

Article

Occupational Health and Safety among Female Commercial Sex Workers in Ghana: A Qualitative Study

Andrea A. Antwi¹, Michael W. Ross^{2,*}  and Christine Markham¹ 

¹ Center for Health Promotion and Prevention Research, School of Public Health, University of Texas Health Science Center Houston, Houston, TX 77030, USA

² Institute for Sexual and Gender Health, University of Minnesota Medical School, Minneapolis, MN 55454, USA

* Correspondence: mwross@umn.edu

Abstract: The topic of occupational health and safety (OHS) has been investigated for many years and continues to be a concept often researched today. Generally speaking, OHS research has been centered around food safety, construction safety, transportation safety, fire safety, drug and alcohol testing, health and medical management, and industrial hygiene, to name a few. However, the concept of OHS concerning female commercial sex workers (FCSWs) has rarely been investigated, often neglected, seldom discussed, and is lacking in sound research. Although regarded as the “oldest profession”, commercial sex work (CSW) has consistently been ignored, disregarded, and under-researched due to the illegality and stigmatization of prostitution. This paper reviews occupational safety and health issues faced by FCSWs in Tema and Accra, Ghana, through in-depth interviews, visits to women’s homes, fieldwork, informal conversations, and observations with FCSWs during the summer of May 2012–July 2012. Facets of OHS that emerged among FCSWs included: sexually transmissible infections, risks associated with harassment and violence from police and clients, alcohol and drug use, irregular hospital visits or lack of hospital visits, immigration issues, legal hazards, and working conditions. We argue that CSW be viewed as an occupation in great need of interventions to reduce workplace risks.

Keywords: Ghana; sex work; occupational health; safety; women; risk



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1. Introduction

Prostitution (i.e., commercial sex work), defined by the United Nations, involves the “exchange of money or goods for sexual services, either regularly or occasionally, involving female, male and transgender adults, young people and children where the sex worker may or may not consciously define such activity as income generating” [1–3]. Although one of the few longstanding “professions”, the field of sex work continues to be demeaned, devalued, ridiculed, and dehumanized due to the stigmatization, legality, and morality issues surrounding the profession [4]. Additionally, those engaged in sex work are often discriminated against and viewed in a discriminatory way mainly because of the perception that these individuals are to blame for the breakdown of the traditional family, epidemics of STIs and HIV/AIDS, escalating crime, and the subversion of youth [4,5]. Because of these perceptions within societies, the OHS issues of FCSWs have been overlooked, leaving sex workers (SWs) in danger.

It is important to note that the field of sex work is vast and encompasses individuals from different backgrounds. Men and women, young and old, are all involved in sex work; therefore, it is important to acknowledge that those engaged in sex work are not homogeneous [3]. Likewise, individuals are drawn into the field of sex work for a number of reasons ranging from payment of school fees, housing, and basic necessities to unemployment.

Additionally, several other factors, such as family breakdown and abuse, low levels of education, lack of support, lack of awareness of the field, death of a breadwinner, and influence of friends, among other pertinent reasons, may contribute to the entry into sex work [2]. Unfortunately, others are coerced and trafficked into the field [2]. Entry into the field of sex work may be based on free occupational choice or based on poverty and powerlessness [1,6].

In line with Ross, Crisp, Månsson, Hawkes [1], and other researchers, in 2011, Onyango et al. [7] conducted a study among young female sex workers in Kumasi, Ghana. They identified the following factors pushing and pulling adolescents and girls into sex work. Push factors included familial poverty, leaving school early, migration to Kumasi in search of economic opportunities, lack of social and economic support upon their arrival in Kumasi, and unemployment. On the other hand, pull factors included encouragement from friends doing sex work, desire for money and small luxuries, and early experimentation with selling sex, leading quickly to dependence on the relatively high income. Likewise, in a study conducted by Adu-Oppong et al., [8], the vast majority (95%) of the respondents reported that they were in this occupation because of financial reasons. No matter what the circumstance may be in which women and men involve themselves in the field of sex work, it is important that we do not condemn or belittle the people in the field and focus on reducing and eliminating risk in the workplace.

According to Alexander [9], when conducting a Medline search from January 1994 to October 1997 using the terms “prostitution” and “occupational health”, the search generated a null set, whereas a search utilizing solely “prostitution” derived more than 375 citations. Likewise, while conducting a search on Medline using the terms “prostitution” and occupational health” with publication years ranging from 1906–2013, only 39 results were displayed, whereas the search term “prostitution” produced 5670 results. Yet, research continues to focus on HIV/AIDS and clients rather than the occupational health and needs of sex workers.

