

UNIVERSITY OF NAIROBI

INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES (IAGAS)

**Behaviourial and Social factors Contributing to HIV Vulnerability among
Female Sex Workers in Kayole Slums, Nairobi County.**

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REG. NO: N69/77171/2012

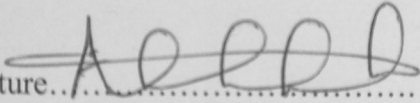
**A PROJECT PAPER SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY,
GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE AWARD OF MASTER OF ARTS IN GENDER AND
DEVELOPMENT STUDIES, OF THE UNIVERSITY OF NAIROBI**



2014

DECLARATION

I hereby declare that this project is my original work and has not been presented for the award of degree in the University of Nairobi or any other university.

Signature 

Date 02/12/2014

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This project paper has been submitted for examination with my approval as the university supervisor.

Signature 

Date 2/12/2014

Dr. T. Ondicho

DEDICATION

To my parents for the continued support, and to my siblings for your invaluable encouragement

TABLE OF CONTENTS

DECLARATION.....	i
DEDICATION.....	iii
TABLE OF CONTENTS	iv
LIST OF FIGURES	vii
ACKNOWLEDGEMENT	viii
ABSTRACT	ix
LIST OF ABBREVIATION AND ACRONYMS	xi
CHAPTER ONE	1
BACKGROUND TO THE STUDY	1
1.1 Introduction.....	1
1.2 Problem Statement.....	5
1.3 Study objectives	7
1.3.1 Overall objective.....	7
1.3.2 Specific objectives	7
1.4 Justification.....	7
1.5 Scope and Limitations of the study.....	8
1.6 Definition of key terms	8
CHAPTER TWO	9
LITERATURE REVIEW	9
2.1 Introduction.....	9
2.2 HIV and female sex workers in Kenya.....	9
2.2.1 Social and structural factors.....	12
2.2.2 Stigma and Discrimination	14
2.3 Violence Against female Sex Workers and vulnerability	15
2.4 Theoretical framework.....	17
2.4.1 Relevance of the model to the study	19
2.5 Study assumptions	20

CHAPTER THREE	21
METHODOLOGY	21
3.1 Introduction.....	21
3.2 Study site.....	21
3.3 Study Design	21
3.4 Study population	22
3.5 Sample and sampling procedure	22
3.6 Data Collection Methods	22
3.6.1 In-depth Interviews	22
3.6.2 Key informant interviews	23
3.6.3 Narratives.....	23
3.7 Data processing and analysis	23
3.8 Ethical considerations	24
CHAPTER FOUR	25
FINDINGS AND DISCUSSIONS	25
4.1 Introduction.....	25
4.2 Demographic characteristics of the respondents.....	25
4.2.1 Reasons for engaging in sex work	28
4.3 Behavioral factors	30
4.3.1 The value of transaction versus condom use	31
4.3.2 Non-reporting of STIs.....	32
4.3.3 Sex venues and power imbalances.....	33
4.3.4 Multiple partners and inconsistent condom use.....	35
4.3.5 Drug use and HIV risk amongst FSW	35
4.4 Social factors contributing to vulnerability.....	37
4.4.1 Stigmatization and the risk of HIV	37
4.4.2 Criminalization of sex work and the HIV risk.....	41
CHAPTER FIVE	45
SUMMARY, CONCLUSION AND RECOMMENDATIONS	45
5.1 Summary	45
5.2 Conclusion	46

5.3 Recommendations.....	47
References.....	48
Appendix I: In-depth interview guide.....	54
Appendix II: Key informant interview guide.....	55
Appendix III: Case narrative interview guide.....	56

LIST OF FIGURES

Figure 2.1: Social Ecological Model (SEM) for HIV risk in Vulnerable Populations	18
Figure 4.1: Age of the Respondents.....	25
Figure 4.2: Marital status of the informants.....	26
Figure 4.3: Education level of the informants	27
Figure 4.4: Income level of the informants.....	28

ACKNOWLEDGEMENT

My sincere gratitude goes to my university supervisor, Dr. Tom Odicho, for his academic guidance and illuminating ideological guidance from proposal conceptualization to project write up. I am humbled and immensely gratified in the maturity of academic guidance accorded to me, forever, you remain a blessing.

I wish to convey my special thanks to the entire teaching staff of the Institute of Anthropology, Gender and African Studies who gave me an insight into the study topic, the Chairman of the Faculty Post-graduate Studies Committee and the entire staff who critiqued my work during the proposal defense. There is no match to your sincere and candid critique that remains a symbol of the desire to grow wholesome scholars.

I am indebted to the female sex workers who braved the stigma associated with their occupation to share their experiences and information on the sex work and the vulnerability to HIV in the context of slum. I believe the knowledge gathered in this study is of utmost use to the interventionists and scientific community as much. I am sincerely grateful for your input.

I thank my classmates for their continual encouragement and peer learning exchanges on the project write up, thank you for such incomparable experience.

ABSTRACT

This was a cross-sectional study on behavioral and social factors contribution to HIV vulnerability amongst the female sex workers in Kayole slums. The study was guided by the Social Ecological Model approach to behavior change planning and communication which provides an encompassing framework that aims not only at achieving short-term behavior change outcomes, but also at changing conditions that prevail in interpersonal relationships, in communities, and in the society as a whole in response to HIV.

The study population comprised all female sex workers within Kayole slums reached through snow balling with whom semi-structured interviews were carried out. Experts to the study were purposively recruited and so were the informants on case narratives. Data were analysed in line with study objectives where selected verbatim were used to amplify the informants voices.

The findings indicate that drug abuse including intravenous drug-use, the issue of multiple partners to a single FSW, compromising condom use over the high amount of money, non-reporting of STI infections as well as risking one's own security by following the clients to their own places of residence remain predisposing factors at behavioral level. Socially, there is a strong stigmatization and discrimination of the sex workers by the family and community at large and discriminatory policy framework perpetuated by the state that increase female sex workers' vulnerability to HIV in Kayole slums.

The study concludes that while sex workers remain an important group in the fight against HIV and AIDS in Kenya, a lot of the state interventions have failed to encompass this group especially those in the informal settlements such as Kayole

without any economic might to seek medical interventions on their own. More importantly, the policy framework operating on the basis of legal criminalization of prostitution generally hinder intervention on this key population group with high prevalence rate of 24% of HIV in Kenya. Any programmatic intervention must therefore address itself to the community stigma, the case of multiple partners amongst female sex workers and socio-economic empowerment in which both health information and economic interventions are met upon this group.

The study recommends Comprehensive, accessible, acceptable, sustainable, high-quality, user-friendly HIV prevention, treatment, care and support must be urgently scaled up and adapted to slum contexts and individual needs such as: actions to address structural barriers, including legislation, and customary practices that prevent access and utilization of appropriate HIV prevention. Similarly, it is recommended that the state has to rethink policies and programmes to ensure freedom from violence, abuse, and discrimination while also information for sex workers and their clients and others involved in the sex industry.

LIST OF ABBREVIATION AND ACRONYMS

AIDS	Acquired Immune-Deficiency Syndrome
FSW	Female Sex Workers
HIV	Human Immune Virus
HRW	Human Rights Watch
KAIS	Kenya AIDS Surveys Indicator
KDHS	Kenya Demographic and Health Surveys
KNBS	Kenya National Bureau of Statistics
KP	Key Populations
MSEM	Modified Social Ecological Model
MSM	Men having Sex with Men
NACC	National AIDS and Control Council
NASCOP	National AIDS and STI Control Programme
STI	Sexually Transmitted Infections

CHAPTER ONE

BACKGROUND TO THE STUDY

1.1 Introduction

Sex workers worldwide are a key population in the fight against the HIV pandemic (Pettifor and Rosenberg, 2011). Several factors heighten sex workers' vulnerability to HIV. Many sex workers are migrants and otherwise mobile within nation states and are thus, difficult to reach via standard outreach and health services. They face cultural, social, legal and linguistic obstacles to accessing services and information. Equally important, many women in sex work experience violence on the streets, on the job or in their personal lives, which increases their vulnerability to HIV and other health concerns. For example, research from Bangladesh, Namibia, India and elsewhere shows that many sex workers, particularly those who work on the streets, report being beaten, threatened with a weapon, slashed, choked, raped and coerced into sex (Rosenberg, 2011).

Given the obstacles, in many places, rates of HIV among sex workers are very high. For example, a study of sex workers in Rwanda found 13 new infections for every 100 person years (Braunstein et al., 2011). Sex workers in Andhra Pradesh, India, were found to have extremely high HIV prevalence, with an average of 14 percent but ranging as high as 38 percent (Ramesh et al. 2008). One study in Miami, Florida, documented HIV prevalence of 21 percent among drug-using sex workers (Suratt and Inciardi, 2010). Throughout the world, sex workers bear a disproportionate share of new HIV infections in both generalized and concentrated epidemics (Price and Cates, 2011).

Sex workers frequently lack the personal or social status to negotiate safe sexual practices, being under the threat of violence or loss of clients. Studies show a correlation between income level and HIV prevalence among sex workers possibly due to the inability of poorer sex workers to negotiate condom use (David, 1997). Condom use is less regular with the intimate partners of sex workers than with their clients thus even where barrier methods are used sex workers and their intimate partners may remain at risk.

