provide healthcare services is fundamental as humanity is perhaps at its most vulnerable when one succumbs to illness. The service received when submitting to the will of healthcare workers, limiting one's own freedom at those moments of vulnerability determines one's ability to retain and maintain dignity. This is an important aspect that most sex workers lose because of their occupation when they seek services.

3.2 Health care needs and experiences of sex workers

Sex workers are not a homogenous group. They come from diverse backgrounds and as such, they also have diverse needs. However, of what they have in common, noteworthy are the political and socio-economic factors that facilitate, or hinder, their access to healthcare services.

[159] Fineman (note 90 above)

Due to the diverse nature of sex work and its criminalisation, it remains a challenge to fully comprehend its dynamics and prevalence.[160] This explains the wide range in the estimated number of sex workers in South Africa provided by different organisations. Health and wellbeing issues experienced by sex workers incorporate both physical and mental health needs. Physical health include sexual and reproductive health needs such as prevention or barrier methods, for example condoms, lubrication gels, contraceptives, HIV/ AIDS testing and treatment, STI screening and prevention, treatment of reproductive tract infections, abortion services as well as hormonal therapy.[161] Mental health and psychosocial support are required by sex workers on account of the stigma, exclusion and isolation that result from their occupation,[162] and are perpetuated by contextual antecedent factors like gender inequalities and inferior educational levels that exist thereby limiting employment opportunities and make sex work the only lucrative option for some people, especially women and transgender people.

There is no uniform experience of sex workers as they exercise their right to healthcare. While some sex workers have established good relationships with certain facilities or individuals in specific health facilities, and as a result enjoy good or comprehensive healthcare services, it would appear that challenges exist for many.

3.2.1 Experiences of migrant sex workers

Due to their diverse backgrounds, and for various reasons that include the need to navigate public and private identities and the quest to counter emotional and psychological violence, some sex workers compartmentalise their lives by alternating personas or conducting their business far away from home.[163] While some sex workers are locals, in their areas of operations as well as by national registration, some internally migrate and others came from nearby countries such as Mozambique and Zimbabwe.[164] Scheibe and others note that the majority of sex workers interviewed in their study are from elsewhere in South Africa and neighbouring countries, and their immigrant status bars them from services and presents an additional health

[160] H Savva 'Factors associated with the utilization of health services by female sex workers in South Africa' Doctoral dissertation, University of the Witwatersrand, 2013 (hereafter Savva 2013)
[161] Savva 2013 (note 159 above) 13
[162] Savva 2013 (note 159 above) 13
[163] E Oliveira 'Volume 44: Research with sex workers in South Africa' (2018) 32 (2). *Agenda* at 3-16. (hereafter Oliviera)
[164] Scheibe and others (note 122 above) 4

risk.[165] In addition to the legality issues due to their immigration status, language barriers also worked to impede their access to healthcare, as well as immigration and justice systems.

UNAIDS submits that increased international movements have impacts which are often overlooked. Migrant status is an important factor in the HIV/AIDS epidemic as the issue of transit presents a challenge for non-natives as they attempt to access healthcare services.[166] They are sometimes overlooked when seeking sexual reproductive healthcare services as pronounced in the following example "Experiences of xenophobia and discrimination during visits to the clinic were also described as reasons for halting antiretroviral treatment"[167]. In a country where there is a lack of resources and competition thereof, mostly illegal migrant sex workers suffer the stigma and discrimination. Migrant sex workers who are HIV positive report to have had challenges in accessing treatment and services as they were excluded by virtue of being foreign and are thus often accused of eroding services and resources meant for deserving citizens.[168]

3.2.2 Discrimination and lack of confidentiality at healthcare facilities

One issue that is apparent in the reviewed literature is the issue of breach of confidentiality when accessing healthcare services by sex workers. Duby and others[169] note that sex workers experience loss of confidentiality within some public facilities and that affects their likelihood of returning to the facilities. This is articulated in the following response captured in their study:

> *They already know what you are … whether it's a policeman or a nurse, will go to another colleague and say that you are from work (selling sex) … That one will also relay it (to colleagues) … Imagine getting that treatment here at hospital … we are even scared to go there because even if I get injured … they say that I was selling, I am a "magosha". [Female SW, FGD, North West][170]*

