"Men want to taste the fresh ones,
the young and undefiled."

Minor female sex workers' agency in entering prostitution, coping with health problems and accessing health care services. Evidence from Zanzibar and Morogoro.

Hannelore Van Bavel

Prostitution remains a contested topic within feminist writings. Contestation derives from the question whether women in prostitution are victims of sexual exploitation or actors who freely choose sex work as a means of generating income. When it comes to minors in prostitution, the question of victim-actor seems to be absent; scholars on child and adolescent prostitution unanimously assume that minors do not have agency and are thus victims of sexual exploitation. This assumption oversimplifies the concept of agency and impedes empirical research on child and adolescent prostitution. To respond to this assumption, this research examines how female minor sex workers (FMSW) exercise agency in entering prostitution, coping with occupational health problems and accessing health care services. The study was conducted in two different sites in Tanzania: Morogoro on the mainland and Stone Town on Zanzibar Island. 31 in-depth interviews were conducted with 19 female sex workers who were 18 years old or younger, and 12 who were 19 or older, at the moment of entry. Focus-group discussions with 4 peer educators and 4 key informants were held. The findings show that FMSW's agency is more severely limited by social, cultural and economic structures than the agency of sex workers who were 19 or older when they entered. However, FMSW do find coping strategies to navigate within this constraints, reflecting different positions on the agency spectrum, ranging from reconciliation, via negotiation, to actual individual or collective agency. Nevertheless, FMSW on Zanzibar seem to benefit from an empowering sex workers organisation and targeted clinics, since they have more collective agency and more positive experiences than their colleagues in Morogoro, for whom these institutions were not available.

CONTENTS

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2. INTRODUCTION

The question of agency, consent and choice has been central to feminist debates on prostitution ever since the beginning of the women's movement in the 19th century. Feminist scholars on prostitution can roughly be put in two groups with opposing conceptions of agency and victimisation among respectively sex workers and prostituted women. Radical feminists conceive prostitution as "[…] a form of violence against women and hence a violation of human rights" (Jeffreys, 2002: 211). The *victimisation perspective* considers prostitution to be inherently harmful towards women and perceives prostituted women as victims of exploitation and poverty[1].

On the other end of the spectrum lies the *agency perspective*, adhered to by pro-sex feminists who prefer to think of sex *work* as a legible profession that is not inherently harmful to women[2]. Pro-sex feminists argue that "[…] abolitionist and prohibitory prostitution laws constitute a violation of human rights of women to control their own bodies, lives and work" (Jeffreys, 2002: 211). This particularly accounts for sex workers in the global South. In *Under Western Eyes*, Mohanty (1991) analyses victim representations of women in the global South and concludes that western discourses construct third world women as a homogenous and victimised population that is regarded as not resilient and dysfunctional. In line with Mohanty's analysis, authors as Doezema (2001) and Kapur (2002) argue that the victim discourse constructs sex workers in the global South as "agentless commodities". Various voices have warned against this tendency and stressed that the potential agency of sex workers in the global South needs to be taken into consideration (Thorbek & Pattanaik, 2002).

Yet, such a call does not seem to apply to child and adolescent prostitution. While scholars and human right activists do not agree on whether adult sex work should be illegalized, there is a considerable unanimity on child and adolescent prostitution as an objectionable violation of human rights (Jeffreys, 2010). The World Health Organisation ([WHO], 2014: xiii) argues that "[…] children and adolescents under the age of 18 who exchange sex for money, goods or favours are "sexually exploited" and not defined as sex workers. This implies that sex work is particularly condemnable when minors are involved, because children are – supposedly – not capable of making informed choices and lack agency. To date, there has been a lack of empirical research to underpin the assumption of female minor sex workers' (FMSW) lack of agency (Heilemann & Santhivereran, 2011: 58), with research on FMSW in general being scarce (McClure, Chandler & Bissell, 2014). Yet, a substantial amount of sex workers started selling their body before the age of 18 (McClure, Chandler & Bissel, 2014). As Heilemann and Santhiveeran (2011: 59) point out, "[t]his limited representation of female adolescents makes it difficult to distinguish the differences in the findings between adolescent girls and adult women." By defining child and adolescent prostitution as a de facto violation of human rights without carrying out any empirical research, the classical view is insensitive to local cultures (Davidson, 2005), disregards the various forms of child prostitution around the world and oversimplifies agency. The assumption of FMSW's lack of agency might serve political goals, but hinders a thorough understanding of their experiences. A more sophisticated understanding of FSMW's agency or lack thereof, with attention to its complexity, is needed.

For this Master's thesis, I chose to conduct my research in Tanzania because the precarious situation of sex workers in this country offers insight in the ways in which agency can still be exercised in the most constraining circumstances. Evidence shows that this group, in comparison to older sex workers, mostly enters prostitution because of poverty, is more vulnerable to health problems (such as STDs, HIV and violence), is more vulnerable to physical force, is unable to

[1] Inter alia Barry, 1984; Dworkin, 1974; Jeffreys, 2002; Jeffreys, 2008, 2009, 2010; MacKinnon, 2011; Miriam, 2005

[2] Inter alia Bernstein, 1999, 2001, 2007; Chancer, 1993; McClintock, 1993

negotiate condom use, faces barriers to access sexual and reproductive health and other services and lacks control over their situation in general (McClure, Chanlder & Bissel, 2014). This research wants to investigate the spaces within these severely constraining situations in which FMSW can still exercise some sort of agency. Focusing on their agency – however limited – might offer a way to support FMSW for whom simply quitting the sex business is not an option.

The question that arises then is how to measure FMSW's agency. Agency is a latent variable that can be found – or found lacking – in every human action. To uncover the agency or lack thereof of FMSW, a direct indicator is needed to "[…] explore a person's agency with respect to their *own well-being*, and probe their *control* (and in some cases its efficacy) in one or more areas that are assumed to matter (*ability*)" (Alkire, 2008: 8).

This research employs three such indicators or moments of measurement that help to explore minor sex worker's agency. A first area that is assumed to matter is prostitution itself: why do minors enter sex work and how is agency or the lack thereof reflected in entering prostitution? A second and third moment of measurement relate to the sex workers' health and safety. The vast majority of commercial sex workers is confronted with occupational health problems, such as HIV or other STIs, unintended pregnancies, alcohol and drug use, sexual, emotional and physical violence, stress and even death (Elmore-Meegan, Conroy, Agala & Bernard, 2004 in Okal et al., 2011: 612-613; The DIFFER Consortium, 2013; Ghoshal, 2013, Scorgie et al., 2013; USAID, 2009). Despite the many health problems that most sex workers face, only few seem to opt for medical treatment. Research has shown that commercial sex workers are often confronted with barriers that hinder them from accessing health care services (Dhana et al., 2014; Scorgie et al. 2013). Occupational health problems and access to health care services can serve as direct indicators to explore FMSW's agency with respect to their own health and well-being and their control and efficacy in protecting themselves against health problems and in accessing health care services. The aim of this research is therefore twofold: first, to examine FMSW's experiences in entering prostitution, protecting themselves against health problems and violence and coping with health problems, and second, to analyse how these experiences mirror their sense of agency or lack thereof.

3. STATE OF THE ART

3.1 Theorising and measuring agency

The debate on the supremacy of agency or structure is central to sociology and focuses on the question to which extent human beings can choose as free actors and actively shape their social environment. The question has divided sociologists in two camps. *Structuralists* argue that human behaviour is determined by structural constrains, while *rational choice scholars* maintain that rational choices of free actors shape the social world. Today, most sociologists consider agency to be constrained by social resources or structures (Barker, 2012; Giddens, 1976; Sewell, 1992). The agent is no longer seen as a free and non-determined actor, but agency is understood as the capacity to act within specific spaces or given social structures. Because of the constraints that structures pose on one's agency, some actors have more spaces to exercise agency than others.

