Report on the Female Sex Workers Program

2018 to 2021

May 2022

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# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral treatment</td>
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<tr>
<td>DIC</td>
<td>Drop-in Centre</td>
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<tr>
<td>DMPA</td>
<td>Deoxy Medroxyprogesterone Acetate</td>
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<tr>
<td>EBI</td>
<td>Evidence Based Interventions</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FSW</td>
<td>Female sex workers</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSV</td>
<td>Herpes simplex virus</td>
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<tr>
<td>ICRHK</td>
<td>International Centre for Reproductive Health Kenya</td>
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<tr>
<td>KEMSA</td>
<td>Kenya Medical supplies Agency</td>
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<td>KP</td>
<td>Key Populations</td>
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<tr>
<td>MFL</td>
<td>Master Facility List</td>
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<tr>
<td>EMTCT</td>
<td>Elimination of mother to child transmission (of HIV)</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Program</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>PBS</td>
<td>Polling Booth Survey</td>
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<tr>
<td>PE</td>
<td>Peer educator</td>
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<tr>
<td>SGBV</td>
<td>Sexual and gender-based violence</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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Executive Summary

Female sex workers (FSW) in Kenya have high rates of HIV, sexually transmitted infections (STIs), unintended pregnancies, and other SRH issues. In 2012, Kenya used a geographic mapping approach to estimate the size of female sex workers. Thirty-two of the country’s 47 counties participated in the study. A total of 133,000 FSW were estimated as a result of this exercise (range from 76,674 to 208,711).

While condom use with paying clients is high, use of condoms with regular clients or non-paying partners is low. Modern contraceptive use in general is also low among sex workers; about 54% are on a modern contraceptive method and unmet FP needs among this population is high. Given this high risk of unintended pregnancies, sex workers need adequate and appropriate information on contraceptives, and they need greater access to reliable contraceptive services. Using modern contraceptive methods, alongside condoms will likely reduce unintended pregnancies in this population. Similarly, HIV prevalence among FSW is higher than among women in the general population. The number of new infections among FSW is also higher than that of general population women. In 2017, FSW, men having sex with men, and persons who inject drugs accounted for almost 40% of all new HIV infections. The high incidence (and thus prevalence) of HIV among FSW is likely due to a high number of sexual partners, inconsistent use of condoms, high rates of sexually transmitted infections (STIs), having sex while under the influence of alcohol and recreational drugs, and sexual and gender-based violence from clients, which can reduce the rate of condom use.

In 2018, the International Centre for Reproductive Health Kenya (ICRHK) established a comprehensive SRH delivery programme for FSWs in Mtwapa and Kilifi townships based on the NASCOP model for KPs in collaboration with the United Nations Population Fund (UNFPA) Kenya and the County Government of Kilifi, Department of Health Services.

In total, 45 peer educators (Pes) were engaged: 30 for Mtwapa and 15 for Kilifi town. A hotspot was assigned to each peer educator. They identified and enrolled sex workers in these hotspots in the programme. Every evening, the peer educators educated their peers about SRH and distributed condoms and lubricants. They also dealt with cases of sexual and gender-based violence. PEs also worked with sex workplace owners and managers to prevent, identify, and respond to SGBV among sex workers. After enrolling sex workers in the programme, PEs kept cohorts of 60 to 80 FSW and reported on those once a month during peer educator meetings with programme staff.

Clinical services were provided at drop-in centers (DICs) and through outreach programmes. During the programme, ICRHK operated two DICs, one in Mtwapa and the other in Kilifi. Sex workers received clinical services at the DICs. DICs were also designated “safe spaces” for sex workers, where they could relax, interact, and learn.
Part 1: A background of the sexual and reproductive health needs of female sex workers in Kenya

In Kenya, female sex workers (FSWs) have been reported to suffer from a wide range of sexual and reproductive health issues, including high rates of HIV and STIs, unintended pregnancies, sexual and gender-based violence, alcohol and substance abuse, and other mental health issues. In 2012, Kenya used a geographic mapping approach to estimate the size of female sex workers. Thirty-two of the country’s 47 counties participated in the study. All subsequent estimates of population size have been based on data from the Key Population (KP) programme. From the exercise, there are approximately 133,000 FSW (range from 76,674 to 208,711). In 2018, this exercise was repeated giving a size estimate of 167,940 FSW an increase of 26%. The current approach for FSW services, as recommended by the National AIDS and STI Control Program recommends a peer-led approach that provides a combination of behavioral, biomedical and structural interventions.

Peer educators from the sex workers program during a training in 2019. The peer educators provide education and services to fellow sex workers to improve uptake of contraceptives, HIV/STI services and other SRH interventions.

