

Healthcare among migrant female sex workers

A case study in Eastleigh and Majengo slums, Nairobi County, Kenya



A research project submitted to Van Hall Larenstein University of Applied Science in partial fulfilment of the requirements for the degree of Master in Management of Development, specialization Rural Development and HIV/AIDS

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ECDC	European Centre for Disease Prevention and Control
FGDs	Focused Group Discussion
FSWs	Female Sex Workers
HIV	Human Immunodeficiency Virus
ICMPD	International Centre for Migration Policy Development
IOM	International Organization for Migration
MARPS	Most At Risk Populations
MSM	Men who have sex with men
NOPE	National Organization of Peer Educators
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNEP	United Nations Environmental Program
WHO	World Health Organization

Abstract

Intersections among migration, sex work and health are underexplored in Kenya, a region with high internal and cross-border mobility and HIV prevalence. Sex work often constitutes an important livelihood option among migrant females. These females are often exposed to challenging health risks. Detailed understanding of enabling factors and perceived barriers in seeking healthcare services would optimize design of improved healthcare services of migrant female sex workers (FSW) in Kenya. In this study, qualitative design using case studies interviews were conducted among 10 migrant FSWs of Somali, Uganda and Tanzania origin, 1 focus group discussion (with 3 Tanzanians and 2 Ugandans), 3 healthcare service providers and 1 immigration officer in Eastleigh and Majengo slums, Nairobi. Respondents were identified through a network of social networks from the centres run by NOPE and IOM Kenya.

Migrant FSWs faced a combination of personal and service related enablers and barriers in seeking healthcare services. Access to healthcare services are facilitated mainly by health literacy, household income and privacy. However, poor language and communication, lack of legal documents and cultural differences appeared to be important barriers in healthcare access among the migrant FSWs. To overcome the low uptake of the healthcare services among the migrant FSWs, some of the identified possible interventions were increased healthcare literacy through awareness creation on the available healthcare services and migratory information for different migrant groups. The enablers such as health literacy, household income and privacy together with perceived barriers such as language, legal status and cultural differences identified in this study provide useful information for promoting healthcare access among the migrant FSWs. This study showed the need for policies and guidelines which in accordance with international human rights law, in ensuring healthcare access among the migrant FSWs and give clarity to the healthcare service providers.

Chapter 1. Introduction

1.1 Background and justification

Female sex work (FSW) remains an important source of HIV infection within sub-Saharan Africa's generalized AIDS epidemic because of FSWs' high HIV prevalence rates (Morris et al. 2010). Kenya is one of the countries in sub-Saharan Africa most affected by HIV infections. Kenya is currently experiencing both a generalized and a concentrated HIV epidemic. It has a national HIV prevalence of 6.3 per cent and 1.3 million people between the ages of 15 to 64 across the country are living with HIV (Kenya National AIDS Control Council 2011). The Kenya National AIDS strategic Plan 2009/10-2012/13 identifies FSWs, male sex workers (MSM), truck drivers, and intravenous drug users as special vulnerable group of Most at Risk Populations (MARPS). They are a key driver in the new HIV infections, and thus the need to look at interventions that would help reduce the number of new infections and spread of HIV. Research by Fonck et al (2001) found HIV prevalence at 27% amongst the MARPS.

The Kenyan national response recently started research and programming efforts towards mobile and MARPS specifically the FSWs. However, migrants have not been targeted as a distinct category with the programmes. FSWs in many settings engage in high-risk behaviour that predisposes them to infection by HIV and other sexually transmitted diseases. This group remains a high-risk core group for contracting and transmitting HIV and other sexually related diseases partly because of inconsistent and occasionally incorrect condom use with regular and casual partners (UNAIDS 2009).

According to Sanders, (2004) being a sex worker has many consequences for a person's health of both mental and physical in nature. Previous research done on health and sex work from public health perspective has focused on sexually transmitted diseases and HIV/AIDS. This has also been the rationale for many interventions aiming at increasing safe sex behaviours among sex workers (Vanwesenbeeck, 2001). There have been few research attempts to examine the topic of migrant FSWs and health access in Kenya. Especially little is known on how migrant FSWs view their own health and what experiences they have with healthcare services in Kenya. Females who engaged in sex work as a means of livelihood in Kenya are particularly marginalized and face multiple vulnerabilities including gender based violence and increased likelihood of engaging in high-risk sexual activity. In addition, the illegal and clandestine nature of sex work in Kenya increasingly renders migrant FSWs to out-skirt of society, limiting their access and uptake of supportive healthcare services.

Migrant FSWs have health special needs due to the nature of their work. The Kenyan constitution guarantees the right to access to health services for all though this does not apply to MARPS. In practise the process is uncertain and migrant FSWs do not access healthcare compared to the rest of population for fears of being asked for official documentation and deportation. The predisposing factors which influence the access to healthcare among migrant FSWs are lack of legal documents, unaffordable consultation fees, language barrier, social stigmatization, limited healthcare awareness, and limited awareness to claim entitlements (Human rights watch 2009). Sex work is also considered illegal in Kenya and together with inadequate legal documents, migrants FSWs may fear accessing Healthcare services. These predisposing factors if not put into consideration could lead to increased risk of HIV infection to the general population, increased country HIV prevalence and the HIV infected individual may lead to death if they fail to seek healthcare services. This study will therefore focus on healthcare experiences including barriers to access of healthcare which contribute to healthcare seeking behaviour among migrant sex workers.

1.2 Research problem

Sex workers are a marginalised group and their social stigma in the society is a barrier to the provision of healthcare for them. Sex workers have a higher risk of exposure to HIV and sexually transmitted diseases related to their lifestyles. As they have well defined 'occupational' risks they need appropriate healthcare specifically targeting their needs both for prevention and treatment of various diseases. Migrant FSWs appear to be the most at risk in destination place. Previous research has shown that sex workers do not access health services available (Sanders 2004). Knowledge of usage of existing health services among the migrant FSWs must be known for comprehensive healthcare interventions among the MARPS. The knowledge on healthcare access among migrant FSWs will contribute to NOPE in creating relevant interventions for the specific migrant group. With the help of a problem tree below, this study therefore aims to explore the current use of healthcare services among the migrant FSWs and their perception on barriers to accessing healthcare services in destination place.

1.3 Problem tree

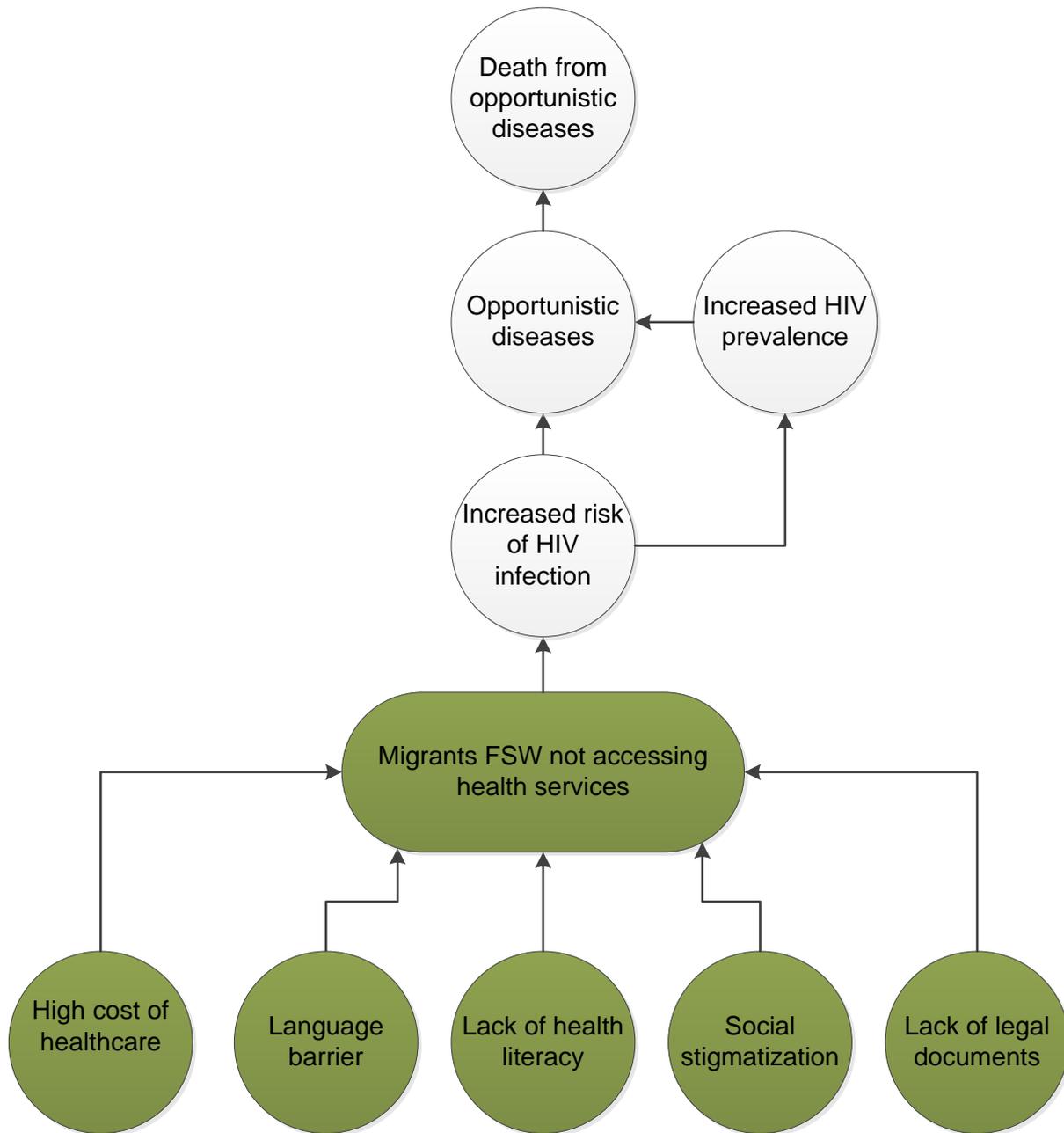


Fig.1.Problem visualization

1.4. Research objective

The objective of this study is to explore the healthcare among migrant FSWs and explore the barriers encountered by migrant FSWs when accessing health services.

1.5. Main and sub research questions

1. What are the enabling factors in seeking healthcare among the migrant FSWs?
2. What are the perceptions on healthcare among the migrant FSWs?

1.1. What are the healthcare concerns (e.g. health needs) of migrant FSWs?

1.2. Which factors (e.g. health literacy, household income, privacy and confidentiality) make it easier in seeking healthcare services?

1.3. Which factors make (e.g. language, legal status and time) it difficult to seek healthcare among the migrant FSWs?

1.4. What are the barriers (e.g. language, legal status and time) in providing healthcare of migrant FSWs from healthcare service provider point of view?

