

Audience Profile: Female Sex Workers

Who They Are (and in the Context of HIV)

In a snapshot: they are enduring varying degrees of agency loss.

Broadly, sex work is defined as the exchange of money (or other items of value) for sexual services—importantly, consensual sexual services. As the following sections will document through recent research, most female sex workers (FSW) in sub-Saharan Africa begin sex work between the ages of 16 and 35, often as a way to support themselves and their families in the face of limited job opportunities. Some gain not only financial security but also a sense of economic liberation through their work. However, it comes at a significant cost, as sex work is criminalized and sex workers face stigma, abuse, and even life-threatening violence.

FSW are not a homogenous group, as one landscape assessment of recent research explained:¹

- Marital status, number of children, and level of education vary among FSW.
- They are more likely to live in urban areas.
- They may have as many as 8 to 20 sexual partners per day.
- Sex work is not necessarily performed year-round. Some people engage in sex work only during the summer or only during times of financial need.

FSW carry an enormous burden of HIV.

FSW in sub-Saharan Africa have a higher prevalence of HIV than other women of reproductive age. Social, legal, and structural barriers reduce their access to care.²

- An analysis of 16 countries in sub-Saharan Africa in 2012 showed a pooled HIV prevalence of more than 37 percent among sex workers.³
- In a 2013-2014 survey in South Africa, the rate of HIV prevalence among sex workers aged 25 and older in Johannesburg was as high as 78 percent.⁴ For sex workers of all ages and across the entire country, a 2012 landscape assessment estimated HIV prevalence at just under 60 percent.⁵
- In Lesotho, there is limited research on FSW. However, a 2014 Ministry of Health study found high rates in Maseru (73 percent) and Maputsoe (70 percent).⁶
- A 2014 report by the Kenya National AIDS Control Council estimated that 29.3 percent of FSW in the country were living with HIV. That same report further quotes the 2009 Modes of Transmission Study, which found that 14 percent of new HIV infections in Kenya occurred among FSW and their clients.⁷

Sex workers have a disproportionately higher risk of HIV acquisition because behavioral, legal, and social barriers increase their vulnerability.⁸ For example, some FSW in certain situations lack the power to insist on condom use. High rates of gender-based violence and rape, as well as a lack of legal protection, also contribute to their risk.⁹ According to a 2015 UNAIDS report, in which “young people who sell sex” refers to those aged 10-24, youth may make a sex worker more vulnerable to HIV because younger sex workers have less power to negotiate condom use, greater susceptibility to violence, and more sexual partners due to exploitation and men’s age preferences.¹⁰

The following is an overview of desk research on FSW, summarizing a broad array of recent studies conducted in communities and countries across sub-Saharan Africa. While this document references broad trends and similarities within this group, there are important distinctions among FSW in different countries and contexts—even from one neighborhood to the next. When used to inform a communications campaign, this summary should be a starting point for further investigation, including direct research engagement with local audiences.

Priorities, Worries, Dreams, Aspirations

When designing a communications program, it's vital to understand the audience's complex lives. This section explores FSW's priorities (not specifically related to HIV), including financial security, the ability to take care of themselves and their families, and sometimes also the freedom and lifestyle that sex work affords.

FSW don't necessarily identify as sex workers; other priorities and goals are more important.¹¹

Per a UNAIDS consultation meeting in October 2014, FSW don't always see themselves as "sex workers," but rather as women. Many consider themselves temporarily engaged in an advantageous but stigmatized way to generate income—it's not something they necessarily build an identity on.¹¹

FSW may also be in a stable relationship. In a quantitative survey in Kenya, South Africa, and Mozambique, for example, one-third to one-half of respondents had regular partners, defined as "a long-standing partner who does not give money or gifts in return for sex, and to whom the sex worker feels emotional attachment."¹² However, some FSW may not disclose their sex work to their parents or families.

These situations may contribute to perceptions of low risk of HIV for some FSW: "You're not talking about me when you say sex worker." Thus, public health campaigns seeking to reach sex workers should investigate with local FSW in order to understand the best way to engage them in communications, as messages speaking to "sex workers" specifically are stigmatizing and may not resonate.

Family pressure and parenting concerns often motivate sex work.

Many sex workers are mothers who are driven by a desire to take good care of their children. Sending children to school is a common economic motivation.