[165] Scheibe and others (note 122 above) 4
[166] 'UNAIDS Guidance Note on HIV and Sex Work' (2009) (hereafter UNAIDS guidance note)
[167] Oliviera (note 162 above) 12
[168] 'Rights Not Rescue: A Report on Female, Male, and Trans Sex Workers' Human Rights in Botswana, Namibia, and South Africa' (here after Rights not Rescue)
[169] Z Duby and others 'Scared of going to the clinic': Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities (2018) 19(1) *Southern African journal of HIV medicine* at 1-8 (hereafter Duby and others)
[170] Duby and others (note 168 above) 5

Another respondent also shared their experience of how patient confidentiality is breached:

> *Healthcare facilities … people who work there are not friendly. When you walk in they stare … (the nurses) will call their friends and tell them that you have an STI and they should come look. They tell you to undress. It will reach a point were you are scared of going to the clinic … they (nurses) call each other every time and about five of them would come. They would say come see, what is this thing? So that's why some of us don't go to these places, and that's why some of us die of HIV/AIDS. That's why. [MSM, FGD, Free State]*[171]

Savva[172] argues that the lack of patient confidentiality within facilities resulted in preference to use traditional healers than using unfriendly public healthcare facilities, and this has also been an emerging and common strategy utilised by sex workers in different studies.[173] These findings tally with a Zimbabwean study carried out by Mutanga & Moen as they observed that LGBTIQ people and sex workers shunned from unfriendly healthcare facilities resorted to de-professionalised lay-kind of health services, where healthcare seekers self-diagnose and use their networks to treat themselves.[174] Most illnesses thus deteriorate, and one usually presents at a facility requiring admission because of delayed care. In other instances, and for the few fortunate ones, this results in the target group resorting to private healthcare, as those facilities are rated as more accessible as they had good customer care, but were not affordable for many due to the high cost.[175]

3.2.3 Stigma, discrimination and stereotyping beyond points of care

While a common thread in the general assessment of access to healthcare and justice services across the country is reportedly suboptimal due to public service workers' misconduct, some provinces have improved on account of the visibility and availability of NGOs in support of sex worker movements. In more rural settings, where these kinds of organisations do not have

[171] Duby and others (note 168 above) 5
[172] Savva (note 159 above) 34
[173] Duby and others (note 168 above) 5
[174] O Mutanga & K Moen 'The push of stigma: a qualitative study on the experiences and consequences of sexuality stigma among same-sex attracted men in Harare, Zimbabwe' (2019) *Culture, Health & Sexuality at* 1-13 (hereafter Mutanga & Moen)
[175] J Hunt and others 'They will be afraid to touch you': LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe—an in-depth qualitative study' (2017) 2*BMJ Global Health* at 1-8

much reach, the situation of access remains dire with sex workers largely experiencing stigma and discrimination.[176] Afzal and others concluded that;

> *Stigma and criminalization of sex work may create a direct barrier to accessing HIV healthcare and to prevention [3]. Sex workers report humiliation and fear of refusal of service and other negative experiences that may preclude seeking care from public health service*[177]

Duby and others also note that this stigma and discrimination mainly manifests in terms of scolding tones, blame, embarrassment, shame and being called derogatory names such as 'moffie-istaban' and 'magosha-prostitute.'[178] Sex workers are seen as not trustworthy and deserving of HIV/AIDS. The continued criminalisation of sex work in South Africa provides tacit approval to the healthcare workers and the society at large to treat sex workers based on sexual moralism, labelling sex workers as promoting sexual promiscuity. [179] The community assumes the moral upholding custodian role and uses violence, physical or otherwise, to enforce morality. One study captures it thus:

> *sex workers face too much violence because our bodies are trapped in the middle of ideas and real life" (December 2014). This in-between state that Sitembile refers to is the space where non-normative sexual desires intersect with heteronormative ideologies, where sex workers' bodies simultaneously represent sites of pleasure and disdain.*[180]

For survival, sex workers resultantly go into hiding and are unable to access services, including healthcare services.

