Migration, Sex Work and Risk Environments: Experiences of Somali Migrant Female Sex Workers in Nairobi, Kenya and Implications for Service Access and Use

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Declaration

I, Kelsi Kriitmaa, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed: 

Date: June 25, 2022

Abstract

The aim of this qualitative PhD research was to fill identified gaps in knowledge, specifically, why do Somali female sex workers (FSW) in Nairobi, Kenya remain at high risk of HIV despite availability of targeted HIV prevention services. Globally, the evidence shows that sex workers are at higher risk than the general population, they have a disproportionate burden of HIV, and as a migrant group they may not have access to services. However, even with targeted services for sex workers, this group of migrant FSW was not accessing services. The research aimed to understand identity construction of Somali migrant FSWs, and how do risk environments and resilience amongst female sex workers who migrate affect health and health seeking behaviour.

Throughout 2012-2013, the research team sought to interview migrant FSWs, through contacts with a Community Based Organization. The study was beset with challenges due to the changing security situation in Eastleigh. In total, 15 Somali FSWs were interviewed two to four times each, for a total of 50 interviews.

Results are presented in three chapters, the first focuses on social networks and support; the second chapter on practices of routine discrimination and violence; and the third chapter looks at experiences of health services and health seeking behaviour.

Somali FSWs in Nairobi are vulnerable and basic human rights not being met including the right to health, stemming from a lack of documented migration status, amongst other factors. FSWs experience systematic targeting by law enforcement, high levels of violence and harassment and

lack of economic opportunities. Cultural factors, such as a religious context resulting in an external sense of control, assuming ‘Allah will fix it’, is compounded by exceptionally low self-esteem and a belief they are ‘bad Muslims’. Finally, their health seeking behaviour is poor, and oftentimes they simply cannot afford and do not prioritize their health over feeding and providing accommodation for their children.

The primary implication for the research is that interventions need to go beyond biomedical sexual health and behaviour change campaigns to take into consideration the dynamics of intersectionality in the design and implementation of interventions.

Acknowledgements

This PhD would not have been possible without my supervisor, Joanna Busza, who has patiently accompanied me on this lengthy journey. Joanna, I am incredibly grateful for your guidance and persistence during the many international moves, interruptions of studies, and resulting delayed timelines. Your attempts to support and direct me to think more conceptually and analytically, and to break out of my operational mindset were countless, and I could not be more grateful for your direction.

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Acronym list

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
FSW	Female Sex Worker
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioural Surveillance
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority for Development
IOM	International Organization for Migration
LSHTM	London School of Hygiene and Tropical Medicine
PEP	Post-exposure prophylaxis
PrEP	Pre- exposure prophylaxis
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infection
SW	Sex Worker
SWOP	Sex Worker Outreach Programme
SWOT	Sex Worker Outreach Tool
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDSS	United Nations Department of Safety and Security (UNDSS)
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
WHO	World Health Organization

PART A: BACKGROUND TO THE RESEARCH

1. Introduction

This research was conceptualized based on years of work with the International Organization for Migration (IOM) in both Kenya and Somalia, working with migrant and mobile populations, and refugees in particular. Following nearly a year with IOM in Nairobi, Kenya (2007-2008), supporting the migrant health programme in Eastleigh, I was posted to Hargeisa, Somaliland; to lead implementation of an Integrated Biological and Behavioural Surveillance (IBBS) survey with Somali sex workers. After just under a year in Somaliland, I returned to Nairobi, still with IOM, to lead a research portfolio with the Intergovernmental Authority on Development (IGAD) and simultaneously, IOM received funding from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Population Fund (UNFPA) to conduct an IBBS survey with migrant female sex workers (FSWs) in Eastleigh, Nairobi.

The IBBS was implemented by IOM and local collaborators in 2010, for which I was the principal investigator. Results revealed an HIV prevalence of 23.1% (Kriitmaa, 2011) similar to other FSWs in Kenya, but revealed some variations in risk behaviour and low uptake of HIV testing (Fonck at al., 2000; Republic of Kenya, 2008). One of the main findings from this study was that although almost three quarters of migrant FSWs knew where to obtain an HIV test, only slightly over half had obtained an HIV test in their lifetime. This finding is low compared to the non-migrant FSW population where 78% had ever had an HIV test (Kriitmaa, 2011). Notably, this data is for all migrant groups, not Somalis specifically. Informal interviews and consultations with respondents, revealed the important emphasis on Somali culture and values and particularities of their

environment and migration situation; however, the quantitative study did not unpack these constructs further. Figure 1 presents additional characteristics of Somali migrant FSWs in Nairobi, in comparison with Kenyan FSW.

Figure 1: HIV status, condom usage, and HIV testing among migrant and Kenyan FSWs in Nairobi

Variable	**Migrant FSW (2011)**	**Kenyan FSW (2015)**
Prevalence of HIV	23.1	29.5
Condom used last time with a client	77.6	86.9
Ever had HIV Test	55.5	86.6

Source: Kriitmaa, 2011; Musyoki et al., 2015

Following completion of the IBBS survey in 2010, many questions remained regarding how IOM and partners, could better provide health and social support services to migrant FSWs in Nairobi. In summary, while data from the IBBS survey showed high HIV prevalence, as well as risky behaviours, awareness and knowledge around prevention and available services was present. The fact that FSWs had some knowledge and awareness about HIV, but nonetheless high behavioural risk and prevalence is a disconnect, resulting in the need for research into how services for migrant FSWs could be tailored to support them in ways that might lead to positive behavioural and health outcomes. Following analysis of the findings of the IBBS, it was deemed that a qualitative investigation was the best way to fill in the gaps left from the quantitative study, this PhD research aimed to fill this gap in knowledge.

2. Research question

The primary aim of this qualitative PhD research was to fill identified gaps in knowledge, specifically, why do Somali FSW in Nairobi, Kenya remain at high risk of HIV despite availability of targeted HIV prevention services? Globally, the evidence shows that sex workers are at higher risk than the general population, they have a disproportionate burden of HIV, and as a migrant group they may not have access to services. However, even with targeted services for sex workers, this particular group was not accessing services. I explored the literature and relevant constructs to help explain explore this anomaly. Specifically, for Somali migrant FSW in Nairobi, Kenya, I explored how their experiences or situations specific to the urban migrant environment in Nairobi culture may shape their environment, access to and use of sexual health services, and ultimately their overall health and well-being.

The research sought to understand identity construction of Somali migrant FSWs, including intersecting identities of being a migrant/refugee, a Somali/Muslim, a sex worker, and the possible compounded effect of these identities, vis a vis their health and health seeking behaviour. The overarching research question is how do risk environments and resilience amongst female sex workers who migrate affect health and health seeking behaviour? The research had the following objectives:

- Explore the risk environment of Somali migrant FSWs in Nairobi, Kenya, including how it is shaped by various social networks and the experience of stigma and discrimination.
- Examine identity construction of Somali migrant sex workers, including that women may perceive themselves to have multiple and intersecting identities, which influences how

they respond to their risk environment and affects both health behaviours and health outcomes.

- Investigate factors related to service access and use, including perceptions of health needs, experiences and perceived and enacted stigma by the community and health workers.

PART B: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

3. Literature review

3.1. Overview

Literature has been chosen for its importance in framing the study's research questions and for its significance to the development of the conceptual framework, including the theories and constructs used to build the conceptual framework. This chapter reviews existing literature on determinants of risk for migrant FSW and determinants for access to health services stigma. Next, I introduce the different concepts of stigma and discrimination, violence and social networks and support, as important constructs because they are particularly salient determinants that shape both migrant FSW's levels or risk and use of services. Lastly, the theoretical approaches that I use to frame my conceptual framework are introduced, these include risk environments and intersectionality, and I incorporate the aforementioned concepts – specifically the influences of stigma and discrimination, violence, and social support for this population in creating the risk environment, and how these constructs might be influenced by different identity constructions.

This thesis focuses specifically on human immunodeficiency virus (HIV) and other sexually transmitted infections (STI) within sexual health and is limited to the experience of FSWs. The literature review did not therefore include studies on other sexual or reproductive health topics, such as unwanted pregnancy, unsafe abortion, infertility, or sexual dysfunction, nor research on male or transgender sex workers.

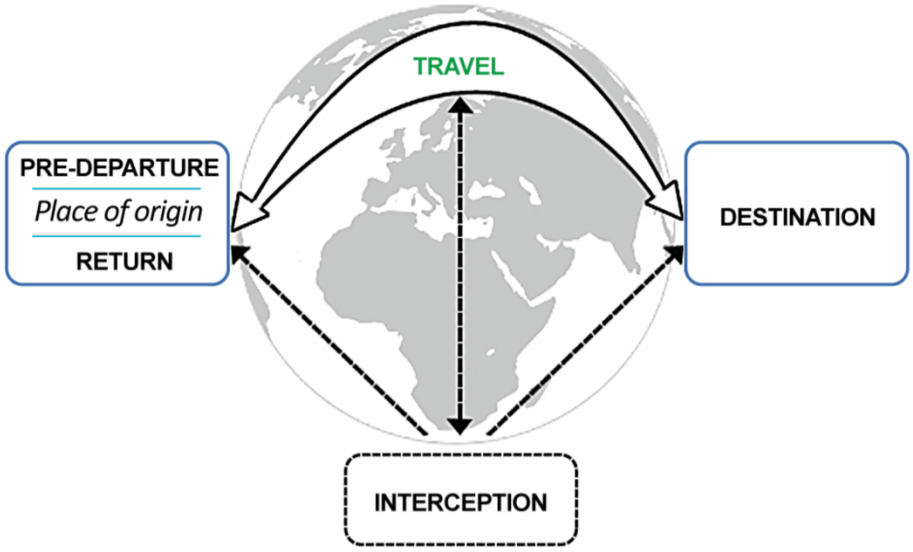
While a thorough analysis of the types of migration is not explored in this thesis (e.g. labour migration, forced migration, human trafficking, etc.), it is important to note there are differences between types of migration as a determinant, including exposure to risk and of access and use of services, with forced migration and refugees having some disadvantages (e.g. trauma; violence; forced nature of departure may mean less preparation) and potentially also advantages (e.g. dedicated services; rights to register for certain benefits, etc.) (International Organization for Migration, 2019). In this thesis the population explored is a refugee population, and therefore the determinants of risk are a result of a forced migration experience. However, the literature review includes more broadly both forced and voluntary migration, and literature outside of Africa, to draw on a wider scope of evidence.

3.2. Determinants of migrant female sex worker health risks

Using Zimmerman's migration and health 21st century policy-making framework, a five stage migration pathway is described (Zimmerman, Kiss and Hossain, 2011), and found in Figure 2. It

provides a summary process framework that showcases a multi-staged and cumulative nature of the health risks and intervention opportunities that characterize the migration process.

Figure 2: Migration phases framework from Zimmerman et. al (2011)



The experience of being a migrant can be both risk enhancing and protective; and while the various influences of migration on health have been well explored, migration and sexual health has been less documented. HIV has been the most widely examined outcome when it comes to migration and sexual health research and while many studies have shown migration or mobility as a risk factor for HIV (IOM, 2002; Lagarde *et al.*, 2003; Lurie *et al.*, 2003; Lydié *et al.*, 2004; Khan *et al.*, 2008; Mmbaga *et al.*, 2008; Vissers *et al.*, 2008; Voeten *et al.*, 2009), others have found no such association (Coffee *et al.*, 2005; Coast, 2006; Mundandi *et al.*, 2006). According to Deane et al. (2010) the conflicting results from the literature may be due to wide definitions of mobility,

which include short and long term mobility, rural to urban migration, seasonal migration and domestic and international migration. The authors also emphasize that in addition to inconsistent definitions of types and reasons for migration, the contexts of departure and destination countries must be considered in any attempt to link mobility and HIV.

The literature highlights wide ranging individual and social risk factors that may increase migrants' vulnerabilities to STIs and HIV during transit and upon arrival at destination, including lack of access to the formal health system, decline of protective social norms, lack of information and education around sexual health, stigma and discrimination from the local communities, and systematic discrimination and violence from local police and immigration authorities (OBrien and Khan, 1996; Duckett, 2000; Arujo de Carvalho, Haour-Knipe and Dehne, 2010). This section breaks down some of these determinants, to look at the potential links between migration and sexual health outcomes.

There are two pathways in which changes in environment due to migration can influence sexual health; first, migration may put individuals in situations of higher risk, both during and after migration, risk that they may otherwise not have been exposed to, and second, migration allows for sexual partners to interact with individuals from higher prevalence contexts (Deane, Parkhurst and Johnston, 2010).

Migration between two places with varying levels of HIV prevalence is another way change in environment may impact sexual health. For example, migration may increase likelihood of additional partnerships for both the migrant and the partner at home (Coffee, Lurie and Garnett, 2007). Furthermore, the environmental context of migration is key. In a study of nearly 10,000 adults in 12 rural communities in Zimbabwe, results found that migration alone is not a risk factor for HIV, but more important is the context, including why someone had travelled, when, and with whom. Respondents who migrated to work in farming estates, migrated as adults and without their spouses, had elevated risk of contracting HIV (Coffee *et al.*, 2005).

It is widely known that FSWs are disproportionately affected by HIV and other adverse sexual and reproductive health outcomes and are a priority key population for that reason. Sex work itself is linked to increased risk of HIV, STIs, mental health problems, violence and lack of access to services (Ward, Day and Weber, 1999; Platt *et al.*, 2013). Furthermore, these cross-sectional studies often show that the risk of contracting HIV is proportional to time selling sex. One long term cohort study in the United Kingdom followed a group of 354 FSWs over 15 years, and with outcome data for 130 FSWs, found that prolonged activity in sex work leads to increased morbidity, mortality, mental health and substance abuse problems (Ward and Day, 2006). A systematic review undertaken in 2012 focusing on FSW in Sub Saharan Africa reviewed 128 journal articles and found risk was typically linked to the contexts of their work, including poor socio-economic status and poverty, widespread exposure to violence, criminalization, high mobility and substance use (e.g. alcohol) (Scorgie *et al.*, 2012). These characteristics were a

predictor for behavioural risk factors, including low and inconsistent condom usage, anal sex and co-infection with other sexually transmitted infections.

Looking at the literature further, when we focus on risk factors for migrant female sex workers specifically, there are many similarities with non-migrants engaged in sex work, but often the risk is amplified because of additional and layered forms of discrimination, violence and access to information and services, therefore amplifying risk factors further. For example, a study of 571 sex workers in India, recruited via respondent driven sampling, found that the female sex workers who were migrants or highly mobile (12% of the sample, n=82), were more likely to report recent risk factors for HIV, such as sexual violence, unprotected sex for increased earnings, and a higher number of clients (Reed *et al.*, 2012).

Some effort has been put into reviewing the environment and risk behaviours, specifically of local versus migrant sex workers. Evidence suggests that migrant sex workers may have different norms and standards around sex work in comparison with non-migrant sex workers, including lower condom use, higher volume of clients, lower remuneration demands, as well as a weaker ability to negotiate safe sex practices (Cooper *et al.*, 2007; Choi, 2011; Platt *et al.*, 2011). Differences in further social-demographic characteristics and environmental characteristics have also been found; for example, a study in London with 268 FSWs found that migrant FSWs were younger, and exhibited less health seeking behaviour, including less frequent HIV testing, compared with local (e.g. UK born) FSW (Platt *et al.*, 2011). More recent work in Mexico showed that migrant sex workers were frequently subjected to violence and abuse before migration, in transit, and upon arrival at the destination (Rocha-Jiménez *et al.*, 2016). The same study found that vulnerability

related to the structural environment such as risk of targeting and abuse by police, may be exacerbated by migration status. Similarly, the threat of deportation also results in increased susceptibility to targeting by authorities. This study is one of the more recent ones which contributed to the body of evidence that interventions for sex workers needs to take into consideration the potential increased vulnerabilities related to migration status and safety issues at various stages of the migration continuum.

In developing countries expressly, the evidence is less extensive, although research has been conducted in South America, China, Cambodia, Thailand, Vietnam, India, Mexico the Caribbean and Zimbabwe, where migrant FSWs were either the primary population under investigation or the role of migration status for a FSW population was examined. In South America, a study of 1,845 FSWs in Argentina, Bolivia, Ecuador, and Uruguay, found 10.1% of the sample were migrants, and HIV related risk behaviour was compared between migrant and non-migrant FSWs (Bautista et al., 2008). The findings varied across the countries; in Argentina migrant FSWs were more likely to be younger, in Bolivia they were more likely to work in bars, in Ecuador they were more likely to be single and use illegal drugs, and in Uruguay migrant FSWs were more likely to drink alcohol, work in brothels and serve foreign clients. Conversely, some factors were inversely associated with migration, including longer history in sex work, use of illegal drugs and sex with foreign clients in Argentina, and more frequent sexual contacts and consistent condom use in Ecuador. These results show that interventions need to be tailored according to particular population groups, and potentially nationality and migration status for FSWs.

In China, literature suggests the majority of FSWs are migrants with estimates ranging from 62 - 95% (Hong et al., 2009). In Hong Kong researchers analysed risk behaviours of FSWs under three varying migration statuses: residents, new migrants (in Hong Kong for less than 7 years), and visitors (illegal migrants). Results indicated illegal migration status contributed to increased vulnerability for STIs (Wong et al., 2011). Non-residents exhibited higher proportions of syphilis and gonorrhoea infection and were subjected to significantly higher fees for health services. Another study in a rural county in China found that local FSWs had increased sexual health risks and higher STIs than migrant FSWs from outside the county (Hong et al., 2009).

3.3. Determinants of migrant female sex worker access to services

Access to health services is a basic human right; however, migrants do not always have access to health and social support services due to factors including lack of knowledge about existence and availability of services; institutional, legal, and language barriers; cultural barriers (e.g., different concepts of health-seeking); and geographical concentration in areas without services.

Overall, a migrant's legal status is one of the most important factors influencing access to health services (Chatterjee, 2006). Institutionally, migrants may be systematically excluded from health services due to undocumented migration status as a result of forced migration or intentional or involuntary departure from camp-based settings in transit or host country. A literature review in 2015 looked at barriers to accessing healthcare for undocumented migrants. Of 66 published papers that met the criteria for in-depth review, 50 (76%) illustrated legal and insurance barriers as a prominent challenge (Hacker *et al.*, 2015). Other factors included fear of deportation (65% of the articles), financial constraints (45%) and communication challenges including language and

cultural barriers (36%). Also, poor knowledge of the health system (33%), discrimination (33%) and bureaucracy (26%) were highly prevalent barriers. Even in cases of legal migration, loss of appropriate paperwork may impede access, mentioned in 27% if the articles in the aforementioned literature review, which was also confirmed across the literature on undocumented migrants in India (Chatterjee, 2006), England and the Netherlands (K, den Otter and Spreij, 2012) and in Costa Rica (Golkade, 2009).

A study in Mexico showed that registered FSWs were more likely than unregistered FSWs to have had HIV testing although they did not show significantly lower HIV or STI prevalence. Interestingly, while most of the FSWs were migrants (78%), in comparison with registered FSWs, unregistered FSWs were more likely to come from Baja California (30% vs. 11%), in other words, not migrants. Therefore, in this situation migrants were more likely to be registered, and more likely to have accessed an HIV test, showing the potential impact of migration on regulation and the possible impact on health seeking behaviour (Sirotin *et al.*, 2010).

A more recent qualitative exploration of migration and sex work is from Zimbabwe, where the authors investigated the nexus between migration and sex work during adolescence, and how these distinct and overlapping risk categories or profiles impacted their health and health seeking behaviour (Busza *et al.*, 2014). The findings showed that migrants may find themselves isolated from supportive social networks in new locations and inexperienced situations, which can result in unsafe or high-risk working conditions. Alternatively, migrants may form stronger bonds with

their peers and may have escaped an even more precarious situation before migrating - both situations potentially impacting health seeking behaviour and access to services.

Stigma, discrimination, and violence

Fear of stigma or discrimination from healthcare providers or police, or fear of detention, arrest or deportation can affect uptake of health services for migrants. This is documented across voluntary migration pathways, including in rural to urban and international migration, not just in the context of forced migration. An example of rural to urban migration and stigmatization comes from China, where researchers developed a model looking at how stigmatization associated with migration aggravates social isolation, contributes to lesser psychosocial integration and transition in the urban environment. Furthermore, researchers found a number of personal and psychosocial factors (including age, gender, socio-economic status and pre-migratory awareness) will mitigate the impact of stigma on mental health symptoms for migrants (Chen *et al.*, 2011).

Criminalization of sex work may lead to harassment by police and the community, violence, reduced access to legal and social support services, difficulties around employment and shelter, and alienation from family, friends, and the community (Rekart, 2005). Sex work is illegal in many countries; however, the precise legal status and ramifications vary widely for those involved in the sex work industry. Different forms of sex work can affect health and the risk environment and criminalisation, and laws and policing are often a key factor in what makes that environment risky. In some countries, sex work is legal amongst consenting adults and considered a profession, such as in the Netherlands (Outshoorn, 2012) and Germany, albeit with various conditions such as minimum age requirements, migration status, and a registration requirement for taxation, as is the

case in Germany (Pates, 2012). While in other countries it is illegal to buy sex but not illegal to sell, and therefore only clients are engaging in an illegal activity, such is the case in Norway and Sweden (Jakobsson and Kotsadam, 2011). In other countries, sex work is illegal, where if caught and convicted, may even be punishable by death, such as in Iran. Nevertheless, Iran has in place harm reduction programmes for this high-risk group (Karamouzian *et al.*, 2016). Research illustrates that barriers to accessing services exist due to stigma, discrimination, harassment, etc., all factors which are exacerbated due to criminalization (Sakha *et al.*, 2015). Even if the profession of sex work is not illegal, sex workers may still be perceived and treated as criminals (Rekart, 2005). A systematic review amongst both female and male sex workers, looked at relationships between legislation, policing and health (Platt *et al.*, 2018), illustrating the significant negative implications of legislation criminalizing sex work and calls for reforms to legalization to counter repressive policies that impact the health adversely.

The risk for sexual assault, a known risk factor for HIV and STIs, during transit and in refugee or IDP camps, are notable examples of relevant changes in environment. Study findings are mixed, with some showing that levels of forced sex amongst women in refugee camps and surrounding host communities is similar in terms of prevalence, such as a study undertaken by the United National High Commission for Refugees (UNHCR) which reviewed data from 27 sites, for 24,219 individuals, comparing refugee and surrounding communities (Spiegel, Schilperoord and Dahab, 2014). Other studies have shown higher prevalence of gender based violence (GBV) amongst host community members, such as a study amongst Somali refugees and a surrounding community in Ethiopia, which showed prevalence of GBV was higher in the town surrounding the camp (Parcesepe *et al.*, 2015). The study also showed women were at increased risk of GBV in the camp,

in comparison with during transit/fleeing from Somalia. A recent systematic review looking at prevalence of sexual violence among refugees analysed data from seven different bibliographic databases, and included articles across four languages (English, French, Spanish and Portuguese) (Araujo *et al.*, 2019). Overall, sexual violence amongst refugees was reported across all continents, however, the prevalence of sexual violence varied greatly, from 0% to 99.8%. Over two-thirds of research papers (42%) focused on sexual violence in Africa, and the most common form of sexual violence reported was rape (65% of the research papers). More than three quarters of the survivors were women (89% of the studies) perpetrators includes intimate partners and individuals in protective roles (e.g., police, authorities, etc.). One third of the studies (32%) reported findings from refugee camp settings. Importantly, amongst all of the GBV related evidence across the literature, a common understanding is that reporting is biased and consistent underreporting is a characteristic in both in populations of humanitarian concern and in non-conflict settings (Palermo, Bleck and Peterman, 2014).

3.4. Resilience amongst sex workers

Across the literature it has been illustrated that sex workers face multiple structural, physical, psychosocial challenges, regardless of the specific context: however, this population also exhibits incredible resilience in the face of adversity. Oftentimes formal resources are limited for sex workers, therefore they rely on peers or colleagues, creating informal support networks, to obtain or reinforce the knowledge and skills needed to stay healthy and survive. In short, they successfully counter the determinants of their vulnerability, and therefore it is of interest to better understand this phenomenon of resiliency and how to encourage and support it.

Overall, there is not a great deal of literature looking specifically at resiliency of migrant sex workers, however various epidemiological investigations into sex work uncover coping mechanisms during the investigation.

In 2022 a study was published illustrating findings from a random sample of 40 FSWS, from a total sample of 1003 women enrolled a 3-year longitudinal mixed-methods research piece in Kenya, exploring the relationship between HIV risk and violence and mental health (Wanjiru *et al.*, 2022). All women in the study (100%, n=40) reported some challenges in their lives, ranging from adverse childhood experiences such poverty, physical, emotional and/or sexual abuse, intimate partner violence, and entering sex work to support their children. The key sources of resilience and coping mechanisms included both individual and collective mechanisms. For example, finding a livelihood in sex work, to support themselves and their children, was self-narrated as resilience, finding way to preserve in the face of destitution. Furthermore, social capital by way of other sex workers, who became their community, in the absence of family or community support was a crucial theme.

An ethnographic investigation into the lives of migrant sex workers in South Africa illustrates an innovative coping strategy for a community of women (Nyangairi and Palmary, 2015). The reappropriation of names such ‘Hure’ (the Afrikaans derogatory term for sex worker), where the FSW created a new group identity, and this identity then enabled them to monitor their community through this framework, provide safety and support, which reduced the stress and fear of FSWs.

Social networks and support

Literature looking at the links between social networks and health is not a new area of research, it is often explored by public health researchers given the interconnectedness of people and their health – and as a result this exploration has implications for health policy and research (Berkman and Glass, 2000). "*A social network is a set of ties among people who have some common interests or interactions … Family, friends, neighbours, co-workers, and sex or drug partners may be members of the social network that influence HIV-related behaviours*" (Shushtari *et al.*, 2018, p. 2). Berkman and Glass (2000) describe five ways in which social networks may affect an individual's health, including 1. Perceived and actual social support; 2. Social influence, such as norms; 3. Social engagement: 4. Individual personalized contacts (e.g., disease transmission): 5. Access and distribution of resources (e.g. information, money, employment, etc.).