Across sub-Saharan Africa, female sex workers (FSW) carry a disproportionate burden of HIV, with prevalence commonly 10–20-fold higher than among the general population. In Guinea and Benin, for example, national HIV prevalence in 2002 was about 3% compared with more than 40% among sex workers (Godin *et al.*, 2008). In almost all studies in southern Africa over the past decade more than half of FSW were HIV infected, with HIV prevalence reaching 86% in one study (Ray *et al.*, 2001). In East Africa around a third of FSW had HIV, though levels of up to 75% were documented in Kisumu, Kenya and Addis Ababa, Ethiopia in the early 2000s (Aklilu *et al.*, 2001; Morrison *et al.*, 2001).

Sex workers frequently work in abusive conditions that endanger their physical safety and health and are outside the protection of the law. More countries are now reviewing their legislative frameworks, in view of the increased public health awareness of the need to reach sex workers with health information and HIV prevention and services. However, even where sex work is legal and licensed, the diagnosis of an STI may cause a sex worker to lose their licence and with it the means of supporting themselves. As a result sex workers may avoid health care facilities and

go underground to escape rules and restrictions that threaten their welfare (d’Cruz-Grote, 1996). Because sex work is illegal in many countries, sex workers are outside the scope of national HIV/AIDS programmes.

Access to the full range of HIV services especially prevention services is integral to a rights and evidence-based approach to HIV. However, risk and vulnerability to HIV are affected by far more than the obvious routes of sexual transmission. Evidence has shown that responding to social drivers of HIV is critical to success in HIV prevention with sex workers (Auerbach et al., 2009). Analysis of the effectiveness of 28 HIV prevention interventions for sex workers in Africa, Asia, and Latin America concluded that “structural interventions, policy change or empowerment of sex workers reduce the prevalence of STIs and HIV” (Shahmanesh et al. 2008, 659).

Research and prevention efforts in countries with generalized epidemics tend to operate on the assumption that key populations such as FSWs are less relevant in widespread epidemics, and focus instead on addressing heterosexual sexual transmission and mother-to-child transmission (Smith et al., 2009). However, there has been an increasing recognition of the importance of Key Populations (KP) is not only concentrated but also generalized epidemics. As the categorization of an epidemic as “generalized” is based on surveillance methods that fail to account for variations within subpopulations, any influence KP may have on transmission dynamics in a particular country is effectively masked (Baral & Phaswana-Mafuya, 2012). There is therefore a need for countries with generalized epidemics to better examine these important groups, an aspect this study seeks explore.

In general, sex workers have comparatively high numbers of sexual partners. This in itself does not necessarily increase their likelihood of becoming infected with HIV if they use condoms consistently and correctly. The reality, however, is that sex workers and their clients do not always use condoms. The 2010 UNAIDS global report found only a third of the 86 countries surveyed reported 90 percent of sex workers using a condom with their last client, while more than half reported condom use by 78 percent of sex workers (UNAIDS, 2010). In 2012, 44 countries reported higher median condom use; 85 percent, up from 78 percent in 2009 (UNAIDS, 2013).

In some cases, sex workers have no access to condoms, or are not aware of their importance. In other cases, sex workers are simply powerless to negotiate safer sex. Clients may refuse to pay for sex if they have to use a condom, and use intimidation or violence to force unprotected sex. They may also offer more money for unprotected sex – a proposal that can be hard to refuse if the sex worker in question is in desperate need of an income.

According to UNAIDS (2010), sex workers are generally stigmatised, marginalised and criminalised by the societies in which they live, and in various ways, these factors can contribute to their vulnerability to HIV. Even though sex work is at least partially legal in many countries, the law rarely protects sex workers. Around the world, there is a severe lack of legislation and policies protecting sex workers from the actions of clients that can put them at risk. For example, a sex worker who is raped will generally have little hope of bringing charges against their attacker. The lack of protection in such cases leaves sex workers open to abuse, violence and rape, creating an environment, which facilitates HIV transmission (UNAIDS, 2013).

Non-governmental organisations report that almost two thirds of the countries they work in have laws that make it difficult for them to provide services to sex worker (HRW, 2012). In some countries, police use the possession of condoms as evidence that somebody is involved in sex work, further impeding sex workers' efforts to protect themselves.

Various social factors – such as gender inequality, sexual violence, and anti-HIV stigma – increase HIV risk and vulnerability (NACC and NASCOP 2012). The nature of commercial sex work exposes the prostitutes to numerous risks such as multiple sexual partners, sexual violence, problems in negotiating for sex safe and poverty which contributes to the reluctance to insist on safe sex. These factors can thus be compounded as social and structural which the study undertook to explore within the Kayole slums.

1.2 Problem Statement

Despite the urgent need, funding for HIV prevention programming for sex workers is lacking (Global Fund for AIDS, Tuberculosis and Malaria [GFATM] 2011; UN General Assembly 2007). For example, GFATM funding for proposals that include prevention activities for sex workers declined from a peak of 67 percent in Round 9 to 53 percent in Round 10, while only 53 percent of funded proposals included stigma prevention or rights promotion activities addressing sex work (GFATM, 2011).

Few studies have been conducted on the vulnerability of women to HIV infection in Kenya (NACC and NASCOP, 2012; Lee 2012). These studies have focused on women in general and have failed to recognize female sex worker's increased vulnerability to HIV infection.

The HIV prevalence among FSWs in Kenya is 14% and prevalence varies by geographical area, gender, age and residence. Socio-cultural factors influence the presence of high risk populations in certain geographical areas and this is particularly true for populations living in slum environments.

Sex workers are generally perceived as defying acceptable social norms and roles for women and men. Women who ask for compensation for sex break traditional norms expected of women in many societies, and those who engage in transactional sex are still labelled as prostitutes. Expressions of female sexuality are expected to be restricted to marriage or legal unions and to observe traditional notions of femininity, such as passivity, virginity and sexual innocence, which are dissonant in sex work. Deeply entrenched social standards marginalise sex workers and seriously limit their access to quality health services, particularly STI management, which is an essential component in HIV prevention. To explore the aforementioned, the study was guided by the following questions:

- i. What are the individual behavioural risks that increase female sex workers' vulnerability to HIV in Kayole slums?
- ii. What are the community-based factors that increase female sex workers' vulnerability to HIV in Kayole slums?

1.3 Study objectives

1.3.1 Overall objective

To assess individual and community-based factors increasing female sex workers' vulnerability to HIV in Kayole slums.

1.3.2 Specific objectives

- i. To find out the individual behavioural risks that increase female sex workers' vulnerability to HIV in Kayole slums.
- ii. To describe the community-based factors that increase female sex workers' vulnerability to HIV in Kayole slums.

1.4 Justification

Sex work must be addressed as an integral part of national responses to HIV; therefore, the findings of this study if adopted by relevant stakeholders will improve the delivery of effective programmes which are much aware of extant cultural, religious, and social dynamics barriers. More succinctly, the study has suggested avenues by which the female sex workers can be involved in the design of HIV prevention programmes in Kayole slums, especially in access to VCTs and other health-related services.

The study contributes to literature on nexus between the socio-cultural norms and illegality of sex work on one hand and the need to address the needs of female sex workers as a key population on the other hand in preventing HIV. Such a debate would be appropriate in improving the layering of populations in social and health intervention programmes more so from a human rights perspective.

1.5 Scope and Limitations of the study

The study was carried out in Kayole slums, Nairobi County and it will focus vulnerability of female sex workers to HIV. Therefore, any vulnerability to HIV amongst key populations such as men having sex with men (MSM) was beyond the scope of the study. Moreover, the study intends to explore the vulnerability through qualitative methods; hence, the scope and extent of vulnerability within this key population was not determined. However, experiences important in designing stakeholder-driven intervention programme have been captured to warrant meaningful intervention.

1.6 Definition of key terms

Vulnerability: This refers to the diminished ability of one to protect self from possible HIV contraction. In this study, diminution is due to individual and community-driven factors.

Sex worker: Any person who engages in transactional sex within Kayole slums. In this study, the focus will be on female sex workers.

Behaviourial factors: These are individual attitudes, norms and practices in the course of sex work that may increase their risk to HIV contraction.

Community factors: These largely refer to societal perception of sex workers which largely result into discrimination against this key group in HIV prevention.

Key population: This is largely a group at increased risk of HIV infection, in this study; female sex workers in Kayole slums are considered a key population.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature as guided by the study objectives. The review has been along the following headings: HIV and female sex workers in Kenya, social and structural factors in vulnerability, stigma and discrimination, violence against female sex workers and HIV vulnerability. The chapter finally discusses the theoretical framework guiding the study and presents the study assumptions.

2.2 HIV and female sex workers in Kenya

Since the first HIV case was detected in Kenya in 1985, HIV prevalence among males and females aged 15-49 years has now stabilized around 6.3%, according to the most recent Kenya Demographic and Health Survey (KDHS) 2008—2009. Kenya has a generalized epidemic with heterosexual sex being the primary mode of transmission. HIV prevalence is nearly two times higher among adult women compared to men. Additionally, there are significant regional variations in HIV prevalence. Over half of all HIV-infected adults live in Nyanza and Rift Valley provinces (PSI, 2012). Data from recent national surveys, including the 2007 Kenya AIDS Indicator Survey (KAIS) and KDHS 2008—2009, have shown promising increases in behaviors that help slow the spread of HIV, including an increase in condom use, delay in sexual debut, and reduction in the number of sexual partners.

