RESEARCH BRIEF

INTEGRATED BIOLOGICAL AND BEHAVIOURAL SURVEILLANCE SURVEY AMONG MIGRANT FEMALE SEX WORKERS IN NAIROBI

IOM International Organization for Migration

KENYA

THE OBJECTIVE WAS TO ESTABLISH INFORMATION THAT CONTRIBUTES TOWARDS DEVELOPING AN EVIDENCE-INFORMED RESPONSE TO HIV AND AIDS AMONG MIGRANT FEMALE SEX WORKERS.

BACKGROUND

Female sex workers (FSW) and their clients account for 14.1 per cent of all new infections in Kenya. Though the Kenyan national response has started targeting programming towards populations at higher risk of HIV exposure, including FSW, to date no study has broken down sex work by nationality. Although FSW are clearly a highly marginalized at-risk population, no data was available for migrant FSW in terms of seroprevalence and environmental and behavioural determinants of risk-behaviour.

OBJECTIVES

- **Establish** HIV and STI prevalence among migrant female sex workers in Nairobi, Kenya;
- **Determine** HIV and STI knowledge, attitudes, risk behaviour, treatment seeking behaviour and preferred sources of HIV/STI information;
- **Provide** baseline HIV and STI behavioural and biological prevalence estimates to measure trends over time.

METHODS

A cross-sectional survey recruited 628 migrant FSW using respondent-driven sampling (RDS), from April to June 2010 in Nairobi. A total of 1,642 coupons were given out with 585 returned, providing a return rate of 35.6 per cent. Face-to-face, structured interviews were completed and blood collected for serological testing of HIV, syphilis, gonorrhoea and chlamydia. Data captured demographic characteristics, risk behaviours, and HIV/AIDS knowledge as well as UNGASS indicators for key populations at higher risk of HIV exposure.

RESULTS

- Migrant FSW are marginalized by social determinants of health such as their irregular immigration status, lack of fluency in the local language, and cultural barriers;
- Migrant FSW predominantly come to Nairobi to find work or to escape insecurity back home;

93 per cent of migrant female sex workers interviewed reported having vaginal sexual encounter for the first time between:

5-14 years of age

- The most common countries of origin of migrant FSW were Ethiopia (31.2%), Tanzania (27.6%) and Uganda (27.6%), followed by Somalia (11%), DRC (1.3%), Sudan (1%), and Rwanda (0.2%);
- Over half (52.2%) of migrant FSW were between the ages of 20 and 29. Almost half had never attended school (47.4%), with the majority being single (61.1%) and of Muslim faith (58.5%);

72.2 per cent were not aware that a healthy looking person can have HIV

- The overall prevalence of HIV was 23.1%, with 2 per cent having syphilis and three cases (0.7%) of comorbid HIV and syphilis, and one case (0.2%) of comorbid HIV and chlamydia.

RESULTS (cont.)

- Almost a third (32.1%) of FSW reported having genital discharge in the past year and 4.5 per cent reported an ulcer or sore in the same time period. None of those who had an ulcer or discharge due to STI told their partners, stopped having sex, or used a condom while having sex;
- There is high reported condom usage. However, only approximately half of the FSW used condoms every time they had sex with a client in the past seven days (54.0%) and with clients in the past month (53.4%). Of those reporting non-condom use more than three quarters of respondents indicated they did not use a condom at last sex because the client objected;
- Though almost all migrant FSW had heard of HIV, knowledge around prevention and transmission is mixed, with many misconceptions still present.

Utilization of HIV counselling and testing (HCT) was low – just over half ever had a test – which is much

lower

than Kenyan FSW

25.8 per cent of respondents did not know that condom use protects against HIV infection

RECOMMENDATIONS

1. Prevalence was found to be similar to other FSW research in Kenya and over three times the national prevalence for general population. This indicates a **need for intensifying prevention programmes** among this vulnerable urban migrant population;
2. With more than three quarters of respondents indicating the reason they did not use a condom during their last sexual encounter was because the client objected, there is a need to **include men in condom programming**, including awareness raising, distribution, and demonstrations;
3. **Combination HIV prevention is urgently needed** for this sub-population of FSW, whilst donor funding is needed for a longer-term programme that includes a migrant friendly/female friendly model for service provision;
4. Interventions are needed that **specifically target migrant FSW**, to increase knowledge and behaviour change, focusing on consistent and correct condom use and health seeking behaviour;
5. Services for this population could be integrated into national FSW programmes, however, **special care must be given to language and cultural needs of migrants.** Non-medical aspects of care should be incorporated to ensure a comprehensive approach, including psychosocial support, income generating and livelihood activities, and legal support;
6. Continuing migration trends into and from Kenya due to East African Community (EAC) integration, climate change, urbanization, economic development and continuing humanitarian challenges in neighbouring countries, necessitates migration health being mainstreamed in health and development legislation, policies, programmes and strategies, and **integrated within the National Health Sector Strategic Plan**.

HEALTHY MIGRANTS IN HEALTHY COMMUNITIES

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