BARRIERS FACED BY FEMALE SEX WORKERS IN SEEKING HEALTHCARE AT PUBLIC HEALTH FACILITIES IN MLOLONGO WARD, ATHI-RIVER SUB-COUNTY

CAROLINE NJERI NDUNG'U

A PROJECT PAPER SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR MASTERS OF ARTS DEGREE IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI.

2016

DECLRATION

This project paper is my original work and has not been submitted for examination in any other university for award of a degree.

Signature_________________ Date________________

Caroline Ndung'u.

(N69/75364/2014)

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

Signature__________________ Date________________________

Dr. Dalmas Omia.

DEDICATION

To my parents Nicholas Ndung'u Mbugua and Miriam Nyambura Ndung'u for their prayers and ceaseless support.

To my siblings Evans, Eva, Duncan, Delani and John for their reassurance and encouragement.

ACKNOWLEDGEMENTS

I wish to extend my gratitude to the faculty members at the Institute of Anthropology, Gender and African Studies for their support especially at the time of proposal development and defense. My special cognizance goes to my supervisor Dr. Dalmas Omia for his support and professional guidance throughout the project. Your inputs were intellectually rich and inspirational.

My incomparable gratitude goes to the Constituency Aids and STI Control Officer (CASCO) for Athi River Sub County Dr. Pauline, for the towering support during data collection at Athi River Health Centre. I also appreciate the resourceful and imperial inputs of Mr. Simon Mwangi a rights advocate officer from Bar Hostess and Sex Workers Programme (BHESP). My study informants for their cooperation throughout the study period. I valued your openness and outstanding assistance during data collection.

I wish to convey special cognizance to my workmates at HCHRC for inspiring my work with Female Sex Workers and their health thereof. It greatly influenced my passion to carry out the study. I also acknowledge my friends Catherine, Hellen, Judy, Eunice and Gilbert Asoka for your encouragement and inputs in to the study. I wish you well in your ventures.

TABLE OF CONTENTS

DECLRATION i

DEDICATION ii

ACKNOWLEDGEMENTS iii

LIST OF TABLES vii

LIST OF FIGURES viii

LIST OF ABBREVIATIONS AND ACRONYMS ix

ABSTRACT x

CHAPTER ONE: BACKGROUND TO THE STUDY 1

1.1 Introduction 1

1.2 Problem statement 4

1.3 Study Objectives 5

1.3.1 Overall Objective 5

1.3.2 Specific Objectives 5

1.4 Assumptions of the study 5

1.5 Significance of study 5

1.6 Scope and Limitations of the study 6

1.7 Definition of terms 7

CHAPTER TWO: LITERATURE REVIEW 8

2.1 Introduction 8

2.2 Sex workers health needs 8

2.3 Barriers FSWs face while seeking healthcare 10

2.3.1 Stigma related barriers 11

2.3.2 Quality of services 11

2.3.3 Attitude of service providers 12

2.3.4 Disclosure and criminalization related barriers 13

2.3.5 Privacy and Confidentiality 14

2.3.6 Fear of prosecution 14

2.3.7 Policing Strategies. 15
2.4 Theoretical Framework 16
2.4.1 Critical Medical Anthropology Theory (CMA) 16
2.4.2 Relevance of the theory to the study 18

CHAPTER THREE: METHODOLOGY 20
3.1 Introduction 20
3.2 Research Site 20
3.2.1 Economic Activities 23
3.2.2 Health Facilities 23
3.3 Research Design 23
3.4 Study population and unit of analysis 24
3.5 Sample and Sampling Procedure 25
3.6 Data collection methods 26
3.6.1 Semi-Structured interviews 26
3.6.2 Key informant interviews 26
3.6.3 Case Narratives 27
3.7 Data Processing, Analysis and Presentation 28
3.8 Ethical Considerations 29

CHAPTER FOUR: BARRIERS FACED BY FSWs IN ACCESSING HEALTHCARE.... 30
4.1 Introduction 30
4.2 Demographic Characteristics of the Respondents 30
4.2.1 Age of respondents 30
4.2.2 Level of Education. 31
4.2.3 Source of Income 32
4.3 Sex Workers Health Needs 34
4.3.1 Physical injuries 34
4.3.2 Sexually Transmitted Infections 35
4.3.3 Reproductive Health Needs 37

4.4 Barriers Faced by FSWs while seeking healthcare 39
4.4.1 Stigma related barriers 39
4.4.2 Healthcare Quality related barriers 41
4.4.3 Attitude related barriers 43
4.4.4 Disclosure and criminalization related barriers 45
4.4.5 Privacy and Confidentiality related barriers 48
4.4.6 Fear of prosecution 49
4.4.8 Health Information related barriers 52
4.5 How the barriers faced by FSWs at public health facilities affect FSWs health seeking behavior 53

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS 59
5.1 Introduction 59
5.2 Summary 59
5.3 Conclusion 61
5.3 Recommendations 62

REFERENCES 63
Appendix 1: Consent Forms 70
Appendix 2: Semi-Structured Interview Guide 73
Appendix 3: Case Narrative Guide 74
Appendix 4: Key Informant Interview Guide 75
Appendix 5: Research Clearance 76
Appendix 6: KNH Letter 77

LIST OF TABLES

Table 4.1 Respondents Age 30

Table 4.2 Level of Education of the Respondents 32

Table 4.3 Source of Income for the respondents 33

LIST OF FIGURES

Figure 3.1 Map of Kenya showing Machakos County 21

Figure 3.2 Map showing Mlolongo in Mavoko Constituency 22

Figure 4.1 FSWs preferences for seeking healthcare 56

LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASWA	African Sex Worker Alliance
BHESP	Bar Hostess Empowerment & Sex Workers Programme
CCC	Comprehensive Care Clinic
CASCO	Constituency Aids and STI control Coordinator
CMA	Critical Medical Anthropology
CN	Case Narratives
DHS	Demographic and Health Survey
FSWs	Female Sex Workers
HCHRC	Highway Community Health Resource Centre
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
KASF	Kenya Aids Strategic Framework
KI	Key Informants
MSM	Men who have Sex with Men
NACC	National Aids Control Council
PTSD	Post Traumatic Stress Disorder
RHRU	Reproductive Health & HIV Unit
SI	Semi Structured Interviews
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
WHO	World Health Organization
ZMOH	Zimbabwe Ministry of Health

ABSTRACT

This was a cross-sectional descriptive study on barriers faced by FSWs while seeking healthcare at public health facilities in Mlolongo ward, Athi River Sub County. The study examined the barriers at the public health facilities that prevent FSWs from seeking health care at public health facilities and how they affect FSWs health seeking behavior. A sample of 30 FSWs comprised the study population and data was obtained through semi structured interviews, key informant interviews and case narratives. The study was guided by the critical medical anthropology theory. Data analysis was done using grounded approach and guided by the study objectives.

The findings indicate that FSWs have unique health needs related to their work. They therefore have constant need of health care. None the less they have barriers that prevent them from seeking health care at public health facilities. Acute levels of stigma and discrimination towards FSWs in most public health facilities was a major barrier. It fuelled negative attitude of service providers towards FSWs. Other key barriers identified were poor quality of health care services, perceptions and fear of prosecution, weak policies, skills and knowledge gaps amongst most service providers. As a consequence of the outlined barriers in government health facilities, FSWs have resulted to other alternatives of health care the most preferred being private hospitals.

The study concludes that stigma and weak health policies remain barriers to access of health care for FSWs. As a result, FSWs seek other alternatives for health care some of which turn out to be unhealthy. The study recommends sensitization of health care service providers on the health needs of FSWs. This should be accompanied by non-discriminatory health policies to ensure accommodation of FSWs. This will elicit broad-based access to healthcare services towards reducing the spread of diseases, infections, buying of drugs across the counter, behavior change and tackling the high out-of-pocket expenditure towards universal healthcare coverage for FSWs.

CHAPTER ONE: BACKGROUND TO THE STUDY

1.1 Introduction

Several structural, behavioral, and biological risk factors place female sex workers (FSWs) at heightened risk of HIV, sexually transmitted infections (STIs), and other detrimental sexual and reproductive health (SRH) outcomes (WHO, 2011). Globally, FSWs and other marginalized populations have often been overlooked in national strategies and programs, denying countries the opportunity to get ahead of their epidemics (UNAIDS 2009). Discrimination towards female sex workers is nearly universal (Balfoor, 2014). FSWs go through a wide range of health and wellbeing issues. A study by Bindel et al (2012), established that a percentage of 79 women among them FSWs complained of physical injuries as well as mental health issues, however, there is a possibility that as much as FSWs suffer from these physical and mental problems the cases have not been diagnosed and reported yet.

Female Sex workers represent a high risk group where communicable yet preventable diseases, including TB, HIV, other Blood borne Viruses and STIs, are common (Collinson et al., 2011). Furthermore, research into the mental health of FSWs in Switzerland found that sex workers often suffered from mental health problems, including depression, anxiety and Post-Traumatic Stress Disorder (PTSD) which negatively impact on physical health (Rossler et al., 2010). In addition to the criminalization of sex work, entrenched social stigma means that sex workers often avoid accessing health services and conceal their occupation from health care providers. Similarly, police and other law enforcement officials often violate the human rights of FSWs rather than promote and protect FSWs (Rossler et al., 2010).

According to UNAIDS (2014) study among female sex workers in Saint Petersburg, health care providers tended to stigmatize those who suffered from HIV. The study further indicates that stigma related with HIV infection prevented many FSWs from seeking HIV testing and counseling. The United Kingdom also reports similar barriers amongst sex workers from accessing health services as evidenced in the publication by the Home Office (2004).

Government health policies are silent on complex healthcare needs of FSWs. This often criminalizes FSW activities driving them into more vulnerable positions (Bradshaw et al., 2004). Moreover, this further subjects them to increased likelihood of violence, poor health, addiction and an inescapable position from their situation (Boynton and Cusick, 2006). The behavior of both the police and criminal justice system discourage FSWs from reporting violence and other crimes. Often, investigations tend to focus on the crimes relating to sex work instead of the crimes originally being reported. As a result, FSWs feel they cannot safely report crimes as they fear being treated like criminals and not as victims (Boff, 2012).

Female sex workers (FSWs) bear a disproportionate burden of HIV and have high levels of sexual and reproductive health (SRH) morbidity (Huet, 2011). In sub-Saharan Africa, 37 per cent of FSWs are living with HIV, a figure three times the global HIV prevalence among FSWs (WHO, 2011). The burden of STIs among this group is also high, with up to two thirds having a curable STI (WHO, 2011). Several risk factors such as multiple sex partners, unprotected sex, and unsafe working conditions place these women at increased risk of HIV, STI acquisition and other health related ailments (UNAIDS, 2009).

Stigmatization occurs in various aspects of FSWs life: from their own clients, the public and healthcare providers among other service providers (Sanders, 2007). This leads to reduced contact and relationship with health services and other providers of support, increased stress which results to mental health problems, and feelings of rejection; contributing to societal exclusion (Cusick and Berney, 2005). Thus, Bury (2011) indicates that adequate service provision for this group could be achieved through holistic, fast track support, and a clear understanding of how to offer services to people who are vulnerable. As highlighted initially, FSWs experience a lot of exclusion and have a complex needs. This include limited access to public funds, lack of rights to work, limited access to drug and alcohol addiction assistance services, extreme poverty, vulnerable mental and physical health, limited education, uncertain immigration status, weak psychosocial support and frail opportunities of breaking from destructive behavior (Hall, 2007).

Due to the nature of the sex work industry, majority of the FSWs lead nocturnal lifestyles which means that they find it challenging to attend regular appointments within the normal working. In many instances, conventional services and support offered at the public health centers are mostly inadequate compared to the complex needs of sex workers. Displacement of services, inaccessible locations, difficulty in reaching services, lack of enough knowledge by service providers and the social stigma associated to sex work leads to inadequacy in the provision of services.

1.2 Problem statement

Studies among FSWs in Africa have mostly assessed the burden of disease, risk behaviors or relative efficacy of individual interventions (Baral, 2012; Beyrer, 2012). FSWs projects in many settings have demonstrated effective ways of altering this risk and improving the health and wellbeing of these women, yet, the optimum delivery model of FSWs projects in Africa is unclear especially for government facilities (Bandewar and Kilimani, 2010). Further, studies among FSWs have looked into services that ought to be offered to this high risk group. This is done without a clear understanding of barriers faced by FSWs in accessing health services in public health facilities leading to unmet SRH needs among FSWs (WHO, 2011). A previous study by Lafort and Cumba (2010) among FSWs only assessed the incidences of unwanted pregnancies among this population and established that 35-86 per cent of FSWs had at least one previous abortion.

Whereas the studies above have concentrated on the working environment of the female sex workers and the risk factors thereof, little has been assessed on the health facility-based barriers that may prevent the FSWs from seeking healthcare and treatment from public health facilities. Hence, this study sought to explore confines experienced by FSWs in reaching healthcare services at the public health facilities in Mlolongo Ward in Athi River Sub-County. The inquiry was guided by the following questions:

i. What barriers do FSWs face while seeking healthcare at public health facilities in Mlolongo Ward, Athi-River Sub-County?

ii. How do these barriers prevent FSWs from seeking healthcare at public health facilities in Mlolongo Ward, Athi-River Sub-County?

1.3 Study Objectives

1.3.1 Overall Objective

To explore barriers faced by FSWs in seeking healthcare at the public health facilities in Mlolongo Ward, Athi River Sub-County.

1.3.2 Specific Objectives

i. To find out the barriers faced by FSWs while seeking healthcare in Mlolongo Ward, Athi River Sub-County.
ii. To determine how the barriers faced by FSWs prevent them from seeking healthcare in Mlolongo Ward, Athi River Sub-County.

1.4 Assumptions of the study

i. FSWs face difficulties in the process of seeking healthcare at public health facilities in Mlolongo Ward, Athi River Sub-County.
ii. The difficulties faced by FSWs in the process of seeking healthcare create barriers that prevent them from accessing health care at public health facilities.

1.5 Significance of study

The findings of this study aid in improving delivery of health care services to FSWs at the public health facilities, by taking into considerations delivery models related to FSWs health and wellness needs especially in Athi–River Sub-County where the study was carried out. The findings also intensify the knowledge around female sex workers health needs especially those whose major clientele happen to be long distance truck drivers.

The findings of this study should add to the existing policy frameworks for example the Kenya Aids Strategic Framework (KASF 2015-2018) which aims at reducing the HIV&AIDS prevalence amid the high risk populations like the FSWs. In addition, it contributes to the field of academia especially the sexual and reproductive health sector through exploring the needs of Most at Risk Populations (MARPs) using the case of FSWs.