Figure 1: Sex worker peer educators during a training in 2019.
Part 2: key health issues among female sex workers in Kenya

1.1 HIV/AIDS

HIV prevalence among FSW is higher than among women in the general population. The number of new infections among FSW is also higher than that of general population women. In 2017, FSW, men having sex with men, and persons who inject drugs accounted for almost 40% of all new HIV infections in Kenya(1). The high incidence (and thus prevalence) of HIV among FSW is likely due to:

- A high number of sexual partners
- Inconsistent and low condom use especially with regular partners,
- High rates of sexually transmitted infections (STIs)
- Having sex while under the influence of alcohol and recreational drugs, and
- Sexual and gender-based violence from clients, which can reduce the rate of condom use and/or the ability to negotiate for condoms.
- Inability to access comprehensive SRH services because of the fear of stigma and discrimination.

While the prevalence of HIV among sex workers is high, there are signs that it has been declining over time. A study among FSW in Mombasa in 2016 that looked at present prevalence and the change in prevalence over the previous 26 years found that HIV prevalence had decreased by around 30 percent, from more than about 50% in the early 1990s to slightly over 10% in 2016 (2). Addressing the issue of HIV among sex workers in Kenya is important because studies done in the early 2010s showed that a significant number of new infections in the general population could be traced to sex workers, their clients and partners.

1.2 Unintended pregnancies and unmet need for family planning.

“Even though she has different clients, there is one particular one she refers to as hers; and this one would not be using a condom all the time” – Participant in a focused group discussion

FSW have high rates of unintended pregnancies. One in every four FSW reported an unintended pregnancy in the last year(8) during a study in 2016 among sex workers in Mombasa. These pregnancies are frequently caused by a lack of condom use with regular partners, and a low uptake of modern contraceptive methods.

It is worth noting that while condom use with paying clients is very high as a result of active condom promotion and distribution by FSW programs (sex workers in Kilifi and Mombasa, during the 2017 polling-booth survey reported...
more than 90% condom use with a paying client in the week preceding the survey), condom use with regular or non-paying partners was very low. Sex workers do not use condoms with their regular partners because some of these partners do not want to use condoms, they have both been tested for HIV as couples or they do not use condoms as a way of showing their partners that they love them.

The use of modern contraceptives is low and this has been one of the program's priorities; By 2018, only about 54% are on a modern contraceptive method(3) and while this has been increasing over time, this is not enough to prevent unintended pregnancies. The increase is as a result of increased awareness from the FSW programs, and increased availability of a wide range of contraceptive methods through drop-in centers (DICs).

1.3 Sexual and gender-based violence

"Nowadays we know, when you go with him to the room, you ask them to give the soldier (guard/caretaker) the money first before you do anything. They cannot take the money from the soldier. They cannot take advantage of you because they know you will call somebody to help you" – A sex worker participant in the focused group discussion.

Approximately 40% of FSW in Kenya (3) experience either physical or sexual violence at least once each year. Both intimate and non-intimate partners are frequently involved in the violence. Younger sex workers face greater violence, and the age at which women begin sex work has a high correlation with lifetime violence rates (4).

When sex workers are arrested in Kilifi, police frequently harass them and demand sex in exchange for their release. Clients who refuse to use condoms cause physical violence when the sex workers refuse to engage in sexual intercourse. Sex workers also face violence from boyfriends and partners who are unaware or discover that they work in the sex industry. In a 2017 survey of Kenyan sex workers, about 13% of those polled said they had been subjected to forced sexual intercourse in the previous three months. HIV infection, unintended pregnancies, and other physical health problems are all increased by physical and sexual violence. Depression, anxiety, and substance abuse disorders are all increased by violence.

In March 2020, following government steps to restrict the spread of COVID-19, the rates of violence among sex workers surged, and more than 80% reported experiencing some form of violence during this time. From discussions with sex workers in the Kilifi Cohort, a major reason was that sex workers lost income sources as a result of the closure of sex work locations (a dusk to dawn curfew was put in place and majority of bars and other places where sex workers operate were closed) and as a result of the loss of income, many sex workers married or moved in with their regular partners and the likelihood of partner violence increases when sex workers have live-in partners but no sources of income.
1.4 Alcohol and substance use

Figure 4: Heroin use among sex workers in Kenya.