Stigma and stereotyping also leaves sex workers with no other option but to lie about who they are and the nature of their work, which can lead to misdiagnosis and late treatment. An example is cited in one of the studies:

> *Lack of access to safe public health services was a critical concern for Limpopo participants. Experiences of being given paracetamol (aspirin) instead of antibiotics to*

[176] O Afzal and others 'Reproductive healthcare needs of sex workers in rural South Africa: a community assessment' (2020) 86(1) *Annals of global health* (hereafter *Afzal and others)*
[177] Afzal and others (note 175 above) 5
[178] Duby & others (note 168 above) 4
[179] UNAIDS guidance note (note 165 above)
[180] Oliviera (note 162 above) 11

treat infections, including accounts of verbal and physical abuse by public health staff, were common[181]

Duby and others notes that experiences of stigma subject sex workers to feelings of guilt, shame and a general loss of dignity. Uptake of services is then affected by enacted and self- stigma, as reluctance to seek care and unwillingness to disclose risk behaviours to healthcare workers combined with healthcare workers own lack of knowledge regarding the needs of the target group. This is supported by Mutanga and Moen who document similar findings of clandestine operations and shame of self-identification leading to inaccurate treatment.[182] Negative attitudes towards, and experiences of disapproval by healthcare workers of, the target group often hold back sex workers from seeking care as they remain hidden out of shame.

Impunity of healthcare service providers and the possibility of arrest of sex workers discourages those seeking care out of fear that revealing their occupation at a clinic may lead to them being arrested. Savva found that healthcare workers ill- treated sex workers based on their occupation and from the knowledge that they can report them to the police should they complain and get them wrongly arrested. As a result, most sex workers are pushed away from healthcare services within easy geographic reach to avoid just being exposed or outed as sex workers.[183] Mutanga and Moen termed this as the 'geographical push of stigma', referring to situations where stigma causes service seekers to move from close facilities to facilities away from their homes, where even if identified as sex workers it would not affect their dignity within their residential communities.[184] What is of interest in the South African context is the fact that discrimination, stigma and stereotyping is happening despite that anti-discrimination is a principle encapsulated in various legal provisions.

There is also stigma tied to healthcare workers who work with sex workers, and this is referred to as 'courtesy stigma or stigma of association.'[185] The GAP report noted that stigma and discrimination associated with sex workers causes other stakeholders such as healthcare workers to distance themselves from sex workers.[186] This results in a lack of support from such

[181] Oliviera (note 162 above) 11
[182] Mutanga and Moen (note 173 above)
[183] Savva (note 159 above)
[184] Mutanga and Moen (note 173 above)
[185] 'UNAIDS The GAP report 2014 sex workers' (hereafter The GAP report)
[186] The GAP report (note 184 above)

important allies, and the lack of support, compounded by an already existing underlying stigma, leads to the further exclusion of sex workers.

While the right to healthcare, including emergency care, is guaranteed in South Africa's Constitution, sex workers suffer intense fear of seeking healthcare from public institutions as they continue to be stigmatised and discriminated against largely because of their behaviour which is said to deviate from social norms.

3.2.4 Physical barriers and capacity constraints

Duby and others note that while healthcare facilities exist, they are not geographically evenly distributed and thus not available to carter for everyone. Where geographic access is a challenge, transportation costs act to deter sex workers from seeking regular healthcare services.[187] Where the facilities exist in close proximity, the environment of some facilities is 'uninviting' and not inclusive and conducive for usage by the target group. They rarely provide informative and educational materials relating to key populations and their behaviour. The healthcare workers at these facilities may also lack equipment and capacity to deliver key population friendly services as they are not well sensitised on the issues.[188]

3.2.5 Lack of protection

As already indicated, regardless of the systems in place, sex workers face a multitude of human rights violations from various players that include healthcare workers, clients, the police and society in general.[189] In the Rights not Rescue report,[190] the authors argue that it is not an exaggeration to conclude that sex workers face health and human rights violations which severely compromise their access to health. Violence, whether physical, systematic or otherwise, increases the risk for sex workers and deters them from seeking services. They are perceived and treated as criminals in the eyes of the law and threatened with arrest or arrested for loitering among other issues. Experiences like these act as barriers to the uptake, or sustained utilisation, of healthcare services, including HIV prevention services.[191]

[187] Duby and others (note 168 above)
[188] Savva (note 159 above)
[189] Savva (note 159 above)
[190] Rights not Rescue (note 167 above)
[191] The GAP report (note 184 above)

The reported common practice by police of confiscating condoms and using them as evidence of sex work is paradoxical given the existence of the public health approach that promotes safer sex and the need to curb the HIV/AIDS pandemic. These kinds of acts have the ultimate result of predisposing sex workers to more health risk from unprotected sex and not seeking treatment.