The research provides a reliable body of literature for future researches in the broader field of FSWs health. The study has made recommendations on areas that require further research. In this sense, this research has provided leads for other related studies in the future.

1.6 Scope and Limitations of the study

This study only documented barriers faced by FSWs in accessing healthcare services in public health facilities Mlolongo area. Specifically, it looked into the healthcare needs of FSWs and the specific barriers they face while seeking healthcare at the public health facilities. Thus, the experience of FSWs with private health facilities in Mlolongo was beyond the scope of the study. The study was qualitative in nature and did not comprehensively document the quantitative trends and patterns of barriers faced by FSWs in seeking healthcare at public health facilities, however, triangulation of data collection methods compensated for limitations associated with single-line inquiries. Whereas the study dealt with a highly stigmatized group that was not easily willing to share their experiences, study participants were assured of anonymity through the study phases so to gain informed consent before their participation.

1.7 Definition of terms

Barriers: In this study, these are challenges that prevent FSWs from obtaining the desired health care from public facilities in Mlolongo and Athi River.

Criminalization: In this study it is a situation where health providers report to the law enforcers the activities for FSWs for possible prosecution.

Disclosure: In this study it refers to the act of FSWs revealing their sex work activities to health care providers at the public health care facilities in Mlolongo and Athi- River.

Female Sex Workers: They refer to women at the brothels in Mlolongo ward who provide sexual services for goods or money.

Health facilities: These are places that provide health care and treatment for patients in this study the FSWs. In Mlolongo they include Athi-River health centre and Mlolongo health centre which are both public health facilities.

Sex work: This is the provision of sexual services for money or goods. In this study the services are provided by the FSWs in Mlolongo ward.

Stigma: In this study it refers to the mark of disgrace associated with FSWs by the healthcare providers in the process of seeking healthcare at the public health facilities in Mlolongo and Athi-River. The disgrace, rejection and marginalization is as a result of the FSWs sex work activities.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on barriers faced by FSWs in seeking healthcare at public health facilities. The review has been carried out along the following topics: healthcare needs of FSWs, barriers FSWs face while seeking healthcare and how these barriers prevent FSWs from accessing healthcare services. The chapter concludes by discussing the theoretical frame work and its relevance to the study.

2.2 Sex workers health needs

A number of services related to health targeted to FSWs provide vast support with regards to sexual and reproductive health as well as drug addiction. However, this intervention does not meet the wider needs of sex workers such as mental health, physical wellbeing, financial needs, housing and educational needs. Lack of necessary healthcare, high morbidity, homelessness, lack of academic qualifications, extreme poverty, stigmatization, addiction and the sale of sex for financial recompense can be detrimental to participation in societal norms and services resulting in adverse outcomes such as poor health (Jeal and Salisbury, 2004).

In his view Arnott (2009), posits that globally FSWs experience an array of negative health outcomes, including high rates of violence, HIV and other sexually transmitted infections, and yet, they remain largely sidelined on the conventional health services. In criminalized and quasi-criminalized sex-work environments, sex work activity is largely unregulated and highly policed, with sex workers experiencing a lot of violence, victimization, and crackdowns from the police

(Goodyear and Cusick 2007; Shannon et al., 2007). There exist information gaps among FSWs on sexual and reproductive health services (Dunkle, 2005).

Female sex workers have unique health needs due to their nature of work that exposes them to sexual and reproductive health hazards among other health concerns. Sex workers across sub-Saharan Africa are marginalized and face gross human rights violations, discrimination, harassment and numerous barriers to accessing healthcare (Day and Ward, 2007).

Ongoing criminalization of sex work globally means that sex workers are exposed to occupational health and safety risks that would never be accepted in any other profession. This includes exposure to injuries, infection with HIV and other sexually transmitted diseases, harassment, violence, rape, musculoskeletal injuries, urinal-genital problems, stress, depression, alcohol and drug use, respiratory infections, the removal of children, and death (Rekart, 2005). Having restricted access to legal protection makes them a soft and easy target for criminals, and sex workers around the world continue to be murdered at rates higher than the general population (Aitken, 2002).

Across sub-Saharan Africa, sex workers also carry a disproportionate burden of HIV, with prevalence commonly 10–20-fold higher than among the general population (Godin et al., 2000). Preventing violence is not only a human rights priority but also a global public health concern, as violence exacerbates the risk of sexually transmitted infections, including HIV (Riedner et al., 2003). Sex workers often have poor access to contraception and HIV prevention commodities since they are excluded from public campaigns for safer sex and their access to health services in

general is impeded by discrimination and prejudice (Harcourt, 2010). Historically, sex workers have been viewed as reservoirs of sexually transmitted disease, and are consequently blamed for Africa's ongoing HIV crisis, with sex work being seen as the cause of disease rather than the consequence of economic marginalization (Elmore-Meegan et al., 2004).

Globally, FSWs are affected by HIV disproportionately (UNAIDS, 2012). A systematic analysis recently indicated that FSWs prevalence of HIV ranges between 10 to 18 times higher than that of general population of women within the reproductive age approximately 50 per cent. (UNAIDS, 2012).The figures are consistent with HIV prevalence data on sex worker populations throughout the region, for example, 59.6 per cent in South Africa, 70.7 per cent in Malawi, and 45.1 per cent in Kenya. Sex workers' share of the HIV burden intervention has not been backed by commensurate efforts to accessible antiretroviral treatment ART (UNAIDS, 2012). New insights from the study also indicate that FSWs suffer from skin infections as a result of skin contact from multiple sexual partners.

2.3 Barriers FSWs face while seeking healthcare

There exists a dis-connect between the health needs of FSWs and access to health care to address their health related needs (Ghimire, 2009). This is because there are perceived health services access barriers by sex workers as seen from previous studies. Sex workers experience being singled out and mistreated in health institutions. Below are some of the barriers that have been pointed out by previous studies.

2.3.1 Stigma related barriers

Goffman (1963) definition of stigma was an attribute that is highly discrediting, with the individual being stigmatized possessing certain undesirable difference and an identity that is spoiled. Noteworthy, a growing number of research studies globally have reported that stigma can act as a key barrier to access to health for FSWs. (Cohan et al., 2006; Kurtz et al., 2005). Sex workers create strategies to hide their involvement in sex work from others because of felt stigma, increasing their exposure to stress, depression and other ailments (Benoit et al., 2005).

Women involved in sex work constantly experience rejection from their home communities (UNAIDS, 2009). They also site difficulty in accessing condoms at health centers due to the stigma associated (Dalmini, 2009). According to the Global Aids Response county report in 2012 by the Zimbabwe Ministry of Health, despite the existence of well-attended services targeted to FSWs in Zimbabwe, fewer than half of women diagnosed with HIV took up referrals for assessment and start of ART, just 14 per cent only attended more than one appointment. FSWs emphasized barriers, such as being demeaned and humiliated by healthcare workers, reflecting broader social stigma surrounding their work (ZNAC, 2009).

2.3.2 Quality of services

The perceived low quality of the service provision, poor communication between the clients and the service providers, judgmental and disrespectful language of the service providers and inadequate training in sexual and reproductive health provision, contributed to poor access to health care for FSWs (Romans, 2009). In Zimbabwe, FSWs reported similar experiences in

accessing health care. In Limpopo, FSWs cited numerous challenges in finding suitable health facilities, because many migrant clinics appeared to have curtailed services (Evans, 2008).

The hospitals were criticized for charging higher fees, notwithstanding the fact that the doctors and nurses were perceived as being inadequately trained and with less experience, a finding similar to that found in Abidjan (Vuylsteke, 2004). Global journal 1st indicates that there exists both structural and individual barriers. Structural includes: social stigma, travel cost, target programme population and office hours. Individual barriers include: fear, drug use and mental stability. The manner in which patients are received and handled at the health services indicates a good measure of the quality of services offered at the health care facility. Bridging these gaps is very important from a public health perspective given the disease burden among FSWs.

2.3.3 Attitude of service providers

The negative attitude of service providers was equally found in Cape Town, Africa (Simbayi et al., 2007). Interpersonal behavior with service providers, sexual harassment, poor communication, lengthy waiting times and judgmental attitudes were brought out as constraints to seeking healthcare services.

Rushing et al. (2005) equally identified high travel cost, reduced privacy and confidentiality, behaviors of service providers, substandard services and long distance difficulties in accessing and negotiating the health care system as external and structural barriers. In South Africa, they reported being denied treatment by health workers, who were often disrespectful and verbally abusive (Crago, 2009).

FSWs described many instances of poor treatment once health providers particularly those in public clinics and hospitals became aware of their work (Glad, 2008). They were said to ask invasive and unnecessary questions of sex work and frequently breached patient confidentiality (Merten, 2010). Sometimes FSW have had to pay health workers additional money for services, especially for STI treatment (Scambler, 2008). As a result FSW generally avoided facilities where providers are known to be cruel or likely to withhold treatment (Scambler, 2010).

2.3.4 Disclosure and criminalization related barriers

In sex work criminalized environments, poor access to non-judgmental and adequate health services have been identified by UNAIDS (2002; 2009). FSWs were particularly sensitive to being identified and belittled within the health care environment (Lambert, 1997). Sex workers experience being singled out and mistreated in health institutions as a result of disclosing their work (Puri & Cleland 2006).

Gaps in privacy and confidentiality at the health care facilities in addition to fear of prosecution are some of the reasons for non-disclosure by FSWs. Most sex workers result to not disclose their occupation and also their illness which undermines diagnostic accuracy Zimbabwe National Aids Council ([ZMOH], 2009). Vindictive environments have been shown to limit the availability, access and uptake of HIV prevention, treatment, care and support services for FSWs and their clients. Criminalization towards FSWs is nearly universal. It is evident that criminalization of sex work increases vulnerability to HIV and other sexually transmitted infections. The criminalization of sex work prevents evidence-informed HIV and other responses for FSWs. (The gap report 2014)

2.3.5 Privacy and Confidentiality

According to National Centre for AIDS and STD Control (2004), HIV counseling in Nepal, Most Nepalese FSWs also felt a lack of privacy and confidentiality in the government hospital because of the crowd of patients and the Behavior of the health care workers. In their opinion it made them feel further stigmatized. Hospital rules often result in women having to queue for long periods of time, and having to disclose personal information and disease history to the doctor whilst undergoing a check-up in a place without privacy (Scambler and Paoli, 2008).

In a research report study carried out in Majengo Nairobi by The International Treatment Preparedness Coalition (ITPC), Almost 40% of respondents said they did not seek health services at the government hospital. They gave various reasons, including: the health worker was rude and the service providers lacked privacy and confidentiality especially for FSWs who were considered young in the business. (Research report 1 May 2014 ITPC: Barriers to accessing HIV treatment from a community perspective).

2.3.6 Fear of prosecution

The views from the United Kingdom reveal that fear of disclosure and privacy of sex work status, fear of prosecution and distrust of authority may prevent sex workers from accessing health services (Day and Ward, 1997). A qualitative research study by Jael and Salisbury (2004) has shown that when contact with health care providers is high among FSWs non-disclosure of sex work status may still contribute to poor health.

Reasons for not disclosing involvement in sex work to health care providers have been suggested to include fear of prosecution and arrest (Rekart, 2005), believing that sex work was not relevant to their health needs, fear of disapproval, negative past experiences with disclosure and embarrassment (Cohanet al., 2006). Whereas women have hidden their involvement in sex work in an effort to increase the likelihood of receiving good services, this means that healthcare providers remain unaware of all their care needs (Kurtz et al., 2005). Female Sex Workers struggle to meet their own health and well-being needs and face significant legal and institutional discrimination. Health care providers often neglect their duty to provide care when serving female sex workers. FSWs on the other hand expressed feeling incapacitated having not gone through formal education to advocate for better health access. Similarly, police and other law enforcement officials constantly violate the human rights of FSWs rather than promote and protect them (The Gap Report 2014).

2.3.7 Policing Strategies.

Recent research by Day and Ward, (2007) has shown that policing strategies that displace FSWs to the margins of society increase health-related harms and experiences of violence faced by women. Simultaneously marginalization policies increase barriers for women attempting to access health care (Rusch et al., 2007). They are a highly marginalized subgroup and their social stigma is a barrier for the use of health care and treatment (Faugier et al., 2000)

Health services are generally not accessible to underprivileged women (Wolffers, 2009). Lack of knowledge of where to access care, limited hours of operation and long waiting hours were equally cited as additional policy barriers (Goodyear and Cusick, 2007). The international

community agrees that the Millennium Development Goals will not be achieved without ensuring universal access to both sexual and reproductive health (SRH) services and HIV/AIDS prevention, treatment, care and support. Policy and system gaps limit universal access for health services by FSWs. United Nations: Millennium development goals (MDGs 2000).

2.4 Theoretical Framework

2.4.1 Critical Medical Anthropology Theory (CMA)

CMA is a branch of medical anthropology that blends critical theory and ground level ethnographic approaches in the consideration of the political economy of health, and the effect of social inequality on people’s health (Baer, 1996). It puts emphasis on the structure of social relationships rather than purely bio-medical factors in analyzing health and accounting for its determinants. CMA includes ways in which health services are differentially allocated based on social factors and perceptions (Baer, 1996).

CMA theory as an analytical perspective in healthcare has been influenced by Marxist theory and dependency theory (Ember & Levinson, 1996; Singer & Baer, 1995:3). It emphasizes the importance of political, social and economic forces, including the exercise of power, in shaping health, disease, illness experience and health care (Singer and Baer, 1995:5). It also looks towards a more holistic understanding of the causes of sickness, the classist, racist and sexist characteristics of biomedicine as a hegemonic system, the interrelationship of medical systems with political structures, the contested character of provider-patient relations and the localization of sufferer experience and action within their encompassing political-economic contexts (Singer and Baer, 1995:6). CMA is concerned with the phenomenology of illness and pain, and the social

construction of the individual. Health is also considered to be socially constructed, rather than organic, and is defined as "access to and control over the basic material and non-material resources that sustain and promote life at a high level of satisfaction" (Baer et al., 1986:95).

The theoretical underpinnings of critical medical anthropology can provide comprehensive support and enlightenment to intervention programming. This focuses on political economy, the social relations of health and disease, and commitment to social action. Applied critical medical anthropological theory can bring a variety of attributes to critical praxis: cultural relativism; concern with insider perspective; support for self-determination; a desire to work with communities to respond to their felt needs; an appreciation of research as a "potent weapon in social struggle" (Singer, 1995:99); holistic orientation and understanding of local customs; recognition that culture shapes and is shaped by social relations and human behavior; and an orientation to "consciousness raising and empowerment through the unmasking of the structural roots of suffering and ill health" (Singer, 1995:99).

