ZIMBABWE NATIONAL COUNCIL FOR THE WELFARE OF CHILDREN

YOUNG WOMEN IN COMMERCIAL SEXUAL EXPLOITATION ALONG TWO TRANSPORT CORRIDORS IN ZIMBABWE: CAUSES, INITIATION PREVALENCE AND USE OF HIV AND SOCIAL SERVICES

"The unavailability of other work or another form of financial and livelihood support is the main reason for staying in the sex trade"
YWSS in Epworth, Harare

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Young women in commercial sexual exploitation along two transport corridors in Zimbabwe: Causes, Initiation Prevalence and Use of Social and HIV Services

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FOREWORD

Sexual violence against children corrodes the strong foundation that children require for leading healthy and productive lives. Globally, studies show that exposure to violence during childhood can increase vulnerability to a broad range of mental and physical health problems, ranging from depression and unwanted pregnancy to sexually transmitted diseases, including HIV. In a Violence Against Children(VACS)study conducted in 2015, patterns in the prevalence of any form of childhood sexual violence reported among females in Zimbabwe was high (32.5%), yet Zimbabwe had a considerably lower reported prevalence of sexual violence against males (8.9%). Zimbabwe has identified young people aged 15-24 years as one of the key populations in the response to HIV. Despite this, in Zimbabwe, the causes of YWSS, average age of entry/initiation prevalence into sex work and the extent of access to and use of HIV and social services by children involved in commercial sexual exploitation is unknown; evidence on the relative importance of the causes of Commercial Sexual Exploitation of Children(CSEC)and estimates are needed to stimulate prevention and response exertions and to monitor progress.

Zimbabwe ratified many international conventions related to Child protection including the United Nations Convention on the Rights of Children (UN CRC). The Convention and its principles have taken root in national and local legislation, motivating the Government of Zimbabwe (GoZ) to place children's rights and their development at the forefront of its legislative agendas. The GoZ, under the leadership of the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) developed different programmes including the National Action Plan (NAP) for OVC I and II. In 2014, Zimbabwe made a minimal advancement in efforts to eliminate the worst forms of child labor. Despite these impressive commitments by the GoZ, the Zimbabwean child rights context is characterized by heightened vulnerability where many children are experiencing violence, exploitation and abuse within their communities. Children in Zimbabwe continue to engage in child labour including sexual exploitation with limited utilization of services. Only ≤2.7% (CI 0.4-5.0) of females aged 18–24 years received services among those who experienced any form of sexual violence in Zimbabwe when aged <18 years.

Zimbabwe continues to lack specific social interventions targeting sectors in which Child Labour is most prevalent. Gaps remain in the country's legal framework against Child Labour. Education is not compulsory or free, which increases children's vulnerability.

The Zimbabwe National Council for the Welfare of Children (ZNCWC) in partnership with Progressio, and National AIDS Council(NAC) commissioned this research study on the 'The causes, initiation prevalence, use of social and HIV services among young women selling sex in Zimbabwe' in order to generate evidence required to contribute to the prevention and response to the challenge of young women involved in commercial sexual exploitation. The study is fully aligned to national HIV and girl child protection priorities as articulated in the GoZ's 2011 Child Labour Survey report of 2013.

Given Zimbabwe's efforts and experience in reducing the worst forms of child labour, the MPSLSW enjoins all key stakeholders to identify with and utilize findings of this research to help prevent and respond to the challenge of commercial sexual exploitation of children in Zimbabwe.

Mr Taylor Nyanhete

National Director

Zimbabwe National Council for the Welfare of Children

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This research on "**YOUNG WOMEN IN COMMERCIAL SEXUAL EXPLOITATION ALONG TWO TRANSPORT CORRIDORS IN ZIMBABWE: CAUSES, INITIATION PREVALENCE AND USE OF HIV AND SOCIAL SERVICES"** is the outcome of a collaborative effort involving several organisation's and individuals in Zimbabwe. We would like to extend a special gratitude to all those who participated in the research and those who supported the research.

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Lastly, we cannot over-express our gratitude to all our project consortium partners NECTOI, ZACRO and ZAPSO who participated in the research study and to all others who have contributed and provided support in one way or the other in the development and implementation of this study. We look forward to your continued partnership and support.

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ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
ARV	Anti-Retro Viral
CDC	Center for Disease Control
CeSHHAR	Centre for Sexual Health, HIV and AIDS Research in Zimbabwe
CSEC	Commercial Sexual Exploitation of Children
FGD	Focus Group Discussion
FSW	Female Sex Workers
GBV	Gender Based Violence
GoZ	Government of Zimbabwe
HIV	Human Immuno Virus
IDI	In-depth Interview
ILO	International Labour Organisation
KI	Key Informant
KIG	Key Informant Guide
MoHCC	Ministry of Health and Child Care
MRCZ	Medical Research Council of Zimbabwe
NAC	National AIDS Council
NECTOI	National Employment Council for the Transport Operating Industry
NGO	Non-Governmental Organisation
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre Exposure Prophylaxis
RDS	Respondent Driven Sampling
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of Children
UNICEF	United Nations Children's Fund
VACS	Violence Against Children Survey
VMMC	Voluntary Medical Male Circumcision
YWCSE	Young Women in Commercial Sexual Exploitation
YWSS	Young Women Selling Sex
ZDHS	Zimbabwe Demographic Health Survey
ZNASP III	Zimbabwe National HIV and AIDS Strategic Plan III 2015-2018
ZNCWC	Zimbabwe national council for the welfare of Children

1. EXECUTIVE SUMMARY

BACKGROUND

The problem of Commercial Sexual Exploitation of Children (CSEC) has increasingly become a major global concern. Young women who sell sex (YWSS) in southern Africa including Zimbabwe are highly vulnerable to HIV, as the risks of being young and female in a high prevalence setting merge with those of commercial sex. YWSS are less able to negotiate safe sex, more likely to have higher risk sexual partners, and less likely to use available health services compared to older sex workers. [1]. A study by Mtetwa *et.al* (2016) established that the number of YWSS accessing and utilising HIV services in Zimbabwe is low despite 18% of adult female sex workers (FSWs) stating that they first sold sex <18 years old.

STUDY AIM

This study sought *to establish the drivers, initiation prevalence and extent to which children engaged in commercial sexual exploitation are accessing and utilizing HIV and social services*. Recent research in Zimbabwe and six other countries has quantified the prevalence of all forms of sexual violence against children [2]This study sought to explore this form of child labour with specific focus on commercialization of sexual exploitation in Zimbabwe with the aim of proposing strategic policy and practice interventions for the elimination of commercial sexual child labour and facilitate rehabilitation and re-integration of those children already involved in the sex trade.

STUDY QUESTION

This study aimed to answer the question: 'what are the causes, initiation prevalence and uptake of social/HIV services for young women in commercial sexual exploitation in Zimbabwe'.

PARTICIPANTS

The study included multiple survey participants focusing on young women in commercial sexual exploitation before the age of 18 years. Participants included: young women selling sex between the ages of 10-17 years at selected 'hot-spot' sites along two transport passageways; female sex workers between the ages of 18-24 at selected 'hot-spot' sites to establish the age at which they entered selling sex.

METHODOLOGY

This study used an analytical cross sectional design collecting data on both the exposure and outcome variables. It included quantitative and qualitative data collection and analysis. Data collection included exposure variables (causes), information on age of entry into commercial sexual exploitation and use of social and HIV services among young women in commercial sexual exploitation (YWCSE). Respondent Driven Sampling technique was used to recruit study respondents. Qualitative data included structured interviews with government departments, non-governmental organizations (NGOs), local authorities and community leaders.

ETHICAL CONSIDERATIONS & REFERRALS

Informed consent/assent was obtained from all participants, special safeguards were incorporated for confidentiality, all participants who preferred, received a referral list of available services, and any victims desiring aid were referred for social and HIV services.

STATISTICAL ANALYSIS

This study adopted a combination of descriptive and comparative analyses, and interviews to assist in the analysis and interpretation of collected behavioural data. Descriptive analyses were performed to explore distribution of key exposures and the initiation prevalence into commercial sexual

exploitation of children and user of social and HIV services. Univariate logistic regression model was used to identify factors predictive of the practice of young women sexual exploitation.

SUMMARY OF MAJOR FINDINGS

Push and pull factors into commercial sexual exploitation.

The magnitude of the problem of Commercial Sexual Exploitation of Children in Zimbabwe cannot easily be quantified due to lack of adequate data and surveillance mechanisms. Study participants reported feeling little control over their entry into sex work at a young age. Analysis of the push and pull factors causing young women to enter sex work revealed common patterns. Push factors included: familial poverty (lack of school fees) 87.7%, breakdown of family unit (23.5%), Gender Based Violence (7.2%) and orphanhood (23.8%) while others reported inherited sex work (i.e., following their mothers into the trade). Pull factors included: peer pressure/introduced by friends and financial need. Poverty and or having no other option as well as breakdown of the family unit, are major push themes in children's vulnerability to commercial sexual exploitation. Most respondents said they would leave sex work if given an alternative viable opportunity.

Estimating the age of entry/initiation prevalence into selling sex

More than two thirds (64.6%) of young women reported starting selling sex below the age of 18 with the highest concentration was between the ages of 16-18 at 35%. 5.8% became sex workers before the age of 12, while 18% started between the ages of 12 and 14. While the general global consensus is that many girls across the world start selling sex at the age of 12, the modal age range of entry into selling sex for children involved in commercial sexual exploitation that we interviewed was 16-18 years 35.1% followed by13-16 years at 23.7%.

Knowledge of HIV and Social Services among YWSS

91.7% of the YWSS demonstrated a high level of knowledge about HIV and AIDS demonstrating awareness of their risk for infection and that correct and consistent condom use prevents transmission. However, the most commonly known methods of HIV prevention among YWSS was the correct and consistent use of condoms at 98.6 percent while knowledge on Post Exposure Prophylaxis (PEP) and Pre Exposure Prophylaxis (PrEP) methods that could potentially turn around the high incidence rates of HIV in young women was the least known at 7.1% and 16% respectively. Given that Zimbabwe is one of the sites for the SAPPH-Ire PrEP demonstration project, looking at how best to roll out PrEP and ARV treatment to sex workers with results expected at the end of 2016, it is critical to ensure that knowledge on PrEP and PEP is widely disseminated among young women especially those engaging in selling sex given their heightened risk to HIV infection

Access to and Use of social and HIV services

While respondents in this study indicated that 41.4% had experienced some illness related to their work, the distribution of respondents by nature of illness shows that the most commonly reported cases were STIs at 81.5% followed by injury from gender based violence at 18.5%. Furthermore, while 96.7% of respondents in this survey reported that correct and consistent condom use is one of the effective ways to prevent HIV transmission, the same study established that only 64% of the respondents reported using a condom always during the last 5 times they had sex with a customer while 4.2% never used a condom. These statistics together with injury from GBV suggest that a significant number of young women engaging in commercial sexual exploitation are in a disempowered position.

SUMMARY OF MAJOR RECOMMENDATIONS

This report recommends that urgent measures need to be put in place in the field of law enforcement, education and recovery, rehabilitation and re-integration of young women involved in selling sex back into their families and communities. Existing

legislation needs to be fully enforced and current child protection programmes focusing on CSEC needs to be enhanced and scaled up. More initiatives are also needed to reduce the number of children getting into the sex trade by giving them and their households alternative methods of household economic strengthening. Training on positive parenting, recovery, rehabilitation and re-integration is clearly required in Zimbabwe. The recommendations are divided per the two categories, children 10-17 and Young Women 18-24 as their needs are somehow different More specifically the following is recommended:

- Recommendations for children 10-17 years. Initiate and scale up training interventions in parenting to increase bonding and positive parent-child interactions and increase protective parenting practices.
- Initiate and expand interventions that reduce the susceptibility to HIV for girls newly entering sex work. For instance, increase access to PrEP and PEP.
- Develop standardized context specific guidelines and model on the re-integration of YWSS into their families and communities in Zimbabwe.
- Develop an early identification response system and recruit and deploy a cadre of youth peer educators targeting hot-spots where young women are mostly found selling sex.
- Ensure that all initiatives with children, families and communities are value and norm sensitive and appropriate. Programmes must build on positive cultural and traditional practices while addressing negative and harmful cultural practices.
- Increased access to basic education, life skills and/or school enrollment is needed, particularly about the plight of the girl-child and the inferior status assigned to women and children in many communities in Zimbabwe.
- Child protection, prevention and rehabilitation must be initiated as part of the community's responsibility and stress child participation.
- There is a need to increase alternative means of household livelihoods and economic strengthening for children involved in commercial sexual exploitation including their families. For instance, cash transfers and savings and loan programmes.
- More operational research and strategic information gathering and evidence generation towards young women involved in selling sex must be improved.
- Awareness at the grassroots levels should be intensified.
- Improve on protective legislation and enforcement of the laws prohibiting sexual exploitation of the girl child.
- **Recommendations for adults 18-24 years.** Increase access to PrEP for young women
- We suggest offering periodic screening for asymptomatic STIs to young female sex workers.
- Ensure access to HIV combination prevention for sex workers.
- Continue education programmes to ensure correct and consistent condoms among young sex workers.
- Alert and engage with the funding partners to ensure that sex worker clinics under CeSHHAR are supported to avoid disrupting access to HIV and RH services for young women.

While the problem of young women involved in sexual exploitation is as immense as ever, opportunities to take new ground thrive in Zimbabwe. Now, more than ever, the increasing measures to end young women involved in selling sex needs to be energized, equipped, encouraged, and inspired in Zimbabwe.