*Adapted from the Third National Polling Booth Survey (National AIDS and STI Control Program; 2018 Report)*

Often, the psychological and social difficulties of sex work has been used to explain the higher use of alcohol and recreational drugs among FSW. In discussions with sex workers, many have stated that it is tough to perform sex work when sober. Peer influence, especially among sex workers also contributes to many of them starting using alcohol and drugs. In a study among sex workers in Mombasa and Kilifi, more than one in four sex workers reported harmful use of alcohol. In a survey among sex workers in Kenya, Heroin use was very common among sex workers in Kilifi, Homa Bay and Meru; All (100%) of the sex workers from Kilifi interviewed in the survey reported injecting Heroin at least once in the previous three months. Excessive alcohol use and binge drinking have been linked to an increased risk of HIV infection as well as mental health issues such as depression and anxiety(6). Many ongoing programs targeting sex workers focus on HIV and other sexual and reproductive health issues and the question of alcohol and substance use is not often addressed.
### Part 3: The National Framework for Sex Worker Interventions

In the past 2 decades, international agencies, including the UNFPA, the United States Agency for International Development (USAID) and the Global Fund for HIV, TB and Malaria, have intensified their efforts on prevention of HIV in sub-Saharan Africa among FSWs, through improving access to preventive and curative care. The integrated interventions are based on the National AIDS and STI Control Program (NASCOP) guidelines for HIV prevention among key populations (KPs)(7).

These guidelines recommend a peer led approach and focus on a balance of behavioral, biomedical and structural interventions as shown below:

<table>
<thead>
<tr>
<th>Behavioral interventions:</th>
<th>Biomedical interventions:</th>
<th>Structural interventions:</th>
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<tr>
<td>• Peer education</td>
<td>• Comprehensive condoms and lubricant programming</td>
<td>• Shaping policy and creating enabling environments in contexts where sex work is criminalized</td>
</tr>
<tr>
<td>• Targeted information (education, and communication)</td>
<td>• ART-related prevention (oral PrEP), HIV testing and counselling</td>
<td>• Reducing stigma and discrimination</td>
</tr>
<tr>
<td>• Promotion, demonstration, and distribution of male and female condoms and water based lubricants</td>
<td>• STI prevention, screening, and treatment</td>
<td>• Empowering the community, including ownership and leadership</td>
</tr>
<tr>
<td>• Risk assessment, risk-reduction counselling</td>
<td>• HIV care and treatment (ART and EMTCT)</td>
<td>• Violence prevention and response.</td>
</tr>
<tr>
<td>• Skills-building</td>
<td>• Family planning</td>
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<tr>
<td>• Evidence-informed behavioural interventions (EBI).</td>
<td>• Cervical cancer screening</td>
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<td></td>
<td>• TB screening and referral to treatment.</td>
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The interventions are implemented as part of a continuum with the overall goal of promoting sexual and reproductive health (SRH) among FSW.
Part 4: The UNFPA-ICRHK FSW program

In 2018, the International Centre for Reproductive Health Kenya (ICRHK) and the UNFPA established a comprehensive SRH programme for FSWs in Mtwapa and Kilifi townships based on the NASCOP model for KPs. This program also collaborated with the County Government of Kilifi, Department of Health Services. The figure below shows Kilifi County at a glance (on the right) and the program coverage areas in Kilifi and Mtwapa Towns.

Around 9 percent (12,000) of Kenya’s estimated 133,300 FSW live in Kilifi County. Mtwapa and Kilifi, two of the largest towns in the county were selected for the following reasons:

- The high number of FSW in Kilifi County, and specifically in the two towns
- Major gaps in FSW SRH needs that was identified in the county – High unmet contraceptive needs, high prevalence of alcohol and drug use among FSW, high risk of HIV among FSW in the towns
- Existing collaboration between UNFPA, ICRHK and Kilifi County Department of Health

The Program scoping and planning:

To identify the target population, design and plan for interventions, we followed the following approach:

1. **Step 1: Hotspot mapping**: Mapping out all known sex work hot spots (sex work venues) in Mtwapa and Kilifi towns, which included bars, nightclubs, casinos, strip clubs, hotels, parks, and beaches. It also included a number of sex work venues and websites that could be accessed from home or via the internet. This was repeated every year to keep the list of hot spots up to date. In total, 328 hotspots from where sex workers operated were identified in the two towns.

2. **Step 2: Estimating FSW populations in Mtwapa and Kilifi**: After mapping all the hotspots, we estimated the total number of FSW operating in each identified hotspot as well as the total number of FSW in the overall catchment area (Mtwapa and Kilifi towns. We estimated the
number of sex workers who work during peak and off-peak hours for each hotspot to get the minimum and maximum population estimates. This was done in 2018. We estimated 3,000 sex workers in Mtwapa and 1800 in Kilifi town. In total, we estimated 4,800 sex workers in the two places.

3. **Step 3: Peer educator selection:** During the size estimation exercise, we identified peer educators to be engaged in the program. These are sex workers who demonstrated an ability to be engaged to reach to fellow sex workers. They conduct individual and small-group teaching sessions, providing education on HIV/STIs; condom promotion, distribution and demonstration; referrals for clinical services and community-based response to sexual and gender violence. Each peer educator would maintain a cohort of between 60 to 80 peers as per the NASCOP guidelines.