Since they are seen as engaging in nefarious activities, sex workers are seen as not deserving of services meant to be enjoyed by everyone,[192] and in some instances, police even fail to act when sex workers come to report cases. The underlying implication appears to be that sex workers cannot be violated in anyway. If they are, it is because they are deserving of the violation, and as a way to punish them further, they are instead detained, leading to secondary victimisation. Harassment by police, including even rape, is commonplace. Due to how sex workers are labelled and presented as the drivers of the pandemic, and the cause the of erosion of moral and social fibre, 'consent 'is not a principle freely accorded to them by various key players in the healthcare system, justice system and society in general.[193] Because of these continuous violations and the societal beliefs that underpin them, sex workers remain poorly served and invisibilised.

Using the building blocks framework,[194] one can reasonably deduce that the HIV regulatory environment that is being facilitated by the government is thus failing to address the needs of sex workers, despite all its effort and the fact that it actually exists.

3.3 Discord between policy intent and practise

South Africa is required by international and domestic laws to fulfil its obligation with regard to the right to healthcare. Section 27 of the Constitution read, together with National Health strategy, is clear that access to health is fundamental and must be respected, in cognisance of the progressive realisation caveat. This is an ideal scenario that is however valorised due to various reasons already established above, selective interpretation and application of laws and policies and entitlement of 'deserving' amongst others. Evidence reviewed as part of this study has shown that sex workers may be regarded as having sub-optimal access to services because

[192] The GAP report (note 184 above)
[193] "Good Practice in Sex Worker-Led HIV Programming"
[194] Scheibe & others (note 122 above)

of barriers experienced on the ground. These barriers include the law that criminalises sex work and activities related to it, and the resultant stigma as well as attitudes against sex workers which are not visible and are not written in law.

Sex workers, in their diversity, continue to face a lot of barriers accessing healthcare services which has negative implications on the actualisation of the National Health Policy. The conflict between health policies and the law on sexual offences, which criminalises sex work, explains some of the continuing barriers for sex workers.[195] Savva[196] notes that 5% of sex workers are estimated to have access to adequate health services, and this is attributed to healthcare worker attitudes, denial of health services, lack of awareness of available services and stigma that increases vulnerability and deeply discriminate against sex workers as less deserving of the health services. Similarly, WHO found that only about one third of sex workers in Africa receive HIV prevention services, and access adequate treatment and care.

The lack of alignment between policy and laws leaves a lot of room for moral majoritarianism to result in multiple interpretation and consequently affect practice. One interpretation is that since sex work is criminal provision of services to sex workers should be discouraged. This gives rise to justified and acceptable non-written social sanctions such as negative attitudes, stereotypes and abuse. This ultimately results in what Dean Spade refers to invisible and complex barriers.[197]

> *The conditions that created and continue to reproduce such immense disparities are made invisible by the perpetrator perspective's insistence that any consideration of the prohibited category is equally damaging. This model pretends the playing field is equal, and thus any loss or gain in opportunity based on the category is harmful and creates inequality*[198]

The challenge with these invisible barriers is that while they are systematic, they are not justiciable in courts of law because they are not as obvious and easy to prove. The laws that criminalise sex work exist alongside the existence of the right to provision of healthcare as encapsulated in the Constitution, which is the supreme law, and which extends this protection

[195] CA Mgbako 'The Case for Decriminalization of Sex Work in South Africa' (2012) 44 *Geo. J. Int'l L.*at 1423-1454 (hereafter Mgbako)
[196] Savva (note 159 above)
[197] Spade (note 56 above) 42
[198] Spade (note 56 above) 43

and access to sex workers. However, the reality on the ground is that there is stigma, made worse by the criminalisation of sex work, and sex workers cannot argue that the provisions discriminate against them. In fact, Duby and others[199] argue that society's vilification of sex workers means that policy remains in force, but invisibilised and incomplete results of this disharmony is eliminating the intended impact of policy.

3.4 Legal reform as the panacea

Sex work is criminalised in South Africa, as already indicated. Calls for decriminalisation are present in most texts because of the growing consensus that the existing laws have negative impacts such as violence, lack of access to healthcare and justice system. Mgbako[200] clearly points out correctly that these laws aim to eradicate sex work. On the contrary, these laws have failed as they have neither reduced sex work nor its demand and supply, but rather have fuelled a lot of human rights abuse.