Agency is mostly attributed to an individual. Recently however, scholars have argued that human agency goes beyond the individual (Alkire, 2005; Hewson, 2010; Ibrahim, 2014). *Individual agency* refers to a person acting on her or his own behalf. *Collective agency* refers to a person acting on behalf of both him/herself and of his/her community. Ibrahim (2014) emphasizes the importance of collective agency when it comes to women in the global South. She argues that "[…] collective agency is a self-empowering and dynamic process that allows women not only to challenge unequal power relations, but also to induce sustainable social change" (Ibrahim, 2014: 52). Deneulin and Stewart (2001) state

that living together influences a person's agency negatively or positively. The potential for empowerment requires an understanding of the positive or negative interaction between sex workers and their peers and of whether collective agency takes shape and, if so, how and when.

Hewson (2010) furthermore distinguishes three properties to negotiate agency: intentionality, rationality and power. *Intentionality* refers to the fact that agents act goal-oriented. *Rationality* refers to people's intellect in guiding their actions and predicting the consequences of their actions. Because of the constraints that structures pose on one's agency, some actors have more spaces to exercise agency – or more *power* – than others.

The lack of agency then is "[…] to be acted upon, to be the object of events, to have things happen to oneself or in oneself, to be constrained and controlled" (Hewson, 2010). In reality, agency and the lack of agency are strongly interwoven, with "complete agency" and "complete lack of agency" being the extremes of a continuum. People are both actors and acted upon, both capable of making choices and constrained by social structures. Agency then appears as the capacity to choose X rather than Y as a course of action within a specific constraining structure (Barker, 2012).

The interplay of agency and structure is central to this research. FMSW are commonly described as victims of constraining structures, but this inadequately explains FMSW's agency. This research will look at how FMSW exercise agency within constraining structures in entering sex work, in protecting themselves against occupational health problems and in trying to access health care services. The underlying premise is that, despite severely limiting structures, FMSW can still exercise agency and that this agency can vary among individuals and situations. In other words: even in hell there might be differences in temperature.

3.2 Structural constraints

3.2.1 Motivations for entry into prostitution

Entry into prostitution offers a first indicator to measure FMSW's agency. Entry consists of two components: the action of entering and the motivation for entry, i.e. the reason and meaning given to the action of entering. The action of entering prostitution *an sich* offers few insights in FMSW's agency, since one can enter prostitution voluntarily or because of coercion. Therefore, it is FMSW's *motivation* to enter prostitution that forms the first indicator to measure FMSW's agency.

The main reasons cited in literature for women all over the world to turn to prostitution are sexual curiosity, early sexual abuse and economic motives (Vanwesenbeeck, 2001). In literature on the global South however, economic necessity is considered the main motivation (Vanwesenbeeck, 2001; Kibicho, 2009, USAID, 2009). Despite the illegal nature of sex business, high levels of unemployment, unsatisfied needs, financial hardships and poverty in general push many African women to the sex trade as a last resort. Research in Tanzania listed survival, debt alleviation, drug dependency, coercion and a desire for wealth as the main motivations for men and women to enter sex business (USAID, 2009).

3.2.2 Occupational health problems

A second indicator to measure FMSW's agency is protection against health problems and violence. Research on female minors involved in prostitution shows that FMSW often become victim to physical and sexual assaults, robbery, (gang) rape and health problems, such as drug use, risky sexual behaviour, hepatitis B and C, reproductive problems, injuries from violent assaults, etc. (Heilemann & Santhiveeran, 2011). Besides physical hardships, FMSW are also confronted with psychological hardships. Several studies show that FMSW commonly experience depression, post-traumatic stress

disorder, suicidal thoughts and suicide attempts, low levels of self-worth and feelings of acceptance and strong feelings of shame and guilt (Heilemann & Santhiveeran, 2011). Finally, FMSW are also confronted with social hardships, such as homelessness, rejection from society, rejection from hospital and health care, social isolation, bad relationships with their children and broken romantic relationships (Heilemann & Santhiveeran, 2011; Scorgie et al., 2013).

Tanzanian sex workers are confronted with similar hardships as sex workers in the rest of the world (ILO, 2001; Kibicho, 2009; Ghoshal, 2013; USAID, 2009). Harassment by law enforcement agents forms an additional problem (Kibicho, 2009: 150, Ghoshal, 2013: 3). Research suggests that the police also targets children in the commercial sex trade, by means of extortion for money and sexual favours.

These hardships have a severe impact on the physical, mental and social well-being and health of sex workers in Tanzania. The number one concern of the vast majority of sex workers in Eastern Africa is health (Kibicho, 2009). Despite the great importance they account to health, they are confronted with barriers that hinder their access to health care services.

3.2.3 Medical needs and access to health care services

Sex workers' health problems are mostly related to sexual and reproductive disorders. Sex workers in Tanzania are particularly vulnerable to HIV/aids and other STDs, unintended pregnancies and sexual, emotional and physical violence (Elmore-Meegan, Conroy, Agala & Bernard, 2004 in Okal et al., 2011: 612-613; The DIFFER Consortium, 2013; Ghoshal, 2013, USAID, 2009). While HIV prevalence has decreased among the general population in Tanzania mainland, it has increased among sex workers (Ghoshal, 2013: 2). HIV prevalence among the general population is estimated around 5 to 7 per cent on the Tanzanian mainland (USAID, 2009; Ghoshal, 2013). This inequality between female sex workers and women in the general population suggests that sex workers are not being reached by health care services.

On Zanzibar, the ratio is 12,8 per cent among female sex workers compared to 0,6 per cent among women in the general population (ZAYEDESA, 2014). Recent research shows that the HIV prevalence among sex workers decreases more quickly than among the general population, suggesting that policies implemented by the Zanzibarian government that target key populations and efforts done by social organisations bear fruit.

Yet, the prevalence of HIV among commercial sex workers remains higher than among the general population. The question then rises why sex workers remain a hard to reach population for health care services. Most sex workers in Tanzania do not dare to expose their profession because of the illegal character of prostitution and they mistrust hospitals because they are often stigmatized by staff (Ghoshal, 2013: 31). The severest barriers to health care services are denial of health care, verbal abuse, harassment and violations of confidentiality, requirement to submit *Police form Number 3*[3] before treatment and requirement to bring your partner (Ghoshal, 2013).

To date, empirical research has not focused explicitly on minors and their difficulties in obtaining access to health care. The most recent research on child and adolescent prostitution in Tanzania dates from 2001 (ILO, 2001) and does not explicitly address access to health care services. Yet it is plausible that underage sex workers are confronted with other specific or extra barriers.

FMSW's attempt to access health care services serves as a third indicator to measure FMSW's agency. Variation in success in accessing health care services will be analysed. A thorough understanding of the sex workers' experiences in coping with health problems and in trying to access

[3] Form that police must fill out before most Tanzanian hospitals will treat victims of assault.

health care services can help to develop appropriate interventions to improve FMSW's access to reproductive and sexual health care services.