A paradigm shift needs to occur in which our society focuses not only on the nature of the work or solely on the clients but on the sex workers as well. As we begin to look at sex work with the understanding that it is indeed a profession and not merely “vile” or “disgusting”, we can successfully intervene and deliver sex workers from the traumatic experiences and risks often faced in the workplace by creating and providing CSWs with sound interventions. This study seeks to identify, examine, and analyze the OHS risks among West African women CSWs in order to add to the body of literature on OHS and assist public health practitioners, health ministries, researchers, medical officers, as well as other notable individuals in creating interventions for the women engaged in sex work.

2. Location

This study was carried out in the Greater Accra Region of Ghana. According to the Greater Accra Regional Co-Ordinating Council [10], the Greater Accra region is the second most populated region after the Ashanti Region. It comprises five districts: Accra Metropolitan Area, Tema Municipal Area, Ga East District, Ga West District, Dangme West District, and Dangme East District. With a population of 4,010,054, the Greater Accra region occupies a total land surface of 3245 square kilometers and accounts for 15.4 percent of Ghana’s total population. In terms of religious groups in the Greater Accra Region, Christians comprise the largest religious group (83.0%), followed by Muslims (10.2%), those who profess no religion (4.6%), and believers/followers of traditional religion (1.4%). Regarding education, sex differences persist at the senior secondary schools and continue to increase to the tertiary level, favoring males over females. Lastly, males are 1.5 times more likely than females to be employees. Due to some of these factors, females are often undereducated or uneducated and typically unemployed, leading to their entry into sex work.

While the exact figure of FCSWs in Ghana is unknown, their population is estimated to fall between 47,780 and 58,920, with individuals entering the field daily [11]. To determine

the OHS issues among FCSWs, a qualitative study was conducted among FCSWs in two of the five districts of The Greater Accra region.

3. Methods

During the summer of May 2012–July 2012, the first author conducted a practicum with a non-profit Civil Society Organization (CSO) in two locations in Ghana: Tema and Accra. As part of the Practicum experience, she was charged with conducting an investigation to evaluate whether services provided by the non-profit Civil Society Organization met the needs of the women who utilized their services. Furthermore, she was tasked with researching occupational health and safety among FCSWs on behalf of The University of Cape Coast. The study design for this research involved in-depth one-on-one interviews, in which quantitative analysis was not utilized.

During the first author's work with the non-profit Civil Society Organization, she was stationed in the community, also known as the "field", from Monday through Friday. Most of the day was spent assisting peer educators in educating the community on HIV/AIDS and STIs, condom use, and the importance of visiting the clinic, among other vital issues. She built relationships with the women during this time. Through the course of several weeks, she began to conduct in-depth one-on-one interviews with the women about the services they received from the non-profit Civil Society Organization, their daily lives, and the issues they faced in the field of sex work.

In-depth interviews were conducted anonymously with no link between the responses and the respondents (i.e., pseudonyms were given to FCSWs), in addition, to observations, fieldwork, and home visits. FCSWs were approached and told the nature of the interviews and provided with the knowledge that an incentive would not be provided; however, those who participated were informed that the information would be used to add to the body of literature on OHS and that the information could assist in reducing workplace risks for themselves and other FCSWs.

FCSWs who gave their verbal consent were asked a set of 15 open-ended questions pertaining to their health status, risks faced at work by clients and other individuals, their daily lives, entry into the field of sex work, condom usage, among other questions pertaining to age, marital status, and place of birth. Based on an extensive literature review, these 15 open-ended questions were developed to identify, examine, and analyze OHS among FCSWs. Although 15 open-ended questions were posed to the respondents, further detailed information arose through informal conversations, observations, and fieldwork with FCSWs conducted during the summer of May 2012–July 2012. A total of 19 FCSWs were interviewed from Tema and Accra, Ghana, and over 50 FCSWs were observed and engaged in informal conversations.

In Accra and Tema, two main categories of FCSWs were approached, "roamers", those who are mobile and travel to actively seek clients, and "seaters", who are stationary and work out of their homes or brothels [7,11].

Through the many encounters with the FCSWs, they were friendly, open, and engaging. Those who denied participation in the study feared they would be exposed or put on television. Because of this fear, assurance was given to the women that this would not occur. With this explanation, some women agreed to participate, and others still refused to participate.