Carrying forward the assumption made earlier that laws are a proxy indicator of societal attitudes, the laws then serve to legitimise and reinforce these societal attitudes. In this case sex workers are perceived and treated as not deserving of health services, as criminals and as not deserving of the protection of the State because they are transgressors. In such an environment, illness is viewed as being earned and suboptimal healthcare service is justified. It is seen as punishment for law breakers and sinners and this results in shame and lack of service uptake. It can therefore be submitted that there is police impunity and abuse experienced by sex workers, simply because they are viewed not only as criminals but also as deviants. Due to the significant power imbalances between sex workers and the police, sexual abuse, arrests and detention often result as a way of correction and punishment. For example, just possession of condoms is often used as evidence of sex work by police. When a sex worker is then faced with sexual gender-based violence, seeking health services that require police clearance can be a challenge as the law enforcement agency are part of the perpetrators, which then becomes a barrier to accessing comprehensive health coverage.

Due to criminalising laws and the unintended resultant impunity, sex workers are seen as not deserving fair treatment by both healthcare workers and law enforcement agents. Providing

[199] Duby and others (note 168 above)
[200] Mgbako (note 194 above)

exemplary service to sex workers would be seen by some as encouraging and supporting sex work. With regard to the government's HIV/AIDS programme, the irony of what happens in practice is that while the government promotes distribution of condoms for epidemic control, police arrest sex workers in possession of condoms, using the condoms as evidence of their guilt. The result is that to avoid these arbitrary and wrongful arrests, sex workers do not carry condoms when they go to work, with the outcome that they end up engaging in sex without protection. Criminalisation of sex work is therefore one of the reasons that impedes successful HIV public health practice, increases risk of HIV and STI transmission, fuels stigma in healthcare and fosters the continued abuse of sex workers, which overall dissuades service use.[201]

Most texts on the South African sex work industry cite the effects of criminalisation of sex work on access to health and argue for decriminalisation. "*If South Africa decriminalises sex work, sex workers will be empowered to access health services, including HIV prevention."*[202] With due respect to those that believe that decriminalisation of sex work is the panacea, such an analysis is unidirectional and simplistic. This is problematic as laws do not directly translate into practise, as already advanced above. This is due to the existence of 'invisible' barriers as Spade suggests, that go beyond legal formalism. These 'invisible' barriers are embedded within non-legal systematic structures such as attitudes, beliefs, stigma and values, and have a substantial impact on sex workers' ability to access healthcare services.[203] This analysis dovetails with earlier findings in this study that show that policy provisions in the South African Constitution and Strategic Health Policies have been compromised by stigma and other factors, and the existence of such policies merely serve as lip service when it comes to sex workers as they do not target the root cause.

Ochoa argues that individual human rights-based frameworks are not always viable alternatives for groups such as these and the focus should thus be on the 'distribution of life chances' framework.[204] This framework enables the focus of effort on social transformation, not window dressing of claims of state inclusion, as the focus is on the impact and not necessarily the intention.

[201] Mgbako (note 194 above)
[202] Mgbako (note 194 above)
[203] Spade (note 56 above)
[204] M Ochoa 'Review of Spade, Normal Life' (2011) *Social Justice* at 144. (hereafter Ochoa)

Laws can be reformed and aligned, but in themselves have not eliminated marginalisation and exclusion, as these have persisted despite changes in law.[205] This is partly also because most people whom the law is intended to protect when violated cannot afford to access legal help, and their cases rarely make it to the courts. Most legal reform is based on perpetrator-victim mentality, with violation and discrimination that is seen at an individual level, allowing for redress to be sought when it is constituted as unfair discrimination. Spade's view allows one to see that such individualised lens renders structural discrimination invisible.[206] Most reform laws apply to disparities that are informed by a deliberate and intentional breaking of the law by the perpetrator. This implies that, the disparities that sex workers experience because of structural and systematic discrimination from long term exclusion cannot be understood as violations under the discrimination clause.[207] Thus, even if the laws are reformed, they are not in themselves the ultimate goal, and only target a limited area of interventions. Attitudes, which also need to be addressed, because legal formalism on its own is insufficient, will continue and perpetuate the narrow understanding and reading of what constitutes a violation and can be recognised as discrimination.[208]

In the current state of affairs in South Africa, even if legalisation, decriminalisation and regularisation of sex work happens, the existing narrow understanding of discrimination will still prevail and will continue to naturalise and solidify the status quo. Ochoa further argues that this perpetrator perspective obscures the historical context of the issues and discrimination, eviscerating affirmative action and daily disparities in life chances that shape human experiences. In this case, sex workers' experiences continue to be viewed as non-discrimination.[209] This undermines the possibility of remedying the severe disparities that exist as the justification of systematic issues are masqueraded as logic of equal opportunities.[210] It is perhaps not surprising that such an arrangement creates a false impression that the once excluded groups are now on an equal footing with others, allowing disparities to continue.[211]