3.2.4 Agency in coping with structural constraints

To measure agency, this research examines the ways FMSW cope with the structural constraints discussed above. Agency comprises two aspects: the possibility/capability to act within a specific space and the actual acting (Franzosi, De Fazio & Vicari, 2012). Analysing the action alone (e.g. entering prostitution) does not offer sufficient insight in agency. The question is whether respondents acted (e.g. entered prostitution) by choice or because of constraints on their possibility or capability to act (e.g. poverty). If constraints reduce their possibility to act, agency can also be studied in the way FMSW cope with these structural constraints.

The focus will be on the intersection of the axes of intentionality, rationality and power (Hewson, 2010). FMSW occupy different places on each of these axes, resulting in different amounts and types of agency. Individual and collective agency are two types of agency that will receive special attention because of the development potential cited by Ibrahim (2014).

The focus on intentionality, rationality and power results in a research design containing the following questions:

1) Do the responses of FMSW reflect intentionality? What are FMSW's goals? Are they the result of conscious choice or rather of coincidence? Is the FMSW's coping with structures to reach this goal intentional?
2) Do the responses also reflect rationality? Are FMSW well-informed or do they lack important knowledge on how to reach their goals?
3) To what extent do FMSW have power within precarious situations?
4) Most importantly, do the different positions of FMSW on these axes result in different amounts and types of agency and how can these types be defined?

4. METHODOLOGY

4.1 Study sites

This research was conducted in two different sites in Tanzania. The first study site was Stone Town on Zanzibar Island, where ZAYEDESA[4] implements an HIV prevention program and provides STD services for key populations through a targeted clinic. Many of the sex workers interviewed at the drop-in centre of ZAYEDESA also attend the public hospital Mnazi Mmoja, which offers a targeted department within the general hospital[5].

Two places in Morogoro Town on the mainland comprised the second study site. The first field, *Itigi*, was located along Dar es Salaam road, a major transport route connecting the Pwani and Morogoro regions. At Itigi, the interviews were conducted in the rooms of *Kwetu Hotel*, a small hotel located at a truck stop. On the other study field, the research took place in the patio of the brothel close to two bars in Morogoro's city centre called *Kahumba Night Bar* and *Moro Night Bar & Guesthouse*.

[4] ZAYEDESA (The Zanzibar Youth Education Environment Development Support Association), a non-profit organisation, was founded in 1998 with the noble vision of tackling the socio-economic problems that youngsters face, such as unemployment, school drop-out, drug abuse, HIV/aids and mismanagement and abuse of their natural environment. ZAYEDESA offers targeted health services for key populations, i.e. commercial sex workers, men who have sex with men and intravenous drug users.

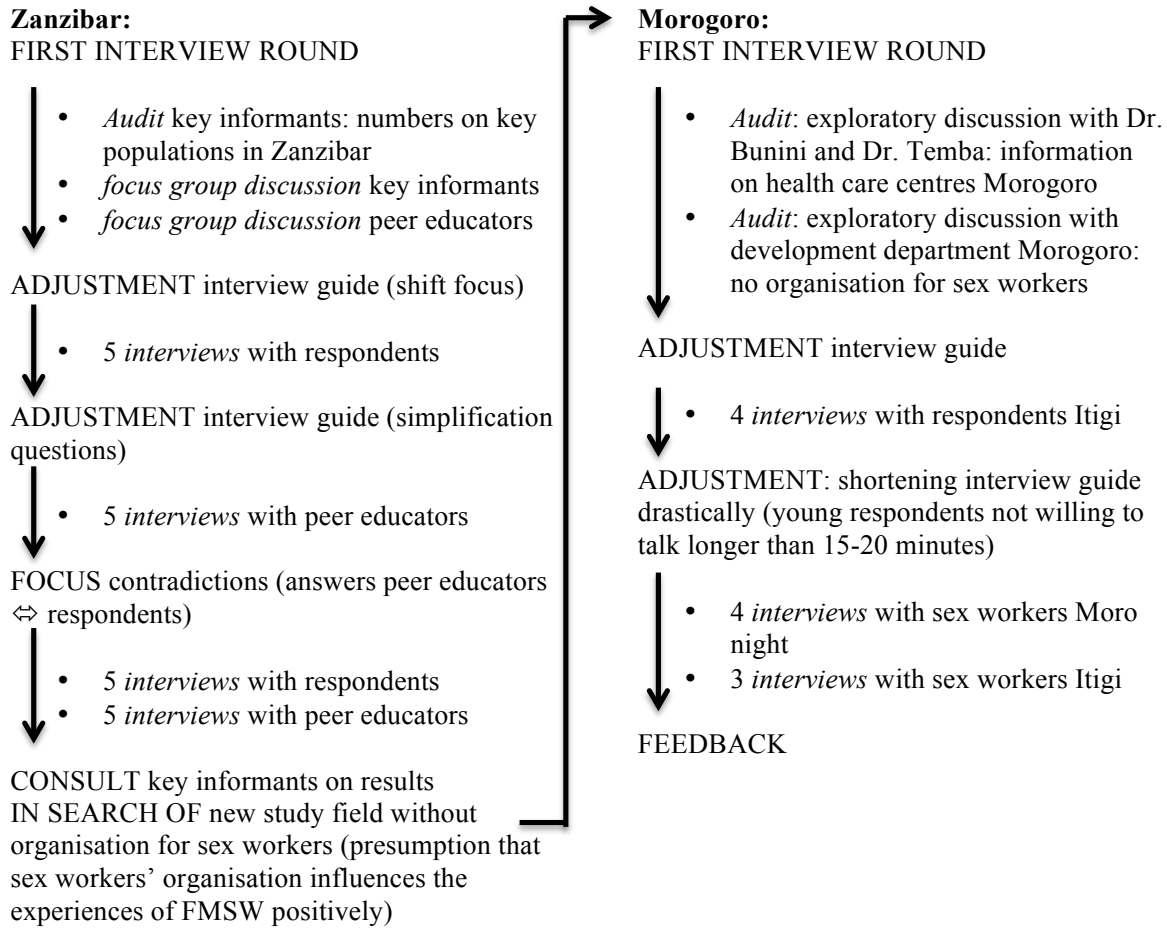
[5] Mnazi Mmoja is a public hospital in the centre of Stone Town with a targeted department for key populations that offers special services for sex workers on Thursdays and Fridays.

Morogoro has a public hospital and three missionary hospitals. Scada Youth Empowerment Project Association NGO aims to educate sex workers on health issues, but most sex workers are unfamiliar with this organisation.

Zanzibar and Morogor were selected as this research's study sites because they allow to compare the experiences of FMSW for whom an empowering sex workers' organisation and targeted clinics are available with those of the group lacking these institutions.

4.2 Method

Figure 1 Method



This research focused on a) FMSW's experiences of entering prostitution, preventing occupational health problems and violence and accessing health care services and b) the ways in which FMSW exercise agency within these processes. Because of the knowledge gap on minors in prostitution, the study adopted qualitative research techniques to explore the topic. In-depth interviews and focus group discussions were used to understand the motivations and rationality behind the actions: two focus group discussions with four key informants (i.e. co-operators of ZAYEDESA) and four peer educators of ZAYEDESA, 19 in-depth interviews with sex workers who entered prostitution before the age of 19 and 11 in-depth interviews with sex workers who started at the age of 19 or older (figure 1)[6].

[6] On Zanzibar, an audit with key informants (i.e. co-operators of ZAYEDESA) was held to obtain information on sex workers and on the available health care services and organisations for sex workers. Two focus group discussions were conducted with 4 co-operators and 4 peer educators of ZAYEDESA, by means of a semi-structured interview guide. Based on the audit and focus group discussions, the interview guide was adjusted. After interviewing 5 respondents who started as a minor, the interview guide was simplified given the respondents' difficulties to understand the questions. After interviewing

Key informants and peer educators were invited beforehand for a focus group discussion at their convenience. On Zanzibar, peer educators and outreach workers of ZAYEDESA were sent out to recruit respondents. Working with peer educators has two benefits: on the one hand, they are able to approach relevant sex workers, while on the other hand, sex workers will be more likely to participate because they trust the peer educator.