Findings from this study concludes that poverty and lack of education are the main influences predisposing the girl child to commercial sexual exploitation in Zimbabwe. Other contributing factors are broken family units, orphanhood and gender based violence (GBV). The modal age of entry into selling sex was 16-18 years. To overcome obstacles to the implementation of the Stockholm Agenda for Action[1] on CSEC, greater attention is required to address the push and pull factors into CSEC, coordination is essential amongst and between non-governmental organizations and government agencies. The most fundamental change must come from the GoZ, who need to develop political will and serve as a catalyst for change by taking the commitments made under the Stockholm Agenda and other international conventions more seriously. A holistic approach is needed to the fight against commercial sexual exploitation of girls in Zimbabwe with full participation of communities and children, considering cultural settings and contexts.

2 INTRODUCTION

Globally, studies show that exposure to sexual violence during childhood can increase vulnerability to a broad range of mental and physical health problems, ranging from depression to acquiring sexually transmitted infections, including HIV [3, 4]. Child sexual violence and exploitation is a form of child labour and the Eastern and Southern Africa region has the highest proportion of children involved in all forms of child labour in the world- 36% of all children between the ages of 5 and 14 years [5]. Furthermore, adolescent girls and young women 15-19 years who reported having had 1st sex before age 15 is 3.9% [6]. Despite this, in Zimbabwe as in many other countries, the extent of sexual violence against children is largely unknown [2]; more so, the magnitude and causes of young women commercial sexual exploitation.

The International Labour Organisation (ILO) Convention 182 stresses the need to address and eliminate the worst forms of child labour by adopting new legal instruments, removing children from hazardous or compulsory work that threatens their health and safety, and providing free basic education as a deterrent against child labour (ILO C.182). In 2014, Zimbabwe made minimal advancement in efforts to eliminate the worst forms of child labour. The Government of Zimbabwe passed the Trafficking in Persons Act that criminalizes trafficking offenses related to child labour and child pornography. However, children in Zimbabwe continue to engage in child commercial sexual exploitation among many other forms of child labour. Zimbabwe continues to lack specific social programs targeting sectors in which child labour is most prevalent. In countries, such as Uganda, an increased number of children have been withdrawn from exploitative and hazardous labour by providing them with other alternatives, including systematic support to return to their communities of origin [5].

[1] In 1996, the first World Congress against Commercial Sexual Exploitation of Children was held in Stockholm, Sweden. It adopted the Declaration and Agenda for Action of the First World Congress against Commercial Sexual Exploitation of Children-"The Stockholm Declaration and Agenda for Action" which has become an essential linchpin globally for mobilising action to protect children from sexual exploitation.

Commercial sexual exploitation against children is common in Zimbabwe, yet most children go unaided. This exploitation sometimes because of human trafficking has been determined by national law as one of the categorical worst forms of child labour [7]. Estimates on child commercial sexual exploitation are needed to encourage policy, prevention and response efforts and to monitor progress.

2.1 Rationale for the research

It is already known that preventing sexual violence against children is essential [2]. Childhood victims of sexual violence are at a significantly increased risk for numerous adverse health outcomes ranging from HIV acquisition to poor mental health and chronic disease development. The prevalence of any form of childhood sexual violence among females in Zimbabwe is high at 32.5%, yet among respondents who reported childhood sexual violence, the proportion who also reported receiving services, including health care, legal/security aid, or counselling support, was low for both females and males at 2.4% and 2.7% respectively [2]. Despite the prevalence on all forms of childhood sexual violence, the proportion of victims involved in child commercial sexual exploitation is unknown in Zimbabwe as in many countries. This study postulates that the first step in addressing commercial sexual exploitation against children is to determine the reported causes and estimates of the initiation prevalence. Most previous studies have had some important limitations as they mainly focused on school-based populations [8] and grouped all forms of sexual exploitation, however, these children might not reflect those out of school and engaging in commercialised sexual exploitation. Zimbabwe should work to assess, respond to, and prevent childhood sexual violence and exploitation. Quantifying and then addressing sexual exploitation is integral to achieving several major national health aims, including HIV prevention and protection of the rights of children.

2.2 Literature Review

Given Zimbabwe's high HIV prevalence in the general population, findings of the CDC-UNICEF Violence Against Children Survey (VACS), prevalence of sexual violence prior to the age of 18 reported by females aged 18-24 reveal yet another worrying pattern: for those who experienced sexual violence as children, they are more disposed towards HIV risky sexual behaviours (Centers for Disease Control & Prevention (US), 2015). Young women selling sex are of specific interest as this group is not only at high risk of getting HIV, it is also especially likely to spread HIV [9]. Children, girls are deemed in need of state protection when at risk of sexual exploitation. This normally leads to the State either acting against the adults concerned or removing the children and putting them into care through police or probation officers' intervention or the courts, depending on the case.

Zimbabwe has ratified all key international conventions concerning child labour including ILO C. 182, Worst Forms of Child Labour and UN CRC Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography [7]. The Government has established laws and regulations related to child labour, including its worst forms. Prohibition of Commercial Sexual Exploitation of Children is embraced in: Section 87 of the Criminal Law Act; Section 3 of the Sexual Offenses Act; Section 8(2) of the Children's Protection and Adoption Act; Section 3 of the Trafficking in Persons Act (6, 10, 20, 21). In addition, the Government of Zimbabwe has established institutional mechanisms for the enforcement of laws and regulations on child labour, including its worst form. These are Ministry of Public Service, Labour, and Social Welfare (MPSLW) and Department for Child Welfare and Probation Services, Zimbabwe Republic Police and Ministry of Justice and Legal Affairs. However, despite this framework, research and anecdotal evidence shows that there has been an increase in child

commercial sexual exploitation in Zimbabwe which is a violation of the established laws and regulations. Research indicates that law enforcement agencies in Zimbabwe have been sluggish to combat child labour, including its worst forms [7] .

A study conducted by Save the Children in Binga established that another type of female sex worker was identified by the women. These are girls as young as 15 years who come from rural areas in bad times such as drought years to earn money from selling sex. The interviewees noted that there had been a definite increase in the number of such women coming to Binga since 2001 when food security in rural areas began to deteriorate [10].

Furthermore, in a study conducted by Kaliyati et.al (2002) [9] on HIV and AIDS and Child Labour in Zimbabwe, out of a sample of 230 children, 23 (10%) were engaged in commercial sex work. All the children in selling sex were females aged between 15 and 18 years. Of the total, 56% began working in this activity for money, one was doing it for fun, 8% started after their parents had died, another two reported that they engaged in this activity because of "frustration", while 21% reported that friends introduced them to the trade. When it came to luring schoolgirls into selling sex, taxi drivers were identified as the main culprits. Of the 23 children engaged in selling sex, 30.4% started this trade at 17 years of age, 21.7% started at the age of 16, while 8.6% started at 12 and 13. Only 8% out of 23 had medical aid; the rest had to pay their own medical bills and most of them also indicated that they never had medical check-ups [9].

Gaps remain in Zimbabwe's policy and legal framework against child labour, such as the lack of prohibitions of hazardous activities for children, and education not compulsory or free, which increases children's vulnerability. The prevention of sexual exploitation and the promotion of safe, stable, and nurturing relationships and environments for children need more research, as does the assessment of access to social or health services. It is essential to target commercial sexual violence among children as a component of HIV prevention but also as a measure to ensure protection and promotion of the rights of children. Thus, beyond simply gathering, this study will have built a mechanism intended to increase advocacy, catalyse action, and effect change in relation to child rights.

2.3 Definition of key terms

- 'Child' means a person under the age of eighteen years and includes infants. For this study, a child is defined as a person between the ages of 10 and 17 years.
- The UN Secretariat uses the terms youth and young people interchangeably to mean age 15-24. The definition of young women in this study shall assume those aged 10-24.
- An HIV and AIDS 'hotspot' is defined as a geographical area or location with evidence of high prevalence of HIV, STIs or behaviours that put people at risk for acquiring HIV infection [11].
- Child Labour: The International Labour Organization (ILO) defines child labour as work that deprives children of their childhood, their potential and their dignity. It refers to work that is mentally, physically, socially or morally dangerous and harmful to children; and interferes with their schooling.
- Sex: is specifically defined as vaginal/anal penetration by the penis, hands, fingers, mouth, or objects, or oral penetration by the penis.
- Sex Worker: Any woman above 18 years of age providing direct sex related services to generate income, compensation or a livelihood. Women between 10-24 years were be considered for this study.

- Child Poverty: UNICEF defines children living in poverty (are those who) experience deprivation of the material, spiritual and emotional resources needed to survive, develop and thrive, leaving them unable to enjoy their rights, achieve their full potential or participate as full and equal members of society. A 2014 study entitled Child Poverty in Zimbabwe: Deprivations and Inequities in Child Wellbeing found that 65% of children experienced severe child poverty (at least one deprivation) while 42% experienced child absolute poverty (at least two deprivations).

2.4 Study Aim

To examine the causes, initiation prevalence and use of social/HIV services for young women in commercial sexual exploitation (YWCSE) in Zimbabwe.

2.5 Research objectives and questions

Table 1: Research Objectives and Questions

RESEARCH OBJECTIVES	SPECIFIC RESEARCH QUESTIONS
1. To establish the drivers that influence children and young women to engage in commercialized sexual exploitation in Zimbabwe.	1. What are the factors driving children and young women into commercial sexual exploitation in Zimbabwe? 2. What is the current policy and legal framework with reference to the causes of YWCSE in Zimbabwe?
2. To estimate the initiation prevalence of children and young women commercial sexual exploitation in Zimbabwe.	1. What is the estimated frequency of child commercial sexual exploitation in Zimbabwe?
3. To establish the existing level of uptake of social/HIV services among children engaging in commercial sexual exploitation and strategies that could be used to address this form of child labour and increase access to social and HIV services.	1. What is the current level of utilisation of HIV and social services among children and young women engaged in selling sex in Zimbabwe? 2. What practice, policy and legal options are proposed to address YWCSE in Zimbabwe?

2.6 Study variables

Table 2: Study variables

3 STUDY DESIGN

3.1 Inclusion and exclusion criteria

Table 3: Study inclusion and exclusion criteria

INCLUSION CRITERIA	EXCLUSION CRITERIA
• Children and Young women who sell sex age 10-17 years or 18-24 years. • Willing to provide written informed consent for participation (including consent for possible future contact). • Currently engaged as a young woman selling sex. • Stationed or routing along one of the sites selected by the study. • Speaks English or Ndebele or Shona.	• Age below 10 years • Age above 25 years • Does not speak or understand English, Ndebele or Shona

3.2 Methodology

Mixed method approach combining both quantitative and qualitative methodologies were used. Qualitative methodologies (Key Informant Interviews & In-depth Interviews) to establish perceptions on commercial sexual exploitation against children were conducted. A Psychometric Quantitative survey questionnaire was used to establish measures of frequency for young women who sell sex.

3.3 Research design

An analytical cross sectional study design was used allowing for the collection and analysis of both exposure and outcome variables on the causes and consequences of child commercial sexual exploitation.

3.4 Study setting

The choice of Harare-Beitbridge and Beitbridge-Victoria-Falls transport corridors in Zimbabwe as study routes for this research was based on a thorough formative research phase to ensure that a high proportion of 'hot-spot' sites attended by a priority population (young women in commercial sexual exploitation) are included in the sampling frame. These 'hot-spots' were informed by the 'Smart Investment to End HIV and AIDS in Zimbabwe Based on Hot-Spot Analysis Report of 2015.' In addition, 'hot-spots' along the selected corridors range from medium to medium with high risk factors and high [12]. It is critical to note that Harare and Bulawayo are the hubs of transport corridors in Zimbabwe hence in Harare Epworth and "Kunjanji" were selected as study sites.

The research team conducted some pre-surveillance survey visits[2] to selected sites where the research will be conducted to assess type of facilities that interviews will take place. The team also interacted with partners such as CeSHHAR who are key stakeholders working with sex workers to discuss the modalities related to this research. As a result of this process the research team concluded that respondents will be interviewed in areas where they conduct their business e.g. truck stops, pubs; clubs and sex worker clinics. Potential respondents (sex workers) indicated that they are comfortable to be interviewed in their areas of operation as they are already known that they are into sex work and thus no possibilities of future stigma will arise.

3.5 Study population

The survey population included Zimbabwean YWSS aged between 10-24 years routing or stationed at one of the selected 'hot-spot' along Harare-Beitbridge and Beitbridge-Victoria-Falls transport corridors in Zimbabwe. The study recognized that ethical considerations especially informed consent/assent for minors below the age of 18 years is critical, but at the same time acquiring parental/guardian permission is not a reasonable requirement given the characteristics of the population under study. However, to ignore research on adolescents due to ethical challenges when there is anecdotal evidence that they are engaging in selling sex is likely to contribute further towards the delay in reaching targets of an AIDS-free generation and curbing the increasing number of girl child involved in sexual exploitation. Issues of informed consent for this study are dealt with in detail under the ethical considerations section.

[2] Beitbridge, , Hwange and Ngundu

3.6 Sampling techniques

Purposive sampling to identify cluster study sites based on initial mapping/formative research of areas frequented by YWSSs was used. Utilizing sites where young women selling sex are known to congregate increased the efficiency of obtaining a complete sample while retaining assurance that the high proportion of routes attended by the target population are included.