Critical anthropology has been influenced by Michel Foucault's writings on the historical production of medical knowledge and the notion that the body can become an arena in which social control issues are played out. Usually focused on medical communication, the approach has been used particularly in relation to women's reproductive health and has developed a controversial literature on the lexicalization of women’s bodies.

2.4.2 Relevance of the theory to the study

CMA is concerned with the phenomenology of illness and pain, and the social construction of the individual. It looks towards a more holistic understanding of the causes of sickness, the classist, racist and sexist characteristics of biomedicine as a hegemonic system. The phenomenology of illness as well as the causes of sickness goes a long way to explain the health care needs of FSWs along issues of sexual and reproductive health, HIV care and treatment and other communicable diseases.

CMA explains ways in which health services are differentially allocated based on social factors and perceptions. This was important in explaining how stigma and discrimination of FSWs emerging from the health care facilities prevented FSWs from seeking health care. The phenomenon resulted into women minimizing health centre visits given the social stigma seeking other alternatives irrespective of the quality of healthcare provided.

CMA emphasizes the importance of political, social and economic forces, including the exercise of power, in shaping health, disease, illness experience and health care. It helped to explain how disclosure and criminalization prevented female sex workers from seeking health care. CMA examined the contested character of provider-patient relations and the localization of sufferer experience and action. In this case it helped to explain the challenges female sex workers face at the health centres in terms of attention by the care-providers which have been labeled discriminatory. The situation has led to overlooking the patients' explanations and conditions within the health centres by the medical attendants. This approach therefore analyzed the biomedical practice and the differentials in power and authoritative knowledge of practitioner

and patient which is critical in understanding challenges faced by female sex workers in seeking reproductive healthcare.

In summary, the literature review generally provided a platform of existing knowledge, knowledge gaps and critical perspectives in the study of sex workers health needs and barriers to seeking health care in public health facilities. It highlighted the unique health needs of FSWs and their experiences at health facilities.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter describes the research site, design, population sample and sampling procedures, data collection methods and tools, analysis and presentation of findings. The chapter concludes by discussing ethical considerations that guided the study.

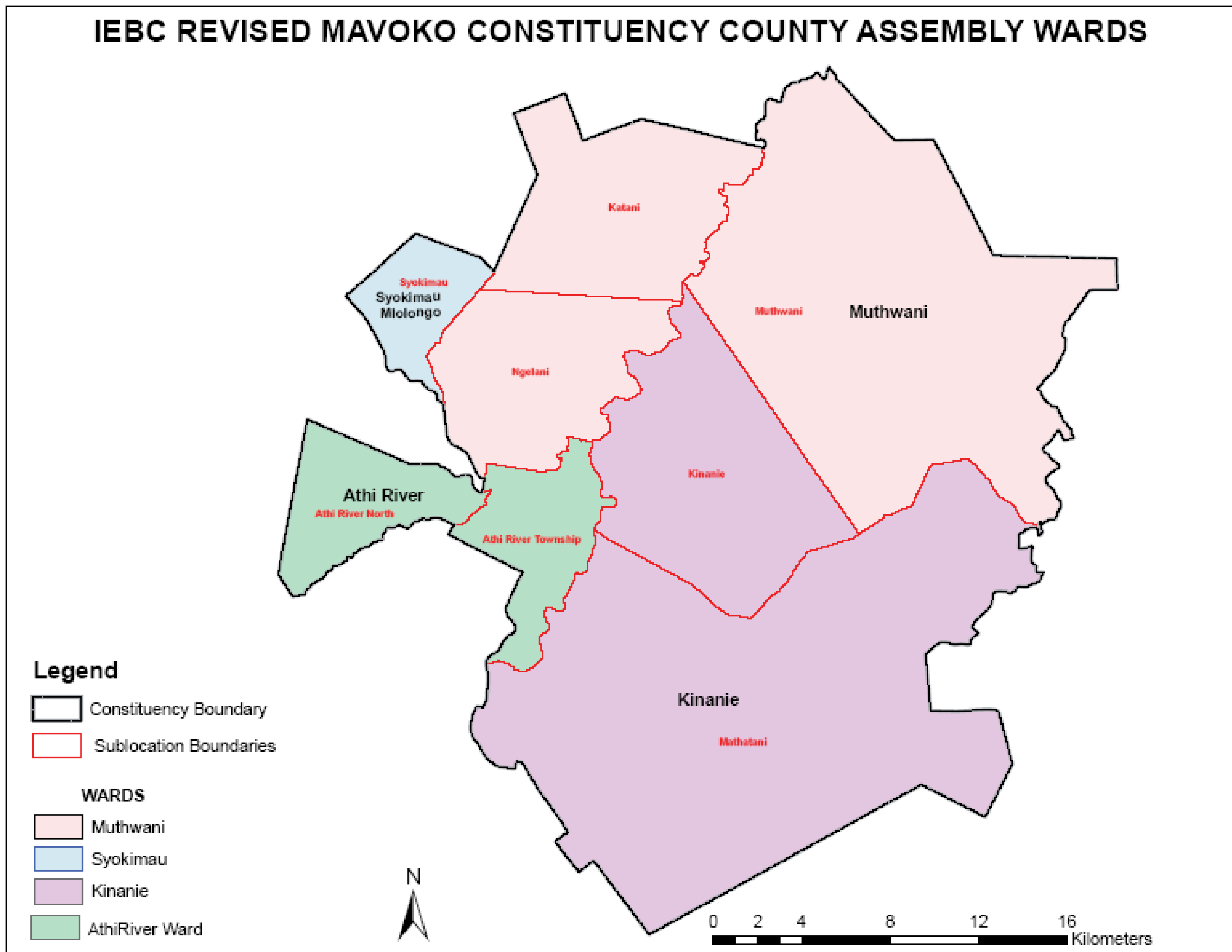
3.2 Research Site

The study was conducted in sex workers brothels located in Mlolongo ward, Athi River Sub-County, Machakos County in Kenya (Figure 3.1). Mlolongo is along the Mombasa Nairobi highway on the northern highway corridor (Figure 3.2). It is 19km from Nairobi in Machakos county Eastern Kenya. Machakos covers 582650 sq. km) with estimated population of 1,098,584 in 2009 with Mlolongo having an estimate of around 6000 inhabitants (2014 Population List). Machakos is approximately 39km/24 mi away from Mlolongo (Open Data Kenya).

Figure 3.1 Map of Kenya showing Machakos County

Source: Maps data 2016

Figure 3.2 Map showing Mlolongo in Mavoko Constituency



Source: Maps Data 2016

3.2.1 Economic Activities

Locally Mlolongo has been considered an economic hub. This is occasioned by the ongoing day to day business activities. Specifically trade and transport are the main business activities. Mlolongo being along the highway the goods on transit constantly exchanging hands. Mlolongo is highly populated by FSWs due to the heavy presence of trucks on transit attracted by the weighbridge where the trucks stop for weighing. The truck drivers form a huge client base for FSWs and hence explaining the reason behind the sex work brothels in Mlolongo.

3.2.2 Health Facilities

There are both public and private health facilities where FSWs seek health care. Majorly the public facilities include Mlolongo health centre which has just been recently constructed and Athi River health centre which is the main government health facility. The private health facilities include Highway Community Health Resource (HCHRC) that offers FSWs HIV care and appropriate referral and North Star Alliance that offers treatment to FSWs. Both facilities have tailor made programs for FSWs unlike the rest of the health care facilities that offer general treatment to the larger Mlolongo community. According to (HCHRC, 2014), there is an estimated 500-700 female sex workers operating in Mlolongo based on their service delivery reports. However, statistics from HCHRC (2014) also indicate that less than twenty per cent of these sex workers seek further care and treatment at the public health facilities after referral.

3.3 Research Design

This was a cross-sectional descriptive study. The fieldwork spanned a period of 4 weeks between April and May 2016. In the study, qualitative data collection methods were employed

to address the stated research questions. Specifically, data was collected using semi structured interviews, case narratives and key informant interviews. Given the exploratory nature of the study, triangulation of data collection methods was deemed necessary so as to compensate for limitations in single-line data collection approach.

To maximize on the data collection methods, the study began by conducting semi structured interviews with informants on FSWs experiences while seeking health care at public health facilities. Case narratives were also introduced to give detailed experiences on the barriers FSWs face while seeking healthcare at public health facilities. Having received information from the FSWs by way of case narratives and semi structured interviews, key informant interviews were conducted to bring in expert opinions on the objectives of the study but also clarify some of the issues raised by the FSWs.

The data collected was translated then transcribed. Thematic analysis followed in line with the specific study objectives. In the presentation, verbatim approach was adopted where direct quotations were used to amplify the informants' voices.

3.4 Study population and unit of analysis

The study was conducted amongst the FSWs operating in brothels in Mlolongo Ward Athi-River Sub- County. The unit of analysis was the individual female sex worker.

3.5 Sample and Sampling Procedure

According to Collis and Hussey (2003) a minimum number of 30 in qualitative research is considered representative and inclusive in the quality of demographic characteristics. It is in view of the same that 30 FSWs were conveniently sampled in the brothels at Mlolongo. Upon reaching the brothels the index persons in this case the head of specific brothels were reached who introduced the researcher to the FSWs. Using the head of specific brothels was a way of ensuring that the participants of the study were FSWs based in Mlolongo brothels. Contact was then established with the selected FSWs through the assistance of the index persons. Those who were available and willing to take part in the study were recruited as study participants. The inclusion criterion was limited to only the FSWs who work in Mlolongo brothels.

To get key informants' input, 3 key informants were purposively selected for interviews based on their work with FSW, two from Athi-River health center who provide health services to FSWs as well as a sex workers rights advocate from Bar Hostess and Sex workers Programme (BHESP).

The informants to case narratives (numbering four) were purposively drawn from the FSWs brothels in Mlolongo. They were sampled based on the length of time they have been FSWs, their experiences during the encounters they have heard with public health facilities while seeking health care and their willingness and availability to delve more into discussing barriers that prevent FSWs from seeking health care at public health facilities in Mlolongo ward, Athi River Sub County.

3.6 Data collection methods

3.6.1 Semi-Structured interviews

The semi-structured interviews were conducted with 30 FSWs in Mlolongo brothels. The method was important in digging out data from the FSWs on their health needs, experiences while seeking healthcare at public health facilities, the barriers they face while seeking healthcare from public health facilities and how these barriers affect their health seeking behaviour. The semi-structured nature was important in probing deep in to the specifics of the barriers as well as the reactions attached. This was significant because it brought out new insights from the discussions. Stigma and discrimination stood out from the experiences shared as a strong barrier to seeking healthcare by FSWs. The interviews were conducted with the help of a semi structured interview guide (Appendix 2).

3.6.2 Key informant interviews

These were semi-structured interviews carried out with professionals amongst them: The Constituency Aids Control Council coordinator who is also a healthcare provider at from Athi River health centre, a nurse and a FSWs rights advocate working with Bar Hostess and Sex workers programme (BHESP) as the programme manager.

The key informants provided information on the on facility based barriers, FSWs related barriers and suggestions for improving access to health care services for FSWs. The inputs of the experts were important in complementing the information from the FSWs as well as understanding the barriers from the healthcare providers' perspective. There seemed to be consistency between the information provided by the experts and that given by the FSWs especially around the issues of

stigma. The healthcare providers maintained that there was a need to sensitize healthcare providers who stigmatize FSWs. More over the inputs gave recommendations on how the barriers FSWs experience at the public health facilities would be faced out moving forward. A key informant interview guide (Appendix 3) was used to collect the data.

3.6.3 Case Narratives

The observation that some of the FSWs had been in sex work longer than others and had multiple experiences seeking health care at public health care facilities necessitated the use of case narratives. To this end, the case narratives were carried out with four FSWs who were willing to talk more about their experiences in the process of seeking health care at public health facilities and the barriers involved. Basically, the narratives focused on determinants of health seeking patterns and behavior among FSWs. This was key in providing information on challenges in seeking health care services, alternatives to public healthcare and individual experiences.

The narratives elicited information on the vast FSWs health needs visa vie the poor quality of health services offered to FSWs at public health facilities. They cited both policy and quality issues like lack of commodities for example condoms as the barriers to health care. They also disclosed their alternatives methods of seeking healthcare besides the public health facilities. This alternatives included self-treat methods and over the counter treatment especially in the case where they could not afford health care at private health facilities. A case narrative guide (Appendix 3) was used to guide the process of inquiry.

3.7 Data Processing, Analysis and Presentation

Data analysis involves the process of combing through the raw data to determine what is significant and transform the data into a simplified format that can be understood in the context of the research questions (Krathwohl, 1998; Miles and Huberman, 1994; NSF, 1997).Data analysis makes it measurable and articulate. According to Peter Drucker (2003) what gets measured gets managed and implemented. Marshall McLuhan (2006) a Canadian research professor contends that analysis of data accords sense to the data.

In this study, the audio-taped data collected through semi structured interviews, case narratives and key informant interviews were translated, transcribed and coded for analysis. Data transcription, translation and analysis were carried out concurrently with data collection. This was done in order to get feedback from the data being collected and to add new insights significant to the study which led to adjusting the interview guides to accommodate for more information from the FSWs.

The transcripts were later coded so as to make the information discrete. Thematic analysis was done in line with the study objectives. Thematic analysis in these context meant grouping data into themes that help answer the research questions. (Taylor-Powell and Renner, 2003). The themes directly evolved from the research questions that were pre-set before data collection began. Some naturally emerged from the data as the study was conducted.

After identification of the themes the data was sub divided into thematic groups so as to analyze the meaning of the themes and connect them back to the research questions in line with the study

objectives to ensure validity. The themes involved stigma related barriers, quality of services, staff attitude, criminalization, lack of confidentiality, fear of prosecution, weak policies and information related barriers. A verbatim approach was used in data presentation where direct quotations and selected comments from informants were used to amplify the informants' voices and to convey actual meaning intended in the discussions.

3.8 Ethical Considerations

Essential ethical considerations and practices were undertaken to ensure that the study was conducted in line with sound research principles and regulations. A research permit (NACOSTI/P/16/08273/10342) was obtained from the National Commission for Science, Technology and Innovation (NACOSTI) before embarking on fieldwork. Ethical clearance from the UoN-KNH Ethical Review committee was equally acquired. The permit number was (KNH-ERC/A/296).

During fieldwork, informants were duly briefed on the purpose, the target groups, selection procedure, duration of the study, and potential use of the research results. An informed consent form (Appendix 1) was signed by the informants as surety of their understanding and acceptance to be involved in the study. Recruitments to participate in the study were based on informed consent of the FSWs. The rights of informants to withdraw at any point of the study were explained, however, the informants were encouraged to participate throughout the study. The study subjects were assured of their anonymity by use of codes and pseudo names during presentation.