In Kenya, HIV rates are much higher for women than for men. This gender differential is particularly pronounced for young women aged 15 to 24 years, who are four times more likely to contract HIV than young men in the same age group (Lee

2012:1) Social conditions heavily influence the degree of vulnerability experienced by individuals and groups. In particular, women's disproportionate vulnerability to HIV is intrinsically linked with the many social, legal, economic, cultural and educational opportunities experienced by women and girls.(NASCOP AND NACC 2012). Kenya's policies over the past decade recognize specific factors that affect girls and young women's vulnerability to HIV infection, such as lower socioeconomic status, lack of education and sexual violence (ibid 2012:2).

As a population whose job involves sex with multiple partners, sex workers (FSWs) are highly vulnerable to HIV. HIV prevalence among FSWs has notably declined over time, with the per-act rate of HIV acquisition among Nairobi FSWs falling more than four-fold between 1985 and 2005 (Kimani et al., 2008). Although the relative share of new HIV infections among FSWs and their clients has decreased, FSWs in Kenya continue to experience an extremely high burden of HIV.

In 2011, 29.3% of all FSWs nationwide were estimated to be living with HIV. A survey in 2005-2006 of 820 FSWs in Mombasa found that 35.2% were infected with HIV (Luchters et al., 2010). An estimated 3,200- 4,148 new HIV infections occur each year among FSWs and their clients along the trans-Africa highway from Mombasa to Kampala (Morris, Ferguson, 2006). Nearly 1% of FSWs surveyed in Nairobi had active syphilis in 2011, potentially increasing their risk of HIV acquisition as well as the odds of onward transmission to clients.

Although definitive data are not available, it is estimated that 10,000 women labour as sex workers in Kenya (Gelmon et al., 2009). The FSW population includes bar workers, women who solicit sex in bars, home-based sex workers, and women who participate episodically in sex work when money is badly needed (Fraser et al., 2008). Economic hardship not only encourages entry into sex work, but may also increase the risks faced by FSWs. In a World Bank study in Western Kenya it was found that women involved in formal or informal sex work were roughly 20% more likely to engage in unprotected sex when a family member was ill, presumably in order to secure the premium available for risky sex in order to cover additional expenses (Robinson, Yeh, 2009).

According to a national survey in 2011, 87% of FSWs report using a condom with their most recent client. Sex workers frequently exhibit distinctly different behavioural patterns for their regular partners than they do for clients, with condom use notably less frequent with regular partners (Ngugi et al., 2007; Ferguson, Morris, 2007; Voeten et al., 2006).

Alcohol use is common among FSWs and is strongly associated with increased sexual risk behaviour (Tegang et al., 2007; Kenya Ministry of Health, 2005; Yadav et al., 2005). Sex work is highly stigmatized in Kenya. Laws prohibit the sale of sex, although clients are not penalised for purchasing sex (IPPF et al., 2008). As one indication of their social marginalization, FSWs are often victims of violence. Among FSWs surveyed in Coast Province in 2007, two-thirds said they had experienced at least one form of sexual violence, half had been forced to have sex without a condom,

and nearly 60% had been beaten or verbally abused as a result of their line of work (Tegang et al., 2007).

Evidence is somewhat more plentiful regarding FSWs themselves than with respect to their clients, who represent a key epidemiologic bridge to other groups. Nearly one in six Kenyan men (15%) surveyed in 2003 said they had ever had sex with a FSW (Hong, 2008), although only 2.9% of Kenyan men reported have had paid sex in the prior 12 months (Central Bureau of Statistics, 2004). Clients of FSWs appear to come from all walks of life, spanning the socioeconomic spectrum (Ferguson et al., 2006).

Other studies have also demonstrated how women's vulnerability to HIV infection is augmented by economic hardship (Ulin 1992:63-73). The economic position of slum women is even more precarious than men's because the majority of the mediocre income generating opportunities that slum residents depend on (working as commercial and residential security guards, manual workers in factories, etc.) are male oriented. In a study of FSWs from the Majengo slum in Nairobi, Andanda (2009:138) reports that the FSWs consist of educationally and economically disadvantaged women who resort to commercial sex work for a living.

2.2.1 Social and structural factors

A growing body of evidence highlights the importance of structural and social factors above and around the individual in relation to HIV-related vulnerability. In a seminal systematic review detailing the global context of sexual practices, Wellings (2006) identified laws and policies that marginalize or stigmatize certain populations as key risk factors for heightened HIV epidemics in both KP and general national populations. By criminalizing targeted HIV interventions or disrupting funding

mechanisms supporting HIV prevention and treatment for KP, these policies can hinder a community's ability to provide preventive or harm-reduction services to its constituents.

Structural factors are thought to indirectly heighten risk for HIV infection among FSW through a complex and self-replicating relationship between social structures and power (Parker & Aggleton, 2003). The illegal nature of sex work can intensify inequalities and power dynamics already at play within a society, limiting a woman's ability to negotiate safer sex (Ghimire et al., 2011). Systemic violence against FSW has been documented as being inflicted by both law enforcement officials and clients (Arnott & Crago, 2009; Simic & Rhodes, 2009), and experiences with police have been linked to outcomes such as physical abuse from clients, inconsistent condom use, and unprotected sex with police officers in return for favors (Erausquin et al., 2011).

Socioeconomic hierarchies can also make condom negotiation more difficult for FSW, as it has been shown to do for FSW who have a greater number of clients (Grayman et al., 2005) or who work in venues thought to serve those of lower social standing (Yang et al., 2010). Importantly, the stigma ascribed to transactional sex may keep FSW from seeking HIV/STI treatment and prevention services. In a 2009 qualitative study of FSW living with HIV in India, FSW cited perceived discriminatory practices at healthcare centers as a key reason to not seek antiretroviral treatment (Chakrapani et al., 2009).

Clients of FSW are also at increased risk of HIV, and act as a bridge for infection from the FSW to the general population. A study of five African countries that compared HIV prevalence among men who have ever paid for sex to men reporting not having paid for sex found that having had transactional sex with a woman significantly increased the odds of having a positive HIV status (Leclerc & Garenne, 2008). Additionally, a cross-sectional survey of 1,405 male workers conducted in rural Zimbabwe—in which 48% of men reported ever having had sexual contact with an FSW—concluded that contact with FSW played a significant role in the spread of HIV (Cowan et al., 2005).

Certain social factors have been shown to be beneficial to FSW in terms of HIV prevention. Studies from both Asia and Latin America have demonstrated that social cohesion and social inclusion among FSW are significantly positively associated with consistent condom use (Kerrigan et al., 2006; Lippman et al., 2010). Intervention models developed in India, the Dominican Republic, and Brazil have sought to mobilize FSW by establishing safe centers that aim to improve social cohesion, facilitate access to resources, and better ensure the protection of their human rights (Lippman et al., 2010). In all three settings, these efforts were found to decrease HIV-related risk behavior.

2.2.2 Stigma and Discrimination

Sex workers face stigma and discrimination from many people and institutions. Sallman (2010) found that sex workers in a mid-western U.S. city reported stigmatization leading to discrimination and violence from a wide variety of social actors, including family and local authorities. Stigmatization and discrimination

against sex workers is institutionalized in laws and policies, such as those that criminalize sex work.

But criminalization is not the only policy challenge. A modeling assessment of prostitution policies that use moralistic criteria found that this approach promotes stigmatization of sex workers and leads to suboptimal outcomes for their health and well-being (Della Giusta, 2010). Stigma and discrimination in health care settings jeopardizes connections with sex workers (Goodyear and Cusick, 2007; Sanders, 2007). Indeed, sex workers themselves may internalize social stigmatization (World Bank, 2010).

Sex workers who use drugs often face additional stigma. The double stigma of sex work and drug use can lead to social marginalization, further restricting opportunities for employment or housing, and increasing the risk of violence. Clients of sex workers may also use drugs, sometimes complicating safe sex practices.

2.3 Violence Against female Sex Workers and vulnerability

The link between violence and the transmission of HIV is well established, as is the fact that sex workers are often targeted for violence because they are sex workers (Decker et al., 2010; Lowman 2000). Violence is a manifestation of the stigma and discrimination experienced by sex workers. In all societies, sex work is highly stigmatized and sex workers are often subjected to blame, labelling, disapproval and discriminatory treatment. Laws governing prostitution and law enforcement authorities play a key role in the violence experienced by sex workers.

Criminalization of sex work contributes to an environment in which, violence against sex workers is tolerated, leaving them less likely to be protected from it. Many sex workers consider violence "normal" or "part of the job" and do not have information about their rights. As a result, they are often reluctant to report incidences of rapes, attempted (or actual) murders, beatings, molestation or sexual assault to the authorities. Even when they do report, their claims are often dismissed. For example, studies among street-based sex workers in Vancouver, Canada and in New York City show that a majority of incidences of harassment, assault, rape, kidnapping, and murder are not reported to the police. Where they are reported, the police do not register the complaints and in the few instances where they are registered, many of the perpetrators are not convicted.

Police treatment of sex workers spans a wide range, from neglect and outright abuse to benevolence. Police may detain and imprison sex workers or may themselves perpetrate violence, including rape, which may have long-ranging effects on the lives of sex workers (Halter, 2010). But in some places, protective policies and training for police have benefited sex workers, who receive assistance from the police rather than abuse or imprisonment. Sex workers in Kenya (Odhiambo, 2011) and India (Biradovolu et al., 2009) have successfully worked with organizations to change law enforcement practices to address police violence against sex workers as well as police resistance to addressing violence against sex workers.