3.1. Participants

The inclusion criteria for this study were intentionally broad to allow for diverse experiences from various age groups, educational levels, marital statuses, religions, ethnicity, and other demographics. The women we visited were asked whether they would like to participate in the study. The first 19 individuals to consent to participating in the study were included. The sample criteria excluded males, individuals who had a mental diagnosis or cognitive delay, those under age 18, and participants whom a linguistically appropriate translator could not be obtained to translate.

The average age of the participants was 35.3 years, with a minimum age of 25 years and a maximum age of 50 years. Additionally, older FCSWs who have been in the field for several years stated that girls as young as nine join the field, similar to findings from Onyango et al. [7]. All respondents were single. One respondent stated she was divorced. Three respondents stated that they had deceased husbands.

The vast majority of participants reported that they were in the field of sex work due to financial reasons. One informant stated, "My son became ill one day, and I did not have enough money to pay for medical service bills". Another informant stated, "My mother and father died: I have two kids, and I needed the money" (Lizzie, 30). Another echoed the same sentiments and stated, "A friend introduced me to the field, and I knew that I couldn't let my children be hungry". The theme of finances was apparent throughout all age groups and the classification of sex workers (i.e., seaters or roamers). Most respondents saw between 3 to 8 clients a day, with some stating that they saw 10 to 15 clients daily. Respondents noted that the actual number of clients varied per day, for example, during holidays and major events, and that their clientele was not always constant. Others stated that depending on whether or not they spent the night at a client's house or in a hotel with a client; they saw one or two clients per day. Lastly, 84% of respondents stated that they worked 5–7 days a week, with respondents stating, "I work every day; there are no holidays unless you are sick", "I work every day unless I am on my menses", and "All week if it comes".

Key features of this study, compared to other studies, involved the following: (1) participants were not provided with an economic incentive, (2) interviews were conducted "in situ", and (3) verbal consent was obtained from participants. These features increased the validity of the results. Most researchers conducting fieldwork with sex workers offer participants an economic incentive. This economic incentive is usually a small compensation for their time; however, in this study, participants were genuinely interested in the research and sought to explain and describe their lived experiences. Furthermore, conducting fieldwork "in situ" provided the researchers with a deeper understanding of the subject under study and the ability to build trust and rapport among study participants. Lastly, the researchers used "verbal consent" and not "written consent" because of the sensitive and delicate nature of the topic. They did not want to be viewed as overly intrusive or be misconstrued as writing a report for government/police officials.

3.2. Data Analysis

Questions were posed and later written into a notebook to rid FCSWs of fear and suspicion. If the first author felt the women were open and not fearful of her, she asked permission to take notes during the interview. The notes from the in-depth interviews were typed up with all identifying details removed. The transcripts were qualitatively analyzed by emerging themes. The themes of occupational health and safety in CSW were then extracted and tabulated to identify the number of interviews with the same themes. The themes were then discussed with the other authors regarding content and consistency. Once the team agreed upon the themes, a minimum of 2–3 quotes illustrating each were extracted. If a theme did not have a particular quote or more than two quotes, such as immigration, legal hazards, and work conditions, the authors utilized the observations and fieldnotes of the first author to develop and expound on these themes.

The themes which emerged from the in-depth interviews included: sexually transmissible infections, risks associated with harassment and violence from police and clients, alcohol and drug use, irregular hospital visits or lack of hospital visits, immigration issues, legal hazards, and working conditions, which will be discussed in more detail in the subsequent sections and additional anecdotal evidence on the contexts of the CSWs observed by the researcher included in the discussion.