Respondent Driven Sampling (RDS), a modified form of snowball sampling which allows researchers to recruit hard to reach populations was used to recruit YWSS aged 10-24 years in areas where they normally congregate in the above mentioned study sites. This did not only provide a probabilistic method to reach the desired sample size of YWSS, but also allows the research team to identify networks and the characteristics of those belonging to the networks.

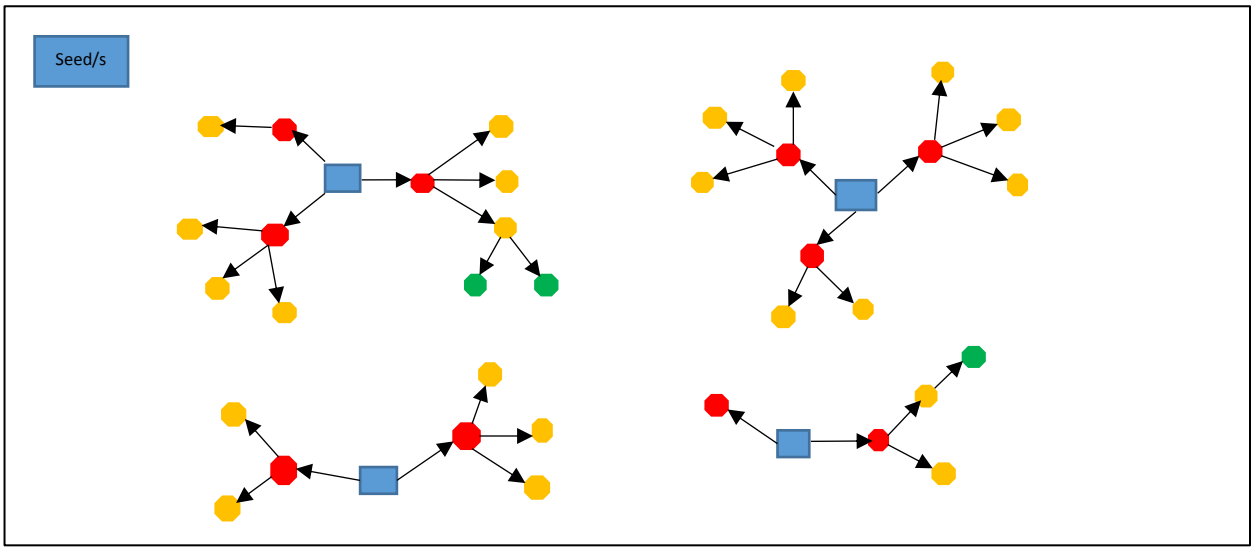
The first step was collaboration with stakeholders such as CeSHHAR and NECTOI site agents working with sex workers in the study sites in order to recruit 18 initial respondents known as 'seeds'. The YWSS 'seeds' (10-24 years) in their respective study sites ('hot-spot') would go to the venue where questionnaires were completed and complete the questionnaire on study variables. After completing the questionnaire, the 'seeds' were being given a small sum of money as an incentive for their time (5 US$). They were also being given three study coupons to recruit and refer a maximum of three young women selling sex between the ages of 10-24 years by providing them with a coupon that had a unique serial number to participate in the study. If their referred peer was eligible and enrolled in the study, the 'seed' received an additional payment of US$1 for each eligible referral. Furthermore, each referred respondent received US$3 for participating and completing the questionnaire and similar number of coupons (3), as do their referee and an additional payment (US$1) for each participant recruited and who completed the study. This process was repeated until either the last possible day of the study (3 weeks) or the sample size is met. The limit of three coupons per participant was set so that a wide group of subjects have the opportunity to recruit participants, reducing homophily[3] between the study participants, and preventing the emergence of semiprofessional recruiters and potential competition over recruitment. The 'seed' referred their peer to the study.

This sampling strategy also provided information on recruitment patterns among the respondents. Although it was important to evaluate whether the recruiters and those they recruited were similar, advanced measures of calculating homophily according to a self-affiliation bias was not computed for this study. Instead, a basic calculation based on age range of initiation into commercial sex selling and reason for engaging in selling sex was conducted to establish if respondents tend to recruit people like themselves. It was important to consider these factors as it enabled the research to have a better understanding of the demographic characteristics and risk factors of this hard-to-reach population.

Figure 1: Demonstrating YWSS participant chains using 'seeds' in RDS method

[3] Homophily is defined as the tendency to affiliate oneself with those who have similar features; for example, level of education, income, ethnic origin etc.

Figure 1. Demonstrating YWSS participant chains using 'seeds' in RDS method



3.7 Sample Size Calculations.

Calculation of the sample size[4]: $n = \frac{z^2\,(p)\,(1-p)(DEFF)/(1-k)}{d^2}$ $n = \frac{1.96^2\,(0.1)\,(1-0.1)(2)/(1-0.1)}{0.05^2}$ **n=307 YWSS**

Based on the above formula, the required sample size was 307 YWSS. The sample size was divided proportionally among the selected 'hot-spot' sites depending on the volume of sex workers at each site. The final sample size, yield above the final required number of **277** completed interviews.

Theoretical sampling for qualitative data collection was used until data saturation is reached. Purposive and convenience sampling was used to select the participants' rich information for the in-depth interviews in the selected study sites.

3.8 Sampling frame

The sampling frame for PSUs (hot-spot study sites) was the Zimbabwe Smart Investment Hot-Spot Mapping Report. The unit of analysis female sex worker (10-24 years) was sampled using RDS.

3.9 Data collection techniques and instruments

The following data collection techniques and instruments were used:

Survey interviewer-administered psychometric questionnaire was used to collect quantitative data.

This instrument is designed to gather information at an individual level on the causes, age of initiation into selling sex and use of HIV and social services among YWSS. They included mainly closed ended questions with a few open ended follow up questions. The questionnaire sought to gather evidence on the whole spectrum of the study variables as reported by the YWSS.

[4] n= required sample size (number of FCSWs); z=95% level of confidence (standard value of 1.96); p=10% or 0.1 based on the prevalence of child commercial sexual exploitation for children aged 15-18 years in the ILO HIV and AIDS and Child Labour in Zimbabwe: Rapid Assessment 2002; DEFF= sample design effect (default value of 2); k= non response or recording error multiplier (average of 10% for developing countries hence 0.1 for k) d=absolute precision at 5% (standard value of 0.05).

In-depth Interviews (IDIs) with sex workers using an IDI guide.
Since literature established that young women are usually recruited by coordinated syndicates, this research interviewed 'queen mothers' or 'king fathers' to gather data that will corroborate findings reported by the YWSS. In-depth Interviews (IDIs) were carried out with i) sex workers and ii) 'syndicates' recruiting young women into commercial sexual exploitation to gather data that would corroborate findings reported by YWSS. An IDI Guide was used for this and there were no FGDs that were conducted in this study.

Semi structured interviews with selected key informants (KIs) using a KI interview guide.
The key informant guide was used to collect data from the key informants of this study. This tool allowed semi structured interviews with the KIs to gather information on study variables. Key informants included policy/decision makers responsible for HIV and social policy and programming for children.

It is critical to note that generally it is difficult to get the truth from participants when conducting a study that will yield self-reported data. However, research assistants in this study were trained on skills that increased their chance of obtaining the truth from participants. These include good interviewing skills including asking question skills, listening skills, probing skills and challenging inconsistency skills. In addition, research assistants were given tips on how to build good relationships and rapport with research respondents while adhering to principles of non-judgmental attitude, confidentiality, non-emotional involvement, self-determination and acceptance. This maximized getting truthful answers from the respondents

3.10 Translation of data collection tools
The data collection tools which include a questionnaire, the KIG and IDI Guides and other accompanying documents were finalised by Progressio and ZNCWC research team, after which they were translated from English into Shona and Ndebele using a professional translator.

3.11 Data collection procedures
Two (2) teams that covered the 6 study sites were constituted. Each team had 5 research assistants and a team leader/supervisor. The research assistants were responsible for administering the questionnaire, and conducting the IDIs. Progressio Advisors assumed the role of team leaders. The Team Supervisor ensured that all logistics for data collection at each selected site were in place while also ensuring that quality data was collected. Each supervisor together with the team informed the district representatives about the research at the commencement stage of data collection.

Potential participants were required to produce birth-certificates and or national identity cards as source documents for age verification where these documents were available. However, it should be noted that given the population under study, some did not have the required source document to verify age. In such instances, the research team relied heavily on CeSHHAR registers for young women involved commercial sexual activities. Also, previous experiences of researchers (CeSHHAR included) who have conducted research work with sex workers indicated that once the research team had established good rapport and relationship building with the sex workers, sex workers would screen themselves to ensure that participants will be of the intended age.

3.12 Supervision and Quality Control

Quality control measures for data collection: Data collection tools were standardised and all data collectors were trained in their administration. Data collectors were evaluated on their performance during the piloting of the tools. Any misunderstanding of questionnaires or other collection tools was addressed before data collection.

Research assistants were trained female data collectors to allow an environment that was conducive for the research respondents to share information freely. However, the research team leaders were male.

Once in the field, each data collector was assigned to a supervisor who would check the quality of the completed questionnaires on a daily basis, identify any inaccurate or incomplete questionnaires or incomplete questionnaires, and ensure that the data collector corrected these timeously. The supervisor maintained a record of these instances, the actions taken, and the outcomes and any additional actions when required.

Regular weekly meetings of supervisors and the study co-investigators took place to address any ongoing issues with the collection process and limitations of the data and to agree on solutions. The study PIs were informed weekly of progress, challenges, their actions, and any further response required.

3.13 Data analysis and Report writing

Quantitative Data was collated and cleaned using Excel and analysed using SPSS. A tabulation framework was developed prior to fieldwork in line with the research questions and variables. Validation of data entry was done through a double entry validation approach. After validation of duplicates files, the data was exported to SPSS for further cleaning and analysis. Analysis of these data involved descriptive analyses, including frequencies and distributions of study variables. Analytical analysis of study variables to establish the strength of association was conducted using multivariate logistic regression model.

Qualitative Data from the field was transcribed, coded and analysed through content analysis (thematic analysis). Since study findings will be used to inform and influence policy on HIV and social service programming for YWSS, a framework analysis of qualitative data was also used in addition to content thematic analysis.

3.14 Data management

Progressio Zimbabwe was the data coordinating centre. This unit was headed by an experienced data manager. Data was cleaned, entered, analysed and safely stored here.

Data management and security standards were equivalent for questionnaire, in-depth interviews and focus group discussion data. Questionnaire data was collected using hardcopy questionnaires with a trained interviewer. Study supervisors ensured that the collected data was as complete and as accurate as possible before the data entry clerks began the process of capturing. Data completeness checks were ensured by checking randomly selected completed questionnaires. Laptop computers on which any data was stored were kept in a safe storage at all times. Other hard-copy data was stored separately in participant files and locked in a file cabinet located in a secure room accessible only to key study personnel. The data entry clerks routinely reported to the supervisors any problems with the data and the responsible data collector was requested to revisit the particular facility and/or respondent to obtain clarity, additional information or corrected data, as required. Data spreadsheets were cleaned and merged into a central database by the ZNCWC and Progressio team. Preliminary analysis outputs were scrutinized by the supervisors to identify errors, data gaps, inaccurate coding and other obvious problems, and address these as early and as comprehensively as possible.

4 INSTITUTIONAL REVIEW BOARD APPROVAL

All participants gave written consent collected according to the principles of research practice. Institutional Review Board approval (IRB) for the study was given by the Medical Research Council of Zimbabwe (MRCZ) and National AIDS Council. The consent forms were approved by both IRBs in English, Shona and Ndebele.

5 STUDY FINDINGS

LEGAL FRAMEWORK FOR THE WORST FORMS OF CHILD LABOUR IN ZIMBABWE

Zimbabwe has ratified all key international conventions concerning child labour.

Table 4: Ratification of International Conventions on Child Labour

Convention	Ratification
ILO C. 138, Minimum Age	✓
ILO C. 182, Worst Forms of Child Labor	✓
UN CRC	✓
UN CRC Optional Protocol on Armed Conflict	✓
UN CRC Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography	✓
Palermo Protocol on Trafficking in Persons	✓

ENFORCEMENT OF LAWS ON THE WORST FORMS OF CHILD LABOUR

The Government has established institutional mechanisms at different levels for the enforcement of laws and regulations on child labor, including its worst forms. However, law enforcement agencies in Zimbabwe have limited capacity to combat child labor, including its worst forms. Research shows that the GoZ lacks sufficient resources, mainly finances, to adequately prevent and respond to violations of child labour laws including commercial sexual exploitation of children (10).

Table 5: Agencies responsible for enforcing child labour laws in Zimbabwe

Organization/Agency	Role
Ministry of Public Service, Labor, and Social Welfare (MPSLW) and Department for Child Welfare and Probation Services	Enforce labor laws and investigate labor-related complaints, including complaints involving child labor. Responsible for child protection services, including investigating and intervening in cases of alleged abuse, providing case reports for courts, coordinating case management processes, and supporting community case workers.(6, 10)
Zimbabwe Republic Police (ZRP)	Share responsibility with the MPSLW and the Ministry of Justice and Home Affairs for enforcing laws against the worst forms of child labor of a criminal nature. (6) Address issues related to child labor through victim-friendly units in every district. Conduct transnational trafficking investigations through an anti-trafficking desk at the INTERPOL. (6)
Ministry of Justice and Legal Affairs	Oversee all courts, including labor courts. Address trafficking and child victim cases through victim-friendly courts.(6)

CHARACTERISTICS OF YOUNG WOMEN SELLING SEX INTERVIEWED FOR THIS STUDY

5.1.1 Participants

A total of 292 YWSS participated in the study. The disaggregation of participants reached is shown in the table below.