2.1. What are the beliefs (e.g. cultural differences) in seeking healthcare as a migrant FSW?

2.2. Which interventions are necessary to increase the uptake of healthcare services among the migrant FSWs?

1.6. Definition and concepts

1.6.1. Healthcare access

Within the context of this study, referred to prevention, treatment and management of various illnesses through services available at the healthcare service provider's offices, the public health department and the NGOs migrant health services clinics. This would include screening tests and maintenance of the general health status.

1.6.2. Migrant female sex worker

The United Nations defines migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. Under such a definition, those travelling for shorter periods as tourists and business persons would not be considered migrants. Female sex worker in this thesis context is first used to refer to women that travel to Kenya, to sell sex in the country for different reasons and stays in the country on temporary or longer basis. This means a migrant is someone in Kenya legally or illegally. This however does not mean that if a sex worker is in the country for a longer period of time they are guaranteed an access to the healthcare services.

1.6.3. Refugee

In this context, the study used the 1951 Refugee convention on UNHCR that states that a refugee is someone who owing to a well- founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable to or owing to such fear, is unwilling to avail himself of the protection of that country.

1.6.4. Sex work

According to WHO (2010), sex work terminology should be used instead of prostitution as it is considered to be less stigmatising. The rationale behind the argument is that sex work emphasises on the income generating aspect of the activity while the term prostitution is more associated with immoral behaviours and implications of those that sell sex (UNAIDS 2009). The term sex work is linked to wider theoretical views on the act of selling sex for money and material goods. For this study, since it focuses on health, the term sex work as of WHO definition would be understood as any person who regularly receives money or goods from a customer in exchange of sexual services excluding other activities of the sex industry such as stripping and pornography.

Chapter 2. Literature review

2.1. Sex work and health

According to Folch et al (2013), sex work is referred as a form of income generating activity involving exchange of sexual services for economic gain. Sex work has been expressed through mobility of individuals through the extension of migratory movements, innovation of routes of access to other regions and the dynamic structuring of nations. As an activity the health problems associated with sex worker such as sexually transmitted infections are often assumed to be as a result of sex work as a trade or occupation. This assumption has made many people assume that sex workers bear the responsibility of propagating the spread of sexually transmitted diseases (HIV) to the general population. This has therefore led to sex workers being discriminated and subject to increased violence particularly from the police. The health, social, and economic consequences of HIV/AIDS have prompted various studies about the risk factors of HIV transmission and knowledge about this disease among sex workers. Sex workers are also threatened by migratory policies which further prevents from accessing legal, social and healthcare support services.

Sex workers are often exposed to health related risks. These risks are highest in Africa where sex work in most countries except Senegal is considered illegal. These risks include exposure to HIV and other sexually transmitted infections, physical violence, rape, stress and sometimes death (Rekert, 2005). Many sex workers from the literature reviewed, however considers risk of violence to be higher as opposed to HIV infection. This clearly demonstrates the daily threats and working conditions that sex workers are exposed to.

Based on studies by Stadler & Delany, (2006) access to healthcare for FSWs was found to be a complex issue that relates to the females themselves and their area of work. Stigmatization can also act as a barrier for obtaining healthcare among migrant FSWs particularly from the healthcare service providers' actions. The concept of stigmatization will in this study context mean restricted access to public spheres (healthcare services) as being identified as a sex worker often means that you are socially excluded from the society. In this view of stigmatization, healthcare service providers have often negative attitudes towards sex workers and this affects the quality of care given to migrant FSWs and leads to refrain to seek healthcare services by the FSWs. A part from stigmatization and discrimination often associated to sex work, migrant FSWs make up heterogeneous group which can experience difficulties in accessing healthcare services due to cultural, language, knowledge and migration status (Wong et al., 2006).

A previous study done among FSWs in Moscow noted for example how in one instance a doctor at a public health service facility used a pen to examine a female sex worker to avoid touching her directly. Such negative experiences with health personnel can be a determining factor for future health behaviour of FSWs (Aral et al., 2003). Sex workers are often referred to as most at risk population, which means the spreading of a concentrated HIV epidemic into the general population. Another health issue related to FSWs is violence and the fear of violence from the clients. It seems that young and inexperienced migrant FSWs are more at risk of HIV infection than non-migrant FSWs who have been in the business for some time and knows the surrounding environment well (Sanders, 2004).

2.2. Migration and health

Human migration has taken place over a long period of time and it is estimated that nearly 200 million international migrants worldwide (IOM 2006). There has been an increased worldwide mobility in recent decades (regional and international mobility). Migration is increasingly a necessary component of

economic and social development everywhere. Migration in Kenya involves a diverse group of people, including migrants in regular and irregular situations, trafficked persons, asylum seekers, refugees and displaced persons and returnees. As migration is increasingly becoming a part of development in Kenya, the health implications of migration and the health of migrants need to be recognised as an important issue in healthcare policy making.

According to IOM (2006), migrants go through several experiences which ultimately affect their health particularly in settings where they face a combination of legal, social, cultural, behavioural and communications barriers during the migration process. Migrants have frequently found themselves amongst those most negatively affected by these imbalances and differences in the society of their final destination. Individual biological, physical, behavioural, and social factors, interventions and access to social and health services determine the health of a migrant. Migrants are likely to experience specific challenges in relation to health due to the nature of being a migrant. Social determinants of migrants' health relate to factors that influence the migration process, reasons for migrating, and the mode of travel, length of stay and the migrants' language skills, race, legal status. These determinants of migrants' health are complex and inter-related.

Different categories of migrants may have very different experiences in migration process as well as settling in the final destination. Determinants of migrants' health are shaped by their experiences and situations in the countries of origin, transit and destination. Migration itself adds a particular dimension to social determinants of health, given that being a migrant can make persons more vulnerable to negative influences to their health. Many of the factors that drive migration also contribute towards the health inequalities between countries and within countries. Being a migrant puts the individual in further social disadvantage when compared with individuals in the host community in the same social strata. In addition to being particularly vulnerable to certain health risks as a migrant, migrants often experience certain challenges and barriers to accessing health and social services, especially if they are undocumented. This in itself is a social determinant to the healthcare of migrants. Social determinants of health among migrants are recognized as the conditions in which people are born, grow up, live, work and age (Commission on Social Determinants of Health 2008). These conditions are shaped by political, social and economic forces.

Generally, migrant populations perceive worse healthcare services than the majority of host populations. Migration is in and not in itself a risk to health status; migration process may increase vulnerability to ill health of migrants. This is in particular to those who migrate involuntarily as a result of violation of human rights, natural disasters, those who fall into hands of traffickers and end up into exploitative situations. The healthcare access and utilization of healthcare services of migrant FSWs is often linked to legal status and lack of recognition of sex work as a distinct group. This therefore makes migrant sex workers not willing to uptake healthcare services especially for the undocumented sex workers despite the International human declaration on equal access to healthcare.

The UN universal declaration on human rights "Everyone has a right to standard of living adequate for the health and well-being of himself or herself and his or her family including safe drinking water and adequate sanitation, safe food, adequate nutrition and housing, healthy environmental conditions and gender equality". The universal declaration asserts to the healthcare as a human right. In relation to this the WHO's (1978) Alma Ata convention has "universal access to healthcare" as its main goal. A number of complex factors such as legal restrictions and socio-economic factors can affect the access to the healthcare among the migrants.

According to United Nations Programme on HIV/AIDS (2001), migrants are people who move between places temporarily or permanently, by option or forced. The report of World Health Organization (WHO 2010) also identified that migrants are more susceptible and vulnerable to ill-health effects and have more limited access to healthcare (they seek care more rarely or cannot pay for the healthcare services). Migrants and especially female migrants are forced by circumstances to engage in unprotected sexual activity with males, exposing them and their partners to HIV infection (IOM, 2006). Women risks to HIV infection can also be associated with forced migration where females are compelled to migrate due to violence against them, social or political disorder, or such factors as poverty, unequal power relations socio-cultural practices, and marginalization (Declaration on the Elimination of Violence against Women).

Apart from the stigma and marginalisation often linked to sex work, migrant FSWs make up a heterogeneous group which can experience difficulties when accessing social and health services due to cultural and language barriers or lack of knowledge of the system (Wong et al., 2006). Previous studies by Jeal & Salisbury (2007) have shown a lower level of access to health services among female sex workers on the streets, in comparison with those working in venues, partly because of the poorer economic and social conditions which these FSWs work live under.

2.3. Migration and sex work

IOM (2006) defines migration as a process of moving, either across an international border, or within a state. It is a population movement, encompassing any kind of movement of people and migration can be long-term or short-term, internal or international. Mobility in and out of African countries has often been in existence for a long period of time. However, political instability, environmental degradation, economic and natural disasters have led to an increased voluntary and forced migration. This type of migration includes traditional trans-border mobility, labour migration, asylum seekers, irregular or undocumented persons, and displaced persons (IOM, 2006).

Kenya is a country of origin, transit and destination for various forms of migrants. This is because it is strategically located, has relatively developed infrastructure and large migrant communities. Population movements in Kenya are not new, however, Kenya's migration management capacity has to match the challenges the country now faces in combating human trafficking, irregular migrations, tapping into remittances and fulfilling its obligation as required by the International human rights law as a host state of more than 500,000 refugees (ICMPD, 2008). Kenya has a long time history as a refugee hosting country, with large movements mainly of Sudanese, Somalis and Ethiopian nationalities.

The refugee flows into Kenya are primarily due to political and civil unrest and the recurring natural disasters from its neighbouring countries. Currently there are efforts underway to repatriate Somali nationals to decongest the refugee camps. Overpopulated refugee camps such as Daadab, lack of political will to naturalise and integration of refugees and limited resettlement plans forces refugees to try their luck in urban areas such as in Nairobi where others end up as sex workers or domestic workers. Others also do opt to leave Kenya more often through irregular dangerous means to seek better livelihood options (ICMPD, 2008).

Migration for labour is very common in the sub Saharan African countries including Kenya. In the rural context young females frequently engage in migration for work related purposes. For most young females, migration often accompanies the search of employment opportunities as low educational attainment and limited opportunities may mean females have to leave home to enter into labour market in order to support their families. On arrival in the cities or towns, the opportunities available for these females are generally limited due to various social related factors hence they end up engaging in informal work such as housemaid or bar attendant, the occupations not being well paid, the females often cease to do such work

and often opt for sex work. Females comprise an increasing proportion of migrant sex workers. Although some of these females voluntarily migrate for sex work, others maybe trafficked for sexual exploitation in various cities.