4. Occupational Health and Safety Issues

4.1. Sexually Transmissible Infections

Even though most (95%) of the women stated that they used condoms every time they had sex, almost all respondents spoke regarding vaginal sex. Additionally, one respondent stated that she did not use condoms frequently because “They (i.e., clients) don’t like to use condoms” (Sally, 25). When asked what occurs during these encounters with clients, she stated that she still has sex with them because she knows they are not infected. Because an individual cannot identify whether someone is infected with a virus or disease because of the asymptomatic nature of some diseases, SWs, including Sally, risk the danger of acquiring HIV/AIDS and other STIs due to a lack of knowledge and vulnerability to clients. Adu-Oppong et al., [8] and others have demonstrated that individuals who are knowledgeable about HIV transmission are more likely to protect themselves by consistently using condoms. Respondents indicated that they utilized lubricants with condoms during sexual intercourse; however, the other forms of sex were excluded. Lack of knowledge of transmission routes of STIs and HIV/AIDS during oral sex and anal sex was evident in the research population. Some respondents were not aware that anal sex could lead to HIV, as well as the fact that oral sex could lead to STIs. Other FCSWs in the community also had myths that anal sex would not lead to HIV. Also, when asked the reasoning for using condoms, participants responded, “Because of HIV” (Sharon, 36) and “Always, for AIDS prevention” (Alice, 30). Most respondents used condoms for the sole purpose of preventing HIV/AIDS and not other STIs. Furthermore, there were several misconceptions about the difference between HIV and AIDS due to the lack of knowledge on the topic and the stigma surrounding the topic. Additionally, because FCSWs were unaware of some of the signs and symptoms of STIs, they self-treated and medicated themselves. When asked where they went to receive care or where they went when sick, individuals stated they went to the drugstore or took medication. Moreover, Juliet, a 43-year-old woman, stated, “I had itching, but I went to the drugstore”. The respondent believed that she had a reaction to the lubricant instead of an infection. This is plausible; however, an infection may be another possibility. Furthermore, due to power differentials and lack of power among women in Ghana, respondents stated, “Clients do not like to use condoms”; therefore, they do not utilize them during every sexual encounter with clients because of the fear of violence and abuse from saying no. Surprisingly enough, one SW from the community stated that if infected with HIV that she would spread the virus to others. Because of such attitudes, the importance of condoms for all sexual acts is pertinent.

4.2. Violence

Consistent findings from respondents were that clients physically abused them through beatings, stabbings, and fights. For example, Lisa, age 28, discussed an encounter with a client in which she stated she was beaten to the extent that she received a swollen eye, marks, and bruises; as well as being thrown out in the middle of the night. Jackie, 27, also recounted the time when she experienced physical violence with a client in which she was stabbed. Expressing sadness and anger in her voice and heart, she was unable to do anything because she was financially unstable and needed the money. Moreover, she was unable to go to the authorities because of the illegality of sex work in Ghana. In addition, to receiving physical abuse at the hands of clients, respondents encountered violence of not paying for services. Respondents said, “You go with a client, and they maltreat you, take phone, take money”. Another SW reported the same, “Clients can steal from you when they come into your room; open a knife on you”. As I spoke with Amy, 40, a mother of six kids expressing anger and feelings of sadness and worthlessness, she also stated, “Sometimes clients do not pay after they finish”. Fear of violence was also universal among participants in a study conducted by Onyango et al., [7] in which one woman recounted how a client stabbed her after they had sex while arguing about payment. Moreover, respondents explained that clients sometimes carried weapons and stole money and cell phones from them after sex. Not only is fear of violence from clients an issue, but fear of violence from

police officers is also apparent. FCSWs expressed themes of harassment in the form of arrests, prison, bail, and physical violence from street fighting, raids, and beatings: “The police come and catch the girls, take them and throw them into prison” (Deborah, 27). Lisa also stated, “Police catch you, arrest you, take a photo of you, put in records, and they ask you to pay bail; if you cannot, then you go to court”. Cecilia, 28, also recounted an event in which she faced abuse by police; she stated, “They come to town scatter us, people fall down, and the police are whipping us, sometimes they ask to bring money or phone”. Instead of seeking protection from the authorities, sex workers experience harassment, ridicule, and judgment from police officers and judges as well. One FCSW reported the following, “My sister” (i.e., another FCSW) was wounded with a stone from a client. We went to a female judge, and she looked at us with disgust or like we were less than human and did not help us”. Their human rights to protection were often neglected; instead, they were penalized, regarded as criminals, berated, and told that they should not be doing that “Type of work” or told to stop the job they were doing (Michelle, 25).

4.3. Alcohol and Drug Use

Occupational health is not limited to STIs or even violence; other hazards are also prevalent in the profession. Alcohol and drugs were commonly associated with sex work for one of two reasons: (1) because the nature of the work led to consumption, “If you do not drink you will be shy”, “Not willing to do that (i.e., sex work.) unless you use”, “I smoke while working unless you cannot do it”, “I smoke a lot because I don’t like job and I just work because I have to” or (2) sex work is used as a vehicle to finance a drug habit. Only two of the 19 respondents said they smoked or drank because they wanted to.

Throughout the interviews and personal observations, sex workers mentioned that they smoked and drank on the job. Moreover, work-related stress is a factor in the use of alcohol and other drugs. Stress may arise because of: (1) the number of sexual clients per day, (2) consistent thoughts on plausible ways to refrain from being arrested, (3) thoughts on how to finance their lives, (4) thoughts on how to deal with the proposed sexual encounters, among other reasons. When asked the following question by one informant, “Do you experience stress in your life? she stated, “Yes, at times you may go sleep with a client and realize they have a big penis and you do not want to have sex with them but are forced to have sex with them for the money”.

