TOWARDS WHOLE PERSON HEALTHCARE FOR FEMALE SEX WORKERS IN BOMET COUNTY, KENYA: IDENTIFY THE UNMET HEALTH NEEDS

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A Research Thesis Submitted to the Institute of Postgraduate Studies of Kabarak University in Partial Fulfillment of the Requirements for the Award of Master of Medicine in Family Medicine

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DECLARATION

1. I do declare that;
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To: The Institute of Post Graduate Studies

This thesis titled '**Towards Whole Person Healthcare for Female Sex Workers in Bomet County, Kenya: Identify the Unmet Health Needs**' and written by Joy Murage, is presented to the Institute of Postgraduate Studies of Kabarak University. We have reviewed the research (proposal) and recommend it acceptable in partial fulfilment of the requirement for the award of the degree of Master in Family Medicine.

Signed: _____ **Date:** 20th March 2020.

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ABSTRACT

Background: Female Sex Workers (FSWs) have complex health needs that predispose them to a higher morbidity and mortality risk than the general population. They have unbounded challenges for example stigma and social exclusion that hinder them from accessing and utilizing healthcare. The healthcare system in Kenya has responded to their physical health needs by providing treatment and preventive sexual and reproductive health services however there is minimal knowledge on how their psychological, social and spiritual needs are met. To meet FSWs needs, it is important to have a paradigm shift from the disease model to a whole person care (WPC) model where there is an integration of the bio-physical, psychosocial and spiritual aspects of health. This study gives us an understanding of female sex workers' experiences and challenges when seeking and utilizing healthcare. It also describes the healthcare practices towards female sex workers by healthcare workers, informs on their unmet health needs and their perspective on whole-person care. Methodology: This is a qualitative research design that targeted the population of female sex workers living in Bomet County, Kenya. It also included healthcare workers who provide health services to this population. The sampling procedure was non- probability, purposive through respondent-driven snowball sampling. Sampling was done until saturation was achieved where data collected did not have any new information. Data was collected through in-depth individual interviews, healthcare workers' interviews and one focus group discussion. Informed consent was obtained for each interviewee and confidentiality of all participants was assured. Safe data handling and specific ethical considerations relating to female sex workers was observed for this study. Results: FSWs experience financial constraints, community and health worker stigma, insufficient drugs in the health facilities which includes their children's prophylaxis; antiretroviral (ART) drugs and poor awareness of health services available to them. Access to healthcare services was a common challenge experienced by the FSWs. The healthcare providers provide sexual and reproductive health services as well as creation of health awareness through community sensitization against stigma of FSWs with an aim of improving utilization of healthcare services. They also provide psychological and social support to the women and their children. The FSWs perspective of whole person care was that it would improve their lives in a way that they can better handle stressful conditions and even find ways on coming out of sex work in contrast to the health workers' perspective, where they were skeptical to integrate the spiritual aspect in WPC during provision of healthcare services. Conclusion: Female sex workers have complex unmet health needs that go beyond the physical. Healthcare providers can meet these health needs by focusing on the person rather than the disease through whole person care service delivery. The unmet health needs namely, lack of access to essential treatment and promotive health services for FSWs, the need for more psychological, spiritual care and an integration of all the four aspects of whole person care emerged in this study. The need to promptly address these unmet health needs by the healthcare system of Kenya has been illustrated if Universal Health Coverage is to be made a reality.

Keywords: Whole Person Care, Health Needs, Unmet Healthcare Needs, Female Sex Workers, Spiritual Care

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CASCO	County AIDS & STI Coordinator
DIC	Drop-In Clinic
FSW	Female Sex Workers
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTC	HIV Testing and Counseling
ICL	I Choose Life
MOH	Ministry of Health
MSM	Men Having Sex with Men
NACC	National AIDS Control Council
NACOSTI	National Commission for Science, Technology and Innovation
NASCOP	National AIDS and STIs Control Program
NGOs	Non-Governmental Organizations
OVC	Orphan and Vulnerable Children
SSA	Sub-Saharan Africa
SRH	Sexual and Reproductive Health
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infection
UHC	Universal Health Coverage
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WPC	Whole Person Care

OPERATIONAL DEFINITION OF TERMS

Female Sex Workers (FSWs): This refers to a group of women who exchange sexual services for money or valuable goods either regularly or occasionally and who may or may not consciously define those activities as income-generating and a part of their livelihood sustenance.

Health Needs: These are health issues that face female sex workers', which leads to agreed priorities and resource allocation that will improve health and reduce inequalities.

Unmet Healthcare Needs: This is the difference between the healthcare services which seem to be necessary to deal with the health problems of female sex workers and the actual health services received by the women. The unmet health care need depends on the services that the health care system provides and the specific characteristics of the female sex workers seeking care.

Whole Person Care: This is an approach that considers multiple dimensions of the patient and their context, including biological, psychological, social and possibly spiritual and ecological factors and addresses these in an integrated fashion that keeps sight of the whole.

Spirituality: Spirituality is that which gives meaning and purpose to one's life.

Spiritual Care: Spiritual care as a foundation of whole person care, an aspect of health care that attends to spiritual and religious needs brought on by an illness or injury.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

Female sex workers (FSWs) are women who exchange sexual services for financial benefits or valuable goods either regularly or occasionally. They may or may not consciously define these activities as revenue producing and a part of their livelihood sustenance (UNAIDS, 2002). Sex work is seen as a social vice in high, middle and low-income countries. It exposes FSWs to occupational-related illness that includes reproductive health conditions for example, sexually transmitted illness (STI), human immunodeficiency virus (HIV) infection, illegal or unsafe abortions and abuse; verbal, sexual or physical. In addition to this, they are also at high risk of psychological disturbances such as alcohol and substance dependency, mood disorders and anxiety disorders (Rössler, Koch, Lauber, Hass, Altwegg, Ajdacic-Gross & Landolt, 2010).

As stated by Pietroni, a human being is made up of a body, mind and soul which are interdependent and that whole is greater than the sum of the parts (Pietroni, 1984). This is how whole person care became popular in the twentieth century as it was a healing art that looked at a person's health as a whole but not merely disease-specific. However, whole-person care lost popularity and the reductionist theory arose and resulted in the disintegration of healthcare services (Thomas, Mitchell, Rich, & Best, 2018).

Due to the nature of their occupation, female sex workers become vulnerable to discrimination by the surrounding society and stigmatized by society and also by self. This leads to their marginalization from the general population and in turn, increases their vulnerability to illnesses. In addition to this, they face shame, guilt, fear and psychological disturbances which also need to be addressed by healthcare providers

(Baral et al., 2012). This chapter will give more insight into the background of the problem and how the research study is related to this problem.

1.2 Background of the Study

Whole person care is defined as an approach that considers multiple dimensions of the patient and their context, including biological, psychological, social and possibly spiritual factors. It addresses these in an integrated fashion that keeps sight of the whole (Thomas et al., 2018). A Canadian report stated that the whole person is the harmonization of physical, behavioral, and social services in a patient-centered manner to make better, health outcomes through efficient and effective use of resources (Tobey, Maxwell, Bateman, & Barron, 2014).

Whole person care is an old practice in medicine that has been present for more than three centuries. It all started from the understanding that the human species is made up of a body, mind and soul. Each entity is dependent on the other and cannot stand on its own. Due to the complexity of the human species, disintegrating the body from the mind and the soul is somehow diminishing the value of the individual from the whole. Through the years, the world and medicine have evolved. Medicine is now highly specialized, compartmentalized and disease-organ specific. This has become the norm rather than realizing that disease can be caused or altered by these three entities: the body, mind and soul. This reductionist theory of medicine has come with positive discoveries such as understanding of the human anatomy, each organ, its structure, functions and how pathology arises and its' interaction with the environment. Such discoveries have favored compartmentalization in medicine and this has resulted in highly specialized health service provision that is disease-specific. This has unearthed a culture of medicine that could have forgotten the whole person.

As stated by Pietroni:

'…… the whole is greater than the sum of the parts (Pietroni, 1984)'

This means that the provision of healthcare that is the whole person can be the best model of healthcare as compared to the summation of the specialized and compartmentalized form of care. The whole-person care model which can also be identified in the biopsychosocial model is in its quest to integrate and address all aspects of a person's well-being. It has been shown to improve the health outcomes of patients through better physician-patient relationships and patients' awareness of their essential contribution to their health outcomes (Borrell-Carrió, Suchman, & Epstein, 2004). A study done in 2002, on the need of integrative medicine in primary health care, supports the need of research to be done, showing the impact and outcomes of whole-person care to prove that it is a desirable and necessary way of providing healthcare to patients (Bell et al., 2002). Also includes the vulnerable populations, in this case, female sex workers.

Female sex workers as a vulnerable group, have a high morbidity and mortality than the general population (Aldridge et al., 2018; Willis, Onda, & Stoklosa, 2016). They are vulnerable to negative health behaviours and have a high burden of intricate social vices such as sexual exploitation, social stigma, violence and insecurity (Lazarus et al., 2012; Mtetwa, Busza, Chidiya, Mungofa, & Cowan, 2013; Ochako, Okal, Kimetu, Askew, & Temmerman, 2018; Parcesepe et al., 2016). This results in poor health outcomes from multiple causes of disease and early death. The poor health outcomes are as a result of physical illnesses such as Human Immunodeficiency Virus (HIV), sexually transmitted diseases (STDs) and other chronic medical conditions. A study done in a primary healthcare centre in Glasgow, Scotland, reported that other than physical health care services such as HIV care, most female sex workers came in for their social services such as exchange of needles since most were intravenous drug users. It was shown that

there was a need to integrate social services in their healthcare provision (Carr et al., 1996).

In the past decade, literature has focused on sex workers being part of the key populations because of their higher risk of acquiring and transmitting HIV. Due to this fact, they have received attention from global organizations that provide aid in tracking and treating HIV causing a shift of focus in scientific research in this population. By World Health Organization's definition, key populations include sex workers both female sex workers (FSW) and male sex workers (MSW), men who have sex with men (MSM), transgender people and people who inject drugs (PWID) (WHO, 2013). As listed, these are individuals who have a higher risk of getting and spreading Human Immunodeficiency Virus (HIV) infection than the rest of the population.

Statistics reported in 2018, shows a projected number of people living with HIV and Acquired Immune Deficiency Syndrome (AIDS) was 36.9 million people both adults and children globally (UNAIDS, 2019). In Eastern and Southern parts of Africa, key populations and their sexual partners account for 25% of the new infections (UNAIDS, 2019). According to Baral et al. (2012), there was a 13% HIV risk for a female sex worker to be living with HIV as compared to women in the reproductive age, in low and middle-income countries. This evidence illustrates female sex workers' vulnerability to HIV infection which is related to their negative health behaviours, stigma, discrimination and violence. However, despite being part of a key population, their access to integrated healthcare services is still problematic globally.