CHAPTER FOUR: BARRIERS FACED BY FSWs IN ACCESSING HEALTHCARE

4.1 Introduction

The chapter begins by presenting the demographic characteristics, Further the findings are presented and discussed in line with the study objectives which include: FSWs health needs, barriers faced by FSWs while seeking healthcare in public health facilities and the effects of the barriers towards FSWs health seeking behavior. Discussions are carried out along the following sub-thematic areas: Stigma related barriers, quality of services, disclosure and criminalization barriers, privacy and confidentiality, fear of prosecution, in adequate policies and information gaps.

4.2 Demographic Characteristics of the Respondents

4.2.1 Age of respondents

In the study, age of the FSWs was deemed important in understanding the relationship between FSWs age and the quality of healthcare received. The findings indicated that 50% of the FSWs were aged between 15-20, 27% were between age 20-25 and 23% were between ages 25-30. Below is a table (4.1) showing the age of the FSWs who participated in the study:

Table 4.1 Respondents Age

Age Category	% of FSWs
15-20	50%
21-25	27%
26-30	23%

It was found out from FSWs that most of the health care providers are older than the FSWs which in their view made the healthcare providers treat them with contempt as one of the FSWs explained,

> *"For us FSWs, who are young, the nurses at the hospitals look down on us and we feel intimidated"* ***(SI #12 with 20yr old FSW).***

On the same, one of the key informants retaliated similar comments as those given by one of the FSWs in the semi structured interviews.

> *"FSWs young age could also catalyze the mistreatment by elder healthcare providers in public health facilities"* ***(KI#1 with FSWs rights advocate)****.*

This means that more than half of the respondents were young and quite innocent. This was important to note in the study since their age could have been a limitation to their ability to bargain for better healthcare at public health facilities. Similarly, a study carried out in Majengo, Nairobi on access and utilization of healthcare and treatment services by International Treatment Preparedness Coalition (ITPC 2014) indicates that the young FSWs aged 15-24 faced a lot of ridicule from health care providers who considered them to be young in the business there for making age a barrier to seeking health care for FSWs.

4.2.2 Level of Education.

Understanding the education level of FSWs was important in the study so as to explore the level of knowledge of FSWs on their health rights and capability to lobby for good health. The findings from table (4.2) below indicate that 67% of the FSWs had gone through basic primary education and among them 26% proceeded to secondary school level. It is noteworthy that among the FSWs interviewed only 7% had received tertiary education in different colleges.

Table 4.2 Level of Education of the Respondents

Level of Education	% of FSWs
Primary Level	67%
Secondary Level	26%
Tertiary Level	7%

This shows that majority of the FSWs had not advanced their education levels. As a result they may not be in a position to understand their health rights and how to advocate for better health as was remarked in one of the interviews:

> "*Most of us are school drop outs and hence we do not have the knowhow to lobby for better treatment in hospitals*" ***(SI #8 with a 29yr old FSW).***

Their judgment and reasoning capacity may also affect the decisions they make while seeking alternative health care options. The findings of the study are in concurrence with the gap report 2014 that indicates that majority of the FSWs felt incapacitated to demand for quality health services at the health facilities some having not gone through formal education.

4.2.3 Source of Income

The source of income of the FSWs was of interest to the study in that the study sought to find out if the FSWs were able to afford quality healthcare. The findings show that 90% earn their income from sex work and around 10% have other income generating activities besides sex work. Below is a table (4.3) showing the sources of income for the respondents who participated in the study:

Table 4.3 Source of Income for the respondents

Source of Income	% of FSWs
Sex Work	90%
Other Sources of Income	10%

This may mean that because of the low income they earn from sex work they may not be able to seek better healthcare at private health facilities. During discussions one of the respondents gave the following remarks:

> "*Regardless of the stigma we face at the public health facilities our choices for alternative health care options are limited due to the high cost of quality care and treatment"* ***(SI #6 with 20yr old FSW).***

A key informant one of the healthcare providers at Athi River health centre contends with the views from the FSWs regarding their limited options of seeking healthcare as a result of their low income.

> "*Despite the stigma suffered at public health facilities, FSWs still seek treatment from the facilities because most of them have limited financial resources"* (***KI#2 with a health care provider***).

On the same, FSWs shared that sex work in Mlolongo earns less compared to sex work business in the city. Therefore the FSWs may be forced to endure the barriers since the cost of healthcare is affordable at the public health facilities. Alternatively some may go for other cheap methods of healthcare which could be harmful to avoid the out of pocket expenditure.

4.3 Sex Workers Health Needs

4.3.1 Physical injuries

Physical injuries in this context are the damages inflicted on FSWs bodies. FSWs face violence at different levels, some from their clients, others from the public and also from the police. FSWs suffer physical injuries as a consequence of violence. There was a common complaint from the FSWs that some of their clients assault them. These views were summed up in the interviews below:

> "*One time I had a client who did not want to use a condom while having sex with me and I insisted on using the condom. The client became agitated and violent. He slapped my face and as I was trying to shield my face he bit my hand"* ***(SI #1 with 25 year old FSW).***

> "*Another client declined paying me after having sex with him and I insisted to get my payment. I threatened him that I will scream and raise alarm to the other sex workers if he was not going to pay for my services. He still refused to pay and told me am only a "Malaya" (prostitute) who doesn't deserve to be paid and all we do is to bring disgrace to society. I started screaming and immediately he covered my mouth and hit me. He almost suffocated me and I needed to go to hospital immediately"* ***(SI #2 with 25 year old FSW).***

> "A truck driver broke my tooth after I insisted on using a condom and he did not want although he was drunk" **(SI #3 with 23 year old FSW).**

These findings concur with results from previous studies where several respondents shared violence cases. A study conducted by Rekart (2005) acknowledged harassment, rape, musculoskeletal injuries, urinal-genital problems, stress, depression, alcohol and drug use, respiratory infections, the removal of children, and death as some of the needs. Arnott (2009) also recognizes that globally, sex workers experience high rates of violence, HIV and other

sexually transmitted infections. Similar comments emerged from a key informant, who advocates for FSWs rights,

> "*Sex workers have several rights violation issues. This could be instigated by their clients or rather their sexual partners in case of violence. It could also be caused by the general population who get agitated by sex work which may result to assault. The police and the city council have also been involved in miss handling FSWs, however it is disappointing that the healthcare providers also violate the health rights of FSWs as they seek care and treatment. The rights violation issues range from lack of receiving proper medical attention at the health care facilities to sex workers being beaten up, miss understood and to also extreme cases of being murdered"* ***(KI #1)***.

These findings concurred with the assessment by Aitken (2002), having restricted access to legal protection makes FSWs a soft and easy target for criminals, and sex workers around the world continue to be murdered at rates higher than the general population.

4.3.2 Sexually Transmitted Infections

By virtue of their work, FSWs suffer various sexually transmitted infections. STIs are diseases that are passed on from one person to another through sexual contact. The infections occur often because FSWs have sexual contact with multiple sexual partners. The STIs include Syphilis, Ghonoria and Chlamydia. A participant in an in-depth interview explained that:

> "*We sex workers suffer illnesses related to our work. That means we have sex with different people unknown to us because at the end of the day it puts food on our table. Apparently, as a result of having sex with multiple partners, we get many sexually transmitted infections for example, I once suffered from very painful genital watts"* ***(SI #4 with 26yr old FSW).***

HIV&AIDS was also shared by a number of respondents' as a dominant sexually transmitted infection which required them to have constant Voluntary Counseling and Testing (VCT) checkup as reported by one of the FSWs.

> "*We frequent the VCT constantly because we like to keep checking our HIV status since our work may expose us to acquiring HIV& AIDS. Personally, I go after every three months but I cannot go to a public hospital. Never"* ***(SI #5 with 20yr old FSW).***

On the same with regards to HIV, FSWs expressed their constant need for Post Exposure Prophylaxis (PEP) a drug taken when one has been exposed to HIV within 72 hours after exposure,

> *"I once had a client who did not want to use a condom but I insisted on using the condom but in the process of having sex the client intentionally broke the condom and I had to go for PEP immediately so that I don't get HIV"* ***(SI #6 with 20yr old FSW)****.*

Some are also raped and hence the need for PEP,

> *"As much as we are sex workers some clients take advantage and rape us. They have sex with us against our wish. It is usually violent and leaves behind injuries and the fear of possible HIV infection. However we usually go for PEP within 72 hours after exposure"* ***(SI #7 with 19yr old FSW)****.*

FSWs go for cervical cancer screening for early detection, prevention and management of cancer as was revealed by a respondent,

> *"Following the nature of our work, we often require cervical cancer screening since we have multiple sexual partners"* ***(SI #8 with 28 year old FSW).***

Historically, sex workers have been viewed as reservoirs of sexually transmitted disease, and are consequently blamed for Africa's ongoing HIV crisis, with sex work being seen as the cause of disease rather than the consequence of economic marginalization (Elmore-Meegan et al., 2004).

HIV&AIDS especially has been associated with FSWs. The findings above are consistent with a resent systematic review that found HIV prevalence among sex workers ranges between 10–18 times higher than that of the general population of women of reproductive age approximately 50 per cent (UNAIDS 2012). This therefore justifies HIV care and STIs treatment a demanded health need by FSWs.

4.3.3 Reproductive Health Needs

Reproductive health needs in this study are the measures that need to be put in place to promote the sexual and reproductive health of FSWs. They made it clear that as much as they practice sex work, they are women with the same reproductive health needs as the rest of the women who are not sex workers as evidenced in the interviews below.

> *"Some of us often require family planning services because with our work one can easily conceive. We do not like assuming responsibility of children whom their fathers are unknown to us. We therefore go for family planning as a caution" (**SI #8 with a 28yr old FSW**).*

On the same, issues of child delivery and abortion were highlighted within sexual and reproductive health as illustrated by the quote below:

> *"We also go to hospitals to deliver our children just like any other women. Even if we are sex workers we still have families. At times when one discovers they are pregnant some may still want to keep the baby even if the father is unknown, hence the need to go to hospitals for child delivery" **(SI #9 with 27yr old FSW)**.*

Post abortion care was also raised by one of the participants as a health need,

> *"The work we do is uniquely challenging. Some of us have opted for abortion after we discover we have unwanted pregnancies as a result of sex work. The challenge comes in*

when we choose "back door" options for the abortion which may leave behind injuries after the abortion process" ***(SI #10 with 22yr old FSW)****.*

FSWs also reported having skin diseases as a result of body contact,

"Sleeping with different people involves close body contact which causes skin infections. The infections may either occur at the vagina area or any other part of the body. This is because some of our clients do not observe hygiene and others could be having a skin infection which can be transmitted" ***(SI #11 with 24yr old FSW)****.*

FSWs visit healthcare facilities in search of commodities such as condoms. Some also go to seek information as exemplified in the quotes below:

"We go to hospitals to look out for our 'tools of trade' in other words the commodities we need for our work. For example we go to hospital to look for condoms and lubricants that will aid us in our work" ***(SI #12 with 20yr old FSW)****.*

"We lack information on how best to stay healthy as much as we still practice sex work" ***(SI #13 with 23yr old FSW)****.*

The findings above speak to an observation by Dunkle (2005); FSWs have limited access to appropriate information on sexual and reproductive health. The findings from the FSWs lamenting on their challenge to access of reproductive health were in line with the sentiments of Harcourt (2010) that sex workers have poor access to contraception and HIV prevention commodities, since they are excluded from public campaigns for safer sex and their access to health services in general is impeded by discrimination and prejudice.

4.4 Barriers Faced by FSWs while seeking healthcare

4.4.1 Stigma related barriers

The findings indicate that stigma is a strong barrier to accessing healthcare services among FSWs. Stigma in this context meant disgrace of FSWs by health care providers. They revealed that at the health facilities especially the public health centers they are treated with a lot of stigma from the health care providers. The case narrative below demonstrates the stigmatization FSWs go through especially at public health facilities.

> *Stella narrated an incidence where she was stigmatized at a public health facility. "I have visited public hospitals often because I have been a sex worker for 5 years. Over the years healthcare providers have continued to stigmatize FSWs. I once visited a public hospital because a client had inflicted an injury on me. I did not want to tell the doctor that I was a sex worker but with my kind of injury, it was necessary to disclose my work. After the nurse saw the injury she enquired if I was a prostitute and I said yes. She asked for an additional pair of gloves on top of the ones she was wearing because in her opinion, I was a 'dirty' person and a disgrace to society who she did not want to get in contact with. She kept saying that she dislikes sex workers and she is only treating me because she needs a salary. She added that sex workers should be eradicated in the society as she treated me with disgust"* ***(CS #I with 30yr old FSW).***

Stella narrates that she has been a sex worker for more than 5years and has continually over the time faced stigma at public health facilities. This means that stigma at the health facilities has been existent for a long time. She then narrates a particular incident where she went to hospital after suffering an injury, when the nurse saw the injury she asked her if she was a sex worker, which in essence was judgmental and stigmatizing because the nurse had already associated the injury with sex work. Stella continues that after she disclosed she was a sex worker, the nurse

requested for additional pair of gloves. This indicates acute level of stigma at public health facilities, therefore justifying such kind of stigmatizing treatment as a barrier to seeking healthcare by FSWs.

Stigma at the health centers is expressed in different ways, for example some health providers may not want contact with the FSWs and others may express it through their communication as shared in one of the semi structured interviews:

> *"Another nurse told me that she develops nausea when she deals with sex workers. It made me feel offended and stigmatized"* ***(SI #14 with 20yr old FSW)****.*

Others may choose to discriminate and offer biased treatment to FSWs compared to the rest of the patients,

> *"At the public health facilities, they discriminate us a lot. They tend to draw a line between us and the rest of their clients. In most cases they side line us and treat us with suspicion in the event that we disclose we are sex workers"* ***(SI #15 with 18yr old FSW)****.*

These episodes of stigma at the health centre prevent FSWs from seeking health care at public health facilities. The study found out that FSWs are often rejected and humiliated in most public healthcare facilities. These results are not different from results from similar studies conducted elsewhere around the globe as highlighted in the literature review section. The findings concurs with results from studies by Cohan et al., 2006; Kurtz et al., 2005; Benoit et al., 2005 which indicates that stigma may act as a key barrier to health access for sex workers. In Zimbabwe, despite the existence of well-attended services targeted to FSWs, fewer than half of women diagnosed with HIV took up referrals for assessment and ART initiation; just 14 per cent attended more than one appointment. FSWs emphasized barriers, such as being demeaned and

humiliated by health workers, reflecting broader social stigma surrounding their work Zimbabwe (Ministry of Health, 2012; ZNAC, 2009). Moreover, most studies concur that stigma increases FSWs vulnerability to disease, increases stress and depression. In addition, the findings of this study report that after their first appointment at the public hospital in most cases FSWs do not go back for the next appointments. This was highly associated with the stigma experienced during the first visit. FSWs also indicated that they are unable to access condoms due to stigma associated with collection of condoms in public facilities as Dalmini (2009) had earlier observed.