[205] Ochoa (note 203 above)
[206] Spade (note 56 above)
[207] Ochoa (note 203 above)
[208] Which can be a challenge in South Africa, as enforceable discrimination is unfair discrimination where for instance one sex worker is denied of their right but other sex workers are not denied that right. As it stands all sex workers are subject to the same law and arguing that unfair discrimination has happened is a misreading of the law.
[209] Ochoa (note 203 above)
[210] Spade (note 56 above)
[211] Spade (note 56 above)

Evidently, the nature of the laws in South Africa, and most countries that criminalise sex work and associated activities, does have a negative impact on sex workers. Policy and legal change alone cannot guarantee equality of access to services. It can actually legitimise and perpetuate violations if the root cause of the problem is not addressed. Ochoa's persuasion that laws can portray issues through a lens that oversimplifies its operations and suggest that the criminalisation or punishment is the proper way to solve it, finds support in the experiences of sex workers in South Africa. [212]

Crenshaw argues that solutions that are meant to help minority groups with intersectional challenges should consider all the possible areas and interacting issues that they face.[213] In this instance, measures that are meant to help sex workers in South Africa should not only look at the legalisation and decriminalisation of sex work, but also at the capacity of the affected groups to utilise the laws, and as such, there is a strong need to improve the building blocks of healthcare such as governance, the structures of the health system itself and other social determinants of health in the long run.[214] In doing so, there is not only a change in what the law says, but in the impact that such laws can have as the overall environment is also being addressed in the process. For Spade, the central point is that individual bias and prejudice in all its forms, inclusive of harassment and discrimination in a significant way accounts for the massive disadvantages facing vulnerable groups. These find systematic expression/manifestation in the administrative barriers that make access to social services extremely more difficult because more aspects of the vulnerable groups lives are directly controlled by legal and administrative systems of domination, which employ binaries.[215] The sustainable avenue therefore is not through the individual but improving overall lives because it is from the numerous barriers embedded in the administration which everyone interacts with at some point.

[212] Ochoa note 203 above)
[213] KW Crenshaw and others 'The public nature of private violence' (1994). *Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color* at 93-118. (Hereafter Crenshaw and others)
[214] Scheibe and others (note 122 above)
[215] Spade (note 56 above)

3.5 Applying the capability framework

The Capability Framework allows for an evaluation of an individual's wellbeing by focussing on the individual's ability to achieve valuable functioning in life.[216] In this case, health is viewed as both a functioning and as a capability. The South African government has a role to provide structures, policies and facilities that enable enjoyment of the highest attainable standard of health as articulated in various legal documents. These resources, as well as utilities, are only a means to an end. The desired end is the highest attainable standard of health. Sex workers should thus, in the presence of conversion factors and or resources, be in a position to achieve functioning (be able to lead healthy lifestyles). In essence, with the existence of these facilities, sex workers from a capabilities approach should be freely involved in accessing healthcare services without any fear of prejudice, stigma and discrimination. This is succinctly put across by Barreda and others as they state that people should not only enjoy valuable functioning such as good health, but, also value the good and the process of bringing the good.[217] A submission can therefore be made that from the experiences shared before, most sex workers in South Africa do not feel empowered to use the public healthcare system and as a result, they are not at their optimal functioning state due to the stigma and discrimination they experience due to the work they do.

3.6 Applying the intersectionality theory

They are various intersecting structural and other factors that affect access to services. These include social, economic and legal restrictions targeted at the sex workers, ultimately limiting programming and planning. [218] This is so because sex work is criminalised in South Africa, and sex workers are often seen as criminals. As a result, sex workers tend to shun services targeted at them because of shame and the stigma they experience on account of being labelled as 'criminals' or sex workers. The stigmatisation and moral judgment are embedded within the society regardless of what the policy dictates, and consequently adversely affect sex workers' access to healthcare services. Savva discussed how healthcare workers thought of sex workers as 'undeserving' of the health services.