In Kenya, the estimated number of female sex workers is 103,298 with a range of between 77,878 to 128,717 (Odek et al., 2014). The prevalence of HIV in Kenya is at 5.4% and female sex workers have a high HIV prevalence of 29.3% compared to the

general population (Kenya AIDS Response Progress Report Progress towards Zero, 2014). Other than the high risk for HIV, female sex workers are also at risk of other reproductive illnesses such as sexually transmitted diseases (STDs), unwanted pregnancies leading to unsafe abortions, abuse and rape. These women are mothers as well, in Kenya, approximately 80.2% of FSWs have children, their children also suffer serious health conditions which may be linked to their mother's occupation (Willis, Welch, & Onda, 2016).

Studies done in Kenya have shown that FSWs are at risk to STDs like Trichomoniasis vaginalis, syphilis, gonorrhea or chlamydia respectively (Musyoki et al., 2015; Lockhart et al., 2019). Unwanted pregnancies leading to induced abortions and death is still high among FSWs in Kenya and this is attributed to the limited knowledge on contraceptive use (Ochako et al., 2018). In a study that was done in Cambodia, 1 in every 3 females who identified as an entertainment worker had had an induced abortion which was much higher than women in the general population (Sopheab 2015). A study done in Laos reported more than half of the respondents narrated that social stigma and disgrace that was related with out of wedlock pregnancies were factors that drove women to induce an abortion (Phrasisombath, 2012).

In Kenya, women who practice sex work are at great risk for sexual abuse and rape, a study was done in both rural and urban towns reported that 17% of its participants had been physically violated and 35% raped by clients (Elmore-Meegan, Conroy, & Agala, 2004). Likewise, a study done in Kumasi, Ghana, young adolescent female sex workers were vulnerable to threats of assault, rape, police exploitation and arrest, lack of money and food insecurity. Violence and rape was a universal perceived threat to the research participants (Onyango, Adu-Sarkodie, & Agyarko-Poku, 2015). Nevertheless, due to their risk for disease, violence, physical and sexual abuse and social isolation, female sex

workers are affected and thus have a high prevalence of mental health illnesses: anxiety disorder, post-traumatic stress disorder, mood disorder and substance abuse (Jun et al., 2008; Rossler et al., 2010; Yacoubian et al., 2002). A study done in South Africa, KwaZulu- Natal reported a high prevalence of depression at 80.9%, anxiety 78.4% and suicidal ideation at almost half (40%) in the study respondents who were female sex workers (Poliah & Paruk, 2017).

Healthcare provision to female sex workers mostly focuses on sexual and reproductive health (SRH) needs such as HIV and sexually transmitted illness (STI) programs, SRH services which include HIV and STI care, family planning and contraceptive services, safe pregnancy and abortion care, reproductive tract cancer screening, clinical care for sexual assault survivors and hormonal and other gender enhancement therapy. Conversely, this does not include addressing the social needs of the individual, for example, self-care when facing stigma and discrimination, giving information on ways to sustain food security for the FSWs and their children, psychological support for mental illness such as substance dependency and spiritual care (NSWP, 2018).

The aforementioned interventions that have been placed to provide appropriate healthcare to female sex workers have focused on the physical aspect and some psychological part of illness but these women also experience other compelling health needs such as social and spiritual needs that require to be met by the health system. There is little evidence as to whether the Female Sex Workers receive whole person care. This study aims to build evidence on the needs for whole-person care for female sex workers living in Bomet County. By understanding their experiences and challenges during healthcare service utilization and if the healthcare practices meet their health needs.

1.3 Statement of the Problem

World Health Organization defines health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. Furthermore, spiritual well-being was included after this constitution was amended in 1999 (WHO, 1999). The health of an individual is complex and can be influenced by four aspects of well-being which are the physical, psychological, social and spiritual. Female sex workers are faced with complex yet competing health needs which are to be addressed by the healthcare system. However, medicine today puts more focus on the physical aspect of health.

Healthcare for female sex workers has emphasized on the physical aspect of health, through the provision of HIV and STI prevention, treatment and care as well as comprehensive SRH services for these women to improve their health outcomes. But then again, in contrast, in this era where these programs are already operational, evidence shows that their HIV and STI prevalence and risk and early death due to multiple causes is still high (Baral et al., 2012; Kavanaugh et al., 2012; Ward & Ward, 2006).

In Bomet County, Kenya, female sex worker are estimated to be 1600 and still increasing, with an estimated HIV prevalence of 8.2% against the County's estimated prevalence of 5.8% and Kenya's HIV prevalence of 5.6% (NACC, 2016a). FSWs are at high risk of contracting and transmitting HIV and identified as a key population in Bomet. As a rural part of Kenya, access to comprehensive health services that have a holistic approach for the female sex workers is still a quest to be achieved. There is still a need to implement a comprehensive health package to the female sex workers (NACC, 2016a).

Evidence has illustrated the need to integrate care and provide whole-person care to vulnerable populations. Nonetheless, being vulnerable, discriminated and marginalized group with social, psychological and even spiritual burden, the healthcare system has not fully addressed their health needs. The healthcare system has a role in formulating policies for provision of quality healthcare services to female sex workers. However, this has inclined more towards improving their sexual and reproductive health (Dhana, Luchters, Moore, Lafort, Roy, Scorgie, Chersich, 2014; Rekart, 2015). This gap in the healthcare system and the unmet health needs could be addressed through the provision of whole-person care. Whereas whole-person care encompasses the four aspects of health, little is known on the health practices as to whether the four domains of health are addressed.

Reviewed literature has consistently shown that the psychological and spiritual aspect of health has not been fully adopted and integrated into the health service provision to the female sex worker. Similarly, anecdotal evidence shows that FSW from Bomet county has unmet needs as far as whole-person care. For instance, there is little evidence of FSWs experiences and challenges when utilizing healthcare services. Therefore, this study seeks to find out if whole-person care is delivered to female sex workers by healthcare services in Bomet County and inform on their unmet health needs. It will also illustrate the relevance of whole person care in todays' science- based modern medicine. In addition to this, an approach that provides the best approach to healthcare services for female sex workers as well as ther vulnerable populations with similar health needs.

1.4 Purpose of the Study

The purpose of this study was to explore the healthcare needs of female sex workers in Bomet county and if their health needs are met by the existing health services in the

region. Therefore, this study sought to comprehend if whole-person care is delivered to female sex workers by healthcare services in Bomet County.

1.5 Research Objectives

1.5.1 Broad Objective

The broad objective of this research study is to find out if whole-person care is delivered to female sex workers by healthcare services in Bomet County.

1.5.2 Specific Objectives

The following were the specific objectives of this study:

i. To describe the experiences of female sex workers when receiving healthcare services in Bomet County.

ii. To determine, if any, challenges encountered by female sex workers when seeking healthcare services in Bomet County.

iii. To explore the healthcare services extended to female sex workers by the health workers in Bomet County.

1.6 Research Questions

The following are the research questions for this study:

i. What are the experiences of female sex workers when receiving healthcare services in Bomet County?

ii. What challenges do female sex workers living in Bomet encounter when seeking healthcare services?

iii. How are healthcare services extended to female sex workers by health workers in Bomet County?

1.7 Significance of the Study

As described by studies, female sex workers have a high morbidity and mortality than the overall population (Aldridge et al., 2018). Not only are the FSWs affected, but their children, their families, their clients, the families of their clients and the community at large (Willis, et al., 2016). Therefore, it is important for the health systems to serve the women and not to focus only on the disease-specific health services but also include the social. mental and spiritual domains of wellbeing and health. In essence, this is the complete definition of health as defined by the World Health Organization (World Health Organization, 1999).

Whole person care has been in existence from the twentieth century however discounted by researchers (Armstrong, 1986). Despite this, there has been an emergence for its need amongst vulnerable populations. It has been shown to improve access to healthcare, reduce the cost to the patient and the healthcare system, improve quality in healthcare delivery and ultimately improves health outcomes in vulnerable populations (Tobey et al., 2014). Female sex workers have complex health needs which may not be addressed by the existing health programmes extended to them. Therefore, by finding out FSWs experiences during utilization of health services, the healthcare practices of health professionals in Bomet County, the challenges they face when seeking healthcare and their perspective on whole-person care, their unmet health needs is unmasked and this will inform policymakers and healthcare providers on the possible best care to this population.

The findings of the study illustrate the need for health workers to incorporate all the four aspects of health when serving FSWs, a vulnerable population. It also adds to the body of knowledge on the importance of a paradigm shift from medicine that focuses on the disease to an art that incorporates whole person care and wellbeing for vulnerable

populations. This is aligned with the third sustainable development goal, which aims to make sure healthy lives and well-being for all is realized and a step towards the provision of quality healthcare services as stated in universal health coverage (UHC).

1.8 Scope of the Study

This research was done in the southwest part of the Great Rift Valley, Bomet County which has an estimated population size of about 730,129 according to the national census done in 2009 (Kenya National Bureau of Statistics, 2009). Estimated numbers of female sex workers are about 1600 in the county (NACC, 2016a). The participants of this study were retrieved from the three top hotspot areas of Bomet, namely, Kapkwen-Chepalungu sub-county, Silibwet- Bomet Central sub-county and Mulot township-Bomet East sub-county. These hotspot are in the centre of the trading towns where female sex workers and their clients meet (Refer to Appendix I which shows the map of Bomet County). Data collection was done in the three hotspot areas convenient venues for the healthcare workers.

1.9 Limitations of the Study

Limitations met were: one, this study was designed to be qualitative research such that it was a perspective based research method and the responses given were not measured. Therefore rigor and truthfulness was used to ensure quality of the data collected. Two, the results collected and analyzed are not representative of the total population of FSWs in Bomet County. The principal investigator ensured that there was diversity in the participants that met the inclusion/ exclusion criteria. Lastly, the sampling procedure heavily relied on social networks which would misappropriate the true representation of female sex workers in Bomet County. This particular limitation was addressed through diversity of the participant which is key in reducing the stated limitations.