The interviews were conducted with a standard interview guide to direct questioning around certain topics, but if desirable, replies could be further explored through probing. Before the actual data gathering, the interview guides were translated to Swahili and the interpreters were educated on unbiased ways of formulating questions and probing. A second interpreter crosschecked translations. During the interview, questions and responses were translated into English, as to make sure that the researcher stayed in control of the interview process.

On Zanzibar, the interviews took place in ZAYEDESA's drop-in centre. In Morogoro Town, a snowballing approach was used and respondents were interviewed on the spot, i.e. in bars, brothels and hotels. The first respondent, who was approached by the researcher, was subsequently asked to bring the interviewer into contact with colleagues who met the criteria, more specifically being 18 years or older, being involved in commercial sex work and having started commercial sex work before the age of 19. The respondents were reimbursed with a non-monetary gift and the amount of 5000 Tanzanian shilling in order to compensate for income loss during the interview period and for transport costs. To trigger a chain reaction, respondents received a first non-monetary reimbursement for completing the interview and a second one for recruiting peer respondents.

After obtaining informed consent of the respondents, the interviews were audio-recorded. These recordings were transcribed, manually coded and analysed together with notes made by the interviewer. For this coding and analysis, the principle of grounded theory was applied. Codes were inductively derived from the main interview topics – i.e. background, health problems, quality of and access to health care services, improvement of health care services – and sub-codes were added, depending on the respondents' own answers. In a second phase, frequently occurring topics were analysed and placed in a code matrix, which served as the basis for a final code tree design[7]. The analyses were carried out by means of a careful reading of the coded text fragments and with attention to potential interrelations. In this phase, the findings were subdivided in findings concerning entry, prevention of health problems and violence and access to health care services.

Quotes used further ahead in this article to illustrate certain statements reflect frequently occurring opinions of several respondents. Specific quotes were chosen because of their intrinsic richness on a particular theme. Efforts were made to include quotes of different respondents.

4.3 Ethical considerations

The researcher explained to the respondents that their participation in the study was fully voluntary and that the data collected would be kept strictly confidential and used for this research's purposes

peer educators, the interview guide was adjusted again to explicitly include topics on which previous respondents gave conflicting answers. After interviewing 5 more respondents who started as a minor and 5 more peer educators, the results were presented to and discussed with key informants. An interim analysis of the results suggested that the existence of an organisation and targeted services led to more positive experiences. To test this presumption, Morogoro was chosen as a second study field since these organisations or services were not available there. In Morogoro, two audits were held: one with two medical doctors and one with officials of the municipal development department. The audits showed that Morogoro does not offer similar targeted services or organisations for sex workers. The interview guide was again adjusted: questions on the respondents' experiences with targeted services and organisations were removed. After 4 interviews with sex workers who started as a minor, the interview guide was shortened drastically, because the respondents lacked the patience to participate in an interview for longer than 15 to 20 minutes. With the shortened interview guide, 7 more interviews were conducted at two study fields in Morogoro.

[7] See annex 8.8 Coded transcriptions

only. They were warned that the study would pose a possible time inconvenience and – in the unlikely event that confidentiality would be breached – a risk of their involvement in sex work becoming known to others.

The project proposal was submitted for ethical and human subjects review to the Tanzania Commission for Science and Technology. Approval for study activities was granted by the relevant institutional review board on national, regional, district and municipal level.

All respondents provided written consent. Measures were taken to avoid exposure of the statute of the sex workers and to ensure confidentially and privacy. No names were audio-recorded nor written down in the interview transcripts. Tape recordings and transcripts were password protected and access was limited to the researcher. The interviews were conducted in discrete places.

On Zanzibar, ZAYEDESA provided secure and discrete offices for this purpose. Given the lack of a facilitating organisation in Morogoro, the interviews in this study site were conducted at night in bars, brothels and hotels, in cooperation with employees of the municipal development department. Morogoro's municipal director advised to call on the protection of an undercover police agent, provided by the municipal. Because of the illegal nature of sex work in Tanzania, the presence of police officers might make respondents feel uncomfortable or scare them away. Therefore, I did not seek assistance of police agents, but rather informed the police of Morogoro on the whereabouts and scope of the research, so that help could arrive quickly in case of complications.

4.4 Challenges

Sex workers in Tanzania, especially those who started as a minor, are difficult to reach. Gaining their trust and attention formed a challenge, that was complicated by the different positionality of researcher and respondents. Access was obtained by working in close proximity with peer educators of ZAYEDESA in Zanzibar and being introduced by the owner or *madame* of the bar, hotel and brothel in Morogoro.

On Zanzibar, the respondents were recruited by peer educators. It remains unclear which group of sex workers is not reached this way. It is plausible that sex workers who are linked to ZAYEDESA were reached on Zanzibar, while the women in Morogoro are independent of an organisation. Given the goal to compare the experiences of FMSW who have access to targeted services with those of the unattended sex workers, this does not pose a problem.

It proved difficult for peer educators to find young girls (approx. between 18 and 20) who were willing to expose themselves as sex workers. The main obstacles were the fact that many of them live with their parents, who usually do not know their involvement in sex business, and that young girls are more ashamed and less comfortable with their involvement in sex work than older sex workers. To obtain a more inclusive image of minors in prostitution, sex workers who were older than 18 when they started sex business, but who live and/or work in close proximity with FMSW were interviewed as well. These secondary data complemented and clarified the primary data. These women also provided information on the youngest group of sex workers – around 12 years old or younger – who proved very difficult to reach. This information was not sufficient to draw conclusions on differences between those of 12 years old or younger and those older than 12, which urges the need for additional research.

In Morogoro, the respondents were interviewed in clubs, brothels and hotels during the night. A clear disadvantage of this approach was that many of the girls impatiently waited to get back to work, which resulted in short answers and drop-out throughout the interview. This formed the biggest problem among young respondents, who were restless, excited or giggly, which complicated the interviewing process.

To determine which of them were children when they started sex work, respondents were asked to state their age. To make sure that respondents were honest about their age, verifying questions were used and friends, colleagues and peer educators were asked about the age of the respondent being interviewed. This method showed that at least 4 respondents on Zanzibar, and 2 in Morogoro, might have falsely stated a later age of entry into sex work.

Relying on an interpreter posed a severe challenge, given the lack of influence on the questions' formulation and the lack of understanding of the respondents' exact answers. Furthermore, the prepossession of the interpreter might have had an influence, which became clear in the exact same wording of certain answers. Language also formed an obstacle at moments when respondents reacted emotionally.

The respondents' language skills and general knowledge complicated a neutral questioning, since abstract formulations proved to be too difficult, thus prompting the need of examples for further clarification. After a first interview round, the questions were therefore simplified. Furthermore, both interpreters and respondents would sometimes pick up their phone during the interview.

Lastly, limited time and budget as a result of changes in the original research plan (which was thwarted by safety issues in the proposed study field) formed an important challenge as well. The time span between interview rounds was rather short.

5. FINDINGS

5.1 Profile of respondents

All respondents were Tanzanian. The mean age of the women interviewed in Morogoro was 21 years, with a mean age of entry into prostitution at 17,8 years. Nine out of eleven respondents started sex work at the age of 18 or younger.