2.4. Healthcare behaviour in relation to healthcare services utilization

Healthcare seeking behaviour in terms of service utilization has often been addressed as individuals' rationale choice. Utilization of health services is seen as the capacity of a person or a group to obtain effective healthcare services when needed in the desired form and convenient way. Migrant FSWs personal characteristics including health providers' attitudes towards each other, space-time opportunity, and constraints in accessing healthcare services also affect accessibility and utilization of health services. Research by Hendryx et al., (2002) indicated that the accessibility and utilization of the healthcare services among migrant FSWs can only be solved if barriers surrounding healthcare service providers and the users of the services are reduced or eliminated.

Researchers have looked into what facilitates the use of health services and what influences people to behave differently in relation to their health (Segall & Tipping, 1995 cited in Sara, 2003). There is often a distinction between the concepts of health behaviour, health seeking behaviour and utilization of healthcare services. Conner & Norman, (2005) have defined health behaviour as various actions taken by individuals who believe to be healthy for the purpose of disease prevention or for detecting diseases at an asymptomatic stage. According to this perspective health behaviour is understood in terms of prevention efforts.

Health-seeking behaviour has been used to explain the process of treatment seeking undertaken by individuals who perceive themselves to have a health problem (Mackian et al., 2004). This approach therefore highlights different determinants which influences how individuals obtain appropriate remedies or treatment for a supposed health problem. The concept of healthcare utilization has tend to focus on the end point of the treatment seeking process in terms of examining the access of different Healthcare services (Mackian et al., 2004).

2.5. Migrant FSWs access to healthcare

According to Boateng et al (2012), migrant perceptions of health, such as cultural beliefs, differences in understanding health needs, healthcare literacy have been linked to poor healthcare access. For instance there is evidence that migrants are often dissatisfied with the host country's healthcare services mainly because of the language and communication barrier, legal status and cultural differences which affect their quality of healthcare. These barriers are however contributing to limiting migrants' access to healthcare. The growing number of migrants in Kenya requires an understanding of their healthcare needs to foster their quality integration in the society. This specifically applies to marginalised group such as migrant FSWs.

It has already been mentioned that access to healthcare services among migrant FSWs may be determined with legal status, with irregular migrants the least or limited access to the healthcare services. Legal status is thus from previous findings a precondition for the ability to seek and access healthcare among migrants. In addition to this the availability, accessibility, acceptability and quality of the healthcare services depend on other various influences including health literacy, financial, time, cultural and privacy factors. The availability is related to the physical presence of health facilities and implies that there is a sufficient quantity of health facilities, goods and services within the country. Accessibility has to be granted in its four dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. According to UFPA report acceptability means that health facilities, services, and

goods must be culturally appropriate and must also be respectful of medical ethics. Quality implies that health facilities are medically and scientifically appropriate and of good quality within the economical possibilities of the country (Potts 2008).

As mentioned earlier, differences in cultural beliefs, knowledge about healthcare services and ill health can prevent migrant FSWs from using the healthcare services. Moreover, health literacy, in the sense of awareness of the availability of the healthcare services and entitlements to healthcare may act as a barrier to the use of the services. This is true for all the migrant FSWs regardless of their socio-economic and legal status. Migrants sleeping during the day and works during the night may not have time to seek healthcare services as they may prefer to receive the healthcare services at night when they are at work.

Previous research by IOM (2006), has asserted that it is only when healthcare needs of migrants in particular sex workers are addressed would the host countries be able to support the healthcare of country as a whole. Although some countries have identified the health of migrants as a public health concern, much is desired in the creation and implementation of policies that integrate the healthcare needs of the migrants in the host country. Thus knowledge about the enablers and the perceived barriers in accessing healthcare experienced among migrant FSWs is important in promoting healthcare access, lobbying for policies that address their health needs. A number of studies among migrant have revealed important barriers in healthcare access, though less is known about the enabling and barriers to healthcare access particularly among the migrant FSWs while insight into this is equally important in having a general overview of the healthcare among the migrant FSWs.

Therefore with this study the researcher aimed to explore the healthcare enabling factors as well as perceived barriers in seeking healthcare among the migrant FSWs in Kenya. By including enabling factors and perceived barriers to healthcare access as mentioned above, the researcher aimed to provide a holistic overview of the experiences in access to healthcare services from both the migrant FSWs and service providers' point of view.

2.6. Conceptual framework

The conceptual framework draws on previous evidence by Richter et al (2012) showing that health status and HIV risk among migrant sex workers is reliant on sole economic dependence on sex work, safety of the sex work environment and the level of seeking healthcare services. The clients of the sex workers often demand unprotected sex and the ability of sex workers to negotiate safer sex depends on their level of economic vulnerability and the prevailing power relations between the client and the sex workers and between the sex workers and the law enforcement agencies. In Kenya for instance sex workers often faces high levels of police harassment and difficulties in accessing the healthcare services because of their migratory status, language related problems, cultural beliefs and financial constraint. The figure 2 below therefore, summarises the enabling factors and perceived barriers in accessing healthcare services among the migrant FSWs. Enabling factors and perceived barriers are dependent variables used to explore the healthcare among the migrant FSWs for this study. Enabling factors in this study referred to the resources acquired by an individual who influences the decision or choice in seeking healthcare services. Perceptions on barriers are referred to the personal or societal resources that are constraints in seeking healthcare.

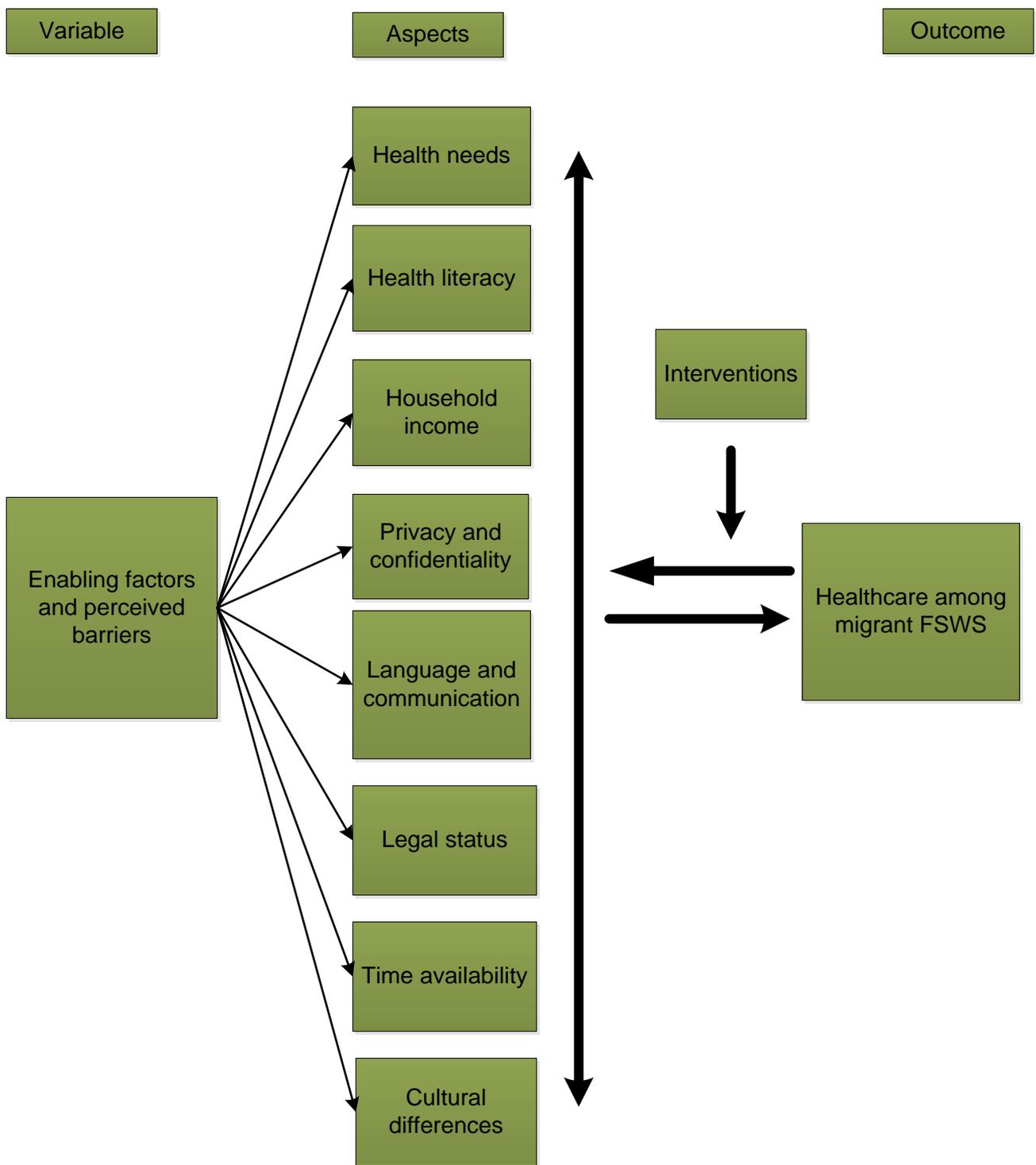


Fig.2. Conceptual framework

Chapter 3. Methodology

3.1 Study area and relevant organizations for the study

The area of study for the research was Eastleigh and Majengo, Nairobi County. The study areas were chosen because they are home to thousands of migrants largely fleeing prolonged poverty and conflict in Somalia. Eastleigh is also a major transit point between refugee camps, Somalia, and other East African countries such as Ethiopia, Rwanda, Uganda, Tanzania, and Sudan to which migrants travel through legal and irregular channels. The area of study is among the growing trading areas of Nairobi. There are new upcoming business opportunities in this area, as a result many people move to find employment opportunity or create their own businesses in these areas. Due to the sensitivity and secretive of sex work, this study was done in collaboration with well-established organization International Organization for Migration (IOM) and National Organization of Peer Educators (NOPE) which works with migrant FSWs in Eastleigh and Majengo, Nairobi.

IOM addresses these migration flows through providing proactive interventions and seeking the effective delivery of programmes to cope with factors such as socio-economic complications, Climate Change and Environmental degradation challenges, intraregional migration management gaps and constricted migration policies and protocols. Within its Migration Health Division, IOM delivers and promotes comprehensive, preventive, and curative healthcare programmes which are beneficial, accessible, and equitable for migrants and Most at Risk Populations (MARPS). Bridging the needs of both migrants and IOM's member states, the Migration Health Division contributes towards the physical, mental, and social well-being of migrants, enabling them and host communities to achieve social and economic development. Within Nairobi area, IOM works with NOPE to implement its healthcare related programs amongst the MARPS.

NOPE are Kenyan-based NGO with operations in the East African region that improves the well-being of youth, people in the workplace and the country's MARPS by providing highly customized sexual and reproductive health and social services. The organization provides comprehensive educational, structural and clinical services. In addition, comprehensive workplace programs, it focus on HIV infection, sexual health and reproductive health issues among the youths and the MARPS such as sex workers, truck drivers and men having sex with men. This organization has two drop in centers for migrant female sex workers in Eastleigh and Majengo slums where the study research took place.