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[216] PM Mitchell and others 'Applications of the capability approach in the health field: a literature review' (2017) 133(1). *Social indicators research* at 345-371(hereafter Mitchell and others)

[217] R López Barreda and others 'Health assessment and the capability approach' (2019) 30 (1). *Global Bioethics* at19-27

[218] Savva (note 159 above)

The other intersecting issue that comes out in the case of South Africa is the issue of 'citizenship' and/or nationality. Migrant status plays a significant role in determining access to healthcare services.[219] Reviewed evidence shows that some of the sex workers in South Africa come from nearby countries, and may be undocumented. In contravention of the Constitution, they are often turned away from public health facilities because of their migrant status. This compromises services uptake and ultimately leads to them rarely seeking the services because of the 'illegal migrant' status and fear of xenophobic attacks and deportation back to their countries of origin.

From the findings shared above, one can note the presence of structural intersectionality dynamics. This is aligned to the radical feminists argument that most sex workers are in sex work as a result of structural factors that predispose them to unfavourable economic and individual livelihoods.[220] In most cases these women and transgender men are already in subordination and sex work is merely the most immediate manifestation of the subordination they experience from other categories relating to educational levels, poverty, structural injustice and their life chances of getting jobs in the formal sector. They are unemployed and poor in most instances, and the formal structures cannot accommodate them, neither can government welfarism adequately cater for them. Crenshaw argues that because many of these burdens are a consequence of class, gender and class oppression. They are compounded by race and other categories as demonstrated above, making access to health a struggle that cannot be resolved by remedying the law only.[221]

These challenges require broad and transdisciplinary perspectives and interventions that acknowledge and factor in these intersecting issues and their effects, visible and invisible.[222] Interventions, and strategies that are narrow based, solely focusing on one aspect of the intersecting issues, would be of limited use as these lives are shaped by a varied set of obstacles. This aligns with Spade's call for interventions that increase distributive chances, as well as the capability framework approach that argues that the ultimate goal of development is not increasing materialistic aspects such as GDP, but the freedoms and functioning of citizens and

[219] Savva (note 159 above)
[220] Weitzer (note 69 above) 214
[221] Crenshaw and others (note 212 above)
[222] Crenshaw and others (note 212 above)

residents.[223] In the context of this study, development would be increases in the freedom to choose healthcare services and the improvement in overall health wellbeing.

Sex worker experiences already shared in this study combine to deter their capability in exercising and actualising their right to access healthcare services. Predictably, under these circumstances, many self-identifying sex workers may resort to self-help and informal or private facilities which raise the issue of affordability and efficacy into question. Policies meant to address sex workers' access to healthcare services should also look at these complexities.

3.7 Applying the 'Building Blocks' model

The State carries the responsibility for legitimising and empowering social institutions that increase human resilience or decrease human vulnerability. Institutions are present in everyday lives as they regulate everyday lives. The laws regulating sex workers' lives are run by the government and so are the laws and policies regulating health institutions. These institutions reveal two things: The State wields both the power to more effectively protect and provide for sex workers, and also the power to leave them in their vulnerability and to fend for themselves.[224] As a result, sex workers are inescapably interwoven into the webs of State institutional regulation that limits their capacity to overcome shocks through its distribution of resources in a manner that produces inequalities.

Formal equality through traditional law reform has proven ineffective as a mechanism to remedy systematic problems that marginalised and vulnerable groups face. Activists must therefore not necessarily change the legal contents of the law because the effects of normative law change do not correlate with resources and opportunities distribution.[225] Formal equality espoused in legal formalism is not enough to address it as it fails to remedy vast disparities in critical resources.[226] Formal equality treats vulnerable groups as the only groups requiring interventions and thus failing to make interventions that have distributive impact that acknowledges that vulnerability is universal and shared by humanity.[227] Solutions should

[223] Mitchell and others (note 215 above)
[224] SA FitzGerald and VE Munro 'Sex work and the regulation of vulnerability (ies): Introduction' (2012) 20(3) *Feminist Legal Studies* at 183-188 (hereafter FitzGerald and Munro)
[225] Spade (note 56 above)
[226] FitzGerald and Munro (note 223 above)
[227] Fineman (note 90 above)

therefore move beyond legal fragmentation. The better option is rather to focus on transforming systems of power in societies. This will address the challenges at the critical points of resource allocation and opportunity distribution.

Fitzgerald and Munro advance that people look upon these institutions of governance to protect them and to uphold their rights, and by so doing, also recognise diversity in personhood despite levels of vulnerability. At any given moment, vulnerability is present and operates in the everyday lives of individuals. These vulnerabilities are then compounded by a range of contexts, emotions, histories and subject positions that intersect and interact with one another to make our experiences unique. As indicated above, sex workers' experiences are shaped by gender, gender expression, class, nationality and other factors which combine to increase their vulnerability. This vulnerability is further heightened when one is ill and is subjected to the whims of health institutions and medical personnel and, metaphorically speaking, lose their freedom.