4.4.2 Healthcare Quality related barriers

The findings show that the quality of healthcare services offered to FSWs in public health facilities is below standard compared to health care services received from other health facilities in the area. Negative attitude, weak interpersonal skills, poor communication, limited time, dis respect, in adequate staff, stock of commodities, knowledge and skills gaps particularly in sexual and reproductive health among service providers were identified as key barriers affecting the quality of health care services offered as evidenced in the interviews below:

> *"They don't understand us. This is because we have special and unique needs as sex workers and hence require that health care providers understand our work and unique needs and treat us as such" **(SI #16 with 20yr old FSW)**.*

> *"They skip us from the queues in the hospital because we are sex workers, when the health care providers learn that we are sex workers they give priority to the other patients and leave us aside. This is usually unfair because we also go to hospital to seek services and if anything we arrive in good time to be treated early and go back to our work but in most cases they delay us a lot" **(SI #17 with 18yr old FSW)**.*

"Lack of a package for sex workers commodities and services. In most cases when we go to a public health facility to look for condoms and lubricants, we find that they are out of stock. Often, we get discouraged to go back there again because we know we may not find what we want" ***(SI #18 with 20yr old FSW)****.*

The findings above indicate compromised quality of health care services for FSWs. They felt that they were not given due priority and their needs were not being understood. Health care providers especially those at the public hospitals gave priority to the other patients and disregarded sex workers. Stock out of commodities was equally highlighted. FSWs said that the public health facilities often suffer stock out of drugs, condoms or lubricants. Some also do not stock condoms yet their demand by FSWs is high. In interrogating the subject of quality of health care services, Romans (2001) Perceived low quality of the service providers, poor communication between the client and the providers, judgmental and disrespectful attitudes of the service providers and inadequate training in sexual health provision, contributed to poor access to health care for FSWs.

In adequacy of time was pointed out as a service delivery indicator. FSWs felt that they were not being given quality and sufficient time at the public health facilities,

"I went to the health centre with my friend a sex worker. She needed PEP and on learning that we were sex workers the nurse said that they had no time for sex workers and instead they have other very serious cases that require their urgent attention" ***(SI #19 with 19yr old FSW)****.*

Generally in most public hospitals there are many patients who require medical attention since public hospitals are affordable. This does not ogre well with FSWs since they spend a lot of time

in the hospitals which according to them lobs them of time to be with their clients as was explained by one of them:

> *"We dislike going to government facilities because there are many patients waiting to be served and the queues are long. Following the nature of our work when one is absent they miss out on their clients. We therefore generally avoid places that take up our time to be with our clients like the public health facilities"* ***(SI #11 with 24yr old FSW).***

FSWs may require urgent services especially when the treatment has to be time bound, however they reported lack of urgency at the public health facility:

> *"Sometimes we require urgent services as a result of some of the issues that arise from our work. For example, if I was having sex with my client and had a condom bursts; I would rush to the hospital in good time for PEP which I should take within 72 hours after exposure. In some instances, the government hospitals do not understand this kind of urgency and one ends up pushing them a lot to get the treatment within the limited time"* ***(SI #16 with 20yr old FSW).***

The quality related gaps raised above prevent FSWs from seeking health care at public health facilities. Vuylsteke (2004) concludes that bridging these gaps is tremendously important from a public health perspective given the disease burden among this population the FSWs.

4.4.3 Attitude related barriers

FSWs revealed that health care providers attitude towards them was negative and unfriendly. Negative attitude in these context meant that the healthcare providers at the public hospitals treated the FSWs with dislike. They perceived the communication from the healthcare providers as being rude and abusive as exemplified in the quotes below:

"We are not received well at the health centre. Right from the reception we are not welcomed. The receptionists do not even look at us while attending to us especially those who already know us. They say we are just sex workers" ***(SI #6 with 20yr old FSW).***

"They are rude to FSWs right from the reception to the service delivery room. Some even abuse us and we feel insulted and not welcome. A nurse once told me that at that health facility they do not treat prostitutes and 'husband snatchers', with such insults I made a decision that I will never go back to a public hospital" ***(SI #20 with 20yr old FSW)****.*

The findings in the study on healthcare providers' attitude towards FSWs concur with the conclusions of Crago (2009) in his study of FSWs in South Africa; FSWs reported being denied treatment by health care workers, who were often disrespectful and verbally abusive.

The negative attitude from health care providers intensified when they learnt about the work of FSWs.

"The nurses and healthcare providers at the public health care facilities have a lot of negative attitude towards us especially when they found out that we are sex workers" ***(SI #8 with 29yr old FSW).***

Similarly, the study concurred with the views by Glad (2008) that FSWs described many instances of poor treatment once health care providers particularly those in public clinics and hospitals became aware of their work. FSWs reported that in many instances they feel ignored and left out because their needs are not met and their voices are not heard,

"In the event that the health care workers became aware that we are sex workers they tend to give a deaf ear. You will keep trying to explain your situation but no one will be willing to pay attention to your situation. They all pretend to be so busy to listen and attend to you" ***(SI #21 with 25yr old FSW)****.*

Most of them said that they end up being referred to other places for care and treatment. This inconveniences the FSWs a lot as was lamented by one of the participants,

> *"They often refer us without getting to listen carefully and understand our problems before rushing to refer us elsewhere. For example as soon as they learn that you are a sex worker they want to refer you to another hospital to receive care instead of their facility. They are quick to dismiss us and send us to other hospitals which in their opinion deal with sex workers issues. Yet they offer the services they are giving us referral for at their health facility" **(SI #22 with 28yr old FSW)**.*

The above findings expose the negative attitude shown by healthcare providers at the public hospitals to FSWs. The FSWs add that this kind of attitude keeps them off public health facilities. Simbayi et al., (2007) in his study established that the negative attitude was expressed through the lengthy waiting times and the interpersonal behavior of the service providers, including sexual harassment, judgmental attitudes and poor communication, were also cited as constraints to seeking health care services.

4.4.4 Disclosure and criminalization related barriers

FSWs informed the study that they rarely disclose their work because of fear of prosecution and criminalization both by the public and the authorities. They revealed that they often face violence form the public and from their own clients. However, different from FSWs in other areas from other studies like that of Goodyear and Cusick (2007) where FSWs experience high rates of violence, victimization, and police crackdowns, the FSWs in Mlolongo did not report any form of violence from the authorities and the police.

> *"We do not face violence from the police but at times the public attacks us" **(SI #22 with 28yr old FSW)**.*

FSWs faced a lot of judgment of character from the health care providers at public health hospitals. This meant that the health care providers formed an opinion about FSWs and looked down upon them with contempt and disdain. As a result, they offer biased services. FSWs are always viewed as the carriers of disease as illustrated by the quote,

> *"They judge and blame us because they view FSWs as the cause of disease especially HIV and STIs" (**SI #23 with 24yr old FSW**).*

This finding resonate with that of Elmore-Meegan et al., (2004) where he says that historically, sex workers have been viewed as reservoirs of sexually transmitted diseases, and are consequently blamed for Africa's ongoing HIV crisis, with sex work being seen as the cause of disease rather than the consequence of economic marginalization. The case narrative below further reinforces the judgment suffered by FSWs in Athi River health centre a public health facility.

> *Zarah a FSW illustrated how she suffered judgment from a health care provider, "One day I went to the government health centre, I was in so much pain because I was suffering from a sexually transmitted infection hence the need for urgent medical attention. On getting to the health facility, the doctor asked what job I was doing and I told him sex work so that he could help me accordingly. Instead of commencing treatment, he kept probing and asking why I was in sex work, why FSWs cause so much harm to the society and why FSWs are so lazy to make honest money instead of having sex with other people's husbands. In his opinion, it was my fault that I had acquired an STI because of my work. I insisted he should just treat me and dis regard what I do for a leaving. He took to advising me on how I should stop sex work, enroll to school, source for a decent job and finally get married because according to him I was too young for sex work. He kept asking why I chose sex work yet there is now free education and cheap colleges, I could take up a course and drop sex work. He even was assuring me that he*

could support me get a marriage partner so that I stop sleeping around. The blame kept on from time to time until I finally got annoyed and left without treatment to seek help elsewhere" ***(CS #2 with 28yrs old FSW)***.

The above Narration from Zarah is a clear illustration on the intensity of judgment FSWs go through at public health facilities. Zarah had suffered an STI and on reaching the health facility the doctor already judged her and made conclusions that she was an FSW. Anyone can have an STI regardless of their occupation. STIs are not only suffered by FSWs as Zarah's doctor insinuated. It was also unfortunate that the health care provider took to judging and probing Zarah instead of offering treatment. She finally left without getting treatment. In this particular case judgment from the healthcare provider got in the way of treatment.

FSWs did not like it that they were being criminalized in health facilities. On the very least a health facility should be more like a help centre when they face criminalization outside. One of the respondents in the study said that they feel helpless when they face criminalization and get mistreated at the health centre when they disclose that they are sex workers. Some healthcare providers also end up blaming them for being sex workers as outlined by the case narrative above. The findings speak to those identified by UNAIDS (2009) that in criminalized sex work environments, poor access to non-judgmental, adequate health services was identified. Sex workers were particularly sensitive to being identified and belittled within the health care environment (Lambert, 2003).

4.4.5 Privacy and Confidentiality related barriers

Besides being criminalized after disclosure of sex work, FSWs are also hesitant to disclose their work at the public health facilities because the information they give is not kept confidential. The written medical records are also not kept under lock and key hence the FSWs do not trust the health care providers as was revealed in the interviews below:

> "*They do not keep our medical records in confidence the records are kept in the open and exposed to everyone. This means anybody can have access to information on both your occupation and illness. So we feel that our information is not well kept and we even get more exposed at the health centers"* ***(SI #12 with 20yr old FSW)***.

> *"They lack privacy in the way they deal with us FSWs. There is a day I went to a government hospital and I was treated at the corridor. The nurse just said that 'you because you are a sex worker just go to the chemist and get a syphilis drug I already know what you are suffering from, by then she had not even examined me to know what kind of STI I was suffering from, she just jumped to her own conclusions at the corridor without even letting me go to the room and explain my problem further"* ***(SI #24 with 26yr old FSW).***

Similarly, scambler and Paoli (2008) posits that hospital rules often result in women having to queue for long periods of time, and having to disclose personal information and disease history to the doctor whilst undergoing a check-up in a place without privacy. FSWs participating in the study complained that healthcare providers probe them a lot by asking curiosity questions for their own satisfaction but not for the good will of the FSWs health.

> "*They ask too many questions before starting treatment, however the information we give them is not kept confidential"* ***(SI #12 with 20yr old FSW)***.

Merten (2010) in his previous study shared the same sentiments that healthcare providers were said to ask invasive and unnecessary questions of sex work and frequently breached patient

confidentiality. The findings above indicate the discomfort FSWs have in disclosing their sex work status to health care providers due to the fear that confidentiality will not be upheld. They felt that they were more exposed at the health care facilities and as a result they either chose not to disclose their work or avoid the public hospital all together. The findings agree with the report of National Centre for AIDS and STD Control (2004), HIV counseling in Nepal, where Most Nepalese FSWs also felt a lack of privacy and confidentiality in the government hospital because of the crowd of patients and the Behavior of the health care workers. In their opinion it made them feel further stigmatized.

4.4.6 Fear of prosecution

Sex work is illegal in Kenya and hence the FSWs are hesitant to disclose their work due to fear of prosecution and arrest. It has not been accepted as a profession like any other and in most cases it is hidden as was explained in an interview.

> "*At times we fear arrest even as we practice sex work, we do not like to expose ourselves but some healthcare providers expose us a lot"* ***(SI #25 with 29yr old FSW)***.

On the same, Day and Ward (1997) in the United Kingdom, the narratives of sex workers reveal that fear of privacy and disclosure of their sex work status, including distrust of authority and fear of prosecution, may prevent sex workers from accessing health services.

In addition to fear of prosecution after disclosure, FSWs also indicated that they fear disapproval and embarrassment from society especially their immediate families. Some also fear harassment as well. One of the respondents shared how she was harassed by a nurse who was going through separation,

"I once went to a public hospital that I prefer not to disclose in this study. The nurse serving me had separated with her husband due to unfaithfulness. On finding out that I was a sex worker she started harassing and accusing me that we are the kind of people who are breaking other people's homes by making their spouses unfaithful. She transferred her separation blame on me instead of treating me. I just left the room and went home without having received treatment" ***(SI #26 with 25yr old FSW).***

In interrogating the issue of non-disclosure of sex work status, Jael and Salibursy (2004) observed that non-disclosure is a barrier to proper healthcare because it compromises diagnosis accuracy. Qualitative research has shown that when contact with health care professionals is high among female sex workers, non-disclosure of sex work status may still contribute to poor health. The non-disclosure as a result of fear of prosecution leaves the health care provider unaware of the health needs of the FSWs hence hindering treatment.

4.4.7 Policy related barriers

Among the policy related barriers that came out from the findings were weak institutional frame works, policy gaps within service delivery, poor Infrastructure, inadequate equipment and unsound systems that define policy of public health facilities. Specifically FSWs pointed out unequal health rights as a key policy issue in healthcare facilities. They tend not to get equal rights as it came out from the study:

"*We do not get equal rights with the other patients yet we are not any different. Before we are sex workers we are in the first place human beings with same rights. Sex work to us is only a job like any other but our right to good health is often compromised"* ***(SI #14 with 20yr old FSW)***.

> *"At times we are even charged differently from other patients because they perceive us as having a lot of easy money which according to them we have not worked hard to get and so it can be easily dished out"* ***(SI #8 with a 29yr old FSW)***.