1.10 Assumptions in the Study

The researcher assumed that the participants were cooperative, open and honest and shared their experiences, challenges and health practices. The research team ensured that the participants were not coerced, intimidated or forced to share information. In addition to this, it was assumed that the current target population was static, not influenced by any changes and that the quality of the study was not to be suppressed. The other assumption is that there could be a researcher effect which was assessed during data analysis. These differences between the researcher and the participants, for instance, age, background, education and language was reduced by acquiring a research assistant from the local community that assisted in translation and sensitization on cultural appropriate interactions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This review will explore the literature on the healthcare needs and the experiences of female sex workers when receiving healthcare services in Kenya, Africa and globally. As well as describe the challenges that female sex workers (FSWs) experience and the documented healthcare services they receive. This literature review aims to bring out the unmet health needs of female sex workers and find out if the whole-person care approach could address these unmet health needs.

2.2 The Experiences of Female Sex Workers (FSWs) Utilizing Healthcare Services

Entry into sex work varies from the spectrum of free choice to exploitation. Across countries, almost 40% of women who take part in sex work first engaged before 18 years of age. and this was resonated in a study done in Mombasa, Kenya, where one-fifth of the study participants were initiated into sex work before the age of 18 years and more than half of them reported childhood physical and sexual violence. The women who engaged in sex work early were more vulnerable to violence and alcohol use (Parcesepe et al., 2016). Childhood sexual and physical abuse, having a family member with alcohol or substance use disorder, peer influence, dependence on drug and substance use, have been cited as risk factors for entry into sex work (Clarke, Clarke, Roe-Sepowitz, & Fey, 2012).

Young women who are are initiated into sex work have a higher risk for illness and death. They become more vulnerable to disease and have a higher risk of death than a person of the same age in the general population. Their health needs become unique and

related to the risks that come alongside sex work. For instance, female sex workers face SRH problems such as HIV and other STIs, unintended pregnancies, unsafe abortions, physical and sexual violence and assault that may lead to death. The other two factors that exacerbate their vulnerability are social exclusion and discrimination.

2.2.1 The Overview of Female Sex Workers in Kenya

In Kenya, female sex workers are estimated to be about 103,298 with a range of between 77,878 to 128,717 (Odek et al., 2014). They are identified as part of key populations in the fight against HIV. Key populations are a significant group in HIV prevention and treatment programs and strategies. In 2017, key populations and their sexual partners had a reported 47% of new HIV infections, worldwide (UNAIDS, 2017). In 2018, the Human Immunodeficiency Virus (HIV) prevalence in adults between the age of 15-49 years was at 4.9% (National Aids Control Council, 2018). This age range is where many females who engage in sex work fall into.

Female sex workers are key people in the fight against HIV. This is due to the high HIV prevalence in this population. In Africa, they are 13% more likely to live with HIV (Baral et al., 2012). A report done in 2014, stated a high HIV prevalence of 29.3% amongst female sex workers ("Kenya AIDS Response Progress Report Progress towards Zero," 2014). In like manner, a study done in Nairobi reported that one in every three female sex workers lives with HIV (Musyoki et al., 2015). This high risk could be as a result of their poor socio-economic status, compounded with their risky sexual behaviours given their multiple sexual encounters and partners as well as their limited use of HIV prevention methods.

In addition, risk factors that were related with their acquisition of HIV infection in another study were the use of alcohol and illicit drugs, multiple sexual encounters

without the use of condoms, the occurrence of STIs and physical and sexual violence (Szwarcwald et al., 2018). Due to poverty and a motivation for higher pay, female sex workers partake in risky sexual behaviors such as having unprotected sex and forego the use of condoms. In a study done in Kondele, Kisumu, Kenya, female sex workers were reported to visit nearby clinics in search of post-exposure prophylaxis treatment after having unprotected sex. Some of the women become desperate to a point that they would provide false information about rape to get the drugs. They do not tell the truth because they fear stigma and discrimination by the health workers (Murenga & Faife, 2014).

As a result of the risky sexual behaviors, the women are predisposed to other morbidities such as STDs like syphilis, gonorrhoea and chlamydia. (Musyoki et al., 2015). Moreover, they are at risk of acquiring human papillomavirus (HPV) which is a cause of cervical cancer and genital warts. In Mombasa Kenya, in a study population of female sex workers, the prevalence of genital warts was low at 2.3% but eight times more frequent in patients with Human Immunodeficiency Virus type I infection (Kavanaugh et al., 2012). Additionally, these women are also prone to unwanted pregnancies and unsafe abortions following their inconsistent and inappropriate use of barrier contraceptives and having unprotected sex for higher pay or as a result of coercion and violence from clients. The women fear unwanted pregnancies and if faced with such, she may choose to undertake an unsafe abortion. An unwanted pregnancy would mean, no work and no clients. This would mean no money for them and their dependents or an opportunity for domestic violence and an extra burden in rearing a child. In a study done in Kenya, more than half of the study participants ever had an unintended pregnancy and one in every three of the participants had ever induced an abortion (Sutherland et al., 2011).

Violence is also a real threat to female sex workers. They are exposed to sexual and physical violence from their clients and pimps, gender-based violence and violence from

the police (Elmore-Meegan et al., 2004; Ippoliti, Nanda, & Wilcher, 2017; Ochako, Okal, Kimetu, Askew, & Temmerman, n.d.; Parcesepe et al., 2016). The violence experienced makes them vulnerable to illnesses and early death. The violators of this violence can be from their clients who physically and sexually abuse them (Okal et al., 2011). There is a power-play between the sex worker and her client. Power differences are observed in this relationship and her power to bargain is lost, the female sex workers have no choice in the type of client, her pay and the use of a condom. This can be as a result of violence or gender; the woman, a weaker being and loses her rights in matters to do with sex. Other than physical illnesses, this group of women can be predisposed to - mental illness.

Due to stigma, discrimination, social exclusion, violence and victimization these women are more likely to have major depressive episodes, post-traumatic stress disorder, alcohol and substance dependency, antisocial personality disorder and generalized anxiety disorder (Iaisuklang & Ali, 2017; Poliah & Paruk, 2017; Rössler et al., 2010). Mental illnesses are predominant in the younger female sex workers that are less than 24 years as compared to older women (Delany-Moretlwe et al., 2015). The health-seeking behavior for mental support and access to mental health services has been a challenge to FSWs due to the disintegration of the health systems. Due to the siloed nature of the health systems, health workers lack the awareness to screen for mental disorders in key populations and this has led to great morbidity among female sex workers.

2.2.2 Experiences on Stigma and Discrimination by FSWs

Nevertheless, female sex workers are still stigmatized and discriminated by society. Stigma is the label that society uses to impound on an individual that lives against or violates the societal moral values. This stigma has an unmeasurable effect on the individual in a way that it rips off one's status and worth and leads to an untoward effect

which is discrimination and even violence. Laws that decriminalize sex work and derogatory terms for instance ‘prostitution’ has fueled stigma by society. Some of the derogatory terms are used to shame the female sex workers and discount their worth. This stigma interferes with how they interact with the community they live with and even hinder them from accessing health services. The women face sex work stigma which intersects with HIV related stigma for those living with HIV (Hargreaves, Busza, Mushati, Fearon, & Cowan, 2016). This makes access to healthcare a challenge.

Besides sex work-related stigma, health worker stigma has been shown to influence their right of entry to health services. The women in sex work are discriminated against and uncovered to humiliation, abusive language, disrespect, denial of healthcare, lack of privacy and at times breach in confidentiality by healthcare workers. As a result of this, they fear judgement from the health providers which in turn increases their unmet health needs (Benoit, Jansson, Smith, & Flagg, 2018). Female sex workers suffer mercilessly in the hands of healthcare workers. They receive hostility and denied treatment once they disclose that they are involved in sex work. This brings fear and unwillingness to disclose their work even if the reception from the health provider is positive (Scorgie et al., 2013). Such negative experiences by health workers have a lasting effect on healthcare-seeking behavior and their overall health outcomes. A study which was done in Nairobi, Busia, Homabay and Kitui, Kenya, reported that sex workers experienced discrimination from health workers. In which sequentially led to avoidance or a delay in seeking treatment by those who experienced healthcare worker stigma, ensued a reduction of the uptake of HIV counselling and testing and use of non- HIV health services. FSWs who anticipated stigma from health workers were more likely to evade non-HIV services (Nyblade et al., 2017).

2.3 The Challenges Faced by FSWs While Seeking Healthcare

2.3.1 Barriers to Healthcare

Access to quality healthcare services is key in the health promotion of vulnerable populations. Economic factors are one factor that can hinder access to appropriate health services. Females in Kenya still experience unequal pay as compared to men (Murumba Stellar & Mungai, 2018) which expose them to unequal access to healthcare due to the high cost of health services. Lack of economic bargaining power places female sex workers at a losing position. The money they collect by the end of work has to settle competing demands such as food and housing. What is left is not enough to pay for their healthcare services when ill. Further, a lack of quality healthcare is yet another factor that can prevent access to the required healthcare amenities. Quality healthcare as defined by the Institute of Medicine U.S (2001), healthcare services for individuals and populations that increase the likelihood of desired health outcomes and is consistent with the current professional knowledge.

Evidence over the years illustrates challenges that are faced by this marginalized group. The challenges reported are stigma both social and sex work-related, discrimination, female gender inequality, lack of self-empowerment, violence and oppression (Lazarus et al., 2012; Mtetwa et al., 2013; Parcesepe et al., 2016) The evidence reflects on how these challenges make them vulnerable to disease and death as compared to the general public. Female sex workers are vulnerable to intricate social vices such as disease, violence, abuse, exploitation. However, as a vulnerable group of women, they are left with unmet health needs due to factors that hinder them from healthcare (Stefan Baral et al., 2012; Hunt, Bristowe, Chidyamatare, & Harding, 2017; King & Maman, 2013; Lazarus et al., 2012; Mtetwa et al., 2013; Scorgie et al., 2013; Shi & Stevens, 2004). These factors are described below.

Policies are closely related to stigma for the various group. Laws, regulations and social policies have criminalized sex work to deter people from practicing it. However, with these stringent laws and policies comes along social stigma and this may be seen as the origin of stigma for this vulnerable population. In Kenya, prostitution stands unlawful according to Penal Code Chapter 63 article 154 (Laws of Kenya, 2012). This exposes the women to social stigma since they are practicing an illegal profession, harshness or violence from law enforcers that hinder their access to healthcare. This also brings fear of carrying contraband items such as condoms as the women do not want to be identified as sex workers.