In the context of sexual health, a great deal of literature is summarized in a recent a systematic review which included 19 articles, suggesting characteristics of social networks, in particular practical elements including social support and social capital, are important factors for understanding HIV risk behaviours (Shushtari et al., 2018). The systematic review further highlighted a lack of knowledge about the association between structural characteristics of the social networks of FSWs and their HIV risk behaviours.

Social networks may be comprised of both sexual and non-sexual relationships, familial support (parents, siblings, children), and peer relationships, both within and external to the sex industry (e.g., FSW and non FSW peers). Financial and moral support in times of illness and treatment may

be acquired through social networks (Lin, 1999), and as such social networks in the context of sex work, in both developed and developing contexts, have been explored.

Support networks have been shown to have important effects on the lives of FSWs, providing practical or emotional support and influencing risk and associated behaviour, including health seeking behaviour and knowledge and awareness of services available (Latkin, Hua and Forman, 2003; Lippman et al., 2010; Tucker et al., 2011). For example, FSWs may draw on social support for education and information around healthy sexual behaviours and in some cases, those reporting stronger/more extensive support networks also demonstrate lower levels of risk and higher engagement with prevention and care services than FSWs lacking such networks (Tucker et al., 2011).

Furthermore, there is literature which indicates that social networks can be protective, and that social support is associated with improved health outcomes and protective behaviours. For example, multiple studies test strengthening social networks in interventions, particularly those for HIV prevention. A successful example of a peer led intervention, described by Jansen (2009) illustrates the benefits of a harm reduction approach, combined with the use of a peer support systems. In Vancouver, Canada, a survey was conducted with 100 women who were accessing a project focusing on mobile access to emergency healthcare, peer counselling, condoms and clean needles, information, and education. The impact of the intervention was assessed, and it was found that one-fifth of women surveyed indicated the presence of the van with peer support workers protected them from a sexual assault, and 90% indicated the van and peers made them feel safer. In addition to the perceived increased protection from the van itself and the presence of people,

the peer support through counselling and provision of information provided increased social protection, and this has been demonstrated in other studies as well.

Similarly, Yang et al. (2010) reviewed the effect of social networks on risk, recommending peer discussion and communication be incorporated into STI and HIV intervention models. Likewise, a study in China showed organizing an HIV prevention programme around a social network to be more effective, utilizing social ties of groups, specifically links to hometowns or regions. Interviews with 34 FSWs and 28 health outreach workers illustrated that social networks affected condom usage, STI and HIV testing, health seeking behaviour and the ability to deal with violent clients. These findings illustrated that sex worker's hometown social ties/connections were more powerful than relationships amongst women engaging in sex work in the same commercial venues.

Another study in China with a sample size of 1,022 FSWs showed that different forms of support from varying sources may influence condom use among FSWs (Qiao *et al.*, 2015). For example, friends, co-workers, and stable partners were the main sources of social support for FSWs in the study, and the quantity and quality of the support resulted in varying levels of condom usage. Specifically, co-workers (e.g., other FSWs) were the primary source of informational support, while friends were a key source of emotional support, and intimate stable partners were the main source of overall concrete support. Furthermore, emotional support from friends was positively associated with correct condom usage, and information support from gatekeepers was significantly associated with higher rates of consistent condom use with stable partners. Support from clients and intimate routine partners was negatively associated with condom use.

A further study in China showed organizing an HIV prevention programme around a social network to be more effective, utilizing social ties of FSW groups (Tucker et al., 2011). In India, discussion around larger social networks was associated with lower odds of forced sex (Go *et al.*, 2011) and in Brazil increased involvement with social networks was associated with fewer instances of sex without a condom (Lippman *et al.*, 2010). Specifically, amongst male and female sex workers, elevated feelings of mutual support and social cohesion were associated with fewer instances of unprotected sexual intercourse.

More recently, Chowdury et. al (2015), through in-depth interviews with 30 FSWs in Tijuana Mexico, found that non-sexual relationships with other women were an important part of social support for venue based FSWs. These relationships included family members such as mothers and sisters, as well as female friends from outside the realm of the sex work sector, as well as peer FSWs. Disclosure of their sex worker status was a crucial factor that affected the feelings of closeness. Respondents also spoke of relationships with peers being hindered due to competition. For example, Mtetwa et. al (2015) found that peer competition amongst FSWs in Zimbabwe can hinder, but not necessarily "cancel out" the positive benefits of social support. This was illustrated following in-depth interviews with 22 FSWs reviewing the elements of FSW relationships and extent of social support.

Sarafian (2012) proposed a framework for social support after reviewing and analysing recorded peer education sessions with venue based FSWs in Dhaka, Bangladesh. The author utilized social support as a framework to understand processes of change, looking at the types of support

provided, including informational, appraisal, emotional, companionship, non-support and others. Peer educators were classified into one of three "social support profiles" based on average levels of emotional and informational support they provided to FSWs. Seeing more peer educators with a higher informational support profile was correlated to more elevated sex worker self-efficacy, self-reported STI symptoms, and self-reported condom usage. Similarly, a correlation was found between the peer outreach high emotional support profile and treatment seeking. Social support constituted a useful framework but needs further exploration. Ultimately, receiving different support types was related to varying outcomes in sex workers.

Tucker et al. (2011) found that FSW in China who had social connections from their home towns were more likely to trust local health services and therefore generally had higher acceptance of HIV and STI services. In a context such as China, where few successful HIV prevention programmes for sex workers existed at the time, these social networks therefore provided some support around mobilization and promotion of risk reduction and healthy behaviours. While peer support for mobilization and promotion of healthy behaviour was not directly found amongst Somali migrant FSW in Nairobi, peer FSW support through child minding or lending money, in order for peers to access health services, was present – therefore positive peer support could potentially be extended to risk reduction behaviours as well.

The above literature illustrates the varying ways in which social networks and support can be theorized and defined; however, the common theme is that support networks can have an important impact upon the lives of FSWs, providing practical or emotional support and influencing risk and

associated behaviour, including access to health and social support services. These theories have supported formation of my research questions, presented previously.

3.5. Summary

The literature shows there are a myriad of individual and social risk factors that may place migrant FSW at greater risk, and there are additional factors (e.g., institutional, legal, and cultural barriers) that may make migrant FSW less likely to access health services - what appears to be a common thread is that local stigma and discrimination, of which violence is the most harmful manifestation, shapes both the risk behaviour and health service use. Nevertheless, some migrant FSW are able to become more resilient through strong social support via their networks of different kinds, and this appears to protect against risk and potentially increase use of prevention and/or care.

4. Theoretical approaches

4.1. Risk environment

Early analysis of risk behaviour in the context of HIV was focused on the individual; however, after extensive social behavioural research, the role of social, economic, political and cultural factors and how these are interrelated are increasingly recognised (Parker, 1996). These combined factors and contexts form a 'risk environment'. Rhodes' (2002) concept of a risk environment, although originally applied in the context of harm reduction for drug users, attempts to understand and explain social and environmental determinants of harm, shifting from the perspective of harm as caused only by individual behaviour. For example, individual risks are related to contact with individuals who may be infected. Socio-economic factors include income, education, and social status, while political and structural factors include community, legal or policy aspects of the

environment (Dean and Fenton, 2010). For example, restrictive policies around HIV testing for migrant workers, and the potential impact on health around laws, policy, and criminalization.

The concept of risk environment has been recently applied in the context of clients of FSWs in Mexico (Goldenberg, S. a Strathdee, *et al.*, 2011; Goldenberg, S. A. Strathdee, *et al.*, 2011)). The authors found that clients' risks were influenced by physical, social, political and economic factors. Physical factors may include physical and sexual abuse, social factors around norms dictating heavy alcohol consumption, political factors such as poor enforcement of sex work regulations in nightlife venues and finally economic factors such as economic exploitation by establishment owners. How these macro level factors play out to form a complex risk environment will vary, but some potential examples include normative heavy alcohol consumption leading to clients' regularly binge drinking in venues where commercial sex is available, and different prices for sex with and without condoms, thus discouraging use. Nightclub and bar owners exploiting sex workers through financial extortion or collusion with clients or police result in added protection challenges and threat of arrest (Goldenberg, S. A. Strathdee, *et al.*, 2011).

A further example of the concept of risk environment comes from a case study of a community based research study in Vancouver, Canada (Rhodes *et al.*, 2012). The research reviewed the impact of macro level policies, such as laws stating that sex work could not be conducted indoors, resulting in micro level decision making and behaviour, such as sex work being pushed to more obscure locations, and less time for condom and price negotiation (Shannon *et al.*, 2008). Qualitative analysis showed that FSWs were in fact avoiding areas with high police presence and enforcement, which were correlated with locations of higher volume of services. In summary, the

macro level policies were impacting condom negotiation, and increasing sexual health risk (Rhodes *et al.*, 2012).

Any study looking at environmental elements affecting risk for sex workers is essentially drawing upon a risk environment framework or socio ecological approach. The ecological approach for health promotion programs, originally described by McLeroy *et al.*, (1988), described a model whereby individual and social environmental aspects are crucial to health interventions, focusing on behaviour change at five levels, precisely "…*interpersonal, organizational, community, and public policy, factors which support and maintain unhealthy behaviours. The model assumes that appropriate changes in the social environment will produce changes in individuals, and that the support of individuals in the population is essential for implementing environmental changes*" (p.1). In comparison, the risk environment looks at more proximate, immediate context-related factors such as how laws are implemented, how sex work is organised and provided, what is going on at the street level, and less so at the broader structural levels of economy/culture/policy.

Examples of a risk environment approach include studies reviewing locations where sex is sold (e.g. indoor versus outdoor according to local laws) (Krüsi et al., 2012), labour regulations (Pitcher and Wijers, 2014), and access to condoms (Urada *et al.*, 2012). However, there is far more evidence from developed, than developing countries, and studies looking at the concept of risk environments is less common that socio ecological approaches.

From a migration perspective, Soskolne and Shtarkshall (2002) provide a variation of the risk environment, which is more similar to a socio-ecological framework, by presenting a multi-level framework to illustrate the links between migration and sexual risk taking, concentrating on structural factors. They describe structural macro factors such as socio-economic status and level of power in the destination country, intermediate structural factors such as social capital and cultural norms, and individual level factors including extent of health service uptake and loss of cultural beliefs. Many migrants may experience changes in social capital and encounter conflicting cultural norms in the new setting.

Sanders (2004) describes a 'continuum of risk' amongst FSWs in the UK, whereby particular threats are prioritized over others, including non-health related dangers such as physical violence and emotional risks. Sanders focused on perceived risk, and how these were ranked by the FSW, eliciting this information via in-depth interviews and observation. Similarly, Busza (2005) presents qualitative data from a participatory study with brothel-based migrant Vietnamese sex workers in Cambodia. The results showed that sex workers framed sexual and reproductive health concerns within a broader understanding of the risks faced through sex work. Priority was around livelihood, financial means to survive and support their family, and minimizing police harassment which impeded their work.

According to Beck (1992), risk is not simply the perception of risk but also the strategies utilized to deal with these risks. Perceived and experienced risk will be explored in the context of risk management and coping strategies, sexual risk reduction, and access to and use of health and social support services. In the same perspective, risk is related to the social and environmental context

within which an individual is situated, and as such a thorough a description of social networks, social, cultural and environmental factors shaping risk will be explored.

4.2. Intersectionality

Intersectionality is a feminist sociological perspective used to study how women simultaneously position themselves against multiple, competing and layered forms of discrimination, including but not limited to race, gender, and class (Avtar, 2004; Bredstrom, 2006; McCall, 2005). Campbell and Gibbs (2009) provide one of the few analyses to date to include intersectionality within discussions of HIV programming to assess relationships between gender and stigma, and implications for a participatory intervention for sex workers. The authors argue that sex worker interventions should include opportunities to increase their agency, through rethinking of their social identities. Drawing on evidence from the wider intersectionality literature, a study from Canada with 15 focus group discussions amongst HIV positive women described the multiple marginalized social identities including HIV-related stigma, sexism, and racism, which were interdependent and compounding in nature (Logie *et al.*, 2011). The authors postulate that the intersecting, concurrent and multiple instances of stigma and discrimination represent an intersectional model of stigma and discrimination. The study further refers to the layers of discrimination and risk factors (specifically referring to '*micro, meso and macro levels'* in the paper), which links with the risk environment models presented earlier. Interestingly, however, the authors suggest that while there are risks from these multiple forms of risk and discrimination, there may also be protective factors, such as social networks providing coping mechanisms, therefore the layered form of intersectionality is complex.

In the research, intersectionality is used as a cross-cutting way of looking at how this population might experience the aforementioned constructs because of their multiple identities. Data from interviews with Somali migrant FSWs was analysed using the lens of intersectionality, where multiple and layered forms of oppression such as being a migrant, a Somali and a female sex worker, may have contributed to in increased risk.

5. Conceptual Framework

Figure 3 illustrates the overlapping influences of the multiple identities explored in this study, and it explores how as a migrant, a Somali and a sex worker, may each result in varying feelings, actions, and resulting risk behaviours; the intersection of all three of these marginalized identities may amplify the effects of each. Intersectionality underpinned investigations around the risk environment and identity construction for Somali migrant FSWs, and implications for service access and use.

Figure 3: Compounded effect of multiple identities

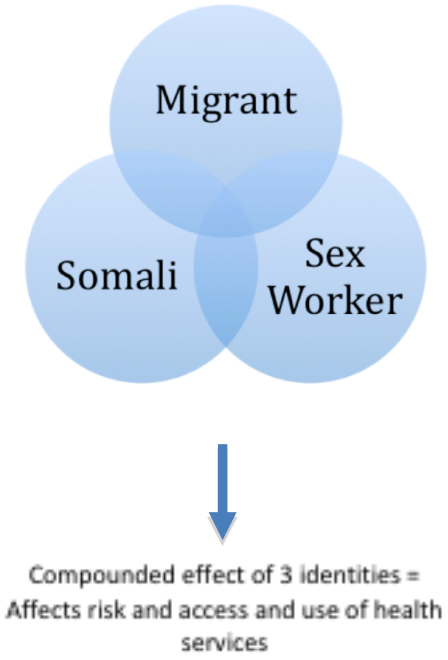
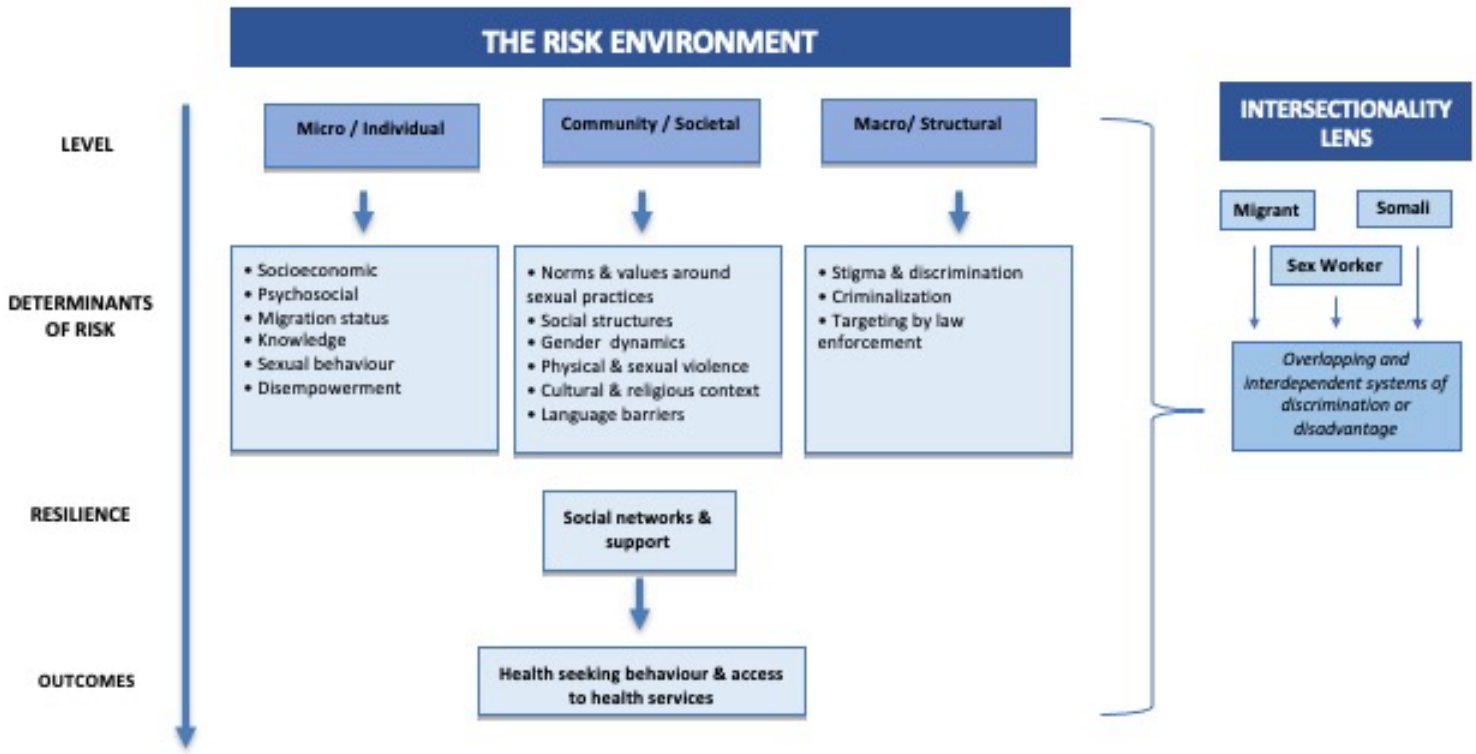


Figure 4 illustrates the possible vulnerabilities for Somali migrant FSWs in Nairobi. Some of these vulnerabilities may be the result of multiple identities, such as targeting by law enforcement for the women either because they are sex workers or because they are undocumented migrants. Others may result from only one identity, such as exposure to STIs and HIV due to sex work. These vulnerabilities are influenced by social networks and stigma experienced by FSWs. Increased social networks could reduce vulnerability, similarly stigma could exacerbate vulnerabilities. Social networks could be both a protective and a risk factor, whereas stigma is likely to be only a risk factor. Rather than a simple concurrent effect, a compounded layered effect may be present, as described by intersectionality. These socially and culturally constructed categories form identities, and these identities interact, although how they do so can change over time. This is reflected by the horizontal arrow along the bottom of the figure displaying the migration pathway. This conceptual framework illustrates the theoretical approach of risk environments by including

not just individual determinants of risk, but also environmental elements, including physical, social, political, and economical factors.

Figure 4: Conceptual framework around Somali migrant FSW using a risk environment and intersectionality lens



PART C: STUDY CONTEXT AND METHODS

6. Study context

6.1. Somali context

Somalia has been plagued by civil war for decades prompting a traditionally migratory and nomadic society to flee beyond their borders (Gundel, 2003). After the civil war began in 1988, the first mass exodus of Somali migrants occurred in 1991, with more than 1 million Somalis estimated to have departed to countries in the region and outside Africa (Centres for Disease Contol and Prevention, 2018). Following decades of civil war, poverty and famine, wealthier Somalis have taken refuge in Western countries including Canada, the USA, UK, Italy, Holland, Sweden and Denmark, whilst poorer Somali migrants have fled to Kenya and Ethiopia (Gundel, 2003). UNHCR reports some returns, specifically since 2014 a total of 90,024 Somali refugees have voluntarily returned to Somalia, from different countries of asylum, including Kenya, Yemen, Djibouti, Libya, Tunisia and Eritrea. Nevertheless, in 2011 at the time of data collection, there were 497,184 Somali refugees in Kenya, and today this number is 420,970 (current estimate from 2015) (*UNHCR - Kenya Fact Sheet*, 2015), with Somalis remaining the most numerous refugee group in Kenya. It is important to note that these are official UNHCR statistics and do not include irregular refugees, i.e., those not registered. Today, many young Somalis continue to leave Somalia, due to being "…*trapped in an environment of violence, fear, unemployment and poverty*." (Federal Government of Somali, 2016, p.1).

6.2. Sexual and reproductive health amongst Somalis

What few studies of health-seeking behaviour amongst Somalis exist have been focused on maternal and child health services and outcomes, with next to no data on sexual and reproductive health (SRH) seeking practices of Somalis both inside and outside Somalia (Brown *et al.*, 2010; Pavlish, Noor and Brandt, 2010; Steinman *et al.*, 2010; Ameresekere M *et al.*, 2011). There is some information on family planning, but none on access to sexual health services including HIV and STI testing and treatment (Degni, Koivusilta and Ojanlatva, 2006; UNHRC and Women's Refugee Commission, 2011).

UNFPA supported the Somali Health and Demographic Survey (SHDS), the first DHS-like survey to be conducted in the country since the collapse of the state, and the findings were released in 2020 (Directorate of National Statistics and Federal Republic of Somalia, 2020). Results of this survey with more than 100,000 households showed that while 69% of women aged had heard of HIV, only 6 percent of the interviewed women had comprehensive and correct knowledge of HIV/AIDS - showing the limitation in sexual health knowledge in the Somali population overall.

6.3. Somali health seeking behaviour and the impact of migration

Over two decades of conflict, as well as natural disasters such as drought and flooding, has resulted in a displacement crisis in Somalia, including nearly a million refugees in the Horn of Africa, in addition to more than 2 million internally displaced persons within the country (UNHCR, 2018). As a result of this mass migration and displacement, many have lived in camps such as Dadaab and Kakuma refugee camps in Kenya, in IDP camps in Somalia, and as irregular migrants in neighbouring countries - all situations and contexts where the conditions to address the required

health needs likely would not have been met. In summary, and as described by Carol et. al (2007) many Somalis have relied upon "*episodic, crisis-based healthcare*" (page 2). Described further by Mazzilli and David (2009, p.6), "*Both past and present realities have no doubt affected Somalis' expectations of health services and their utilization behaviour*."

All of these factors undoubtedly affect how Somali migrants in Nairobi will perceive their health, and even furthermore for migrant FSWs, with the added condition of high-risk sexual behaviour and therefore resulting health risks. Furthermore, throughout the migration process, the availability of existing health services intersects with their beliefs both about what health challenges they face and their attitude towards health seeking. While many of the respondents may seek health services for general health needs if absolutely needed, there does not seem to be a sense of urgency or prioritization overall to take care of their overall health, including their sexual health, by going for regular and routine HIV testing.

Studies exploring health seeking behaviour amongst Somali migrant and refugee populations after resettling in developed countries exist, although the majority of the research focuses on mental, perinatal health and female genital mutilation (Carroll *et al.*, 2007; Brown *et al.*, 2010; Deyo and Deyo, 2012; Deyo, 2013; Råssjö *et al.*, 2013). Nevertheless, some investigations around sexual health seeking behaviour and knowledge are presented in the literature. For example, Lazarus et al. (2006) explored HIV and AIDS knowledge and condom use among Somali and Sudanese immigrants in Denmark and found low HIV and AIDS knowledge and low condom knowledge among less educated women. Furthermore, the immigrants reported receiving minimal information around HIV. A second study exploring contraception use amongst married Somali women living

in Finland found almost three quarters did not use contraception and their attitudes towards contraception were linked with religious beliefs (Degni et al., 2006).

A more recent qualitative study amongst Somalis in the United States, where they form the largest resettled African group, found a significant relationship between how religious a person was and their health-seeking behaviour (Freeman *et al.*, 2013). The purposive study interviewed 20 Somalis and found the three primary themes to be related to the Quran as treatment, religious limitations to healthcare, and Allah's will. This article highlighted the importance of religion and cultural practices when planning access and equity in health services for Somali populations.

6.4. Sex work, risk and HIV at destination

In Kenya, extensive research has been implemented around sex work and HIV over the last three decades. Studies with FSWs have reported HIV prevalence between 24% and 47%, more than three times the prevalence in the general population (Fonck *et al.*, 2000; Kaul *et al.*, 2004; National AIDS and STI Control programme, 2007; Kimani *et al.*, 2008; Luchters *et al.*, 2008, 2010; Musyoki *et al.*, 2015; Becker *et al.*, 2018; Bershteyn *et al.*, 2018; Bhattacharjee *et al.*, 2019). Much of the FSW research to come out of Kenya is from the Majengo Observational Cohort Study (MOCS), created in the 1980s through a collaboration of Canadian and Kenyan researchers, the cohort still currently exist today and provides a wealth of evidence regarding long term sexual behaviour of a group of Kenyan FSWs (Bandewar et al., 2010).

Data from this cohort illustrates overall HIV prevalence amongst FSWs decreased over three decades, from 81% in 1986 (Kimani et al., 2008) to 35% by 2005. Although the reasons for this

decline can only be hypothesized, the authors state the decline was potentially due to enhanced STI prevention and treatment or decreases in proportion of exposures to clients with acute HIV infection. Furthermore, as the HIV prevalence has fallen in the general population, this decline amongst FSWs reflects the national trend (Musyoki *et al.*, 2015). More recent evidence from 2015 shows a further decline to a prevalence of 29.5%, using respondent driven sampling, widely considered a robust methodology for estimating prevalence amongst hard to reach groups (Musyoki *et al.*, 2015). Nevertheless, despite declining HIV prevalence, a 29.5% prevalence amongst FSWs is still high, and research shows condom use remains inconsistent. Overall, Somali FSW are entering a context with a V much higher HIV prevalence than the one they come from.

6.5. Interventions with FSWs in Kenya

The Kenya key populations HIV prevention programme, led by the National AIDS and STI Control Programme (NASCOP), within the Kenyan Ministry of Health, covers 32 of the 47 Kenyan counties (Bhattacharjee et al., 2019). The Kenya key population programme encourages implementation of combination prevention interventions in accordance with global standards (World Health Organization, 2013). The FSW program aims to reach over 156,000 FSWs in 32 counties, and overall, the programme has had some successes, and also some challenges. For example, while high levels of coverage of FSWs through peer education and condom distribution (>80%) were achieved, programme monitoring shows regular gaps between the estimated condom needs and the actual number of condoms distributed. Furthermore, behavioural findings show consistent condom usage remains elusive, similar to other ad-hoc studies described previously. Moreover, while HIV testing is high, referral networks and linkages to care, ART initiation and adherence require enhancement. Finally, individual-level and systemic and structural barriers, such

as stigma, discrimination, violence and drug-use, remain challenging to improving initiation and adherence to ART programme success (National AIDS and STI Control programme, 2015).