While some women engage in sex work voluntarily, there are others who are coerced into sex work through means such as trafficking. The latter often experience physical and sexual violence during and after being trafficked into sex work. However, both

trafficking and violence against trafficked women need to be understood more broadly in the context of migration, and examined separately from sex work. At the same time, it is important to note that in several countries, certain activities such as rescue raids of sex establishments have exacerbated violence against sex workers and compromised their safety.

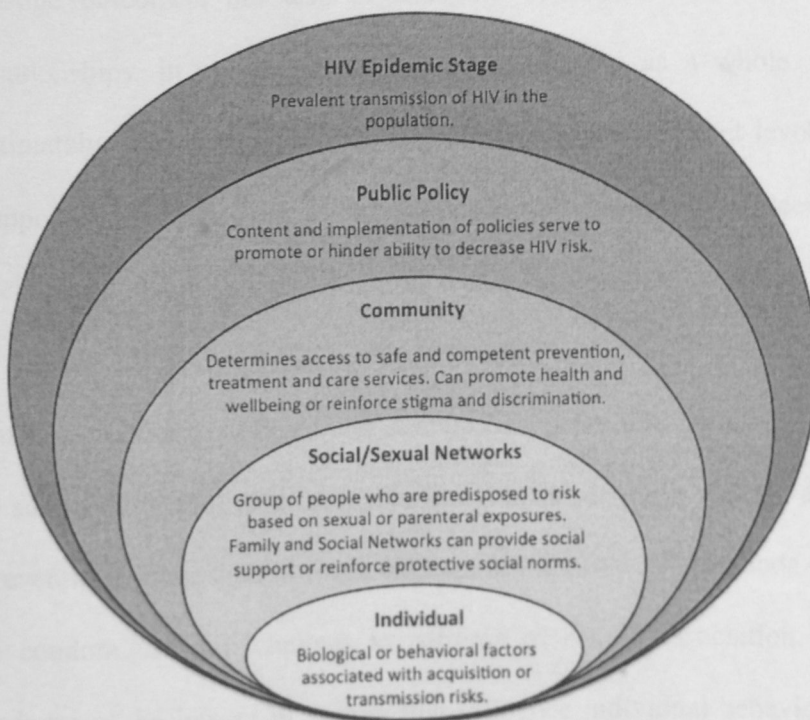
Antiviolence programs should act to deter violence committed against sex workers and encourage law enforcement to take appropriate action when crimes are committed against sex workers (Okal et al., 2011; Sanders, 2007). Even the presence of outreach workers has been reported to prevent violence against sex workers (Janssen et al., 2009).

2.4 Theoretical framework

To explore the associations between behavioral, social and structural factors with HIV in FSW, this study used the Modified Social Ecological Model (MSEM) as a guiding theoretical framework, presented in Figure 2.1 below (Baral, et al., 2013). The MSEM posits five layers of risk for HIV infection: individual, network, community, policy, and stage/level of the HIV epidemic. It modifies the traditional Social Ecological Model (Krieger, 2001) by tailoring the levels of risk to HIV-relevant domains. For example, the “interpersonal” level present in the original model has been changed to “social and sexual networks,” and an additional level specifying HIV/epidemic stage has been added.

The MSEM is based on the premise that while individual-level risks are necessary for the spread of disease, they are not sufficient; higher-order social and structural levels of risk (network, community, policy, level/stage of epidemic) represent risk factors outside of the control of any individual person (Wellings et al., 2006). This model therefore recognizes the important role social and structural factors can have in HIV transmission dynamics in KP, which has been demonstrated by research in African settings (Fay et al., 2010).

Figure 2.1: Social Ecological Model (SEM) for HIV risk in Vulnerable Populations



Source: Kriegler (2001)

2.4.1 Relevance of the model to the study

The individual layer of the framework explains the behavioural aspects that increase vulnerability to HIV amongst the sex workers in Kayole slum. More specifically, the section can put into context how issues such as alcohol abuse, engagement with multiple partners, non-conformity to use of condoms, solicited sex and home-based commercial sex contribute to HIV vulnerability.

A social ecology approach to behavior change planning and communication provides an encompassing framework that aims not only at achieving short-term behavior change outcomes, but also at changing conditions that prevail in interpersonal relationships, in communities, and in the society as a whole. These conditions, ultimately, cannot be separated, and changes at the different levels can be mutually supportive. All HIV prevention methods require some level of decision making about their adoption, and almost all require some form of commitment to adherence.

Underperformance of behaviour change HIV prevention interventions reflects failures to successfully motivate or enable individuals' decision making and commitment to prevention, rather than intrinsic failures of the promoted methods of prevention, such as condom use and changes in patterns of sexual association. It is important to understand the impact of factors that influence individual behavior, to work to undo those conditions that constrain or counteract HIV prevention behaviors, and to promote those conditions that enable HIV prevention behavior.

The social ecology approach conceives opportunities for individual behavior change as located within broader spheres of influence at the levels of social networks, communities, and the societal influences on individual agency and, ultimately, prevention behavior. Interpersonal networks influence the forms of relationship and communication contexts in which behavior occurs and have a strong bearing on behavioral prevention outcomes. Individuals are constrained in their prevention behaviors by the attitudes and norms of their peers, families, and partners, who may also enable opportunities to exercise HIV prevention choices. Family conditions and poor communication within relationships can act as obstacles to HIV prevention dialogue and decision making. Similarly, interpersonal and peer group norms and pressures can create contexts of HIV risk.

2.5 Study assumptions

- i. Individual behavioural risk factors increase female sex workers vulnerability to HIV in Kayole slums.
- ii. There are social and legal community-based factors contributing to female sex workers' vulnerability to HIV in Kayole slums.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter gives a description of the study site, the study design, study population, sampling procedure and sample size, data collection methods and data analysis. The chapter finally discusses the ethical considerations that guided the study.

3.2 Study site

The study was carried out in Kayole slums. Kayole lies in the South East of Nairobi City, just 6 km from the city centre. Kayole is the second largest slum in Kenya after Kibera slums in Nairobi. Unemployment rates are consistently over 50% with an average monthly income of Kes12, 000 /\$150(KNBS, 2009). The area has land tenure in the form of allotment letters with an estimated population of 89,600 distributed in 22,400 households (KNBS, 2009). Njambi (2013) states notes the informal context coupled with poverty in Kayole have provisioned room for commercial sex trade. This urban area is a source of cheap rent relative to the rest of Nairobi and attracts many small businesses which offer informal employment to people who are largely excluded from formal avenues of employment in Nairobi and neighbouring cities.

3.3 Study Design

This was a cross-sectional descriptive study. The study used qualitative data collection methods, that is, individual in-depth interviews and key informant interviews, and the data were analyzed in line with the study objectives. During the analysis of the findings, verbatim were used to amplify the informants' voices in the themes and/or discussions.

3.4 Study population

The study population comprised all female sex workers in Kayole slums. The unit of analysis was the individual female sex worker in Kayole defined as a female commercial sex worker residing and operating in Kayole slums.

3.5 Sample and sampling procedure

This being a qualitative with hard to reach population, there was no predetermined sample size. Data collection continued to the point where adequate information to warrant analysis was reached. Sampling was realised through snowballing. In this case, the first female sex worker was identified for interviews from whom further references were mapped and obtained. The network of the female sex workers was traced and interviews conducted.

Key informants were purposively identified for interviews on the basis of their professionalism and experience in addressing the plight of female sex workers across aspects as health access and other rights advocacy issues. In addition, purposive sampling was used to select informants for case narrative interviews. This was done on the basis of the informants' willingness to further discuss their experiences around sex work in Kayole slums, the challenges and perceived vulnerability to HIV.

3.6 Data Collection Methods

3.6.1 In-depth Interviews

These were carried out with female sex workers in Kayole slums. The interviews will be semi-structured to allow for further probing on the basis of the informants' responses. The method was significant in collecting data on the individual and

community-driven behaviours and practices that predispose the female sex workers to HIV based on their experiences. The interviews were carried out with the help of an interview guide (Appendix, 1).

3.6.2 Key informant interviews

These semi-structured interviews were conducted with experts. The aim was to clarify issues raised by female sex workers on the nature of their work, predisposition to HIV and possible multi-stakeholder interventions. In specific, the method was important in collecting information on the laws and policies which largely bar direct interventions targeted at this key population (female sex workers) in HIV prevention efforts in Kenya. An interview guide (Appendix, 2) was used to guide the interviews.

3.6.3 Narratives

These were carried out with three female sex workers who have operated in Kayole slums for the last two years and are willing to discuss their experiences in details. The aim was to obtain information about the individual and community driven vulnerability to HIV as lived by the informants, interventions from state and non-state actors that have helped mitigate the same etc. an interview guide (Appendix, 3) was used to guide the interviews.

3.7 Data processing and analysis

Data collected through in-depth interviews, case narratives and key informant interviews were sorted and transcribed. The subsequent analysis of data was conducted in line with the study objectives: individual behavioural and community-

driven vulnerability to HIV. The voices of the informants was captured in the analysis through use of selected verbatim.