"A sex worker, she's thinking, 'When I wake up in the morning, I think about how to feed my children. Yes, I could maybe get (HIV) and die in 10 or 20 years but my children are alive today and they need food today.'"¹³ — Medical Research Institute, stakeholder interview

Younger women may also enter sex work with the encouragement of their families, who condone the occupation in some areas. For example, a 2006 UNICEF study of underage (younger than 18) sex workers noted that due to high rates of poverty in the coastal regions of Kenya (Malindi, Kilifi/Mombasa, and Kwale), many families support their teenagers in performing sex work as a more lucrative way of obtaining the household income than menial labor.¹⁴

Some FSW stay in sex work because they appreciate the independence and lifestyle it affords.

According to research conducted by the African Sex Workers Alliance in South Africa, Kenya, Uganda, and Zimbabwe, many FSW initially entered the sex industry for reasons of clear economic survival, often in the face of severe poverty and unemployment; however, among these, some found financial independence and a dramatic life improvement through sex work.¹⁵

“First, I love sex. Second, it gives me money. Third, I like traveling here and there, and my work allows me to do that.”¹⁵ — Female sex worker, Kenya

The African Sex Workers Alliance also reports that sex work pays better than other jobs that require no formal qualifications, while providing flexible working hours. Some sex workers report job satisfaction.

Some women become migrant sex workers for better economic opportunities.

According to a 2014 report from the Wits Reproductive Health and HIV Institute in South Africa, individuals currently engaged in sex work in their place of origin may migrate to another country or province seeking improved economic opportunities or better working conditions in the sex industry.¹¹

Migrant sex workers are often less identifiable than other sex workers and have traditionally been overlooked in sexual and reproductive health services. This mobile lifestyle also affects their ability to access health care (see more in the “Relationship to Health & Healthcare” section).

Priorities for FSW are survival, stability, and community.

Whether or not they identify as sex workers, FSW are well aware of the steep physical and financial risks they face—customers refusing to pay, police threatening them with raids and arrests, and the dangers of sexually transmitted infections (STIs) and HIV infection. According to quantitative market research conducted in 2017 in Kenya by the OPTIONS Consortium, FSW value “survival” more than any other group at risk of HIV acquisition.¹⁶

They also place a high value on financial stability. The OPTIONS study found that FSW want to support themselves and their families financially, and many aspire to start their own businesses (potentially to exit sex work). Many are trying to save money and may join a “money-saving group.”

They also care about their health and condom use (despite obstacles that may prevent them from actually using condoms). In the OPTIONS research, about 50 percent of FSW surveyed get regular health checkups and HIV testing, and 26 percent use PrEP when appropriate.¹⁶

FSW are also looking for community and peer support.

The desire for social connection may be tied to successful HIV interventions and prevention. According to research conducted in South Africa, Kenya, Zimbabwe, and Uganda, the reasons sex workers seek out support for HIV prevention include:

- Being able to share and reflect on their problems; emotional support.¹⁵
- Learning how to collectively protect themselves.¹⁵ In Kenya, for example, the Bar Hostess Empowerment Programme has trained local sex workers as paralegals, which included learning about local and national laws and educating other sex workers about their rights.³

CASE STUDY

Economic and Social Pressure on Sex Workers

Changing circumstances in Zimbabwe led to new practices and adaptations.¹⁷

A 2017 study in Zimbabwe published in the journal PLoS One found that sex work—like many industries—is changing due to economic pressures and changing social norms. Because of hyperinflation, for example, sex workers have had to accept new forms of payment, such as commodities instead of cash, or to extend sex on credit.

An increased awareness and fear of HIV has also altered the demand for commercial sex, leading many sex workers to branch out from the bars where they traditionally find clients. Sex workers recruit clients at workplaces or meet truck drivers on the road; they also find clients during grain distributions from international aid organizations. In focus groups, respondents described events where men and women congregate as avenues for negotiating sex work—including Chenura ceremonies (annual celebrations of ancestors), all-night church meetings, concerts, weddings, and funerals.

The changing specifics of sex work in Zimbabwe today offer a window into the necessity of local, specific, up-to-date audience engagement and research in planning HIV interventions.

Challenges They Face

Any person's risk factors for HIV acquisition are closely tied to the challenges they face. For FSW, the challenges are extreme—violence, abuse, rape, discrimination, extortion, and stigma come from almost all sides (including from clients, family, officials, landlords, and others).