Table 1 Respondents' profile

RES	Age	Age entry	Nationality	Educational level	Interview location	Interviewed as
1	36	**18**	Tanzania	Standard 3	ZAYEDESA – Zanzibar	FMSW
2	18	**15**	Tanzania	Standard 3	ZAYEDESA – Zanzibar	FMSW
3	24	**21 (16)**	Tanzania	Standard 7	ZAYEDESA – Zanzibar	FMSW
4	19	**15**	Tanzania	Form 2	ZAYEDESA – Zanzibar	FMSW
5	19	**15**	Tanzania	Standard 7	ZAYEDESA – Zanzibar	FMSW
6	34	26	Tanzania	Standard 7	ZAYEDESA – Zanzibar	Peer educator
7	35	28	Tanzania	Form 4	ZAYEDESA – Zanzibar	Peer educator
8	37	32	Tanzania	Standard 7	ZAYEDESA – Zanzibar	Peer educator
9	32	25	Tanzania	Standard 2	ZAYEDESA – Zanzibar	Peer educator
10	45	38	Tanzania	Standard 4	ZAYEDESA – Zanzibar	Peer educator
11	35	**20 (16)**	Tanzania	Standard 3	ZAYEDESA – Zanzibar	FMSW
12	24	**16**	Tanzania	Standard 4	ZAYEDESA – Zanzibar	FMSW
13	24	**20 (15)**	Tanzania	Form 4	ZAYEDESA – Zanzibar	FMSW
14	22	**13**	Tanzania	Standard 10	ZAYEDESA – Zanzibar	FMSW
15	23	**20 (16)**	Tanzania	Form 4	ZAYEDESA – Zanzibar	FMSW
16	46	36	Tanzania	Form 2	ZAYEDESA – Zanzibar	Peer educator
17	43	33	Tanzania	Form 1	ZAYEDESA – Zanzibar	Peer educator
18	27	20	Tanzania	Standard 6	ZAYEDESA – Zanzibar	Peer educator
19	35	30	Tanzania	Form 3	ZAYEDESA – Zanzibar	Peer educator
20	31	20	Tanzania	/	ZAYEDESA – Zanzibar	Peer educator
21	19	**15**	Tanzania	Standard 7	ITIGI – Morogoro	FMSW
22	24	22	Tanzania	Standard 7	ITIGI – Morogoro	Key informant
23	18	**15**	Tanzania	Standard 7	ITIGI – Morogoro	FMSW
24	25	25	Tanzania	Form 4	ITIGI – Morogoro	Key informant
25	24	**18**	Tanzania	Standard 5	MORO – Morogoro	FMSW
26	19	**18 (?)**	Tanzania	Standard 7	MORO – Morogoro	FMSW
27	18	**16**	Tanzania	No schooling	MORO – Morogoro	FMSW
28	20	**16**	Tanzania	Standard 4	MORO – Morogoro	FMSW
29	17	**16**	Tanzania	No schooling	ITIGI – Morogoro	FMSW
30	20	**17**	Tanzania	/	ITIGI – Morogoro	FMSW
31	23	**18**	Tanzania	Standard 7	ITIGI – Morogoro	FMSW

On Zanzibar, ten respondents started sex business before the age of 18 and thus provided primary data, while ten others started sex work after the age of 18, but currently live in close proximity to or guide underage girls as peer educators, thus providing the research with secondary data. The mean age of this first group was 24,4 years and the mean age at the moment of entry into sex business 15,5. An important observation is that some respondents' answers on Zanzibar showed inconsistencies concerning age. To ensure the accuracy of the data, current ages and ages at entry were double-checked with peer educators and staff of ZAYEDESA. As mentioned before, this showed that at least 4 respondents possibly mentioned a higher age at the moment of entry than their actual age at that time.

5.2 Motivations for entry into sex work

5.2.1 Intentionality

Both key informants and peer educators on Zanzibar agreed unanimously that poverty is the main motivation for underage girls to enter prostitution.

> *"The stories tend to be the same. A lot of them are not in school. They drop out of school because of social-economic reasons and then they sell their bodies for money, because they have to take care of their families and of themselves."* (Key informant, Stone Town)

This was backed by the Zanzibarian sex workers, who all mentioned economic hardships, poverty or a difficult home situation as the main motivations to enter prostitution. Among the sex workers of Morogoro, only two said they are in the business because they like it; the other nine respondents mentioned a difficult home situation, economic hardship and poverty as their main motivation. Most FMSW lost one or both of their parents at an early age. Additional reasons for entry were the need for money to buy drugs or introduction by thirds, i.e. mostly friends or relatives who convinced them that sex work is a lucrative business and an easy way to support one's family.

5.2.2 Power

The answers of all but two respondents clearly show the same *intentionality*, i.e. earning an income in order to support themselves and their families. *Economic constraints* reduce FMSW's *power*, resulting in low or fake agency. Therefore, the "choice" to enter prostitution does not seem to be attributed to their own volition, but rather to the only perceived alternative within a precarious situation. The space within which minors can exercise agency when "deciding" to enter prostitution is thus very limited.

5.2.3 Rationality

Almost all respondents – both on Zanzibar and in Morogoro – said they did not fully understand what prostitution entails before they entered or that the reality turned out to be different than expected. The vast majority believes that they were not mature enough at their age of entry to make such a decision. All but two respondents said they would readily accept any alternative to leave the sex business. Many respondents spontaneously asked for help to leave prostitution, in the form of advice, capital to start their own business or a job. *Cultural constraints*, reflected in limited knowledge and rationality, explained by young age and lack of education and experience, seem to reduce FMSW's ability to predict the consequences of their actions, suggesting low levels of agency at the moment of entry.

5.3 Protection against health problems and violence

5.3.1 Intentionality

Respondents mentioned various health problems caused by sex work, ranging from HIV/aids and other STDs, vaginal fungi or irritation, unintended pregnancies, pain and injuries resulting from being beaten or (gang) raped, pain and fissures caused by the incompatibility of minors' immature sexual organs and big male sexual organs.

> *"Some [clients] have elongated and big [penises], so that may cause a problem to the young ones. But if they are adults, they are familiar with any size; they are ready to serve them. But the younger do not know how to handle it, so that can cause health problems."* (RES 23, Morogoro, 15)

The responses of FMSW all showed the same intentionality, namely avoiding health problems and protecting themselves against violence.

5.3.2 Power and rationality

Remarkably, the vast majority of respondents believed that minors are more at risk of obtaining occupation health problems. The reason for this is that most clients prefer the younger sex workers, because they are considered to be more fresh and attractive. Men believe that FMSW have less chance of being affected with HIV, thus resulting in more clients asking to provide services without condom. The perceived risk of being infected with HIV/aids then acts as protection for older sex workers. FMSW are perceived as "clean", resulting in a higher pressure to provide the services without condom and lower *power* to exercise agency for FMSW. Clients sometimes force sex workers to have sex without a condom. Minors are less likely to be capable to defend themselves when a client tries to remove, break or pierce the condom or to physically attack her.

> *"The problems – like being raped, being beaten and all that – were mostly facing her when she was young, because when she grew up, she knew almost everything, how to fight back. […] You can be beaten by this age too, but it is not that much compared to when she was young. […] At this age, she can fight back."* (RES 1, Zanzibar, 18)

The unequal power relation between FMSW and their clients forms a *social constraint* that limits FMSW's agency. This power relation is further strengthened by stigma, a *cultural constraint* that leads clients to dehumanize and objectify sex workers.