3.8 Ethical considerations

A research permit was obtained from the National Council for Science and Technology (NCST) before embarking on the fieldwork. During fieldwork, informants were briefed on the purpose, the target groups, selection procedures, duration of the study, and potential use of the research results so as to achieve informed consent of their participation.

During the interviews, the informants' were requested to allow for taping of discussions which will later be transcribed for the sake of cross-checking with written notes during analysis. The study subjects' anonymity during publication of the research findings would be ensured through the use of pseudonyms. To the scientific community, the study results will be availed to through publication to be made in refereed journals.

CHAPTER FOUR

FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings and observations of the study on behavioural and social factors contributing to HIV vulnerability among female sex workers in Kayole slums. The demographic characteristics of the informants have also been presented. An analysis introducing the findings has been carried out.

4.2 Demographic characteristics of the respondents

Most of the respondents in this study were aged between 31 and 45 years comprising 50% of the informants, the youthful informants were aged between 18 and 30 at 30%, those aged 46 years and above at 20% as summarized in figure 4.1 below.

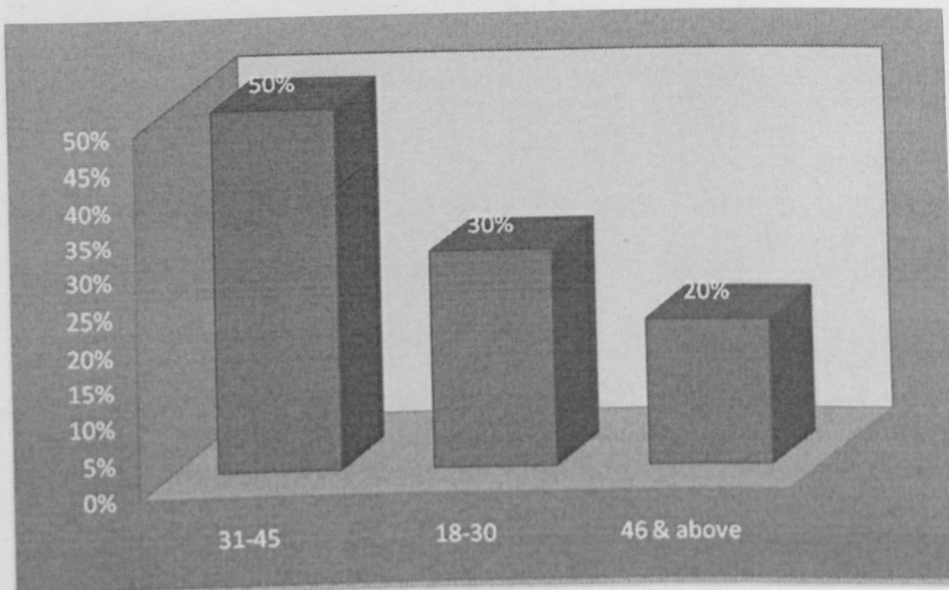


Figure 4.1: Age of the Respondents

On gender disaggregation, females comprised 100% of the informants given the absolute focus on women's experiences in the study thus there was no need to involve men. Analysis on marital status revealed that single women informants in this study

stood at 10%, married informants at 60% while those either divorced or separated at 30%. Marital status was an important variable in this study because the presence or absence of a spouse is an important determinant of entry into the sex trade. While it might be argued that the single females and divorced women have more space to maneuver into the trade, those who reported being married were found to dominate the sex trade in the slums. This could be explained by the fact that a number of these females have to shoulder the burden of raising their families, have their spouses living back in the upcountry or are in 'come-we-stay' marriages in which the male spouse is more temporal and not obligated to provide for the family. Figure 4.2 below summarises the findings on the marital status:

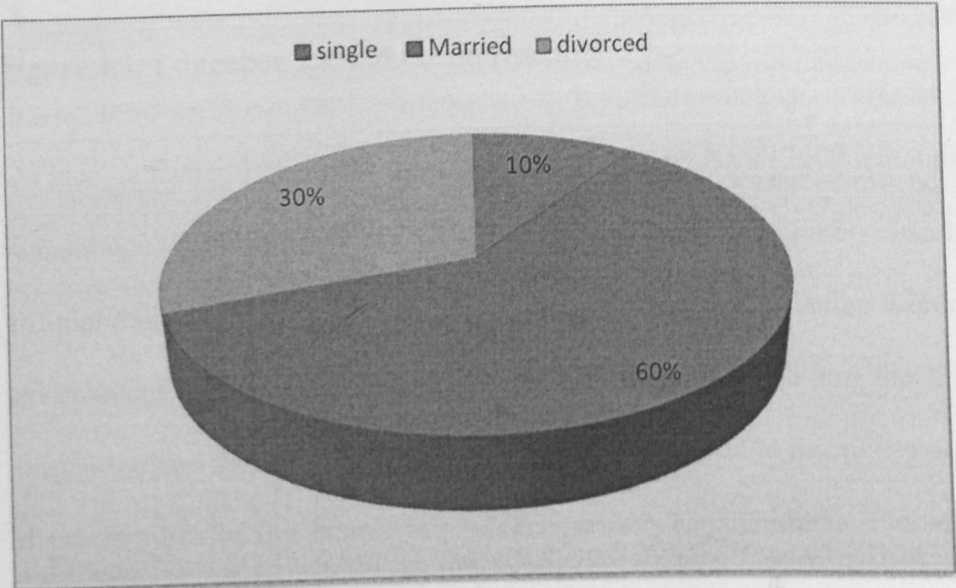


Figure 4.2: Marital status of the informants

On education level, those who had completed primary comprised 88%, those with incomplete secondary education 11%, while those who completed secondary school comprised 1% of the informants. None of the informants interviewed had any access to tertiary education. Educational defines the female sex worker's knowledge of the HIV prevention mechanisms, availability of the service providers and the authorities

that one should inform in case they are violated in the process of their trade. Figure 4.2 below summarises the educational level of the informants:

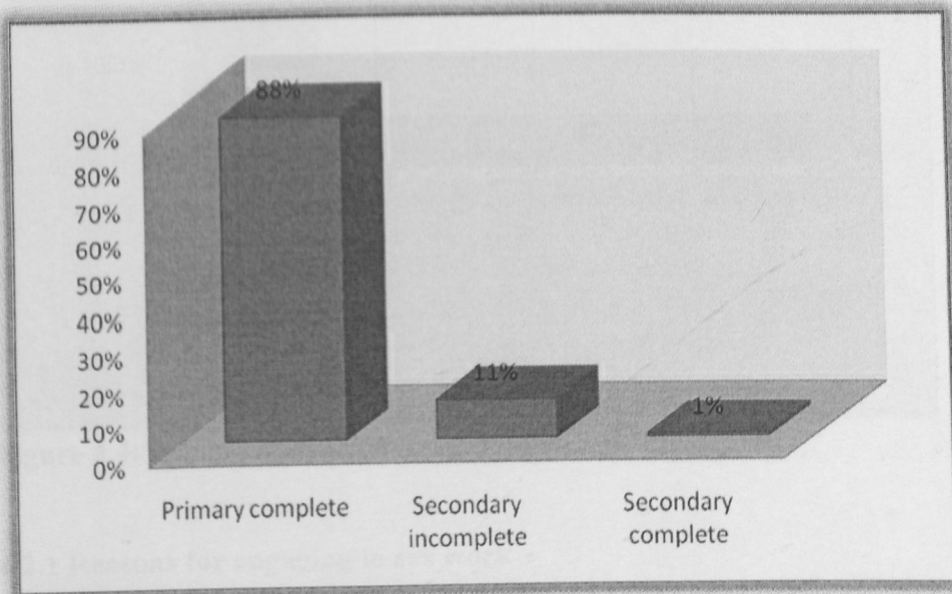


Figure 4.3: Education level of the informants

On income levels, 76% of the informants earned below Kshs. 2000 a month while the remaining 14% earned between 3000 and 10% earned 5000 monthly. Income level is an important variable since it is part of the economic push factors within the slum environment leading to engagement in sexual transaction. From the findings, the meager income earnings across the groups is so inadequate to meet the practical needs of the families of the female sex workers within Kayole slums. Figure 4.4 below summarises the income levels of the informants:

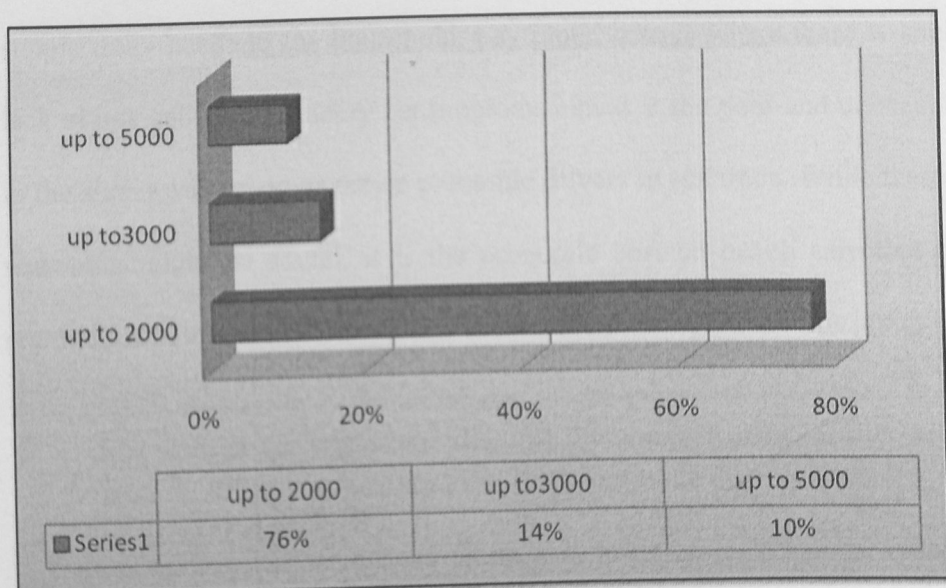


Figure 4.4: Income level of the informants

4.2.1 Reasons for engaging in sex work

From the narratives of women in the study, factors such as lack of education and appropriate vocational skills, combined with the stress of economic constraints, seemed to be the underlying mechanism related to women entering sex work as the sole means of ensuring survival for themselves and their families in the slums.