4. **Step 4: Peer educator training:** After their selection and engagement, the peer educators underwent a five-day training in January 2018. The training was conducted at the Mnarani Hotel in Kilifi Town. A total of 48 peer educators were trained. The training was conducted using a NASCOP curriculum, by NASCOP accredited trainers. Curriculum content included an introduction to contraceptives and SRH, HIV and sexually transmitted infections, qualities of a good peer educator, building trust in relationships, interpersonal communication and using visual aids and materials to communicate on SRH issues.

5. **Peer educator paralegal training:** We conducted a paralegal training for peer educators in 2020, at the onset of the COVID-19 pandemic and in response to an increase in reported sexual and physical violence cases. The three-day paralegal training was attended by fifteen peer educators. Because this was a three-day refresher course, we prioritized peer educators who had previously received paralegal training or who had served as paralegals in a previous program. Peer educators were trained during the course to recognize and respond to sexual violence, to report cases, and to follow-up on cases at the police station and at the specific sex work venue where the violence occurred. They were taught about their (and their peers’) rights to be safe from sexual violence and to report it when it happened. UNFPA provided funding for the training. Following the training, each site (Mtwapa and Kilifi) created a violence response matrix, which included an outline of the steps for reporting violence as well as important phone numbers for reporting violence. At each drop-in Centre, the matrix outlined the primary person to be contacted whenever a sex worker experienced violence (usually a peer educator or a paralegal). The second level of response was usually a police person at the Gender Desk in one of the police stations. They had received training from ICRHK through a sister project (The AmplifyChange Project) and where usually available whenever a case of violence was reported. The third level of reporting was to the Project Officer from ICRHK who would support the PE to follow-up cases at the police station. The Violence Response Chart was drawn on a manila paper and was posted on the DICs.

**Peer-led outreach approach**

In total, 45 peer educators were engaged over the tree years: 30 for Mtwapa and 15 for Kilifi town. They identified and enrolled sex workers in the programme. Several times a week, peer educators educated their peers about SRH and distributed condoms and lubricants. They also dealt with cases of sexual and gender-based violence. Every time a peer educator came across a new FSW, they documented it through a Contact Form (MOH reporting tool). They wrote down the name of the PE,
socio-demographic and sex work characteristics. The FSW peers received education, information materials, condoms and lubricants if they needed.

Each PE was allocated a cohort of 60 to 80 FSW and reported on them once a month during peer educator meetings with programme staff. Information on the FSW peers and the services they received each month was reported in the Peer Educator Calendar (an MOH tool). They reported on the numbers they had reached with information, number who received condoms, lubricants and information materials, and the numbers who were referred and received clinical services, including FP, cervical cancer screening and HIV services.

Figure 5: A Peer Educator during a meeting.
Clinical service delivery

Clinical services were provided at drop-in centers (DICs) and through outreaches. DICs are designated "safe spaces" for sex workers, where they relax, interact, and learn. The DICs have a lounge as well as other amenities such as a restroom and a shower. Some sex workers do not have a home and require a place to shower, rest, and sleep when not at the sex work locations. For such sex workers, the DICs provide such amenities free of charge. This is also a place for sex workers to learn from one another and from their peer educators how to stay safe from HIV, STIs, and unintended pregnancies.

The project hired one clinical service provider to provide clinical services, one community mobilizer to supervise peer educators, and one data clerk to manage patient records at each DIC. The Kenya Medical Practitioners and Dentists Council has registered the DICs as clinics. Each year, clinical licenses are renewed. The government provides free family planning, HIV, and STI medication at the DICs through the Kenya Medical Supplies Agency (KEMSA), and each facility has a master facility list (MFL) code. The County Reproductive Health Coordinator and other county health officials also visit the DICs once every three months to ensure the services meet the required standards and provide mentorship to the clinical and data staff.

Table 1: List of services available at Kilifi and Mtwapa DICs.

<table>
<thead>
<tr>
<th>Services</th>
<th>Specific services available</th>
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<tbody>
<tr>
<td>HIV testing Services</td>
<td>Risk assessment, risk reduction counselling, pre-test counselling, post-test counselling, HIV testing, HIV self-testing</td>
</tr>
<tr>
<td>Prevention and treatment for sexually transmitted infections</td>
<td>Quarterly screening for STIs, genital examination, syndromic treatment for STIs, Counselling on STIs, Condom promotion and distribution, Contact tracing for those with STIs</td>
</tr>
<tr>
<td>HIV care and treatment services</td>
<td>ART for all eligible individuals, management of opportunistic infections, Positive Health, Dignity and Prevention, Home based care where necessary</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Counselling on FP use, counselling on dual protection, FP methods: barrier methods – condoms, combined oral contraceptives, Medoxyprogesterone acetate (DMPA), intrauterine devices, implants</td>
</tr>
<tr>
<td>Screening for cervical cancer and referral</td>
<td>Visual inspection under acetic acid and Lugol’s Iodine</td>
</tr>
<tr>
<td></td>
<td>Referral for treatment for advanced lesions</td>
</tr>
<tr>
<td>Screening and Referral for Tuberculosis</td>
<td>Screening for TB for all HIV positive FSW and referral for treatment, if necessary</td>
</tr>
<tr>
<td>Screening and treatment for alcohol use disorders</td>
<td>Screening for alcohol use disorders for FSW</td>
</tr>
</tbody>
</table>
Part 5: Service uptake