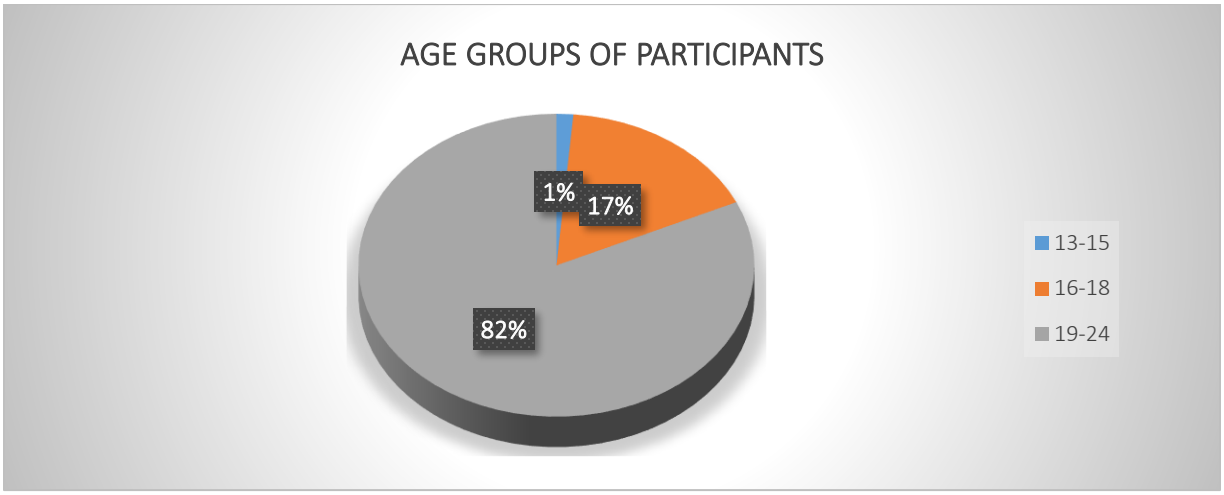
Table 6: Provinces covered in the study

Name of Province	Frequency	Percent
Harare	55	18.8
Masvingo	54	18.5
Matebeleland South	55	18.8
Matebeleland North	128	43.8
Total	292	100.0

Table 7: Districts covered in the study

Name of District	Frequency	Percent
Beitbridge	54	18.5
Chivi	50	17.1
Epworth	34	11.6
Harare	21	7.2
Hwange	129	44.2
Mwenezi	4	1.4
Total	**292**	**100.0**

Figure 2: Age of respondents in the study



5.1.2 Alcohol consumption among young women selling sex in Zimbabwe

While 18% of the respondents were below the age of 18 years, 68.7% of the YWSS reported that they take alcohol with almost half (42%) of the respondents indicating that they took above 6 pints of alcohol per day/night. This is worrisome given that children engaging in commercial selling of sex are already exposed, have low negotiating power and alcohol consumption will further worsen the exposure and reduce the ability to negotiate for safer sex.

Table 8: Average pints taken by YWSS per day/night

Number of alcohol pints	Frequency	Percent
1-5	113	57.9
6-10	58	29.7
11-15	13	6.7
15+	11	5.6
Total	195	100.0

5.1.3 YWSS Level of Education in Zimbabwe

Results of this study indicate that 97.3% of the young women selling sex reported that they had ever been at school at some point in their lives. Despite the fact that 18% of the respondents are children below the age of 18 years only 2.2% (n=6) of the YWSS are currently attending school. This suggests that the around 88% of the eligible primary and secondary school going age are not in school. Also having children who are attending school (2.2%) but at the same time engaging in commercial selling of sex is very disturbing as this scenario is not conducive for children to concentrate on their studies and violate their protection issues.

5.2 DRIVERS THAT INFLUENCE YOUNG WOMEN TO ENGAGE IN COMMERCIAL SEXUAL EXPLOITATION IN ZIMBABWE

5.2.1 Main reason why YWSS left school in Zimbabwe

Access to education is a basic right for children as enshrined in different UN conventions to which Zimbabwe has ratified. Also the new constitution of Zimbabwe Section 19 articulates that children have the right to access uninterrupted basic education in Zimbabwe. Whereas girls drop out of school for a number of reasons including teenage pregnancies and early marriage, this study established that chief (81.2%) among young women selling sex respondents left school because of lack of school fees. Also around 14% of the respondents indicated that they left school because they wanted to engage in own business in order to generate income for self or take care of the family and siblings.This is in line with UNICEFs definition of Children in Poverty (UNICEF defines children living in poverty (are those who) experience deprivation of the material,spiritual and emotional resources needed to survive,develop and thrive,leaving them unable to enjoy their rights,achieve their full potential or participate as full and equal members of society).While lack of school fees may in a way be a result of misplaced prioritization within a family set up, it is directly correlated with family poverty and so is the reason for leaving school to work in own business to generate income. However, family choices on what cost cutting measures to take need to be examined and challenged to shift the mentality. Many select to keep their girl child out of school since she will marry into another family anyway, and the thinking is that this will be enriching the in laws. Again all these are very strong proxy indicator that children protection issues are not being accorded the requisite attention from the Government as the custodian of child protection including other key child focused stakeholders.

Table 9: Main reason why YWSS left school

Main reason for leaving school	Frequency	Percent
Lack of school fees	190	81.2
Family does not allow schooling	3	1.3
Not interested in school	6	2.6
To take care of sick family member/s	2	.9

To work in own business to generate income	33	14.1
Total	234	100.0

Findings from this study are in line with findings in GoZ Child Labour Report of 2013 that established that school fees are often prohibitively expensive and limit access to education [13, 14]. In addition the Government is failing to meet its obligation of supporting secondary school students with school fees [14, 15, 16].

5.2.2 Level where YWSS left school

Table 10: Level where YWSS left school

Level of education	Frequency	Percent	Percent reported in ZDHS 2016
Primary	101	36.3	25.8
Secondary	174	62.6	65.6
Tertiary	3	1.1	7.3
Total	278	100.0	

Note: Education categories refer to the highest level of education attended, whether or not that level was completed.

The table above shows results of the level of education at which respondents in this study left school. While education in Zimbabwe is considered widespread[5] most respondents in this study reported that they left school at primary and secondary level: 36.3% and 65.6% respectively. These primary level proportion is higher than the 25.8% reported at national level. These results suggest that the majority of the respondents are literate, however, it means that their opportunities to engage in viable economic or livelihood activities are extremely limited and thus most of these children are forced into negative coping mechanisms and in this case selling sex. When girls are educated, their families are healthier, they have fewer children, they wed later, and they have more opportunities to generate income. Studies from a number of countries suggest that one extra year of primary school boosts a girl's future earnings by 10 to 20 percent and an extra year of secondary school increases that earning potential by 15 to 25 percent. It is critical that Zimbabwe, with the support of the relevant United Nations agencies and other key stakeholders in the child rights sector establishes a predictable formal education support system that will reduce and eventually eliminate the number of girls that drop out of school at primary level. In addition, based on these findings, Zimbabwe will need to seriously consider that the right to education for children especially the girl child is upheld through ***keeping girls in school*** and creating opportunities for post-secondary opportunities.

5.2.3 Young women in commercial sexual exploitation willingness to go back to school

Table 11: Indicating whether YWSS would like to go back to school

Response	Frequency	Percent
Yes	181	64.4
No	93	33.1
Don't know	7	2.5
Total	281	100.0

[5] Zimbabwe Demographic Health Survey Report 2015/16

Results in the table above indicates the proportions of respondents with whether they would like to go back to school if given an opportunity. Interestingly, the majority (64.4%) of respondents answered 'yes' to the question 'would you like to go back to school' while 33.1% answered 'no'. Remarkably, these results suggest that given an opportunity and a supportive conducive environment, the majority of young women engaging in selling sex would go back to school. Thus it is important that investments are made to re-integrate these children and young women back into the education system.

5.2.4 Main reason preventing YWSS from going back to school

Table 12: Main reason preventing YWSS from going back to school

Reason	Frequency	Percent
School is too far	4	1.5
Cannot afford school	178	66.7
Family does not allow schooling	3	1.1
Not interested in school	39	14.6
illness or disabled (self)	1	.4
To help in household	1	.4
To take care of ill family members	4	1.5
To work for wages	10	3.7
To work in own business for income	4	1.5
Other (specify)	23	8.6
Total	**267**	**100.0**

Findings presented in the table 12 above indicates the proportions on the main reasons preventing respondents of this study from going back to school. The majority (66.7%) reported that failure to afford school fees is preventing them from going back to school followed by around 14% who reported that they were no longer interested in school. These results suggest that to alleviate the challenge of lack of school fees among this target population, it is critical to initiate a re-integration model and household economic strengthening programmes targeting those young women selling sex who would like to go back to school. Second chance education for girls who have dropped out of school and are engaging in selling sex must be promoted and the school re-entry policy well implemented in Zimbabwe.

5.2.5 Factors pushing or pulling young women to engage in selling sex in Zimbabwe

Table 13: Push and Pull factors for young women to engage into sex work

Proportions of young women selling sex age 10-24 categorised by different push and pull factors

Factors	Percent
Poverty	87.7%
Breakdown of family unit/s	23.5%
Mobilised/Recruited by syndicates	1.1%
Gender Based Violence	7.2%
Orphanhood	23.8%
Peer pressure/Introduced by friends	16.6%

Study participants reported feeling little control over their entry into sex work. Analysis of push and pull factors causing young women to enter commercial sexual exploitation revealed common patterns. Push factors included: familial poverty, breakdown of family unit (23.5%), Gender Based Violence (7.2%) and orphanhood (23.8%) while others reported inherited sex work (i.e., following their mothers into the trade). Pull factors included: peer pressure/introduced by friends and financial need. Poverty and or having no other option emerged as a recurring pull theme at 87.7%. Most respondents said they would leave sex work if given an alternative viable economic or livelihood opportunity. The unavailability of other work or another form of financial support or livelihood was the main reason for staying in the selling sex trade. While anecdotal evidence suggests that young women are into commercial sexual exploitation because they have been mobilised/recruited by syndicates/pimps, these results suggest that, in reality, most young women in Zimbabwe enter the sex industry without 'pimp coercion' but as victims of their situation- disempowered, have no autonomy, no other skills and limited livelihood/economic options. This situation suggest a severely broken down child welfare and protection system that requires innovative sustainable interventions that will provide social safety nets at household level to arrest family poverty and consequently curtail more young women from entering into the sex trade. These findings suggest that the supply for children in the sex trade industry in Zimbabwe is greatly influenced by the deterioration of the economic and social structure of the country.

> *"I have been driven into selling sex because of the economics of everyday life. While perhaps others do it as a choice or for fun, for me it's a quick fix to my financial and poverty situation".*
>
> Young women selling sex Kunjanji, Harare

5.2.6 YWSS with boss managing and organizing clients for them

Table 14: YWSS with a boss managing or organizing clients for them

Response	Frequency	Percent
Yes	12	5.5
No	207	94.5
Total	219	100.0

Whilst the general perception is that YWCSE are organized and managed by pimps and/or syndicates, findings in this study indicated that only 5.5% were managed by bosses. These findings are in line with the low (1.1%) of young women selling sex age 10-24 category who reported that they were in sex work as a result of being mobilised by syndicates. However, these results may indicate the under-reporting that is associated with the potential legality implications for pimps or syndicates managing young women selling sex. A further study, in the form of ethnography may help to unearth the situation and provide relevant recommendations for policy and programming in this regard.

Table 15: Mode of payment for YWSS services

Payment Mode	Frequency	Percent

Cash	287	99.0
In Kind	3	1.0

The majority (99%) of YWCSE in Zimbabwe reported that they were paid cash for providing their services. For the minority that reported being paid in kind the items for payment included among other things: used blankets, clothes and food.

Table 16: Amounts paid to YWSS for sexual services

Amounts of money paid to young women selling sex aged 10-24 categorised by client, night, session and day

		How much do you get paid per client?	How much do you get paid per night?	How much do you get paid per session?	How much do you get paid per day?
N	Valid	174	219	171	83
	Missing	118	73	121	209
Mean		$6.7527	$15.8426	$5.7267	$16.1486
Median		$5.0000	$13.0000	$5.0000	$13.0000
Mode		$5.00	$10.00	$5.00	$10.00
Std. Deviation		$6.75711	$12.44787	$4.74993	$14.64333
Variance		45.658	154.949	22.562	214.427
Range		$39.50	$98.00	$29.50	$98.00
Percentiles	25	$2.0000	$10.0000	$3.0000	$7.0000
	50	$5.0000	$13.0000	$5.0000	$13.0000
	75	$10.0000	$20.0000	$5.0000	$20.0000

Results presented in the table above shows that the mean payment for young women selling sex was almost the same per client and per session at $6.75 and $5.72 respectively. The Std. Dev of the mean payment per client was as large as the average at $6.75 reflecting the large amount of variation in payment received per client in the group under study. Similarly the average payment received by young women selling sex was almost the same per night and per day at $15.84 and $16.14 correspondingly. Again the Std. Dev for payment per night and per day were $12.44 and $14.64 indicating the amount of variability in terms of payment within the young women involved in commercial sexual exploitation. 75th percentile on payment received per sexual session shows that young women selling sex who responded to that question earned $5 and below and that one quarter earned more than $5 while 25th percentile of the YWSS who responded to the question on payment per client $2 and less. Large amount of variations shown by large standard deviations on all the four questions on this variable could reflect large amount of variations in the YWSS group based on geographical location and age leading to variations in negotiating power. If the study had narrowed the group down by looking at those below the age of 18 or those in similar geographical locations the Std. Deviation could have been smaller.