As mentioned above, healthcare worker stigma has been shown to decrease the use of health services by women practicing sex work for fear of being judged (Ndung'u, 2016). This was reported to be more common in the public hospital as compared to private hospitals. Further, Ndung'u (2016) observed that female sex workers preferred to go to private health facilities because they were treated humanely and health information was provided, unlike public hospitals. This study also pointed out a barrier on a lack of training of health providers on how to provide quality healthcare to female sex workers. The untoward effect of this health worker stigma is the provision of low-quality health services, denial of treatment and violations in their human rights. Before during and after the diagnosis of HIV, female sex workers have reported issues on lack of effective pre and post-testing counselling, the inadequacy of informed consent, lack of confidentiality of HIV results, delayed linkage, poor follow up and no proper linkage to social support groups. Violations in inappropriate HIV testing results to serious mental, physical and social impacts in women who are found to be HIV positive (NEPHAK, 2015). After being exposed to these unrelenting iniquities, female sex workers stop their treatment, follow up and may even lead to self-stigmatization, depression and suicide. Other

structural barriers that female sex workers face are stringent clinic opening hours that female sex workers cannot access care when working, long waiting hours, high cost of health services and lack of transport from the healthcare facilities.

2.4 Health Service Provision

2.4.1 Preventive Services

The fight against HIV has led to the emergence of preventive and treatment services that is universally accessible by all people worldwide. Female sex workers have equal rights as people in the general population to access these services. However, these services have been underutilized and inaccessible by vulnerable populations. The available prevention services are Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). Kenya was the second country in sub-Saharan Africa to approve the use of PrEP. PrEP is a medication used before potential exposure to HIV. The Kenyan government aims at creating awareness for the use of PrEP and by 2020 more than half of the adults will be aware (Otieno, Kohler, Bosire, Brown & John-Stewart, 2010).

The level of awareness on PrEP and PEP is still low amongst sex workers in Mombasa Kenya but are willing to use PrEP and PEP. The side effects of the drugs were raised as a possible hindrance to the utilization of these drugs (Restar et al., 2017). According to Bekker et al. (2015), South Africa estimated a 40% reduction of HIV transmission between sex workers and their clients when PrEP is combined with HIV testing and counselling. Therefore, awareness and the use of post-exposure prophylaxis has gained popularity over the years as compared to pre-exposure prophylaxis (Otieno, et al, 2010). Female sex workers need to be more aware of preventive services for HIV infection and can easily access these services due to the high HIV prevalence among them.

To prevent HIV, STIs and unwanted pregnancies there are campaigns encouraging women to correctly and consistently use condoms. Still, there are policies placed to discourage entry and practice of sex work. To this effect, female sex workers are apprehensive in carrying condoms, with the fear of being identified as a sex worker by the law enforcers. The police may confiscate the condoms, exploit or assault and detain them on the grounds of condom possession and place charges for practicing an illegal form of work (Shields, 2011). Correct and consistent use of condoms is a challenge that FSWs face, a study was done in Naivasha and Changamwe reported inconsistent use condoms by FSWs with regular partners. In other circumstances, the integrity of the condoms would fail during a sexual encounter. However, those women were receptive to modern contraceptives and most of them used dual contraceptive; a male condom and either an implant or an injectable contraceptive method. These modern contraceptives were chosen due to their convenience (Sutherland et al., 2011). Health programs have mushroomed to create awareness on the need for the consistent and correct use of condoms, to provide easy access to condoms and to neutralize policies that contraband condoms.

There is a growing need for the provision of preventive services to female sex workers. Preventive services available in Kenya are screening for STIs, presumptive treatment of STIs, screening for cervical cancer, vaccination against human papillomavirus (HPV), hepatitis B and other routine vaccines. Screening of asymptomatic sexually transmitted diseases periodically and presumptive treatment on their first clinic visit has been shown to reduce the spread of STIs among sex workers and their clients. Medication given as a single drug regimen is readily available and accessible (Steen & Dallabetta, 2003).

A study which was done in Nigeria, Abuja, on cervical cancer screening among female sex workers reported a high level of awareness at about 71% however the uptake of

cervical cancer screening was low at 40%. The reasons stated for not utilizing cervical cancer screening services was a lack of interest and a lack of awareness (Ilesanmi & Kehinde, 2018). Screening for cervical cancer amongst sex workers is comparable to screening women in the general population. Every three years and yearly for HIV positive women (Ankomah, Omaregie, Akinyemi, Anyanti, Ladipo & Adebayo, 2011).

2.4.2 Treatment Services

In 2015, Kenya gave recommendations for the treatment of all people diagnosed with HIV (UNIADS, 2015). As a result, adults and children who required treatment received it. Nonetheless, the ART (Antiretroviral therapy) coverage among female sex workers was at 34% in 2015 but increased to 79.7% in 2017 (NASCOP, 2015; UNAIDS, 2017). The sexual and reproductive health services tailored for the needs of sex workers including female sex workers include family planning and contraceptive care, reproductive tract cancer screening and care for sexual assault survivors (NSW, 2018). SRH services are to be tailored to the specific health needs of female sex workers in context.

A research was done in South Africa, Johannesburg and Pretoria recommend the inclusion of FSWs during the formulation of new health programmes. In addition to this, the use of treatment guidelines that have been standardized by the health workers may be a barrier by itself in providing effective health care to the women. More so, the healthcare services should mirror the health needs and sexual behaviours of the women in prostitution (Slabbert et al., 2017). Therefore, modifying their health services to meet their social, psychological and spiritual needs should be reviewed.

A systematic review done in low and middle-income countries identified barriers and gave recommendations on what can be done for FSWs to meet their reproductive health

needs at multiple levels: the individual, interpersonal and structural. In the individual level, improve knowledge on contraceptives and encourage, correct condom uses and use of dual contraception. Also, integrate family planning into their care through peer-led programs. In the community level, to use community empowerment approaches so that they can address issues that affect them such as violence, promote healthy behaviours like consistent use of condoms and sensitize the community on the reduction of stigma. On the health system level, to sensitize and train health providers on how to meet the health needs of key populations. Start drop-in clinics where the specific needs of women engaged in sex work are met. On the structural level to implement protective laws that would reduce stigma, discrimination and violence (Ippoliti et al., 2017).

Besides, countries should include key population by meeting their specific health needs rather than making them fit into the official policies. This may include, giving health services that meet their needs, for example, eliminate discrimination, provide more flexible of operating hours and locations of health facilities that are easily accessible to them from their areas of work (Marin, Silberman, Martinez, & Sanguinetti, 2015).

2.4.3 Social, Legal and Spiritual Services

Social services play a role in the provision of healthcare more so in vulnerable populations such as female sex workers. A study was done in a primary healthcare centre, Glasgow, reported that during the time, most FSWs who were intravenous drug users were more likely to come for exchange of the intravenous needles. This informed on the need to integrate social services into health provision of female sex workers (Carr et al., 1996). Training on legal matters has led to success in services championed by the community. For example, in Kenya, the Bar Hostess Empowerment Program provided platforms to train the local sex workers as legal assistants. Where they would educate

other sex workers on their rights and laws that would protect them from exploitation (UNAIDS, 2014).

A systematic review done on spirituality and health in areas of mental health outcomes, health behavior and physical health outcomes by Koening, reported the importance of integrating spirituality and religion (S/R) into the health care systems. Having a look at the health needs of female sex workers, studies done on spirituality and religiosity show that these two entities brought together as one is life-enhancing and a coping resource. It improves better coping skills with adversity such as stress, living with HIV/AIDS, improves emotions, well-being happiness, self-control, self-esteem and gives meaning to life. Spirituality and religion improve mental disorders such as depression and substance abuse. It was illustrated that there were greater impacts when applied in individuals struggling with addiction to alcohol and other substances about 86% of the studies and more than half of the prospective cohort studies reported lower levels of depression. S/R was seen to improve risky sexual behavior. Which implies a lower risk for HIV and other sexually transmitted diseases (Koenig, 2012).

Overall mortality is improved when S/R is applied. With high mortality of female sex workers, about 4.8 per 1000 per years due to AIDS, murder and substance use, spirituality and religion has been shown to increase longevity (Ward & Ward, 2006). This is evident in individuals who attend religious services more often (Koenig, 2012). Good health services are evidence-based therefore integrating spiritual, psychological and social aspects of health is imperative.

2.4.4 Whole Person Care

As reviewed above, the health needs of female sex workers are complex and the causes are not linear but interdependent to each other. To achieve complete health of this group of women it is important to achieve the physical, mental, social domains- including the

spiritual component which was supported and its clinical importance highlighted by WHO later in 1999, where a declaration was made that health is a state of complete physical, mental, spiritual and social well-being, and not merely the absence of disease or infirmity (World Health Organization, 1999). Evidence shows that whole-person care through the integration of mental health and behavioral health improves overall health. Whole person care can give a platform which supports further research and policy formulations (Kaslow, Glueckauf, Greca, & Weinreb, 2007). Below are shown benefits of whole-person care.

The benefits associated with whole-person care can be experienced by three levels; the health system, the healthcare provider and the patient. First, at the health systems level, the compartmentalized organization of the health services can be expensive and not be optimized to its full capacity to generate quality healthcare and the desired health outcomes. Every health systems goal is to refine quality healthcare services. Services that are safe, effective, patient-centered, efficient, timely and equitable and whole-person care meets each of these goals (Institute of Medicine (U.S.), 2001). Second, in the health provider's perspective, not identifying and addressing other aspects of the patients' health needs such as the psychological, social and spiritual domains may lead to sub-optimal health outcomes, increased cost and inefficiency during health service delivery to the patient. Health providers who practice whole-person care are likely to practice self-care and get healing through their clinical relations. If they were to practice whole-person care, then their health services would transfer better health outcomes to their patients and reflect on them (Thomas et al., 2018).

Finally, in the patient's perspective, the level of fragmentation that our health systems run on currently can be cumbersome: moving from one caregiver to the next and expensive to the patient. The psychological, social, spiritual and behavioral health needs

of the patient may not be fully met due to the siloed nature of this health system. Integration of health services and the provision of whole-person care meets the patient's health needs as a 'whole' (Tobey et al., 2014).

There have been ongoing discussions on the need for whole-person care in vulnerable and high-risk populations, for example, female sex workers, however, due to the underlying limitations in the current health systems, which has not come to the realization yet (Ditmore, 2011). Vulnerable individuals have a greater risk of poor health and access to health care. They are at high risk of disease and death than the rest of the population. These individuals present with complex health care needs and their economic and social environments can hinder their access to quality health care. Therefore they are left with an unmet need by the healthcare system (De Chasney, 2019; Shi & Stevens, 2005; Wahed, Alam, Sultana, Alam, & Somrongthong, 2017).