“I did not have money to buy milk for my children. My in-laws were torturing me, there was nobody to take careMy husband did not take care of me...no parents to turn to...I waited for a whole day without any food or drink... one man came, fed me, consoled me...He took me to a lodge and had sex with me....and gave me money.... He said he will take care of me and the children. And when he knew that I wanted more money to support my children he introduced me to his friends...and then I started going to them too.” (40 year old FSW in Kayole)

“There is no job for the youths in this place...the casual work is hard to come by...I need money to buy food and keep my two children in nursery school...this is my office” (28 year old FSW, Kayole)

The key informants in the study also observed that the unpredictable high cost of living coupled with low income within the informal settlement have pushed many young women into sex trade despite its illegal status in the country. The need to

supply daily needs to the household, pay rental houses where these women live and lack of any substantive safety net programs aimed at the poor and unoccupied people in the slums were cited as major economic drivers to sex trade. While these economic reasoning might be sound, it is the economic cost on health care that the experts regretted is being passed onto the government unwittingly once this group is infected.

“they engage in commercial sex to get money to meet their family needs, however, at the end of the day, the government pays heavily since it has to provide drugs that go into their treatment once they are infected” **(interview with legal expert)**.

“these young women are economically vulnerable and as long as there is no direct income generating activities directed at them by the state, it will be difficult to eradicate the sex trade especially in the informal settlements” **(Interview with the local chief)**

It was also evident that in the ‘high demand/low control’ sex work environment, brokers and pimps played a vital role in negotiations with male clients that determined women’s incomes. The sex workers narrated that the issue of brokerage cropped when there the need to feel protected from gangs who have often harassed them in their trade:

“I have not solicited any man directly. All these are handled by the many brokers....clients approach brokers who approach us....the rate varies... 10% of my earnings go to my broker....” **(Married female, aged 35, illiterate, mother of four, sex worker).**”

“we have our point-men and women in the slum, most of them operate local bars...we are occasionally invited and after that we are asked to share the proceeds...it is safer with this organized practice because your security is guaranteed as opposed to when you just wait on the streets for your clients” **(35 year old FSW, Kayole)**

The experts in the study were of the opinion that whereas brothels are always associated with up market areas, the trend is trickling down to informal settings where the economically vulnerable females are promised consistent income if they

become regular entertainers in some of the established spots with regular patrons. Moreover, there is also the guarantee that one would not be subjected to humiliations as opposed to cases where they operate on their own, and in case of arrests by the law enforcers, the sex workers are guaranteed that the bonds would be paid by their middlemen.

“the informal brokerage for sex work is on the basis of the security of the sex workers and the fact that they have some people watching their back in the illegal trade...these people happen to be the owner of the entertainment cubs that you find around the slums” (interview with CHW in Kayole)

“the brokers got into the whole picture as possible bridge between the female sex workers and the authorities fighting the sex trade... the brokers have a way with law enforcers hence their presence encourage more girls into the trade despite the HIV risk (interview with a legal expert)

From the findings, it is quite clear that female sex workers in Kayole slums are roped into the illicit trade due to economic hardships abound within the slum environment. Lack of employment and business opportunities for this group of females make them opt for what is readily available which happens to be sex trade. Similarly, the entry of brokers in the slums to facilitate the sex trade has largely contributed to its perpetuation despite the illegality. This is because the brokers have provided safe havens for the conduct of transactions within their business premises pulling a majority of the female sex workers from the exposing open streets within the slums where they are subject to police harassment and clientele abuse.

4.3 Behavioral factors

Individual behaviours of the female sex workers can be sources of risk to contracting HIV. In the study, drug use, compromise on condom use, multiple partners, and the exposing one to unsafe environments where their power to negotiate safe sex is insubordinated were found to be the major individual factors leading to HIV

vulnerability in this key population group. Similarly, the refusal to take up HIV tests after having unprotected sex or group sex was another behaviours predisposing this group to HIV. These findings are herein discussed below.

4.3.1 The value of transaction versus condom use

In the study, it was established that a number of the female sex workers would compromise the need for protected sex dependent on the amount of the money on offer by the client and upon the request of the client to have free sex. The sex workers reported those clients who would pay more than double the usual charge would be allowed to have unprotected sex despite the fact that their whereabouts on HIV and other STI status remained unknown to the female sex workers.

“you would rather have one man who will pay pay Ksh. 500 than have three paying a mere Ksh. 100 each and they want to walk with you all over the place... as long as the client is rich, they have it as they want, we do not ask them for protection, you risk turning them off yet you need money” (34 year old FSW Kayole)

“when you go to the clubs where our brokers operate, their men happen to want unprotected sex because they say that is what they miss from their wives who are insisting on condoms for family planning...so they pay more and we give in” (26 year old FSW, Kayole)

The experts observed that most females in the slums are largely driven by economic need into sex trade, and as long as that need is provisioned for in large quantities, they would compromise on their health. They contended that the danger with that is that they risk being infected by consumers of the same who might have contracted the virus from a previous client or their own spouses back at home.

“The money might be high with the so called rich clients, however, it provides a chain for viral transmission between these female sex workers and their clientele, who eventually go back and infect their regular sex partners or spouses” (**interview with health officers**)

“There is the belief amongst the female sex workers that those with money are safe and only hunger for sex...there is no need to have protection, so this attitude puts them at the risk of contracting the HIV virus which they could easily avoid” (**Interview with CHW, Kayole**).

The fact that female sex workers opt for the money at the expense of their health point to lack of community health intervention that would empower and inform the decision making process of this group. While it can be argued on the economic vulnerability, their survival in the business is dependent on better health that should be prioritized. Moreover, the warrant for intervention should be examined from the lens that these female sex workers do not have a limited group of clientele but transact with other members of the general population who eventually fan the HIV spread across board. In essence, the vulnerability while high amongst the female sex workers in Kayole, the net effect are felt amongst the population not necessarily within the slum environment whose spouses seek their services.

4.3.2 Non-reporting of STIs

The study established that female sex workers do not report infections at initial detection in the change around their genitalia; instead, there is the effort to consult within the group and administer individual therapy to the problem over some time. This is often the case when a group member suffers similar symptoms as a previous case in any other member. The danger with that is the fact that it risks the chances of one contracting the HIV virus as other STIs weaken the immune system.

“We try a lot of home remedies when a member falls sick, mostly we rely on over the counter prescriptions...we only go to the hospital when it can no longer be managed...” (31 year old FSW, Kayole)

“I had no idea my client had gonorrhoea, I managed the irritant itches with painkillers and some herbs till a community health worker assisted me to get medication at the local health centre” (25 year old, FSW, Kayole)

In the study, the experts observed that the competing need to get money and fend for the family tends to circumvent the health needs of the female sex workers. STIs though very risky is not taken as serious as pregnancy which all of them tend to test for more often. The female sex workers are more concerned with situations that might undercut their business rather than the health threatening behaviours.

“These ladies mostly test for pregnancy but hardly want VCT services unless you really persuade them to...they are least concerned with infections but they know a pregnancy would keep them out of business for some time” (interview with health expert, Kayole).

“it is a worrying trend that they do not seek any tests even when they have had unprotected sex, yet they continue to engage with more clients...”(interview with CHW, Kayole)

4.3.3 Sex venues and power imbalances

Female sex workers in the study indicated that they are often confronted with issues of violence by their clients especially when disagreements over venue for transaction and the amount of payment are concerned. The sex workers reported most of their clients at times coerce them into unprotected sex especially once they are tricked into alleys patrolled by the slum gangs in Kayole slums.

“after I refused to have unprotected sex, he made calls to members of his gang who came in and held me to the ground as he forced sex on me, they only ran away when my colleagues came around with a rival gang...I had to be taken to a local VCT that morning to avoid contracting HIV” (27year old FSW, Kayole).

“the clients always take us into their own houses and threaten violence when you resist unprotected sex...one held a machete over my head and asked me to oblige or else he would kill me..when I went for the test thereafter, I was diagnosed with syphilis...(40 year old FSW, Kayole)

In previous study, it was concluded that sexual encounters between women and men hinge on unequal power relations between the genders (Taylor, 1995). Complexities of the sexual negotiation between married couples also involve familial and economic situations based on cultural norms and the resources available to them individually and jointly, in addition to differential sexual norms and expectations (George, 1998). While economic hardships, power differentials, victimization, and societal norms play a major role in limiting options for women to assert their sexual rights, it is amply clear that it may be dangerous to assume unitary responses in all heterosexually-related sexual encounters. These tendencies are largely abundant in the context of female sex work in Kayole slums hence risking HIV contraction.