A key informant from a sex workers rights advocate organization concurred with insights given by FSWs in the discussion below:

> *"FSWs do not get equal rights as the rest of the patients. Their right to good health is often compromised because a lot of emphasis is placed on their work. They report getting poor treatment or lack of treatment all together. At the health centres FSWs are constantly judged. For example if a sex worker has anal warts the nurses mistreat her because of having anal sex while in actual sense they should treat her without any form of discrimination. Such cases are quite common among sex workers at the public health facilities and as a result most of the sex workers dis like the public health facilities"* ***(KI #2)***

The findings speak to a study by Wolffers (2009) which indicated that health services are generally not accessible to underprivileged women. Sex workers across sub-Saharan Africa are marginalized and face gross human rights violations, discrimination, harassment and numerous barriers to accessing healthcare (Day and Ward, 2007). FSWs pointed out that they are often displaced to places that compromise their health and expose them to health hazards. These places are usually "safe" for them to practice sex work because the policies are not so strict. FSWs in most cases are under privileged because they are seen as outcasts in the society. It therefore becomes difficult for them to seek health care services among other services. The issue of having policies that do not apply to all patients equally discourages FSWs from seeking health care and treatment. Previous research has shown that policing strategies that displace sex workers to the margins of society increase health related harms and experiences of violence faced by women

(Day and Ward, 2007). Simultaneously marginalization policies increase barriers for women attempting to access health care (Rusch et al., 2007).

4.4.8 Health Information related barriers

FSWs require to be sensitized on health education. Constant rising of awareness is beneficial to them since their job is classified as a most at risk job to their health. The study findings indicated that most public hospitals do not conduct this kind of health sensitizations to FSWs as it was discussed by one of the respondents,

> "*They don't give us information like we get at the private health care facilities. This is so because if we go to private hospitals the healthcare providers on site give us plenty of information on how to protect ourselves from HIV&AIDS as sex workers"* ***(SI #8 with a 29yr old FSW)***.

The study established that most FSWs prefer private health facilities than public health facilities because the private ones offer health capacity building as elaborated in the quote below:

> "*Some private facilities enroll us for trainings and sensitizations for good health as sex workers. They even give us booklets to educate ourselves and to also share with other female sex workers. Like me, I was taken for training as a sex workers peer educator to educate my fellow peers who are sex workers but such initiatives are rare to find at the public health facilities"* ***(SI #6 with 20yr old FSW)***.

Lack of Information may become a barrier to better healthcare especially for FSWs since it widens the health risk gap. Goodyear and Cusick (2007) reckon that lack of knowledge of where to access health care would also act as a health barrier for FSWs.

In conclusion, the CASCO of Athi River Sub County agreed with the barriers raised by FSWs in the semi structured interviews as well as the case narratives in the key informant interview below:

> *"It is true that FSWs have certain health needs as a result of the work they do. They commonly report of STIs, HIV care, body injuries as a result of violence and PEP among other infections. However, they face some barriers in seeking healthcare in public health facilities. This is so because it is not all the staff and health care providers are trained and sensitized on how to serve sex workers. The staff just like any members of the society treats FSWs with attitude and a lot of stigma as well. The sex workers have not been accepted by the society and so are some of the health care providers. Sometimes the healthcare providers accuse them because they are sex workers and to some extent judge them. At the public health facilities we also lack a full package for sex workers supplies and services. Sex workers require certain commodities that the general population may not require for example a lot of condoms and lubricants which the government facilities may not have at all times. In addition, FSWs in most cases are not followed up keenly compared to the rest of the patients who are not FSWs. There lacks some consistency in the follow up of FSWs health"* ***(KI #3 with a healthcare provider)****.*

4.5 How the barriers faced by FSWs at public health facilities affect FSWs health seeking behavior.

As a result of the above outlined barriers and disgraceful treatment at the public health facilities, FSWs feel discriminated upon and sidelined to seek health care at public health facilities. They complained that they do not get equal services as the other patients. They lack a sense of belonging and feel they are not welcome at the public health facilities. According to FSWs their needs are not understood and given due attention and priority in these health facilities. Most

FSWs also said that they do not trust the public health hospitals because confidentiality is not assured and their medical records are not protected.

In summary, The FSWs said that their health needs were not adequately met at the public health facilities as summed up by the quotes below:

> *"At the end of the day one may not even receive the treatment they wanted initially. The services are compromised"* ***(SI #6 with 20yr old FSW)***.

As a result of these barriers sex workers said that they do not prefer going to public health facilities. Some opted to remain ill or wait until they got enough funds to go to a private health facility so that they can receive proper care and treatment,

> "*Going to a public hospital for treatment as a sex worker is not an option for me. I would rather not disclose I am a sex worker or source for funds to be able to receive treatment from a private health facility"* ***(SI #8 with a 29yr old FSW)***.

Others are forced to lie about their work so that they are treated as normal patients without being judged like in the interviews below:

> "*I do not reveal the work I do when I go to a public health facility. Even if I have an STI, I tell them that I am married and I got the STI from my husband. That way, I receive treatment without being judged"* ***(SI #8 with a 29yr old FSW).***

> "*I don't feel comfortable going to the public health facilities. I am well treated in our sex workers clinics. There I feel more at home"* ***(SI #27 with a 18yr old FSW).***

Some result to traditional ways of treating themselves which in most cases are harmful, for example one shared that after not being treated for an STI in the government health facility she resulted to using "Jik" a washing detergent which aggravated her illness. A case study revealed

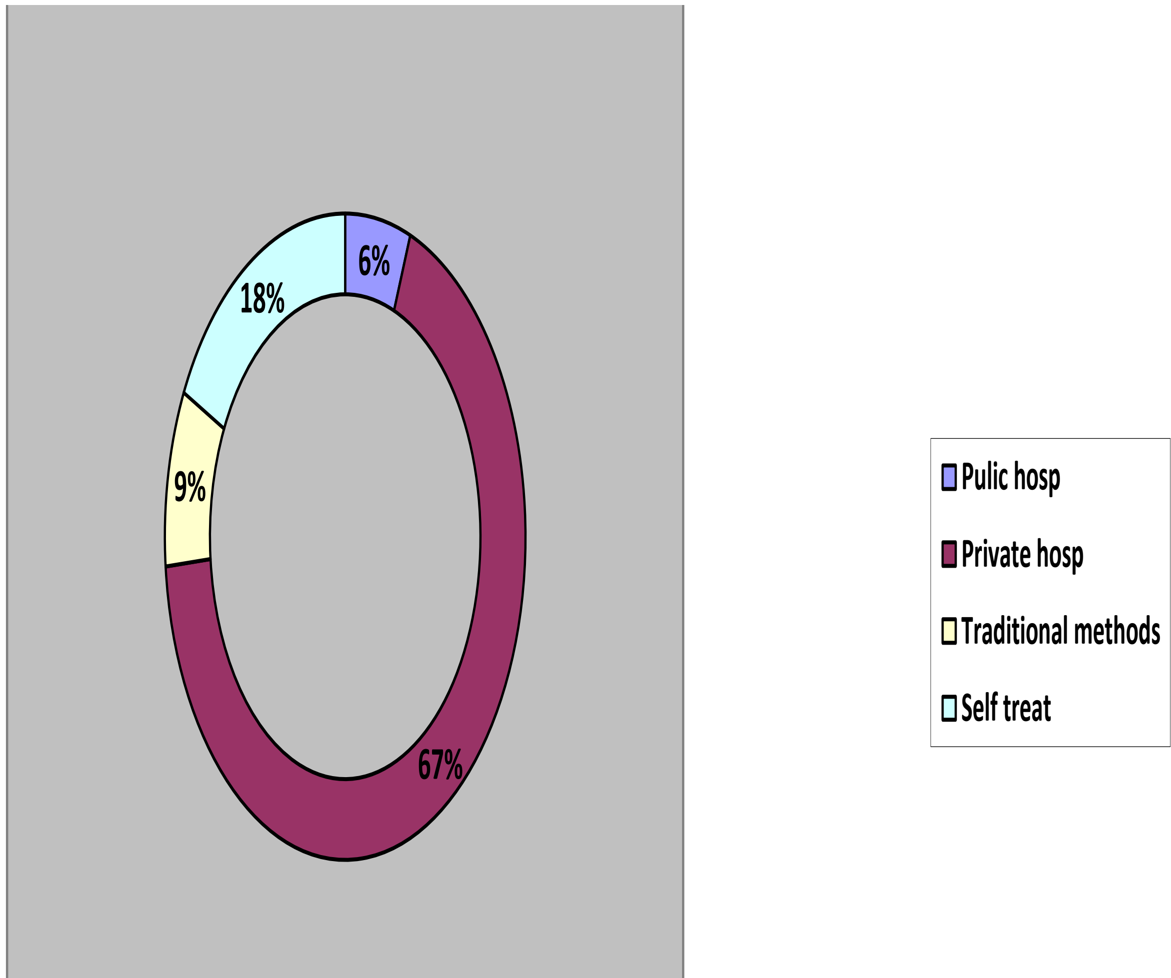
some of the mechanisms FSWs opt for as alternatives to seeking health care in public health facilities:

*Nadia narrated of how she had to seek alternative health care options after not receiving treatment in a public hospital, "I was suffering from an STI and I decided to go to a public hospital for treatment. On getting there, I had to explain the work I do to the nurse attending to me. The nurse was extremely rude to me when she learnt that I was a sex worker. She kept insulting me and making me feel worse than I was already feeling with the STI. I felt hurt by the way she was mishandling me instead of offering treatment. I finally got annoyed and left the hospital. My friends fellow sex workers told me that STIs come as a result of dirt in the vagina due to having sex with multiple sexual partners, and the best treatment would be to clean up with a detergent like 'Jik'. Following my desperation after not receiving treatment at the public health facility, I thought my friends advise was the right thing to do. I went ahead and used the detergent which caused me so much pain and made my illness worse. An elder sex worker took me to SWOP clinic a sex workers clinic when I was in a very bad state" (**CS 3 with a 25yr old FSW**).*

Nadia a FSW suffered an STI but did not get treatment. She said that the health care provider had a negative attitude towards her and so she opted to leave without treatment. On getting back to the brothels she had to seek an alternative measure to treat the STI, she went for her friends advises who were sex workers, they told her to use a detergent to clean up the STI. The detergent intensified her illness making the situation worse until she was helped by an elder sex worker who took her to a sex workers clinic. Had Nadia received treatment at the healthcare facility she would not have gone for the alternative self-treat method.

FSWs Preferred Options for Health Care.

Fig 4.1 FSWs preferences for seeking healthcare



The figure indicates that FSWs prefer seeking healthcare from other health facilities other than public hospitals. It came up that the most preferred was the private hospitals by around 67% of the entire respondents. The rest, among them 18% said they would rather self-treat themselves than go to a public hospital. The other 9% reported that as an alternative for public hospitals they go for traditional methods of healthcare. Only 6% of the entire population was comfortable to seek healthcare at the public health facilities.

The implication of such acts is that first it is expensive to seek healthcare from a private health facility as compared to a public health facility. This may limit sex workers who are not financially capable as one of the respondents said:

> "*When we don't have the money to go to private hospitals we suffer a lot because we don't want to reach out to our families and relatives for help since they do not know we are sex workers"* ***(SI #8 with a 29yr old FSW)****.*

The FSWs are therefore forced to incur out of pocket expenditure in their quest to seek health care. Secondly the FSWs are forced to go for long distances to look for friendly clinics like the SWOP clinics (Sex Workers Programme) and some may opt out because of the distance.

> "*SWOP clinics are good but they are far apart"* ***(SI #12 with a 20yr old FSW)****.*

The nearest to Mlolongo where the study was carried out is in Eastland or at the city centre which both require bus fares. Thirdly some indicated that they result to traditional ways of self-treating which cause more harm and aggravate the illness. For those who do not disclose they are sex workers at the public health facilities to evade judgment, they risk miss diagnosis because they do not give true information and hence may not get the right treatment. Following the lack of commodities at the public health facilities, some FSWs found themselves having sex without protection which exposes them to HIV and other sexually transmitted infections. In some extreme cases some resulted to not seeking health care at all which could even lead to death.

In the context of the study, Rushing et al. (2005) also identified long distance and higher travel cost, behaviors of the service providers, lack of privacy and confidentiality, consultation with multiple and substandard service providers and difficulties in accessing and negotiating the

health care system as external or structural barriers. Sometimes FSW have had to pay health workers additional money for services, especially for STI treatment (Scambler, 2008). None the less, in her response during a key informant interview the CASCO Athi river sub county said that the situation could be improved if the following was to be done in government hospitals:

> "*I would recommend that first all the healthcare providers receive health education and sensitization so that they are able to accept sex workers and treat them just like other patients in need of care and treatment. I would also encourage my fellow health service providers to try and put their beliefs and values aside while serving sex workers so that they don't judge them in the course of treatment. In addition it will be worthwhile to put up wellness centers friendly to sex workers integrated within the health centers. This is because the public health facilities often serve many patients and may not delve deeper to sex workers issues. You also find that some sex workers are highly impatient and this agitates the health care providers, thus the wellness centers will offer fast services to them and make the public health facilities friendly. Finally it will be important to have a focal person dealing with sex workers issues within the health centers. The person should come right from the county heads to the communities at the ground level. This way there will be someone answerable to the issues of sex workers and ensuring their wellness within the health centers"* ***(KI #4 with a healthcare provider).***

These remarks communicated a possibility of bridging the gaps at the public health facilities hence increasing the uptake of health services by FSWs.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study assessed barriers faced by FSWs while seeking healthcare at the public health facilities in Mlolongo ward, Athi River Sub County. More precisely, the study undertook to establish the FSWs health related needs and the barriers they face in the process of seeking healthcare at public health facilities as well as how the barriers they face prevent them from seeking healthcare.

5.2 Summary

FSWs health needs are unique to their work. There was a trend of common illnesses specifically reported by FSWs at the public health facilities more than the general public as was explained by a healthcare provider. These therefore meant that FSWs have common health needs. They range from sexually transmitted infections among them HIV&AIDS, Cervical cancer treatment and screening, HIV testing and Counseling, Antiretroviral treatment, Reproductive health, Need for pre and post exposure prophylaxis, Alcohol and drugs anonymous services, Child delivery and treatment of body assault from their clients or the public inclusive of the police. It is therefore important that access to health care for FSWs is simplified and enhanced.

Whereas FSWs bear a huge burden of disease, they often experience barriers that prevent them from seeking health care at public health facilities. The study established certain barriers that FSWs face especially at the public health facilities as they seek healthcare. Consequently, there has been continued practice of stigma and discrimination by health care providers directed

towards FSWs. The trend is fueled by the attitude the health care workers have against sex work which is manifested in the manner in which they offer health services to FSWs. As a result sex workers have difficulties seeking health care at public health facilities. FSWs strongly felt that they were not prioritized and neither were their needs understood. Generally there was laxity when it came to serving FSWs at the public health facilities. The laxity cut across issues of delayed services, lack of confidentiality, low quality of health services and weak health policies. FSWs were seen to dislike the services they receive at the public hospitals due to the stigma attached to them among other issues as discussed. FSWs reported that besides not being accepted they were often discriminated upon, not prioritized and treated as outcasts in the society even at health facilities. As a result they were therefore discouraged to seek healthcare in public health facilities.