4.4. Irregular Hospital Visits/Lack of Hospital Visits

Some respondents explained that when they became ill or symptomatic, they went to the drugstore, or they visited the drugstore when they felt sick. In a conversation with Gloria, 34, I asked her whether she received regular testing for STIs or only if a symptom presented itself. Unfortunately, she responded, “Only when a symptom presented itself”. Moreover, when asked what would happen or where she would go if she had an STI, she stated, “I would go to the drugstore”. One SW stated that the lack of “Lolli” (i.e., cab fare) fare kept her from the clinic, in addition to the payment of medication once found ill. Moreover, Juliet, 43, stated that lack of money was the reason for infrequent hospital visits. It was apparent that she was angry at the hospital staff because she stated, “When sick, you will always have to pay”. She believed that it was the duty of the hospital and staff to provide medication to clients free of charge. In addition to lack of money, insufficient time was among the major factors hindering women from partaking in clinic or hospital visits. One respondent stated that she does not go to the clinic. When asked the reason for the lack of hospital visits, she stated, “No time”. Surprisingly, the respondent also believed that she was free of infections and sicknesses, even though she had not been to the clinic or hospital. Surprisingly respondents knew the various hospitals and clinics which they could utilize for services and treatment (i.e., Community 2 Polyclinic and Adabraka Hospital); however, they did not take advantage of the services and unfortunately self-treated themselves. Aside from STI testing, I further investigated the nature of hospital visits by asking respondents how often they received testing for HIV/AIDS; the response to this was very high. Some

answers included, “Every 3 months”, “3 months ago”, “Yes, I have had it 3 times”, and “Yes, I have had it 5 times”. As mentioned previously, respondents stated they utilized condoms for the sake of preventing HIV/AIDS. Respondents also utilized clinics only for the sake of HIV/AIDS screening. It appears that a greater focus is paid towards HIV/AIDS and not on other STIs or illnesses for a variety of reasons, including: (1) the frequent discussion of HIV/AIDS in the media and the community, (2) fear due to the depiction of those with HIV/AIDS in the media and surrounding communities, and (3) the encounter with those affected/infected with HIV/AIDS, which can be detrimental.

4.5. Immigration

Those migrating from neighboring cities in Ghana and those migrating from neighboring countries in Africa face the risk of isolation, disempowerment, lack of services, slander, and harassment, as well as other risks. For example, one Liberian woman who migrated to Ghana from Liberia stated, “They call us refugees, foreigners”. Immigrants such as these face significant barriers to care, such as being harassed and identified as a foreigner. In addition, to being isolated from friends, many foreigners must learn to adjust to a new country and/or region and its rules and regulations. Moreover, those who come from neighboring cities in Ghana to major cities often find themselves without others and without knowledge of how sex work works in that particular city or country, exposing them to many risks and dangers.

4.6. Legal Hazards

According to Alexander [9], the overarching factor that affects the health of FCSWs is the legal climate of sex work. As stated earlier, in Ghana, “prostitution” is illegal. Once caught, the women involved in sex work face arrests, jail time, violence by police officers, and loss of income due to bail. Fear of arrest and harassment by police forces women to go underground and hide, making it hard to reach those needing services the most. Because of the intense law enforcement on the streets and the fear of police raids in particular neighborhoods and street corners, the women hide under trees, in dark places, near bushes, and away from the light, endangering themselves. Moreover, when cars pass by, women quickly approach the car, hoping to obtain a customer without being caught by authorities. Due to the intense law enforcement, a number of effects are apparent (1) sex workers must migrate to other areas in order to avoid arrest (2) sex workers must move from the streets to hotels, and clients’ homes (3) sex workers remain isolated and (4) they do not seek help from the authorities when faced with a current or previous danger. All of these circumstances create the environment for violence, STIs, alcohol and drug use, and stress.

4.7. Work Conditions

Walking through the various communities in which SWs lived and worked, one could see the income differential between the FCSW population and the general population. Often located near polluted areas, one would have to cross over sewage and pollutants to reach the homes of the workers. Moreover, surrounding neighborhoods and communities included drug users, unemployed individuals, and those who committed petty crimes. Additionally, as one walked through some of the neighborhoods of the SWs, one could observe small children playing and running around the community where business took place. This living environment was not conducive to the health and well-being of the children living in the community. Additionally, some individuals lived in confined spaces. In one of my encounters, approximately five young girls lived in the same house held up by stilts. Furthermore, the neighborhoods in which the SWs worked were dark and without any light, making it possible for clients to steal from them and harm them.