5.2.7 Relative importance of the causes of young women to enter sex work

Reasons that YWSS considered as the most important causes of child sex work/exploitation

Table 17: Most common causes for young women to enter sex work

Factor	Important		Very Important	
	Frequency	Percent	Frequency	Percent
Poverty	21	7.2	244	84.1
Breakdown of family unit	83	28.4	128	44.4
Recruitment by syndicates	48	17.1	54	19.2
Orphanhood	56	19.7	167	58.8
Peer Pressure/Introduced by friends	51	18	102	35.9
Household GBV	62	21.7	57	19.9
Doing it for fun	58	20.4	53	18.7

5.3 YOUNG WOMEN SELLING SEX KNOWLEDGE OF HIV AND AIDS

A 15 year old YWSS from Hwange had this to say: "My mother died and my father had gone to South Africa 5 years back and never got in touch with us. I and my young brother had been left in the custody of our aunt. One day my aunt said please don't bother me with school fees money. Do sex work like others, save your money and pay your school fees. That's how I started engaging in selling sex. Now I have adequate money to go back to school for a few terms but I am feeling rotten because of sleeping with different people/clients. So am now thinking of supporting my young brother with school fees instead. Me I will continue with sex work"

5.3.1 YWSS Knowledge on transmission of HIV in Zimbabwe

91.7% of the YWSS demonstrated a high level of knowledge about HIV and AIDS demonstrating awareness of their risk for infection and that correct and consistent condom use prevents transmission. They reported receiving regular voluntary HIV testing services, condoms, and treatment for minor ailments mainly from CeSHHAR. While the knowledge levels on HIV are high, it critical to emphasise that high knowledge about HIV among young women selling sex respondents (and possibly in many other populations) does not, however, always translate into safer sexual behaviour. In addition, young women engaging in commercial sexual exploitation have significantly compromised power to negotiate safer sex hence knowledge with no power may not translate into safer practices. Key themes emerging from qualitative data in this study indicated that younger women selling sex are more likely to engage in unprotected sex or to be taken advantage of. Inexperience and poor negotiation skills increase the vulnerability of younger sex workers.

5.3.2 Knowledge of Prevention Methods among YWSS in Zimbabwe

Table 18 below shows knowledge of HIV prevention among young women selling sex aged 10-24 who were interviewed in this study. Almost all (96.2%) young women selling sex interviewed in this study reported that they know what they can do to protect themselves against HIV infection in Zimbabwe and are knowledgeable about different HIV prevention methods. However, the most commonly known methods of HIV prevention among YWSS was the correct and consistent use of condoms at 98.6 percent while knowledge on Post

Exposure Prophylaxis[6] (PEP) and Pre Exposure Prophylaxis[7] (PrEP) methods that could potentially turn around the high incidence rates of HIV in young women was the least known at 7.1% and 16% respectively.

Given that Zimbabwe is one of the sites for the SAPPH-Ire PrEP demonstration project, looking at how best to roll out PrEP and ARV treatment to sex workers with results expected at the end of 2016, it is really critical to ensure that knowledge on PrEP and PEP is widely disseminated among young women especially those engaging in selling sex given their heightened risk to HIV infection. In addition, given evidence that new female sex worker recruits especially young women become rapidly infected with HIV after entering the trade it is extremely important that YWSS are given adequate information on the whole spectrum of HIV prevention methods especially those that they can control.

> *"Some men refuse to wear a condom. Some already have HIV, so they just don't care'*
>
> 16 year old YWSS at Lupinyu

Table 18: YWSS knowledge on HIV prevention methods

Prevention Method	Percent
Consistent and correct use of condoms	98.6%
Abstinence	21.6%
Being faithful to one mutually faithful negative partner	29.4%
PrEP	16.0%
PEP	7.1%
PMTCT	17.0%
VMMC	13.5%

Comprehensive knowledge about HIV prevention means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting HIV, knowing that a healthy-looking person can have HIV, and rejecting the two most common local misconceptions about transmission or prevention of HIV: 1) HIV can be transmitted by mosquito bites, and 2) A person can become infected by sharing food with a person who has HIV. However, others define comprehensive knowledge of HIV prevention as a combination of 5 indicators: knowledge of 2 modes of transmission and 3 misconceptions UNICEF

5.3.3 YWCSE knowledge on HIV and AIDS in Zimbabwe

In the table below, respondents demonstrated a **high level of HIV knowledge,** demonstrating awareness that HIV causes AIDS (90%) and that correct and ART can help to control the HIV infection and should be commenced early at 89%. However, it is important to note that YWSS' knowledge was low on the difference between HIV and AIDS and fatalism with 43.6% agreeing or unsure with the statement "HIV is the same as AIDS' while only less than half 43.5% disagreed with the statement 'getting infected with HIV or not is predetermined and therefore inevitable.'

[6] PEP stands for post-exposure prophylaxis. It means taking antiretroviral medicines (ART) after being potentially exposed to HIV to prevent becoming infected

[7] PrEP (pre-exposure prophylaxis) refers to an antiretroviral (ARV) drug that can be taken by an HIV negative person before potential HIV exposure to reduce risk of HIV infection

Table 19: YWSS Knowledge on HIV and AIDS

Statement on HIV & AIDS Knowledge	Agree	Unsure	Disagree
Do you believe HIV causes AIDS	90.3	8.3	1.4
One can get infected with HIV if they have sex without protection?	94.2	4.1	1.7
ART can help to control the HIV infection and should be commenced early?	89.3	6.2	4.5
Seeking early medical attention to STIs reduces the risk to HIV?	83.6	12.3	4.1
Condoms used correctly and consistently can help you reduce the risk to get STIs including HIV	89.7	6.8	3.4
Reducing the number of sexual partners can help reduce the risk of HIV?	69.5	14.4	16.1
Getting infected with HIV or not is predetermined and therefore inevitable?	32.6	23.9	43.5
Avoiding shaking hands with an HIV positive person prevents HIV infection?	11.7	13.8	74.5
HIV is the same with AIDS?	29.2	14.4	56.3

5.3.4 Sources of information on HIV and AIDS among YWSS in Zimbabwe

Table 20: YWSS sources of information on HIV and AIDS

Reason	Percent
From employer/manager/pimp	1.9%
From the media (TV, Newspapers, Radio)	8.4%
From friends/co-workers	12.6%
From Government Officials	22.9%
From Voluntary Organisations	51.5%
Others (specify)	26.0%

Slightly above half (51.5 percent) of the respondents in this study indicated they got information or knowledge from voluntary organisations in their respective areas of work. Qualitative data revealed that whilst 51.5 percent reported that they received HIV information from voluntary organisations, the most referred to organisation was Centre for Sexual Health, HIV and AIDS Research[8] (CeSHHAR) Zimbabwe. This is a proxy indicator that CeSHHAR has made HIV and SRH services accessible, available and acceptable to sex workers resulting in increased utilisation.

5.4 YOUNG WOMEN IN COMMERCIAL SEXUAL EXPLOITATION RISK SEXUAL BEHAVIOURS

Study respondents highlighted two categories of risk sexual behavior in their 'work'. The most common and based on their own decisions was reported to be unprotected sex with boyfriends or regular partners. While all of the young women interviewed in this study claimed high rates of condom use with clients, a significant proportion mentioned the influence of drugs and alcohol and being offered large sums of money as circumstances that might cause them to agree to unprotected sex with a client. The second category is risk behaviors imposed on YWSS by others or their clients. The greatest perceived risk was violence and rape by clients, and condom slippage or breakage during rough sex or intentional damage by clients.

5.4.1 Sexual Clients of YWSS

[8] CeSHHAR Zimbabwe is an organization that specializes in sexual health, HIV and AIDS research in Zimbabwe. The organization is implementing a National Sex Work Programme aimed at reducing HIV acquisition among sex workers thereby reducing HIV transmission to their clients.

While the majority (78%) of the young women selling sex are general people, respondents in this study reported that 10.7 per cent of the clients of YWSS along corridors are long distance truck drivers, hence prevention and treatment efforts need to focus beyond the YWSS to include truck drivers and their diverse clientele.

Table 21: Different types of clients for young women selling sex

Type of client	Frequency	Percent
General People	228	78.6
Long Distance Truck Drivers	31	10.7
Small Scale Miners	4	1.4
Business People	12	4.1
Other (specify)	15	5.2
Total	290	100.0

5.4.2 Source of Clients for YWSS

Whereas only 10.7% of the YWCSE in thus study reported that their sexual clients are long distance truck drivers, 27.6% indicated that their source of clients was truck stops. This suggest that the truck stops are 'fertile' areas where YWCSE can get both truck drivers, their assistance and the general people. Most concerning is that the truck stop model in Zimbabwe can facilitate commercial sexual activities. However, the research team noted that the truck model used at Victoria Falls, to a greater extent, deterred sex workers from soliciting truck drivers from within the truck inn as it is properly secured, and manned by security guards who do not allow women to enter the truck stop after 5pm.

Table 22: Places where YWCSE get their customers

Place where YWSS get their clients	Percent
Hotel	9.1%
Nightclubs/Beerhalls	69.6%
Brothels	5.2%
Street	38.8%
Lodges	4.9%
Truck stops	27.6%
Other	5.2%

5.4.3 Place where sex mostly take place

Table 20 presents data on the different places where young women involved in commercial sexual exploitation mostly have sex after getting their clients. More than half, 57% reported that they had sex in the house while almost a third (27%) and 5.5% reported that they had sex in either cars /trucks and hotels/lodges respectively. While the proportion having sex in cars/trucks is 27% it is confirmation of the YWSS who reported that 10.7% of their clients are long distance truckers.

Table 23: Place where YWSS usually have sex with their sexual customers

Place where sex take place	Frequency	Percent
Car/Trucks	79	27.1

House	167	57.4
Bush	20	6.9
Brothel	5	1.7
Offices	1	.3
Hotels/Lodges	16	5.5
Other Specify	3	1.0
Total	291	100.0

5.4.4 Type of sex done with clients

Table 24: Different types of sex that YWSS do with their clients

Type of sex	Percent
Penetrative (Vaginal)	99.7%
Oral	10.7%
Penetrative (Anal)	7.6%

7.6% of the respondents in this study reported that they engaged in penetrative anal sex with their clients while 99.7 reported that they engaged in penetrative (vaginal) sex. Although receptive anal sex (bottoming) is much riskier for getting HIV than insertive anal sex (topping), it is possible for either partner-the top or the bottom to get HIV. The bottom's risk is very high because the lining of the rectum is thin and may allow HIV to enter the body easily during anal sex. The top is also at risk because HIV can enter the body through the opening at the tip of the penis (or urethra). The risk of HIV transmission during anal intercourse may be around 18 times greater than during vaginal intercourse, according to the results of a meta-analysis published in the *International Journal of Epidemiology*

5.4.5 Average number of clients seen per day/night

Table 25: Reported average number of sexual clients per day/night

Average Number of clients	Frequency	Percent
1	37	12.7
2-5	189	64.9
>5	65	22.3
Total	291	100.0

Despite that one of the effective ways of reducing the risk of getting HIV through sexual contact is reducing the number of people you have sex with in addition to using condoms correctly and consistently and choosing less risky sexual behaviours, it is striking that 64.9% of the respondents indicated that on average, they had >2=5 clients per day/night while around 22% reported seeing >5 clients per day/night. Various studies have shown that PrEP and PEP is highly effective for preventing HIV from sex if it's used as prescribed, and given the risk to contract HIV among YWSS in Zimbabwe investment should be made towards these prevention methods.

5.5 CONDOM USE AMONG YWSS IN ZIMBABWE

5.5.1 Availability of condoms at place of work

Uninterrupted availability of HIV prevention commodities such as condoms is critical for the prevention of HIV infection for both the young women selling sex and their clients. In this study, young women in commercial sexual exploitation were asked a number of questions to check on the availability of condoms at place of work. Impressively, 84.4% indicated that their place of work provides and insists on the use of condoms. This means that access to condoms was high for YWCSE. However, availability of HIV prevention services does not guarantee utilisation and/or uptake.

Table 26: Availability of condoms at place of work

Statement on availability	Frequency	Percent
Establishment provides and insists/enforces use of condoms	206	84.4
Establishment does not provide but insists/enforces use of condom	13	5.3
Establishment does not provide but encourages use of condom	2	.8
Establishment does not care	23	9.4
Total	244	100.0

5.5.2 Frequency of condom use in the last 5 sexual encounters with a sexual customer

Table 27: Frequency of condom use in the last 5 sexual encounters with a sexual customer

Response	Frequency	Percent
Always	183	64.0
Sometimes	91	31.8
Never	12	4.2
Total	286	100.0

While 96.7% of respondents in this survey reported that correct and consistent condom use is one of the effective ways to prevent HIV transmission, this study established that only 64% of the respondents used a condom always during the last 5 times they had sex with a customer while 4.2 never used a condom during the last 5 times they had sex with a customer. These statistics suggest that while high levels of knowledge on HIV transmission and prevention is important, knowledge does not always translate to safer practices.