In the study, the experts observed that as long as the environment favours the client in terms of control, the female sex workers are likely to be raped, have an unprotected sex or sometimes be kicked out without pay. In most cases, it is the lure of unprotected sex that make their male clients take them to places where the female colleagues cannot be of help.

“Male clients are already aware of the protection networks of the FSWs, they tend to take them as far as possible to force their sexual demands on these women, sometimes and unprotected hence the risk of HIV transmission in case one is infected.” (interview with legal expert)

In Wingood and DiClemente's (2000) model, the structure of sexual division of power focuses on physical exposures such as intimate partner violence and partners with high risk behaviors in addition to other risk factors including use of alcohol,

women's perceived lack of control in intimate relationships, and low assertive skills to negotiate condom use that may increase women's vulnerability to HIV.

4.3.4 Multiple partners and inconsistent condom use

In general, sex workers have comparatively high numbers of sexual partners. This in itself does not necessarily increase their likelihood of becoming infected with HIV if they use condoms consistently and correctly. In other cases, the female sex workers are simply powerless to negotiate safer sex. Clients may refuse to pay for sex if they have to use a condom, and use intimidation or violence to force unprotected sex. They may also offer more money for unprotected sex – a proposal that can be hard to refuse if the sex worker in question is in desperate need of an income.

“You are desperate for the little money as a mother...when the man offers you double the amount usually charged, you easily give in...then another will come with similar offers and the chain grows as such...”(37 yearl FSW in Kayole)

With Kayole slums, the clients of sex workers are fuelling HIV transmission, because they act as a link between sex workers and the general population. Many women do not report using condoms with their husbands and may therefore be at risk of HIV infection if their partners frequent sex workers. This is particularly true for wives of migrant workers who travel long distances and spend extended periods of time away from home.

4.3.5 Drug use and HIV risk amongst FSW

Alcohol use is also an important behavioral risk factor that poses obstacles to safe sexual practices, and the study established that this was true for both sex workers.

While many female sex workers admitted using alcohol to overcome inhibition and dull the pain of engaging in sex work, their ability to engage in safe sex and protect themselves was often compromised as a result:

“Someone while having sex with me, he will remove the condom and do as it is. . . . I would have been drunk and I may not know. Afterwards when I notice and ask him, he will say that he is not able to do it with the condom on, they will force me and have unprotected sex. . . .(27 year old FSW, Kayole)”

“I have to intoxicate myself with alcohol before going to be with strange men...when I have no money to buy beer, we share some injectibles with my colleagues...you cannot be sober in this trade” (29 year old, FSW Kayole)

While commenting on the drug use and vulnerability to HIV amongst the female sex workers in Kayole, the experts observed that the clients always seize the opportunity to have unprotected sex with the females increasing the risk of virus transmission. Similarly, they observed that sharing injection needles amongst the female sex workers might also be a risk factor in the HIV virus spread.

“It is easy for the male clients to manipulate drunken females mostly when they want unprotected sex...having sex in this status reduces one’s ability to demand for protection hence becoming more vulnerable to contracting HIV virus” (interview with Health expert in Kayole)

“Sharing of needles especially for intravenous drugs has been found to transmit HIV virus, it is one of the areas that interventions must be directed at amongst this key population in the slums (interview with CHW)

Earlier findings by (Asthana & Oostvogels, 1996; Blanchard et al., 2005), established that intimate partner violence and client violence in the case of sex workers were important factors that limited women’s abilities to engage in safe sex behaviors. Further, lack of control in relationships with aggressive clients and in the face of accusations of infidelity by suspicious spouses were important determinants that impinged on women’s abilities to protect themselves.

4.4 Social factors contributing to vulnerability

Structural and social factors also contribute to HIV among FSWs and so should be considered in the design and implementation of rights- and evidence-based HIV prevention programming for this population. Evidence has shown that responding to social drivers of HIV is critical to success in HIV prevention with sex workers (Auerbach *et al.*, 2009). In the study, stigmatization of sex work at the family and community levels coupled with the criminal status of sex work were found to contribute to environments where the trade becomes an under dealing and any significant interaction with social service and medical providers.

4.4.1 Stigmatization and the risk of HIV

Stigmatization and discrimination against sex workers is institutionalized in laws and policies, such as those that criminalize sex work. In the study, the FSWs in Kayole reported that they found it difficult to reveal incidences of gang rapes to their family members while in the business. Similarly, they hardly reported any circumstances where their clients had insisted on unprotected sex and subsequently not paying because of the criminalized nature of sex work in Kenya.

“you can only share a bad ordeal that is health-threatening to your confidants within the group, the family members though benefitting from the proceeds of the trade do not want to be associated with the same ...the police will charge you for abetting prostitution...so the whole community turns against you just because you are engaged in sex trade”(32 year old FSW, Kayole)

“my children do not know where I work at night, I fear revealing the same to them for fear of rejecting, sometimes I suffer serious STIs but I have to conceal it as strong malaria or a case of food poison” (35 year old FSW, Kayole)

Key informants in the study revealed that criminalization of sex trade while morally holding does not take care of the health risks that come with it on the other hand. The experts observed that the trade has largely co-existed with its criminal status and the best thing would be to find a way of intervening health-wise amongst practitioners. While observing the long sexual analysis chain, the health worker in the study concluded that the male consumers of the trade could easily infect their family members if the female sex workers were greatly discriminated by the health providers and hence continually transmit the virus.

“it is criminal and stigmatized but it is still practiced...we need to have VCTs operate at night and respond to their health needs if we ever dream of containing the spread of HIV...how about someone who comes for the service and then goes back to the wife...won't they transmit the same...the government needs to look at this as key population in driving down HIV /AIDS in the country” (**expert interview with clinical officer in Kayole**)

“criminalizing sex work only depletes their entitlements to protection from violence as enshrined in the constitution, more so, it provides opportunities for coercive sex which bears the risk of infection from partners who take advantage of the legal loophole” (**expert interview with an advocate in the study**)

Sex workers face stigma and discrimination from many people and institutions. Sallman (2010) found that sex workers in a midwestern U.S. city reported stigmatization leading to discrimination and violence from a wide variety of social actors, including family and local authorities.

Discrimination is not only realized with the work and living environments of the sex workers but also while seeking healthcare. In the study, the informants observed that public health officers aware of the nature of their trade would be reluctant in attending to their health needs with strong sentiments of condemnation of their trade always a

common denominator when being attended to. They observed that the health providers look at them as being immoral and inviting upon them miseries of infection.

“When you get to the hospital and you happen to be known, the nurses always scold for being irresponsible...no counseling is given to known sex workers before testing, they think that you are naturally a bother”(29 year old FSW **Kayole**).

“The sex workers are largely seen as responsible for the STIs, there is observed laxity by the medical personnel to attend to them especially in the public hospitals, this is merely a case of stigmatization” (**Expert interview with CHW in Kayole**)

In addition, the stigma that sex workers face can make it hard for them to access health, legal, and social services. They may either be afraid to seek out these services for fear of discrimination, or physically blocked from accessing them – for instance, if a nurse refuses to treat them after finding out about their occupation.

In a previous study, a modeling assessment of prostitution policies that use moralistic criteria found that this approach promotes stigmatization of sex workers and leads to suboptimal outcomes for their health and well-being (Della Giusta, 2010). Similarly, Stigma and discrimination in health care settings jeopardizes connections with sex workers as observed by Goodyear and Cusick (2007). Indeed, the World Bank (2010) report concludes that sex workers themselves may internalize social stigmatization, this might affect the general response to HIV/AIDS across the key populations.

Sex workers who use drugs often face additional stigma. The double stigma of sex work and drug use can lead to social marginalization, further restricting opportunities for employment or housing, and increasing the risk of violence. The study established

that female sex workers have a well-established mutual support systems among sex workers to deal with potentially violent clients, which points to women's efforts to ensure safety in the often dangerous, clandestine sex work environment:

“When the argument continues, they (friends) will knock the door from outside, ask what is happening, and enquire whether it is over. . . . I will tell that man—look they are calling. . . . I will push him and tell him that it is getting late and I am leaving . . .” (32 year old FSW, Kayole)

Sex workers frequently lack the personal or social status to negotiate safe sexual practices, being under the threat of violence or loss of clients. Studies show a correlation between income level and HIV prevalence among sex workers possibly due to the inability of poorer sex workers to negotiate condom use (David, 1997). Condom use is less regular with the intimate partners of sex workers than with their clients thus even where barrier methods are used sex workers and their intimate partners may remain at risk.

While sex workers in Kayole slums face significant hurdles in their attempts to control their work lives and remain safe, there is evidence of success by some. A few of the sex workers in the study described very firm, scripted sexual negotiation patterns that were executed in advance, while others narrated experiences of being firm with clients during sexual acts. As one woman described:

“I myself will make them wear trust condom. I won't accept such people. I will ask them to move or I will move from that place I have fear as I have to protect my body. . . .” (34 year old FSW, Kayole)

Asthana and Oostvogels (1996) also observed that although the risks for sex workers in Chennai are high for violence, these women are sometimes better able to assert and

protect themselves than married women given their strong informal support networks. George's (1998) study reported similar findings from Mumbai, India, where women negotiated the nature of sexual outcomes under specific circumstances, instead of outright refusals which had the risk of resulting in violence and/or forced sex. Interestingly, similar to findings from other studies among sex workers that found evidence of male acquiescence to female controlled sexual negotiation (Campbell, 2000; Cusik, 1998; Sanders, 2004), some male clients in our study also seemed to accept sex workers' terms of sexual negotiation.