4.8. Occupational Health Promotion

Through my encounters with the FCSWs, the topic of finances and income were always mentioned. Through a casual conversation with an SW, she stated that the Landlord

continuously increased rent. She perceived this to be due to the perception of others, especially landlords, that SWs were well off; however, this was not the case for all. Many of the women I came into contact with were struggling to make ends meet as well as fighting off the competition to stay relevant in the market. Many SWs thought it best if organizations and local community officials spoke with the Landlords of the communities to decrease the rent and keep the rent steady. They felt cheated and overwhelmed because they were: (1) in a job they did not like but had to do for financial reasons and (2) they could barely make enough money to pay for rent and sustain their livelihood. Additionally, respondents stated that cab fare allowance or incentives such as free condoms be given to SWs in order to compensate for time lost from work and income lost due to cab fare, medications, and other services. Many SWs stated that if provided with cab fare or incentives, they would use the services at the various hospitals and clinics. Moreover, I also observed that hospitals and clinics were only accessible through public transportation. Additionally, most FCSWs in our sample stated that if provided with another means of work or if they received alternative financial assistance, they would not be in the field; proving the need for other income-generating activities. Important to note that the women sampled were between the ages of 25 and 50 (the average age of participants being 35.3), therefore, their ideas and opinions concerning another means of work or receiving alternative financial assistance may be different from younger sex workers.

5. Discussion

OHS is crucial to the field of sex work as it is to engineering, health agencies, construction sites, and other workplaces. STIs are one of the most well-known occupational risks of SWs. This is mainly due to the nature of their work. According to UNAIDS [2], in several regions, significantly higher rates of STIs and HIV infection are found among SWs and their clients compared to the general population [12]. One common attribute of SW is the encounter with multiple sexual partners. During these encounters with clients, FCSWs may choose not to use condoms or be forced by clients not to use condoms, "They don't like to use condoms". Additionally, breakage in condoms may occur due to friction or dryness. Although engaging in sexual intercourse with multiple partners may increase one's likelihood of acquiring STIs and HIV/AIDS, this may not be the sole factor. A combination of factors that increase women's risk of acquiring sexually transmitted infections includes poverty, limited access to healthcare services and prevention commodities, such as lubricants and condoms [8]; gender inequalities and limited ability to negotiate condom use [8]; social stigma and low social status; drug or substance abuse, compromised sexual interactions; lack of protective legislation and policies and low educational level and knowledge about HIV/AIDS and prevention methods [3]. Because of the lack of knowledge on other STIs, modes of transmission, acquisition, and risk factors; FCSWs are at increased risk of contracting STIs and HIV/AIDS and are placed in excessive danger of acquiring long-term effects of these illnesses, such as pelvic inflammatory disease, infertility, cervical cancer, among others if not diagnosed and treated properly.

Most individuals associate sex work with STIs, yet other occupational risks exist. Alongside STIs, violence is one of the most noteworthy occupational hazards faced by FCSWs [5]. Bletzer, [13], as cited in Ross, Crisp, Månsson and Hawkes [1], identifies two types of violence in the form of physical violence and the violence of not paying for services (i.e., theft), which were both experienced by FCSWs. Moreover, from the many encounters with the respondents, violence encompassed verbal, and sexual abuse, traumatic intercourse as well as emotional trauma. The effects of violence towards women are not merely evident through bruises or scars but through disability, morbidity, emotional scarring, psychological stress, and low self-esteem [5], which all have lasting impacts and consequences on SWs. Instead of being silenced, their voices should be heard, and human rights evoked.

Because of the illegal environment of sex work, FCSWs often fall prey to their clients, feeling not only condemned but defenseless as well. Because SWs are outside of the

protection of the law due to their occupation, they are vulnerable to physical violence. SWs continue to hide and remain invisible because of the fear of being caught by law officials. Due to intense law enforcement, women lose regular clients by relocating to different locations; they must restructure their business daily by deciding to move from the streets to hotels and homes. Additionally, because of the negative connotation around SW and the social stigma of SW and SWs in Ghana, an environment that perpetuates a culture of violence is cultivated and accepted [3]. Onyango and colleagues [7] also recognized the harassment that came from the police in their study. In all four focus group discussions and some in-depth interviews, harassment from the police emerged as a critical risk and was mentioned among respondents. Several respondents reported experiences in which police blackmailed them in exchange for sex. The following quote was representative of reports from many of the participants involved in the study, "The police are worrying us a lot, and if you complain, then they ask you for sex in exchange for our freedom. A lot of these policemen have sex with us because they know we are vulnerable. Often they do not use condoms". Research and services focused on sex workers are much needed to further harm reduction efforts in this highly vulnerable and overlooked population.