At the time of the research and thereafter, there were no know interventions targeting migrant FSWs in Kenya. There were, however, sex worker interventions, which included migrant sex workers. For example, the Sex Worker Outreach Program (SWOP), supported by the University of Nairobi, US Centres for Disease Control (CDC), and others, focuses on prevention, bio-medical service provision, advocacy, research and alternative livelihoods. As of early 2020, SWOP-Kenya had seven facilities located within Nairobi county offering services to over 45,000 sex workers, 3,000 MSM and over 1000 priority populations, such as adolescent girls and young women (*Sex Worker Outreach Program, Kenya*, 2020).

6.6. Somali migrant and refugee context in Kenya

Estimating the number of Somali migrants residing in Kenya is difficult because many individuals cross the Kenyan border undocumented, thus becoming irregular or illegal migrants. Nevertheless, at the end of March 2020 estimates for all asylum seekers and urban refuges was 81,024. (UNHCR Kenya, 2000). The Government of Kenya has a refugee encampment policy, which states that all refugees in the country must reside in camps. Nevertheless, there are many refugees and asylum seekers residing in Nairobi illegally thereby presenting a challenge in estimating the total number of urban refugees (Campbell, 2006). Despite the encampment policy thousands of refugees and asylum seekers live in Nairobi, predominantly in Eastleigh, and engage in the formal and informal employment sector – own businesses, conduct trade, live on remittances from family, and

participate in casual labour (Campbell, 2006). Importantly, Somali migrant FSW are residing illegally in Kenya, and they are engaging in a criminalized occupation. a

6.7. Summary

Overall, we know that sex workers are at risk for poor health outcomes due to a myriad of factors related to their occupation – these include physical and mental adverse effects. We know that this is less documented amongst migrant sex workers, but nevertheless still the case, and in fact amongst migrant sex workers these risk factors are likely to be exacerbated due to further marginalization and stigmatization, poor access to services, and potential for a more fractured social network, which has been documented as part of a resiliency framework or coping mechanism for these vulnerable populations.

We know that previously there was only one study on Somali migrant FSW in Kenya, and that gaps remained in the knowledge the nature of their risk environment, and the coping mechanisms available. Uncovering this evidence could help in the development of tailored interventions to support his vulnerable group, that would take into consideration the unique intersectional nature of their lived realities, and ultimately improve their health outcomes as a result

7. Methods

7.1. Study Design

I had originally planned to conduct a prospective cohort design utilizing two qualitative methods: semi structured and narrative interviews and participant observation. The initial study design aimed for three in-depth semi-structured and narrative interviews with each Somali migrant FSW,

over a short period of 6-8 weeks, as well as non-participant observation. A case study design was selected as most appropriate and feasible, to enable multiple forms of data to be collected through an intensive period of data collection including repeat interviews, through which triangulation of the sources would provide a rich picture of the experiences of Somali migrant FSWs in Nairobi.

The case study approach can be defined as " ...an in-depth, multifaceted investigation, using qualitative research methods, of a single phenomenon" (Feagin et al., 1991, p. 2). Case studies typically collect data prospectively to understand how a phenomenon evolves, or to explore a specific environment or context. In this context, a case study approach in the Eastleigh environment was selected to support a qualitative investigation into the risk environment of Somali migrant FSWs in Nairobi, to examine identity construction and how this influences how they respond to their risk environment and how it affects both health behaviours and health outcomes.

In order to gain the trust of the target population to elicit valuable and rich information over a relatively short period of time, a research assistant was recruited based on her previous experience with this population, specifically working on the IBBS survey previously described. The research assistant was Somali-Kenyan, spoke the Somali language, had a Master's in Public Health and experience conducting both qualitative and quantitative research. I elected to hire a research assistant so she could spend time with each respondent over a period of approximately 6-8 weeks, get to know them and communicate in their native language, and build rapport so they felt comfortable opening up about their experiences as a Somali migrant FSW.

7.2. Sampling and recruitment

A peer referral recruitment strategy was utilized, with participants originally recruited using contacts with local organizations and gatekeepers and the SWOP clinic and IOM pilot project. Theoretical sampling was planned in an effort to recruit participants reflecting diversity in age, marital status, length of time in Kenya, length of time in sex work, varying migration characteristics (forced versus voluntary migration) and HIV status. The definition of sex work, for the purpose of this research, was the exchange of sex for money or gift at least once in the previous 30 days.

Study respondents were initially purposively selected using community and FSW contacts from the previous IBBS survey undertaken in 2010 with the same population. All participants were recruited from Eastleigh, a predominantly migrant neighbourhood located East of the Central Business District of Nairobi. Selection criteria for initial recruitment was Somali born women (i.e., migrants) whom who had exchanged sex for money or a gift at least once in the previous 30 days. While many FSWs in Kenya identify as Somali-Kenyan, only women who were born in Somalia were eligible to participate. Additional eligibility criteria included a minimum age of 18 and ability to provide informed consent.

Thereafter, a peer referral recruitment strategy was utilized, where respondents would ask their peers if they were interested to participate, at which point we would organize a meeting with the participant and her peer recruit, myself, and the primary research assistant, to provide further information regarding participation in the study. This discussion included a summary of the time commitment (3 interviews of approximately one hour in duration each), confidentiality, incentives,

and also the potential for harm due to the illegal nature of sex work in Kenya (e.g., potential disclosure as a FSW if others were to learn about the study, and the participants). Importantly, myself and the research assistant explained that participation in the research was not linked to any ongoing resettlement processes with UNHCR or IOM. Interviews were all held at either the IOM clinic in Eastleigh or the Umma CBO premises (both in Eastleigh).

7.3. Sample Size

A target sample size of 15 was sought for a total sample size of 45 interviews; however, given the mobile context of the population, loss to follow was envisioned and therefore all 15 participants were not anticipated to complete all three interviews. Additionally, it was planned for data to be reviewed continuously for the possibility of data saturation (Glaser and Strauss, 1987) at which point recruitment would stop before reaching 15. Similarly, if after three interviews with each case study participant, sufficient data had not been reached in order to answer all of the research objectives, additional interviews with each participant would be requested, and additional research participants would potentially be recruited. Overall emphasis was on flexibility and an iterative data collection process. Other qualitative case studies have utilized similar sample sizes, including a study of sexuality amongst MSM in China with a sample size of 42 interviews conducted (Chapman *et al.*, 2009).

7.4. Research Team

The research team was comprised of one female research assistant who had previously worked with the migrant FSW population in Eastleigh. This research assistant, a Kenyan born Somali, was responsible for scheduling and conducting the interviews, as well as maintaining a relationship

with the participants throughout the data collection period. A second team member, a translator, and a Somali born urban refugee, residing in Nairobi, was responsible for transcribing and translating the audio recordings. Both of the team members had worked in the previous IBBS survey undertaken in 2010 with FSWs, had experience in both quantitative and qualitative methodologies, and were fluent in Somali and English. Given their previous work with the IBBS survey, this meant they were already familiar with the challenges of conducting research with FSWs.

The Executive Director of Umma CBO was the primary focal person during study design and implementation. Umma CBO was the local partner who supported in implementation of the IBBS Survey with Migrant FSWs, implemented IOM in 2010, for which I was the Principal Investigator. Umma CBO had been operating in Eastleigh since 2005, primarily as a drop-in centre for victims of SGBV. The Executive Director, Ms. Lul Issack Ali (‘’Mama Lul’’, as known by the community in Eastleigh), is a Kenyan Somali, who established the CBO in order to provide care and support to families, particularly those affected by HIV and AIDS. Early on in her work, she discovered that many of the women she supported where survivors of sexual exploitation, abuse and domestic violence. She expanded the focus of her services to support with medical, legal and psychosocial support, as feasible. Increasingly, Umma CBO became known as a safe haven for FSWs in Nairobi, particularly migrant FSWs, and most prominently Somalis.

The role of Umma CBO in the research was to support in recruitment of research participants, provide the key venue for undertaking the interviews and participant interaction and observation. FSWs often participated in various activities at the CBO and convened there for both official and

non-official activities. It was a trusted venue for the migrant FSW community, and therefore thought to be a suitable venue.

The interviews were conducted in Somali and audio recorded by the bilingual Somali/English and bicultural research assistants, with myself present when feasible (due to the security situation explained later). Interviews were conducted in a mutually agreed upon confidential interview space, typically at the Umma CBO office. This location was selected given its central location within Eastleigh, typically not far from where many of the participants lived and worked, as well as participants ease and familiarity with the premises.

7.5. Interviews with FSWs

Four data collection instruments were developed – three topic guides for the three consecutive interviews, as well as a note taking/observation form for the research assistant and myself. The first in-depth interview would follow a semi-structured format, collecting basic socio-demographic details including age and marital status. The interview would then focus on the experiences of the Somali migrant FSW, describing the pathway from departure, through transit and arrival in Kenya, to entry into sex work. The second interview would explore identity construction and risk environments through narrative recounting of experiences in Nairobi around sex work. Probing would attempt to elicit information on social networks and social capital. This narrative approach was selected to elicit information around identity of respondents, focusing on experiences, in an attempt to capture multi-level processes. Lastly, the third interview would utilize a semi structured approach, would focus on experiences with health and social services in Nairobi, including perceptions of health needs, as well as perceived and enacted stigma from the community, health and social service providers.

The narrative interview approach provides an opportunity for respondents to reconstruct social events by asking the respondent to recount an important life event or experience (Jovchelovitch and Bauer, 2007). By contrast, the semi structured interview approach utilizes a topic guide with set themes to be explored, but also provided flexibility for the interviewer to introduce new questions during the interview, depending on the information elicited. Figure 5 summarizes the key areas of investigation covered in the three interviews with Somali migrant FSWs.

The first FSW interview was designed to be semi-structured, while the second and third interviews were designed to be more narrative. Additional interviews with each respondent would be scheduled, if necessary, although ideally each respondent would be interviewed three times. Preferably two to three FSWs would be undergoing interviews at any given time, with ongoing recruitment so that upon completion of all three interviews with each respondent, another respondent would be ready to commence.

Topic guides can be found in Appendix A. While the topic guides were structured, the research assistants were instructed to follow the logical flow of conversation and deviate where necessary or relevant. Upon completion of the interview, an immediate debrief was to be conducted between the research assistant and myself before transcription and translation.

Figure 5: Interview style and key areas of investigation for the three in-depth interviews with Somali migrant FSWs

Interview	Interview Style	Overall Area of Investigation	Specific Themes
1	Semi-Structured	Basic socio-demographic details	Age, marital status, family structure, religion, education
		Migration pathway	Departure, transit and arrival in Kenya, migration status
		Entry into sex work	Experience, expectations
2	Narrative	Risk environment	Risk perception, condom usage, violence, social networks, relationships, social capital, stigma from community, experiences as a Somali FSW in Nairobi
		Identity construction	Somali culture, religion, norms and values, coping mechanisms, plans for future
3	Semi-Structured	Service access and use	Knowledge of services, accessibility, history of service use, health needs, perceptions of services, barriers, stigma from providers

7.6. Non/participant observation

Non-participant observation was planned throughout the data collection period, with myself and the research assistant to be based in the community with Umma CBO in Eastleigh. Social contact was planned to be maintained throughout data collection with myself and the research assistant spending extensive time within the community, along the lines of an ethnographic approach; however, whilst still maintaining boundaries as an external researcher and non-participant. In this context, I had not planned to interact with the target group as a service provider, nor would I be able to integrate into the environment as would be the case in an ethnographic approach, and as such the term 'non-participant observation' was envisioned. Observation is a technique often used to elicit reflective commentary on issues brought up during formal interviewing (Blanchard & Aral, 2010). In practical terms, I had planned to visit health services and other social service provider locations, social venues (tea shops), community gatherings, spend time with the migrant FSWs and also those who interact with them, observing, interacting and taking notes.

7.7. Field Notes

After every interaction with a study respondent the research assistant and myself had a debrief session to review the content of the interviews, as well as the study field notes. The field notes tool was used to record observations such as the interview setting and dynamic (e.g. mood, conversation flow, body language, etc.); reflections on the methods (e.g. topic guides, questions, probes, what worked, did not work, etc.); themes and reflections for coding and analysis (e.g. common subjects/themes, noteworthy answers, etc.); any notes for follow-up in the next interview; and finally the date and time for the next scheduled meeting. While the field notes form was

intended to be used as a form of data collection in itself, the type and style of information provided from the research assistant can be described as flat, rather than exceptionally analytic.

7.8. Institutional affiliation

IOM's investment in supporting this PhD research was primarily to complement findings of the previous IBBS survey. This support included institutional, operational, and logistical support (e.g. transport, office space, venue for data collection in Eastleigh, security support, access to Government partners, ease with local ethics review board submission, etc.). Of note, at the time IOM was not officially a UN agency (until 2015), but was part of the UN country team, and was renowned for its work with refugees and IDPs, both in urban and rural areas across Kenya. This association, therefore, brought credibility and access to Government and academic partners. At least this was the original assumption. However, as the state of security in Eastleigh changed rapidly throughout 2011, the association to IOM became more complex, and the rigorous security protocols resulted in poor access to the population itself. This complexity, and the implications for the research, will be further described later in this chapter.

7.9. Incentives

Participants were compensated 300 KES ($3.50 USD) for each interview. This incentive amount was comparative with other research studies in Nairobi at the time among the FSW population. Reimbursement or incentives are common in sex worker research in Kenya, to compensate for time spent away from other income generating activities and transportation assistance. All participants were also given information on health and social support services in the area, including health clinics with FSW tailored services.

7.10. Ethics

The research protocol was passed through the London School of Hygiene and Tropical Medicine (LSHTM) Ethics Committee as well as a local ethics committee - the Kenyatta National Hospital/University of Nairobi Ethics and Research Committee (Appendices D and E). Sex work in Kenya is illegal; therefore, an important ethical concern was around the legal ramifications for participants, as such all necessary government and ethical approvals were obtained from the Kenyan Government, including the Kenya National AIDS Control Council. At the time of developing the research protocol, sex work over the past three decades had been conducted with relatively little interference from the authorities in Kenya; however, as described later on, this changed significantly during the course of data collection. Participant confidentiality was a priority, with pseudonyms used for all participants. Additionally, all data collection forms were locked in a cabinet and data in electronic form were password protected on the computer. All respondents provided informed consent before each interview. If participants were unable to read the consent form (provided in both English and Somali) then the research assistant read and explained the consent process. Participants signed the consent form, using a pseudonym of their choosing, and if they were not able to sign then the research assistant signed on their behalf, which was the case for more than two thirds of the respondents.

All respondents were at least 18 years of age, the age of consent for sexual activity according to section 143 of the Republic of Kenya penal code (*Laws of Kenya: The Sexual Offences Act, No 3*, 2006). Referral for follow up counselling and sexual and reproductive health services for the respondents was provided to health clinics with targeted services for FSWs. Safety of myself and

the research assistant was monitored closely, with strict field protocols put in place including travel to and from Eastleigh, whilst conducting interviews and observing, and ultimately at some stage due to the security situation, I was unable to travel for many of the interviews.

The research team made every effort to be discrete in all aspects of study implementation and prioritized the confidentiality of study respondents. Relevant permissions from the National AIDS Control Council was sought to conduct the survey, with a corresponding letter of support, which the research team carried at all times.

7.11. Experience in the field and adaptation to study design

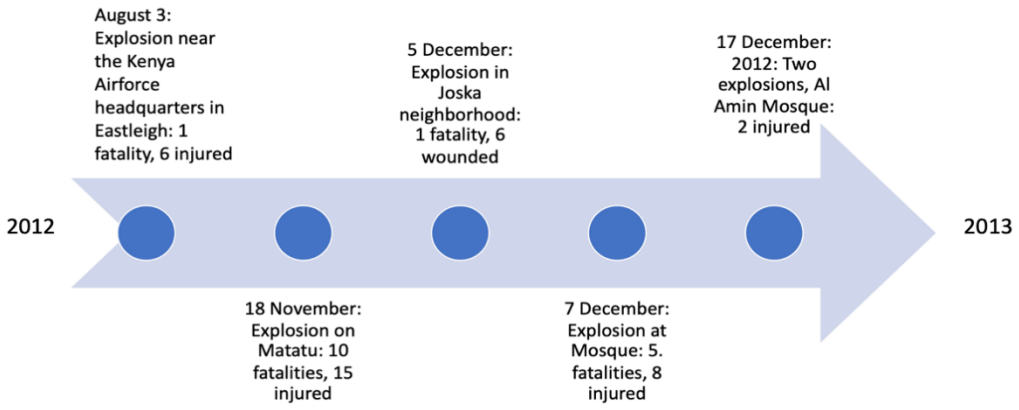
The data collection period was completely fraught with challenges due to the security shift and changes within the overall environment in Eastleigh at the time of the study. In August 2012, terrorist attacks began, followed by a period of intense insecurity in November and December 2012. These consisted of a series of roadside bombs and grenade attacks which resulted in several deaths and injuries, and therefore implementation of security restrictions meant I could no longer travel to Eastleigh.

Reports suggest that the attacks were being carried out by Al Shabaab, in retaliation for a coordinated military mission between the Somali and Kenyan Military, which started in October 2011. Operation Linda Nchi was initiated when troops from Kenya entered into South Somalia, across the border. Due to the increasing number and severity of the attacks, many developed countries issues travel advisory warnings to Kenya, and the UNDSS restricted non-essential movements to various locations, including Eastleigh.

The previously safe neighbourhood was under intense national, regional and international scrutiny, with the attacks attributed to Somalia's Al-Qaeda-linked Al Shabaab. Reports of crackdowns for Somalis across Nairobi were reported, including searches, detentions and arrests. FSWs reportedly engaged in less street-based activity, and expressed lack of availability for interviews, not feeling safe to spend time outside of their homes or places of work, unless necessary.

Figure 6 shows a timeline of terrorist attacks in Eastleigh, which is a snapshot of the insecurity happening across Kenya at the time. Notably, there were multiple attacks happening in parallel across the country in Garissa and Waji, predominantly Somali dominated towns, close to the Somali border.

Figure 6: Timeline of security events in Eastleigh, during data collection



As my research was being hosted by IOM and thus subject to United Nations Department of Safety and Security (UNDSS) regulations, this meant that I could rarely travel to Eastleigh, and when I could, I could only visit the IOM clinic, less than 10 blocks away from Umma CBO. As such, instead of the interviews taking place at the Umma CBO premises, the venue for interviews was moved to IOM's clinic in Eastleigh. This venue was not a venue where the FSWs felt as comfortable, in comparison with Umma CBO.

Furthermore, due to the new security situation, myself and the research assistant were unable to spend as much time in Eastleigh as originally intended, thus gaining the trust of the population was more difficult. For example, during the data collection period, I was not able to visit and meet face to face with the research participants more than 4 times in total. The primary research assistant was going to Eastleigh multiple times per week in the beginning, then from January we restricted her movement to Eastleigh almost entirely. These events also resulted in a general sense of mistrust and unease in the entire community of Eastleigh, and this overall environmental shift greatly affected data collection overall.

Due to the shifting security situation, one of the planned research methods was removed from the study altogether - non-participant observation, originally to be undertaken throughout the data collection period, with a research assistant and myself based in the community with Umma CBO. This type of social contact that ideally would have been maintained during data collection along the lines of an ethnographic approach, was not feasible. Information collected from non-participant observation was to be used to complement data collected through the interviews. Half of respondents were referred from the initial respondents and half from Umma CBO. Despite these aforementioned challenges, non-response rate was low, with fewer than five potential respondents who were approached refusing to participate.

Two group interviews were conducted in July and August 2012, with three participants (Fatma, Halima, and Shukri) and two participants (Amal and Muna) respectively. These methods have been termed ‘group interviews’ rather than ‘focus group discussions’ as the conversation never

reached a point where discussions amongst the participants ensued. These group interviews were an attempt to pilot an alternative data collection technique, hoping to solicit more narratives and personal life experience information, than what was being elicited during the one-to-one semi structured interviews. I was present at both group interviews, along with the primary research assistant, and the discussion was predominantly continuous with only a few short breaks for discussion between myself and the research assistant. This method was also intended as a coaching experience for the research assistant, in an attempt to support in improving her probing and facilitation skills, to improve the quality of the data being collected. Unfortunately, after the two group interviews in the summer of 2012, the security situation began to deteriorate and therefore gathering the women in larger groups was difficult and travelling to Eastleigh for further individual or group interviews was not feasible.

Towards the end of data collection, it became clear that the data lacked depth in many of the key thematic areas under research, and the security situation still would not allow for me travel to Eastleigh. There were attempts made to try to undertake remote video interviews by Skype, where the research assistant would be present, and I would join remotely. In the end, none of the participants felt comfortable with this approach, worried about their identity, privacy, use of the video – even when it was explained that nothing was being recorded. There is evidence that even carrying a notebook and paper can make Somalis uncomfortable in a research setting, therefore the unsuccessful attempt to implement this method was not surprising (Rift Valley Institute, 2016). Furthermore, consistent internet connection was a persistent challenge in Eastleigh, and ultimately the time available to undertake the research was ending.

In summary, 15 Somali FSWs were interviewed two to four times each between May 2012 and January 2013, for a total of 50 interviews, and two group interviews were undertaken.

7.12. Data Management and Analysis

Audio recorded interviews were transcribed first into Somali, and then translated by a second research assistant. The data was then imported into a qualitative data analysis software (NVIVO 10). Data transcripts were analysed continuously throughout data collection to identify emerging themes for exploration in follow-up interviews. Transcripts were read multiple times and analysis was firstly undertaken as individual case studies, looking at all interviews by the same respondent holistically, and then secondly coded using content and thematic analysis (Patton, 2002; Silverman, 2004). At the time of writing, data was anonymized, and names replaced with pseudonyms. Key nodes and sub nodes used in coding are included in Figure 7.

Figure 7: Key nodes and sub-nodes exported from NVivo

Node	**Sub-Nodes**
Challenges	Clients Police Sexual assault Suffering Condom usage Violence Stigma/Discrimination
Demographic details	Income Migration status Children Current age Education Marital status Religion
Nairobi context	Accommodation Other financial means Time in Nairobi
Departure from Somalia/Travel/Transit	Age at departure

	Challenges en route Means of transport Reasons for leaving Somalia Route Time in transit Travel companions Refugee camp
Health and Healthcare	Access Experiences Private and Public Costs Importance HIV and STIs Infectious Diseases General Ill-Health
Sex work characteristics	Entry into sex work Meet clients Volume of clients Location where engage in sex with clients Client profile Amount of money
Support/Networks	Family Friends Other FSWs Disclosure
Expectations	Future Of life in Nairobi Marriage
Identity and Coping	External locus of control God Hopelessness

Data transcription and translation took a considerable amount of time; however, the research team endeavoured to have the full translated transcripts before scheduling the next interview, in order for clarification to be sought around previous data, if necessary. When asked to clarify previously collected data around age, date and journey of entry in Kenya and narratives around experiences accessing healthcare, information was still not always clear, after further probing. Stories around experiences with clients, police and aspects of sex work were able to be recounted in meticulous detail; however demographic details were far more difficult to clarify.

PART D: RESULTS, DISCUSSION AND CONCLUSION

8. Results

8.1. Introduction to the results

The results chapters focus on sex workers' perceptions of their lives and work, the risks they face and the range of experiences that define and affect FSW identity. Sections are broken down into various experiences including perceived and actual social networks and support, practices of routine discrimination and violence, and experiences of health services and health seeking behaviour. The intersection of identity, as from the perspective of being a migrant/refugee, a Somali/Muslim and a sex worker is reflected throughout all three results chapters – including frequent references to religion and Alla's will, an external locus of control, and hopelessness regarding the future as a result of their current life circumstances.

In the first results chapter, perceived lack of social support and dynamics around social networks affect FSW identity, which in turns affects both perceived and experienced discrimination and access to and uptake of services. Conflicting sentiments towards their community are present across the data, with stark contrasts where persons are not considered friends, despite showing physical, emotional and monetary support when needed – this contrast may potentially be linked to the concept of community from the traditional Somali perspective, typically linked through clan lineage. Furthermore, in this chapter on social networks, there is critical reflection on how invisible and unacknowledged networks of support were interrogated through the literature around collective action, community empowerment and resulting health outcomes.

In the second results chapter, the focus is on describing how FSWs experience violence in all aspects of their lives - during the conflict in Somalia, as FSWs (from clients), from police, and in intimate relationships, but also various forms of hostility and assault. Violence is instigated and perpetuated because of their position as irregular migrants, rejection from their own Somali community and the Kenyan community and resulting enacted and perceived stigma and discrimination.

The third and final results chapter focuses on FSW perception of health and health seeking behaviour. FSWs sense of health needs is a combination of traditional beliefs, practices and what they are accustomed to receiving in terms of care mediated through their sense of health problems confronted as sex workers, as well as barriers experienced as undocumented migrants. The FSWs are coming to terms with how services are provided and so are reflecting the relative unimportance in their lives for STI, HIV, testing, examinations, etc. despite the awareness and knowledge around sexual health risks being present.

Using Rhodes' concept of 'risk environments', while also drawing on the frameworks of Soskkolne and Shtarkshall, looking at individual, community, structural and socio-cultural levels of influence, there are real and perceived barriers to health service access and how these intersect with presence or lack thereof, of social networks/support and discrimination/violence.

8.2. Summary of research participants

In total, 15 Somali FSW were interviewed two to four times each between May 2012 and January 2013, for a total of 50 interviews. All participants included in the research had similar demographic

profiles in terms of age, marital status and religion. Information was also asked around the context of their departure from Somalia. All respondents reported forced departure from their homes in Somalia and various degrees of trauma and challenges upon fleeing, during transit and upon arrival in Kenya. This chapter summarizes demographic details and basic details of their stories. Pseudonyms are used throughout and kept consistent between chapters. A summary of the demographic characteristics is provided in Figure 8.