Eastleigh is located east of the Nairobi Central Business District (Pumwani district as shown in the map below) and has been predominantly Somali neighbourhood with both Somali speaking-Kenyans and the Somali refugees mostly from Dadaab refugee camps in Northern part of Kenya border with Somalia. Following the civil wars and natural disasters in the late 1980's and early 1990's, many Somalis fled to seek refuge in Kenya to escape violence and famine. Some went to refugee camps located near the Kenyan border with Somalia while others opted for refuge in refuge in Eastleigh because of its business nature and mostly because of the Kenyan Somali community that had already settled in the area.

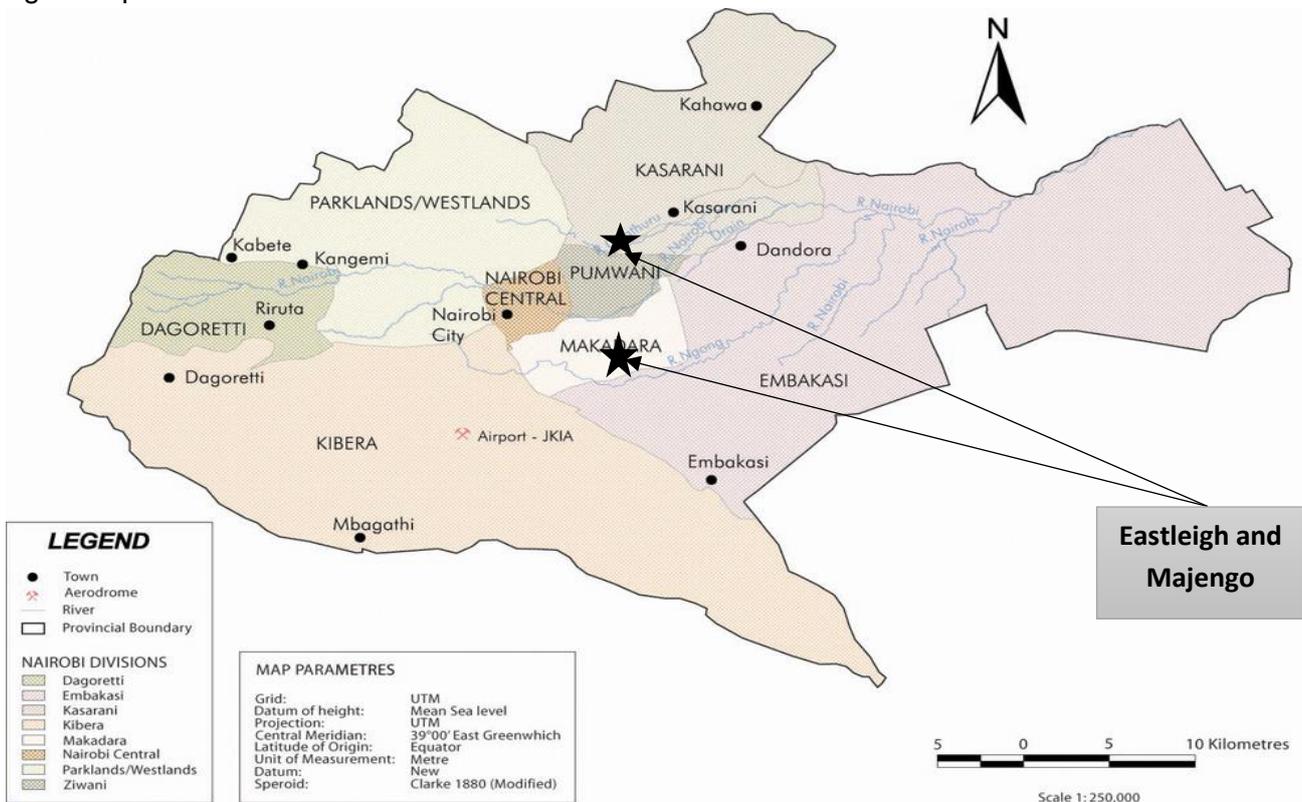
The early 1990's saw Eastleigh's rapid economic development, shaped by its growing population of rural Kenyans, Sudanese, Eritreans, Ethiopians and recently Rwandese and Congolese. Somalis are still the largest population with Muslim being the largest religious faith in the area. As a result of the growing population, Eastleigh has become economic hub among other areas in Nairobi. This is because of the high demand of goods and services in the area and outside the areas such as other East African bordering countries. Refugees as well as small scale business persons invested in import and export

business. The influx of Somalis into Eastleigh was contrary to the Kenyan government insistence on non-existence of refugees in the urban areas (Lindley, 2007).

Despite thriving business and being a place of great business opportunities, Eastleigh has many refugees, documented and undocumented. The population is increasingly over- populated with poor infrastructures. Roads are with deep and long muddy stretches, during rainy seasons, many roads are inaccessible. Housing are of permanent and semi-permanent structures build of stones and mud. Eastleigh is popularly known as ‘Little Mogadishu’ a reference to Somalia’s capital among the Somalis and Kenyans. This name captures the fact that the Somali refugees are dominant majority traders and entrepreneurs running businesses in Eastleigh.

Majengo slum is located in the east of the central business district of Nairobi. Majengo slum is well known for its high number of commercial sex workers dating back in the early eighties. The area is where research among the female sex workers who are resistance to HIV infection for the last twenty years took place. It is characterized by poorly built shanties that are close-knit with mud walls and floors. There is poor infrastructure and the place gets very muddy during the rainy season. There are inadequate toilets of which waste is poorly drained leading to pools of sewage all around the slum. Garbage is poorly disposed as evidenced by the heaps of garbage thrown around the area. Most inhabitants are migrants from neighbouring East African countries (Uganda, Tanzanians, Rwandese, and Sudanese) and the locals who do manual jobs around the slum and in the CBD. Women in the area engage in activities such as sex work, washing clothes and frying potatoes in order to get some money to sustain them.

Fig.3. Map of the area of research



Source: UNEP- Kenya

3.3. Research design

A desk study was done by reviewing of the existing relevant literature on healthcare among the migrant FSWs prior to data collection. This was to get insights on the enablers and barriers that influence healthcare seeking and access. The desk study facilitated the formulation and designing of the conceptual framework and methodology for the research. A qualitative study was conducted using individual respondents and focus group discussions (FGD). A case study was conducted to gather in depth data from the respondents. FGD comprising of five respondents (3 Tanzanians and 2 Ugandans) was used in this study because it offers respondents the opportunity to share their opinions and addresses themes that the researcher may not have anticipated. A check list was used to gather information from both migrant FSWs and the service providers. Open ended questions based on the checklist themes were used to probe in depth information from the respondents. This gave a chance for both the researcher and the respondents to explore more on the healthcare related issues which influences uptake of the healthcare among migrant FSWs. Three sources of information were selected for this research, one with migrant FSW, another consisting of healthcare providers and the government immigration officer. The sample of migrant FSWs was further subdivided as home-based sex workers and brothel based sex workers. Home-based sex workers sold sexual services at their own premises while brothel based sex workers were staying a temporary common rental hotel where they engaged in sexual activities with the clients. The summary of the category of the respondents is shown on the table below.

Table.1.Category of the respondents.

Respondents	Female	Male
	n	n
Brothel sex workers (Somalis)	5	
Home-based sex workers(Tanzanians and Ugandans)	5	
Government healthcare provider with focus on sex workers patients		1
Government immigration officer		1
National Organization for Peer Educators(NOPE) healthcare providers	2	
Total number of respondents	12	2

3.4. Respondent selection criteria for data collection

The research criterion that was also used as the eligibility criteria for the respondents included:

- Had to be female.
- Been engaged in sex work on a weekly basis for the last five months.
- Immigrant born outside Kenya.
- Aged between 18 – 60 years old.
- Exchange sexual intercourse for money or a favour
- Currently residing in Nairobi (Eastleigh and Majengo area).
- Willing to voluntarily participate in the study.

3.5. Data collection

Due to the nature of the sex work, especially among the Somali sex workers who are of Muslim faith which prohibits sex work, one of the priorities was to gain access to the respondents in the field. In the planning process, NOPE and IOM Kenya offices were contacted in assisting in gaining contact with the respondents throughout the data collection process. The two organizations assisted in access to the study site and as well as doing introduction to the perceived respondents and the resource persons (healthcare service providers and the immigration officer). By working with these organizations it was much easier to gain trust and understanding among the respondents. This was so because some of the respondents interviewed (two) were receiving healthcare services such as monthly HIV and cervical cancer screening from the organizations. The healthcare service providers from the above mentioned organizations introduced the researcher to some of the respondents and they also did share their knowledge and experiences in working with migrant FSWs.

Before the interviews took place, the respondents were informed of the objectives of the study research. Sex work being a sensitive topic, the respondents were assured of their confidentiality and anonymity would be preserved. Respondents thereafter were offered 500 Kenya Shillings (~ USD 5) for each time they took part in the interview as a form of appreciation of taking their time to participate in the interviews willingly. The interviews with the healthcare service providers were done first to bring more themes that were used while interviewing the migrant FSWs. These interviews with service providers were also easier to start with as they were easier to access. The interview with the healthcare service provider took place at their area of work for convenience purposes.

As a result of the security concerns of the respondents and the researcher, the interviews with migrant FSWs were done at different locations where NOPE offers services to the migrant FSWs. In depth interviews for some of the respondents were done in the houses of the migrant FSWs and the brothels in the comfort of respondents and for confidentiality. The security situation in Eastleigh area was of concern for both the researcher and the migrant FSWs. This was because the area of research in the recent past faced suicide bomb attacks. Most respondents were interviewed during the night as the majority of the respondents were fasting and also because during the day there were police restraint on the refugees to go back to the refugee camps. This therefore, resulted in most of the undocumented migrants of Somali origin feared being interviewed upon during the day.

The data collection was from the migrant FSWs, healthcare service providers and the immigration officer. The interview with Tanzanians and Somalis were in Swahili while for Ugandans was a mixture of English and “Sheng”. Sheng is a mixture of Kenyan local languages. There were issues attached specifically to the study of migrant FSWs, as they are with any other group of people involved in illegal or supposedly immoral behaviour. One of the first problems as mentioned earlier was how to make the initial contacts with the sex workers. The first initial research contact was made after the first visit three days visit. The respondents were visited in three consecutive days before the research. This was because sex workers form a very dynamic population and also to get to know their working environment and build their trust. The respondents were reluctant and not willing to open up to any discussions as they feared of their legal status as well as that of being a sex worker. During these days the researcher discussed about life in general. After three days of an attempt to gain trust of the sex workers, they became friendly and willing to discuss their healthcare related issues with the researcher. Data collected was triangulated by comparing the information obtained through healthcare service provider, migrant FSW, and government immigration officer interviews. This was used to check the validity of the information received from the respondents. Below is how data was collected among various samples of the study research.