From the findings, it can be deduced that social stigma and discrimination against sex workers create an environment that perpetuates a culture of violence. Their basic human rights to protection and redress are commonly disregarded; they are more often penalized and regarded as criminals. They are often targets of harassment, extortion, and deportation from within their own networks of clients, pimps, regular partners and law enforcers.

4.4.2 Criminalization of sex work and the HIV risk

Sex workers frequently work in abusive conditions that endanger their physical safety and health and are outside the protection of the law. In Kenya, benefitting from proceeds of prostitution is punishable by law to the extent that identity with commercial sex is deemed criminal in itself. In the study, informants reported that the criminal nature of their trade had largely hindered their access to healthcare, undermined individual protection and more often created an environment defined with violence. All these factors contribute to the spread of HIV and vulnerability to the same as discussed below.

Informants reported that they more often concealed their occupation when seeking healthcare on STIs since any overt identification might not only attract discrimination from the health providers but also attract the authorities for subsequent prosecution. This means that even accessing health information that is largely required by this group remains a private affair with the non-state actors but largely missing in the public health departments.

“While the law is clear that everyone has right to equal access to health, you will find that the public sector does not approve of prostitution and more often discriminate anyone who identifies with commercial sex...denying/delaying the treatment might actually cause the virus to mature or be spread to unknowing clients...also remember you are violating their rights to healthcare” **(interview with legal expert in Kayole)**

“ the government insists on criminality of sex work yet in practice it occurs, that illegality discourages most the female sex workers from seeking treatment in public health facilities” **(interview with the head of CBO in Kayole)**

The informants stated that while well aware that their work is illegal, it was not helpful that even the law enforcers who would harass them for illegal fees to keep operating would opt for sex in cases where they could not raise money. Given the power differences between the female sex workers and the law enforcing agents, a lot of the sex would take place unprotected.

“the police would harass us for money but end up forcing sex on you if you cannot bail yourself ten release you the next day...so even those charged with maintaining are only interested in money and are at risk themselves” **(35 year old FSW Kayole)**

“I cannot go to public health clinics, they will question the frequent infections and refer me to the authorities...they say that sex workers should be hanged” **(30 year old FSW, Kayole)**

While criminality of sex remains, it is time the state understood that a lot of the trade is needs-driven and aimed at bettering the welfare of the female sex workers and that of their family members. To criminalize the practice only adds to a large number of people within the key population not taking HIV tests and STI related treatments that are important in containing the virus spread. Indeed, d'Cruz-Grote (1996) posits that due to criminalization, sex workers may avoid health care facilities and go underground to escape rules and restrictions that threaten their welfare (Because sex work is illegal in many countries, sex workers are outside the scope of national HIV/AIDS programmes).

In the study, informants observed that even when they are raped and sexually violated in the course of their business; it is always difficult for them to report such abuses because of the illegality of the nature of their activity.

“some clients would rape you and you can identify them in the community but the police would blame you for abetting crime in the first place...so you have to deal with the pain even if they leave you with some infections” **(41 year old FSW, Kayole)**

In observing criminalization of sex work, Jordan (2005) asserts that criminalization is a restrictive policy that transforms the selling of sex between consensual adults into a criminal act. Therefore, criminalizing sex workers makes it harder for them to protect their health as they may avoid health services for fear of prosecution. This not only creates barriers to achieving the effective implementation of STI/HIV prevention strategies but also distances sex workers from support organizations and peer education. As a result, these policing practices act in direct opposition to public health

objectives. For example, the possession of condoms has been used as proof of sex work which has in turn promoted the prosecution of sex workers).

The overall effect of criminalization is that it has the potential to increase STI/HIV transmission rates and is more likely to increase the stigma and discrimination experienced by sex workers. Violence and exploitation have been reported as features of the criminalized environment.

When the sex industry remains or is pushed underground (West, 2000), sex workers have less control over the conditions of their workplace. There is no evidence that criminalization has reduced the amount of people working in the sex industry. Therefore, criminalization is unlikely to have the desired impact of reducing the size of the sex industry or of protecting the sexual health of the community.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The study has assessed the behavioral and social factors contributing to HIV vulnerability amongst the female sex workers in Kayole slums. In the process, the Modified Social Ecological Model which posits five layers of risk for HIV infection: individual, network, community, policy, and stage/level of the HIV epidemic has been used to contextualize the risk amongst the female sex workers in Kayole slums.

Assessment of the vulnerability to HIV amongst the female sex workers was deemed significant because on overall, the sex workers that are generally criminalized remain a key population in the spread of the virus, and more specifically, the plight of female sex workers operating within the informal settlements largely remains outside the programmatic intervention on HIV/AIDS by the state actors leaving the whole process to non-state operatives. Moreover, this study has employed a women's lens to bring out their experiences in the process of engaging in the sex trade within the slums. Thus, any material intervention in the slums will benefit from the voices of women which have been projected in this study.

The study has made significant revelations: individually, drug abuse including intravenous drug use, the issue of multiple partners to a single FSW, compromising condom use over the high amount of money, non-reporting of STI infections as well as risking one's own security by following the clients to their own places of residence remain predisposing factors. On the other hand, there is a strong stigmatization and discrimination of the sex workers by the family and community at large. The net

effect is the laxity of female sex workers to seek medical attention at the public health facilities while at the same time suffering continual violence which acts as predisposing factor to contracting HIV. Criminalization of sex trade as a social variable has not helped the situation either; the fear of prosecution upon identity and diagnosis with virus has made many female sex workers in Kayole to rely on over-the-counter prescriptions. Similarly, both the clients and law enforcers have exploited the legal loophole to sexually abuse the female sex workers during their operations.

5.2 Conclusion

Female sex workers in the slums in general and Kayole in particular remain largely at risk of being infected with HIV virus on the basis of their individual behaviours and social factors at the community and state levels. While sex workers remain an important group in the fight against HIV and AIDS in Kenya, a lot of the state interventions have failed to encompass this group especially those in the informal settlements such as Kayole without any economic might to seek medical interventions on their own. More importantly, the policy framework operating on the basis of legal criminalization of prostitution generally hinder intervention on this key population group with high prevalence rate of 24% of HIV in Kenya. Any programmatic intervention must therefore address itself to the community stigma, the case of multiple partners amongst female sex workers and socio-economic empowerment in which both health information and economic interventions are met upon this group. Similarly, the state has to move towards regulating the commercial sex industry with a pure objective of improving the health of the people involved.

5.3 Recommendations

- There is need for non-state actors to train female sex workers on techniques for safe sex negotiation and for the practice of non-penetrative sex acts. This should be coupled with training on consistent use of condoms.
- Economically empower the female sex workers in the slum through devolved funds such as UWEZO from the government. Sex workers face multiple risks, including social marginalization, violence, and poor health. These overlapping and mutually reinforcing factors have been shown to restrict sex workers' ability to improve their living and working conditions, and achieve economic security. They are also among the most frequently cited factors affecting the ability of sex workers to adopt safer sexual practices and condom use.
- Comprehensive, accessible, acceptable, sustainable, high-quality, user-friendly HIV prevention, treatment, care and support must be urgently scaled up and adapted to slum contexts and individual needs such as: actions to address structural barriers, including legislation, and customary practices that prevent access and utilization of appropriate HIV prevention.
- The state has to rethink policies and programmes to ensure freedom from violence, abuse, and discrimination while also information for sex workers and their clients and others involved in the sex industry.

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Appendix I: In-depth interview guide

- i. Are you aware of your HIV status?(if not answered ask: since when, how often do you check, how about your partners before sex)
- ii. Are there some form protection you use in your work?(which ones, what is the source, how often)
- iii. Are there circumstances where you have been involved in this work without protection? (what caused the miss, how did she handle that, how often has this occurred)
- iv. Do you have any particular client in this work? (if not mentioned: why do multiple partners come in, how does she protect herself, are these people known to her,)
- v. Have you ever been involved in this work under any drug influence?(is it a common occurrence, how often, how does she ensure her safety in this case)
- vi. In the course of your work, have you been beaten up or forced upon by a client? (did they use protection, how often, how do you handle post rape cases)

Social factors

- i. How has the community around treated you when you identify yourself as a sex worker? (are you frowned upon, do they want to identify with you?)
- ii. Do you experience any kind of discrimination when you identify your trade to health authorities?(Are you properly attended to? Do the providers ignore you? Do you)
- iii. Do the members of your family know about this work?(how do they advise you health wise, are they comfortable with you?)

Appendix II: Key informant interview guide

- i. What is your opinion on the fate of FSW and HIV within the slums?
- ii. How has this population been treated in HIV response in Kenya?
- iii. What are some of the behaviors that might increase female sex workers vulnerability to infection?(if not mentioned ask: the issue of multiple sex partners, drug abuse, knowledge of status, issues of SGBV between the FSW and the workers etc)
- iv. What are some the community factors that might increase such risks?
- v. Have there been state and non-state actors responses to address these issues?(what are these programs, what policies, how are these groups reached, how effective , what are the gaps)

Appendix III: Case narrative interview guide

Tell me about your experience as an FSW around Kayole slums. (probe on HIV knowledge, sex behavior, service seeking behavior, personal and community limitations on the same)