Figure 8: Demographic details of study respondents

#	Pseudonym	# Interviews	Marital Status	Age	Education	Religion	Children
1	Fatma	4	Never married	27	Never attended	Muslim	2
2	Halima	4	Widowed	22	Never attended	Muslim	2
3	Shukri	4	Widowed	27	Never attended	Muslim	3
4	Ayan	4 (over 3 times)	Separated	25	Somali classes up to 5th	Muslim	3
5	Hodan	4 (over 3 times)	Never married	22	Only Islamic school	Muslim	2
6	Amal	4 (over 3 times)	Separated	46	Never attended	Muslim	2
7	Amina	1	Divorced	22	Data not available	Muslim	1
8	Fardows	1	Divorced	27	Data not available	Muslim	1
9	Muna	3 (over 2 times)	Widow	30	Data not available	Muslim	3
11	Maryan	3 (over 2 times)	Mentions boyfriend	25	Data not available	Muslim	1
12	Nawal	4 (over 3 times)	Never married	25	Some schooling (non-Islamic)	Muslim	6 (3 adopted)

13	Rahma	3 (over 2 times)	Never married	27	Data not available	Muslim	4
14	Sagal	4 (over 3 times)	Divorced	25	Data not available	Muslim	1 (deceased)
15	Sarah	3 (over 2 times)	Data not available				
16	Zeinab	4 (over 3 times)	Never married	27	Yes, Somali school		0

8.3. Demographic details

All respondents were between the ages of 22 and 46 at the time of the first interview. Although the oldest respondent did not know her birth year, given details of her story, myself and the research assistant estimated that she was around 46 years of age. Similarly, in Somali culture, birthday and knowing one's age is not as precise as in some Western cultures, and therefore ages are as self-reported or deduced based on stories, and therefore approximate. Most of the women in the sample were currently unmarried, either having never married (n=5), been separated/divorced (n=5), or been widowed (n=3). No respondents reported leaving their husbands, all reported their husbands either died or left them. One respondent had a partner and data on marital status were not available for one respondent. Most had never attended school, and those who had predominantly attended Islamic school providing religious education, only up to 5th level primary, in Somalia, before they left. None of the respondents mentioned any schooling beyond primary school. All respondents self-reported Muslim as their religion.

8.4. Context around departure

Most respondents described their departure from Somalia in factual terms, stating conflict, insecurity or death of a loved one for catalysing departure. For example, at the age of 12, Fatma fled Somalia with her sister after her parents died. Halima was 18 when her husband was killed

by a rocket, she had two children at the time when they left their home. Similarly, Shukri, with three children also lost her husband, and therefore fled for Kenya. Other respondents came at a younger age with their parents, such as Amina, aged 22, who travelled with her parents via donkey carts to reach Kenya. The duration of time in Kenya varies across the respondents, some had been in Kenya for nearly twenty years, while others had only left Somalia a couple of years previously.

8.5. Entry into and context of sex work

The common theme across all respondents, in terms of entry into sex work, was the need for exchanging sex for food, safe passage, accommodation or money – in summary, for survival. Many respondents started selling sex upon arrival in Nairobi after difficulty surviving in the refugee camps, they made their way to Nairobi in search for better conditions.

Rahma, first interview: When I came to Nairobi, I met a lot of problems. If I asked people to please give me somewhere to sleep, they would tell me tomorrow, I will help you find somewhere to sleep. As I was that way, a bad way, one day I met some women who told me, sister, we were like you but now we do this kind of work so stay with us, be the way we are. They said no woman will sleep with us while we struggle to sell our body, so it's better you join our business so that you survive. That is how I started trading my body.

Muna, aged 30, recounts starting to sell sex after being widowed, and then accidentally getting pregnant [through a consensual relationship] and being unable to support her children.

Muna, first interview: I started this job the moment I came to Nairobi, I never sold my body while I was living in Somalia, I was married then my husband was killed. I sold my body that first time… because of lack of money, no one helps you, more problems and hunger. I started when I heard some other people saying that they make money from this business, they were Ethiopians. So I told them to take me with them, so I followed them…that is how I started selling.

Others, such as Ayan, aged 25, and Hodan, aged 22, were sexually assaulted en route to Kenya, and started selling sex after the incident. In fact, multiple respondents entered sex work after a sexual assault. In the below quote, Fatma is referring to a Somali expression. When she says "Wall of sheets", she means why should you sleep on an empty stomach when you can work and earn money to feed yourself and your family.

Fatma, first interview: I joined after I was raped, there was no future marriage or other opportunities in life. Nobody would give me a job, nor did I have a brother to support me or relatives. Whenever you would look for a job, you would be told must have a Kenyan ID or you must have UN identification. Whatever we have was a card for ration only. This is the course of our problem. I started [sex work] with one person. I was directed by a lady who knew the job, she saw me in a very difficult situation and asked me to go with her. Why should you sleep under wall of sheets?

Amal, at aged 46, the oldest respondent, sold sex in order to be able to afford the journey from Somalia, back in 1993. She left Somalia after her brothers were killed, she travelled through Ethiopia, and the only way to survive the journey was to sell sex during transit.

9. Social support and networks

9.1. Introduction

In this section, I examine the way in which Somali migrant FSWs perceived and experienced different forms of social support, and how it affects their risk environment, health and well-being. Despite potentially different interpretations or definitions of social support, respondents described different types of social networks, including those based on being sex workers, neighbours, Somali and Muslim. They received support from these individuals as well as from outside sources (e.g. NGOs). I have categorised social support across four key categories: emotional, instrumental, financial and informational, see **Figure 9** (Glanz, K., Rimer, B. K., & Viswanath, 2008; Rausa B.A., 2008).

Figure 9: Types of social support

Type of Social Support	Definition
Emotional Support	Refers to showing empathy, compassion and genuine concern for others, through discussions, openly sharing and conversing.
Instrumental Support	Involves assistance received from others that is tangible, and that is comprised of the things that others physically do or provide in order to assist you (e.g. looking after one's children, offering a place to stay, etc.)
Financial Support	Any form of financial or monetary support, (e.g. when FSWs provided funds for food and housing for their peers.)
Informational Support	Provision of information, which in the context of FSWs may include

	information on clients (e.g. client to avoid due to violence or not paying), potential threats (e.g. round ups by the police).

9.2. Interpretation of Support

Topic Guide B, implemented in the second interview with research participants included one section on social support, networks and relationships. The first and primary question was "***What kind of social support do you have in your life***?" and secondly, "***Can you tell me more about your relationship with each person*?".** The research assistant then prompted by asking about family, friends, and other FSWs; people in Nairobi, in other parts of Kenya, in Somalia; the type of support they provide (emotional, financial, etc.), social organizations and finally whether these people know about the respondent's involvement in sex work." Despite the focus of the second interview being very focused on social support and networks, aspects of this construct came up across all interviews when asked about other aspects of their lives, therefore data in this chapter encompasses responses from the holistic dataset, and not simply just the second interview.

While most of the respondents verbally stated that they do not receive support from anyone, when the conversations progressed it becomes clear that acts of social support for and between Somali FSWs do exist, but that Somali FSWs do not necessarily see these acts as support. A common theme that emerged from the research is that unless there is a monetary component (e.g. giving someone money), it is not seen as provision of care or support.

Shukri, second interview: No, there is nobody I get support from. I have not seen any person living in Nairobi or Kenyan who assisted me. (The other side, in Somalia)…They are just the same no difference.

However, further on in the interview, Shukri goes on to describe how friends have supported through non-financial means.

Shukri, second interview: No, they don't give me money but they buy food for my children when they are hungry.

Some cases of monetary sustenance are described, such as paying each other's rent and sharing earnings when someone has a 'bad day'. The most common cases of non-monetary support appear to be watching each other's children, assisting when sick or a hospital visit is required and provision of accommodation, particularly upon first arrival in Kenya. For example, Maryan states that when she arrived in Kenya no one helped her, but then goes on to describe how she stayed with a girl when she first arrived. Further on, it becomes apparent that Maryam's concept of support is predominantly focused on blood relations, specifically those who are not family are unlikely to care for you in the same way as a parent, reinforcing the cultural importance for Somalis of family lineage, and a clan-based system.

Maryan, first interview: After arrival in Kenya...I met my people (other Somalis), and they chased me away, I slept many nights in hotels. We are not having good relationships with my people. They fight with me and shout at me. A human being who is not your biological parent will not love you, am I right? My parents are in Somalia, I don't know if they alive or not. When I first came here, I lived with a girl. She lived on eighth street. I lived with her for many months but later we fought, and I left her. We are not related; it is out of friendship that she helped me.

It also appeared that feelings of being alone and isolated were both pervasive and associated with low self-esteem, fatalism and internalized stigma that reflect their self-perception as underserving of support. For example, Zeinab (27) who arrived in Kenya a few years back, and is one of the few who described having engaged in sex work in Somalia, responded with the following when asked if she received any support from family or friends:

Zeinab, first interview: There is no family who want a lady who is a sex worker. None of my family want me…They don't want people like us…Yes, they dismissed us, and they don't want us…There is nobody who wants us.

Similarly, Halima describes herself as a solitary individual referring to herself as a "*loner*" and Hodan indicates she has few friends because she does not "*like to socialize.*" These '*sister like'* individuals are referred to as support, but again not in relation to financial support. In the quote below, Halima differentiates between 'real friends' and friends defined by the context and new environment.

Halima, second interview: I have no friends and generally I am a loner, but normally I visit these two ladies for company and chat while treating them like sisters…They help me a lot, when I don't have money they do support me they pay the rent, they do shopping for my children and they do many things for me. And when I get the money, I pay them back. They support me when I am unwell like when I am sick, so they support me because they fellow Somali sisters.

Throughout the interviews, within the research team meetings and field notes compiled from the research assistant, the negative self-perceptions exhibited by migrant FSWs were a common theme, not just in relation to their work in transactional sex, but also as per their migration status, not having proper documentation, not being Kenyan and not '*belonging*'. Furthermore, most participants, when asked directly, indicated they had no source of social support but then went on to describe various types of emotional, financial, informational and other instances from friends, other FSWs and neighbours.

The most frequently mentioned form of social support for Somali FSWs was other FSWs. Most respondents mentioned other FSWs as a source of support in terms of instrumental, financial and informational support, such as looking after children, places to stay upon arrival in Kenya, initiation information into the field of sex work and sharing of sex trade and client information. When recounting a story about a client who asked her to spend the night in a lodge and then left without paying, Muna recounts how she will confide in a fellow Somali FSW, but not just any Somali.

Muna, second interview: I didn't tell anybody, I will get problem. I told a Somali girl who pass in the town, she gave me hundred shillings and I made it fare and that saved me not to foot. I didn't tell anybody else. Somalis will not help you its better you keep quiet.

Research assistant: What about your friends?

Muna: I and my friends do share problems. Female sex workers do share every single problem they come across, if they are beaten, raped, if you are excited or sad, we do tell things each other.

Sagal, first interview: We know each other, if we see our neighbour who cannot pay for the rent, we do help each other.

Sagal, fourth interview: In our female sex colleague workers we share everything, even where we were the other night, the type of men we were with, and the amount of money we got from them and if there were some challenges.

Fatma, second interview: They *{other FSW}* support me by giving advice on the business, they ask that man to pay this much or go to that place the business is good there. That is what they tell me. I take their advice or sometimes they lead me there…The day I don't make any income and they are better off they give me some cash.

Sagal also mentioned that a fellow FSW accompanied her to the hospital, Sarah and Halima both indicated that other FSWs introduced them to condoms, and Nawal specifically mentions other FSWs looking after her children. Notably, however, the word '*friend*' was infrequently used, rather referring to people in their lives as "*other*

FSWs", "*Somali sisters*", or "*neighbours*". While Ayan and Fardows both mentioned knowing other FSWs, they mentioned not being close, and not "*relating*". Fatma in particular described how she interacts with Somali FSWs, but not Kenyan FSWs, making the distinction around having legal paperwork to reside in Kenya.

Research assistant: Do you befriend the Kenyan girls who are commercial sex workers regardless of whether they are Somali or not?

Fatma, fourth interview: No, we don't mix up with them…those people have national identity cards while we don't have…we don't even have something to prove that we are refugees.

However, the dynamic amongst the Somali and Kenyan FSWs is unique, with aspects of support and competition simultaneously. When asked if they work together, Halima stated that everyone is on their own when it comes to work, a sentiment supported by other participants as well. Muna reported that the Kenyan FSWs sometimes report them to the police and goes even further to state there are aspects of jealousy.

Rahma, first interview: No, no prostitutes don't support each other. It's because of selfishness and being mean.

Research assistant: These women (referring to the Kenyan FSWs) you claim to be jealous of you, why do you think they are jealous?

Muna, first interview: We are more beautiful and cleaner than them.

Similarly, when asked if they can share experiences or problems with other FSWs, not everyone has the same view, with the below quote illustrating aspects of competition.

Amina, first interview: We don't talk about such things, when the sun sets everybody go on her own.

Sagal mentioned that a client assisted her to go to the hospital and paid for her health services on that one occasion, and Hodan mentioned clients as someone who could potentially share her feelings and worries with (e.g. emotional support); however, these two were the only instances of respondents mentioning clients as a source of support. While mention of any support from men was rare, Fatma did reference an act of protection from a male neighbour[1] while she was being sexually assaulted.

Halima, fourth interview: I had left home for a club to get drunk. I was raped when I came out of the club, while I was a drunkard … they were not people that I know … God saved me, they were three men, they came on top of me, after which I screamed and some man in the neighbourhood came to my rescue and saved me from them. They were just unknown men to me who wanted to take advantage of my drunkenness.

None of the respondents indicated that they received any support from their families, monetary or otherwise, despite the fact that in Somali culture the connection of the family and clan base system is typically crucial (Koshen, 2013). The disconnection of these women from these standard support structures, in most cases, appears to be as a

[1] It was not clear whether this support was from a strange or someone known to her, the use of the term 'neighbour' was unclear, but my assumption was that it was someone known.

result of their engagement in sex work; while can also be caused by separation due to death, war, moving and losing touch. Some are not sure if their families are still alive in Somalia (Maryan), others are certain their parent passed away before they left (Zeinab), others lost track of siblings en route to Kenya (Fatma) or upon arrival in Kenya (Rahma). Rahma did have one relative in Kenya, who later returned to Somalia. Some have family still in refugee camps (Sarah). Others call women their "*sisters*", but they are generally referring to "*Somali sisters*" and not biological siblings (Zeinab and Halima).

Others say that due to the nature of their work, their families will not support them (Halima), despite the fact that they have some wealth. When the RA asked if Halima's family supports her, Halima responded as follows.

Halima, second interview: My family don't allow me to do this kind of work. There is nothing they give me. They don't support me, and they don't want me to work. They are rich people; they can afford to give me ten thousand shilling to start small business. I don't know why they don't want to give me, they refused to give me. Is it because of the kind of the work I do or because of my children since we came from different clan, I don't understand for sure.

The second most commonly mentioned type of support for Somali FSWs is from neighbours, including caretakers at the lodges (a mix of Kenyans and Somalis) where they live. Specifically, cases of neighbourly support were mentioned by Halima,

Shukri, Amal, Nawal and Rahma, with most respondents mentioning leaving their children with neighbours.

All respondents were asked if they have received any support from organizations in Nairobi, and the only organization mentioned was Umma CBO (where much of the data collection took place). Halima mentioned support when she was in Kakuma, the refugee camp in Northern Kenya, that the UN provided shelter in the form of bricks and an iron sheet.

Oftentimes respondents mentioned "*Muslim brothers and sisters*" or "*Somali persons*" showing ties within the Somali, and Muslim communities, both in Somalia prior to departure and upon arrival in Kenya. When Muna was asked about her journey to Kenya, how she could afford the travel and with whom she travelled, her responses often referenced this phenomenon of Somalis helping Somalis. Similarly, Shukri mentions a "*clan mate*" who helped her to pay the bill for the lodge when she first arrived in Nairobi, and Maryan said "*A Somali lady*" is looking after her children when she is working. These references are commonplace throughout the discussions, where assistance and support are based on this religious, cultural and clan-based system within which Somalis operate.

Research Assistant: How were you related with these people who paid your fare?

Muna, first interview: We are not related in anyway, but they Muslim brothers and sisters who just did us a favour…Some people who were our neighbours paid for us.

Maryan, first interview: There is a lady who is taking care of my child…she is helping me because she is a Muslim lady. She is doing this because I am Muslim lady…Yes, she is aware of what I do for she also does the same business…the children don't know… I leave the children in the house.

9.3. Summary

When directly asked, the women interpreted social support to be about financial support but examples of other forms of support emerged throughout interviews, such as emotional, instrumental and informational. As respondents are so fixated on daily survival, when asked about *"support*" they immediately think about financial support almost exclusively. This could be the result of different understandings of social support due to lived and perceived experiences, different priorities and could also be impacted by the NGO/aid culture across Nairobi and engagement with researchers and those present to provide services.[2]

While reported and perceived social support is nil (e.g. many indicate that they do not receive support from anyone but then they provide specific cases where individuals are helping them in various ways); actual support received does exist when asked more in depth about aspects of their lives. For example, support with childcare, translation when needed, sharing key information about sex work (e.g. clients, venues, etc.) and visiting health services in groups. Particularly, it is worth exploring whether it is

[2] Reference to aid/NGO culture in Nairobi, and how this potentially impacted the research, is explored further in the methodological and limitations section of this thesis.

perceived or received support that is likely to help FSWs improve their health and circumstances, as shown in the literature globally that social networks can support with health education and positive health seeking behaviour. Furthermore, while there is mention of Somali sisterhood and the clan-based support system across the research, including in the questions around social support and networks, the disgrace and shame of being a sex worker appears to have trumped the ties of being Somali. As such, most of the support received is from their FSW peers. Figure 10 provides a summary of self-reported social support by migrant FSWs in Nairobi.

Figure 10: Summary of Social Support reported by migrant FSWs in Nairobi

Type of Support	From whom	Details
Emotional	**Somali FSW**	Never expressly stated with the exception of Muna who indicated they '*tell each other everything'*, otherwise through engagement, observations and interpretation of the data, it is understood that peer Somali FSWs do support each other emotionally; albeit without using this terminology. Furthermore, some respondents mentioned going for HIV testing as a group, thereby potentially illustrating some level of emotional support.
Financial	**Somali FSW**	Provision of funds if FSW encounters a 'bad day' (i.e., no remuneration and cannot pay rent), or when funds needed for health services
Instrumental	**Somali FSW**	Accommodation upon arrival in Kenya; support looking after kids when working or sick, translation when needed
Informational	**Somali FSW**	Knowledge around entering sex work, where to find clients, problematic clients, health and HIV information
Instrumental	**Friends (non FSW) and neighbours**	Accommodation upon arrival in Kenya; support looking after kids when working

Instrumental/financial	**Clients**	Accompaniment or provision of funds for health service
Informational	**Organizations**	Umma CBO: Health and HIV information
Instrumental	**Organizations**	UN: Shelter and food in Kakuma refugee camp
Absence of support - Competition	**Kenyan FSW**	Kenyan FSW considered the competition, no mutual support provided
Absence of Support	**Family**	While respondents allude to the importance of family and clan-based culture, none were receiving support from family at the time of the research

Most of the respondents did not have support networks outside of the community in Eastleigh, due to the direct or indirect results of war (e.g., death, forced displacement, migration and losing touch), or through stigmatization from family due to their engagement in sex work, and as a result there has been no contact or support. Multiple respondents mentioned their work was going against Allah's will, thereby bringing in their religion as a rationale for their families to have ostracized them, laying the blame on themselves. Competition exists amongst FSWs in general, including between Kenyan and Somali FSWs; however, Somali FSW nonetheless support each other in times of need. There was minimal reference to organizations/institutional support, outside of refugee camps, aside from Umma CBO where the research took place[3].

FSW perceptions, interpretations, and the negative "lens" through which they observe their own experiences resulting in a negative self-worth could be linked to their interpretation of minimal support, and ultimately the resulting ecosystem of minimal

[3] The bias of research participants recruited through Umma CBO is noted and is explored further in the limitation section.

social support, thus impacting access to information, knowledge and access to health and social support services. This aligns with the literature which documents that social dynamics, in particular social support, plays an important role in overall health and wellbeing across those who are unemployed, the elderly, students, and migrants (Ghasemipoor M, 2010; Fasihi Harandi, Mohammad Taghinasab and Dehghan Nayeri, 2017; Salami B, Yaskina M, Hegadoren K, Diaz E, Meherali S, 2017; Brydsten A, Hammarström A, 2018; KM *et al.*, 2018). Harandi et al (2017) recently undertook a meta-analysis of 64 studies in Iran looking at mental health and social support, and found that overall there is a high correlation between social support and better mental health outcomes. Specifically, positive social interactions and dynamics with family and friends can reduce anxiety and support with development of feelings of security. Those with stronger social interactions and more social support had better communication skills, which was a mitigating factor for depression and other mental conditions.

The evidence is similar amongst sex worker communities, where community empowerment and collective action are shown to have a correlation with better health outcomes. Multiple studies from India have resulted in a growing amount of literature supporting community empowerment as a best practice in addressing the health and human rights of sex workers, including decreased odds of STIs, including HIV (Halli *et al.*, 2007; Swendeman *et al.*, 2009) and these studies have informed global guidance issued by the United National Joint Program on HIV and AIDS (UNAIDS) and the World Health Organization (WHO). In the context of invisible and unacknowledged

networks of support, if the FSW does not acknowledge that this support exists, not only might they be unable to capitalize on the individual benefits of knowledge, learning, sharing of strategies and occupational information around dangers and mitigation measures, they would then likely also not be able to capitalize on the potential aspects of collective action of the community empowerment that may provide some additional amount of resilience.

Furthermore, a key question for further reflection is, if people receive support but do not perceive it to be support, can they still benefit from its positive effects? Low self-esteem and sense of worthlessness appears to feed into how the FSWs perceive support they receive, minimizing the help they receive because they are not expecting to be worthy of any support. They have internalised their own stigma and tend to have low self-esteem and a fatalistic attitude to life (i.e., hopelessness), and as a result do not necessarily even recognise examples of support or assistance that they do receive. Moreover, seeing themselves as loners and not believing they deserve much, further weakens the potential to build strong supportive networks. Their inability to perceive these social bonds as such likely prohibits the potential for positive benefits, both perceived and actual. It is possible these sentiments of preferring to be alone are the result of shame around their work as sex workers, resulting in low self-worth. However, it may also be that between working, caring for their children, and the daily battle to survive, they have little time for anything that is not providing sustenance for their family and keeping safe. Nevertheless, stories were recounted of women visiting each other, sharing challenges, and seeking and providing advice and support – and

yet this social support did not translate into any expressed examples collective action or community empowerment, which is documented to lead to better health outcomes.

Similarly, this sense of worthlessness (e.g., thinking they are worthless, not good enough for anything, worse off than Kenyans, not belonging, etc.) combined with an external locus of control reviewed in other chapters, may result in reaching out less to support that is out there (e.g., friends, other FSWs, etc.), as well as organizational support (the little that exists). Overall, contrary to their narratives, there are indeed supportive architecture that could be harnessed for the kinds of benefits seen in the literature.

10. Violence, stigma and discrimination

10.1. Introduction

Violence has been identified as a significant risk factor for multiple adverse physical, mental and sexual health outcomes (Bonomi *et al.*, 2007; Breiding, Black and Ryan, 2008). Sex workers report experiencing high rates of violence in diverse contexts (Deering *et al.*, 2014), which appears to be correlated with policing practices (e.g. enforcement criminalized laws), economic pressure, gender inequality and stigmatization of sex work. Furthermore, evidence shows that violence hinders health seeking behaviour and reporting of STI symptoms (Prakash *et al.*, 2016). One of the few studies to specifically explore migrant FSWs in Kenya is the previously mentioned IBBS survey undertaken in 2010, which showed more than a quarter (28.7%) of migrant FSWs had experienced forced sex in the last 12 months (Kriitmaa, 2011), ten percent of whom were Somali.

In this chapter, I consider how violence contributes to the experience of Somali FSWs in Kenya, specifically as it may lead to their health risks. I apply the concept of "risk environments" to do so, focusing on the structural and environmental factors of criminalization and violence, as well as the protective and mitigating factor of social networks, as described in the previous chapter. I found that violence played a central role in the everyday environment of FSWs in Nairobi, and thus is hindering migrant FSWs physical and mental health, sense of safety and trust in the community, while also contributing to a sense of hopelessness for their future, which ultimately reduces

their health seeking behaviour – as their poor self-worth results in minimal importance on their health and wellbeing.

10.2. Physical Assault

Various types of physical assault were described by respondents. One of the respondents, Nawal, described an instance in which a client attacked her with a knife, and she feared for her life. When asked in her second interview what the main challenge for Somali FSWs is in Nairobi, she specifically stated beatings. The following excerpt was recounted when the research assistant asked if she encounters any challenges in her current profession as a sex worker.

Nawal, first interview: There was a man who wanted to kill me he took me to his house…He broke [me], he hit, hit me, I was admitted in ward where people who have fractures are admitted. …he had a knife. In the morning I ran to hospital bleeding…I was helped by white woman; God send them to me… I show you right now the way he cut; you will be shocked.

A frequent theme across the stories of violence reported by participants is disputes over payment which often leads to violence. The stories ranged from clients' refusing to pay the pre-negotiated rate or refusing to pay at all, as illustrated in the below excerpts from interviews. These stories were provided when respondents were asked about challenges in their life in their first interview, and subsequently in their second interview about any health challenges.