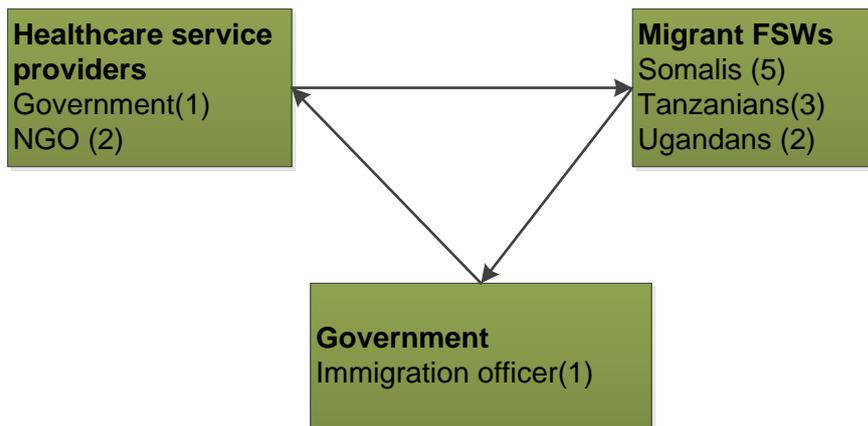


Fig.4. Triangulation of data

3.6. Limitation of the study

The findings presented in this thesis are based on self-reporting by migrant FSWs. As sex work is considered illegal in Kenya, some of the information provided by sex workers may be incomplete. The information is not generalizable to other migrant FSWs, because there was no assurance that the purposive sampling was an accurate representation of the total population of migrant FSWs in the two areas of study. Due to low inferential weight, study findings were limited to the target study populations. Getting respondents for the interview was very difficult because sex workers are highly mobile population. The respondents were hesitant to take up the interviews because they feared exposure to the police and other previous concerns of confidentiality violation. It took quite some time to build trust from the respondents. Another challenge during data collection was the timing for the interview coincided with the Ramadan period (Muslim fasting period). The respondents were not open to talk about any sexual related topic during the fasting period as it was religiously forbidden. This therefore created reluctance and difficulty with discussing and reflecting on experiences and choices around sexual health.

The Somali FSWs were interviewed during the night at their work place after they broke the fasting time. Ethiopian FSWs were scheduled for interview unfortunately due to language barrier between the respondents and the researcher, they had to be discontinued from participating in the interview process. The Ethiopian respondents only understood Amharic, the researcher decided to drop the Ethiopian FSWs as interpretation may have not been appropriate for some of the sensitive issues being discussed. There was insecurity related issues in the area of research, in the recent there had been several suicide bomber attacks on the residents, hence the area was on high security alert by the police. There were various police raid on the residents during the time of the research. In addition, as mentioned in previous chapters, the sensitive nature of sex work, often generated emotional responses during discussions or interviews with various respondents, this made it difficult to complete painful experiences.

3.7. Data Analysis

The data was analysed based on the study objective and conceptual framework mentioned earlier. A process of constant comparative and review of the data collected was used throughout the process of the research which meant comparing:

- Different individuals and service providers (healthcare, migration officer) perspectives
- Data from the same individuals at different points in time
- Analysis from interviews and lessons from previous recent literature

Themes for data analysis were created based on the conceptual framework and research sub questions. Throughout the fieldwork for the data collection, the information was redefined based on the emerging data from previous interviewed respondents. This guided the researcher through the interview process as well as the exploration of new questions and insights that arose in the process of interviews.

Table. 2. Aspects considered for the data analysis

Variable	Aspects
Enabling factors and perceived barriers(in healthcare access and healthcare experiences)	<ul style="list-style-type: none"> • Health needs
	<ul style="list-style-type: none"> • Health literacy
	<ul style="list-style-type: none"> • Household income
	<ul style="list-style-type: none"> • Privacy and confidentiality
	<ul style="list-style-type: none"> • Language
	<ul style="list-style-type: none"> • Legal status
	<ul style="list-style-type: none"> • Time availability
	<ul style="list-style-type: none"> • Cultural differences
	<ul style="list-style-type: none"> • Interventions

Chapter 4. Results

The average age of the brothel based respondents was 23 years and 45 years for the home-based migrant FSWs. The average age of all the sex workers interviewed was 30(range 14 – 60 years).The brothel based respondents have been in Kenya for an average duration of 1.5 years as sex workers compared with 18 years for the home-based sex workers. The brothel based migrant FSWs respondents have been in Kenya as refugees while the home-based migrant FSWs have been in Kenya to seek employment opportunities. Eight respondents interviewed were unmarried and two respondents were mothers and divorced with three children respectively. However, only one respondent lived with the children. Six of the respondents had not completed primary education and of these four could neither write nor read. The average income of the respondents ranged from 0.5 - 5 USD/day (1 USD equivalence 87 Kenya Shillings July 2013). The table below shows characteristics of respondents.

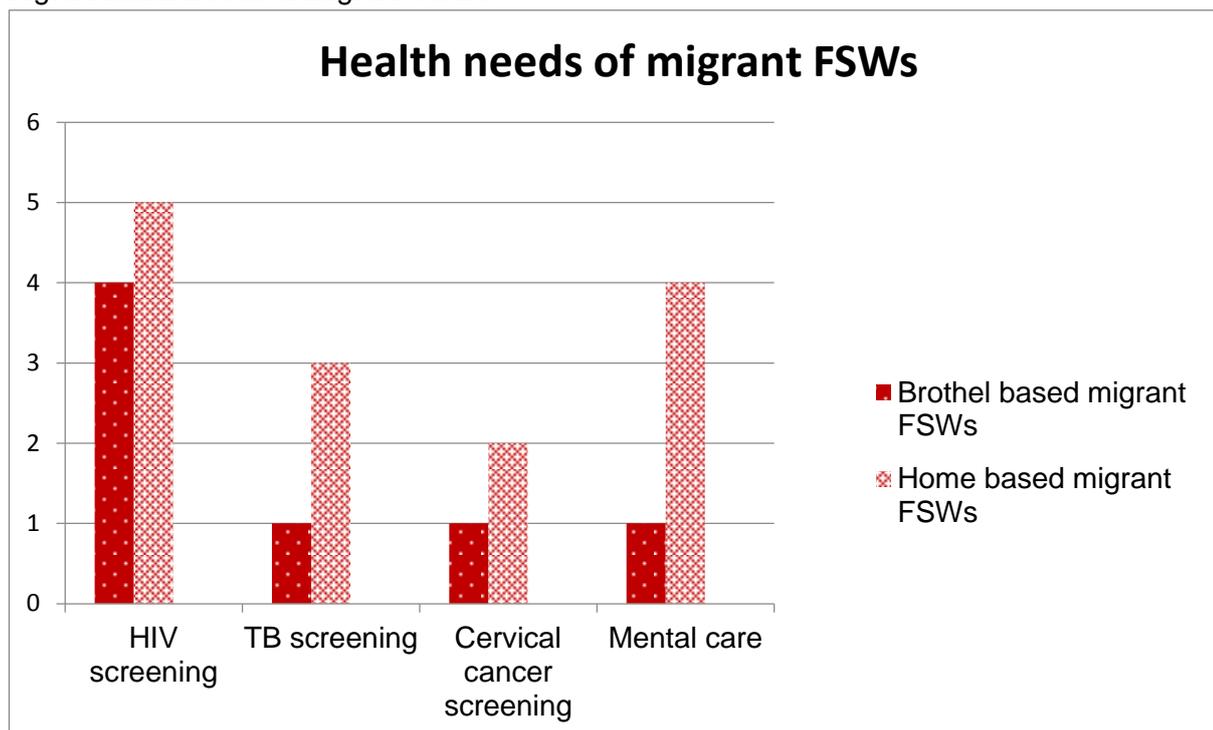
Table. 3. Respondents characteristics (n= 10)

Category of the respondents	Marital status	Number of respondents	Number of children	Reasons for migrating
Brothel based	Single	5	None	Refugees
Home-based	Married and divorced	2	3 + 3	Employment
	Single	3	None	Employment

4.1 Health needs

Among four other health needs, seven of the respondents reported HIV screening as their major health need. HIV was reported as a result of frequent exposure to sexually transmitted infections and the consequent need for proper treatment and diagnosis follow ups. One respondent who are home-based migrant FSW, stated that sexually transmitted infections were perceived as inevitable as a result of the nature of their work as sex workers. Home-based migrant FSWs stated condom as part of their sexual health need. The majority of the respondents expressed unmet health needs such as provision with female condoms, screening for cervical cancer and mental health. A few of respondents mentioned reproductive health as a need, this was linked to unwanted pregnancies that rose as a result of rape or when a client refused to use condoms or the condom busted in sexual act. In this study however, condom use was viewed as part of sexual health need based on the perception and experiences of the healthcare provider. Vulnerability to HIV infection emerged as a strong concern among the majority of the respondents. Much of this was linked to the violence accompanied by sex work and criminalization of sex work which undermined the sex workers ability to seek for protection from the police.

Fig.5. Health needs of migrant FSWs



It was also interesting to note a higher number of home-based respondents who mentioned mental health as one their health needs. It was also important to note the fact that the respondent who had been in sex work for a period of over thirty years, mentioned mental health as an important health need. According to her sex work had created a lot of distress and unhappiness putting her life in a miserable situation for the last thirty years. During the interview she expressed a need for someone to talk to often and she felt she lacked someone to express her emotions and instead she has to pretend to smile when working despite the distress. This respondent clearly stated the need for services targeting mental health needs among the migrant FSWs.

“I think it is very important to do HIV and cervical cancer screening. Because the type of work we do is very risky, sometimes our clients rape us or force us to have sex without using condoms and since we are weak and need money to survive we give in to them. Even for myself who has been in sex work for over 30 years, it is necessary to receive these screening services (Home-based migrant FSW, 60 years).”

All the respondents in the FGD agreed that the key health needs of their priority were reproductive and sexual health needs though the most sighted as pressing health need was sexual health. This was emphasized on and confirmed by the healthcare service provider who reported the health needs of sex workers as ranging from family planning, health education, cervical cancer, and TB screening, HIV and other sexually transmitted screening among others. These services were reported by both the government and NGO healthcare service providers to be available in the local healthcare facilities.