Alcohol and drug use pose safety risks to the SWs as well, such as (1) being unable to negotiate prices, (2) poor judgment (or lack of choice) in the selection of clients who may be abusive, and (3) engagement in unsafe sex. Additionally, long-term consequences such as liver disease, gastrointestinal cancers, heart disease, obesity, neuropsychiatric impairment, and pancreatitis, among other health consequences, may arise [1]. While some women drink and smoke to remove shyness or even to perform their job, it is important that they become educated on the risks and hazards involved. Although it is ultimately the decision of the woman whether or not she utilizes drugs or alcohol, it is still an occupational health concern needing attention given that occupational health is an area of work in public health that seeks to promote and maintain the highest degree of physical, mental and social well-being of workers in all occupations [14]. According to the World Health Organization, the objectives of occupational health are threefold, (1) the maintenance and promotion of workers' health and working capacity, (2) the improvement of working conditions and the working environment to become conducive to safety and health, and (3) the development of work organization and working cultures that should reflect essential value systems adopted by the undertaking concerned, and include effective managerial systems, personnel policy, principles for participation, and voluntary quality-related management practices to improve occupational safety and health [14].

Occupational health includes violence and alcohol and drug use; nonetheless, the topic of irregular hospital visits and or lack of hospital visits is almost often never mentioned. During hospital visits or even clinic visits, individuals may be screened, tested, and diagnosed with a host of diseases. Additionally, when ill, the proper medication and assistance can be provided to women. However, due to many reasons, such as lack of money, insufficient time, and lack of transportation and accessibility to clinics/hospitals SWs are not benefiting from the services being provided by the clinics and hospitals. Ultimately, the women in the field are overlooked and neglected, causing their health status to be in jeopardy. Physicians and other healthcare providers play an essential role in preventing and treating STIs and other health issues; therefore, it is essential that physicians and staff bridge the gap between hospital visits and SWs.

Migrating sex workers face cultural, social, legal, and linguistic obstacles to accessing services and information, which are often times more challenging than the residents of that particular country [15]. Instead of isolating these individuals, organizations and interventions must target and incorporate them into the framework to enhance their lives.

One of the most significant barriers to the safety of sex workers is legal. Ideally, one would say that we should seek to legalize sex work; nevertheless, in some regions and parts of the world, this is nearly impossible for various reasons. Laws can be implemented in which police officers are penalized for abusing, beating, whipping, or attacking any individual. Although sex work is illegal, it is unacceptable that sex workers fall victim

to abuse because of their profession. Legalization of sex work is not the only way to reduce hazards in the field of sex work, it is possible to provide protection and social health services to women in prostitution [1,16]. For example, in Papua New Guinea, an intervention targeting police officers was embarked upon. SWs in Papua New Guinea who were part of a targeted intervention to prevent HIV, reported rape and harassment by police officers as a serious issue. The intervention sought to target police officers in order to reduce the practice of group coercive sex. Several strategies were utilized: (1) Police officers were trained as peer educators and utilized diagrams and demonstrations to show the men how rapidly HIV could spread through group coercive sex, and (2) A cartoon book specifically about coercive group sex entitled *"Hit 'n Run"* was developed. After the intervention, an evaluation was conducted, and results revealed that in the pre-intervention phase, 10% of police officers had been engaged in a "lainap" (coercive group sex) during the previous week, whereas this number was reduced to 4.2% post-intervention phase [15]. This is one great demonstration of how the voice of SWs and intervention can impact their occupational safety and health.

Interventions must also take into account social stigma and discrimination [4]. These two propel and perpetuate an environment conducive to violence, it is essential that we work on eliminating the stigma surrounding the profession [4]. The following recommendations have been posed to reduce and ultimately eliminate the stigma attached to sex work, (1) police should be trained and sensitized on issues pertaining to sex workers [12], (2) condoms should not be confiscated or used as evidence of sex work, (3) health care workers should be trained and sensitized to treat sex workers with respect and ensure confidentiality is protected [12,17,18], (4) health care should be available at hours and locations that are accessible to sex workers, (5) education about condom use and harm reduction, as well as supplies should be made available and accessible to all sex workers, (6) mental health and psychosocial support should be available for sex workers, (7) access to housing, including owning property, and (8) building strong partnerships between organizations to address the needs of sex workers [19].