“Sex workers are marginalized, victimized, and criticized. They face abuse, physical violence, and even death on a daily basis. Help and compassion, for them, are scarce commodities.”¹³ — Program manager, Wits Reproductive Health and HIV Institute, South Africa

FSW face violence and abuse from both commercial and noncommercial sexual partners.

The 2017 OPTIONS study in Kenya found that 68 percent of FSW have experienced some kind of victimization or stigmatization. The most common forms were harassment, physical abuse, and sexual assault.¹⁶

FSW are highly vulnerable to their clients. Some reported that refusing to comply with clients' demands often results in abuse or violence.

FSW described being treated as less than human by clients who consider them objects. One FSW described telling a client to stop and getting the response, “Didn’t I buy you with my money?” They often fall victim to regular human rights abuses: In a 2011 report by the African Sex Workers Alliance, the misconception that “sex workers cannot be raped” was highlighted as a major concern.⁵ This misconception exists in the stable relationships of FSW as well, as one FSW described in the 2011 report:

“My boyfriend harasses me because I am a sex worker and he demands sex...and if I refuse he rapes me.”¹⁵

— Female sex worker, Kenya

It is important to note that while FSW are frequently victimized, reports have found that members of this group do not necessarily perceive themselves as victims.¹⁸

In addition to violence, FSW are subject to serious sexual pressure.¹⁶

The 2017 OPTIONS study also found that FSW in Kenya experience the most sexual pressure of all the at-risk groups studied. Sexual pressure in FSW often occurs when they need the money (25 percent) or when the client refuses to wear a condom (18 percent)—pushing them to choose between their health, safety, and financial security. Four in 10 FSW surveyed by OPTIONS in 2017 said they “give in” to sexual pressure because “there’s nothing [they] can do.”

FSW also face humiliation, extortion, and discrimination from multiple groups.

FSW may be persecuted by friends and family due to the stigma of sex work. One respondent in Mombasa described her father refusing to give her food “for even one day” because of her sex work.¹⁵ FSW also deal with extortion from people on the fringes of the sex industry, such as landlords and bar owners: One respondent described turning over half of her money to bar owners, “so that they treat me well and allow me into their bars.” Other FSW said that landlords often demand sex, threatening to throw women out of their properties if they don’t comply. These experiences were reported in a 2011 study of human rights violations of sex workers in Kenya, Uganda, South Africa, and Zimbabwe.¹⁵

In addition to these pressures, research also shows that FSW are vulnerable to abuse and extortion by the police. The UNAIDS 2014 Gap Report reports sexual abuse, rape, extortion, and mandatory testing for HIV and Sexually Transmitted Infections (STIs) as abuses perpetrated by law enforcement officers against FSW.³ A small qualitative survey funded by the Sex Worker Education and Advocacy Taskforce (SWEAT) in South Africa found that 12 percent of street-based FSW in Cape Town had been raped by a policeman.¹⁹

“I was arrested and ordered to remove my panties at gunpoint and I had to give in to sex with [the police] and then I was let free.”¹⁵— Female sex worker, Kenya

With no other source of protection, FSW rely on one another.¹⁵

Some civil society and advocacy organizations are encouraging networks and peer support among FSW. For example, Viviane is a sex worker in Nairobi, but when not canvassing for clients, she spends much of her time convincing other sex workers to test for HIV and use condoms. She is also a peer educator with the Sex Workers Outreach Programme.²⁰

“Many FSW are members of organized groups like Bar Hostess, like KESWA. These groups have benefits like protection, advocacy, correct information regarding sexual and reproductive health—so they also get their info from these organizations.”¹³—Jilinde, stakeholder interview

The stigma of sex work overlaps with (and compounds) the stigma of HIV.

In a 2016 report from Zimbabwe, 91 percent of FSW reported experiencing some form of stigma because of their sex work.²¹ Rates of sex-work stigma were higher than those of HIV-related stigma. For example, just 38 percent of FSW reported being “talked badly about” for living with HIV, while 77 percent reported being “talked badly about” for sex work. There also seems to be a layering effect, as those who reported any sex work stigma also reported experiencing more HIV stigma compared to those who did not report sex work stigma.²¹

The blame for spreading HIV is placed on FSW, not their clients.²²

In addition to stigma, FSW experience discrimination from health, justice, and security service providers. The criminalization of sex work legitimizes stigma and discrimination and creates barriers to healthcare. For example, the 2013 National Strategic Plan for HIV Prevention in South Africa reported that 8.5 percent of FSW had been denied services by healthcare workers due to sex work, suggesting a greater stigma than that associated with HIV, which just 1.7 percent named as the reason for denied services.