Shukri, second interview: He will kiss you and later when he finishes with you, he will jump out of the deal or he can even beat you up, you can meet with all kind of things…There was one time I had negotiated with a man so he did not take away whatever we have agreed on but he wanted me to give him extra time, to stay with him until morning…so I told him I have children, I want to leave…he asked me to sleep with him one more time and I accepted. So, he refused to release [me] even after that, so he told me you are going nowhere we exchange a few words and he punched me, don't you see my lips? Look at how I broke my teeth.

Ayan, first interview: I was hit on the teeth…we couldn't agree on the fee…the guy was drunk…he hit me with blows. I didn't do anything to the guy, it was late in the night when it happened…and I didn't have any money…I didn't see him again, I only saw him once

Amal, first interview: We agree on a certain amount, you know people are different and they have different character, some will pay cash, and some say we will pay you after we sleep with, and they can deny, so these men we can't do anything, can we fight them? We run for our life; we leave them without even a coin.

Nawal, first interview: Even at times men sleep with us and later they tell you I don't have money… I felt shy I could not ask him in the street…He slapped me and beat me…I didn't do anything to him I felt shy to fight him because I feared the crowd of people.

Other stories showed the normalization of violence, not just around negotiation for payment, but also stigma and shame around the violence they experienced. Furthermore, while the above chronicles situations all linked to violence with clients, cases of violence from the community are also narrated. In the first FGD, a discussion around violence from other Somalis in the community was raised.

Group Interview 1, RA translating simultaneously: She said that the people who throw the stones are Somalis because they know the work they do, like yesterday she was in the club, and she was wearing some mini skirt…so some men followed her - some Somali men - chased her. That is why she fell down, so she was chased even yesterday. She didn't do any work today; she doesn't have enough money.

Hodan, first interview: A lot of problems, sometimes you are beaten when you are just walking in the street, sometimes are forced and not given money, I encountered many things sometimes they take away the little I have worked for, and I come home empty handed.

Reports of weapons, such as guns, in addition to knives referenced above, were also mentioned.

Amal, second interview: The biggest problem that is facing the Somali female sex workers happens almost every night…you meet men armed with guns…and when you

agree and go to a place, sometimes they are drunk men…the one that picked you up is the one that robs you sometimes, beats you up and leave out in the cold.[4]

10.3. Sexual Assault

Nearly half of participants (n=6) spontaneously mentioned being sexually assaulted, four participants recounted stories of individual or gang rape by clients, others described sexual assault before entry into sex work in Somalia or in transit to Kenya, described in a previous chapter describing the study sample. In addition to recounting specific personal examples, respondents often referred to rape in a nonchalant and casual way, considering it commonplace.

Hodan, second interview: Somalis encounter big problems because this country is not theirs. They are being humiliated and raped.

Research Assistant: You told me ladies are always raped, is it something that happens often?

Ayan, fourth interview: My sister it is always.

Research Assistant: And who are these people who raped you?

Fatma, third interview: Different people I cannot differentiate them.

[4] In this scenario it is unclear where the respondents is referring to clients, potential clients, or rather unknown men from the street.

Two respondents recounted stories of attempted and successful acts of rape by multiple persons, that appear to have been premeditated and organized.

Halima, second interview: There is a time that I agreed with a client who was black…after we have agreed with the black man, he booked a lodge…he told me this five thousand[5] I will give you…these four men and me being the fifth. We want to use you. I told him I can't have sex with five black men. I want you guys to stop this and take your money, and they reached a stage to force me. They took their money. I felt pain and I became sick … I was brought to my house, I stayed for weeks…I could not cook food for my children for a week and I could not pay the rent of the house.

Amal, second interview: I can tell you one night I met a man, he told me he likes me, he will take me with him tonight…I told him how much I wanted…I told him my problems…I told him that I have a small kids, that I left them in the house alone and this is the time I am supposed to go home so my kids will go to school on time. He told me, ok let's go then, when we get there, we met three other men…he was alone and he called his friends, even though I have been telling him about myself. I escaped without my shoes.

RA: He didn't chase you? No, I told them I will go to the toilet and left my handbag and shoes with them.

[5] 5,000 Kenyan Shillings would be equivalent to approximately 62.50 USD (exchange of .80)

Another form of reported sexual violence was forced anal sex. Respondents alluded to the commonplace practice that Muslims typically do not engage in anal sex due to beliefs it is against the teachings of the Quran, but it is sometimes forced, as illustrated below.

Fatma, first interview: One of the experience I always remember is I met a man and we agreed and he took me to a lodge…then he said he wished to have [sex] through the anus…I told him he can't have it for my religion doesn't allow or forbids…he said your religion doesn't say but still I wish have the anus allow, but I don't care I will use force on you…and he tried to rape me…and he tried to penetrate me through the anus and I shouted…the security at the hotel rushed in…and it's them who saved me.

Amal, third interview: There was a man who admired me…for example a girl's body…have many places…there is the mouth, the front side and the back side…the man was a Pakistani…Christian…he wanted to give me good money for about ten thousand…the man grapples with me and I could not defeat him…he wanted the anus…he told me I won't, leave! so I broke the windows…when I broke the windows many people who were there came to us…they heard us they broke the door and came to us…so some people gave him two thousand and I was rescued.

Finally, sexual intercourse with military or law enforcement personnel was also mentioned, and in the context of such a differential power dynamic, is an abuse of power and sexual exploitation.

RA: You told me here in Kenya you move up and down and Kenyan soldiers don't ask for document, what is the reason? Do you give them money or are they not interested with you?

Ayan, fourth interview: We give money to them sometimes and other times we sleep with them, sometimes they give us money.

RA: So you sleep with them?

Ayan, fourth interview: Yes, there was a day I was coming from Dadaab. I didn't have UN card or any legal document. I was very young, beautiful girl with all the freedom. If you are beautiful and in sex work, you should be clean, smart and hardworking because there are other beautiful girls who will overtake if you are not serious. No one will look at you. I don't know what he is, but I can see he is a black man. The car stopped at remote area. When they stopped us, they asked for legal document and where we are going because we were many people. We were told refugees should go to refugee camp and settle there. He was a young handsome, good-looking man and me I didn't have any document

RA: Is that the reason you slept with him?

Ayan, fourth interview: That is the reason I slept with him.

10.4. Drugging

Descriptions of respondents being administered drugs, without their knowledge, were mentioned by two different respondents, in the context of clients administering drugs

to either take advantage of the FSW through not paying or engaging in additional sex acts against their knowledge.

Nawal, third interview: So, in this business, some would even kill you after they drug you…some will even spike the tea or soda you are drinking.

Halima, second interview: I had negotiated with a man and we come his place he paid me two thousand shillings he asked me to stay in his house for he would go and buy some food, he came back with other men and the drinks and I drunk, and had some food only to lose consciousness and fall on the bed. Once I fell on the bed nobody was there to assist me out and there were five or six men…I was not able to talk but could see images. I was raped, I only remember being penetrated. I could not talk for my tongue was very heavy.

Research Assistant: You told me last time there are some men who put medicine into your drinks…can you tell me something small about your drinks?...

Amal, third interview: In the Name of Allah this problem is everywhere…it is not happening to Somalis only…It is also happening here in Kenya, mostly in women…the current men be it blacks or white…they don't what to give the amount you negotiated…they try to sweet talk to you, beside that we have to keep eye on our drinks…there is a lot to think about we are human being we can't keep eye we have a lot to do…you try to go to the toilet so they make use of that time and add something to your drinks…in the morning you wake up without even a coin.

Shukri, second interview I and the man concurred, we went to a room… we were chewing mira[6], later he told me I bring you soda…the soda he brought me was open and I had suspicion about it…but I was so high I just took the soda then the man did sex and left, he even took the little I collected from others and went off. When I woke up, I was alone at the place, I didn't see a condom, so I went to the hospital to get an examination.

Only one respondent mentioned that they had engaged in sex work back home in Somalia, and this respondent compared work back home to that in Kenya, highlighting the use of drugs, particularly clients drugging drinks.

Amal, first interview: When I come to this country, I saw big difference, the clients don't give enough money, I never slept with Somali men, I used to sleep with white men, Arabs and Hindus. So, if you want to sleep with someone here, they add medicine to the drinks, and they leave you there, so I don't trust them.

10.5. Violence outside of sex work

Violent assaults were mentioned not just in the context of sex work, but also routinely mentioned when describing their journeys from Somalia to Kenya. Two respondents (Ayan and Amal) were raped during transit, Hodan was raped in Somalia and again in transit, and Halima was raped upon arrival in Kenya. More specifically, Ayan described how she was sexually assaulted en route to Kenya by militia between

[6] Mira, otherwise known as Khat, is a plant native to the Horn of Africa, which acts as a stimulant, and is frequently chewed amongst men, and less often women, in Somalia and amongst Somali communities in Kenya.

Afmadow and Qoqani. Hodan was sexually assaulted in Somaliland, and then en route by bandits near Afmadow and Caanjeel (two cities in Southern Somalia). Multiple participants (Halima and Hodan) actually stated rape as their reason for entry into sex work.

10.6. Threats, intimidation, and fear

Aside from the pervasive physical and sexual assault, there was also frequent reference to generalized aggressive behaviour and discrimination such as threats, insults, theft, and targeting due to being a Somali FSW specifically, resulting in what appears to be widespread fear. Three respondents also referred to threats of being killed, and to peers who have been killed.

Fatma, fourth interview: We cannot do commercial sex because we will be stoned to death by the Muslims.

Sagal, first interview: They can tell you anything, you prostitute, they can kill you they can do everything they want.

Nawal, fourth interview: So, in this business, some would even kill you after they drug you.

RA: In the first interview you told me that there are some men who kill the female sex workers, who are those men, and have you ever witnessed someone they killed?

Sagal, fourth interview: No, but I heard. I heard that they take you to a hotel, instead of paying you, they kill you. They are both Somalis and non-Somalis who rob people from their money and at times they kill people because of that.

The fear of being killed caused one respondent to move location frequently as a strategy for staying safe.

RA: You told me you keep on changing houses when many people get to know where you live, so do you do that to ensure you are safe or for other reasons?

Zeinab, fourth interview: Yes, we fear for our lives, if it is known where you stay there could be a lot of problems and people may fight because they don't want you, they discriminate against you, so we rent other houses, or live in hotels.

In other cases, the fact that the FSWs are refugees and not from Kenya, appears to play a role in the discrimination and threats.

Amal, fourth interview: And the difference here is when I decide to go with men, I get scared because men give us the amount of money we agreed upon but a short while they change they mind, they take the money from us, beat us and only mind his business. Then later he insults you saying you are refugee what can you do to me.

Multiple respondents referred to the 'Superpowers' in Eastleigh. Although a precise definition was never obtained, they were generally described as a group of Somali men enforcing the teachings of the Quran in Eastleigh and in surrounding areas.

Azan: So many people were beaten even my friends who do this work. She (another FSW) was beaten by some men who name themselves as 'superpowers.' They are a group of men, and they demand by force…everything of theirs is force…They were sent by (Sheiks) Muslim preachers. These sheikhs are from Eastleigh…but they are fake sheikhs.

Amal also referred to the 'Superpowers', mentioning they have guns, in the context of describing challenges such as men drugging FSWs, and not paying.

10.7. Harassment by law enforcement

Most respondents mentioned being harassed or arrested by the police in Nairobi; others who weren't arrested or harassed mentioned they knew of peers who had been. These narratives seem to be directly related to the vulnerability of being a FSW and an undocumented migrant. Most notably, respondents mentioned arrests due to lack of ID, but it is unclear whether they were initially targeted due to being Somali or being a sex worker. Details of negative interactions with law enforcement came up when respondents were probed about whether they had ever been arrested, such episodes also emerged when respondents were asked about the main challenges they experience as Somali FSWs in Nairobi.

RA: Do soldiers disturb you; do they ask you for money?

Zeinab, first interview: Sometimes when I go out at night…I don't have legal document, I was caught one night…the Somali lady I was telling you…looked after for me, she speaks a little Swahili.

Fatma, second interview: We get arrested**…**and the main problem is we don't have any ID and we frequently get arrested for our business normally done by coming out and we normally buy our release. And sometimes you get prosecuted and sentenced for 3 months and therefore you finish your jail term. And if you are not able to pay the fine you are forced to finish the jail term.

Nawal, first interview: It is not like in Somalia where you go out and work, here you will be asked to bring ID card and if not, they will put you in jail or you have to bribe them.

Fardows, first interview: When I am caught by police, I claim to be Kenyan**.** When am asked about ID card I tell them it is somewhere in my home, I try to contact someone to bring it to me. I don't have either ID or UN Alien card, I just use this as an excuse just to claim I have ID otherwise I am jailed.

There appears to be competition between Kenyan and Somalia FSWs, as illustrated by one respondent stating that the Kenyan FSWs can call the police to arrest the Somalis. However, the challenges with law enforcement extend to all FSWs, including the Kenyans.

Muna, first interview: When we go to town, the police are all over and sometimes we don't get clients, and sometimes we do get them, but the Kenyan women also tell the police about us.

Alternatively, Maryam recounted a narrative contradicting the above statement, as she believed Kenyan FSWs are just as persecuted as her Somali peers.

RA: Do the police disturb you, asking for papers and IDs?

Maryan, first interview: They ask for identification whenever they arrest us. They take the money we have worked for and let us go. If you don't have identification, and prostitution is not allowed in this country.

RA: Do you think the Kenyan women are also arrested?

Maryan: Yes, we are the same.

Multiple participants commented that they pay the police on a regular basis to avoid harassment and arrest, including Nawal, Halima, Amal and Ayan. The choice of language used by respondents, makes it appear that the arrests are such a normalized part of daily life.

Halima, second interview: This country is for Kenyans and me, I am not Kenyan, so sometimes on the road you are told to show ID card, which we don't have…Where will I get ID card, I am a refugee? … They catch you and jail you…It can take four or five months in the jail …If we have money two thousand to three thousand, we are Somalis, so we just give them. They release us out of the jail. This is the biggest problem we have today, if we have ID this could not happen.

Halima, fourth interview: Other ladies who have fallen victims and been in jail for three months and two months respectively. Same problems that we experience of being illegally in the country with no identity or any document from the UN.

RA: You said you normally hide, who are these people you hide from when working or at your place of work…?

Halima: The Kenyan government forces. These officers who loiter around the chief and other problematic people. I don't intend to disclose as those are people I hide from.

Amal, third interview: The problem is that every night you might get arrested by the police, should they take you to city hall, should you pay money to buy your freedom or should you go to court. You live in fear.

RA: Were you arrested or caught since you got here?

Ayan, first interview: Only once or twice

10.8. Summary

Running away from insecurity in Somalia in search of a better life, Somali FSWs in Nairobi find themselves encountering routine and widespread violence in terms of physical and sexual assault, robbery, threats, harassment, and fear. Their risk environment in Kenya is immediately contextualized by the fact that sex work is criminalized, thereby increasing harassment by police, client and the community, and

a lack of legal recourse not just due the illegal nature of their work, but also their irregular migration status.

Violence from their workplace, local community and law enforcement is frequently mentioned and participants speak of these cases of violence as 'normalized' within their typical daily lives, referring to both personal experiences of violence and reporting anecdotal stories experienced by FSW peers. This violence does not appear to be experienced only by Somali FSWs; respondents cite this as commonplace amongst all FSWs in Nairobi. Most of the incidents were reported during or around condom negotiation or payment, similar to the published reports of violence from the aforementioned study in Naivasha and Mombasa, two other areas of Kenya (Okal *et al.*, 2011).

Furthermore, the way violence coalesces around the FSWs differing roles shows the intersectionality of these identities, targeted by clients and their community, for being Somali, migrants and FSWs engaging in criminal behaviour, compounding their risks – thus amplifying the likelihood to be targeted given the multiple and layered forms of potential discrimination, and amplifying the potential severity – a Kenyan FSW may feel more confident to access services, for the risk of arrest and deportation may not be as present. These FSWs transgress from being good women, good Somalis, good Muslims, and legal citizens, through a downward spiral of compounding risks across their risk environment. The chapter on violence implies that the intersecting

identities of migrant, gender (female) and sex worker and the violence they experience are interlinked, but it is not clear how

Evidence from my research showcases the widespread presence of violence and discrimination, including at the intersection with law enforcement. How these experiences of violence affect health seeking behaviour, networks and support, and intersect to form the overall risk environment for Somali migrant FSWs in Nairobi, links to theoretical frameworks presented earlier. Specifically, the experiences of violence as pervasive, and limited mitigation or recourse, and an acceptance that this is part of their life, due to their circumstances. The need to address structural factors within the risk environment, that lead to this widespread and recurring violence and harassment by police, clients and the community, will be explored in the Discussion section, subsequently.

A recent systematic review and meta-analysis, looking at quantitative and qualitative studies, amongst both female and male sex workers, considered relationships between legislation, policing and health (Platt *et al.*, 2018). The results of this review illustrate the significant negative implications of legislation criminalizing sex work and calls for reforms to legalization to counter repressive policies that ultimately impact the health of individuals and populations.

In other countries it has been found that criminalization of sex work may lead to harassment and violence by police, and this trend holds strong in Kenya as well, with

Somali FSWs reporting routine harassment by law enforcement (Rekart, 2005; Rhodes *et al.*, 2008). In addition to harassment by police, discrimination, and violence from members of the community are now also documented, both from within the Muslim/Somali community, as well as from the Kenyan community.

Globally, the lack of legal protection for sex workers due to the typically illegal nature of their work, results in underreporting and minimal repercussion to perpetrators of the violence (Deering et al., 2014). Amongst this population, formal reporting of violence to any authorities appears to be completely lacking. Not one respondent had reported any incidents to police. In this context, it is likely that Somali FSWs may feel even less empowered to report incidents of violence, given their irregular migration status (e.g. lack of paperwork to be in Kenya, or to be outside the refugee camp in an urban area) thus resulting in a multifaceted and complex set of interconnecting structural factors including criminalization and irregular migration status leading to increased discrimination, violence and underreporting. Ultimately, criminalization provides an opportunity for harassment and exploitation, and often further provides impunity for those who perpetuate violence against FSWs, and in Kenya with Somali migrant FSWs, this is no different.

11. Health seeking behaviour, experience at health facilities and knowledge of sexual health

As previously mentioned, there is some indication that Somali FSWs in Nairobi may be particularly vulnerable to sexual and reproductive health ailments, given that they have come from a country with low functioning health system and documented poor knowledge and awareness of sexual health and HIV. Furthermore, as already explored, FSWs appear to feel isolated, unsupported, and generally exhibit low self-esteem, therefore this coupled with their involvement in sex work and the high rates of violence they experience, this will likely exacerbate their vulnerability further. In this final results chapter, I review the evidence from the data about how the women perceive health and health services, and relationships with their overall experiences of their broader social, economic, political and physical conditions that make up their risk environment.

11.1. Introduction to the Health Case Studies

Of the 15 women with whom we conducted repeated interviews between May 2012 and January 2013, I selected four cases for in depth analysis to illustrate understanding of health, health care and health seeking behaviour among migrant Somali FSWs in Nairobi. These four cases provide an in-depth analysis of this population's understandings of health, its interface with their current environment and effects on their behaviour. The four case studies were selected based on a variety of experiences ranging from high and low involvement with health services, use of private versus

public health services and HIV positive and negative status (as disclosed voluntarily in the interviews). In summary, these cases reflect the variation across the wider sample, and specifically these were chosen for maximum variation to reflect the broadest range of experiences but permit more holistic presentation of sex workers' experiences in this context and how these interact with their wider lives.

Among the four case studies, all completed the second interview where health and health seeking behaviour were discussed. Of these, three of four women had been for HIV testing at least once in their lives, and all disclosed their HIV status voluntarily to the research assistant (RA) without being directly probed. Only one respondent disclosed a positive HIV status. While general health status was not the primary focus of the discussions with participants, they referred to malaria, tuberculosis, stomach ailments, typhoid, and vaginal itching. This chapter will present findings on how women perceived and sought health care related to HIV and STIs, and their levels of awareness of these conditions through four women with diverse experiences. Figure 11 summarizes key characteristics of the four Somali migrant FSW participants, forming the four case studies.

Figure 11: Characteristics of select study respondents for health case studies

Pseudonym	# of Interviews	Age	Time outside of Somalia	Ever Tested for HIV	HIV Status	Typical Health Service Usage (Public/ Private)	Typical experience accessing health services / views around health services
Hodan	4 (over 3 times)[7]	22	8 years	Yes	Data not provided	Public	Does not reference any challenges, aside from difficulties sometimes paying, and queues, but does not appear very concerned about these.[8] Believes if you have good intention and believe in God, you can get treatment. Wants to stay healthy so she can make money doing sex work.
Amal	4 (over 3 times)	46	18 years	Yes	Negative	Public & private	Typically goes to Government hospitals or city council clinic, but also references going to private facilities due to discriminatory treatment at public facility, where she was refused medicine. At certain clinics she has no challenges, such as the MSF and GTZ clinics.
Muna	3 interviews (over 2 times)	30	8 years	No	Never tested	Private	Has never been for an HIV test because Allah has not made her, and she does not speak Swahili. If God tells her, she will go for a check-up. Has gone for treatment for malaria, typhoid and pneumonia. Has experienced

[7] As the security situation continued to deteriorate, the number of times we would be able to interact with participants was a concern, and therefore what was meant to be four interviews over four separate occasions, was for some participants amended for the research assistant to undertake two interviews in one sitting.

[8] While primary health care is meant to be free in Kenya, in reality this is not the case. Many clinics will ask for identification that migrants are unable to provide. Furthermore, to receive services there are often systems whereby you need to pay before you receive a consultation and before you receive medications. The processes are not always intuitive or clearly explained, signage may be in English of Kiswahili and clinics may be understaffed with minimal explanation or support to those unfamiliar with the systems.

							challenges around translation predominantly, at private facilities, and hence one of the reasons mentioned for never having been for an HIV test.
Zeinab	4 interviews over 3 times	27	2 years	Yes	Positive	Public	Typically goes to public sector, even sends children to the clinic to collect her treatment, as she has a good relationship with the service provider there. Challenges she has experienced in the past with health facilities include translation difficulties, long lines, and 'rude black Kenyans'.

HODAN, age 22

As described in the previous chapter, Hodan came to Kenya from Somalia at the age of 14. She was a resident in Nairobi ever since she left Somalia, never married, and has two children. Hodan experienced a serious car accident when en route to Kenya, during which she suffered a brain injury for which she received treatment in Nairobi. After she was raped by two men while en route to Kenya, losing her virginity, she started engaging in sex for money. In addition to problems including tonsillitis, headaches, and high blood pressure (at the time of the first interview), she also had a history of pneumonia and unspecified "infections". When asked about sexual health, Hodan discussed problems experienced as a result of sex from her first experiences. She described experiencing abrasions following sexual debut that had to be stitched. She had also been admitted to hospitals (Kenyatta and Pumwani) during her pregnancies, due to complications which were not further specified. She spoke of her two living children during her interviews.

Hodan was the only respondent to repeatedly emphasize the importance of her health, and also the only respondent to report relative ease of accessing health services. During one of her pregnancies, Hodan was tested for HIV at the Umma CBO clinic, two years prior to data collection. Generally, Hodan did not describe experiencing challenges to receiving care, although she did mention occasional trouble paying for the costs, and long waiting times, but did not appear very concerned about either.

Hodan, second interview: There is nothing better than your health … if you are not healthy you cannot also do the sex work we are doing properly as you will be sick all the time **…** If you have good intention, you can get treatment. It's because of their foolishness that they

(*referring to other FSWs*) don't go for check-ups, if you care for your health, you will definitely do that…

Hodan's general belief was that with faith in God, one can get treatment. She expressed wanting to stay healthy to she can make money doing sex work. When asked if she or other FSWs meet problems when they go to the hospitals, Hodan replied:

Hodan, second interview: There is nothing like that, if someone believes something he/she will never get treated … If you have good intention, you can get treatment … and if you believe in God.

In her second interview Hodan asserted that "poor people" go to Government hospitals, which is where she herself accesses health services. In her final interview, she was asked by the research assistant to clarify what she meant by that, and she further explains selection of health service providers is not an issue of personal choice, but rather a product of economic strata.

Hodan, second interview: I meant people are not the same; some are very rich they go to expensive hospital; some are middle class they go to the hospital that they can afford and other poor they go to where they can get free service and medicine.

Hodan mentioned that Kenyan FSWs have better health seeking behaviour habits than Somali FSWs and when asked the reason for this potential pattern, Hodan touches on denial and fear of receiving a life changing diagnosis, as well as a lack of awareness about treatments for these diagnoses.

Hodan, second interview: Do you know Somalis generally don't like to rush to hospital…we Somali prostitute girls don't like to go to hospital… these other non-Muslim sex workers girls are better than us … I don't know, I mean these diseases they tell us like AIDS, TB and things

like this are big thing to them and that is why they don't want to know their status. They are to be given medicine that help them, which will protect your life, but they don't know.

For example, Hodan was required to pay 16,000 Kenyan Shillings and a fellow Somali man, not a client, assisted her with the bill. When asked about this Somali man, she recounted with surprise the following:

Hodan, second interview: I don't know him, if he is a Borana or not … He came to me and asked me are you Somali? I told him yes, I am a Somali lady, and I don't have relatives here, he told me, you will hear from me soon. He came to me the sixth day, he paid bill of sixteen thousand and he discharged me from hospital … I don't even know his tribe, even now.

Had this Somali man from the community not helped her with these costs, she did not know how she would have covered these costs. In regard to knowledge, awareness and prevention behaviours, Hodan is fully aware of STIs, and how to protect herself, and she herself uses condoms.

Hodan, second interview: There are many problems, these men we are doing sex with can pass diseases to us, and you can meet everything. So, whatever it's good to reason, even when I was conceiving these two children it wasn't my wish the condom bursts.

Amal, aged 46[9]

Amal, originally from Mogadishu, left Somalia in 1993 at just under 30 years of age, when her brothers were killed. She passed through Ethiopia and sold sex in order to pay for the carfare to Kenya. Upon arrival in Kenya, Amal shifted to a refugee camp in Uganda for eight years.

[9] Exact age is unknown, she left Somalia in 1993 and she indicated she was 27 or 29, her age was deduced to be between 46 and 48.