Clients may offer a higher payment for unprotected sex. Most respondents agreed that minors are more readily inclined to accept the money because they are less aware of the long-term consequences and merely focus on the short-term additional income. Again, reduced *rationality* and knowledge, resulting from young age, lack of experience and lack of education (*cultural constraints*), put minors in a difficult situation to predict the consequences of their actions.

Some respondents believed the opposite, i.e. that minors are less at risk of having health problems, because minors are too scared to go outside and find customers, thus reducing the risk of facing problems. Adults are more used to the business and do not shy away from going out and exposing themselves to risks, which therefore results in being confronted with more problems. This suggests yet another constraint on FMSW's liberty and agency: fear hinders them from obtaining their goal (i.e. supporting themselves and their family), thus reducing their agency. Fear of performing the job they

"chose" to obtain their goal again stresses the limited agency they could exercise when "choosing" to go into prostitution. This behaviour does not reflect agency, but rather *negotiation*, which appears as a way of navigating between structural constraints by withdrawing rather than participating. Minors who do not go out to find clients do make an informed/rational decision (i.e. to reduce harm by avoiding the source of harm), but this decision does not bring them closer to their goal and does not alleviate the constraints, but rather avoids them.

A few respondents said that the amount or severity of health problems sex workers face does not depend on age, but on the sex worker's own ability to protect herself or on the behaviour of the client.

> *"The age does not matter. It depends on the person herself and on the customer. Because if the customer decides to tear the condom […] or use her without the condom, it does not matter if she is young or old."* (RES 9, Zanzibar, 25)

The answers of most respondents however suggest that the ability to protect oneself is closely related to one's age and experience in the sex business.

The ability to protect oneself is furthermore related to the motivation for entry into prostitution, which in turn is linked to economic factors. The two respondents who became sex workers because they like the profession, were more able to protect themselves against health problems because a) losing income by refusing clients who want services without protection is bearable, and b) they seem to have more self-respect and less self-stigma, resulting in a stronger voice to oppose clients or defend themselves. *Economic constraints* furthermore impact agency in protecting oneself against health problems in a more direct way, i.e. in the ability to afford condoms. Respondents explicitly expressed that they want to protect themselves through the use of condoms, were it not for their lack of money.

FMSW are thus confronted with more constraints (economic, social and cultural) than adult sex workers in protecting themselves against health problems and violence, though in varying degrees. This variation can be attributed to *cultural constraints*, more specifically to differences in cultural constraints between FMSW who benefit from ZAYEDESA and those who don't have such an organisation at their disposal. FMSW on Zanzibar have more knowledge on the prevention of health problems as a result of outreach work and sensitisation by ZAYEDESA. Furthermore, the support of the organisation seems to empower FMSW and to encourage them to think about themselves as human beings with rights. Knowledge on prevention and a better self-image seem to result in a higher capability to prevent health problems and violence. The respondents indicated that this stronger position was also the result of experience, older age and peer education. It can therefore be argued that, while *individual agency* is strongly limited by social, economic and cultural constraints, *collective agency* is an important way forward to help FMSW navigate within severely constraining structures. FMSW on Zanzibar, who can rely on peers and an empowering organisation, demonstrate more agency than their peers in Morogoro, for whom these benefits are not available.

5.4 Access to sexual and reproductive health care services

5.4.1 Intentionality

When asked about their reaction to health issues, some FMSW showed very few intentionality by stating they did not really do anything about it. Most however said they would try to cure themselves or seek medical assistance – mostly from official hospitals, but sometimes from witch doctors or traditional healers. The responses showed that FMSW are confronted with multiple barriers complicating their access to health care services.

5.4.2 Power

Respondents in Morogoro mentioned the high cost of health services as an obstacle. On Zanzibar, two respondents said that some doctors and nurses ask money for medicines that are supposed to be free of charge.

> *"It is free, but sometimes the doctor or nurse can say, like: 'We don't have pills, medicine or injections […] but if you give me 5000 [shilling], I can look somewhere for you.' So she thinks they are there, but they just pretend they are not available, so that one can give them […] money."* (RES 13, Zanzibar, 15)

The high cost of health care services in private hospitals is an *economic constraint* for many sex workers. Public hospitals offer health care services for key populations free of charge. Some respondents mentioned that even in public hospitals doctors or nurses sometimes ask for money. A few FMSW said they would not go to private hospitals because of the high costs, but neither to public hospitals because of the stigma.

The Zanzibarian respondents mentioned stigma as the strongest barrier in seeking professional health care.

> *"[…] because people are scared and stigmatisation is also one of the reasons. Because other people are like: 'Oh, she is a sex worker' and 'she is HIV positive'. So they will start discriminating her."* (RES 10, Zanzibar, 38)

Stigma thus forms a severe *cultural constraint*, reducing FMSW's agency. Many of the Morogoro respondents who started as a minor however said they always go to the hospital whenever they face health problems. Most of these women however did not tell the hospital staff about their profession. When asked why they did not inform the hospital staff, they answered that sex work is not considered to be a good job and hospital staff might stigmatise them or treat them badly.

Despite the different ways of coping with it, stigmatisation proved to be the biggest obstacle, both in Morogoro and on Zanzibar. The opinions on the severity and nature of stigma varied. Respondents on Zanzibar stressed that stigmatisation is a problem in the hospitals, but also – and maybe even more – in the community as a whole. Some peer educators and sex workers who started as an adult, both on Zanzibar and in Morogoro, were remarkably more positive about the attitude of health care providers. Some expressed the opinion that minors delude themselves in thinking that the hospital staff stigmatise them or gossip about them, which results in avoiding the hospital and the endurance of their prejudices.

Sex workers who started as a minor agreed that *expected* or *perceived* stigmatisation is the biggest obstacle: FMSW expect to be treated differently or to be stigmatised by the environment, without having experienced so, or are highly sensitive, resulting in interpreting routine behaviour of hospital staff as stigmatizing or insulting.

Despite the severe barrier formed by *fear* of stigmatisation, *actual* stigmatisation seems to be less of a problem for FMSW on Zanzibar. Most respondents who did not dare to go to the hospital when they were younger, did seek medical assistance in recent years, allowing them to experience the actual treatment by hospital staff. All but one said that stigmatisation in the hospitals and health care centres is minimal or absent and that hospital staff are mostly friendly and understanding and provide the sex workers with advice and help. Respondents said that it has become easier for them to attend health care services, because their experience has shown that the hospital staff is cooperative. Only two out

of ten Zanzibarian respondents said they were not satisfied with the health care services provided. They mentioned being asked for money in order to receive treatment, simply being denied health care or being insulted and stigmatised when the hospital staff know they are sex workers. Three respondents said that health care services on Zanzibar are perfect and hospital staff are friendly and cooperative. The others all agreed that most doctors and nurses are friendly, but some tend to stigmatise or insult them when they know they are commercial sex workers.

One respondent on Zanzibar who started in the sex business when she was 13 years old and did attend health care services at that age talked about experiencing a bad attitude by the hospital staff. This possibly shows that minors are more sensitive to presumed judgements and more self-conscious about their involvement in sex business. It could be argued that this reflects lack of experience rather than young age. Yet, respondents who started at a later age and who only recently entered prostitution at the moment of the interview did not display the same sensitivity towards criticisms. Lack of experience might be a contributing factor, but age does seem to have an impact on how treatment by hospital staff is experienced. This higher sensitivity was also reflected in the higher self-stigmatisation among FMSW. This suggests that confidential and adolescent-friendly services are needed.