Sex worker population

Through peer educators and DICs, we reached a total of 7,500 FSW with SRH information and services between January 2018 and December 2021. More sex workers were reached than those identified during the mapping and size estimation exercise. This is possible because many sex workers travel from other parts of the country during certain seasons (especially during the holiday season between August and April) and then return to their hometowns once the season is over. Also, some women in Kilifi engage in sex work for a period of time before stopping or moving to other parts of the country.

Majority of the sex workers in Mtwapa (62%) operate from bars without designated lodging places. Home based sex workers account for less than 4% of the total sex worker population.

*Other sex work venues as a category include those who operate in traditional alcohol dens (Mangwe), massage parlors and those who operate along the beach.

3.1 The average number of sex acts per day among sex workers in this population

Majority of the sex workers in Mtwapa (62%) operate from bars without designated lodging places. Home based sex workers account for less than 4% of the total sex worker population.

*Other sex work venues as a category include those who operate in traditional alcohol dens (Mangwe), massage parlors and those who operate along the beach.

Sex workers who received peer education each year

The figure below shows the number of sex workers who were reached by peer educators each year. We reached the most number of sex workers in 2020. There are two possible reasons: The first was reason could be that there were more women in sex work in 2020 compared to the other years. It is likely that many women began sex work as a result of lost income from COVID-19 lockdown measures, and thus the number of sex workers in Mtwapa and Kilifi increased. This happens often during pandemics. Also a survey done by the Performance Monitoring and Accountability (PMA survey) reported that more women in Kenya, in general engaged in transactional sex in 2020 compared to the previous years. The second reason could be that the programme increased clinical outreach activities.
in 2020 in order to meet service needs and hence more sex workers were reached than during the other years.

HIV testing:
All sex workers who were contacted at sex work venues (hotspots) were referred for HIV services at the drop-in centre and clinical outreach. The graph below depicts the proportion of sex workers who received HIV testing. Overall, HIV testing in this FSW cohort was very high and more than 90% of all sex workers contacted each year, over the four years received HIV testing at least once every year, as recommended by NASCOP.

![HIV testing per year](image)

**Number who tested HIV positive**

![Number of FSWs who Tested Positive](image)
Linkage to antiretroviral treatment

All FSW of reproductive age were offered FP services. FP was provided at no cost. FP was obtained from the Kenya Medical Supplies Agency and distributed along with the other commodities. The figure below shows the number of FSW who received FP. There were several occasions each year, but most notably in 2019 when the DICs ran out of FP commodities and clients had to be referred to other health facilities. The most common stock-out was for injection contraceptives (Depo-Provera) and implants. We noted that among FSW who did not use FP, majority of them were young sex workers (19 to 24 years). This age demographic also reports the highest proportion of FSW with unintended pregnancies each year. Challenges in providing FP to young FSW include unclear policies on FP provision to women below 18 years and the difficulty in reaching out to this population through peer educators.

Family Planning

Figure 9: Family planning services per year.
Contraceptive types

Condoms, injectables and implants were the most common type of contraceptives used. DMPA injection was the most common type of contraceptive (40%), followed by combined oral contraceptive pills (31%) and condoms (22%). Only 6% of the women used an implant method of contraceptive. Less than 1% used an intrauterine device (IUD) or had a tubal ligation. While injectables and pills are the most common methods, the project encouraged women to take up longer-acting reversible contraceptives such as implants because these were more reliable and better suited for women who did not want to give birth immediately. The figure below shows the common FP methods used by FSW in this cohort.

![Figure 10: Type of contraceptive uptake.](image)

Physical and sexual violence

The number of reported cases of violence was very low at the start of the programme in 2018. A very likely reason was that there was a lot of violence against FSW but none of it was reported because the violence response mechanism had not been developed and many sex workers were unsure if they would get help if/when they reported sexual violence. Following the paralegal training in 2019, the number of FSW who reported cases of violence increased exponentially. The increase in the number of violence cases reported in 2020 and 2021 shows just how successful the program was to identify peer educators, train them as paralegals and help them set-up a violence response system.