Relationship to Health & Healthcare

This section examines how FSW think about their health broadly, especially with respect to preventive health practices. It also considers their access to and interactions with formal healthcare. FSW are well aware of the dangers sex work poses to their health and seek care and prevention services. However, stigma and discrimination from healthcare workers, as well as economic considerations, often impede their access to care.

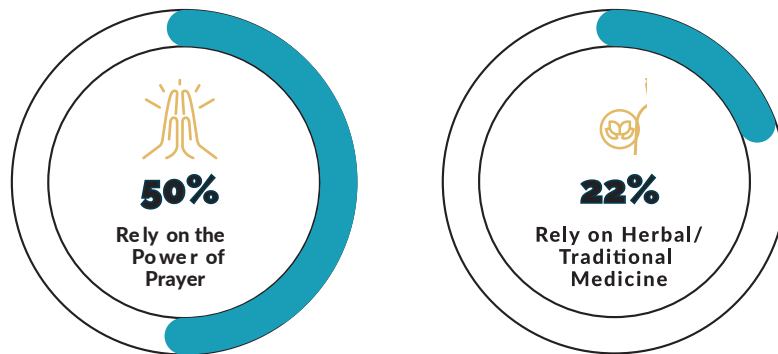
FSW are widely concerned about their health.

The 2017 OPTIONS research in Kenya found that a strong majority—94 percent—of FSW respondents were concerned about their health, and the risk of HIV was generally their highest concern.¹⁶

Although the barriers previously described may often prevent FSW from engaging in preventive health practices, respondents in the 2017 OPTIONS survey expressed that preventive care was a high priority, placing “using condoms” and “practicing good personal hygiene” at the top of their list of preventive practices. They also described sleeping under a mosquito net, eating healthy, drinking water, and being more selective of their sexual partners.¹⁶

When asked about their peers’ main health concerns, FSW reported HIV, tuberculosis, and sexually transmitted diseases (and in higher rates than any other at-risk group studied).¹⁶

39 percent of FSWs do rely on religious and cultural beliefs to stay healthy, however...¹⁶



They are highly likely to seek health care alone—and to experience discrimination.

More than any other at-risk group studied by OPTIONS, FSW were likely to go to healthcare visits alone—98 percent reported going alone. They primarily (79 percent) receive health care at government hospitals.¹⁶

In seeking health care, FSW in Kenya reported a number of barriers to the OPTIONS research, including a lack of knowledge of where to go, a lack of money to pay for services, and the long wait times and inconvenient operating hours of healthcare centers. Their romantic partners may also negatively influence their decisions to seek health care.

High mobility can limit FSW' healthcare access.²²

Multiple studies across sub-Saharan Africa have described patterns of poor treatment, harassment, and even refusal of service for FSW.

“Most of these health workers at public hospitals, they discriminate against me. They don’t take me as a patient...they mistreat us like we are not human beings.”¹⁵ — Female sex worker, Kenya

In a 2016 study in Zimbabwe, FSW explained that once health providers became aware of their work, they asked the FSW invasive and unnecessary questions and frequently breached patient confidentiality.²⁵ Many in this study plainly described health providers as “abusive” or “hostile.”

“We are despised in the hospitals. They say, ‘We don’t have time for prostitutes,’ and they also say that if one prostitute dies then the number reduces.”²⁵ — Female sex worker, Zimbabwe

Some sex workers report having to pay health workers additional money for services, especially STI treatment. Others said they were almost always refused service if they did not bring their sexual partners to the clinic.

For sex workers living with HIV, this discrimination creates financial and logistical barriers to treatment. Hostility during examinations and counseling limits women’s motivation to begin treatment.