5.5.3 Reason why condom was never or sometimes used with a client

Table 28: Reason why a condom was always, never or sometimes used with a client the last 5 sexual encounters

Reason for not using a condom	Percent
Customer pays more	32.1%
Customer refused to use	28.4%
No condom available	2.8%
Did not know/care about use of condom	4.6%
Other (please explain)	43.1%

Reasons why a condom was never or sometimes used with a client demonstrates a strong proxy indicator to the compromised inexperience and poor negotiation skills for safer sex increasing the vulnerability of younger women in commercial sexual exploitation. 32.1% and around 28% indicated that condom use was compromised because customer pays more or refused to use respectively. More work is required to empower young women selling sex to have more negotiating power.

5.6 ESTIMATING AGE OF ENTRY (INITIATION PREVALENCE) INTO COMMERCIAL SEXUAL EXPLOITATION IN ZIMBABWE

In this study, more than two thirds (64.6%) of young women reported starting selling sex below the age of 18 with the highest concentration was between the ages of 16-17 at 35%. 5.8% became sex workers before the age of 12, while 18% started between the ages of 12 and 14. While the general global consensus is that many girls across the world start selling sex at the age of 12, the modal age range of entry into selling sex for children involved in commercial sexual exploitation that we interviewed was 16-18 years 35.1% followed by13-16 years at 23.7%.

> *"I have many friends of my age and less (≤15 years) in this locality who are selling sex, but they are afraid to be interviewed because of the legality issues related to our age in this profession*
>
> *A YWSS in Epworth*

Table 29: Initiation Prevalence or Age of entry into sex work

Percentages of young women selling sex 10-24 years disaggregated by age

Initiation Age	Frequency	Percent
<10 years	7	2.4
10-12 years	10	3.4
13-15 years	69	23.7
16-17 years	102	35.1
>18 years	103	35.4
Total	291	100.0

5.7 ACCESS AND USE OF HIV AND SOCIAL SERVICES BY YOUNG WOMEN SELLING SEX

Table 30: Distribution of illnesses related to selling sex

Response	Frequency	Percent
Yes	121	41.4
No	158	54.1

Total	279	95.5

Table 30 above illustrate the distribution of YWSS by whether they had ever experienced some illness related to their work. Around 41% reported having experienced such illnesses. And while this is below half of the number interviewed in this study, it is too high considering that the population under study is highly vulnerable.

Table 31: Distribution of respondents by nature of illness

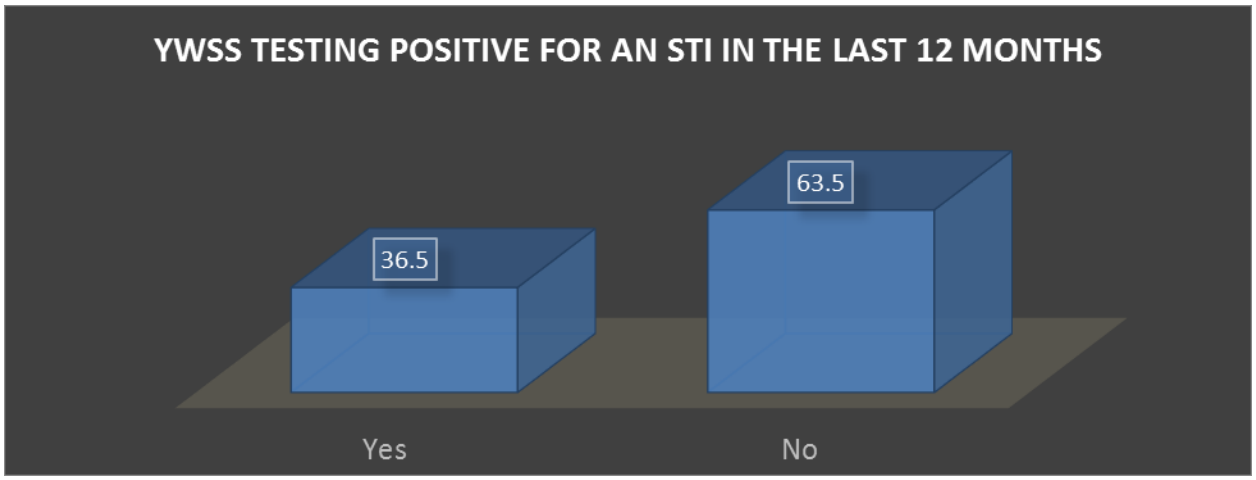
Nature of illness	Responses		Percent of Cases
	N	% Response	
STI	97	74.0%	81.5%
Injury from GBV	22	16.8%	18.5%
Other Specify	12	9.2%	10.1%
Total	131	100.0%	110.1%

While respondents in this study indicated that 41.4% had experienced some illness related to their work, the distribution of respondents by nature of illness shows that the most commonly reported cases were STIs at 81.5% followed by injury from gender based violence at 18.5%. These statistics suggest that a significant number of young women engaging in commercial sexual exploitation was not using condoms and that injury from GBV could be a proxy for YWSS's disempowered position. Stakeholders must intensify work to increase use of protection among young women selling sex.

5.7.1 YWSS reporting having an STI excluding HIV in the last 12 months

Being young girls, we face a lot challenges related to our work. One of the biggest challenge is lack of negotiation power to safer sex which result in most girls acquiring unnecessary STIs.

Figure 3: Proportion of YWSS testing diagnosed with an STI in the last 12 months



While it was established that YWSS in this study had an elevated risk of contracting STIs other than HIV based on their high risky sexual behaviours such as having multiple sexual partners with 87.2% having an average

of >2 sexual partners per night/day and 64% reporting having always used a condom during the last 5 times they had sexual intercourse, the same study also noted 36.5% of YWSS tested positive for at least one STI in the last 12 months. This indicates high STI incidence among this vulnerable group.

5.7.2 YWSS reporting seeking treatment for diagnosed STIs

Table 32: Proportion of young women selling sex seeking treatment for diagnosed STIs

Sought treatment	Frequency	Percent
Yes	88	90.7
No	9	9.3
Total	97	100.0

Of the 36.5% YWSS who had an STI in the last 12 months preceding the survey, a remarkable 90.7% sought treatment with 95.5% seeking professional medical treatment while less than 5% sought treatment from a traditional healer.

5.7.3 Type of STI treatment sought

Table 33: Type of STI treatment sought by young women selling sex

Type of treatment	Frequency	Percent
Medical (Professional)	84	95.5
Traditional healer	4	4.5
Total	88	100.0

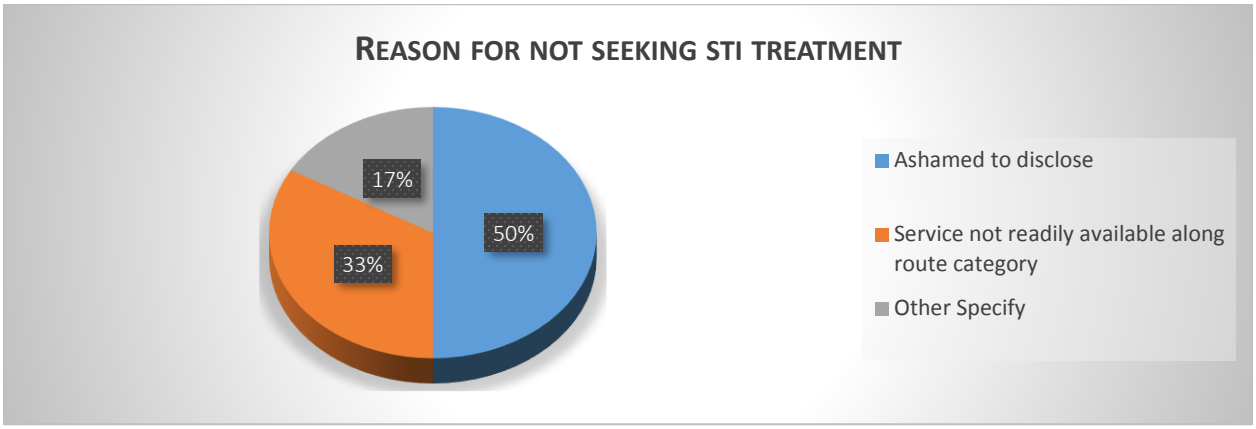
Health care related costs among YWSS

Responsible for payment	Frequency	Percent
Yourself	74	59.2
Other Specify	51	40.8
Total	125	100.0

YWSS interviewed in this study indicated that 59.2% were responsible for meeting their own medical costs whilst 40% mentioned other. Given the high STI and injury from GBV incidence among young women selling sex in Zimbabwe, this means that YWSS bear the brunt of a high financial burden as a result of health care direct costs.

5.7.4 Reason for not seeking treatment for STIs

Figure 4: Reported reason for not seeking STI treatment



Of the less than 5% who did not seek treatment for a diagnosed STI, half 50% reported that they were ashamed to disclose their status while 33% indicated that the service was not readily available.

5.7.5 YWSS reporting 'ever' been tested for HIV Status

Table 34: YWSS reporting ever been tested for HIV status

Response	Frequency	Percent
Yes	277	94.9
No	15	5.1
Total	292	100.0

YWSS in this study had an elevated risk of contracting HIV including other STIs based on their high risky sexual behaviours such as having multiple sexual partners with 87.2% having an average of >2 sexual partners per night/day and 36% reporting having never or sometimes used a condom during the last 5 times they had sexual intercourse, interestingly the same study also noted above 94% of the YWSS had ever been tested for HIV status.

5.8 REFERRALS TO SOCIAL AND HIV SERVICES

Out of the 292 YWSS who participated in the study, a total of 241 YWSS responded to the question whether they had requested for a referral during and or after the interview. Of those who responded, 51.5% of them reported that they had requested for a referral. Since, the data collection process involved full participation of the District Child Welfare and Protection Services (DCWPS) all those that requested a referral were referred to the relevant service providers and their case files were opened with the DCWPS. The DCWPS committed to follow up all the cases that were referred to ensure that the clients (YWSS) accessed the service.

Table 35: Proportion of interviewees who required a referral

Response	Frequency	Percent
Yes	124	51.5
No	117	48.5
Total	241	100.0

5.9 BARRIERS TO ACCESS HIV AND SOCIAL SERVICES

Accessibility and availability of HIV and Social to YWSS

Table 36: Accessibility and availability of HIV and Social services for YWSS

> *One YWSS in Hwange had this to say: "Our work is too demanding. At night we are out providing sexual services to clients and we rest/sleep during the day. But if I find a client during day time, it game on."*

Response	Frequency	Percent
Yes	241	84.6
No	40	14.0

While we acknowledge that YWSS due to the nature of their work they have a higher risk of contracting HIV and being abused therefore would require easy access to prevention and treatment services, 84.6% reported that accessibility and availability of HIV services was easy. In addition 64.9% also reported they have access to psychosocial support whenever needed. These suggest that access to HIV and social services is higher for this vulnerable group. However, access and availability does not guarantee quality and consumption of services. Health care workers were reported as the major providers of psychosocial support services at 50% with Social Workers providing 17.6% of the PSS services. Snob

Table 37: Barriers that hinder access and utilisation of HIV and Social services

	Not Important		Not Sure		Less Important		Important		Very Important	
Barrier	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
No time to visit clinic	113	39.5	31	10.8	12	4.2	18	6.3	112	39.2
No money to cover medical costs	97	34.2	33	11.6	33	11.6	64	22.5	57	20.1
Health Care Worker Attitude	134	47	38	13.3	33	11.6	40	14.0	40	14.0
No near clinic/hospital that offer services	161	56.7	44	15.5	22	7.7	19	6.7	37	13.0
Stigma and discrimination	126	44.1	39	13.6	24	8.4	41	14.3	56	19.6
No information on HIV & AIDS	149	52.7	23	8.1	25	8.8	32	11.3	54	19.1

Table 37 above presents relative weighting of the barriers faced by YWSS in their line of work that hinder access and utilisation of HIV and social services on a factor scale of 1-5. The most weighted factor (very important) was no time to visit clinic followed by no money to cover medical costs. No time to visit clinic was given a higher weight because of the nature of the work of YWSS where they provide their services at night and spent the whole day resting/sleeping in preparation of the coming nightfall. This call for innovative ways to reach YWSS with services such as night outreach work at hotspots to test people. Stigma also emerged as

a major barrier to young women selling sex seeking care from health facilities especially the public sector at 19.6%. Young women spoke about not feeling comfortable talking about their work, getting tested for STIs, and requesting condoms. They reported significant stigma towards FSWs in public health facilities thus they access most of their HIV and SRH services from CeSHHAR sex work clinics. There is need to engage HCWs from the public institutions to address negative HCW attitudes. Factors that were given a higher weight as not important are no near clinic and no information on HIV. This suggest that stakeholders are providing HIV information to this group and that services are within reach.

6 POSSIBLE INTERVENTION AREAS TO REDUCE YWSS

The table below show the proportion of YWSS according to their relative weighting of the interventions focus that they believe would significantly reduce the number of children involved in commercial sexual exploitation. Of all the intervention points that were proposed the most weighted in terms of its potential impact to reduce YWSS was increased access to social protection at household level which scored 73.9%, followed by increased access to social services at 67%. The proportion weighting cracking syndicates as the most important was low at 25.3% which is in agreement with findings of this study that the proportion of women reporting being in sex work as a result of being recruited by syndicates was low at 5.5%. However, it is important to accentuate that an intervention package to address all the potential intervention points should be put in place though with different level of investment based on perceived and actual importance and the related impact.