4.2. Health literacy

Health literacy refers to the degree to which individuals have the capacity to seek and understand the basic health information and services needed to make appropriate healthcare decisions (WHO 2010). Knowledge about different illnesses and whereabouts of the local healthcare services appeared to be a contributor in seeking healthcare services among all the respondents. Seven respondents mentioned HIV

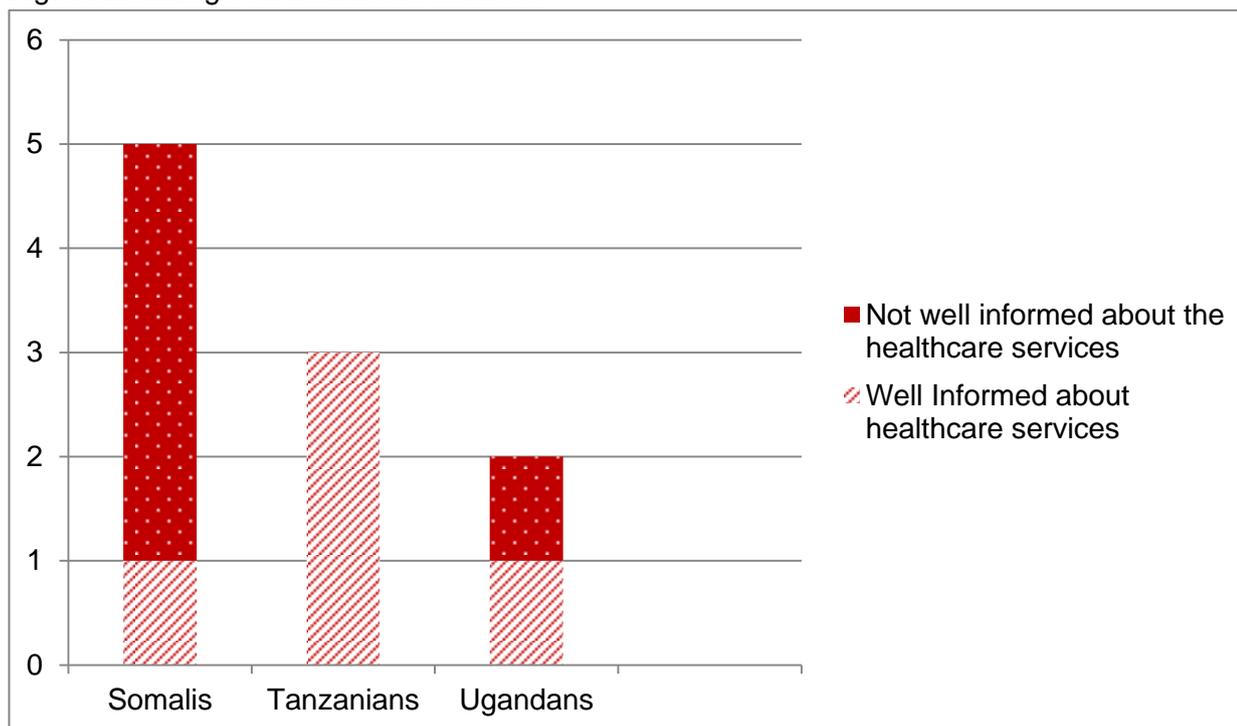
and TB to be an important health issue among their group as sex workers. It was interesting to note that all the respondents who were brothel based were unaware of the available local healthcare services. Lack of provision of information about diagnosis and treatment of migrant FSWs were seen as related to attitude of the healthcare service provider. From the information provided by most of the respondents it is clear that knowledge on available health related services appeared to be an enabling factor in seeking healthcare services.

“I have been living indoors since I moved to Nairobi from the camp. When I feel unwell I borrow some pain releasing medication from my friend. I think I do not need to see a doctor unless maybe when am about to die. I feel confined here in brothel and so I got no better life to live that where I am now. I never went to school in the camp and little knowledge is through experiences I go through. When I was in the camp, I got treated with traditional medication from my neighbours (Brothel based migrant FSW, 20 years).”

The FGD respondents emphasized that having both knowledge on their illness and location to available healthcare services enabled them to access the available healthcare services. The findings also showed that four of the home-based migrant FSWs were aware of the available healthcare services within their locality. This was so especially among the Tanzanian FSWs because they were very conversant with the local language and could easily mix with the Kenyan sex workers to know where to receive the available healthcare services. They further stated to be aware of these healthcare services as they frequently received condoms from the nearby healthcare centre for protection.

The above statement was also confirmed through the healthcare service provider who reported low uptake of screening services (e.g. TB, cervical cancer and HIV) among the brothel based migrant FSWs. Healthcare provider further reported that most of the migrant sex workers come to seek healthcare services because of very severe sexually transmitted diseases such as HIV and genital warts. It was also noted that many migrant FSWs in particular of Somali origin are reluctant to seek healthcare services. This was due to high level of illiteracy among the migrant FSWs. Additional to this, it was indicated that many sex workers avoid seeking healthcare services due to stigma associated with sex work and the discrimination and isolation that they may follow once they were known to be sex workers.

Fig.6. Knowledge on healthcare services



4.3. Household income

Limited financial resources among the respondents interviewed were reported to be a perceived barrier in utilization of and access to the healthcare services. However, sufficient income or good social economic status of the respondents can be an enabling factor in seeking healthcare services. Eight respondents interviewed stated that most of the money they received from sex work was not sufficient to use for healthcare services. The respondents further stated that they could receive as low as Kenya Shillings 20 (0.1 USD) for the sexual services. Part of the money received for the sexual services were sent as remittance to assist their families back to their country of origin as well as pay for their accommodation services at their places of work. Thus it was not a priority to spend it on healthcare services.

The brothel based and home-based sex workers quoted below reflect on the challenges they had balancing their own health with financial needs of their families. Seeking healthcare services meant giving up finances for other important requirements such as food, rent and support for the family. As a result they would avoid any costly healthcare services.

“My father died, my mother is already practically dead, and I expect her to die from drug abuse or alcohol. I am not a Kenyan, I am the oldest in my family, and I do not recall how I ended up being a sex worker. My sisters need food, we need money to survive otherwise we all die hungry. What I receive from clients can only buy food for my sisters to eat. I fear for my life, I wish I could get out of this sex work activity, I feel wasted as a child (Ugandan FSW, 15 years).”

“You know that I came here to work to earn money and send money home for my family, if I go to seek healthcare services I will spend a lot of money for the services. Only when I am very seriously ill I go to the healthcare services, but often I wait for the illness to get better by itself (Tanzanian FSW, 35 years).”

All the respondents interviewed stated that sex work is their only source of income. The FGD also did report that healthcare cost was a major determinant in health seeking behaviours especially for the sexually transmitted diseases that were costly in terms of treatment. In addition, the FGD further clarified that healthcare consultation services are free though the patient may have to buy nutritious food especially for the HIV positive sex workers to remain strong and healthy. Service providers though gave contrasting information by reporting that all the public healthcare services are for free, there are no consultation fees. In in-depth discussions with the service provider, it was indicated that medication for sexually transmitted diseases such as HIV infections were free though patients fear going to receive the medication especially migrants who do not like to be identified as HIV infected persons.

4.4. Privacy and confidentiality

According to the migrant FSWs interviewed, five respondents reported lack of confidentiality among the healthcare service provider. The home-based respondents felt that there are limited trained healthcare service providers for consultation on sexually transmitted infections and treatment among the sex workers. The respondents felt that the healthcare providers did share their personal health information with other staffs. They further reported that healthcare service providers did not appear to be fully confident in dealing with migrant FSWs once they opened up as being sex workers. The respondents of brothel based FSWs were very concerned of their privacy as sex work was prohibited in Muslim faith and because they lived in a communal society where they know each other. They reported not going to seek healthcare services because they felt some of the healthcare service providers may share their personal information to their communities which are very tied to Muslim religion.

The FGDs respondents also confirmed that they were not confident with the healthcare service providers as they felt they could give their personal information to the government or the police about their stay in the country. They feared being deported once the information reached the police. The healthcare provider did inform that, the migrant FSWs value their confidentiality and privacy hence their information were very dynamic as they try to keep away from the police. One respondent described her feelings about lack of confidentiality on the part of healthcare service provider as follows:

“I do not feel like to tell the healthcare provider all about my personal information relating to sex work. I do not trust that the healthcare service provider will maintain it as a secret. The healthcare provider may be from the same community as I am in, and this will make the entire community aware that I am a sex worker which may lead to myself being stoned to death as it is prohibited in Muslim culture (Somali FSW 25 years). ”

4.5. Language and communication

Language and communication problems were mostly reported, with frequent references made to ‘language barrier’ between healthcare service providers and the patients (migrant FSWs). The majority of the respondents of brothel based migrant FSWs, expressed concerns in inability to communicate their health problems due to language difficulties, with the risk of being misunderstood and maybe leading to misdiagnosis. This was a concern despite the respondents having stayed in Kenya for a while with the basic knowledge on the local languages. They further stated that they may have knowledge of the local language (Swahili) but expressing themselves to the healthcare service provider is much easier in their own local languages. Some of home-based migrant FSWs outlined how difficult it was for administrative procedures as some of the procedures had to be written down by the patient before they could see the doctor. This process could take longer time or even the patient giving up before seeing the healthcare provider. Almost all the respondents were only confident to express themselves in their own languages when seeking healthcare services.

The FGDs carried out also confirmed that sometimes there would be barriers in communication between the healthcare provider and the patient especially among the new migrants. They further stated that there was complexity in some of the questions that could be asked by the healthcare provider and a translator may be required. A healthcare service provider reported that lower healthcare service turn out among migrants was related to language barriers.

“I feel that language is a problem in access of the healthcare services among migrant FSWs. This was so especially when everything had to be translated by a friend of the patient. A friend may opt to select what to translate or even summarize the information between the healthcare provider and the patient. Sometimes it is not easy to translate sensitive health issues pertaining to sex work. Sex workers often do not open up to all the information required. As a healthcare provider I need to know more information related to illness before any diagnosis is administered (Government healthcare service provider).”

4.6. Legal Status

Legal status was mentioned by eight of the respondents as an obstacle in accessing the healthcare services. Among the interviewed respondents seven did not have legal documents to stay in the country. Four of the brothel based respondents had no legal documents to permit their stay in Kenya. The situation of being an undocumented or irregular migrant FSWs was very disturbing among respondents. They had to stay indoors all the time because of their migratory status. They feared being arrested by the police. Testimonies from the respondents, mostly of Somali origin, revealed that they were mostly victims of suspicion by the police hence this limited their movement to seek healthcare services.

The FGDs confirmed that many of the undocumented migrant sex workers were reluctant to seek healthcare services because they feared being deported or being harassed by the police. Service providers confirmed that healthcare access among the migrants' sex workers was not a policy priority in relation to migrant populations within Kenya and that many migrant FSWs could not seek healthcare services because they did not have appropriate legal documents. The healthcare service provider further reported that though it was a human right access healthcare service, many of the migrant FSWs and healthcare service providers were not aware of such rights. The government immigration officer also stated that sex work is prohibited in Kenya and therefore services specific to sex workers are not a priority to the government. One migrant FSWs of Somali origin (18years old) noted:

“I'm from Somali and I can tell that I ran away from Dadaab refugee camp in Northern Kenya without any identification document. I fear being deported by the police, I stay indoors, I cannot risk to go to the hospital because the police may find me and send me back to the camp, I do not remember having any parents, I ended up here without my knowledge.”