![Figure 11: Sexual and gender violence reporting per year.](image)
Sexually Transmitted Infections

Sexually transmitted infections are common among FSW. The NASCOP recommends a syndromic approach for such a population with high rates of STIs and where multiple STIs may coexist. In fact, NASCOP has previously recommended periodic presumptive treatment as a strategy for managing STIs in areas with a high STI prevalence, in which FSW receive STI treatment on a regular basis (once every several months) without testing. In the third national polling booth survey (2018), STI prevalence among surveyed participants was about 18%. The most common STI syndrome is vaginal discharge. By etiology, the most common STIs among FSW in Kenya are Bacterial Vaginosis, Herpes simplex virus type 2, Chlamydia Trachomatis, Neisseria Gonorrhea and Trichomonas Vaginalis.

![STIS AMONG FSW](chart.png)

**Figure 12 sexually transmitted infections among FSW**

This population’s FSW were all tested for STIs. In 2018, STI rates were at their lowest. In 2019, the rates were 15%, while they were 4% and 5% in 2020 and 2021, respectively. The rates in all the years, with the exception of 2019 are much lower than those reported during the PBS and other surveys, suggesting that sex workers in this population have lower rates of STIs. This is most likely due to the success of the peer education services and the clinical services that are available.
Part 6: Costing Female Sex worker Services

We undertook a costing of the FSW project between October and December 2019 to inform the project on the unit costs of the intervention and to advise the UNFPA and other donors who fund FSW projects.

6.1 Rationale for the FSW costing study

1. The majority of the current 42 FSW HIV projects in Kenya are donor-funded, as are most such projects in Sub-Saharan Africa.
2. As global pandemics such as COVID-19 emerge, and funding shifts to other priorities, funding for FSW HIV programs may be diverted to address these needs.
3. Kenya devolved health service delivery to subnational units (counties) from 2013. These counties are now urged to budget for, and manage health services, including HIV prevention and FSW interventions. This budgeting needs to be guided by costing studies.
4. To address these emerging realities, both the national and county governments and FSW programs are exploring novel funding models such as public-private partnerships and social franchising.
5. To inform resource allocation, data on the costs of HIV services for FSW are required.

6.2 Methodology for the costing of FSW services.

We calculated the unit expenditure of FSW program in the two sites, Mtwapa and Kilifi DICs. The estimation was undertaken from the program perspective following the principles specified in the Global Health Cost Consortium Reference Case. We estimated unit expenditure per FSW reached, the unit expenditure per month and the unit expenditure per service. Financial data collected consisted of program expenditures on the project and number of FSWs reached. In general, all expenditures explicitly marked as being related to the FSW projects were included in the data for analysis. Data on service delivery were obtained from monthly program records on two indicators selected from those regularly reported; the number of FSWs reached per month, the site-level utilization of services such as HIV/STI and FP. Retrospective costing study was undertaken from the program perspective using step-down costing methods. The step-down costing method is used to allocate overhead costs or resources that serve different programs. Overhead costs were allocated in a step wise fashion to the two programs and then to final FSW services. The study focused on financial costs which represent actual expenditure on goods and services. Program records included monthly, quarterly and annual reports on the number of FSWs reached with SRH and HIV services in Mtwapa and Kilifi DICs.
6.3 Overall unit expenditure

The overall unit expenditure across the two sites was $105.93 per person per year. At the average exchange rate for 2018 of 100 Kshs = $1), this was equivalent to Kshs 10,593 per sex worker per year. The unit expenditure of per FSW per year of SRH services was highest at the Kilifi DIC compared to Mtwapo DIC.

6.4 Unit costs by the key components

The two figures below present the components of the unit expenditure. The largest cost component in the FSW program is personnel costs (59.7% of all costs). This is followed by the drop in Centre rent (rental and utilities) (10.2%), stipends for peer educators (7.7%) and the costs of clinical supplies excluding medication (4.7%). Personnel costs include the salaries of clinical and other service providers at the drop-in centre, as well as the costs of running the project, which include salary costs for the Project Coordinator and other central office staff. Peer educators are paid a monthly stipend of 4,500 Kshs (USD 45) to cover transportation and communication costs during peer education. Pregnancy test kits and cervical cancer screening supplies were among the clinical supplies. We did not include the costs of ART, oral PrEP, family planning, and STI treatment because these services are provided for free.

Figure 13: Costing for the various program elements.
6.5 The cost of contraceptive services

The overall unit cost of contraceptives per person per year across the two DICs was USD 9.93 (993 shillings per year). The unit costs of FP services were higher in Kilifi DICE than in Mtwapa DICE: USD 11.75 versus USD 8.10, respectively.