Whole-person care for vulnerable populations is invaluable. With their complex health needs, whole-person care addresses the wellbeing by looking at the four domains of health. Female sex workers are a vulnerable population with physical or biomedical health needs, psychological issues, social burden and spiritual needs from the guilt and shame they carry. Research done on female sex workers has focused on the physical and psychological health needs but has not delved into the two other domains of wellbeing. Addressing their health needs as a whole rather than a summation of all four domains could improve their health outcomes. This research study will look into the experiences and challenges that female sex workers face when seeking healthcare and the health worker's health practices. It will also inform, if any, unmet health needs that need to be addressed by the health system.

2.5 Theoretical Framework

2.5.1 The Bio Psychosocial-spiritual Model

The bio psychosocial model was introduced by George L. Engel (1913-1999) where he inferred that the biological, psychological and social levels must be taken into account in the health system. Engel championed this ideology as a fundamental part of medicine that would bring humanity and patient empowerment. He brought in a holistic approach to health care as compared to the biomedical model that had gained popularity. One of his critiques to the biomedical model was that the appearance of an illness is not only from the biochemical alterations but from interactions of different causalities from different levels; the molecular, individual and social. He embraced the system approach where there is a hierarchy of causality factors that interact and contribute to illness.

Borell described the bio psychosocial model as "both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease, and illness are affected by multiple levels of an organization, from the societal to the molecular. At the practical level, it is a way of understanding the patient's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care" (Borrell-Carrió et al., 2004). The bio psychosocial model integrates the biological, psychological, and sociocultural factors in an approach to understand the complexities and development of human behavior. The biophysical aspect of health from the molecular level to organ systems and its relation to health. The psycho-psychological aspect that involves human behavior, emotions, and mental processes that leads to symptoms and can influence the health of an individual. Socio- social aspects of health, individual interaction with one another, the influence of culture, social values and the community institutions.

The bio psychosocial- spiritual model is used in this study, as it will give a stepwise approach to uncovering the health needs of female sex workers. Itt also finds out if health services provided, address the women's health needs- the physical, psychological and social and the unspoken spiritual needs. It also informed the structuring of the interview guides used in the study. By using this model, it will unmask the health needs and if the health system addresses these needs.

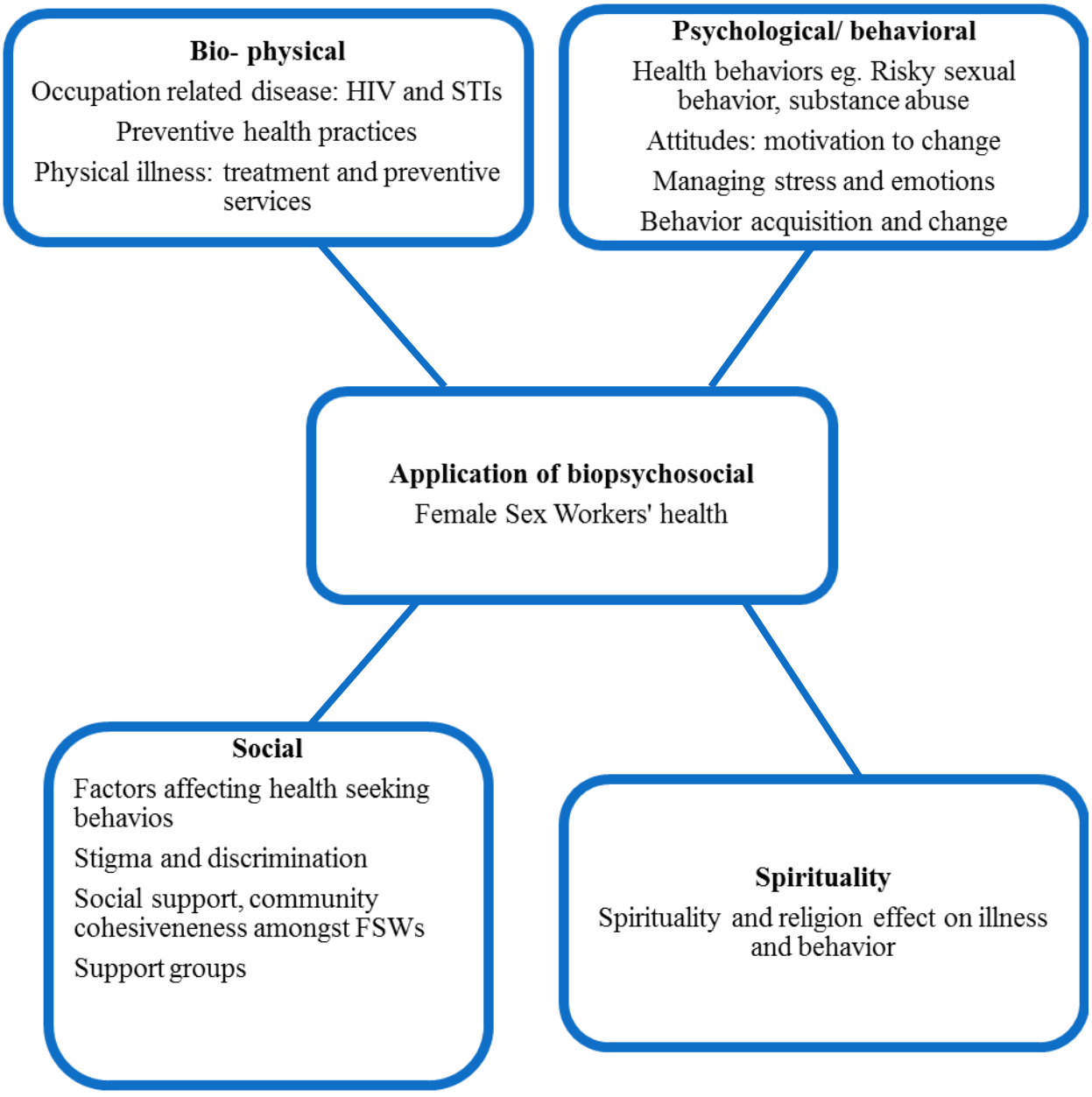

Figure 1 : The conceptual framework for the study

2.5.2 Conceptual Framework

The diagram above is a schematic representation of the bio psychosocial model that was operationalized to inform the formation of the study. This conceptual framework focuses on how the four aspects of whole person care can influence the health of a female sex worker. The four constructs illustrated which are the bio-physical, psychological/ behavioral, social and spiritual interacts with one another and need to balance out in harmony to maintain good health of FSWs. If one of these aspects are not met, this can result to illness and even death of the individual. Therefore this conceptual framework was used to understand the unmet health needs of female sex workers in Bomet County.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The study methodology is explained at full length in the following subheadings: Research design, location of the study, the population of the study, sampling procedure and sample size, instrumentation, data collection procedure, data analysis and ethical consideration.

3.2 Research Design

The primary objective of the study is to understand the experiences of female sex workers when seeking healthcare, the health services provided to them and the challenges if any, they face when seeking healthcare. Bearing in mind, the whole person care approach to address female sex workers unmet health needs. Phenomenological qualitative research was used to describe the experiences and challenges of female sex workers when utilizing healthcare and the health practices by the health workers in Bomet County (Teherani, Martimianakis, Stenfors-Hayes, Wadhwa, & Varpio 2015).

3.3 Study Locale

The study was done in three hotspot towns in Bomet which are Kapkwen (Site C) in Chepalungu Sub County, Silibwet (Site B) in Bomet Central Sub County and Mulot (Site A) in Bomet East Sub County township areas. The estimated population of sex workers who operate in the region is 1600 (NACC, 2016a). These hotspots include areas where female sex workers gather such as bars with and without lodgings and along the highways at truck stops. The HIV overall prevalence is at 5.8%, 2 times higher in women than men at 8.4% and 4.9% respectively (NACC, 2016a). In 2016, only 29% of female sex workers had been tested against the national target of 80% (NACC, 2016b). Bomet is a rural town and the main source of income is farming. There is a migration pattern of

female sex workers during peak times of the year. Towards the end of the year, being a tea zone area, the farmers are given tea bonuses and during this time immigration of sex workers occur at Bomet's small township areas (Kipkemoi, 2016). Some of the sex workers come from neighboring counties, Narok that enjoys a robust tourism sector and Kisii which relies heavily on farming. Other than the tea farms, the people in Bomet also practice dairy farming. In towns like Chebole and Siongiroi, female sex workers are seen to flock the centres to lure the milk traders (NACC, 2016a).

From the researcher knowledge of the area, female sex workers receive their healthcare services from one drop-in clinic in Bomet Central, as well as the public and private health facilities. The drop-in clinic is manned by a non-government organization (NGO) that works with sex workers. The NGO works with sex workers and provides peer-led outreach programs which offer HIV Testing Services (HTS), condoms and refer the women to health facilities for specialized care. There is marginal evidence on the healthcare services for female sex workers in Bomet County.

3.4 Population of the Study

Participants included were female sex workers as well as healthcare workers in Bomet County. The estimated size of female sex workers in Bomet County is at 1,600 (NACC, 2016a). The study included FSWs working in brothels, streets, bars or from their homes, in the top three hotspots amongst the five sub-counties. Access population identification was through the County AIDS & STI Coordinator (CASCO). Snowball sampling was used to recruit participants for the in-depth interviews.

An individual working with sex workers was identified by the CASCO officer. She introduced the principal investigator to the community of female sex workers. This individual provided physical contacts of the prospective participants who she contacted

using her personal mobile telephone. Once the prospective participant agreed to take part in the study, a date and venue was set. Consent was sought after and upon giving the informed consent the interview was held. After the interview was completed, at her own free will, the participant introduced the principal investigator to fellow female sex workers who met the inclusion criterias of the study. Two participants, declined to participate in the in-depth interviews due to their personal preferences. The participants of the focus group discussion were selected from the in-depth interviewees. Whereby the focus group discussion succeeded the in- depth interviews.

Four health providers were identified with the help of the CASCO officer. They were approached in person by the principal investigator. Three out of the four healthcare workers agreed and consented to take part in the study.

3.4.1 Inclusion Criteria

The following forms the inclusion criteria for this study:

i. Any female that self-identified as a sex worker and depends on sex work for sustenance of their livelihood
ii. A female sex worker who understands either Kipsigis, Kiswahili or English
iii. A female sex worker who has ever utilized health services in Bomet County
iv. A female sex worker who has lived in Bomet County for more than six months (six months is sufficient time to get experiences on the utilization of health services and encounter challenges when doing so)
v. A female sex worker who agrees to give a written consent to participate in the study

3.4.2 Exclusion Criteria

Any female sex worker

i. Who appears unable to participate due to a debilitating illness

ii. Below the age of 18 years

3.5 Sampling Procedure and Sample Size

Before sampling of study participants took place, a research assistant who had experience working with FSWs in the area was recruited for data collection. The research assistant is from the Kipsigis community, able to speak and write English, Kiswahili and kipsigis. He is reputable and part of the Kipsigis community. He also assisted in the recruitment of potential participants who met the standards of inclusion.