These hindrances suffered at public hospitals push FSWs to seek for alternative options of accessing health care. The alternatives reported were private hospitals, self-treatment, traditional healing methods and others resolve to not getting treatment at all. These options on the other hand may cause more harm for example the self-treat which lacks medical information and therefore poses a health hazard. Other alternatives may be expensive like the private healthcare option which some FSWs may not afford. Ultimately some may opt out of treatment which could result to death.

5.3 Conclusion

Quality health is a right to every human being regardless of one's occupation. However continued stigma has compromised this right for FSWs whose burden of disease remains high. Stigma is accountable for perpetuating and fuelling barriers that prevent FSWs from seeking health care at public health facilities. The study ascertained the existence of factors that prevent FSWs from seeking health care in government hospitals. Among the barriers FSWs revealed, health service delivery at public hospitals seemed to be most prevalent. The study concludes that FSWs disapprove public health care facilities and prefer other alternatives for health care. The most approved being private hospitals.

None the less the sex workers indicated that if these gaps were addressed, they would be willing to seek health care services at public hospitals. They remained cognizant of the fact that public hospitals remain available at all times since they belong to the government unlike private hospitals whose operations are availability to donor funding based. Thus if there is no donor then the services are not available. The public hospitals are equally easily accessible since every county and some sub counties have a government facility. It would therefore be easier for FSWs to access health services at public hospitals than private hospitals if the public hospitals become more accommodative of FSWs.

5.3 Recommendations

Emanating from the above findings and in order to make government hospitals more accommodative to FSWs, certain undertakings need to be considered. Some of these considerations could be the following:

- There is need for community empowerment which is a broader social movement that reduces stigma towards FSWs. It requires governmental, nongovernmental, public, private, political and religious institutions and organizations to address and remove the social exclusion, stigma, discrimination and violence that violate the human rights of sex workers and heighten associated health risk and vulnerability.
- There should be development of wellness centers for FSWs integrated within the healthcare facilities. The centers should be fully stocked with commodities often required by FSWs. These include condoms, lubricants and PEP. The centers will offer specialized services to FSWs making the public hospitals more accessible and accommodative of FSWs.
- Public hospital policies should be strengthened so that they can inform right practices within the facilities. There should be disciplinary measures for health service providers who do not offer services to FSWs because they are biased to sex work or those who breach the confidentiality of FSWs as it is against the health practices.
- There is need for further research on health policies that affect FSWs. This will be important in understanding FSWs health entitlements and will go a long way in improving health interventions for FSWs especially at public health facilities.

REFERENCES

Aitken, C., D., Moore, P., Higgs, J., and Kelsall, M. (2002). The impact of a police crackdown on a street drug scene: Evidence from the street. *International Journal of Drug Policy,* 13:189–198.

Arnott, J. and Crago, A. L (2009). *A Report on Female, Male, and Trans Sex Workers' Human Rights in Botswana, Namibia, and South Africa.* Johannesburg: OSISA.

Baer, H. (1996). Toward a Political Ecology of Health in Medical Anthropology. *Medical Anthropology Quarterly, 10(4):451-454.*

Baer, H., M., Singer and I., Johnsen (1986). Introduction: Toward a Critical Medical Anthropology. *Social Science and Medicine,* 23 (2): 95-98.

Bandewar, S.V., J. Kimani and J.V. Lavery. (2010). The origins of a research community in the Majengo Observational Cohort Study, Nairobi, Kenya**.** *BMC Public Health*, 10:630-633.

Baral, S., C. Beyrer, K. Muessig, T. Poteat, A.L. Wirtz, M.R. Decker, S.G and Sherman, D. K. (2012). Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis**.** *Lancet Infectious Diseases,* 12:538-549.

Benoit, C., and Carroll D. (2003). In search of a healing place: Aboriginal women in Vancouver`s Downtown Eastside. Social Science & Medicine. 2003; 56:821–833.
Bindel, J., Brown, L., Easton, H., Matthews, R., and Reynolds, L. (2012) *Breaking down the barriers: A study of how women exit prostitution.* London: Eaves and London South Bank University.

Boff, A. (2012). *Silence on Violence: Improving the Safety of Women. The policing of off-street sex work and sex trafficking in London.* Available at: http://www.uknswp.org/wp-content/uploads/SILENCEONVIOLENCElondonmajorofficereport.19/03/2012.pdf

Boynton, P., and Cusick, L.(2006). Sex workers to pay the price: UK plans to cut street prostitution will threaten sex workers' health. *British Medical Journal*. 332: 190-191.

Bradshaw, J., Kemp, P., Baldwin, S., and Rowe, A. (2004). *The drivers of social exclusion: A review of the literature for the Social Exclusion Unit in the Breaking the Cycles series.* London: Office of the Deputy Prime Minister.

Bury, L. (2011). *Men in the Shadows: Reaching the need of male partners of street based sex workers – Evaluation Report. Open Doors Male Partners Project.* London: Open Doors, City and Hackney Primary Care Trust.

Cohan D., Lutnick, A., Davidson, P., Cloniger, C., and Herlyn, A (2006).Sex worker health: San Francisco style. *Sexually Transmitted Infections*, 82:418–422.

Cohen, C. R., M., and.Meier, A. (2007). Mycoplasma genitalium infection and persistence in a cohort of female sex workers in Nairobi, Kenya. *Sexually Transmitted Diseases,* 34:274-9.

Cohen, M.S., Chen, Y.Q., McCauley, M., Gamble, T., and Kumarasamy, N. (2011). Prevention of HIV infection with early antiretroviral therapy. Journal of Medicine, 365:493–505.

Crago, A. (2008) Our lives matter: sex workers unite for health and rights. New York.

Cusick, L., and Berney, L. (2005) Prioritizing punitive responses over public health: commentary on the Home Office consultation document *paying the Price*. *Critical Social Policy.* 25(4): 596-606.

Day, S., and Ward, H. (1997). Sex workers and the control of sexually transmitted disease. *Genitourinary Med,* 73:161-68.

Day, S., and Ward, H. (2007). British policy makes sex workers vulnerable. *Biomedicine Journal*, 334:187-189.

Dlamini, P.S., Wantland, D., Makoae, L. N., and Greeff, M. (2009). HIV stigma and missed medications in HIV-positive people in five African countries. *AIDS Patient Care*, 23:377–387.

Dunkle, K. L., Beksinska, M. E., and Rees, V. H. (2005). Risk factors for HIV infection among sex workers in Johannesburg, South Africa. *International Journal of STD and AIDS,* 16**:** 256-61.

Elmore-Meegan, M., Conroy, R.M., and Agala, C. B. (2004). Sex workers in Kenya, numbers of clients and associated risks: an exploratory survey. *Reproductive Health Matters,* **12:** 50-57.

Evans, C., and Lambert, H. (1997). Health-seeking strategies and sexual health among female sex workers in urban India: implications for research and service provision. Social Science Medicine, 44:1791–1803.

Family Health International (2001). Nepal Programme Overview. Kathmandu: FHI.

Faugier, J., Hayes, C., and Butterworth, C. (1992). *Drug-using prostitutes, their health care needs, and their clients.* Manchester: University of Manchester. *Feminist Criminology.* 2: 74-95.

Ghimire, L., Smith, W., and Teijlingen, E., (2011) Utilisation of sexual health services by female sex workers in Nepal. BMC Health, 11:79.

Goffman, I. (1963) Notes on the management of spoiled identity. Englewood Cliffs, NJ: Prentice.

Goodyear, M. D., and Cusick, L. (2007). Protection of sex workers. *Biomedicine Journal* 334:52–53.

Government of Zimbabwe (2009) UNGASS Country Progress Report for the period January 2008 to December 2009.

Groves, J., Newton, D.C., Chen, M.Y., Hocking, J., Bradshaw, C.S., and Fairley, C.K. (2008). Sex workers working within a legalized industry: Their side of the story. Sexually Transmitted Infections. 84:393–394.

Harcourt, C., O'Connor, J., Egger, S., Fairley, C.K., Wand, H., and Chen, M.Y. (2010). The decriminalization of prostitution is associated with better coverage of health promotion programs for sex workers. *Public Health* , 34:482–486.

Home Office (2004). *Paying the Price: a consultation paper on prostitution*. London: Home Office Communication Directorate.

Home Office, (2006). *A Co-ordinated Prostitution Strategy and a summary of responses to paying the Price.* London: Home Office.

HSRC (2008). *South African National HIV Prevalence, Incidence, Behavior and Communication Survey*. Cape Town:HSRC Press.

Huet, C., Ouedraogo, A., Konate, I., Traore, I., Rouet, F., and Kabore, A. (2011). Long term virological, immunological and mortality outcomes in a cohort of HIV infected female sex workers treated with highly active antiretroviral therapy in Africa. *BMC Pub Health*, 11:700-707.

IOM, ZNAC, UNAIDS, UNFPA (2009). *Sex work and HIV and AIDS in Zimbabwe: analysis of current settings, policies and interventions*. Harare: National AIDS Council.

International Treatment Preparedness Coalition: ITPC (2014) Research report on Missing the Target: Access and Utilization of treatment in Majengo, Nairobi Kenya.

Jeal, N., and Salisbury, C (2004). Self-reported experiences of health services among female street-based prostitutes: A cross-sectional survey. *British Journal of General Practice* , 54:515–519.

Kurtz, S. P., Surratt, H. L., and Kiley, M. C. (2005) In Ciardi JA. Barriers to health and social services for street-based sex workers. *Journal of Health Care for the Poor and Underserved*. 16:345–361.

Krathwohl, N (2003). Qualitative data analysis procedures. *Lancet*, 281:1119–1312.

Lafort, Y., Geelhoed, D., Cumba, L., Lazaro, C.D., Delva, W., Luchters, S., and Temmerman, M. (2010). Reproductive health services for populations at high risk of HIV: Performance of a night clinic in Tete province, Mozambique. *BMC Health Serve Res*, 10**:**144-151.

Luchters, S., Chersich, M. F., and Rinyiru, A. (2008). Impact of five years of peer-mediated interventions on sexual behavior and sexually transmitted infections among female sex workers in Mombasa, Kenya. *BMC Public Health,* **8,** 143.

Marshall, M., Luban, C. (2006) Analyzing research data. Canada. *Lancet*, 187:2649–2819.

Morin, D., Godin, G., Alary, M., and Sawadogo, M.R. (2008). Satisfaction with health services for STIs, HIV, AIDS among a high-risk population in West Africa. *AIDS Care*, 20**:**388-394.

National Centre for AIDS and STD Control (2004). HIV counseling in Nepal. Available on www.unaids.org.np/HIV/AIDS in Nepal.

Owan, M. C., Hennebry, A., Chislett, G., and Mandalia, L. (2008). Young people's views on provision of sexual health services. *Sex Transm Infect* 78: 342–45.

Puri, M., and Cleland, J. (2006). Sexual behavior and perceived risk of HIV/AIDS among young migrant factory workers in Nepal. *J Adolescent Health* 38: 237-46.

Rekart, M. L. (2005). Sex-work harm reduction. *Lancet*, 366:2124–2134.

Reza-Paul, S. (2008). Declines in risk behavior and sexually transmitted infection prevalence following a community-led HIV prevention intervention among female sex workers in Mysore, India. *AIDS*, 22(5):91–100.

Riedner, G., Rusizoka, M., and Hoffmann, O. (2003). Baseline survey of sexually transmitted infections in a cohort of female bar workers in Mbeya Region, Tanzania. *Sex Transm Infect,* **79:** 382-7.

Romans, S.E., Potter, K., Martin, J., and Horbison, P. (2001). The mental and physical health of female sex workers: A comparative study. *Aus New Zealand J Psychiatry* 35: 75-80.

Rossler, L., Koch, U., Lauber, C., and Landolt, K. (2010). The mental health of female sex workers. *ACTA Psyciatrica Scandiavica*. 1-10.

Rushing, R., Watts, C., Rushing, S. (2005). Seeking serenity living with HIV/AIDS in rural Western Canada. *J Midwifery Women's Health* 50: 41-44.

Sachs, J. (2001). Macroeconomics and health: Investing in health for economic development. WHO report of the commission on macroeconomics and health.

Sanders, T. (2007a). Becoming an Ex-Sex Worker: Making Transitions Out of a Deviant Career. *Feminist Criminology.* 2: 74-95.

Sanders, T. (2007b). Protecting the health and safety of female sex workers: the responsibility of all. *BJOG.* 114(7):791-793.

Sanders, T., and Neville, L. (2012). *Women's Open Space Project Evaluation: Final Report.* London: New Horizon Youth Centre.

Scambler, G., and Paoli, F. (2008). Health work, female sex workers and HIV/AIDS: Global and local dimensions of stigma and deviance as barriers to effective interventions. *Social Science & Medicine*,66:1848–1862.

Scorgie, F., Vasey, K., and Harper, E. (2013). Human rights abuses and collective resilience among sex workers in four African countries: a qualitative study. *Global Health* , 9**:**33.

Shannon, K., Bright, V., and Duddy, J. (2005). Access and utilization of HIV treatment and services among women sex workers in Vancouver's Downtown Eastside. *Journal of Urban Health*, 82(3):488–497.

Shannon, K., and Csete, J. (2010). Violence, condom negotiation, and HIV/STI risk among sex workers. *JAMA,* 304:573–574.

Shannon, K., Kerr, T., Strathdee, S.A., and Shoveller, J. (2009a). Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. *British Medical Journal*, 339:29-39.

Shannon, K., Strathdee, S.A., Shoveller, J., and Rusch, M. (2009b). Structural and environmental barriers to condom use negotiation with clients among female sex workers: Implications for HIV prevention strategies and policies. *American Journal of Public Health.* 99(4):659–665.

Shannon, K., Rusch, M., Shoveller, J., Alexson, D., Gibson, K., and Tyndall, M.W. (2008). Mapping violence and policing as an environmental-structural barrier to health service and syringe availability among substance-using women in street-level sex work. *Int J Drug Pol,* 19:140-47.

Sharma, N. (2002). HIV/AIDS awareness for migrant communities in the rural hills of Nepal. Amsterdam, Netherlands. *Global Journal of Health Science,*1(1):20-37.

Simbayi, L.C., Kalichman, S., Strebel, A., Cloete, A., Henda, N., and Mqueketo, A. (2007). Internalized Stigma and Discrimination and depression among men and women living with HIV/AIDS in Cape Town. *S Afr J Soc Sci Med* 64:1823-31.