Moreover, it is evident that power issues play a major role in the safety of sex workers, both between male and female, and among police, judges, and the sex workers themselves. Interventions that utilize sex workers themselves to assist women with negotiation skills, access to care, and resources to assist in reducing violence have been shown to be effective and additional interventions such as these are needed [3]. We must meet the women at their point of risk and need; therefore, health and outreach workers who are concerned with the well-being of sex workers are also needed to infiltrate the neighborhoods of sex workers to provide health services, information, and assistance to FCSWs.

Health Promotion is significantly needed in the field of sex work to eliminate risks, dangers, and hazards in the workplace, thereby creating a safer work environment for workers. Interventions that focus solely on clients will not improve the workplace. Additionally, interventions focusing solely on HIV will not provide safer workplace environments; this is only a piece of the bigger framework. Throughout this article, there has been mention of violence by clients, police officers, STIs, alcohol and drug use, immigration issues, legal hazards, and working conditions. A complex approach that utilizes the distribution or promotion of condoms; provision of health services, especially to treat STIs; discussion groups or classroom-based HIV and sexual health education; networking to promote better laws, working conditions, and health services for sex workers; dissemination of information through printed materials and street theatre; and economic development programs for sex workers seeking other types of employment are needed [3,5,15–17].

Most importantly, sex workers must mobilize themselves and empower themselves to eliminate and reduce safety hazards. The main aim of empowerment is to reduce vulnerability by strengthening and increasing awareness of personal skills and options to control and improve sex workers' lives. Furthermore, community empowerment strengthens the community's ability to engage in positive changes. Social empowerment enables sex workers to fight for their rights and acceptance in society, which they so well deserve [5].

By empowering women and communities, the difficulties in acquiring and using condoms, negotiating safe sex, refusing clients, organizing, using contraception, parenting, and accessing public services may be reduced and even eliminated. Interventions focusing on empowerment have been proven to be effective, resulting in enhanced self-esteem, improved negotiating skills; ability to refuse clients; access and use of condoms; STI and HIV preventive services; drop-in centers, and most importantly training to recognize, avoid, and escape violence [5].

An innovative multilayered strategy devised by sex workers to combat violence through a community mobilization drive is a case example of how mobilization and empowerment can mitigate violence and reduce STIs and HIV/AIDS among FCSWs [16]. The Sonagachi Project started in 1991 to ascertain and arrest the incidence of STIs and HIV/AIDS among sex workers in and around the Sonagachi district in Calcutta, India. Initially funded by a national healthcare research institute and later by the state-based West Bengal AIDS prevention council, in 1995 onward, the project was spearheaded by the sex workers themselves, who acted as peer outreach workers. The initial activity of the project involved the mobilization of sex workers as peer educators who disseminated information and awareness among colleagues. Over time, the project developed to promote work on community development and intervention at different levels to handle crises and environmental barriers faced by sex workers. In addition to its initial activities and targeted goals, the project achieved the following outcomes: the unionization of the sex workers (Durbar Mahila Samanwaya Committee (DMSC)) and the establishment of micro-credit societies and vocational training centers for the sex workers. Through the unionization of the sex workers and the formation of DMSC, a drastic reduction of violence perpetrated against the sex workers was seen. Moreover, the identification of stakeholders within and outside the realm of sex work and the engagement of these stakeholders in dialogue helped in generating empathy and significantly diminished the incidence of violence. Unionization and stakeholder negotiation comprised a multilayered strategy to combat violence perpetrated against sex workers. This also resulted in a significantly increased condom compliance rate and significantly decreased HIV/AIDS and STI infection incidence. The study conducted by Dasgupta [16] thus shows that sex workers can confront the system and actively engage with it to change their marginalized status and attain empowerment, in low- and middle-income countries [16].

Legal issues and stigma have both proved to be significant barriers to providing OHS for sex workers. Yet, we must move forward in overcoming these issues and providing sound interventions not only for clients but for sex workers as well. Instead of judging and condemning the profession and workers, additional research needs to be undertaken in order to uncover the magnitude of occupational health and safety problems encountered by FCSWs; in addition to providing services and interventions to safeguard the health of the women involved in sex work, while increasing their quality of life.

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