Assessing 'institutions' as they are perceived by the vulnerability framework enables an understanding of how government actions through policies and laws produce particular framing that perpetuates the conditions that increase sex workers' vulnerability to health inequalities and human rights violations. It is also worth noting that government's idioms of 'vulnerable' 'key' or 'special' populations may in reality, and unintentionally, reproduce vulnerability. This is an issue that Spade deals with at length.

The vulnerability framework also enables the understanding of how a less agentic being creates a desire (on the part of the State) to extend bodily control and limit the groups' autonomy. The creation of a 'sex-worker-in-need-of-rescue' mentality makes invisible webs of the patterns of heteronormativity, thereby legitimising sex workers' bodies to be viewed as those in need of rehabilitation or punishment. The framework also allows for an understanding of how the government distributes resources and what its priorities entail. A government has a responsibility to ensure that all its people have an equitable access to societal institutions that distribute resources. The findings on the sex workers' experiences in accessing healthcare services is indicative of the structural ill preparedness and incapacities of the health fraternity to enable sex workers exercise their right to accessing healthcare services. This also explains how the level of vulnerability has replaced group identity (sex workers have been classified as key populations, indicating their vulnerability and almost implying an 'acceptable or palatable

term') Sex workers are forced to accept and internalise this terminology as it opens and increases opportunities for them to access services and present a platform for advocacy to improve their status in the country.

4 CONCLUSION AND RECOMMENDATIONS

On the basis of evidence reviewed as part of this study, it can be argued that sex workers in South Africa are underserved by the public health systems. They are criminalised and endure violence, stigma, stereotyping, all of which make most fail to access comprehensive health services.[228]

The intersection and interaction relationship of oppression and privilege is intrinsic to societal practices, excavating the multiple ways in which a person with multiple identities is designed and embedded within systems of inequalities. These inequalities can be linked to institutions and vulnerability that have ramifications on people's functioning, wellbeing and freedoms, as they relate to structural levels of power given within a socio-historical context of advancing equity.[229] Addressing these intersecting inequalities should go beyond the liberal, autonomous being, and extend to a constantly and universal vulnerable being whose predicaments are not sufficiently addressed through traditional legal reform alone. Dean Spade's framework enables the move from approaching intervention discussions from the perspective of an individual sex worker to a more focused discussion of power differentials in sex workers' lives and how, given the socio-historical contexts and situational landscape, such an analysis can serve as an anchor to advance equity for marginalised groups.[230]

Evidently, health disparities do not exist in isolation, but are part and parcel of a reciprocal and complex web of processes associated with inequality, as social determinants of health overlap and interact with intersecting inequalities.

Mindful of the inherent limitations of this study, recommendations are made to guide future research and to also stimulate ongoing discussions regarding this very important topic. Recommendations relatable to this study may include some of the following:

- This study demonstrated why law reform alone will not achieve a better outcome for sex workers. Attitudinal barriers in healthcare facilities and in communities need to be aggressively targeted, paying attention to issues of socialisation and individual beliefs

[228] Scheibe and others (note 122 above)
[229] N López and VL Gadsden 'Health inequities, social determinants, and intersectionality' 2016 at 1-15.
[230] Crenshaw and others (note 212 above)

such as religion and patriarchy. This can be achieved through efforts to educate and sensitise communities, including healthcare service providers and the police, must be complemented by an equally strong drive to empower sex workers to know the law and demand their rights.

- Institutions and other building blocks of healthcare, such as the health fraternity itself, need to be structured in a way that does not only look at sex work from an individual victim-perpetrator mentality as this invisibilises already existing challenges, and relegates sex workers. For example, the recognition and reinforcement of agency could assist with empowering sex workers and enable better access.
- Interventions in this regard therefore will require careful planning and a sustained effort. This has implications for resources that need to be committed to such an intervention

Understanding how entrenched societal views are regarding sex work and sex workers, any likely change will be long term. Given the religious convictions within South Africa, there will be strong backlash. It is therefore advisable that an incremental approach be taken, perhaps beginning with targeting healthcare service providers, and then the police, and then other sectors of society. The status quo needs to change if any further progress is to be made in terms of the fight against the HIV/AIDS pandemic, and if sex workers are to ever fully enjoy the right guaranteed by the South African Constitution.

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