Table 38: Relative importance of the factors that will reduce the number of YWSS

	Not Important		Less Important		Important		Very Important	
Intervention	Freq	%	Freq	%	Freq	%	Freq	%
Increased access to household Social Protection	15	5.2	19	6.6	41	14.3	212	73.9
Increased access to Social Services	11	3.9	20	7.0	61	21.5	192	67.6
Cracking syndicates recruiting children into sex work	115	40.4	46	16.1	52	18.2	72	25.3
Increased support to orphaned households	44	15.5	18	6.4	59	20.8	162	57.2

7 DISCUSSION

This is one of the first systematic surveys of HIV and associated factors among young women involved in commercial sexual exploitation to be conducted in Zimbabwe. Of note, we explored factors associated to the causes that push and pull young women to engage in selling sex, age of entry (initiation prevalence) into the sex industry and the access to and utilisation of social and HIV services for this population, critical if the UNAIDS 90-90-90 treatment targets to end AIDS epidemic is to be achieved. We recruited young women selling sex along two transport corridors in Zimbabwe where the phenomenon of "mobile men with money", socio-economic disparities, and 'vibrant' night life along corridors encourages both men and women including YWSS – in large numbers – to engage in unsafe sex, including long-term multiple concurrent partnerships where condom use, due to lack of negotiation power, is persistently low for young women selling sex. The findings in this report present the results of experiences and views gathered through face-to face interviews with young women involved in commercial sexual exploitation in Zimbabwe; such exploitation is both a fundamental violation of children's rights and a major risk factor for a wide range of illnesses. This step is crucial in addressing the challenge of women involved in selling sex as most previous studies have had some important limitations as they mainly focused on any form of sexual violence in childhood; school based populations and presenting causes of commercial sexual exploitation of children without weighting their relative importance from the survivor's perspective. Despite elevated risk of contracting HIV infection from their clients, in this study, a significant proportion of YWSS reported sometimes (318%) and never (4.2%) using a condom in their last 5 sexual encounters preceding the survey. While young girls were noted at all study sites, extremely younger ages were noted in Hwange and Victoria Falls. In Hwange, the main reason reported to be pushing young girls into selling sex was household poverty triggered by high unemployment rates due to below whereas in Victoria Falls the main reason provided was the existence of the Victoria Falls International Airport construction community amid surrounding communities in Lupinyu that that re marred by poverty and lack of fees to attend school. During data collection, the research team witnessed Chinese employees at the airport construction company soliciting sex services for as little as US$2 from young girls.

One Chinese working for the construction company was heard saying this to young girls "fucker fucker $2"

In one study done by CeSHHAR in 2016, the young female sex workers that were recruited were at extremely high risk of HIV with a prevalence of HIV between 50-70%, 3-4 times that of the women in the general population. While the majority of those who reported that they were HIV positive on the questionnaire said they were accessing ART services, overall only 26-38% of those with laboratory-confirmed infection. Few of those who were positive but were unaware of their diagnosis reported having tested recently.

Whilst it is not possible to identify the cause and effect between the variables in this study, we can still see relationships between study variables. Although reported condom use was high the majority of women reported that they had not used condoms at each recent sexual encounter either with client or regular partners.

From the findings presented above, the reality is that most of the young women engaged in commercial sexual exploitation in Zimbabwe come from families affected by poverty, broken family units and/or orphanhood and do not have safe places to return to. In addition, other young women are trading sex as a way to escape from gender violence and abuse that they have experienced in their homes and communities.

Findings of this study provides an opportunity to listen to the young women in commercial sexual exploitation who are struggling to survive in hostile circumstances with a view to address the root causes of their vulnerability and exploitation with a view to provide re-integration services.

Although the prevention of and response to commercial sexual exploitation of children in Zimbabwe traditionally has been seen as the responsibility of law enforcement and social welfare, health sectors can integrate violence prevention and care into routine programmatic activities, building clear links to social services to achieve maximal benefit for various social and health measures. For instance, improved identification of those newly entering into the trade and those who are already there and the successive delivery of counseling and re-integration assistance might aid victims. The results of this study provide nationally representative estimates by which key stakeholders can customize their interventions and measure their performance in reducing CSEC in Zimbabwe.

Data sources indicates that although numerous agencies in Zimbabwe are providing various HIV-related services to sex workers along the transport corridors targeted interventions for young women commercial sexual exploitation are limited and the collective impact of this work is minimal. Bottlenecks to effective HIV prevention programming for YWSS include a lack of interventions that aim to re-integrate YWSS back into their families or school, identifying of young women selling sex in some sites, identifying appropriate referrals, inadequate interventions that strengthen vulnerable households in order to stop young women from entering in the sex industry and legality issues that impact YWSS access and utilisation of HIV and SRH services especially from the public health institutions.

8 CONCLUSION

Given global acknowledgement of enhanced HIV vulnerability among young key populations, commercial sexual exploitation of children in Zimbabwe is on the rise. Whereas available information on the practice remains haphazard and anecdotal, this study provides evidence for strengthening interventions for this underage and underserved group. Findings from this study also profile the drivers, modal age of entry into selling sex for young women in Zimbabwe as well as access, utilisation and barriers to HIV and social services associated with young in commercial sexual exploitation in Zimbabwe. Poverty (lack of school fees) and breakdown of family units are the main influences predisposing children to engage in commercial sexual exploitation. Other contributing factors are orphanhood and gender based violence. Whereas Zimbabwe has taken steps to fight this practice, there is still a lot to be done. There is evidently limited political will to tackle the problem.

Interventions should include preventing girls from entering the sex industry, mitigating the risks faced by girls and young women as they enter and stay in sex work and re-integrating young women back into their families, communities and in school where possible. Zimbabwe is well-positioned to implement effective strategies focused on dimensions grounded in national strategies such as the National Case Management system and National Plan of Action. The following recommendations urge that existing services and interventions sharpen their focus on prevention, re-integration and protection of young women in commercial sexual exploitation.

9 RECOMMENDATIONS AND THE WAY FORWARD

Whilst an attempt has been made to separate recommendations for children from young women it is important to note that these recommendations overlap and thus what is recommended for children may also apply for young women and vice-versa.

Recommendations for children

- **Develop standardised context specific guidelines and model on the re-integration of YWSS into their families and communities in Zimbabwe:** Government of Zimbabwe (GoZ), leading UN agencies and development agencies have come together to create new Guidelines on the Reintegration of Children who are involved in commercial sexual exploitation in Zimbabwe. The Guidelines should call for greater investment in re-integration, and advocate for it to be pursued as the primary response before other permanent care options are considered.

- **Develop alternative means of livelihoods for child victims and their families to prevent further commercial sexual exploitation**: Strategies in income generation and informal education should be designed to provide choices for children and their families, to whom the sex trade may be the only option. For children who are excluded from mainstream education, their future prospects and choices are severely restricted and this downward spiral of opportunity reduction creates greater risk of being sexually exploited.

- **Initiate interventions that reduce the susceptibility to HIV for girls newly entering sex work:** Improve outreach to girls newly entering sex work; recruit and train a cadre of adolescent peer educators and sensitize health care workers, police, and other service providers to the special needs of this highly vulnerable age group. This model can build on lessons learnt from CeSHHAR pilot programme that recruited, engaged and linked YWSS to existing prevention and treatment, a programme that proved feasible and acceptable to young women selling sex. Access to PEP and PrEP can be improved.

- **Develop an early identification response system and recruit and deploy a well-trained cadre of youth peer educators:** Find girls just starting in sex work and provide them with safer sex education, condoms, condom (safer sex) negotiation training, and alcohol and drug counseling.

- **Strengthen links with social welfare and child protection services to promote sustained access to individual and household level social services and social protection interventions:** Stronger links to social welfare services, the Department of Child Welfare and Protection Services (DCWPS) and ensure un-interrupted education and livelihood support services.

- **Engage clients and other regular partners:** New initiatives aimed at encouraging safer sex practices between intimate partners may be implemented through the existing network of service providers and peer educators to address this driver of HIV infection among YWSS.

- **Interventions must therefore be culturally sensitive and appropriate:** Since children in Zimbabwe exist within a cultural context, work with children, families and communities to curb commercial

sexual exploitation of children needs to take into account the social and cultural settings and experiences.

- **Protection, prevention and re-integration must be seen as part of a community's responsibility**. To be effective and sustainable, communities need to be aware of the threats to children and assume child focused and supportive systems of monitoring, reporting and re-integration. Thus communities can no longer rely on outsiders (government and NGOs) to offer long term protection.

- **Increased access to basic education and keeping girls in schools is needed**: Particularly with regard to the plight of the girl-child and the inferior status assigned to women and children in many communities in Zimbabwe.

- **Strengthen public and targeted information campaigns to target the demand side, the sex exploiters:** Key stakeholders need to work consistently with the mass media, look at program for increasing sensitivity in reporting, and create the opportunity for changing public awareness and sensitivity on this issue.

- **Ensure comprehensive enforcement of existing laws that hinder CSEC:** Existing legislation needs to be put be fully ipmlented. Implementation of anti-CSEC laws need to be monitored to ensure efficiency and effectiveness and remove a culture of impunity surrounding the sexual exploitation of children. This will also go a long way in developing non-punitive strategies of dealing with victims.

- **More operational research and information gathering and evidence generation is required on sexual exploitation of children in Zimbabwe**. This will go a long way in providing adequate information on which meaningful intervention efforts can be based to reduce the number of women involved in commercial sexual exploitation.

Recommendations for young women

- Increase access to PrEP for young women
- We suggest offering periodic screening for asymptomatic STIs to young female sex workers.
- Ensure access to HIV combination prevention for sex workers.
- Continue education programmes to ensure correct and consistent condoms among young sex workers.
- Alert and engage with the funding partners to ensure that sex worker clinics under CeSHHAR are supported to avoid disrupting access to HIV and RH services for young women.

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ANNEXES

PSYCHOMETRIC SURVEY QUESTIONNAIRE

QUESTIONNAIRE ID
NUMBER…….

RESEARCH TOPIC: Young Women in Commercial Sexual Exploitation along Two Transport Corridors in Zimbabwe: Causes, Initiation Prevalence and Use of HIV and Social Services

HOT SPOT IDENTIFICATION DETAILS

'Hot-Stop' Name		**Name of Province**	
Location of 'Hot-Spot' Site	1 Border Post 2 Growth Point 3 Town 4 City 5 Other	**Name of District**	
Date of interview	(dd/mm/year)		

A. RESPONDENT BACKGROUND INFORMATION

Variable Description	**Code/s**
A1. Profession of respondent a. Sex worker b. Other	 1 2
A2. Sex a. Female b. Male	 1 2
A3. Age Group a. 10-12 years b. 13-15 years c. 16-18 years d. 19-24 years	 1 2 3 4
A4. Do you have a physical disability of any kind (not including general ill health related to HIV)? (includes limitation in vision, movement, hearing & touching) a. Yes b. No	 1 2
A5. Ethnicity *(list taken from the recognised languages in the Zimbabwean Constitution)*	
A6. Place of birth (name of district)	
A7. Where do you live (Name)	

1	Chewa	4	Koisan	7	Ndebele	10	Sotho	13	Venda
2	Chibarwe	5	Nambya	8	Shangani	11	Tonga	14	Xhosa
3	Kalanga	6	Ndau	9	Shona	12	Tswana	15	English

A8. Have you always lived there? a. Yes b. No	 1 2	If yes go to **Qn A12**
A9. If no, why did you move? *(tick all that apply)* a. Parents/Guardian relocated b. Parents/Guardian died c. Poverty d. Seeking for a better life e. Child abuse f. No money to continue with education g. Household Gender Based Violence h. Chased away by parents/relatives/guardian i. Coming to join a friend j. Influenced by a syndicate k. Peer pressure l. Other (specify)……		 1 2 3 4 5 6 7 8 9 10 11 12
A10. Where did you live before *(Name of district or city)*		
A11. Whom did you live with before? *(check all persons that apply)* a. Father b. Mother c. Sister/s (specify younger or old)…… d. Brother/s (specify younger or old)…….. e. Grandparents f. Guardian g. Uncle/Aunt h. Employer i. Non relative j. Other (specify)		 1 2 3 4 5 6 7 8 9 10
A12. Whom do you live with now? *(tick all that apply)* a. Father b. Mother c. Sister/s (specify younger or old)…… d. Brother/s (specify younger or old)…….. e. Grandparents f. Guardian g. Uncle/Aunt h. Employer i. Non relative j. Other (specify)		 1 2 3 4 5 6 7 8 9 10
A13. How many people do you live with? a. 0 b. 1-5 c. 6-10		 1 2 3

d. >10	4
A14. If a child lives with any person other than both parents: where is your father/mother? a. Died b. Original Home c. Don't know	 1 2 3
A15. Do you take alcohol *(if yes go to Qn A16)* a. Yes b. No	 1 2
A16. Average pints per day/night a. 1-5 b. 6-10 c. 11-15 d. 15+	 1 2 3 4

B. EDUCATIONAL CHARACTERISTICS

Variable Description	**Code/s**
B1. Have you ever been to school? *(if no, go to Qn* B14**)** a. Yes b. No	 1 2
B2. Educational Level a. No formal education; b. Completed primary education c. Completed secondary education d. College or University	 1 2 3 4
B3. Are you currently attending school? a. Yes b. No c. Finished	 1 2 3
B4. How regularly do you attend school? a. Every day b. Once per week c. Twice per week d. Thrice per week e. Four times a week f. Five times per week g. Depends on the season	 1 2 3 4 5 6 7
B5. Are there any days you miss school?	