Amal is one of only two respondents to indicate that she was a FSW in Somalia, in comparison with the other participants who describe their experience of being a migrant as what led them into sex work. She says she was married in Kenya, but after she and her husband separated, she went back to sex work.

Amal goes for HIV testing approximately twice a year as she does not trust her clients. Her last HIV test was the week prior to her second interview at the city council clinic, because a condom broke, and she was suspicious as the client had "disease" on his body and his genitals.

Amal uses a mix of both private and public facilities, having tried various donor funded public clinics specific for certain vulnerable populations, including the SWOP clinic, but indicating it is too far for regular usage.[10] She mentioned that the city council (public) hospitals are free, but result in long queues and discriminatory service for "*people like us*". At the time of the research, awareness of key populations amongst the majority of health service providers would have been limited. She has also tried the Médecins Sans Frontiers (MSF) and German Agency for Technical Cooperation (GTZ) clinics, indicating there were no problems accessing services at these locations.

Amal, third interview: The reason we go to the private hospitals is that the free hospitals have long queues, and we don't get the best service there for people like us, commercial sex workers, it is just wasting our time, so we run to the private clinics to get help, we just have to pay whatever we have like six hundred, five hundred.

Amal brings in nationality, religion, migration status and being a sex worker as potential reasons for poor treatment at the public facilities.

Amal, third interview: It's the government hospitals that I usually go, when we get to this government hospitals, there is nothing they do for us because us sex workers we are Muslim,

[10] The SWOP clinic would be a 50 minute walk from Eastleigh, or 30 minutes on the bus if bus fare could be paid.

Somali, so we get there in the morning we stay there till evening with no help from the hospital, so we give up and use Panadols and other painkillers…but the Kenyan people get the medicine for free...

…To be honest I went to a government hospital about two months ago, and I encountered bad experiences like insults and judgments. I was asked one time who are you? That was when they found out that I had an STI infection; they asked me, where did you get it from? Then I told them that am a commercial sex worker, they are like are Muslims like that? I told them no, but I was forced by circumstances that it doesn't matter whether you are Muslim or not, I don't have any money with me now, I will like to get some medicines…

…The workers don't know what we do but I think they are doing this because of our nationality, and they neglect us because we are refugee.

Muna, aged 30

Muna left Mogadishu, Somalia when she was 22 years of age, after her husband was killed. Neighbours paid for her and some other girls to travel by road to Kenya. She has been in Kenya 8 years, always in Nairobi, having not spent any time in refugee camps. She was impregnated by a Somali man in Nairobi who wanted her to have an abortion, but she chose to have the baby. Forty days after the birth of this child she started selling sex. Muna has never been for an HIV test because "Allah did not make me do it," and she does not speak Swahili. However, she refers to symptoms that indicate the potential for an STI. She has gone for treatment for malaria, typhoid and pneumonia, specifically at private facilities, and has experienced challenges around translation, and hence one of the reasons mentioned for never having been for an HIV test. If God tells her, she will go for a check-up.

Muna, third interview: We go to hospitals when we sense itching in the lower part, and we go for check-up.

When queried about her choice of private facilities, she is unable to explain the reason for selection of these facilities, but seemed confused, and perhaps the selection was more related to location and convenience, rather than the distinction between the one 'type' over another. It is possible she simply didn't know the difference between a public or a private facility. In terms of knowledge and awareness, misconceptions are present, for example, Muna believes that HIV does not affect certain nationalities. Overall, she shows low levels of knowledge and very limited health care seeking and prevention behaviour, as indicated in the following excerpts.

Muna, third interview: We don't get this disease, Africans get most or the ones with hard hair.

Muna touches on aspects of fear and also denial, in terms of contracting HIV.

Muna, third interview: Some of them are illiterate they don't know what it is, some of them fear hospitals and most get scared when they are being checked for HIV and they say go away we will not get that disease.

Zeinab, aged 27

Zeinab has been in Nairobi for about four years, having left Somalia by bus with her sisters. She has never been married, does not have any children, and is the only other participant to reference exchanging sex in Somalia, and also en route, and in a refugee camp upon arrival in Kenya. She is also the only respondent to disclose a positive HIV status, and is currently taking antiretrovirals, at the time of data collection. She tested positive for HIV approximately a year and a half previously, at a public health facility. In her interviews, Zeinab explained how in the beginning the news of her positive HIV status was a shock, but how over time this normalized. She likens being HIV positive to a common cold. Her reflection also shows how previous to

her diagnosis, she had not really considered how consequences from sex work could have implications for her health and her life.

Zeinab, third interview: I was shocked I could not move for a week. I didn't know anything about it, and I was not expecting it. I wasn't using condoms and I didn't know about it. Now I am used to it, it is like common cold to me, and I use the medicine.

Zeinab typically goes to the public sector for health needs, she sends her children to the public clinic to collect her treatment, or sometimes they deliver it to her home, as she has a good relationship with the service provider there. Challenges she has experienced in the past with health facilities include translation difficulties, long lines and that the '*black Kenyans'* are rude, and when asked why they may be rude, she responded:

Zeinab, third interview: Who wants a Somali lady who doesn't speak their language … They only see their fellow Kenyan who speaks their language.

Despite these challenges, she continues to visit the public facilities as she understands that she needs to take the medication consistently.

Zeinab, third interview: I don't want to pay money because I am there is free hospitals why do I waste my money on a free thing.

In terms of HIV awareness, knowledge and prevention information is mixed, which may be linked to changes in knowledge over time. Zeinab stated "*it is a must for a sex worker to know her health status*", specifically referring to HIV, though she chooses not to disclose her positive HIV status to her clients for fear of losing business. She indicated she did not use condoms in Somalia, that she did not even know what they were, but alludes to using them now, despite not coming out directly and saying this. She speaks of condoms as "*shameful things*", that they

are not part of Muslim culture, but when asked what Somali migrant FSWs need, she mentions her community needs to be taught to use condoms.

Zeinab, third interview: Am I mad to tell my disease to a man that I am sleeping with he will run away from me…God is great my sister, I am not mad.

11.2. Perceptions around health and health seeking behaviour

The case studies from these four women demonstrate how they have limited knowledge about the health risks of engaging in sex work. However, at least two of the case studies show that this has developed over time, and they are engaged in some form of preventive behaviours to protect their health. It is further intimated, although not stated directly, that they believe that their health is important, despite the well-documented impact that their profession may have on their lives, physically, psychologically and interpersonally. Only Hodan describes in detail the need to maintain her health in order to adequately perform her job, and furthermore, acknowledges that her health can be negatively affected by her involvement in sex work. Given the limited emphasis on health, it is not surprising that only Hodan reported accessing health services with relative ease, furthermore she is the only one who described somewhat positive experiences with health service providers as well. On the other hand, while also facing barriers including long waiting times, lack of medicines, refusal of service due to lack of documentation/identification, language barriers, poor treatment, quality of care and fear.

This reflects the kinds of barriers faced by migrants and specifically migrant sex workers in other contexts. Lack of identification is likely an issue for many undocumented migrants in Kenya, although not well documented in the literature, and for FSWs who often need to access health services as an outcome of work-related injuries or complications, this issue is exacerbated. Language barriers were cited as one of the most common difficulties experienced

by respondents in trying to access health services. Both Muna and Zeinab recount difficulties with language and lack of interpreters at public health facilities. This suggests that Somali migrant sex workers' identities as migrants or refugees without legal documentation, as non-Kenyans who do not speak the language, and as FSWs who may be discriminated against due to their profession as a sex worker, all impact their health seeking behaviour. Based on these multiple facets of their identities, health seeking behaviour and experiences at health facilities varied amongst Somali migrant FSWs, including attitudes and expectations, and selection of and types of facilities visited.

Multiple anecdotes around poor quality of care and accounts of discrimination by health service providers were provided. Lack of financial resources was another often-mentioned challenge in accessing health services. When faced with lack of financial resources to pay for healthcare, some respondents received support from various persons, or resorted to public facilities – although the consistency of not having to pay is not always present.

Almost all respondents mentioned fear as a barrier to health seeking behaviour. These fears ranged from hospitals in general and of potentially of being treated badly, to being discriminated against and their FSW status not being kept confidential. Other fears related to the 'big *disease'*, and anxiety around a potential diagnosis, potentially linked in with a form of denial or coping mechanism.[11] When specifically asked why other Somali FSWs may not access health services, or go for HIV testing, the responses were similar – discriminatory treatment, not having the money to pay for consultations or treatment, fear of being asked for

[11] 'Big disease' was referenced in the first focus group discussion with three participants, not included in these case studies.

identification, etc. Both Hodan and Zeinab only use public facilities, and for Zeinab, the reason is purely based on economic reasons – she chooses public facilities.

Other research has shown that Somalis do not necessarily have positive patterns of health seeking behaviour both in Somalia and out of their home country. In my study, I did not find that Somali migrant FSW perceive their health as a priority, although given the literature it is possible that this is a continuation of existing health seeking behaviour from their country of origin. Furthermore, the additional layers of challenges presented by their circumstances, and intersecting identities, comes out in these case studies. Given migrant Somalis are engaging in sex work after arrival in Kenya, it is not enough to simply offer health services and other health related interventions. Educating this population on the need for health services, including prevention of HIV and STIs, and treatment of common health concerns amongst this population - including TB, malaria, gastrointestinal problems, and nutritional deficiencies - is needed. Similarly, what we learned here suggests that migrant Somalis struggle to engage with services provided as health services in the usual manner, as these do not align well with their own perceptions of health and how it fits into their priorities and concerns.

Another finding across the four cases relates to perceived differences between Government and private facilities (e.g., hospitals and clinics). The respondents generally felt that while Government hospitals are free, the waiting times are longer, and while seeing a provider and receiving treatment is supposed to be free, bribes are often paid, and medication not available. As a result, the respondent must go to a separate private facility or pharmacy to purchase

medications anyways, resulting in two different trips. The "UN Hospital", "City Council Hospital" and the "Blue Hospital" were the most frequently reported facilities visited.[12]

The decision made by Somali FSWs in regard to which health facility to select is based on an array of factors including location / convenience, cost, referral from peers, previous experiences, migration status and languages spoken by health providers.

11.3. Understanding and knowledge around STIs, HIV and AIDS

All respondents had heard of HIV, and when asked which STIs they were familiar with, were able to mention HIV or AIDS without probing. However, despite being 'aware' of its existence, with a seemingly superficial level of knowledge, many do not want to think about it, take it into consideration in their daily lives, or assume only certain individuals are at risk. Although not as commonly mentioned as HIV, syphilis and gonorrhoea were also mentioned by some participants. The levels of awareness and knowledge varied, with most respondents mentioning condoms as a way of prevention. Higher levels of knowledge were also exhibited, with one respondent mentioning treatment options for HIV. While the case studies show some higher levels of awareness and knowledge, many misconceptions are still present, for example, that HIV does not affect certain nationalities, as expressed by Muna.

11.4. Summary

While health seeking behaviour may not intrinsically, nor anecdotally, be part of traditional Somali culture, some Somali migrant FSWs in Nairobi are visiting health services for general health conditions, as well as for routine HIV and STI testing; however, the emphasis placed on

[12] "UN hospital" is the colloquial term for the IOM clinic, the "City Council" hospital refers to the Government clinic on fourth street, and the "Blue Hospital" refers to the MSF clinic that offers TB and HIV treatment.

these health services is in no way extensive. The reason as to what drives some to greater health seeking behaviour over others, may be linked to the other aspects of the challenges they are facing and their experiences in Nairobi, cumulative experiences or sources of support (e.g., social networks) or cumulated risks and negative experiences (e.g., violence and discrimination). For example, barriers to health service uptake such as language and fear of discrimination by health workers, for being Somali, in the country illegally, Muslim, and a sex worker, combined with the very real fear of arrest and deportation, not being understood culturally, or the reasons for their current realities (e.g., death, separation or ostracization by family and community). Moreover, the compounded nature of being a victim of violence, which means the potential for increased need of health services, the likelihood of not seeking out these services, and the potential longer-term severity or complications for leaving health needs unattended. Additionally, the potential for additional medical costs, thus reinforcing the need to engage further in sex work, and thus repeating the cycle of desperation, engagement in sex work, exposure to violence, the need for medical services, ostracization from their original families or communities, and so forth. These examples show how the intersection with migration status and specifically the intersection of violence, and the migration status of Somali women, FSW and health uptake.

This qualitative work revealed that some Somali migrant FSWs understand the importance of their health, particularly in their field of work, but the widespread presence of multiple and overlapping barriers are a hindrance to health seeking behaviour. Barriers ranging from structural issues related to their migration status and nationality – lack of identification, language and communication challenges - to inherent challenges with the health system - long queues and lack of medicines – result in not all Somali migrant FSWs consistently accessing services.

Fear is also a strong theme emerging from the research, showing the need for more education to reduce the stigma around HIV and hospitals in general. Visiting health facilities in groups, with Somali speakers who can translate is one strategy being used by this group to gain access and information, however, the provision of health services whereby migrant FSWs are not asked for identification, and where interpreters are available, is needed in the long term.

Furthermore, while all respondents had heard of HIV, are aware that it can be transmitted through sex and that condoms can be a source of protection, misconceptions are still present around what exactly is an STI and to what degree condoms provide protection. Some of these women go for routine testing as often as every three months and are aware and empowered enough to refuse higher pay for sex without condoms. Others indicate that it is '*Allah's will'* whether or not they would get tested or seek further health services, thus using their religion as an excuse to display a sense of fatalism or external locus of control over their health.

12. Discussion

The aim of this research was to investigate the complexity and the components of the risk environment for Somali migrant FSWs in Nairobi, Kenya and how their experiences or situations in the urban migrant environment in Nairobi impacted their overall health and well-being. More precisely, the research aimed to understand identity construction of Somali migrant FSWs, including intersecting identities of being a migrant/refugee, a Somali/Muslim, a sex worker, and the possible compounded effect of these identities, as related to their health and health seeking behaviour.

The research considered social networks and how they appear not to provide Somali FSWs with a foundation for resilience and identified both the magnitude and acceptance of multiple forms of violence in the lives of migrant FSWs, and how their prioritisation of health and proactive attempts to maximise their well-being appear low. This Discussion section reflects the analysis of the entirety of the data set and as a result, implications and future considerations for research and programmatic implementation.

12.1. Hopelessness, externalization, and religion

In this study, we see a pervasive sense of hopelessness and fatalism as it pertains to Somali migrant FSWs in Nairobi, in terms of their current situation as (often) undocumented migrants, with minimal access to health and social support services, the subject of persistent harassment by police and stigma from the community (both their Somali community and the Kenyan host community); but also overtly and through less obvious references to their lack of opportunities now and in the future. This hopelessness appears to be both internalized, whereby they do not think they deserve anything better, and externalized, whereby their future is out of their control, and in the hands of 'Allah'. Every participant referenced religion to some degree in their interviews. Whether this was Halima praying to God for marriage, Fatma insisting to clients she cannot have anal sex as it is against her religion, Shukri mentioning going hungry and eating only when God gives her food, or Nawal recounting a story of a white woman helping her after she was attacked, who was sent from God to help her. Religion was a routine part of participants references to how they should have been behaving, how they were going against their religion, how they were receiving various aspects of support or assistance, or how the only way for them to exit this life would be if God provided them the opportunity or the pathway. Most of the respondents describe a sense of powerlessness over their involvement in

this work, as a result of meeting basic needs for survival but nonetheless still site the fact that they are going against Islam and are therefore 'bad' Muslims.

There is limited literature on the role of religion in the lives of sex workers, though some published work originates from Ecuador and Thailand. In Ecuador, qualitative interviews with 12 street FSWs resulted in researchers finding that FSWs believed God would protect and provide for them, rather than blame them for their involvement in sex work (Toledo, 2002). Furthermore, the research participants presented a dependency on God and also a reliance on protection and forgiveness. In Thailand, Sorajjakool and Benitez (2015) had a sample size of 12 sex workers, from 2 karaoke bars across Bangkok, of whom eight indicated they were religious. Overall, they found two factors impacted the level of engagement with religion, these were 1. Life challenges, and 2. Sense of internal conflict. Specifically, those who experienced more difficulties in life tended to be more religious, and those with more internal conflict, who wanted to pay for their 'immoral' behaviour, were more likely to be religious, and gained comfort in pursuing charitable acts.

Looking at these two studies, in comparison with my findings, the relationship between religion and sex work for Somali migrant FSWs in Nairobi seems omni-present across most aspects of their lives, contributing to a sense of hopelessness in terms of their potential future plans, citing "Allah" as one of the only options for them to exit this lifestyle, if it would be "His" will, it would happen. Another hypothesis is that this could be a coping mechanism in the face of powerlessness. This differs in comparison with the findings of Toledo (2002), where participants believed God would protect them; but aligns with the findings of Sorajjakool and Benitez (2015) where Somali migrant FSWs in Nairobi did reveal, through overt and

interpreted messaging, that there was a sense of internal conflict. A good Muslim does not sell sex for money, and yet they needed to do so to survive.

Additionally, similar to other evidence from Somali communities globally, this study found that religion often plays a crucial component in diminished health seeking behaviour, with an external locus of control - Allah (God) has a plan. While this sentiment was not exhaustive across all participants, it was nevertheless present. Given the aforementioned conditions with which many Somalis have lived, and the conditions with which many of the Somali migrant FSWs live in Eastleigh - hand to mouth - it would not come as a surprise, that health simply would not be a priority, but rather feeding their children and getting by day to day is a priority. Nevertheless, some respondents still exhibit health seeking behaviour and this behaviour is wide ranging from extensive routine testing, to having never been tested.

Overall, a combination of negative experiences with previous health facilities (for some respondents, not all), alongside stigma and discrimination based on being Somali and also a FSW, as well as fear of ill-understood illnesses due to lack of education and present misconceptions (e.g. "*we don't get this disease*"), are compounding to create a disabling health seeking environment. Furthermore, creating the potential for lack of interest and empowerment in health. However, despite all of these conditions, some health seeking behaviour is still present, notwithstanding all of these obstacles

Hopelessness amongst vulnerable groups has been referred to in the literature as pertaining those diagnosed with HIV early on in the epidemic, where high mortality, loss of life around them and stigma were heavily present (Kenneth H Mayer and Pizer, 2008). A sense of hopelessness has also been shown with sex work populations, as related to societal disapproval

and high stigma (UNAIDS, 2000). Furthermore, hopelessness amongst migrant communities, and the Somali refugee community in Kenya, has been illustrated in particular, as pertaining to lack of services/basic needs being met, and as the displacement persists for decades, with no durable solutions in sight (UNHCR, 2017).

These three aspects of hopelessness, externalization and religion are interlinked, creating a pervasive sense of lack of control over their lives, hopelessness to change their situations, shame around their behaviour via a vis what is a good Somali or how a good Muslim would behave, breeding low self-esteem and a lack of empowerment to change their situation.

12.2. Intersectionality

It is not clear if the support received from peer Somali FSWs is reciprocal based on profession, nationality, religion, location, or some combination of these factors. How the respondents' different identities feed into their social networks and the strength of support that they receive, is unclear, but analysis of the data and themes alludes to a combination of these influences. These women are not only sex workers, Somalis, or undocumented migrants, but the resulting confluence of these factors results in a network of support amongst them, while concurrently creating challenges and a complex risk environment as well.

One of the dominant narratives is that Somali FSWs feel displaced, separated from their traditional family and social structures, and this is made worse by the shame and stigma of being sex workers. However, once they get past this greater loss of social fabric, they describe their newly forged relationships of support of different kinds. Whether or not this then can bring about positive effects or just provide the potential for positive effects will be reflected further on in the Discussion.

Bredtsorm (2006) argues the need for expanding the focus of HIV research away from the intersection of only gender and sexuality, and rather expanding it to include sexual agency, race, class and ethnicity. Given the dearth of literature looking at sex work and intersectionality, this research calls upon the researchers and practitioners to utilize the concept of intersectionality to analyse the risk environments to look at enabling and risk factors for increasing access to health services for sex workers, and even more so for the case of migrant sex workers, with the added complexity of nationality and migration status, omnipresent within their realities.

12.3. Risk Environment: Supportive and inhibiting factors and implications for health seeking behaviour

In order to identify strategies and opportunities for increasing FSW access to and use of health services, it is crucial to understand how they navigate their lives and work that lead to their health risks. The primary theoretical approach I used to do so, is the concept of risk environments, focusing on the structural and environmental factors of criminalization and violence, as well as the protective and mitigating factor of social networks. In an attempt to identify barriers to health service uptake and its intersection with migration status, a key theme emerged from the findings, which is the central role of violence in the everyday environment of FSWs in Nairobi.

Somali FSWs in Nairobi are vulnerable to routine and widespread violence in terms of physical and sexual assault with clients, intimate partners, police, and their community/the public (from both Somalis and the Kenyan host community). The compounded nature of being an irregular

migrant, a Somali and a FSW breads more susceptibility to violence and its repercussions, in addition to violence being a public health concern in its own right.

Somali migrant FSWs in Nairobi indicate they do not have social support, but then openly mention various types of people within their networks, including neighbours and other FSWs. The importance of clan lineage and family ties in the Somali culture is historically a crucial component of the Somali culture, both in Somalia and abroad, and its linkage with well-being for women is documented (McMichael and Manderson, 2004). The fact that Somali FSWs in Nairobi have broken most of their ties to this traditionally very strong support network in their culture, may create a self-fulfilling prophecy, whereby they do not reach out/maintain ties to their family and fellow clan members, due to shame and internalized stigma, and they become further ostracized from the traditional Somali way of life.

Their interpretation of not having a support system may be shaping their risk, with them focusing on the most basic needs on a short term, often daily basis, including shelter and food for themselves and their children. Were they to see the social support around them, perceive this support, and actively capitalize on the knowledge, resources and social capital, perhaps they would not internalize so reverently an external sense of control and hopelessness, as it pertains to the state of their lives.

Drawing on the literature, the impact of social networks (Latkin et al., 2003; Tucker et al., 2011), social inclusion and exclusion (Jackson et al., 2009), interpersonal support networks (Dalla, 2001), and social support (QIao 2015), has been reviewed in relation to impact on risk behaviour and in relation to health outcomes, for FSW. Specifically, Latkin et al (2003) found that exchanging sex for drugs or money, amongst drug users in Baltimore in the Unites States,

was not simply a result of socioeconomic status, but also social network factors. The potential association given by the authors is that individuals who had family in their networks had additional social capital, which alleviated the economic need to sell sex. Somali migrant FSW in Nairobi differ in that they do not have strong family ties, oftentimes due to the ostracization due to being a sex worker, therefore this protective mechanism is not present.

Other research has found the role of social support to mitigate risk and/or be leveraged as a resource to cope with or prevent some risks; for examplec Tucker et al. (2011) who show that FSWs may draw on social support for education and information around healthy sexual behaviours, and in some cases those reporting stronger and more extensive support networks also demonstrate lower levels of risk and higher engagement with prevention and care services. Interestingly, this does not seem to be the case in this sample of Somali migrant FSWs, despite the clear existence of different forms of support presented previously.

While outdated, Dalla (2001) explains how the personal lives and specifically the interpersonal networks of 31 street-based FSWs in a mid-Western city in the US, through in-depth interviews. The research focused on relationships with partners, parents, and children, describing various patterns around relationships and resulting emotional support. Specifically, family environments were described as tumultuous, and affection amongst family members often not present. Domestic and parental violence, abandonment, alcoholism, and drug use, were all commonplace. Moreover, relationships between women and their partners were characterized lacking emotional substance, but rather based on sexual relations and drug use. These findings are similar to those amongst Somali migrant FSW in Nairobi, where family ties

are minimal. In contrast to the literature, however, drug and alcohol use remains low amongst migrant FSW in Nairobi, likely linked to strong Somali cultural norms against substance use.

Similar to existing literature, migrants in Nairobi have awareness of sexual and reproductive health risks associated with their livelihoods; however, there are various structural and individual factors that affect health seeking behaviour. In Laos, some of the barriers associated with health seeking behaviour included not knowing where to go for services, as well as poor quality of services (e.g. long waiting times and negative attitudes from service providers) (Phrasisombath *et al.*, 2012). Similarly in Nairobi, migrant FSWs experience barriers ranging from structural issues related to their migration status and nationality – lack of identification, language and communication challenges - to inherent challenges with the health system - long queues and lack of medicines.

Dozens of conceptual frameworks around sex workers' health already exist; however, most of them do not consider the dynamics of migration and the concept of intersectionality, which in the context of migrant FSWs may be more impactful on health and health seeking behaviour than being a sex worker (e.g., exposure to sexual health risks).

Many ideological positions look at sex worker health and take one of two approaches; 1. Abolitionism and 2. Empowerment. The first, abolitionism, focuses on the exploitative nature of the sex industry and supports major changes, if not eradication, of the industry altogether (Vanwesenbeeck, 2017). The second approach, focusing on empowerment, takes more of a harm reduction lens, and encourages improving sex workers' rights, and their involvement in constructions of interventions (Tucker and Tuminez, 2011). A third, alternative model, proposed by Tucker and Tuminez, proposes a behavioural–structural conceptual framework,

which falls somewhere in between, highlights that many may have been coerced into the industry, the fundamental significance of social networks, cohesion and sex worker collective; while also focusing on the importance of sex worker led solutions and interventions, (Tucker and Tuminez, 2011).

One model in the literature that takes into consideration migration, looks at risk factors to HIV acquisition amongst migrants, and showed a link between HIV transmission and mobility linked risk factors. The authors make the case that given new trends in HIV programming focusing on prevention, migrants may be a key population group for which these efforts should be placed (Cassels, Jenness and Khanna, 2014). However, the conceptual model focuses on a mathematical network-dyadic approach, looking at a network of potential partners, and potential pathways within and external to the networks, as a result of migration. Structural determinants models would typically include structural factors shaping disease transmission such as migration, legal parameters including criminalization, stigma and discrimination; and this is what Shannon et al. advocate for in their work, specifically looking at HIV infection (Shannon *et al.*, 2014). These models, however, do not cater to the competing and additive nature of being a migrant, a sex worker, and potentially from an already stigmatized and underserved segment of the population, as is the case with Somali FSWs in Kenya.