The sampling procedure was non- probability through snowball sampling for the in-depth interviews and focus group discussions. Snowball sampling was chosen as it was easier to gain entry in the FSWs community. Female sex workers are a 'hidden population', therefore using snowball sampling technique was most preferred (Noy & Noy, 2015). The female sex workers were chosen according to those who have lived the experiences relating to the objectives of the study. To minimize bias related to snowballing, respondent-driven sampling was used as the ideal sampling technique for this study and to ensure diversity, even though it relied mostly on referrals. Participants were selected from different backgrounds such as education level, age, current socioeconomic status, different residential areas and work venues.

The officer present in the CASCO office assisted in identifying a suitable organization and an individual who worked with female sex workers. The identified individual provided access to the community of FSWs. She was contacted through a mobile telephone and the study was explained at full length and once they accepted to

participate, they assisted in recruiting other study participants. Individuals such as healthcare workers working with FSWs and leaders of the FSWs population were approached to participate in the healthcare workers interviews.

The sampling procedure began with the non- purposive selection of 'seeds' who were the first set that included three participants from the three hotspots. The 'seeds' then voluntarily contacted other female sex workers in their social circles. Thereafter, the next set of participants were requested to provide contacts of other three possible participants at will and this process continued until saturation was achieved. The contacts provided was in the form of telephone numbers which was written down in a book and kept by the research assistant. The referred individuals who met the inclusion criteria were invited to participate in the study through a mobile telephone call and any records of the participants' contacts were destroyed after the completion of the research.

For in-depth interviews, sampling continued until saturation was achieved. The sample size number was attained at the twentieth participant when no new information was generated from the individual in-depth interviews. The sample size minimum estimation was adjusted until the saturation of the collected data was achieved (Guest, Bunce, & Johnson, 2006).

There was one focus group discussion done after all the in-depth interviews were completed. A sampling of its participants was done as follows. A selected number of the in-depth interview participants were selected and invited to join the focus group discussion that was held in one of the hotspot areas. Diversity in the women selected for example age, education, residential areas, socioeconomic status and ethnicity was ensured. Eight participants who shared more information in the in-depth interview were invited to participate at the selected location.

The healthcare worker participants, purposive sampling was used and this was informed on their role in the provision of healthcare services to FSWs and their influence on health policies in Bomet County. Three participants were selected who played important roles in providing healthcare services to the female sex workers. They all had more than a year's experience working with female sex workers.

3.6 Instrumentation

A semi-structured in-depth interview guide was used to explore female sex workers' experiences on the utilization of health services, challenges they come across when seeking healthcare and unmask their unmet health needs by the health system. Also to explore the health services provided to FSWs by health workers. The semi-structured interview guides included key questions and probing questions to better understand their health issues. The open- ended questions were peer reviewed for clarity purposes. The instruments used had a rich description of the content sought after, thus validating them. In addition to this, rigor and trustworthiness was used to ensure reliability of the instruments. For the purposes of reliability of the instruments used, the given reports and descriptions were accurate representations of the experiences and challenges of female sex workers when receiving healthcare services in Bomet County, Kenya.

3.7 Rigor and Trustworthiness

Rigor and trustworthiness are assessed through credibility, neutrality and triangulation. For the study to be credible, the principal investigator appointed a multi-linguistic research assistant who is a graduate and assisted in back-translation of three interviews. This was done to compare the original interviews to the translated. In addition to this, the principal investigator was familiar with the female sex workers' population during a period and likewise, the participants were accustomed to the researcher. In this study, neutrality meant the study was free from bias in the research methods and results from

the study. The research assistant who was not in the medical profession was from the local community and spoke the local language was recruited to assist in translation and data collection. This was also implemented by maintaining the distance between the researcher and the participants, to allow free expression of views and experiences. Lastly, triangulation was ensured through triangulating data sources, where in-depth interviews and focus group discussions were used to confirm the completeness of the study (Krefting, 1991).

3.8 Data Collection Procedure

After recruitment of the research assistant, the purpose of the study, the structure of the study and how the study will be carried along was fully explained, so that he had full knowledge of the study. Data was collected through in-depth interviews, a focus group discussion and health workers' interviews and below is a descriptive account of the procedure followed.

3.8.1 In-Depth Informant Interview Data Collection Procedure

With the help of the research assistant, the recruitment of participants for the in-depth interviews was done in the following ways:

i) Gained access to the community of FSWs in Bomet County and reached out to their representatives or potential informants with consent from the CASCO office. They were contacted either through a physical address or a mobile telephone number by the principal investigator and the research assistant.

ii) The venue, date and time for individual interviews were given to the potential participants who had met all inclusion criteria. The interviewee was expected to arrive at the specified time at the allocated setting.

iii) Safety of the participants were determined in the following ways:

1. The principal investigator and the research assistant understood and were sensitive to the political and social factors that could affect the safety of the study participants.

2. The identity of the participants is protected. There are no names or identifying information used in this thesis document or the audio recorded tapes.

3. Consent was sought after and this was signed by the participant and the principal investigator to agree that the information shared will be confidential.

4. Any implicating risk to the research participants during data sharing process are considered, therefore no identifying information will be shared.

5. The interview location was chosen in such a way that it did not draw unnecessary attention or raise suspicion and the interviewees could not be heard. The setting was near the participants' location and it was a room with the least possible distractions. It was safe for the participant and the researcher without any form of identifiers that linked the participants to sex work. Sites for the setting was an inner room in a food and drink hotel and a voluntary counselling and testing (VCT) office.

The timing of the interviews was during the evening hours to encourage attendance. People who were expected to be present in the interview were the principal investigator, research assistant and the interviewee. The roles were clearly defined before the interview. The interviewer (either the researcher or research assistant) lead the interview using an interview guide.

The interview assistant assisted in answering any emerging questions when participants were giving consent. His/ her other role was to confirm that the consent was well understood and signed, handling the audio recorder putting it on and off and taking field notes if need be. The interviewee also took the responsibility of sharing her history, perspectives and experiences in the interview with utmost honesty and clarity. At the beginning of the interview, the purpose of the study was explained at length to the

participants and terms of confidentiality addressed. Confidentiality was accorded to all research participants by removing any identification at the setting of the interview, during the data collection period and storage of data. No names were required although, for coding purposes and quicker retrieval of information, name initials were included. To maintain confidentiality, all audiotapes and interview notes were placed in a safe location.

The research assistant read out the consent to the participant and upon agreement to the terms and conditions, signed consent was obtained. A confirmatory signature or for those who could not write, a fingerprint in the consent was crucial for ethical purpose. Consent for audio recordings was obtained before audio recording begun. This interview was face to face and recorded using a digital audio recorder device- model name was zoom. The interview took approximately thirty minutes. During the recording of in-depth interviews, the voices were distorted and the stored recordings were not in their original voices.

Contact information of the interviewer was given at the end of the interview in the event a participant had any clarifications or questions to be asked. A token was given as appreciation for the time and transport used by the participant. The information recorded and written was in codes, for example, audio- J.M IN/2/09/2019 (J.M initials of both names of participants) to remove any identifiers to the participants. If there arouse an event where the participant needed to be referred to a professional health provider, this was done by the principal investigator. A phone call was made to the professional health provider, a brief clinical history provided and if the health professional accepts the referral, the participant was given details on where to seek the health service required.

3.8.2 Focus Group Discussion Data Collection Procedure

The focus group discussion succeeded the in-depth interviews. The participants were selected from the in-depth interviewees who seemed to have vital information on the phenomenon being studied and bring value to the discussion. Eight participants in total were approached consecutively and recruited for the focus group discussion. Thereafter, they were informed of the venue to meet for the focus group discussion. The setting was similar to that of the in-depth interviews.

Informed consent was obtained for each focus group participant before the FGD. Introduction of the study, the purpose of the study and ground rules during the discussion was explained at the beginning of the focus group discussion the principal investigator and a research assistant helped in moderating the discussions. They also assisted in explaining the questions posed or probes to the participants. The instrument for the focus group discussion was a set of semi-structured and open-ended questions that explored their health needs, experiences and challenges faced when seeking healthcare by female sex workers living in Bomet. Probes were used to keep the conversations flowing and also give clarity to ambiguous words. The discussions were audio-recorded and lasted for about forty to fifty minutes. Just as the in-depth interviews, the voice recordings were distorted. The respondents had a free-will to walk out during an ongoing discussion or remain silent at any point in the discussions if they felt uncomfortable with the subject being discussed. The principal investigator ensured all participants shared, by allowing each person to share their ideas and experiences. To offer a balance between the most active participant to the most silent.

3.8.3 Healthcare Workers' Interviews

The participants chosen are individuals who have first-hand knowledge about female sex worker's community in Bomet County. Three health workers interviews were held. The interviewees included healthcare practitioners, working in the drop-in clinic, from one public health facilities and amongst the community of female sex workers. The healthcare workers were requested to participate in the study through a telephone call made by the principal investigator. Once consent was given, the setting was determined, an area convenient to the health worker and the researcher. A short interview guide was used and the interview audio, recorded. At the start of the interview, the researcher and research assistant were to introduce themselves, a leaflet stating the purpose of the study and its design was handed to the interviewee. Confidentiality was assured and a written informed consent obtained. The interview lasted for about thirty minutes. The interviewee was thanked and a request for permission to get back to the respondent for any clarification or more data collection was made.

3.9 Data Analysis

Data analysis is a methodical search for meaning.. The data collected was systematically searched to get the meaning of all data. This was done using content analysis (Erlingsson & Brysiewicz, 2017):

i) Data was collected by audio records and labelled.

ii) Analysis: Analysis was done in these five steps:

- Organizing the data
- Finding and organizing ideas and codes
- Building overarching themes in the data
- Finding explanations of the findings

iii) Storage: Data is stored under lock and key until a minimum time of ten years after publication. It will be destroyed thereafter or when approval from the university archivist is obtained. The principal investigator will ensure that the data will be destroyed in a way that it will not be recreated. The principal investigator and the examiner are the only two people who have the right to access this information during and after the study period.

The following steps were followed during data analysis:

3.9.1 Data Organization

i) Transcription of data: a transcriber was approached for services. The qualitative data was relayed and he/she transcribed the data into a written document.

ii) Translation: The written document was translated to English if in Kipsigis for easier understanding by the principal investigator and during reporting of data.

iii) Labelling of data: the data transcribed, translated and cleaned up then structured and familiarized.