“She opened my file and I saw her face just changed instantly, and she actually frowned and looked at me like I was disgusting her. Her first words to me were, ‘So you are a prostitute and you actually have the guts to come here to waste our time and drugs on you? Why do you do such things anyway? Why can’t you find a man of your own and get married?’²⁵ – Female sex worker, Zimbabwe

Other types of public humiliation from hospital staff that women in Zimbabwe described included public announcements in the waiting room instructing all sex workers to move to the back of the waiting line or to stand in a separate line.²⁵

Relationship to and Engagement in High-Risk Activities

In this section, we specifically look at the behaviors and social norms that commonly put FSW at most risk of HIV acquisition. For FSW, inconsistent condom use is a driver of risk, as discussed below.

Inconsistent condom use is a major risk factor with multiple causes.

FSW consider condoms the way to protect themselves against HIV. Despite this belief and understanding, FSW find it challenging to use condoms consistently, for three primary reasons:

- Clients’ refusal or monetary rewards
- Criminalization of condom possession
- Expressing trust and love with a regular partner through non-condom use

First, refusal by clients is the most important reason for non-use of condoms. Clients will sometimes offer more money for sex without a condom or demand it through threats or violence. According to a study in South Africa, unequal power relations between sex workers and their clients, limited knowledge of HIV, and the use of alcohol and drugs during times of sex work all contribute to high levels of unprotected sex.²²

The criminalization of condoms also thwarts the agency of FSW to insist on protected sex. In Kenya, condom possession is considered proof of sex work, and FSW can be arrested for carrying condoms.³ The same is true in Zimbabwe, with many sex workers reporting being arrested and/or having their condoms confiscated. This practice discourages sex workers from carrying condoms, hampering their ability to negotiate condom use with clients and heightening their risk of HIV.²⁶

Finally, some FSW will forgo condom use with a regular partner.²⁷ Even though a polling booth survey conducted in Nairobi in 2011 found that 86 percent of sex workers used a condom at last sex, FSW often don’t use condoms with regular partners because unprotected sex is largely seen as an expression of love and trust.²⁷

“Her regular partner may pay her rent, her children’s school fees...so you start to look at this person differently. If he doesn’t want to wear a condom, you accept it. The sex worker could also be his wife, his property, so the issue of condoms becomes uneasy.”¹³

– Bar Hostess Empowerment & Support Programme, stakeholder interview

Working or living “on the streets” heightens her vulnerability.²³

Across sub-Saharan Africa, women’s levels of migration have met or exceeded those of men. Many of these girls and young women who move to the cities in search of a “better life” find themselves in slums or on the streets.²³ For many, transactional sex has been described as a survival technique (see the AGYW profile for more on the broader culture of transactional sex).

“If your man is around, you will just be with him, but if he is not around—for example, if he is jailed—you cannot stay hungry as you wait for him. You will look for another man to have sex with so that you can get money. So, during such times, you will be sleeping with any man who comes across as long as he has money to give you.”²³ — Female sex worker, Kenya

Drugs and alcohol are also commonly traded for sex:

“For me, when I do it, I usually pay like 150, 200, or 100 shillings (about \$1 or \$2 USD), although there are other girls who just need glue or alcohol. You can buy her alcohol; then, when she drinks, she accepts to have sex with you.”²⁸ — Male client of female sex workers, Kenya

Population-based studies have found that HIV rates in informal settlements are twice as high as those in urban and rural areas. For example, one study in Nairobi, Kenya, found that HIV prevalence in slums is 12 percent, compared with 5 percent among non-slum urban residents, and 6 percent among those who reside in rural areas.²⁹

Relationship to Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

This section examines access to and habits with important preventive practices specifically related to HIV for FSW. For many in this group, high interest in sexual health and preventive practices is hampered by financial barriers, stigma, discrimination from healthcare workers, and fear.

FSW perceive their own risk but may underestimate or dismiss it.

Compared to other key audiences, many FSW hold a more accurate perception of their risk of HIV. In the 2017 OPTIONS study in Kenya, 82 percent of FSW respondents considered themselves personally at risk for HIV, and only 4 percent cited not going for regular HIV testing.¹⁶

Fatalism may also play a key role in the behaviors of FSW. A study with female brothel sex workers in Nigeria, for example, uncovered a strong sense of fatalism.³⁰ Most sex workers surveyed described HIV risk reduction, especially condom use, as beyond their control or even unnecessary, as a result of their strong beliefs in predestination to HIV infection.

FSW face multiple barriers in accessing HIV testing.