Singer, M., and Baer, H. (*1995). Critical Medical Anthropology.* Amityville, NY: Baywood Publishing Company, *Medical Anthropology Quarterly* 10(4): 496-515.

Singer, M. (2001). Farewell to Adaptationism: Unnatural Selection and the Politics of Biology. STD/AIDS counseling and training services (SCATS) female sex workers sero-prevalence study in Kathmandu, Nepal.

Tonybee, H. (2007). *Housing Need for Women in Prostitution in Tower Hamlets. : November 05 – January 06. London: Toynbee Hall.*

UNAIDS, (2009) Guidance note on HIV and Sex Work. Geneva: Joint United Nations Programme on HIV/ AIDS. http://data.unaids.org/pub/BaseDocument/2009/ jc1696_guidance_note_hiv_and_sexwork_en.pdf

UNAIDS, (2008). *Report on the global AIDS epidemic*. Geneva, UNAIDS.

UNAIDS (2014). Global Aids Response Report (GAP Report) Geneva 27 Switzland. ISBN9713-92-9253-062-4

UNAIDS (2012). Guidance note on HIV and Sex work. Geneva: UNAIDS.United States Agency for International Development. (USAID, 2004). Nepal's Country Profile HIV AIDS. Kathmandu: USAID.

Vuylsteke, B., Semde, G., Sika, L., Crucitti, T., and Ettiegne, V. (2012). HIV and STI prevalence among female sex workers in Cote d'Ivoire: Why targeted prevention programs should Be continued and strengthened. *PLoS* , 7:32627.

Vuylsteke, B., Traore, M., Mah-Bi G, Konan, Y., Ghy, P., Diarra, J., and Laga, M. (2004). Quality of sexually transmitted infections services for female sex workers in Abidjan Co□te d'Ivoire. *Trop Med Int Health* ,9: 638-43.

WHO (2005). *Violence against women and HIV/AIDS: critical intersections.* Geneva: WHO.

Williams, B. G., Taljaard, D., and Campbell, C. M. (2003). Changing patterns of knowledge, reported behavior and sexually transmitted infections in a South African gold mining community. *AIDS,* **17(20)**:99-107.

Wolffers, I. (2009). Appropriate health services for sex workers. Research for Sex Work 2: 1-3 [Online] Available:
http://www.nswp.org/pdf/R4SW-02.PDF Accessed 7-11-09.

World Health Organization (2011). *Preventing HIV among sex workers in sub-Saharan Africa: a literature review*. Geneva: WHO.

Zimbabwe Ministry of Health: Global AIDS response country report (2012).Harare: UNAIDS; (2012). http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_ZW_Narrative_Report.pdf.

APPENDIX 1: CONSENT FORMS

UNIVERSITY OF NAIROBI KENYATTA NATIONAL HOSPITAL
COLLEGE OF HEALTH SCIENCES P O BOX 20723 Code 00202
P O BOX 19676 Code 00202 KNH/UON-ERC Tel: 726300-9
Telegrams: varsity Email: uonknh_erc@uonbi.ac.ke Fax: 725272
(254-020) 2726300 Ext 44355 Website: http://erc.uonbi.ac.ke Telegrams: MEDSUP, Nairobi

Written Consent Information for Semi Structured Interviews.

Hello, my name is Carol Ndung'u an MA student from the University of Nairobi. You have been chosen at random to be in a study about the barriers faced by FSWs while seeking healthcare at public health facilities. This study involves research whose purpose is to find out barriers FSWs face at the public health facilities while seeking healthcare. This will take 40 minutes of your time. If you choose to be in the study, I will engage you in a semi structured interview and you will be expected to provide information on the barriers you face as a FSW while seeking health care at public health facilities and how the barriers affect your health seeking behavior.
There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. I will do my best to keep your information confidential but I cannot guarantee absolute confidentiality.
If you have questions about this research study you may contact Carol Ndung'u on 0726124864(cndungu.highwaycommunity@gmail.com) or the lead supervisor Dr. Dalmas Omia whose email is dalmas.ochieng@gmail.com in the event of a research related injury. If you feel as if you were not treated well during this study, or have questions concerning your rights as a research participant call the KNH/UoN-ERC Chairperson on Tel. No. 2726300 Ext 44102.
Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. May I continue?
I certify that I have consented the participant(code no.) ……….
Researchers name ……………………………………………………………….
Signature---
Date --

UNIVERSITY OF NAIROBI KENYATTA NATIONAL HOSPITAL
COLLEGE OF HEALTH SCIENCES P O BOX 20723 Code 00202
P O BOX 19676 Code 00202 KNH/UON-ERC Tel: 726300-9
Telegrams: varsity Email: uonknh_erc@uonbi.ac.ke Fax: 725272
(254-020) 2726300 Ext 44355 Website: http://erc.uonbi.ac.ke Telegrams: MEDSUP, Nairobi

Written Consent Information for Key Informants.

Hello, my name is Carol Ndung'u an MA student from the University of Nairobi. You have been chosen at random to be in a study about the barriers faced by FSWs while seeking healthcare at public health facilities. This study involves research whose purpose is to find out barriers FSWs face at the public health facilities while seeking healthcare. This will take 40 minutes of your time. If you choose to be in the study, I will engage you as a key informant to the study having had contact with FSWs while offering them health and wellness services. Your inputs as an expert will be resourceful in the study. There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. I will do my best to keep your information confidential but I cannot guarantee absolute confidentiality.
If you have questions about this research study you may contact Carol Ndung'u on 0726124864 (cndungu.highwaycommunity@gmail.com)or the lead supervisor Dr. Dalmas Omia whose email is dalmas.ochieng@gmail.com in the event of a research related injury. If you feel as if you were not treated well during this study, or have questions concerning your rights as a research participant call the KNH/UoN-ERC Chairperson on Tel. No. 2726300 Ext 44102.
Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. May I continue?
I certify that I have consented the participant(code no.) ……….
Researchers name ……………………………………………………………….
Signature---
Date --

UNIVERSITY OF NAIROBI KENYATTA NATIONAL HOSPITAL
COLLEGE OF HEALTH SCIENCES P O BOX 20723 Code 00202
P O BOX 19676 Code 00202 KNH/UON-ERC Tel: 726300-9
Telegrams: varsity Email: uonknh_erc@uonbi.ac.ke Fax: 725272
(254-020) 2726300 Ext 44355 Website: http://erc.uonbi.ac.ke Telegrams: MEDSUP, Nairobi

Written Consent Information for Case Narratives.

Hello, my name is Carol Ndung'u an MA student from the University of Nairobi. You have been chosen at random to be in a study about the barriers faced by FSWs while seeking healthcare at public health facilities. This study involves research whose purpose is to find out barriers FSWs face at the public health facilities while seeking healthcare. This will take 40 minutes of your time. If you choose to be in the study, I will engage you in a case narrative to share how your prior experiences have been while seeking health care as a FSW at public health facilities. There are no foreseeable risks or benefits to you for participating in this study. There is no cost or payment to you. If you have questions while taking part, please stop me and ask. I will do my best to keep your information confidential but I cannot guarantee absolute confidentiality.
If you have questions about this research study you may contact Carol Ndung'u on 0726124864 (cndungu.highwaycommunity@gmail.com) or the lead supervisor Dr. Dalmas Omia whose email is dalmas.ochieng@gmail.com in the event of a research related injury. If you feel as if you were not treated well during this study, or have questions concerning your rights as a research participant call the KNH/UoN-ERC Chairperson on Tel. No. 2726300 Ext 44102.
Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop. May I continue?
I certify that I have consented the participant(code no.) ……….
Researchers name ………………………………………………………………….
Signature--
Date ---

APPENDIX 2: SEMI-STRUCTURED INTERVIEW GUIDE

I am going to ask you some of the health needs you encounter in the course of you work.

Possible probes

What are some of the common ailments you encounter? Have you ever needed some form of psychological counseling? Have you ever needed STI treatment? Do you have any contraception needs? Have you needed HIV care and treatment? Have you needed treatment as a result of violence? Where do you seek health intervention? How often do you seek health care?

I am now going to discuss with you some of the challenges you face while seeking health care.

Possible Probes

Do you face any form of harassment as a result of your sex work status? Are you marginalized from other patients because you are a female sex worker? Do you face any form of rejection at the health care facility due to your work? How do the health care providers react to you? How is the attitude of the health care provider as they serve you?

I am now going to discuss with you some of the consequences you face after disclosing your sex work status

Possible Probes

Do you face any form of criminalization? Do the health care providers report you to the authorities? Are you prosecuted as a result of your work being disclosed by health care providers? How are you served after disclosing your sex work status at health care facilities?

Do these barriers faced at public health facilities prevent you in any way from seeking health care?

Any recommendations on how access to health care could be improved for FSWs?

APPENDIX 3: CASE NARRATIVE GUIDE

Thank you for agreeing to discuss your experience at the health care facilities in Mlolongo and Athi River further and get into details that will benefit this study.

Please describe to me your reasons for wanting to seek health care

Generally, kindly share your experience at the health care facility while seeking health care

Please feel free to include any suggestions of how the services at the health centre would have been offered differently for ease of access of the FSWs

APPENDIX 4: KEY INFORMANT INTERVIEW GUIDE

i. What are some of the health needs of FSWs?

ii. How often do FSWs seek health care?

iii. What are the facilities based barriers at the health centers that may discourage FSWs from seeking health care at the public health facilities?

iv. What are the differences in FSWs service delivery both at the public health facilities and private health facilities?

v. What are the human rights violation issues reported by sex workers to their rights advocates relating to their health?

vi. What would you say are the major challenges in offering health services to FSWs

vii. What recommendation would you give to improve access to health services at the health care facilities?

APPENDIX 5: RESEARCH CLEARANCE

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit
2. Government Officers will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

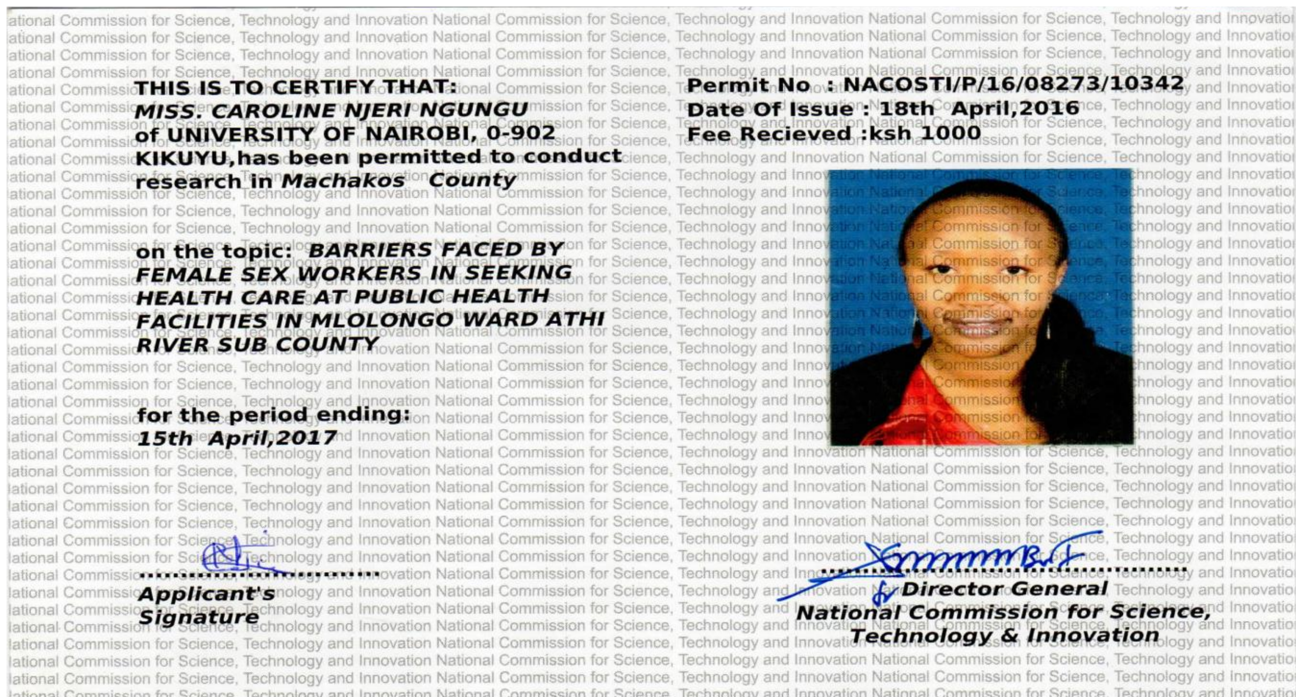
NACOSTI

National Commission for Science, Technology and Innovation

RESEARCH CLEARANCE PERMIT

Serial No. A 8698

CONDITIONS: see back page



THIS IS TO CERTIFY THAT:
MISS. CAROLINE NJERI NGUGU
of UNIVERSITY OF NAIROBI, 0-902
KIKUYU, has been permitted to conduct research in *Machakos County*

on the topic: *BARRIERS FACED BY FEMALE SEX WORKERS IN SEEKING HEALTH CARE AT PUBLIC HEALTH FACILITIES IN MLOLONGO WARD ATHI RIVER SUB COUNTY*

for the period ending:
15th April,2017

Permit No : NACOSTI/P/16/08273/10342
Date Of Issue : 18th April,2016
Fee Recieved :ksh 1000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation

APPENDIX 6: KNH LETTER

UNIVERSITY OF NAIROBI
COLLEGE OF HEALTH SCIENCES
P O BOX 19676 Code 00202
Telegrams: varsity
Tel:(254-020) 2726300 Ext 44355

KNH-UON ERC
Email: uonknh_erc@uonbi.ac.ke
Website: http://www.erc.uonbi.ac.ke
Facebook: https://www.facebook.com/uonknh.erc
Twitter: @UONKNH_ERC https://twitter.com/UONKNH_ERC

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/296

10th August, 2016

Caroline Njeri Ndung'u
Reg. No. N69/75364/2014
Institute of Anthropology, Gender and African Studies
College of Humanities and Social Sciences
University of Nairobi

Dear Caroline,

REVISED RESEARCH PROPOSAL: BARRIERS FACED BY FEMALE SEX WORKERS IN SEEKING HEALTHCARE AT PUBLIC HEALTH FACILITIES IN MLOLONGO WARD, ATHI- RIVER SUB- COUNTY (P285/03/2016)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH-UoN ERC) has reviewed and **approved** your above proposal. The approval period is from 10th August 2016 – 9th August 2017.

This approval is subject to compliance with the following requirements:

a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH-UoN ERC before implementation.
c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
f) Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
g) Submission of an *executive summary* report within 90 days upon completion of the study.
This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

"Protect to discover"