Sexual and reproductive health risks among key populations vulnerable to HIV in Kenya

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In Kenya an estimated 1.5 million people are living with HIV; and in 2009 80,000 people died from AIDS related illnesses. Many people are still not being reached by HIV prevention and treatment services. Among the most affected are vulnerable populations who are hidden and are largely outside the net of prevention, care and treatment services. Such groups have an increased risk of HIV infection and onward transmission to the general population. Existing laws criminalize their practices and a majority is confronted with high levels of stigma and discrimination, which present individual barriers to control risk of HIV infection and poor SRH outcomes.

In Kenya, key vulnerable population groups include, but are not limited to, sex workers (female sex workers, male sex workers and their clients); men who have sex with men; mobile populations; and injecting drug users. Currently, HIV and SRH prevention needs of these groups are not evident across the compendium of prevention framework in Kenya – where programmes have been implemented it has sometimes only been partial or episodic. Therefore addressing HIV and SRH needs of these populations is necessary to mitigate risk factors and to prevent HIV infection in a mixed HIV epidemic like Kenya. Currently, a better understanding is required of the factors associated with sexual risk behavior including sexual and reproductive health needs among these populations groups to effectively develop tailored interventions. The studies presented in this thesis focus on two of these key population groups: female sex workers and male sex workers but also highlight the role of persons who are HIV positive in the dynamics of the HIV epidemic. The studies presented deepen the understanding of the risks of the populations of interest and seek to identify effective prevention strategies to control HIV and sexual and reproductive risks.

In Kenya interventions for female sex workers mostly focus on risk reduction strategies (peer education, IEC material etc) and emphasis on condom use with clients. However, available evidence suggests sustained high STI and HIV rates among sex workers. In Chapter 4.1 we assessed the social and legal contexts that underpin the high levels of sexual and physical violence that pervade sex work in Kenya. We therefore explored factors that underlie sex workers vulnerabilities to sexual and physical violence and how it impacts on their HIV risk. Eighty-one female sex workers shared their experiences in eight focus-group discussions. The women's narratives show that sex workers face dou-

ble threat of violence from clients and the law enforcement agencies. Sexual and physical violence among female sex workers is pervasive and is commonly triggered by negotiation around condoms and payment for sexual service. Women are also exposed to violence due to pressing financial needs, gender-power differentials, illegality of trading in sex and cultural subscriptions that empower men. In particular, widespread violence experienced by sex workers illustrates some of the intersections between violence and risk of HIV, and the significance of violence in the compendium of HIV prevention.

Chapter 4.2 describes the subjective experiences of diaphragm users to inform development and promotion of such methods. We explored perspectives of female sex workers and women attending sexual and reproductive health services in Mombasa. Data from focus group discussions and in-depth interviews highlight the importance of female-controlled technologies in counteracting socio-cultural vulnerability to HIV. Covert use of the diaphragm was noted by women as a favourable attribute especially in relationships in which sexual negotiation is limited (sex workers and women who experience intimate-partner violence) or where partners differ over decisions about fertility. When compared to male condoms women felt empowered to use the diaphragm as they did not require male partner's cooperation or approval. Our results show that if proved effective against STIs, diaphragm uptake may be high in this setting.

We also investigated the contraceptive needs of female sex workers in Mombasa and Naivasha (chapter 4.3). As earlier mentioned, interventions for female sex workers in sub-Saharan Africa have often been focused on preventing sexually transmission infections, including HIV, while overlooking broader reproductive health needs. We therefore investigated contraceptive use and unmet contraceptive needs among female sex workers. The results revealed a high reliance on male condoms, coupled with inconsistent use, which resulted in a higher potential for unmet need for contraception and likely exposure to infection with HIV and other STIs. The findings suggest that interventions targeting female sex workers should promote dual method use to meet their broader reproductive health needs.

In Chapter 4.4, we explore the sexual and behavioural determinants of sexual risks among men who sell sex to men in Mombasa. In-depth interviews and focus group discussions (36 men) elicited information on the dynamics of male sex work. Most male sex workers revealed that condom use with clients and regular partners is erratic and is dependent on common constraints, including notions of sexual interference and motivations of clients. Similarly, low level of knowledge among male sex workers compounds sexual risk taking, with a widespread belief that the risk of HIV transmission through anal sex is lower than vaginal sex. Poor knowledge of transmission routes is exacerbated by public prejudice and by the family.