The discrimination FSW experience from healthcare workers is one of the reasons why many of them do not get tested for HIV. A 2011 qualitative study by the African Sex Workers Alliance found that FSW in four African countries face a variety of other barriers that discourage them from HIV testing, including:¹⁵

- Lack of awareness of services
- Distance to facilities
- Transportation costs
- Opportunity costs
- Time constraints
- Fear of a positive result

To avoid stigma, sex workers may sidestep clinics and hospitals altogether and rely only on self-treatment or the services of traditional healers.¹³

“The only thing that forces me to go to hospital is abortion. Whenever I forget to use a condom I get pregnant, but I don’t like hospitals. I buy medicines from pharmacies and terminate my pregnancy. I use alcohol to remove pain.”¹⁵— Female sex worker, Kenya

“After sex, they shower and wash vagina with water. Or urinate immediately after unprotected sex. [FSW also] go to a witch doctor (Mchawi), who gives them protection with lotions/oils, which they can apply every day, or can give feather of a chicken or a necklace.”¹³ — KP Consortium, stakeholder interview

Others try to be selective, avoiding particular facilities where providers are known to be cruel and stigmatizing, or are likely to withhold treatment or ask too many questions. Another common solution, provided a sex worker has enough money, is to access private healthcare, which is perceived as higher quality than public health services.

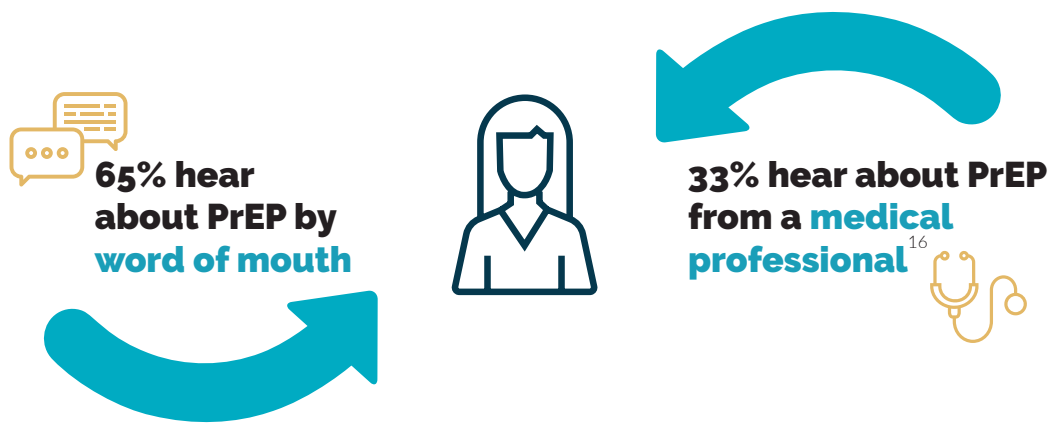
Relationship to PrEP Specifically

When thinking about how best to influence an audience’s behavior and encourage PrEP uptake, it is important to consider five factors: 1) awareness, 2) understanding, 3) benefits, 4) interest, and 5) barriers. This section looks at how FSW currently understand and consider PrEP across these five dimensions:

- 1) Awareness is high.
- 2) Understanding is moderate to low.
- 3) Benefits for FSW (perceived) include health and financial protection.
- 4) Interest is high.
- 5) Barriers include concerns about daily adherence, as well as stigma (fear of being mistaken as HIV positive).

Awareness of PrEP among FSW is high.

According to the 2017 OPTIONS research in Kenya, roughly half of FSW were aware of PrEP, primarily hearing about it by word of mouth (65 percent) or from a medical professional (33 percent). Further, about one in three FSW understood that PrEP can be used as a preventive measure to avoid HIV.¹⁶



However, awareness does not equate to understanding or consideration.

Awareness doesn't necessarily mean the audience has a solid understanding of what PrEP does and the benefits it can provide. After reviewing a PrEP information sheet, only six out of ten FSW surveyed in the 2017 OPTIONS research said they had confidence it would work for them, while roughly one in three remained unsure about its effectiveness.¹⁶

FSW perceive other benefits to PrEP apart from reducing their HIV risk.