Table.4. Showing migration status of the respondents

Sex works categories	Migration status		
	Documented migrants FSWs	Undocumented migrant FSWs	Nationality
Brothel based	1	4	Somalis
Home-based	1	1	Ugandans
	1	2	Tanzanians
Total	3	7	

4.7. Availability of time

Generally availability of time among most the respondents was reported as a constraint in utilization of the healthcare services. According to migrant FSWs interviewed, they reported that during the day they were asleep and work during the night, they had no time to seek healthcare services. The healthcare services in Kenya mostly operate during the day while the respondents felt they needed the healthcare services more in the night when they were working. The healthcare services that were mentioned to be of urgency were provision of condoms. The respondents further reported that they needed the healthcare services especially in the night in cases where a condom burst or the clients insisted not to use condoms or when raped. These services were reported not to be available during the night and the services available during the night were private institutions which were expensive and time consuming to access. This time schedule of the opening hours of the healthcare services was reported to contribute to exposure of the sex workers to sexually transmitted diseases as they had nowhere to go for healthcare services during the night that was accessible in terms if costs and also their own security was not guaranteed. A healthcare service provider indicated that long waiting hours and inflexible opening and closing hours of the healthcare services contributes to a risky environment for MARPS such as the sex workers. This was perceived as a barrier in seeking healthcare:

“As a sex worker, I work in the night and during the day I sleep. I would like to go to the hospital but mostly in the night when am working because I need condoms in the night when am working, I also need to seek healthcare services when raped by my client or when the client refuse to use condoms on me, this is mostly during the night. Here there is no healthcare facility open at night. Most healthcare here closes by 5pm when am sleeping. It is very difficult for me to go to the hospital at this time of the day. I would like to have the healthcare services mostly in the night also because not many people would identify with me (Somali FSW 30 years old). ”

“I am not comfortable to go to the hospital during the day. I fear that someone could recognise me. In the hospital there are longer waiting hours and as a sex worker I do not have much time to wait because my client may call at any time. Money comes first for me as a sex worker. I do not like to waste a lot of time queuing to see the healthcare service provider (Ugandan FSW 40).”

4.8. Cultural differences

Culture did not feature as a barrier among the home-based (Ugandan and Tanzanian) FSWs as a concern. All the home-based respondents reported concerns regarding physical examination by the healthcare provider and respecting religious norms and beliefs. Respondents of brothel based felt they could not consult with a male healthcare provider about their sexual health problems. They preferred to talk to female healthcare provider in the physical examination rooms. According to the FGD and healthcare service provider, cultural norms and religious beliefs were reported in some instances resulting in patients refusing to seek healthcare services or unwilling to disclose all the sensitive information to the healthcare providers. Some of the respondents also did fear discussing their genital parts with the male healthcare providers, for example:

“Members of Muslim religious communities prohibit sex work. I am expected to be a virgin when am getting married. I am now practising anal sex and consider myself a virgin sex worker. Unfortunately I suffer silently from anal warts, I fear going to see the healthcare provider because I fear telling male healthcare provider I am a sex worker. I feel ashamed of myself and fear being scolded by the male healthcare provider or maybe he could be of Somali origin. I fear he may report me to the Muslim community (Somali FSW 14 years old).”

The migrant FSWs interviewed of Muslim faith relied on the assumption that the healthcare service providers were often male that resulted in being reluctant to seek healthcare services. This however, was evident in the local healthcare service centres visited, on a weekly basis for a period of one month, it was observed that most of the healthcare service providers were males, and there was no option of requesting to be treated by a female healthcare provider.

4.9. Interventions

The majority of respondents spoke of the importance of a flexible and individualised approach in increasing uptake of healthcare services among migrant FSWs. Several respondents believe that the underlying reasons for low healthcare uptake could be majorly because of the migratory status. The assumption was that there would be more migrant FSWs seeking healthcare services when they have appropriate legal documents. The respondents in the study together with the healthcare service providers stated specific interventions that would increase the uptake of the healthcare services among the migrant sex worker. In discussions with the respondents it was clearly noted that information and awareness creation on available healthcare services and migratory services would increase their healthcare uptake. Perceived interventions were further discussed by the respondents and healthcare service providers based on each study themes that were later summarised by the researcher in the table 5 below.

Table.5. Perceived interventions to improve healthcare services uptake of migrant FSWs

Enablers and barriers	All perceived interventions to improve healthcare access among migrant FSWs
Health needs	<ul style="list-style-type: none"> • Provision of various healthcare services such as reproductive, mental and sexual health needs to migrant FSWs • Availability of maternal and child healthcare services to migrant FSWs • Facilitate referrals to higher levels of healthcare needed by migrant FSWs.
Health literacy	<ul style="list-style-type: none"> • Provision of education programmes to migrants on healthcare system in host country. • Provision of healthcare leaflets with multiple languages on health related issues. • Education about the importance of the uptake of reproductive and sexual healthcare services among sex workers.
Income	<ul style="list-style-type: none"> • Encourage engaging in other livelihood income generating activities • Provision of low cost healthcare services • Provision of healthcare insurances that are inclusive of migrants • Provision of mobile clinics that visit places where migrant FSWs work or stay.
Privacy and confidentiality	<ul style="list-style-type: none"> • Provision of quiet spaces for confidentiality. • Train staff on the importance of confidentiality.
Language	<ul style="list-style-type: none"> • Creation of language friendly healthcare system by offering option for translators • Encouraging improvement of migrant patients' command of the local language as long term solution to language barriers.
Legal status	<ul style="list-style-type: none"> • Provision of clear guidelines and information on what type of care different migrant groups are entitled. • Provision to healthcare services to all migrants despite their legal status. • Transparency with immigration officers in the provision of legal status and advice in advance on the procedures of acquiring appropriate legal documents.
Time	<ul style="list-style-type: none"> • Flexibility in opening and closing of the healthcare services. • Provision of evening and weekend healthcare hours that migrant FSWs can access at any time. • Try to reduce the waiting times by hiring more staff and giving sex workers quicker access healthcare services.
Cultural differences	<ul style="list-style-type: none"> • Training of staff in different cultural and religious practises. • Expertise and exposure in the treatment of migrant FSWs for cultural sensitivity awareness.

Chapter 5. Discussions

Comparison with the existing literature on the key findings.

5.1. Health needs

In this study finding, many of the health needs as mentioned by the respondents were universal. However, it is interesting to note that the majority of the respondents both brothel and home-based FSWs pointed out HIV screening and mental health their most health needs of concern. It can therefore be interpreted or assumed that based on the nature of their work as sex workers they are more vulnerable to HIV infections. As mentioned earlier in the findings by one of the respondents, there are instances whereby the clients of the sex workers refuses to use condoms or they are raped hence they may be exposed to the risk of HIV infections. This is confirmed by previous research that found sex workers often find it difficult to use condoms especially with their regular clients who would interpreted condom use as a sign of distrust (Stadler & Delany, 2006).

In addition, it became clear that respondents perceived mental health needs to be a major challenge in their work despite having been in sex work for a couple of years. Studies by Vanwesenbeeck (2001), confirmed that sex workers are not homogeneous group and have different experiences and social context before and during the sex work.

5.2. Health literacy

From the findings, knowledge has been revealed as an enabler in accessing healthcare services among the migrant FSWs. Study further found that limited knowledge on health needs and healthcare services contributes to the vulnerability of migrant FSWs. Unawareness of healthcare services or lack of knowledge about local healthcare services at one's disposal can act as a barrier in seeking healthcare services. When migrant FSWs have limited knowledge on the availability of healthcare services, they may become more vulnerable to various health risks. The service providers, based on their experiences, the use of screening services (HIV, TB and cervical cancer) was low among the brothel based migrant FSWs. This was found to be a result of limited knowledge on the available healthcare services. Other studies by Scheppers et al. (2006), have found that knowledge is an enabler in seeking healthcare services, whereas limited information appears to be a barrier to seeking healthcare services. Findings of Boateng et al. (2012), among the migrants, also found that knowledge on diseases and healthcare services whereabouts influenced the healthcare seeking ability.

Even though this study did not investigate the differences between migrant and non-migrant sex workers in accessing the healthcare services, it is important to note the differences in healthcare and barriers in accessing healthcare services. For instance the Kenyan FSWs seemed to be very knowledgeable about sexual and reproductive health needs. Most of the Kenyan sex workers had basic formal education and they had knowledge on where to seek healthcare services. They were more confident in doing sex work as form of livelihood option. With such knowledge they had sex workers group/association where they could voice out there right whenever they experienced any form of gender based violence from their clients. This could therefore be concluded that due to the knowledge on the available healthcare services, they are likely to be less vulnerable compared to the migrant FSWs.

5.3. Household income

Although healthcare consultation costs were free, the majority of the respondents felt they could not afford to seek healthcare services. This was because their finances were constraint as a result of the remittances they had to send back home to their country of origin as well as for their sustainability in

Kenya. The home-based respondents cited cost in terms of buying nutritious food especially for those who were on strong medication for HIV which needed good and nutritious food to stay healthy. The cost also arose for an instance when one is referred to the general hospital for further diagnosis. This therefore did result in under- utilization of the available healthcare services.

In this study, it was found that cost of healthcare services resulted in under-utilization of healthcare services among the majority of the respondents. This led to holding on with the illnesses among the migrant FSWs until they felt better again. These findings were similar to those of (Bollini & Siem, 1995 cited in Hansen & Donohoe, 2003) among migrant populations in country of final destination. It was worth noting that among all the migrant sex workers interviewed stated that reasons for not utilizing healthcare services were based on affordability and not availability of the healthcare services.

5.4 Privacy and confidentiality

Privacy and confidentiality was described by respondents as an enabling factor to seeking healthcare services. Discussions with respondents exploring privacy and confidentiality such as sharing information with other healthcare service providers indicated that the majority of the respondents were concerned about the issue. Previous study in Nepal found privacy and confidentiality to be a determinant to seeking sexual health related needs among the FSWs. Together with this findings, it suggest that migrant FSWs value privacy and confidentiality and will seek healthcare services where they have trust in the provision of privacy and confidentiality from the service providers. Given the fact from the findings, home-based migrant FSWs were already seeking healthcare services, they were less satisfied with the level of confidentiality provided by the healthcare providers.