3.9.2 Developing Codes (Data Organization, Concepts and Ideas)

This step involved finding words and phrases used frequently, finding meaning in the language used, learning that which was not expected and hearing the stories shared. After these codes and categories of ideas and concepts were formed. Manual coding was done. The transcribed and translated documents were read by the principal investigator and codes were written at the left margin of the pages.

3.9.3 Building Over-Arching Themes in the Data

The categorized ideas and concepts may bring out different themes. Therefore, this step brought codes and similar categories together and built overarching themes. The principal investigator and an independent researcher went through the transcribed and

translated documents and came up with themes. These were compared against each other to find out if they were agreeable.

3.9.4 Finding Explanation of the Findings

A summary of the findings and themes were made. Thereafter, the findings were compared to existing literature, if they were similar or different. Then lastly, completion of writing of the final thesis report.

3.10 Ethical Considerations

This research study upholds the four central ethical considerations which are respect for persons, beneficence, non- maleficence and justice. The principle of respect to a person means that confidentiality was assured to all participants in this study. An informed consent was obtained for each individual who participated in this study. All participants who wished to withdraw from the study had the right to withdraw and their decisions were respected. Some women were approached but did not self-identify as sex workers and they expressed their lack of comfort on the subject and they were granted the right to withdraw. In addition to respect of persons, the information shared is handled safely and stored by the principal investigator. No identification is available in the collected data and whatever information shared with an external researcher is not linked to the source. On reporting of the findings, brief unidentified quotes and no identifying information was written.

Beneficence- health service interventions that will appropriately match the health needs of FSWs are potential benefits that will come from this research study. Minimal risk was applied in this study by maximizing potential benefits and striking a balance between benefits and risks. Since the methodological plan of accessing data in this study is in the form of qualitative research design and non-therapeutic procedures applied, the

magnitude of risk of exposure is expected to be minimal. Appopriate referral of one participant who reported on experiencing intimate partner violence was done as follows. The principal participant linked her to a healthcare worker who provides gender based violence services in I choose Life, Bomet County.

Justice is applied when the potential benefits from the study is accessible to all female sex workers who participated in the study and if possible beyond. In the event where medical concerns arouse from a participant in the study, it was the responsibility of the principal investigator to provide a safe referral system to a health care worker who can provide the needed healthcare services in a timely fashion. The healthcare worker is based at I Choose Life an organization that provides healthcare to FSWs, and is a clinician. Permission was obtained from CASCO office in Bomet County as the entry point and the letter is attached under appendix section.

Lastly, this study is based on the fundamental right of a person and health. A right to access timely, acceptable and affordable health care of appropriate quality. This is why it is important to explore the unmet health needs of female sex workers and the appropriateness of whole person care in meeting the unmet health needs.

Approvals from the ethical committee such as IREC in Kabarak and NACOSTI was confirmed and obtained.

Please find the attached in-depth interview guide, focus group questions and budget prepared.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

Presentation of the data analysis, presentation and discussion of the findings will be found in this chapter. This was done in relation to the objectives of the research study:

i) To describe the experiences of female sex workers when they are receiving health care services in Bomet County

ii) To determine if any challenges encountered by female sex workers when seeking healthcare services in Bomet County

iii) To explore healthcare services extended to Female Sex Workers by healthcare providers in Bomet County

Analysis of data was performed using the framework for content analysis (Erlingsson & Brysiewicz, 2017) Manual coding was done where the participants' views were assigned codes, categories and themes and viable conclusions drawn from the same.

4.2 Socio-demographic Information

4.2.1 Age of the Respondents (Female Sex Worker's Age Distribution)

Table 1: Showing the Age Distribution for Participants' In-depth Interviews

Age of the Respondents	Number of the Respondents (n)	Percentage Representation
20-30	15	75%
30-40	5	25%
Total	**20**	**100%**

A total of 28 female sex workers were interviewed. 20 participants were in the in-depth interviews and 8 in the focus group discussion. From the data set, it is evident that 75% of the respondents, represented by a frequency of 15 were female sex workers aged

between 20 and 30 years. The respondents between the ages of 30 and 40 years were represented by a frequency of 5 and a percentage of 25%. It is worth noting that a total of 3 health workers participated in this study.

4.2.2 Level of Education of the Respondents (Female Sex Workers)

Table 2: Showing the Level of Education for the Participants

Level of Education	Number of the Respondents (n)	Percentage Representation
High School	2	10 %
Primary School	18	90%
Unschooled	0	0%
Total	**20**	**100%**

From the total in-depth interview respondents of 20 female sex workers, it is evident that a majority of respondents, 90%, had primary school education as their highest level of education. This was evidenced by a high frequency of 18. Only two respondents had a high school education as their highest level of education; represented by 10% of the total.

4.2.3 Length of Period in Sex Work

Table 3: Showing the Length of Period of Involvement as a Sex Worker

Period as a Sex Worker	Number of the Respondents (n)	Percentage Representation
1-5 years	15	75%
6-10 years	4	20%
More than 10 years	1	5%
Total	**20**	**100%**

Out of the 20 respondents who participated in the study, it is evident that majority of the respondents have practiced sex work between 1 and 5 years. This group of female sex workers was represented by a frequency of 15 and a percentage of 75%. 4 of the respondents had practiced sex workers between 6 and 10 years. They were represented

by 20%. Only one responded had operated as a sex worker for more than 10 years, specifically 11 years. This was represented by 5%.

Table 4: Showing Representation of the Participants in the In-depth Interviews

Names of participant	Age of the participants	Residence
Participant 1	36	Site A
Participant 2	29	Site A
Participant 3	23	Site A
Participant 4	33	Site A
Participant 5	32	Site A
Participant 6	22	Site A
Participant 7	26	Site A
Participant 8	22	Site A
Participant 9	28	Site A
Participant 10	35	Site B
Participant 11	24	Site B
Participant 12	24	Site C
Participant 13	28	Site C
Participant 14	26	Site C
Participant 15	24	Site C
Participant 16	36	Site C
Participant 17	27	Site B
Participant 18	33	Site C
Participant 19	22	Site C
Participant 20	25	Site C

4.2.4 Focus Group Discussion

There were eight participants in the focus group discussion held in site C following the in-depth interviews and three key-informant interviews were held.

4.2.5 Health workers' Demographic Data

Table 5: Health Workers' Demographic Data

Health care worker	Responsibility& qualifications	Work experience with FSWs
HCW participant 1	Clinical Officer	Over 1 year
HCW participant 2	Counsellor	Over 3 years
HCW participant 3	Social worker	Over 3 years

4.3 The Experiences of Female Sex Workers when Receiving Health Care Services

Table 6: Showing Thematic Representation for Healthcare Needs for FSWs

Code	Category	Theme
No money Harassment from health workers/ threat to confidentiality Discrimination by fellow women	Economic Societal imposed stigma	Socio-economic factors
Drugs for HIV and STIs Family Planning Services	HIV treatment and preventive services	Sexual and reproductive health (SRH) and other health care needs
Spiritual matters Control stressful conditions		Need for spiritual Care
Use of Condoms HIV prophylaxis drugs Sexual Responsibility Health Education	Preventive Healthcare	Need for health Information
Healthcare that meets all aspects of health		Female sex worker's perspective on whole-person care provision

In this study, it is evident that female sex workers seek for various health services in health facilities in Bomet. These services include testing and treatment whereby nineteen out of the twenty in- depth individual interviewees sought after HIV and sexually transmitted illnesses, twelve- general health conditions, nineteen- family planning services, one- psychological support, one- spiritual care, six- sexual responsibility and five- health education. However, their reasons for seeking health services at the health facility of choice vary and below are the findings of their experiences when seeking healthcare.

4.3.1 Socio-Economic Factors

All female sex workers who participated have no other major sources of income besides sex work. Their returns from sex work need to cater to their everyday needs. For the ones who have other sources of income, the main source of income cannot sustain their needs, more so, afford appropriate healthcare services. On average, female sex workers in this study make between three hundred and two thousand Kenya shillings per day. This is money that is spread out to meet their needs and that of their children. This money is meant to meet their competing needs such as food, shelter, cost of education and health.

During the interviews, a participant, 24 years said that she sometimes mops the bar and does not have any other major source of income except for the sex work she does. Below is a response that a participant gave,

> "*Sometimes, I go to the bar and mop… I don't have any other work besides the sex work I do "Participant 12, 24y, sex worker*

The women are forced to delay treatment of illnesses which can be attributed to financial constraints. For instance, a 24-year-old sex worker reported that when she goes to the nearest government health facility, the doctor tests and confirms her illness but she is told that there are no drugs. This is her experience as captured,

> *"When I go to the hospital and get tested for an illness, the doctor tells you that there are no drugs…… If I miss the drugs, I go back home and look for money so that I can buy them from the chemist. "Participant 15, 24 y, sex worker*

One of the healthcare workers confirmed that most of the female sex workers suffer from gonorrhea and syphilis and can stay for a long time without seeking treatment,

"*…. The female sex workers most of the time suffer from gonorrhea, syphilis. Now, you can find someone stays with these conditions for a long time without finding help." HCW participant*

A 33-year-old, purported that most times when she takes her children to the nearby dispensary for drugs, the drugs are not available and she is forced to buy them at the chemist and at times she cannot buy due to lack of money, as reported:

"Most times when I take my children I do not get drugs and this forces me to buy from the chemist and sometimes I do not have the money." Participant 18, 33 years, sex worker

Due to competing economic needs, female sex workers, lack money for transport to go to their clinic of choice. Therefore, some opt to go to the nearest health facilities which at times the drugs are unavailable. One participant explains this in detail:

"At times I do not have the opportunity to go to Bomet because I did not have money, therefore, I went to the nearest hospital…." Participant 3, 23y, sex worker

Stigma a social determinant of health is a common phenomenon among female sex workers. Stigma was encountered from the community, health workers and also from self. Health worker stigma was the most common type of stigma experienced by 11 of the twenty in-depth participants when seeking healthcare services. Which could lead to loss of follow up or delay in the appropriate treatment. A 25-year-old female sex worker alleged that when she has psychological stress she would rather talk to her friend than the doctor. She later describes how they are harassed when they go for family planning services at the nearby dispensary. This harassment leads to discouragement to even open up to the health worker. This particular participant describes:

"I talk to my friend when I have stress… There is no doctor you can talk to…Yes, every time we go for family planning they harass you until you feel discouraged" Participant 20, 25y, sex worker

In addition to this, a 29-year-old participant explained that she fears to talk with a health worker. She revealed this:

"You know you cannot go share your secret with everyone" Participant 2, 29y, sex worker

Stigma by self and other women in sex work, where one participant, a 33-year-old participant. She is living with HIV; however, she faces discrimination from her fellow sex workers. The other sex workers would approach her clients and candidly ask why they are with her. This form of stigma from other sex workers as presented, caused psychological distraught and anguish and even suspicion between the participant and her colleagues. Her experience as captured below:

"…Some ask what makes you happy when you are with that woman?" Participant 18, 33 y, sex worker

4.3.2 Sexual and Reproductive Health and Other Healthcare Needs

Medical services like testing for HIV, STI's and general health issues are some of the explanations of why female sex workers in the study, went to seek healthcare services. In this study, eighteen out of the twenty in-depth participants, alluded to the fact that they visited the hospitals for either HIV and STI Testing and treatment and nineteen of them, went to seek methods of contraception such as emergency pills as well as barrier methods such as condoms. Other than the sexual and reproductive health services, twelve of those interviewed in the in-depth individual interviews, also went to seek non-reproductive health-related medical services. Four participants alluded to this fact.