- **More money:** In 2014 research in Kenya, FSW said the products might help them earn more money, because they would feel safer accepting more clients or having sex without condoms for a higher price.²⁷
- **Additional protection:** FSW respondents in a 2016 study in Kenya described the benefit of “added protection” when other prevention methods are not at hand, especially in the case of forced sexual assault. Respondents also said it would be useful to have added protection in dealing with older partners, when drugs/alcohol are involved, when condoms break, or with multiple partners.³¹
- **Replacement for condoms:*** In the 2017 OPTIONS research, FSW in Kenya saw PrEP as a beneficial replacement for condoms. The belief that condoms may no longer be necessary also accompanied 27 percent of FSW' perceptions of PrEP.¹⁶

**Note: This false assumption should be taken into account when planning to educate this audience group about PrEP.*

FSW are definitely interested in trying PrEP, but a number of concerns create barriers to their consideration.

According to the 2017 OPTIONS research in Kenya, at least 76 percent of FSW interviewed are interested in trying PrEP.¹⁶ However, the majority appeared to assume initially that PrEP would provide 100 percent protection against HIV, and many were disappointed to learn that they would still need to use condoms for additional protection from HIV and protection against other STIs.

FSW' concerns about PrEP may include:

- **Lack of STI protection.** The majority of FSW' concerns about PrEP in a 2014 study in Kenya could be related to its degree of effectiveness and to their preference for a PrEP product that could prevent both HIV and other STIs.²⁷
- **Potential increase in unsafe sex practices.** In the same 2014 Kenya study, FSW expressed fear that they (and other users) would forgo condoms if PrEP became available, thus increasing the likelihood of transmitting HIV and STIs.²⁷

- **Fear of side effects.** Finally, in the 2014 Kenya study, FSW expressed concern about side effects, either generally or in relation to particular formulations. Most of these participants emphasized the need to help each woman identify the formulation appropriate for her. Several women were concerned about the side effects associated with an oral product or interactions between pills and alcohol.²⁷
- **Risk of oral PrEP being mistaken for antiretroviral treatment.** In the 2017 Kenya OPTIONS research, some FSW expressed fear of being labeled HIV positive when taking PrEP.¹⁶
- **Concern about daily adherence.** FSW in the 2017 study were also concerned that they might forget or that it would be burdensome to take a pill consistently. A few women were also worried that people would see them taking pills. However, others liked the idea of taking a pill because it was daily, something they controlled, and similar to a contraceptive pill.¹⁶

Among these barriers, a major roadblock to uptake is stigma.¹⁶

As with many HIV interventions, being assumed to have HIV is a major barrier to uptake. For many FSW surveyed in the 2017 OPTIONS research in Kenya, the potential risk for being mislabeled overshadowed the lower risk of HIV transmission. Many consider it necessary to keep their PrEP use a secret as a result.

Only one in three FSW surveyed by OPTIONS believed their peers would be supportive of their decision to use PrEP (however, this is likely less of a barrier for FSW than for other audiences).¹⁶



Only one in three FSWs believed their peers would be supportive of their decision to use PrEP.¹⁶

How to Reach and Connect with FSW: Best Channels to Connect

The following details primarily reflect the findings of the 2017 OPTIONS research in Kenya. Except where otherwise noted, these insights are specific to FSW in Kenya. Like all information in this document, this information is only a starting point for further investigation focused on a specific audience and context.

Main interests of FSW include:

Going to clubs, watching TV, dancing, socializing with friends, and singing.¹⁶

Radio and TV are the best ways to reach FSW through mass media.¹⁶

OPTIONS research conducted in 2017 found that TV dominates radio for FSW:

- 85 percent own a TV set.
- 78 percent own a radio.

Internet use is not yet mainstream, but it is growing in popularity.

The majority of FSW do not have a computer, but two-thirds have access to a smartphone, making internet and social media viable options.¹⁶ A number of FSW are moving online, facilitating their work in Kenya through websites such as nairobiiraha.com, nairobitamu.com, and nairobiescort.com.³²

FSW get information related to sexual health primarily via mass media and health centers.¹⁶

The most popular channels for information for FSW are radio, TV, and health centers. They also get information from friends, as well as from posters in bars, hotels, and other locations.

According to a 2010 Integrated Biological and Behavioral Surveillance Survey (IBBS) among migrant female sex workers in Nairobi, the preferred place for FSW to receive sexual health information is from a hospital. Seventy percent expressed this preference, while 8.2 percent preferred to get information from TV and 7.5 percent preferred to get it from community health workers.³³ Drop-in centers are also preferred information sources.