6.6 Unit costs for HIV services

The overall unit cost of HIV testing services (HTS per person year) across the two DICES was USD 63.90 which was equivalent to Kshs 6390 per person per year. The average cost per FSW tested ranged from US$ 0.89 to USD 13.20 (SD USD 3.98) in Kilifi DICE, whereas average cost per FSW test in Mtwapa ranged from USD 0.81 to to USD 13.59 (SD USD 4.41). The unit costs for HIV services were therefore higher than the costs for FP services.
Part 7: Innovations during this program period:

Clinical Outreaches:
Through outreach, clinical services were made available. The DICs carried all clinical equipment (test kits, medications, etc.) and rented space at a sex work venue (hotspot). Following that, sex workers from that hotspot were mobilized by peer educators and received care at the mobile clinic. During these outreaches, FSW received access to all services, including FP and cervical cancer screening. This model was particularly effective in reaching out to young FSW who did not yet identify as sex workers and were hesitant to seek services at DICs. Additionally, it meant that FSW received services in-situ and did not have to travel to the DIC, which benefited FSW who worked in areas remote from the clinics or who lacked transportation to the clinics for other reasons. Additionally, clinical outreaches enabled us to reach clients of sex workers (sometimes the sex workers requested for couple counselling services with their clients at the outreach). Additionally, we were able to help other at-risk women, such as waitresses and servers at bars who are not overtly sex workers but occasionally exchange sex for money. From March 2020, we put in place measures to reduce the number of FSW who came to the DICs in order to limit the risk of COVID-19 infection. As a result, the program relied more on outreaches to provide services as these could be held at multiple hotspots, targeting a limited number of sex workers and it was therefore easier to control the number of people who received treatment.

Differentiated care for antiretroviral services:
We began providing differentiated care services to all HIV positive FSW on ART in March 2020. This meant that instead of HIV positive FSW on ART visiting the DIC monthly for medication refills, we implemented measures to reduce their visits to the facility and their time spent there. Differentiated services have been shown to be effective in following up HIV-positive patients on antiretroviral therapy (ART). While differentiated care was initially recommended for HIV positive individuals who had been on antiretroviral therapy (ART) for more than a year and had a controlled viral load, all HIV positive individuals were placed on differentiated care from March 2020 as a measure to reduce the spread of COVID-19 by reducing the number of people who visit the DIC.

We used the following three models of differentiated care:

- Multi-month scripting – in which FSW receive ART for a period of three to six months and are therefore not required to come for ART on a monthly basis.
- Community and facility-based ART groups – Where FSW on ART designate members of their communities to pick drugs for them. One person picks ART for five to ten sex worker peers and deliver the drugs to their homes.
- Fast track model - FSW on ART Could present to the DIC and proceed directly to the pharmacy for medication refills. They were not required to see a clinician, which saved considerable time.

These three models have improved ART adherence and viremia control for FSW. More than 95% of FSW in the cohort are virally suppressed.

In-reaches and special days
Special days were organized by peer educators and sex workers to raise awareness on DICs, encourage sex workers to visit the DIC, and allow clinicians to provide information and services. The DICs, for example, held a movie night several times, during which FSW were invited for a special screening of a
film, and after which they received services and were enrolled into the program. The DIC also held beauty pageants for FSW on occasion. The FSW organized the events, designed the costumes, and acted as models to show off their skills. Such activities piqued the interest of the FSW communities in Mtwapa and Kilifi, and it was through these activities that FSW were educated, served, and enrolled in the programme. Such innovations have been critical in generating demand, delivering services, and increasing FSW participation in the programme.

Support for the FSW Technical Working Group

The problem supported the Technical Working Group for Kilifi County. The TWG was a multi-disciplinary forum that drew membership from all organizations and networks working with sex workers. The TWG was convened and Coordinated by the County and Sub-County AIDS and STI Control Officers. During the TWG meetings, partners and KP networks discussed data from the KP program, came up with interventions to improve how KPs were reached and how services were offered, and came up with ways to address violence among sex workers.

Between 2018 and 2021, the ICRHK project participated in 16 TWG meetings and supported at least one of the four meetings each year.
Part 8: Sex worker stories:

These dialogues have been translated from the original language (Swahili) and re-written. They are not redacted verbatim. They capture stories from sex workers beneficiaries of the program who were interviewed in the course of the program.

*Names have been changed to protect the identity of the women.

How did you get into sex work?