a. Yes b. No	1 2
B6. If yes, what makes you miss school? a. Work b. Lack of school fees c. Other (specify)	 1 2 3
B7 Who pays for your education? a. Myself b. Parents/Guardian c. Relative/s d. Friend/s e. Education is free f. Other (specify)	 1 2 3 4 5 6
B8. What is the main reason you left school? a. School is too far b. Lack of school fees c. Family does not allow schooling d. Not interested in school e. School not suitable and safe f. Illness of disabled (self) g. To help with household chores h. To take care of sick family member/s i. To work for wages to support siblings j. To work in own business to generate income k. Other (specify)……	 1 2 3 4 5 6 6 7 8 9 10
B9. When did you leave school? a. <3 months ago b. 3-6 months ago c. 6-12 months ago d. >12 months ago	 1 2 3 4
B10. How old were you when you left school? *(Specify age)*	
B11. What level were you when you left school? a. Primary b. Secondary c. Tertiary	 1 2 3
B12. Would you like to go back to school? a. Yes b. No c. Don't know	 1 2 3

B13. What is the main reason preventing you from going back to school?	
a. School is too far	1
b. Cannot afford school	2
c. Family does not allow schooling	3
d. Not interested in school	4
e. School not suitable or safe	5
f. Illness or disabled (self)	6
g. To help in household	7
h. To take care of ill family members	8
i. To work for wages	9
j. To work in own business for income	10
k. Other	11
B14. If you have been never to school, what is the main reason that hindered access to school?	1
a. School is too far	2
b. Could not afford school	3
c. Family does not allow schooling	4
d. Not interested in school	5
e. School not suitable or safe	6
f. Illness or disabled (self)	7
g. To help in household	8
h. To take care of ill family members	9
i. To work for wages	10
j. To work in own business for income	11
k. Other (specify)	12
B15. Can you read?	
a. Yes	1
b. No	2
B16: Can you write?	
a. Yes	1
b. No	2

C. KNOWLEDGE OF HIV AND AIDS

C1. Do you know about HIV and AIDS?	
a. Yes	1
b. No	2
C2. If yes, how did you learn about HIV and AIDS?	
a. From employer/manager/pimp	1
b. From the media (TV, newspapers, radio)	2
c. From friends/co-workers	3
d. From government officials	4
e. From voluntary organizations	5
f. Others (specify)……	6
C3. Do you know what you can do to protect yourself against HIV infection?	

a. Yes b. No	1 2
C4: If yes to C3 above, please mention the HIV prevention methods that you have heard a. Consistent and correct use of condoms b. Abstinence c. Being faithful to one mutually faithful negative partner d. PrEP e. PEP f. PMTCT *g.* VMMC	 1 2 3 4 5 6 7
C5: If you have answered yes to **C3** above, have you heard of PrEP? a. Yes b. No	 1 2
C6: If you have answered yes to **C4** above would you consider taking PrEP if it becomes available? a. Yes b. No c. Not sure	 1 2 3
C7. Does your place of work (employer/manager/pimp) provide you with a supply of condoms? a. Establishment provides and insists/enforces use of condom b. Establishment does not provide but insists/enforces use of condom. c. Establishment does not provide but encourages use of condom d. Establishment does not care	 1 2 3 4
C8. During the last five times you had sex with a customer, how often was a condom used? a. Always b. Sometimes c. Never	 1 2 3
C9. If a condom was sometimes or never used, why not? a. Customer pays more b. Customer refused to use c. No condom available d. Did not know/care about use of condom e. Other (please explain)……	 1 2 3 4 5
Choose a number that corresponds with your (respondent's) opinion on the questions:	

1-Agree; 2-Unsure; 3-Disagree	
C10. Do you believe HIV causes AIDS?	1 2 3
C11. One can get infected with HIV if they have sex without protection?	1 2 3
C12. Antiretroviral treatment can help to control the HIV infection and should be commenced early?	1 2 3
C13. Seeking early medical attention to Sexually Transmitted Infections (STIs) reduces the risk to HIV?	1 2 3
C14. Condoms used correctly and consistently can help you reduce the risk to get STIs including HIV?	1 2 3
C15. Reducing the number of sexual partners can help reduce the risk of HIV?	1 2 3
C16. Getting infected with HIV or not is predetermined and therefore inevitable?	1 2 3
C17. Avoiding shaking hands with an HIV positive person prevents HIV infection?	1 2 3
C18. HIV is the same with AIDS?	1 2 3

D. CHILD SEXUAL EXPLOITATION

D1. What pushed or pulled you to start engaging in sex work?	
a. Poverty	1
b. Breakdown of family unit/s	2
c. Mobilised/recruited by syndicates	3
d. Gender Based Violence	4
e. Orphanhood	5
f. Peer pressure/Introduced by friends	6
g. Doing it for 'fun'	7
h. Other *(specify)*	8
D2. At what age did you start sex work?	
a. <10 years	1
b. 10-12 years	2
c. 13-16 years	3
d. 16-18 years	4
e. >18 years	5
D3. When did you start engaging in sex work?	

a. <3 months ago b. 3-5 months ago c. 6-12 months ago d. >12 months ago	1 2 3 4
D4. Where do you get your clients? a. Hotel b. Nightclubs/Beerhalls c. Brothels d. Street e. Lodges f. Truck stops g. Other (specify)	 1 2 3 4 5 6 7
D5. Who are most of your clients? a. General people b. Long distance truck drivers c. Small scale miners d. Business people e. Other (specify)	 1 2 3 4 5
D6. Once you get your clients, where do you mostly have sex with them? a. Car/trucks b. House c. Bush d. Brothel e. Offices f. Hotels/lodges g. Other (specify)	 1 2 3 4 5 6 7
D7. What type of sex do you normally do with your clients*? (circle all that apply)* a. Penetrative (Vaginal) b. Oral c. Penetrative (Anal) d. Other (specify)	 1 2 3 4
D8. On average, how many clients do you see per day/night? a. 1 b. 2-5 c. >5	 1 2 3
D9. How do you normally get paid? a. Cash b. In kind c. Other (specify)	 1 2 3
D10. Do you have a boss who organizes clients for you? a. Yes b. No	 1 2

D11. If yes, does the boss collect the money for you? a. Yes b. No	 1 2
D12: If the boss collects the money for you does she/he inform you how much he/she will have collected? a. Yes b. No	 1 2
D13. Do you have a payment arrangement with your boss a. Yes b. No	 1 2

D14. How do you get paid and how much?

		Amount in US$
1	Per client	
2	Per Night	
3	Per Session	
4	Per day	

D15. Are you provided with the following facilities by your boss/employer? *(tick all that apply)* a. Clothing/uniforms b. Accommodation c. Transportation d. Meals e. Free medical treatment f. Regular health checks g. Easy loans h. Assistance when you get into trouble with the law i. Other (specify)	 1 2 3 4 5 6 7 8 9

E. ACCESS TO MEDICAL and SOCIAL ASSISTANCE

E1. Do you have medical aid? a. Yes b. No	 1 2
E2. If no who meets your medical bills? a. Self b. Employer/boss c. Medicals are free d. None	 1 2 3 4
E3. Where do you normally receive medical assistance? a. Public health facility b. Private health facility c. Outreach Clinic d. Other (specify)……	 1 2 3 4

E4. Have you received any kind of information about the possible health dangers or diseases you could be exposed to in your job?	
a. Yes	1
b. No	2
E5. If yes, who provided the information?	
a. Employer/manager/pimp	1
b. Government health worker	2
c. Department of Labour official	3
d. Other government officials	4
e. NGO volunteers 2	5
f. Colleagues in the 3same line of work	6
g. Media (TV, radio, n4ewspapers)	7
h. Other (specify)	8
E6. How often do you have health/medical checkups?	
a. Whenever I feel sick	1
b. Once a month	2
c. Once in 3months	3
d. Once in 6 months	4
e. Once a year	5
f. Never	6
E7. If regularly arranged, who arranges your checkups?	
a. Employer/manager/boss	1
b. Government	2
c. NGO	3
d. Yourself	4
e. Others (specify)	5
E8. Have you ever had any illness related to your work?	
a. Yes	1
b. No	2
E9. If yes, what was the nature of the illness?	
a. STI	1
b. Injury from GBV	2
c. Other (specify)	3
E10. Who paid for your medical treatment?	
a. Employer/manager	1
b. Yourself	2
c. Others (specify)	3
E11. Do you have access to psychosocial support?	
a. Yes	1
b. No	2
E12. If yes who is providing the support?	
a. Employer/manager	1
b. Health care workers	2
c. Social Workers	3
d. Others (specify)	4

F. Physical and Mental Health Related Challenges

F1. What physical body health challenges related to your work do you face? (Circle all that apply) a. Yes b. No c. Don't know	 1 2 3
F2: If yes to Qn **F1** above please specify *(circle all that apply)* a. Headaches b. Back pain c. Abdominal pain d. Stomach pains e. Vaginal tearing f. Fatigue g. Dizziness h. Pelvic pain	 1 2 3 4 5 6 7
F3. Have you had any mental health related symptoms resulting due to your nature of work? a. Yes b. No c. Don't Know	 1 2 3
F4. If yes to **Qn F3** above, please specify *(circle all that apply)* a. Depression b. Anxiety c. Memory loss d. Other	 1 2 3 4

G. STI & HIV Health Seeking Behaviours

G1. Have you ever had an STI excluding HIV in the last 12 months? a. Yes b. No	 1 2
G2. If yes, did you seek treatment? a. Yes b. No	 1 2
G3. What type of treatment did you seek? a. Medical (professional) b. Traditional healer treatment c. Religious treatment d. Other (specify)	 1 2 3 4
G4. Why did you not seek treatment for STIs? a. Time constraints	 1

b. Ashamed to disclose	2
c. Health Care Worker Attitude	3
d. Service not readily available along route category	4
e. Other (specify)……	5
G5. Have you ever been tested for HIV Status? *(If yes go to Qn G6, no, go to G9)*	
a. Yes	1
b. No	2
G6. Do you know your HIV Status?	
a. Yes	1
b. No	2
G7. If yes to G5 & G6, what reasons contributed to you deciding to get a test and know your HIV status?	
a. Just wanted to know my status	1
b. I had fallen sick	2
c. Sexual partner had tested positive or died	3
d. Sexual partner or child had fallen sick or died	4
e. For ANC purposes	5
f. Other: Specify	6
G8: If you answered yes to G6 above, do you disclose your HIV status to your clients before engaging in sexual activities with them?	
a. Always	1
b. No	2
c. Sometimes	3
Why……..	
G9. Why have you never been tested for HIV Status?	
a. Scared of a positive result	1
Why?……	
b. Lack of time or access to the service	2
c. Never felt the need	3
Why?……	
d. Other (specify)	4
G10. How often do you go for HIV testing?	
a. Once in 3 months	1
b. Once in 6 months	2
c. Once in 12 months	3
d. Once in >12 months	4
e. Never	5
G11. When was you last HIV test?	
a. 3 months ago	1
b. 6 months ago	2
c. 12 months ago	3
d. >12 months ago	4

H. BARRIERS TO ACCESSING HEALTH INCLUDING HIV AND SOCIAL SERVICES

H1. Are HIV and Social services easily accessible and available to you? a. Yes b. No	 1 2

H2. What barriers do you face in your line of work that hinder access and utilization to HIV and Social Services? *(Circle 1 (one) response per row)*

	Not Important	Not Sure	Less Important	Important	Very important
a. No time to visit clinic or hospital	1	2	3	4	5
b. No money to cover medical costs.	1	2	3	4	5
c. Health Care Worker Attitude.	1	2	3	4	5
d. No near clinic/hospital that offer services.	1	2	3	4	5
e. Stigma and Discrimination	1	2	3	4	5
f. No information on HIV and AIDS	1	2	3	4	5
g. Other (specify)	1	2	3	4	5

H3. In the last 3 months, have you encountered negative health care worker attitude? Yes No	 1 2

I. CAUSES/REASONS WHY YOUNG WOMEN SELL SEX

I1: What do you think are the most common important causes of child sex work/exploitation *(Circle one response per row)*

	Not Important	Less Important	Important	Very important
a. Poverty	1	2	3	4
b. Breakdown of family units	1	2	3	4
c. Recruitment by 'syndicates'	1	2	3	4
d. Orphanhood	1	2	3	4
e. Peer Pressure/Introduced by friends	1	2	3	4
f. Household GBV	1	2	3	4
g. Doing it for 'fun'	1	2	3	4
h. Level of education	1	2	3	4

	i. Marital Status	1	2	3	4
	j. Alcoholism	1	2	3	4
	k. Fatalism	1	2	3	4
	l. Low risk perception	1	2	3	4
	m. Other (specify)				

J. SUGGESTIONS TO OVERCOME YOUNG WOMEN SELLING SEX

J1. What do you believe will significantly reduce the number of children involved in commercial sexual exploitation? *(Circle 1 (one) response per row)*

	Not Important	Less Important	Important	Very Important
a. Increased access to household Social Protection	1	2	3	4
b. Increased access to Social Services	1	2	3	4
c. Cracking syndicates recruiting children into sex work	1	2	3	4
d. Increased support to orphaned households	1	2	3	4
e. Other (specify)	1	2	3	4

J2: Generally, what do you believe it would take to leave sex work?	1…… …2…… ……3…… ……4…… ……5…… ……

J3. If you had sisters or girl children, would you encourage or discourage them if they wanted to enter this line of work?	
a. Encourage them	1
b. Discourage them	2