Although the constraints FMSW face in Morogoro and on Zanzibar are the same (i.e. stigma and high costs), their experiences are different. In Morogoro, only three out of nine respondents who started sex work as a minor reported a positive experience. This can be attributed to differences in agency reflected in different coping strategies. To cope with high costs, FMSW in Morogoro and on Zanzibar seek health care services free of charge. On Zanzibar, FMSW can find these free services at a targeted department within the public hospital and at ZAYEDESA. In Morogoro, FMSW can attend public hospitals for free services, but these are not targeted. To cope with the cultural constraint of stigmatisation, FMSW on Zanzibar avoid going to the hospital, while FMSW in Morogoro did go to the hospital, but without mentioning their profession. The fact that they did seek medical help suggests that they have more agency than their peers on Zanzibar, who said that they did not go to the hospital when they were younger. Yet, by concealing their job as a sex worker, they do not exercise full agency in order to achieve their goal – i.e. receiving proper treatment – but rather *negotiate* constraints and only partially reach their aim – i.e. receiving treatment that might not be adjusted to the exact complaints.

Avoiding medical help all together brings Zanzibarian FMSW further from their goal than those in Morogoro who might not receive the most accurate treatment, but do receive some check-up. Yet, throughout their career, they seem to find the courage to go to the hospital and fully expose the cause of their health problems and the nature of their job. The reason for this change during their career can be found in collective agency. FMSW on Zanzibar can rely on peer networks, empowerment and education supported by ZAYEDESA, which strengthens their sense of self-worth and their resilience against stigma. This was also reflected in the way they spoke about themselves and their rights: sex workers on Zanzibar remarkably referred to themselves as *dada poa* (lit. "cool sister") or *changudoa* (i.e. a fish in the Indian Ocean that attracts other fish with its beauty). In Morogoro however, the women talked about themselves as *malaya*, which can be translated as "whore" and is considered to be a disrespectful word. While the sex workers interviewed on Zanzibar easily talked about their rights and how their situation could be improved by educating the community and hospital staff, sex workers in Morogoro showed some hesitation in expressing their needs and mostly imposed on themselves a higher responsibility:

> *"All Tanzanians know that prostitution is an illegal business, so she wouldn't expect there to be a special ward for prostitution. […] They [FMSW] should make it a routine process to go and get their health checked in a hospital and they should be much more careful in doing the prostitution business." (RES 25, Morogoro, 18)*

In Morogoro, six out of nine FMSW said that minors should receive education on health and risk behaviour, thus stressing FMSW's own responsibility. Two believed that health care providers should be educated.

Only two out of ten FMSW on Zanzibar mentioned education of sex workers as a way to improve their health situation. The other eight said that the health situation of FMSW can be improved by educating both health care providers and the community, improving the availability of resources such as condoms, injections and pills, assuring that the services are free and that doctors or nurses do not ask for bribe money to improve or speed up the treatment, employing more specialised doctors and appointing peer educators who work in the hospitals and take FMSW under their care. According to the Zanzibarian sex workers, the responsibility for their health lies mainly with the hospitals and community, while most FMSW in Morogoro blame themselves and *reconcile* in their second-class citizenship. Agency is thus expressed in different ways: collective agency among FMSW on Zanzibar and *reconciliation* (or very low agency) in Morogoro.

This difference can also be contributed to the fact that the women interviewed in Morogoro were found in the streets, bars and brothels, while peer educators of ZAYEDESA recruited the women who were interviewed on Zanzibar. While it is likely that the sample on Zanzibar mainly included sex workers who are willing to identify themselves as sex workers and to testify about it, this also shows that the efforts of ZAYEDESA to empower sex workers and to make them aware of their human rights bear fruit. A similar organisation does not exist in Morogoro, seemingly resulting in sex workers being less aware of their rights and acquiescing in their discrimination and marginalisation. This suggests that sensitisation and empowering organisations alleviate cultural constraints on FMSW's agency and facilitate health care seeking behaviour.

Respondents were furthermore asked which kind of health care service they preferred. All FMSW preferred a targeted health care service exclusively for sex workers. Half of them preferred this targeted health care service to be an exclusive hospital, like the health care centre of ZAYEDESA, because the services provided by such centres are free and because stigmatisation is much lower.

> *"[…] she prefers the specific hospital for sex workers, because […] she can be open, because the doctors and nurses already know that she is a sex worker, so it will be easier for them to help her. Instead of going to Mnazi Mmoja and introducing her as a sex worker."* (RES 14, Zanzibar, 13)

The other half preferred a targeted department within the hospital for the general population, like the department within Mnazi Mmoja public hospital. The reason given by most respondents is that the department within the general hospital offers more anonymity.

> *"[…] like Mnazi Mmoja, you cannot know if the person is a sex worker […]. You will just be mixed. Nobody can know that this one is looking for this, or this one is looking for such kind of service. That's why she prefers that. But for the specific hospital for sex workers, everybody […] is saying like: '[…] she is a sex workers, because she is getting services from here.'"* (RES 1, Zanzibar, 18)

Despite the different preferences, the motivation behind the choice remains the same, namely safeguarding one's anonymity in order to prevent stigmatisation.

Eight out of ten respondents interviewed in Morogoro said they preferred a targeted health care service, exclusively for sex workers. The reasons for this differed from those cited by the respondents on Zanzibar, who focused mainly on anonymity, while the respondents in Morogoro cited more practical reasons: a specialised department within the general hospital would speed up the health care

process, because sex workers would be registered and thus more easily treated. Another respondent said that these targeted services – both specialised hospitals and targeted departments within the general hospital – should be located close to the location where sex workers mostly operate, so that they can easily drop by for a check-up during working hours. Two respondents expressed their preference for a targeted hospital because the staff at this kind of hospital is fixed and thus knows the sex workers, which results in a more understanding relationship and less stigmatisation.

> *"Why she prefers like the centre exclusively, and not the centre in the hospital, is because if you build a centre in the hospital, the workers keep on changing shifts, so maybe the day you go, […] you find a worker, then the next time, you find a different worker. Then you will face the same problem of stigmatisation. However, when the centre is exclusive, out of the hospital, the problem of stigmatisation is reduced, because now they know that the centre is specifically for the young, for the minor sex workers. So the problem of stigmatisation will be reduced."* (RES 27, Morogoro, 16)

Two respondents however said to prefer a general hospital: one out of fear to expose herself as a sex worker by going to a targeted health care service, while the other believes there is no difference between sex workers and other women, so they should not be separated.

> *"Because we are human beings, the health services shouldn't separate us."* (RES 21, Morogoro, 18)

Despite the different preferences, the motivation behind the choices remains the same: avoiding stigmatisation. Some FMSW choose a targeted hospital because they expect stigmatisation among the hospital staff to be lower. Others choose a targeted department within the general hospital because no one can know they are headed for the sex workers' department. A few respondents choose to go to a normal hospital without telling they are sex workers, so stigmatisation becomes impossible. Even the respondent who believed that health care services should not be separated expressed the aspiration not to be stigmatised, but treated as any other human being.

That avoidance of stigmatisation is FMSW's main concern should not come as a surprise: the above has shown that stigmatisation – whether in the hospital, in the community or through self-stigmatisation, whether perceived, expected or actual stigmatisation – poses the main barrier in accessing and receiving health care services. Stigmatisation poses a severe constraint on the spaces in which FMSW can exercise power and thus agency.

5.4.3 Rationality

In accessing health care services, FMSW's rationality corresponded to their rationality when protecting themselves against health care problems. Those who were aware of the health dangers of sex business were more likely to (try to) attend health care services, while those who were less aware of the importance of health issues would attend witch or traditional doctors or not seek medical assistance at all.