FSW believe radio, TV, and health centers are the best ways to communicate about PrEP.

When asked how they think information about PrEP should be communicated to people like themselves, FSW primarily answered radio, TV, and health centers; other information sources (seminars, social media, and doctors) lagged behind.¹⁶

How to Reach and Connect with FSW: Best Tactics to Connect

Work hotspots may be effective locations to reach FSW.³⁴

Major hotspots for soliciting sex include bars, clubs, on the street, at brothels, and at the beach. Others include taxi ranks, bus stops, fuel stations, shopping malls, massage parlors, parks, hotels, and casinos.

Condom dispensaries may serve as key touchpoints.³⁴

FSW procure condoms, as well as other HIV interventions or health services, at public health facilities, pharmacies, shops, supermarkets, and clubs, and from community-based organizations (such as BHESP in Kenya).

Reaching FSW will mean accommodating their potentially unorthodox work schedules.²⁴

Many street-based sex workers sleep during the day and work most of the night. Alternative HIV outreach times and locations are necessary for sex workers.

Peer educators and respected influencers may be effective in delivering information.³⁵

FSW trust and rely on one another for support. Peers, peer educators, and PrEP champions can give advice on safe sex and condoms, and provide information related to HIV testing. Prevention initiatives that involve sex workers educating their peers have led to increases in protected sex and reduced HIV prevalence.

The International Reporting Project, for example, followed one FSW who now works as a peer educator in South Africa and has built trust to successfully distribute PrEP on the streets:

“What I’ve experienced, I’ve got that knowledge now to give out to sex workers.”³⁶ — Peer educator and former female sex worker, South Africa

Safe social spaces may be prime venues for delivering messages.

Community-based organizations, such as KEWSA and Bar Hostess Empowerment Programme, pass on information and provide trainings and empowerment activities. Other specialized social gatherings also offer safe, supportive spaces that a campaign may use to reach FSW. For example, a Kenyan stakeholder described a social event called a Merry-Go-Round:

“It is a social gathering (where) we contribute some money, and every week, the money goes to one sex worker. We help fellow sex workers cover the expenses—e.g., sending their child to school, buying cutlery, that sort of thing.”¹³ — KP Consortium, stakeholder interview

To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

Bottom line: sex workers need to be involved.

Sex workers know that they are extremely vulnerable and protect themselves as best they can in many areas of their lives. The most effective HIV prevention efforts are those that allow FSW greater agency in protecting themselves. Including and empowering sex workers is the best way to combat the epidemic among this group.

For example, in Virginia, South Africa, peer educators met weekly with the clinic nurse at the local clinic to plan activities and discuss solutions to problems they encountered. Similarly, in Cross River State, Nigeria, monthly meetings were held with “chairladies” elected by their sex worker peers to elicit input on project implementation and serve as a forum to discuss topics of concern.³⁴

To Keep in Mind for Communicating PrEP

Emphasize that PrEP does not replace condoms for STI and pregnancy prevention.

For 27 percent of FSW interviewed in the 2017 OPTIONS study, perceptions of PrEP accompany a belief that condoms may no longer be necessary. This misperception should be addressed when educating FSW about PrEP.¹⁶

The research for the FSW profile was based largely on three publications as well as a stakeholder interview and a market intelligence report. The three publications used FGDs and IDIs as means for data collection. The participants included men, women, and transgender people, both HIV positive and negative. The study by Camlin et al (2013) looked at HIV acquisition risks among female migrants in western Kenya, and data collectors spoke with 40 female and 15 male migrants. The Africa Sex Worker Alliance (2011), conducted IDIs and FGDs with male, female, and transgender sex workers in Kenya, Uganda, South Africa and Zimbabwe. The Mtetwa study (2013) interviewed 38 HIV positive female sex workers in Zimbabwe. Both the OPTIONS stakeholder interview (2016) and the OPTIONS market intelligence report (2017) were conducted in Kenya. The stakeholder interview was conducted with a PrEP implementation project staff person who works with FSWs whereas the market intelligence report collected data from 100 FSWs (OPTIONS 2017). The ages of participants ranged from 18-58 years old, and the years of data collection spanned from 2009 to 2017.

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