Privacy and confidentiality is a greater to the potentially stigmatised MARPS such as sex workers. These findings were consistent to the studies of Scorgie et al. (2013) which revealed that sex works do experience stigma and discrimination as a result of lack of privacy and confidentiality among the healthcare service providers. As a result, it was noted that many respondents simply chose not to disclose their work as sex workers to the healthcare providers because they feared being stigmatised or reported to the police. This would however, undermine diagnosis accuracy and effectiveness if treatment of various illnesses among the sex workers populations. To increase uptake of the healthcare services, migrant FSWs perceive that information given to the healthcare service provider will be treated in a confidential manner.

5.5. Language and communication

The study found that difficulties with self-expressing in the national Kenya language influenced their access to the healthcare services. This was of interest because the majority of the respondents having stayed in Kenya for a long time were not able to express themselves well in the local language. It can therefore be interpreted that respondents limited understanding of the healthcare services or seeking the healthcare services could be due to communication barriers.

Language differences become barriers to healthcare by making communication between healthcare provider and patient (FSW) difficult. Findings by Collins et al. (2002), reported language as a barrier in seeking healthcare. Language was found to reduce patients' ability to express self while ill, difficulties to follow the healthcare service providers' diagnosis and adhere to prescribed treatments. Language as a barrier to healthcare service seeking was also found to lead to additional risk on patients' health as they felt dissatisfied with the healthcare services and hence may live the healthcare premises before seeing the

service provider. It was also reported to be time consuming before the healthcare service provider could figure out the exact patient's illness.

5.6. Legal status

It was found that the majority of the respondents were undocumented migrants. Due to their migratory status, they faced both formal and informal barriers in accessing the Kenyan healthcare system. These barriers included limited healthcare rights, fear of being reported to the police, lack of knowledge on where to seek healthcare services and limited social networks with the neighbours. These barriers induced other alternative healthcare seeking strategies such as purchasing over the counter medication and staying at home until one feels better. According to ECDC (2009) study on migrant health, it was found that migration policies (legal status) and asylum procedures prevented access to healthcare services by undocumented migrants. Policies and regulations that prevent migrants from accessing services were found to be obstacles for seeking healthcare services and support. These regulations hindered access to healthcare services among the migrant populations. Such obstacles may make migrants more vulnerable despite the International Human Rights Guideline on the right to all persons access to health (UNAIDS 2006).

The majority of the respondents being undocumented migrant FSWs as mentioned above, it was interesting to note that migrant FSWs consider violence as “normal” or part of their job and they did not have information about their human rights. As a result, they are often reluctant to report incidences of rapes, sexual assaults, or physical harm to the authorities. These incidences could not be reported by the migration FSWs because of their migratory status, they feared being detained or deported back to their countries of origin. At the same time, it is important to highlight that in several countries where sex work is considered illegal including Kenya, certain activities such as police rescue raids of sex workers have led to violence against sex workers and compromised migratory status of the migrant sex workers (WHO, 2005). Research from India and Indonesia has indicated that migrant FSWs who are rounded up by police officials in exchange of their release they were sexually exploited or physically abused before being released and deported. The police raid of sex workers is often accompanied by violation of human rights and thus increases their vulnerability to various health related concerns.

Discussing migration status of migrants' access to healthcare is relevant in human rights framework. The fundamental principles of non-discrimination and the right to health are outlined in the International Human Rights laws where it is specified that states are obliged to respect an individual's right to health by refraining from denying or limiting equal access for all persons including undocumented or illegal migrants. In reference to the international human rights laws, it can be argued that migration status should not influence entitlements to healthcare services (Biswas et al., 2011).

5.7. Cultural differences

Cultural differences of any group of individuals is often said to function in the lives of those who compose them. A review of literature on culture as a barrier on healthcare seeking among migrants showed that effects of cultural diversity on quality of healthcare are complex and challenging such as cultural ignorance and misunderstandings of both healthcare provider and patient. It can therefore be said that cultural differences in this study appeared to influence how some brothel based FSWs would access the healthcare services. The availability of female healthcare provider contributes to healthcare seeking behaviours among the brothel based sex workers who are majorly of Muslim faith.

The findings were similar to studies by Bauer et al., (2000), that attitude of an individual as part of their cultural or religious beliefs influenced the access and utilization of healthcare services. When patients are

migrants (for example Somali speaking migrants), it be justified given the likelihood of such patients growing up in a different culture and speaking different language. Some studies have shown fairly strong evidence of the role of cultural differences in lowering healthcare seeking ability among migrants (Boateng et al., 2012).

Chapter 6. Conclusion and recommendations

6.1 Conclusions

In this thesis, healthcare services is recognised as a fundamental human right and that right is often denied because of the legal status, financial constraints, limited knowledge on health status and social status of the sex workers. The findings showed experiences of healthcare access as perceived by the migrant FSWs. It was noted that the decision to uptake healthcare services is the composite result of personal health needs, migratory status, social forces, and actions of the healthcare service providers and to some extent culture at a particular service point. Healthcare service providers also did have experiences and views about what constitutes enablers and perceived barriers in healthcare access among the migrant FSWs. The extent to which migrant FSWs experienced healthcare services varied among different migrant FSWs. Healthcare experiences and access by migrant FSWs reflected on their healthcare seeking behaviour.

Based on different experiences in accessing healthcare services, migrant FSWs did have specific health needs regarding HIV, cervical cancer, TB screening and mental health. For sexual health needs, the study understands the need for specific information on sexuality, psychology, and access to the healthcare services among migrant FSWs. Like other females, migrant FSWs also do need access to the general health. Financial related constraints such as household income can greatly influence healthcare accessibility and utilization. When people have limited finances they cannot seek healthcare services, their priorities may not be centred on healthcare services even if the illness seem serious. Survival priorities such as accommodation, food, and sending remittances may seem more important than healthcare services. The financial difficulties place migrant FSWs in more vulnerable positions in seeking healthcare services. Even though the available care maybe affordable, financial constraints may cause difficulties in paying for prescribed treatments as well as buying nutritious food.

With sufficient knowledge an individual is enabled to seek healthcare services. Knowledge is a strong influence on whether to seek healthcare services or not. Migrant FSWs need to determine if they have a general health problem or need immediate care. Such determination calls for the ability of an individual to assess their health status and have a general overview about the illness. Once the individual is able to assess self, then other assessments needed are knowledge of where to go for care and what resources are needed for the healthcare. These assessments are often influenced by perceptions on knowledge about the quality of care and beliefs about healthcare service providers.

As argued in this thesis, language, cultural differences and legal status posed as the major barriers for the majority of the migrant FSWs in seeking healthcare services. Lack of translators or staff who understood differences in cultural beliefs practises exacerbated the difficulty in seeking healthcare services among migrant FSWs. The migratory policies and practises made the situation more difficult for the migrants FSWs to access the services as the majority were undocumented migrants hence their movement in accessing the services were limited. The existing Kenyan policies are not inclusive of the migrants FSWs as sex work is considered illegal hence no provision of migrant sex workers its laws. All in all, this thesis however, has shown how the enablers and perceived barriers among migrant FSWs influences their healthcare seeking behaviour in terms of personal health needs, healthcare service providers actions and what interventions are considered most suitable.

6.2 Recommendations

The recommendations suggested in this thesis for consideration by NOPE-Kenya are based on the findings that showed the need for increased healthcare service uptake among the migrant FSWs. Awareness raising needs to be continued and scaled up by NOPE among the migrant FSWs. Migrant FSWs healthcare uptake particularly in Eastleigh area seemed low. It appeared that the majority of the respondents in this area had minimal exposure to the available healthcare services and limited information on the available healthcare services.

The service providers expressed their willingness and concerns in providing healthcare services to the migrant FSWs as it was a human right to access healthcare services. However, healthcare service providers have to reconsider some challenges arising from the undocumented migrant FSWs. NOPE needs to do analysis to check that the rights of migrants FSWs are not violated in terms of healthcare accessibility and encouraging the need to defend the rights of undocumented migrant FSWs in utilization of the available healthcare services.

Healthcare service provider needs specific trainings in sensitivity around sex work and migrant related issues. This should include understanding of the health needs and barriers that prevent migrant FSWs from accessing the healthcare services such as cultural differences, translations for those who do not understand the Kenyan national language, options for legal, and protection referrals that are available.

Respondents mentioned time as a factor that determines healthcare seeking behaviours. Thus NOPE needs to create a flexible operating hours to enable the migrant FSWs access the healthcare services that the organization provides. Non-medical aspects of healthcare such as psychosocial support, other livelihood generating activities and legal support for the migrant FSWs needs to be integrated into the comprehensive services offered by NOPE.

With due respect to the already existing NOPE projects, I therefore strongly recommend the continued support of services that are targeting migrant sex workers in particular the healthcare services offered by NOPE among the migrant communities. These services are very important for the migrant FSWs healthcare seeking behaviour and access in terms of understanding of the services, prevention efforts and treatment.

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Annex 1

Checklist guide for the interview

1. What are the health needs of migrant FSWs?
 - a. Type of sexual and reproductive health services
 - b. Consultation cost of sexual and reproductive health services
 - c. Cost for treatment
 - d. Proximity to healthcare services
 - e. Knowledge of local care services
2. What factors make it easier in seeking healthcare services among the migrant FSWs?
 - a. Health literacy/knowledge
 - b. Family and friends networks
 - c. Household income
 - d. Attitude towards healthcare services
3. What factors make it difficult in seeking healthcare services among migrant FSWs?
 - a. Language barrier
 - b. Legal status
 - c. Stigmatization by healthcare service providers
 - d. Availability of time
 - e. Consultation costs
 - f. Income
 - g. Fear of deportation
4. What personal circumstances of migrant FSWs influence their healthcare access?
 - a. Income
 - b. Legal status
 - c. Fear of deportation
 - d. Religious beliefs
 - e. Fear of stigmatization
5. What are the perceived barriers to access healthcare services from the health service provider point of view?
 - a. Shortage of healthcare providers
 - b. Health workers attitude on sex work
 - c. Consultation cost
 - d. Legal status
 - e. Availability of time
 - f. Treatment services
 - g. Language
6. What are the beliefs in seeking healthcare services among migrant FSWs?
 - a. Religion
 - b. Gender
 - c. Culture
7. What interventions are necessary to increase healthcare uptake among migrant FSWs?
 - a. Policies
 - b. Programmes

Planning of the research project

Date	Activity
Early May to mid-June	Presentation of the first draft proposals and development of conceptual framework or what the researcher has to study
Mid June - 12 July	Review of previous literatures relevant to area of study interests and preparation for data collection
13-14 July	Logistics and flight back to Kenya for data collection
16 July – 20 August	Data collection and data entry
21 August	Flight back to the Netherlands
22 August – 12 September	Review of the findings, data analysis and finalisation of the thesis
13 September	Final submission of the thesis

Picture of a respondent of Ugandan origin.