6. CONCLUSION AND DISCUSSION

The agency-structure debate has been central to sociology from the start. Today, most sociologists agree that agency and structure cannot be separated: agency is always constrained by structures and people can always exercise some degree of agency within social structures. The same discussion is

central to the feminist wars on prostitution, centring around the question whether people can freely choose to be a sex worker. However, this important debate is forgotten when it comes to FMSW, assuming a total lack of agency for this group instead. This research focused on FMSW in Tanzania 1) to challenge the de facto victimisation of FMSW and 2) to investigate how agency can take form within the most constraining social structures. Rather than employing a dichotomous approach (agency – no agency), attention was paid to different positions on the axes of intentionality, power and rationality, resulting in different amounts and types of agency exercised by FMSW to navigate within structural constraints.

Postmodern prostitution scholars have often warned against victimising sex workers, because the victim/agent distinction can obscure a complex reality. However true and important this warning is, it should not make us fearful or reluctant to articulate the precarious situations in which many third world girls and women who turn to sex work find themselves. Without wanting to deny their agency, I think it is important to acknowledge that all but two girls said they did not fully understood what sex work meant before they entered; they did it because a difficult home situation and poverty forced them to do so and they would readily accept any alternative so they could leave the sex business. When asked whether FMSW are mature enough to choose to go into sex work, one of the key informants of ZAYEDESA answered:

> *"Is hardship a choice? Is poverty a choice? I think that's the question to ask yourself. I think they do it out of necessity. […] I mean, they are selling their bodies for 3000 shillings [€1,40]."* – *"1000 shilling [€0,50] sometimes."* (Key informant 3 and 1, Zanzibar)[8]

Most Tanzanian FMSW turn to prostitution because of economic hardship, hoping that sex business will help them to survive and support their families. Lack of agency at the moment of entry is not universal; research on sex work in the West for example has shown that sex workers can exercise agency when entering prostitution[9]. However, when it comes to FMSW in Tanzania, agency at the moment of entry is very low.

Sex business in turn often leads to more hardships in terms of physical and mental well-being. This research showed that minors are disproportionally burdened with occupational health problems, because their young age not only attracts more customers in general, but also more customers who want to have unprotected sex with them, believing the girls are not yet infected with HIV. Despite the heavier burden of health problems, FMSW feel more reluctant to seek medical care, resulting in late or lack of treatment.

The findings thus show that FMSW's agency is severely limited by economic (poverty), cultural (stigma and lack of knowledge/education) and social (unequal power relations) constraints. These constraints influence FMSW's positions on the axes of intentionality, rationality and power, resulting in different amounts and types of agency.

Most FMSW's entry into sex work is strongly determined by poverty. Prostitution for them is a way of survival rather than a choice. The negative motivation to enter prostitution impacts the rest of their career.

In protecting themselves against health problems and violence, FMSW are limited by economic (money for condoms), cultural (lack of knowledge of/education on health issues) and social (unsafe sex forced by clients) constraints. Some FMSW do not go out to fiend clients, as such avoiding health problems and violence, but also reducing the opportunity to obtain their goal of earning an income. This is a form of semi-agency or *negotiation*. While FMSW in Morogoro *reconciled* in stigmatisation

[8] To compare: a soda costs 1000 Tanzanian shilling
[9] inter alia Bernstein, 1999, 2001, 2007; Chancer, 1993; McClintock, 1993

and dehumanising treatments by clients – and thus in exercising very few agency – FMSW on Zanzibar benefited from networks of peers, education on health issues and empowerment by ZAYEDESA. Sensitisation and empowering organisations alleviate cultural constraints (lack of knowledge on health issues). The higher agency in coping with cultural constraints comes mainly from outside the sex workers. Sex workers themselves do not try to find ways to compensate their lack of knowledge on health issues – because they are unaware of their knowledge gaps. Initiatives that aim to educate, empower and sensitise sex workers are therefore crucial to increase FMSW's agency. These initiatives can furthermore strengthen informal networks and FMSW's self-esteem, resulting in higher *collective agency.*

Economic (poverty) and cultural (stigma) constraints limit FMSW's agency in accessing health care services. Economic constraints can be overcome by turning to public hospitals (although some respondents mentioned being asked for money there too). Yet, many FMSW say that stigmatisation is the actual barrier hindering them to seek medical help. Three different types of agency appear when looking at the coping strategies that FMSW employ to overcome this barrier. First, some *reconcile* (very low agency) in their precarious situation and do not seek medical assistance, resulting in worsening diseases and sometimes even dead. Others do attend a doctor, but are not open about the cause of their health problems and the nature of their profession. This form of semi-agency or *negotiation* allows them to avoid stigmatisation, but also entails the risk of getting an inaccurate treatment. A third group, represented by respondents on Zanzibar, relies on *collective agency*. Again, an organisation for sex workers improves FMSW's situation, both by softening the constraints (e.g. by sensitising the community and hospital staff) and by empowering sex workers and encouraging them to see themselves as full humans with rights, resulting in higher resilience against gossip and stigmatisation.

The structure/agency dichotomy within sociology and victim/agent binary within feminist theories on prostitution prove inadequate. Structural constrains – poverty, interpersonal power relations, lack of education and stigmatisation – negotiate FMSW's individual agency and within these structures FMSW are no passive victims nor free agents. The lower levels of agency do not derive from lack of intentionality – FMSW had the obvious goal of survival – but rather from a low amount of resources and abilities (*power*) and a lower *rationality* to guide their actions and predict the consequences. Yet, within severely constraining structures, FMSW show different positions on the agency spectrum, ranging from reconciliation, via negotiation, to individual and collective agency.

Therefore, I suggest being careful with labelling minors in prostitution as victim of sexual exploitation, as the WHO argues. I believe it is important to distinguish between an analytical and normative approach (Mahmood, 2005). Portraying them as exploitation victims can serve a normative goal – it allows sensitising a broader audience on the problematic situation of many FMSW – but oversimplifies the reality and burdens FMSW with another stigma. Furthermore, the victimisation approach involves a rescuing discourse that has the idea that FMSW can be "freed" from exploitation by rescuing them from prostitution. Paradoxically, this approach does not pay attention to the many constraints and lack of alternatives and strongly oversimplifies their problematic situation.

Therefore, I argue that, in analytical work and research, it is more productive to see them as sex workers (i.e. human beings who navigate within constraining structures by selling their body and by coping with the hardships of prostitution), because it allows focusing on FMSW's *agency* and taking concrete measures to strengthen this agency and reduce constraints. The agency approach allows focusing on the provision of necessary sexual and reproductive health and other rights, when direct removal of minors from prostitution is not an option. It is important that continuous efforts should be made to protect minors from entering prostitution. Yet, in order to help minors who have already entered, policies and programmes should not be based on the assumption of agentless victims, but rather on the realities, aspirations and needs of FMSW. This research suggests that the way forward

lies in recognising their agency and promoting empowering organisations for sex workers that offer health care services, education and protection of their human rights.

This research involved only few sex workers who started before the age of 16 and even less before the age of 12. Future research should try to include girls who started at a younger age as to compare their experiences with those who started around 16 years or older. More research is also needed on agency of (minor) sex workers in other contexts. As was shown in this research, sex workers' agency strongly depends on the positions sex workers occupy on the axes of intentionality, rationality and power and thus varies between sex workers and contexts.

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8. ANNEX

For annexes see DVD attached.