The experiences of violence affect health seeking behaviour, networks and support and intersects to form the overall risk environment for Somalia migrant FSWs in Nairobi. As well, hopelessness and a lack of perceived control over their health outcomes, may be contributing to a lack of prioritization of health in the lives in Somali FSWs. Ambar Basu (2010), found a similar findings in his work with FSWs in Calcutta, India, through ethnographic research with

a FSW community. Conceptualizing health in the present, was simply not an option for this community.

12.4. Implications for tailored interventions

Over a decade ago a prominent article in the Lancet called for a more strategic investment approach end the HIV and AIDS epidemic (Schwartländer B, et al., 2011). This framework included a focus on community mobilisation, the importance of interconnectedness across programme elements, and benefits of the extension of antiretroviral therapy for HIV transmission prevention. Thereafter, a guidance document was published by WHO in 2013 entitled "*Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*", which incorporated clearly a recommendation to support community mobilization as part of a comprehensive approach to supporting sex workers and improving health and human rights outcomes. This tool is commonly referred to as the Sex Worker Implementation Tool (the 'SWIT'), and includes 6 core interconnected areas of guidance for supporting sex workers, illustrated in

Figure 12 below (World Health Organization, 2013).

Figure 12: Structure of the sex worker implementation tool (SWIT)

Kenya has made great strides in all six areas of intervention illustrated; however, these are geared towards national sex workers, rather than migrants. While of course this is the case in many contexts and often the focus of national AIDS control programmes, in a context such as Kenya, where migration is a core characteristic of the country and the region, interventions should reflect a more holistic approach. More precisely, isolated migrant FSW services are not needed, but tailoring services to ensure they are accessible and appropriate for migrants as well, in this case Somalis, requires attention. Implications for tailored interventions include utilizing Somali FSWs as peer outreach workers with appropriately developed information, education and communication (IEC) materials and trainings, training peers as paralegals to provide FSWs with support around their migration status, rights and support in cases of arrest and violence; provision of Somali translators at sex worker clinics; provision of childcare services and culturally appropriate training schemes to look at opportunities for employment diversification, and language training to enable better negotiation with clients, health services, their community and promote integration into their new communities.

12.5. Conducting research in conflict affected/unstable situations and other limitations

This research was beset with challenges, including a lack of ability to access the populations, to spend time with them to gain their trust, and to participate actively in data collection (ability for me to be present), which resulted in a change to the methods employed, and a lack of depth and scope to the data. Had I been able to be present in the interviews more frequently and had the possibility to observe first-hand more interviews, with simultaneous translation, the interaction with the participants, the probing of follow-up questions, and the analytical aspects of this method would potentially have been more fruitful.

It has long been documented that conducting research in fragile states poses challenges including insecurity, lack of access, quickly changing contexts, and potential lack of trust by research participants; resulting in possible issues around data availability, quality and comprehensiveness (Martineau *et al.*, 2017).

Undertaking data collection in a fragile environment impacts data quality, monitoring of data collection, changes to methods, expectations from research participants given changes to political and operational environmental on the ground. As such, there were limitations of the research, as a result of the changing context (e.g., history of Eastleigh, not being able to access the site and population, etc.).

12.6. Strengths and limitations

The primary strength of this research was my long-term involvement with the population, familiarity with the culture and locale, relationships with NGOs and community groups, and

prior involvement in the IBBS survey which provided perspective and grounding in the realities of this context.

Nevertheless, there were also multiple limitations to this research. While the initial desired sample size of 15 respondents was reached, the study was beset with challenges due to the changing security situation in Eastleigh, thus resulting in changes to the study design, including the withdrawal of one study method (participant observation) due to difficulties to visit the data collection site to work with the research assistant and spend time with the study population. As a result, only individual semi-structured interviews and group interviews were able to proceed.

Furthermore, purposive sampling was used, and as such does not reflect a representative sample, nor was this the intention and as such generalizations to the entire Somali FSW population cannot be made. A theory driven approach was utilized, whereby I had identified key concepts in advance, to provide a foundation for the research, to be then reviewed continually during data collection and reframed. However, due to the lack of ability to be engaged in the actual data collection, but rather more in a 'remote control' manner, the depth and quality of the data was affected.

Midway through data collection, and certainly during analysis, it became clear that eliciting information through a narrative approach was exceptionally difficult with this population. This was a result of multiple factors, including the lack of experience of the primary research assistant in conducting qualitative research; the lack of ability for myself to be present to support the interviews in real-time due to the worsening security situation; and finally the delays in time for transcription and translation, and thereafter team meetings to review the data;

where we could discuss flow and content of interviews, where more appropriate probing would have elicited more relevant information.

Interestingly, there were different theories at different phases of the research, whether my presence in the interviews would support more high-quality data, given I could support and coach the primary research assistant on how and where to probe, or whether my presence would be a hindrance. Evidence shows that trust is perceived as a crucial element of Islamic character, and those who are not Muslim, or devout Muslims, may not be perceived as trustworthy on this basis alone (Rift valley institute, 2014). Nonetheless, this question could not be tested more thoroughly to my lack of ability for movement to and within Eastleigh.

Furthermore, another weakness was the lack of quality assurance over the research assistants during fieldwork, due to aforementioned access constraints and the long time between data collection and analysis/write up.

12.7. Learnings and insights for future research

Despite the challenges mentioned, the ability to transfer learnings to other settings is present. Particularly, the importance of sufficient time to train research assistants in qualitative techniques. Furthermore, when working with undocumented migrant populations, as well as those engaging in high-risk and illegal behaviour such as sex work in Kenya, the need to establish trust with the community is pertinent and should the context change where that is no longer feasible, the study design should potentially be revisited altogether.

Also, affiliations with large and well-known organizations that are known to provide support to refugees, while providing credibility, can affect the perception of the research, potential

gains to the populations (e.g., resettlement support), and the position of the researcher(s) within the community. The most basic example is pulling up to a small CBO in a very poor area, in a large white land cruiser, with a driver – this is not inconspicuous, it attracts unwanted attention, makes it difficult for the researchers to blend in, diminishes the ability for participants to feel safe and comfortable, and most notably further exacerbates the divide between researcher and participant.

Moreover, looking at some of the inconsistencies in the data, around their demographic details and migration trajectory, such as age, when they left Somalia, length of time in Kenya, etc. some of these can be explained by expected lapses in memory recall for events that are historical, and all research as this potential bias. Also, Somali culture places less emphasis on birthdays and dates, therefore, recall based on dates and age at certain life events could be affected. However, another possible explanation is that the participants were changing details of their life stories, if perhaps they thought they would be eligible for resettlement or additional services based on humanitarian ground.

Finally, while it is known that qualitative research is more dependent on experience and judgement than quantitative research; nonetheless the potential biases as myself the principal investigator, as well as the research assistant, in the recruitment, data collection and analysis of the study findings must be acknowledged.

One of the key lessons learnt for future research would be to invest far more time in recruitment and training of an experienced research assistant, and preferably utilizing someone from the population directly, to support design and implementation of the research. It was only in hindsight, the realization that the partnership with Umma CBO was superficial, and that in

reality the design and implementation of the research was top down, taking an outsider and exclusionary approach to the population in question, and this impacted the overall results.

13. Conclusions

The conclusions from this study focus on the theoretical, but also practical, in the hopes they can be used for future studies and interventions with this population, and those in similar contexts. While the research is dated, the findings are transferable, and the situation has not changed greatly for these populations in the years since the data was collected.

Somali FSWs in Nairobi are vulnerable and basic human rights not being met, including the right to health, stemming from a lack of documented migration status and other factors. Typical barriers to health seeking behaviour present in other migrant contexts exist, such as language, costs, etc. Furthermore, systemic discrimination is present as part of the urban refugee conundrum, and lack of economic opportunities prevail. Cultural factors, such as a religious context resulting in an external sense of control, indicating 'Allah will fix it', is compounded by the exceptionally low self-esteem and belief that they are already 'bad Muslims', 'bad Somalis', and they cannot come back from this status. Furthermore, Somali FSWs are systematically targeted by law enforcement, experience high levels of violence, harassment, and discrimination. Finally, their health seeking behaviour is poor, and while not all treatment experiences have been poor, oftentimes they simply cannot afford and do not prioritize their health, over feeding and providing accommodation for their children.

This study shows that the compounded nature of being a migrant, and in particular a Somali in Kenya at the time the study took place, as well as a sex worker, places this population at increased risk to both their physical and mental health. The multiple layers of stigma and discrimination; ostracization and exclusion from a traditional Somali clan-based community and support structure; and both internalized and externalized hopelessness and overall

optimism for their circumstances to change in the future; all contribute to a lack of prioritization of their health and therefore poor health seeking behaviour.

Structural interventions are recommended, focusing on community empowerment, stigma reduction, rights awareness, and social justice; however, none of these activities differ from gold standard and best practice FSW interventions globally. Incorporation of components catering to the needs of migrant FSWs could be added, such as awareness raising around migrant and refugee legal rights and development of community building across the Somali and Kenyan communities, to build tolerance and acceptance. Furthermore, ensuring Somali FSWs are trained as peer outreach workers with appropriately developed IEC material and trainings, and including across the cascade of FSW clinical and social support services would better support the needs of Somalia FSWs in Kenya, including tackling language, cultural and stigma barriers.

Community interventions are needed, such as community empowerment to reduce violence, including provision of mechanisms for FSWs to reflect on their challenges, rights, and inherent origins of these challenges. Furthermore, to develop mechanisms for FSWs to organize and advocate to contest and modify policies and behaviours of influential groups or institutions that systematically deny their rights and perpetrate violence (World Health Organization *et al.*, 2013). Community based interventions should consider focusing on negotiation skills in these contexts, mechanisms for reporting of violent acts, and FSW rights in these situations. Lastly, capacity of law enforcement could be strengthened, with a focus on stigma reduction and the basic human and legal rights of Somali sex workers in Kenya. Additionally, interventions to prevent violence against all FSWs, including migrant FSWs should be considered and could be done through training and awareness raising amongst law enforcement. Empowering the

Somali migrant FSWs around their rights, and recourse in the case of harassment, entrapment and arrest is crucial. Furthermore, this study indicates the need for multilevel interventions, including legal reforms so that laws governing sex work promote the health and human rights of sex workers in Kenya.

Ultimately, health interventions should ideally move away from the traditional bio-medical models assuming that when services are available (e.g. supply), and populations are made aware, that all groups, including those most vulnerable, will prioritize uptake (e.g. demand). Perhaps changing perceptions around health – emphasising the importance of good health, the impact on their profession, their future, and that they have control in this matter, changing their locus of control around this issue, is necessary in order to ensure success of interventions.

The contextual and cultural factors framing Somali FSWs in Nairobi, such as religious and migration aspects, and an external sense of control, need to be addressed to ensure increased and sustainable engagement with health and social support services. Outreach and peer to peer models are not novel but incorporating the dynamics of migration and intersectionality are essential. Implications for reducing stigma, shame, blame, and competition while increasing the presence of peer support networks, coalitions and allegiances between women, in order to design effective community-based interventions, could be explored.

REFERENCES

Ambar Basu (2010) 'Communicating Health as an Impossibility: Sex Work, HIV/AIDS, and the Dance of Hope and Hopelessness', *Southern Communication Journal*, 75(4), pp. 413–432. doi: 10.1080/1041794x.2010.504452.

Ameresekere M *et al.* (2011) 'Somali immigrant women's perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the

USA.', *International Journal of Gynaecology & Obstetrics*, 115(3), pp. 227–230.
Araujo, J. de O. *et al.* (2019) 'Prevalence of sexual violence among refugees: a systematic review', *Revista de saude publica*. NLM (Medline), 53, p. 78. doi: 10.11606/s1518-8787.2019053001081.

Arujo de Carvalho, I., Haour-Knipe, M. and Dehne, K. L. (2010) 'Migration and HIV Infection: What do data from destination countries show?', in Thomas, F., Haour-Knipe, M., and Aggleton, P. (eds) *Mobility, Sexuality and AiDS*. Routledge, p. 224.

Bandewar, S. V., Kimani, J. and Lavery, J. V (2010) 'The origins of a research community in the Majengo observational cohort study, Nairobi, Kenya.', *BMC public health*. BioMed Central Ltd, 10(1), p. 630. doi: 10.1186/1471-2458-10-630.

Becker, M. L. *et al.* (2018) 'Vulnerabilities at first sex and their association with lifetime gender-based violence and HIV prevalence among adolescent girls and young women engaged in sex work, transactional sex, and casual sex in Kenya', *Journal of Acquired Immune Deficiency Syndromes*, 79(3), pp. 296–304. doi: 10.1097/QAI.0000000000001826.

Bershteyn, A. *et al.* (2018) 'The influence of mobility among high-risk populations on HIV transmission in Western Kenya', *Infectious Disease Modelling*. Elsevier Ltd, 3, pp. 97–106. doi: 10.1016/j.idm.2018.04.001.

Bhattacharjee, P. *et al.* (2019) 'HIV prevention programme cascades: insights from HIV programme monitoring for female sex workers in Kenya', *Journal of the International AIDS Society*. John Wiley and Sons Inc., 22(S4). doi: 10.1002/jia2.25311.

Blanchard, J. F. and Aral, S. O. (2010) 'Emergent properties and structural patterns in sexually transmitted infection and HIV research.', *Sexually transmitted infections*, 86 Suppl 3, pp. iii4-9. doi: 10.1136/sti.2010.046037.

Bonomi, A. E. *et al.* (2007) 'Health outcomes in women with physical and sexual intimate partner violence exposure', *Journal of Women's Health*. Mary Ann Liebert, Inc. 2 Madison Avenue Larchmont, NY 10538 USA , 16(7), pp. 987–997. doi: 10.1089/jwh.2006.0239.

Brah Avtar, P. A. (2004) 'Ain't I A Woman? Revisiting Intersectionality By Avtar Brah and Ann Phoenix', *Journal of International Women's Studies*, 5(May), pp. 75–86.

Bredstrom, a. (2006) 'Intersectionality: A Challenge for Feminist HIV/AIDS Research?', *European Journal of Women's Studies*, 13(3), pp. 229–243. doi: 10.1177/1350506806065754.

Breiding, M. J., Black, M. C. and Ryan, G. W. (2008) 'Chronic Disease and Health Risk Behaviors Associated with Intimate Partner Violence-18 U.S. States/Territories, 2005', *Annals of Epidemiology*. Elsevier, 18(7), pp. 538–544. doi:

10.1016/j.annepidem.2008.02.005.

Brown, E. *et al.* (2010) '"They get a C-section...they gonna die": Somali women's fears of obstetrical interventions in the United States.', *Journal of Transcultural Nursing*, 21(3), pp. 220–227.

Brydsten A, Hammarström A, S. S. M. (2018) 'Health inequalities between employed and unemployed in northern Sweden: a decomposition analysis of social determinants for mental health.', *Int J Equity Health*, 17(1), pp. 59–10.

Busza, J. (2005) 'How Does a "Risk Group" Perceive Risk? Voices of Vietnamese Sex Workers in Cambodia.', *Journal of Psychology & Human Sexuality*, 17(1–2), pp. 65–82. doi: 10.1300/J056v17n01_05.

Busza, J. *et al.* (2014) 'Triple jeopardy: Adolescent experiences of sex work and migration in Zimbabwe.', *Health & place*, 28C, pp. 85–91. doi: 10.1016/j.healthplace.2014.04.002.

Campbell, C. and Gibbs, A. (2009) 'Stigma, gender and HIV: case studies of inter-sectionality.', in Boeston, J. and Poku, N. K. (eds) *Gender and HIV/AIDS: critical perspectives from the developing world*. Surrey: Ashgate Publishing, pp. 29–46..

Campbell, E. H. (2006) 'Urban Refugees in Nairobi: Problems of Protection, Mechanisms of Survival, and Possibilities for Integration', *Journal of Refugee Studies*, 19(3), pp. 396–413. doi: 10.1093/jrs/fel011.

Carroll, J. *et al.* (2007) 'Caring for Somali women: implications for clinician-patient communication', *Patient Education & Counseling*, 66(3), pp. 337–345.

Cassels, S., Jenness, S. M. and Khanna, A. (2014) 'Conceptual Framework and Research Methods for Migration and HIV Transmission Dynamics', *AIDS Behavious*, 18(12), pp. 2302–2313. doi: 10.1038/jid.2014.371.

Centres for Disease Contol and Prevention (2018) *Somali Refugees: Population Movements*. Available at: https://www.cdc.gov/immigrantrefugeehealth/profiles/somali/populationMovements.html.

Chapman, J. *et al.* (2009) 'Sex and sexuality in the Shenzhen tongzhi circle: HIV risk context and migrant men who have sex with men in China.', *Culture, health & sexuality*, 11(7), pp. 689–702. doi: 10.1080/13691050902977562.

Chatterjee, C. B. (2006) *Identities in Motion; Migration and Health In India*. Available at: http://www.cehat.org/go/uploads/Hhr/migrants.pdf (Accessed: 3 September 2017).

Chen, X. *et al.* (2011) 'Social Stigma, Social Capital Reconstruction and Rural Migrants in

Urban China: A Population Health Perspective.', *Human organization*, 70(1), pp. 22–32. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3080703&tool=pmcentrez&rendertype=abstract.

Choi, S. Y. P. (2011) 'Heterogeneous and vulnerable: the health risks facing transnational female sex workers.', *Sociology of Health & Illness*, 33(1), pp. 33–49. doi: 10.1111/j.1467-9566.2010.01265.x.

Coast, E. (2006) 'Local understandings of, and responses to, HIV: rural-urban migrants in Tanzania.', *Social science & medicine (1982)*, 63(4), pp. 1000–10. doi: 10.1016/j.socscimed.2006.03.009.

Coffee, M., Lurie, M. N. and Garnett, G. P. (2007) 'Modelling the impact of migration on the HIV epidemic in South Africa.', *AIDS (London, England)*, 21(3), pp. 343–50. doi: 10.1097/QAD.0b013e328011dac9.

Coffee, M. P. *et al.* (2005) 'Patterns of movement and risk of HIV infection in rural Zimbabwe.', *The Journal of infectious diseases*, 191 Suppl, pp. S159-67. doi: 10.1086/425270.

Cooper, K. *et al.* (2007) 'Maids, Migrants and Occupational Health in the London Sex Industry', *Anthropology & Medicine*, 14(1), pp. 41–53. doi: 10.1080/13648470601106319.

Dalla, R. L. (2001) 'Journal of Family Issues', *Journal of Family Issues*. doi: 10.1177/019251301022008006.

Dean, H. D. and Fenton, K. A. (2010) 'Addressing social determinants of health in the prevention and control of HIV/AIDS, viral hepatitis, sexually transmitted infections, and tuberculosis.', *Public health reports (Washington, D.C. : 1974)*. SAGE Publications, 125 Suppl 4(Suppl 4), pp. 1–5. doi: 10.1177/00333549101250S401.

Deane, K. D., Parkhurst, J. O. and Johnston, D. (2010) 'Linking migration, mobility and HIV.', *Tropical medicine & international health : TM & IH*, 15(12), pp. 1458–63. doi: 10.1111/j.1365-3156.2010.02647.x.

Deering, K. N. *et al.* (2014) 'A systematic review of the correlates of violence against sex workers.', *American journal of public health*, 104(5), pp. e42-54. doi: 10.2105/AJPH.2014.301909.

Degni, F., Koivusilta, L. and Ojanlatva, a (2006) 'Attitudes towards and perceptions about contraceptive use among married refugee women of Somali descent living in Finland.', *The European journal of contraception & reproductive health care: the official journal of the European Society of Contraception*, 11(3), pp. 190–6. doi: 10.1080/13625180600557605.

Deyo, N. (2013) ‘Cultural Traditions and the Reproductive Health of Somali Women University of San Francisco’, (January).
Deyo, N. S. and Deyo, N. (2012) ‘Cultural Traditions and the Reproductive Health of Somali Refugees and Immigrants’.

Directorate of National Statistics and Federal Republic of Somalia (2020) *The Somali Health and Demographic Survey 2020*.

Duckett, M. (2000) ‘Migrants and HIV / AIDS.’, *Development bulletin (Australian Development Studies Network)*, (52), pp. 18–20. Available at: http://www.ncbi.nlm.nih.gov/pubmed/12179440 (Accessed: 30 April 2011).

Fasihi Harandi, T., Mohammad Taghinasab, M. and Dehghan Nayeri, T. (2017) ‘The correlation of social support with mental health: A meta-analysis’, *Electronic Physician*. Mehr Publishing Group, 9(9), pp. 5212–5222. doi: 10.19082/5212.

Feagin, J., Orum, A. and Sjoberg, G. (eds) (1991) *A case for case study*. Chapel Hill, NC: University of North Carolina Press.

Federal Government of Somali (2016) *National Development Plan: 2017-2019*.

Fonck, K. *et al.* (2000) ‘A randomized, placebo-controlled trial of monthly azithromycin prophylaxis to prevent sexually transmitted infections and HIV-1 in Kenyan sex workers: study design and baseline findings.’, *International journal of STD & AIDS*, 11(12), pp. 804–11. Available at: http://www.ncbi.nlm.nih.gov/pubmed/11138916.

Freeman, C. *et al.* (2013) ‘The Intersection of Health Beliefs and Religion Among Somali Refugees: A Qualitative Study’, *Journal of Religion and Spirituality in Social Work*. Taylor & Francis Group, 32(1), pp. 1–13. doi: 10.1080/15426432.2013.749141.

Ghasemipoor M, J. G. S. (2010) ‘The relationship between the social support and mental health in Lorestan university students’, *Yafteh*, 12(1), pp. 57–64.

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008) *Health Behavior and Health Education: Theory, Researech and Practice, 4th Edition*. Jossey-Bass. Available at: https://www.med.upenn.edu/hbhe4/index.shtml (Accessed: 4 July 2020).

Glaser, B. and Strauss, A. L. (1987) *The DIscovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.

Goldenberg, S. M., Strathdee, S. A., *et al.* (2011) ‘How important are venue-based HIV risks among male clients of female sex workers? A mixed methods analysis of the risk environment in nightlife venues in Tijuana, Mexico.’, *Health & place*, 17(3), pp. 748–56.

doi: 10.1016/j.healthplace.2011.01.012.

Goldenberg, S. M., Strathdee, S. a, *et al.* (2011) '"Over here, it's just drugs, women and all the madness": The HIV risk environment of clients of female sex workers in Tijuana, Mexico', *Social science & medicine (1982)*. Elsevier Ltd, pp. 1–8. doi: 10.1016/j.socscimed.2011.02.014.

Golkade, K. (2009) 'Health is hard here" or "health for all"? The politics of blame, gender, and health care for undocumented Nicaraguan migrants in Costa Rica', *Med Anthropol Q.*, 23(4), pp. 483–503.

Gundel, J. (2003) 'Somalia Case Study', in Van Hear, N. and Nyberg Sorenson, N. (eds) *The Migration-Development Nexus*.

Hacker, K. *et al.* (2015) 'Barriers to health care for undocumented immigrants: A literature review', *Risk Management and Healthcare Policy*, 8, pp. 175–183. doi: 10.2147/RMHP.S70173.

Halli, S. S. *et al.* (2007) 'Migration and HIV transmission in rural South India: an ethnographic study.', *Culture, health & sexuality*, 9(1), pp. 85–94. doi: 10.1080/13691050600963898.

International Organization for Migration (2019) *Intrnational Migration Law: Gloassry on Migration*. Geneva. Available at: https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf.

IOM (2002) 'Position paper on HIV/AIDS and Migration'. Geneva, p. 8. Available at: https://www.iom.int/jahia/webdav/shared/shared/mainsite/about_iom/en/council/84/Mcinf252.pdf (Accessed: 7 June 2020).

Jackson, L. a *et al.* (2009) 'Intimate relationships and women involved in the sex trade: perceptions and experiences of inclusion and exclusion.', *Health (London, England : 1997)*, 13(1), pp. 25–46. doi: 10.1177/1363459308097359.

Jakobsson, N. and Kotsadam, A. (2011) 'Gender equity and prostitution: An investigation of attitudes in Norway and Sweden', *Feminist Economics*. Routledge , 17(1), pp. 31–58. doi: 10.1080/13545701.2010.541863.

Jovchelovitch, S. and Bauer, M. W. (2007) 'LSE Research Online', *Narrative*.
K, G., den Otter, A. and Spreij, J. (2012) 'Access to health care for undocumented migrants: a comparative policy analysis of England and the Netherlands.', *J Health Polit Policy Law*, 37(1), pp. 37–67.

Karamouzian, M. *et al.* (2016) 'How sex work becomes an option: Experiences of female sex

workers in Kerman, Iran', *Culture, Health and Sexuality*. Routledge, 18(1), pp. 58–70. doi: 10.1080/13691058.2015.1059487.

Kaul, R. *et al.* (2004) 'Monthly antibiotic chemoprophylaxis and incidence of sexually transmitted infections and HIV-1 infection in Kenyan sex workers: a randomized controlled trial.', *JAMA : the journal of the American Medical Association*, 291(21), pp. 2555–62. doi: 10.1001/jama.291.21.2555.

Kenneth H Mayer and Pizer, H. F. (eds) (2008) *HIV Prevention: A comprehensive Approach*. London: Elsevier. Available at: http://medcontent.metapress.com/index/A65RM03P4874243N.pdf (Accessed: 11 June 2014).
Khan, M. R. *et al.* (2008) 'Mobility and HIV-related sexual behavior in Burkina Faso.', *AIDS and behavior*, 12(2), pp. 202–12. doi: 10.1007/s10461-007-9314-8.

Kimani, J. *et al.* (2008) 'Reduced rates of HIV acquisition during unprotected sex by Kenyan female sex workers predating population declines in HIV prevalence.', *AIDS (London, England)*, 22(1), pp. 131–7. doi: 10.1097/QAD.0b013e3282f27035.