When I was around 15, I was having financial difficulties at home and needed to get away. My mother was an alcoholic and a sex worker. She would come home inebriated and start a fight with myself and my siblings. I was also mostly alone at home with my two younger brothers. I grew up in Nakuru and spent my evenings with older friends who would leave home and go to the club. Our parents were rarely present. The bars would give us a flat rate on drinks because we were pretty and the men came in because of us, and we’d be paid whenever a guy bought us a drink while we were there. It was a lot of fun for me. I’ve always enjoyed going out and having a good time. We would occasionally meet men who would buy us drinks, but I never accompanied any of them home. At some time, the men started offering us more money. We found that we could use the money for many things. I moved from Nakuru to here (Mtwapa) because it’s more fun and you get more money. I send money to my siblings. That is how I found myself here. They do not know what I do. –

*Asha, a 21 year old sex worker from Mtwapa.

I’ve never had an open conversation with anyone about sex work. I did not finish high school. I dropped out of Form Three because I became pregnant and needed to raise my child on my own. My mother did not have much money when I lived with her. My best friend relocated to Mombasa. She became a girlfriend to a “Mzungu” (white man) and received a large sum of money. In December 2019, I paid her a visit in Mombasa. We went to a nightclub. That was my first step in the door. I had sugar daddies after that. The majority of them were tourists, though we did occasionally go out with Kenyans. I still have a boyfriend and I do not go to the club very often. I go once in a while but even then, I do not have to go home with anyone.-

*Jane, a 23 year old sex worker from Mtwapa.

How did you get to know about this program?

I was brought here by a friend. There were a lot of us. When we first arrived in Mombasa, I shared an apartment with a few girls. We were (possibly) four people. We had put money aside. We put it all together and rented a one-bedroom apartment in Bamburi. We’d all chip in money and buy food, and one of us would cook for the rest of us. My friend ran into a girl she knew from home one day. She was an older woman who had lived in Mombasa since 2016. She was married with two children at home, but she was also one of the girls who “went out” in Mombasa. She invited us to accompany her to her favourite Mtwapa nightclub. We tracked her down with (another) friend. They were having a conversation. Her friend, she said, was a peer educator. A non-governmental organisation hired her to talk to sex workers about condoms. She also handed out condoms. If you wanted, she could bring condoms to your house. The other girls who had accompanied us had left. They were afraid of being forced to take an HIV test. My friend and I stayed
and spoke with the peer educator. She handed us condoms and lubricants and advised us to never have
sex with anyone without using a condom. She told us that many of the young upcountry girls became
infected after agreeing to have sex without using a condom. They also advised us not to have boyfriends
because they would exploit us, which is how many girls contracted HIV. She took us to this clinic in Mtwapa
a few days later. We came across a (doctor). We were given more information and condoms and lubricants.
I was tested for HIV and given PrEP by the doctor. –

*Mukami, a 26 year old peer.

I was seated alone in the Mangwe. It was early and I didn’t have a client. There were these two girls talking
near me. They mentioned something about an NGO-run clinic for sex workers. They claimed that the
services were provided for free. They also claimed that the clinic provided a drug that would protect you
from contracting HIV. This did not seem to be the case to me. I didn’t realise there were HIV-prevention
drugs on the market. Anyway, I went back later that night and asked one of the girls where I could find this
clinic. They directed me to the clinic in Mtwapa. I went to this doctor and he gave me all the information.
Unfortunately, when they tested me, they discovered that I had HIV. I was not ready to begin using drugs,
so I waited at least a year. They would call every few weeks to remind me to return to the clinic, but I was
too afraid to go. I returned after nearly a year. I’m glad I started taking my medication before I got too sick.

*Anita, a 30 year old peer.

How have you benefited from this program so far?

I think that I know a lot more now than I knew before I joined this program. I also feel a lot more protected.
Some time back, I went with this guy (client) to the guest room. When we got there, he was very drunk and
he wanted to beat me up. I had not done anything. He said that I took his money and refused to have sex
with him. But the problem was that he was too drunk. We could not do anything. He got violent. I was
scared. I locked myself in the toilet and called my peer educator. The peer educator called a “boda boda”
rider. The two of them came to the guest house. They also came with the manager of the guest house. They
all came to get me. They rescued me.

* Mary, a 24 year old peer.

I am only 18 years old. I had my first child when I was 16. I was employed as a house girl for a family in
Mombasa. They were very harsh towards me. One day, the wife said that I had beaten their young child. I
had not. She beat me up very badly. I went to sleep without food. She called my mother upcountry and said
that I had become very rude words her and her husband and children. My mother cried. I decided to run
away that day. I went to live with my friend in Changamwe. We would go out every night and meet different
men. They paid us well, better that what I earned. I eventually got my own house in Mtwapa and went to
live there. I went to the Mtwapa DIC and they gave me family planning. I am using the three monthly
injection. I like it a lot, even when the condom breaks, I know that I cannot get pregnant. I do not want to
get pregnant again. Also, whenever I have a condom break, I know that I go to the hospital immediately
and get treated. I take PEP. I know that I take very good care of my body. I want to be there for my son as
he grows up.

*Angela, an 18 year old peer.
References