KM, H. *et al.* (2018) 'Social capital, socioeconomic status, and depression in community-living elderly.', *Journal of psychiatric research*, (98), pp. 133–40.

Koshen, H. I. A. (2013) 'Strengths in Somali families', in *Strong Families Around the World: Strengths-Based Research and Perspectives*. Taylor and Francis, pp. 71–99. doi: 10.1300/J002v41n01_05.

Kriitmaa, K. (2011) *Integrated Bio-Behavioural Surveillance Survey among Migrant Female Sex Workers in Nairobi, Kenya, Final Report*. Nairobi, Kenya.

Krüsi, A. *et al.* (2012) 'Negotiating safety and sexual risk reduction with clients in unsanctioned safer indoor sex work environments: a qualitative study.', *American journal of public health*, 102(6), pp. 1154–9. doi: 10.2105/AJPH.2011.300638.

Lagarde, E. *et al.* (2003) 'Mobility and the spread of human immunodeficiency virus into rural areas of West Africa', *International Journal of Epidemiology*, 32(5), pp. 744–752. doi: 10.1093/ije/dyg111.

Latkin, C. a, Hua, W. and Forman, V. L. (2003) 'The relationship between social network characteristics and exchanging sex for drugs or money among drug users in Baltimore, MD, USA.', *International journal of STD & AIDS*, 14(11), pp. 770–5. doi: 10.1258/09564620360719831.

Laws of Kenya: The Sexual Offences Act, No 3 (2006).
Lazarus, J. V *et al.* (2006) 'HIV/AIDS knowledge and condom use among Somali and Sudanese immigrants in Denmark.', *Scandinavian journal of public health*, 34(1), pp. 92–9.

doi: 10.1080/14034940510032211.

Lippman, S. a *et al.* (2010) 'Social-environmental factors and protective sexual behavior among sex workers: the Encontros intervention in Brazil.', *American journal of public health*, 100 Suppl, pp. S216-23. doi: 10.2105/AJPH.2008.147462.

Logie, C. H. *et al.* (2011) 'HIV, gender, race, sexual orientation, and sex work: a qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada.', *PLoS medicine*, 8(11), p. e1001124. doi: 10.1371/journal.pmed.1001124.

Luchters, S. *et al.* (2008) 'Impact of five years of peer-mediated interventions on sexual behavior and sexually transmitted infections among female sex workers in Mombasa, Kenya.', *BMC public health*, 8, p. 143. doi: 10.1186/1471-2458-8-143.

Luchters, S. M. F. *et al.* (2010) 'Association of HIV infection with distribution and viral load of HPV types in Kenya: a survey with 820 female sex workers.', *BMC infectious diseases*, 10, p. 18. doi: 10.1186/1471-2334-10-18.

Lurie, M. *et al.* (2003) 'Who infects whom? HIV-1 concordance and discordance among migrant and non-migrant couples in South Africa.', *AIDS (London, England)*, 17(15), pp. 2245–52. doi: 10.1097/01.aids.0000088197.77946.ba.

Lydié, N. *et al.* (2004) 'Mobility, sexual behavior, and HIV infection in an urban population in Cameroon.', *Journal of acquired immune deficiency syndromes (1999)*, 35(1), pp. 67–74. Available at: http://www.ncbi.nlm.nih.gov/pubmed/14707795 (Accessed: 28 April 2011).

Martineau, T. *et al.* (2017) 'Health systems research in fragile and conflict affected states: A qualitative study of associated challenges', *Health Research Policy and Systems*. Health Research Policy and Systems, 15(1), pp. 1–12. doi: 10.1186/s12961-017-0204-x.

McCall, L. (2005) 'The Complexity of Intersectionality', *Signs: Journal of Women in Culture and Society*, 30(3), pp. 1771–1800. doi: 10.1086/426800.

McLeroy, K. R. *et al.* (1988) 'An Ecological Perspective on Health Promotion Programs', *Health Education Quarterly*. Sage PublicationsSage CA: Thousand Oaks, CA, 15(4), pp. 351–377. doi: 10.1177/109019818801500401.

McMichael, C. and Manderson, L. (2004) 'Somali Women and Well-Being: Social Networks and Social Capital among Immigrant Women in Australia', *Human Organization*. Society for Applied Anthropology, 63(1), pp. 88–99. Available at: http://www.jstor.org/stable/44126994.

Mmbaga, E. J. *et al.* (2008) 'The role of in-migrants in the increasing rural HIV-1 epidemic: results from a village population survey in the Kilimanjaro region of Tanzania.', *International journal of infectious diseases : IJID : official publication of the International*

Society for Infectious Diseases, 12(5), pp. 519–25. doi: 10.1016/j.ijid.2008.02.007.

Mundandi, C. *et al.* (2006) 'No difference in HIV incidence and sexual behaviour between out-migrants and residents in rural Manicaland, Zimbabwe.', *Tropical medicine & international health : TM & IH*, 11(5), pp. 705–11. doi: 10.1111/j.1365-3156.2006.01614.x.

Musyoki, H. *et al.* (2015) 'Prevalence of HIV, Sexually Transmitted Infections, and Risk Behaviours Among Female Sex Workers in Nairobi, Kenya: Results of a Respondent Driven Sampling Study', *AIDS and Behavior*. Springer New York LLC, 19(1), pp. 46–58. doi: 10.1007/s10461-014-0919-4.

National AIDS and STI Control programme (2007) *KAIS: Kenya AIDS Indicator Survey*. Nairobi.

National AIDS and STI Control programme, G. of K. (2015) *Kenya AIDS Strategic Framework (KASF) 2015-2019*.

Nyangairi, B. and Palmary, I. (2015) 'Watching Each Others' Back, Coping with Precarity in Sex Work'. Springer, Cham, pp. 121–134. doi: 10.1007/978-3-319-08768-9_7.

OBrien, O. and Khan, S. (1996) 'Stigma and racism as they affect minority ethnic communities', in Haour-Knipe, M. and Rector, R. (eds) *Crossing borders: migration, ethnicity and AIDS*. London: Taylor & Francis, pp. 102–117.

Okal, J. *et al.* (2011) 'Sexual and physical violence against female sex workers in Kenya: a qualitative enquiry.', *AIDS care*, 23(5), pp. 612–8. doi: 10.1080/09540121.2010.525605.

Outshoorn, J. (2012) 'Policy Change in Prostitution in the Netherlands: from Legalization to Strict Control'. doi: 10.1007/s13178-012-0088-z.

Palermo, T., Bleck, J. and Peterman, A. (2014) 'Tip of the iceberg: Reporting and gender-based violence in developing countries', *American Journal of Epidemiology*, 179(5), pp. 602–612. doi: 10.1093/aje/kwt295.

Parcesepe, A. *et al.* (2015) 'Measuring Physical Violence and Rape Against Somali Women Using the Neighborhood Method', *Violence Against Women*, 22(7), pp. 798–816. doi: 10.1177/1077801215613852.

Parker, R. G. (1996) 'Empowerment, community mobilization and social change in the face of HIV/AIDS.', *AIDS (London, England)*, 10 Suppl 3, pp. S27-31. Available at: http://www.ncbi.nlm.nih.gov/pubmed/8970709 (Accessed: 26 April 2011).

Pates, R. (2012) 'Liberal laws juxtaposed with rigid control: An analysis of the logics of governing sex work in Germany', *Sexuality Research and Social Policy*. Springer, 9(3), pp.

212–222. doi: 10.1007/s13178-012-0092-3.

Patton, M. (2002) *Qualitative evaluation and research methods (3rd ed.).* Thousand Oaks, Ca: Sage.

Pavlish, C., Noor, S. and Brandt, J. (2010) 'Somali immigrant women and the American health care system: discordant beliefs, divergent expectations, and silent worries', *Social Science & Medicine*, 71(2), pp. 353–361.

Phrasisombath, K. *et al.* (2012) 'Care seeking behaviour and barriers to accessing services for sexually transmitted infections among female sex workers in Laos: a cross-sectional study', *BMC Health Services Research*. BioMed Central Ltd, 12(1), p. 37. doi: 10.1186/1472-6963-12-37.

Pitcher, J. and Wijers, M. (2014) 'The impact of different regulatory models on the labour conditions, safety and welfare of indoor-based sex workers', *Criminology and Criminal Justice*, pp. 1748895814531967-. doi: 10.1177/1748895814531967.

Platt, L. *et al.* (2011) 'Risk of sexually transmitted infections and violence among indoor-working female sex workers in London: the effect of migration from Eastern Europe.', *Sexually transmitted infections*, 87(5), pp. 377–84. doi: 10.1136/sti.2011.049544.

Platt, L. *et al.* (2013) 'Factors mediating HIV risk among female sex workers in Europe: a systematic review and ecological analysis.', *BMJ open*, 3(7). doi: 10.1136/bmjopen-2013-002836.

Platt, L. *et al.* (2018) *Associations between sex work laws and sex workers' health: A systematic review and meta-analysis of quantitative and qualitative studies*, *PLoS Medicine*. doi: 10.1371/journal.pmed.1002680.

Prakash, R. *et al.* (2016) 'Effect of physical violence on sexually transmitted infections and treatment seeking behaviour among female sex workers in Thane District, Maharashtra, India', *PLoS ONE*. Public Library of Science, 11(3). doi: 10.1371/journal.pone.0150347.

Råssjö, E. B. *et al.* (2013) 'Somali women's use of maternity health services and the outcome of their pregnancies: a descriptive study comparing Somali immigrants with native-born Swedish women.', *Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives*, 4(3), pp. 99–106. doi: 10.1016/j.srhc.2013.06.001.

Rausa B.A. (2008) 'Encyclopedia of Aging and Public Health', in Loue S.J., S. M. (ed.). Massachusetts, Boston: Springer.

Reed, E. *et al.* (2012) 'Migration/mobility and risk factors for HIV among female sex workers in Andhra Pradesh, India: Implications for HIV prevention', *International Journal of*

STD and AIDS. SAGE PublicationsSage UK: London, England, 23(4). doi: 10.1258/ijsa.2009.009421.

Rekart, M. L. (2005) 'Sex-work harm reduction.', *Lancet*, 366(9503), pp. 2123–34. doi: 10.1016/S0140-6736(05)67732-X.
Rhodes, T. (2002) 'The "risk environment": a framework for understanding and reducing drug-related harm', *International Journal of Drug Policy*, 13(2), pp. 85–94. doi: 10.1016/S0955-3959(02)00007-5.

Rhodes, T. *et al.* (2008) 'Police violence and sexual risk among female and transvestite sex workers in Serbia: qualitative study', *BMJ open access*, 337.

Rhodes, T. *et al.* (2012) 'Structural violence and structural vulnerability within the risk environment: theoretical and methodological perspectives for a social epidemiology of HIV risk among injection drug users and sex workers', in O'Campo, P. and Dunn, J. R. (eds) *Rethinking Eocial epidemiology*. Dordrecht: Springer Netherlands, pp. 205–230. doi: 10.1007/978-94-007-2138-8.

Rift valley institute (2014) *Eastleigh and beyond: The Somali Factor in Urban Kenya*, *Refugees Management*.

Rift Valley Institute (2016) *Understanding research and knowledge systems in the Somali regions Report of a roundtable convened by INASP and the Rift Valley Institute*.

Rocha-Jiménez, T. *et al.* (2016) 'Migration, violence, and safety among migrant sex workers: a qualitative study in two Guatemalan communities.', *Culture, health & sexuality*. NIH Public Access, 18(9), pp. 965–79. doi: 10.1080/13691058.2015.1122229.

Sakha, M. *et al.* (2015) 'Challenges and Successes of Harm Reduction Services in Women's Drop-in Centres: Perspective of Vulnerable Women', *Materia Socio Medica*, 27(6), p. 434. doi: 10.5455/msm.2015.27.434-437.

Salami B, Yaskina M, Hegadoren K, Diaz E, Meherali S, R. A. et al. (2017) 'Migration and social determinants of mental health: Results from the Canadian Health Measures Survey.', *Canadian journal of public health, Revue canadienne de sante publique*, 108(4), pp. e362–e7.

Schwartländer B, Stover J, Hallett T, Atun R, Avila C, Gouws E, Bartos M, Ghys P, Opuni M, Barr M, Alsallaq R, L. B. (2011) 'Towards an improved investment approach for an effective response to HIV/AIDS', *The Lancet*, Jun 11(377), pp. 2031–41. doi: 10.1016/S0140-6736(11)60702-2.

Scorgie, F. *et al.* (2012) 'Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-Saharan Africa: A systematic review', *AIDS and Behavior*, 16(4), pp. 920–933. doi: 10.1007/S10461-011-9985-Z.

Sex Worker Outreach Program, Kenya (2020).

Shannon, K. *et al.* (2008) 'Social and structural violence and power relations in mitigating HIV risk of drug-using women in survival sex work.', *Social science & medicine (1982)*, 66(4), pp. 911–21. doi: 10.1016/j.socscimed.2007.11.008.

Shannon, K. *et al.* (2014) 'HIV infection among female sex workers in concentrated and high prevalence epidemics: Why a structural determinants framework is needed', *Current Opinion in HIV and AIDS*, 9(2), pp. 174–182. doi: 10.1097/COH.0000000000000042.

Silverman, D. (2004) 'Qualitative research: Theory, method and practice (2nd ed.)', in. London: Sage.

Sirotin, N. *et al.* (2010) 'A comparison of registered and unregistered female sex workers in Tijuana, Mexico.', *Public health reports (Washington, D.C. : 1974)*, 125 Suppl, pp. 101–109. doi: 10.2307/41434925.

Sorajjakool, S. and Benitez, A. (2015) 'The role of religion among sex workers in Thailand', *Religions*, 6(4), pp. 1263–1276. doi: 10.3390/rel6041263.

Spiegel, P. B., Schilperoord, M. and Dahab, M. (2014) 'High-risk sex and displacement among refugees and surrounding populations in 10 countries: The need for integrating interventions', *Aids*, 28(5), pp. 761–771. doi: 10.1097/QAD.0000000000000118.

Steinman, L. *et al.* (2010) 'Understanding infant feeding beliefs, practices and preferred nutrition education and health provider approaches: an exploratory study with Somali mothers in the USA', *Maternal & Child Nutrition*, 6(1), pp. 67–88.

Swendeman, D. *et al.* (2009) 'Swendeman D, Basu I, Das S, Jana S, Rotheram-Borus MJ. Empowering sex workers in India to reduce vulnerability to HIV and sexually transmitted diseases. Soc Sci M', *Social Science & Medicine*, 69(8), p. :1157–66.

Toledo, G. A. (2002) 'Prostitutes ' Understanding of God'.

Tucker, J. D. *et al.* (2011) 'Female Sex Worker Social Networks and STI/HIV Prevention in South China.', *PloS one*, 6(9), p. e24816. doi: 10.1371/journal.pone.0024816.

Tucker, J. D. and Tuminez, A. S. (2011) 'Reframing the interpretation of sex worker health: a behavioral-structural approach.', *The Journal of infectious diseases*, 204 Suppl(suppl_5), pp. S1206-10. doi: 10.1093/infdis/jir534.

UNAIDS (2000) *Female sex worker HIV prevention projects: lessons learnt from Papua New Guinea, India and Bangladesh*. Geneva.

UNHCR (2017) ‘Growing hopelessness grips forgotten-somali refugees warns unhcr’. Available at: https://www.unhcr.org/news/latest/2017/1/58738b174/growing-hopelessness-grips-forgotten-somali-refugees-warns-unhcr.html (Accessed: 12 January 2017).

UNHCR (2018) *UNHCR Somalia*. Available at: www.unhcr.org/somalia (Accessed: 17 February 2019).

UNHCR - Kenya Fact Sheet (2015). Available at: https://www.unhcr.org/protection/operations/524d84b99/kenya-fact-sheet.html (Accessed: 3 May 2020).

UNHCR Kenya (2000) *Urban Areas*. Available at: https://www.unhcr.org/ke/urban-areas (Accessed: 1 June 2020).

UNHRC and Women’s Refugee Commission (2011) *Baseline Study : Documenting Knowledge , Attitudes and Behaviours of Somali Refugees and the Status of Family Planning Services in UNHCR’s Operation in Nairobi , Kenya*.

Urada, L. A. *et al.* (2012) ‘Condom negotiations among female sex workers in the Philippines: environmental influences.’, *PloS one*. Public Library of Science, 7(3), p. e33282. doi: 10.1371/journal.pone.0033282.

Vanwesenbeeck, I. (2017) ‘Sex Work Criminalization Is Barking Up the Wrong Tree’, *Archives of Sexual Behavior*. Springer US, 46(6), pp. 1631–1640. doi: 10.1007/s10508-017-1008-3.

Vissers, D. C. J. *et al.* (2008) ‘Separation of spouses due to travel and living apart raises HIV risk in Tanzanian couples.’, *Sexually transmitted diseases*, 35(8), pp. 714–20. doi: 10.1097/OLQ.0b013e3181723d93.

Voeten, H. A. C. M. *et al.* (2009) ‘Strong Association Between In-Migration and HIV Prevalence in Urban Sub-Saharan Africa.’, *Sexually transmitted diseases*. doi: 10.1097/OLQ.0b013e3181c3f2d0.

Wanjiru, R. *et al.* (2022) ‘Beaten but not down! Exploring resilience among female sex workers (FSWs) in Nairobi, Kenya’, *BMC Public Health 2022 22:1*. BioMed Central, 22(1), pp. 1–12. doi: 10.1186/S12889-022-13387-3.

Ward, H. and Day, S. (2006) ‘What happens to women who sell sex? Report of a unique occupational cohort.’, *Sexually transmitted infections*, 82(5), pp. 413–7. doi: 10.1136/sti.2006.020982.

Ward, H., Day, S. and Weber, J. (1999) ‘Risky business: health and safety in the sex industry

over a 9 year period.', *Sexually transmitted infections*, 75(5), pp. 340–3. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1758230&tool=pmcentrez&rendertype=abstract.

World Health Organization *et al.* (2013) *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborating Institutions*. Geneva.
World Health Organization (2013) 'Implementing Comprehensive HIV/STI Programmes with Sex Workers', p. 171. Available at: https://apps.who.int/iris/bitstream/handle/10665/90000/9789241506182_eng.pdf?sequence=1%0Ahttp://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng.pdf?ua=1.

Zimmerman, C., Kiss, L. and Hossain, M. (2011) 'Migration and health: a framework for 21st century policy-making.', *PLoS medicine*, 8(5), p. e1001034. doi: 10.1371/journal.pmed.1001034.

APPENDICES

Appendix A. Data Collection Tools

TOPIC GUIDE A – MIGRATION EXPERIENCE			
THEME	**KEY AREAS OF INVESTIGATION**	**QUESTION**	**EXAMPLE PROMPTS**
Introduction	Socio-Demographic Details • Name • Age • Marital Status • Education • Religion • Children	Can you tell me about yourself?	Is there any other information you would like to share?
Migration Details	Risk Environment at different stages of migration pathway <u>Departure</u> • Reason for leaving • Age at departure • People departed with • Means of transportation • Financial means / arrangements to depart <u>Transit</u> • Countries travelled to in between Somalia and Kenya • Length of travel	I am interested in the story of how you came to be here, can you tell me about your <u>departure</u> from Somalia, <u>transit</u> and <u>arrival</u> in Kenya?	Is there anything else from your migration experience that you would like to share?

	Arrival • Problems upon arrival • Accommodation upon arrival (Eastleigh, refugee camp, etc.) • Kind of help received upon arrival (friends, family, contacts) • How have expectations differed from the reality • How long since arrival in Nairobi • Time in camps		
Migration Status	• Legal versus illegal status (i.e. refugee status from UNHCR) • Paperwork and documentation	What is your current legal migration status?	Can you explain this further?
Current migration	• Internal migration within Kenya • Travel to Somalia (returning – temporarily or permanently)	Do you move around Kenya much or travel now?	Where, why?
Living Arrangements	• Fluidity / shifting of accommodation • Reliability of accommodation • Number of people they live with • Relation to people they live with • Whether these people know about their work in the sex industry (disclosure)	Can you tell me where you currently live and with who?	Who (i.e. friends, family, other FSW)?
Entry into Sex Work	• Context around entry into sex work • Involved in sex work before coming to Kenya (in Somalia?) • What made them decide to start selling sex (in Somalia, in transit, and in Kenya) • How did they find their first client • Experience with first client • Help / advice from others to get in to sex work	Can you tell me about how you first got started in sex work?	When? Where? How?

Context and Experience of Sex Work	• Likes / dislikes • Expectations different from reality • Frequency of clients • Where they find clients • Where they go with clients • Description of clients (Nationality, occupation, regular or casual)	Can you tell me a bit about your work?	Where, how, with who? Can you tell me anything else?
Livelihoods	<u>Sources of income</u> • Upon departure from Somalia • In transit • Upon arrival in Kenya • Current • Planned / future	Do you earn money doing any other activities other than sex work?	Other jobs / sources of funds?

TOPIC GUIDE B – RISK ENVIRONMENT, SOCIAL NETWORKS AND STIGMA, AND IDENTITIES			
THEME	**KEY AREAS OF INVESTIGATION**	**QUESTION**	**EXAMPLE PROMPTS**
Risk Perception	• General health risk • Sexual health risk (HIV and STI) • HIV status • Condom use and negotiation • Violence • Legal risks • Level of risk compared with Kenyan FSW	Can you tell me some examples / situations where you have been at risk? Definition of risk = Felt in danger, insecure, scared, or vulnerable, etc.	How did you feel?
Stigma	• Stories / experiences of stigma • Perceptions of reasons for stigma – migration, Somali, sex worker	Can you tell me some examples from your everyday life where you have encountered stigma / disapproval from people? *Definition of stigma = Disapproval based on certain characteristics	From who, why, how was it directed? Was it acted on or did you just feel / sense it?
Social support, networks and relationships	• Family • Friends • Other sex workers • People in Nairobi, in other parts of Kenya, in Somalia • Type of support they provide (emotional, financial, etc.) • Do these people know about respondent's involvement in sex work (disclosure) • Social organizations	What kind of social support do you have in your life?	Can you tell more about your relationship with each person?

Identity construction	• Nationality (i.e. Somali, Somali-Kenyan, Kenyan, etc.) • Religion • Norms • Values • Culture • Occupation • Length of time plan to stay in sex work	Can you tell me about your identity (how you identify)? *Definition of identity = what defines you, how are you recognized, how do you describe yourself in terms of birth place, occupation, culture, religion, etc.	And what about ... .nationality, religion, culture, etc...?
		Can you tell me some examples / situations illustrating how being Somali impacts your life and work in Kenya?	

TOPIC GUIDE C – ACCESS AND USE OF HEALTH SERVICES			
THEME	**KEY AREAS OF INVESTIGATION**	**QUESTION**	**EXAMPLE PROMPTS**
Service access and use	• Type(s) of services accessed • Experiences at services	Can you tell me about the health services that you use and your thoughts around these services?	How were you treated?
STI & HIV Testing	• Overall experience • Obtain results • Frequency of testing • Knowledge of status	Can you tell me about the last time you went for STI testing, including an HIV test?	When, where, with who? How were you treated?
Barriers	• Barriers to service access and use (e.g. fear, do not know where to access, bad previous experiences?)	What do you think are the main reasons why Somali sex workers do not access sexual health services?	Can you tell me more about these barriers?
Interventions / Programming	• Recommendations to improve life as sex worker • Recommendations to improve health services	What type of support could be provided to improve your life as a sex worker?	
		How could health services be improved, so that you and other Somali sex workers would access them?	

Appendix B. Ethical Approval Letter - University of Nairobi and Kenyatta National Hospital

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KNH/UON-ERC
Email: uonknh_erc@uonbi.ac.ke
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Link:www.uonbi.ac.ke/activities/KNHUoN

KENYATTA NATIONAL HOSPITAL
P O BOX 20723 Code 00202
Tel: 726300-9
Fax: 725272
Telegrams: MEDSUP, Nairobi
2nd February 2012

Dr. Joshua Kimani
UNITID
University of Nairobi

Dear Dr. Kimani

Research proposal: "Migration, Sex Work and Risk Environments: Experiences of Somali Migrant Female Sex Workers in Nairobi, Kenya and Implications for Service Access and Use" (P462/11/2011)

This is to inform you that the KNH/UON-Ethics & Research Committee has reviewed and **approved** your above revised research proposal . The approval periods are 2nd February 2012 – 1st February 2013.

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimens must also be obtained from KNH/UON-Ethics & Research Committee for each batch.

On behalf of the Committee, I wish you a fruitful research and look forward to receiving an **executive** summary of the research findings upon completion of the study.

This information will form part of the data base that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

[redacted]

PROF A N GUANTAI
SECRETARY, KNH/UON-ERC

c.c. The Deputy Director CS, KNH
The Principal, College of Health Sciences, UON
The Director, UNITID, UON
The HOD, Medical Records, KNH
Co-investigators: Kelsi Kriitmaa, Joanna Busza, Wilbert Shihaji, Jason Theede, Dr. Nicholas Muraguri, Helgar Maswii Mutua, Dr. Davies O Kimanga, Ben Mundia, Dr. Geoffrey Okumu

Appendix C. Ethical Approval Letter – LSHTM

OBSERVATIONAL/INTERVENTIONS RESEARCH ETHICS COMMITTEE

19 December

Kelsi Kriitmaa

Dear Kelsi

Study Title: **Migration, Sex Work and Risk Environments: Experiences of Somali Migrant Female Sex Workers in Nairobi Kenya and Implications for Service Access and Use**
LSHTM ethics ref: **6079**
Department: **Epidemiology and Population Health**

The Committee reviewed the above application.

Documents reviewed

The documents reviewed were:

Document	*Version*	*Date*	
LSHTM ethics application	n/a		
Protocol	V1.0	09/12/11	
Information Sheet	V1.0	09/12/11	
Consent form	V1.0	09/12/11	

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

- Interviewing the applicant three times sees unnecessary.
- The consent form should allow space for participants to specifically consent
  a) to being recorded and
  b) to being quoted anonymously in reports, publications or presentations.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates, please ensure that you keep the same file names.

If the Committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the Committee.