A 19-year-old participant attested to the fact that she went to the hospital to receive treatment for gonorrhea:

> *"Yes, I have been to the hospital. I ever went to the hospital and received medication for gonorrhea…. I went to the lab to be tested and they found out that I indeed had gonorrhea" Participant 19, 32y, sex worker*

One 22-year-old participant alleged that she had slept with a client and surprising the condom had burst and that triggered her to go to the hospital to seek treatment. Upon presentation, the client was given medication to prevent pregnancy. As she disclosed:

> "*I slept with a client and found that the condom had burst and decided to go to the hospital. When the condom had burst, I was given medication for seventy-two hours to prevent pregnancy." Participant 13, 22 y, sex worker*

Yet another 24-year-old participant reported that she specifically went to the hospital to seek VCT services,

> "*Specifically, I went for VCT services to know my status" Participant 11, 24y, sex worker*

Other than STI treatment, a 36-year-old female participant said that she goes to the dispensary to seek treatment for common colds or any other problems. As she reported,

> *"If I have an STI, flu or any other problem, I go to the dispensary" Participant 1, 36y, sex worker*

A 22-year-old female participant said she goes to the dispensary if she has symptoms that suggest gonorrhea or when she wants to prevent pregnancy or HIV. She disclosed as follows,

> "*I go to Site A dispensary when I think I have symptoms of gonorrhea or when I feel like preventing pregnancy or even testing for HIV…" Participant 6, 22y, sex worker*

Most commonly mentioned healthcare need that female sex workers want are methods of prevention, for example, male and female condoms that prevent them from STIs and unplanned pregnancies. Most of the respondents alluded that they often go to the health facilities to get condoms and drugs used for prophylaxis. For example, seven women sought after post Exposure Prophylaxis drugs for HIV. Below are some of the participants' remarks',

A 25-year-old participant attested that she receives condoms from her local dispensary as well as the community peer educators,

"*We always have the condoms brought to us here, at the dispensary" Participant 20, 25y, sex worker*

A 33-year-old participant living in site C, alluded to the fact that availability of the condoms was not an issue and whenever she went for condoms at the health facility she always received them,

"When we go for condoms, we get them." Participant 18, 33y, sex worker

A health worker confirmed this. She narrates how she supplies both male and female condoms and lubricating gel from a non-government organization, I choose Life. She revealed,

"I supply condoms, lubes and female condoms, they get them from me" HCW participant

Female sex workers also go to health facilities to receive family planning, which was reported by nineteen of the participants and HIV preventive services, seven had used post exposure prophylaxis, apart from condoms. One of the participants said that she uses the 3-months injection for family planning and got to know about it after she delivered her child,

"*Yes, I use family planning, the three months' injection and I got to know about it when I delivered my child." Participant 20, 25 y, sex worker*

A 33-year-old FSW said that in case the condom bursts, she would go to the dispensary to get the HIV preventive treatment,

"*In the case of condoms bursting, I stay for three months and then go to pick the drugs for risk "Participant 18, 33y, sex worker*

However, from her statement, it highlights the participant's insufficient knowledge on when to use post-exposure prophylactic (PEP) drugs for HIV which will be discussed in the next theme.

It was also noted that there was a limited supply of drugs at the women nearest dispensary in Site C. Participants in the focus group discussion which was held in Site C, reported that there was no supply of pre- exposure prophylaxis (PrEP) of HIV drugs as well as other drugs and they had to go buy at the chemist which would cost them money. These are the reports of some of the participants,

"PrEP drugs are not easily available" FGD participant 3

"It is not available in the dispensary" FGD participant 1

"You are tested and are told to go to the chemist because there are no drugs in the dispensary. You are told to buy your drugs." FGD participant 3

"If you go to Kapkwen, there are no drugs. You are given amoxicillin, piriton or Panadol. For every sickness you are given Panadol then you go home." FGD participant 7

Agreeing to this, a 26-year-old participant living in site A, reported that she was not satisfied with the healthcare services she got at the nearby government health facility and looked for alternative healthcare from the chemist.

"No, I was not satisfied with their services. I went to Mulot health centre, they did not test me and only gave me drugs which did not help me recover. I went to the chemist and they tested me and gave me drugs and got well. "Participant 7, 26y, sex worker

Female sex workers seek out for health services from both health facilities and even chemists. A 25-year-old participant said that she only went to the hospitals to get condoms and headed to the chemist for other services in case she feels unwell,

"*I can only go to the hospital for condoms. Other services I can get at the chemist" Participant 20, 25y, sex worker*

As described above, female sex workers have various reasons for seeking sexual and reproductive health services. In the face of these reasons, the participants voiced out their experiences when seeking healthcare and found an inconsistent supply of the drugs, inappropriate treatment and non-flexible clinic opening hours.

A 25-year-old female who is in her reproductive age reported that she conceived a baby because she did not get family planning services in the local dispensary at the time she went seeking for help. She further explained that due to this experience she decided to go to the local chemists,

"Yes, there is one time I went to seek family planning and it was not available, this made me conceive and get another baby. This also made me start going to the chemist..." Participant 20, 25 years, sex worker

Sex work is a trade that occurs mostly in the evening and night hours and services that are considered as emergency services and are not readily available at the time. These are services such as HIV testing in the case when one has an incident of a burst condom or supply of condoms. Health facilities are opened during day hours and closed at night

which can pose a barrier to provision of urgent services in the night hours. As conveyed by a 24-year-old participant,

> *"...What happened is that the condom burst and the clinic had closed. I had to buy a testing kit from the chemist near here" Participant 12, 24y, sex worker*

On the contrary of how other women felt on their displeasure of the health service they receive at their nearest health facilities, a 36-year-old female living in Site A, reported that she was satisfied with the health services in Site A and had not met any challenges. As explained,

> *"I have not met any challenge here. The doctors here are good; they care for people well. There are places where you go and if people hear you are from far, they refuse to take care of you well but over here I haven't seen anything wrong." Participant 1, 36 y, sex worker*

This was also expressed by participants in the focus group discussion who reported that they were satisfied with services provided by a health facility by the name Tarakwa dispensary which is a government-led facility, near-site C. They liked going to Tarakwa dispensary and the drop-in clinic because they were served better. As they unveiled,

> *"Tarakwa dispensary has really helped us. They do not have doctors but the other health workers are hardworking" FGD participant 1*
>
> *"They hear our grievances there. When we reach ICL and miss drugs, they refer us to Longisa and there they direct us to a room which we enter. They take good care of us" FGD participant 2*

However, on the contrary, they said that when they go to Kapkwen government dispensary they are dissatisfied with the health services given. One participant re-counted that at times, they are given drugs at the facility but they are not told why they are taking the drugs.

"They treat you but they do not explain what illness you are suffering from, until you go to the chemist and they explain what the prescribed drug is for treating which illness." FGD participant

4.3.3 Need for Health Information

HIV awareness and safe sexual practices such as consistent use of condoms, post-exposure prophylaxis and emergency pills was a concern expressed by the women in this study. One 36-year-old female sex worker explained that if health workers could inform female sex workers on the proper use of condoms, this would reduce the spread of disease such as STIs. As raised by the participant,

"They need to be taught, some of them do not know how to properly use the condom, therefore they should get taught. If one gets a client and he only has two hundred shillings, she may accept the money and that is the reason as to why you see there is widespread of disease, even the STIs" Participant 1, 36y, sex worker

Also, she went on to express the need to have accessible HIV testing services especially for the women who are either afraid to be seen going for HIV testing or have not fully understood the need for testing. The community needs information on HIV testing to understand its importance as well as the reducing stigma attached to testing. As the respondent put across:

"…what I had told you, that you need to bring a tent where people can be tested-VCT. You can even place it outside here, you know many people find it hard to come out especially the ones who have not understood its importance, it is very hard for them to come out" Participant 1, 36 y, sex worker

She also added,

"Yes, it is hard and then get a person who will walk around talking to them, teaching them about condom. The person can carry items for illustrating how to

properly place the condom. Some of them do not know about the female condom. They should be taught how to place it well. Here, the rate of STI is too high." Participant 1,36y, sex worker

2 out of the 20 participants, in- depth interview participants said get to know on safe sex practices through the media, for example, the radio. One 28-year-old participant said that she heard the use of condoms and family planning on radio,

"*I heard about condoms and injectable family planning method via radio" Participant 9, 28y, sex worker*

However, because of the peer outreach programmes run by I choose life, one focus group participant reported that they are taught on how to protect themselves from HIV by using prophylactic drugs.

"We were taught about PEP… They come every three months. We last did it in December last year" FGD participant

During the interviews, it was noted that the women did not know much on the services offered for prevention. For example, fifteen of the FSWs had not heard of services like pre-exposure prophylaxis and post exposure HIV drugs. Nineteen participants of the in-depth interviews, had not gone for cervical cancer screening services and had little information on the importance of this service. All women who participated in the in-depth interviews, had no knowledge and had not received any kind of vaccines and STI prophylactic drugs that would protect them from sexually transmitted diseases for example Hepatitis B and other illnesses.

"I do not know about cervical cancer screening or other preventive measures" Participant 2, 29y, sex worker

More so, there was a clear need on health awareness not only to the FSWs but also their male clients. A health worker expressed her desire that the male clients need to be tested

for HIV and also get educated on the need to start safe sexual behaviours like consistent and correct use of condoms.

> *"No, men to men. They start their program for testing and they agree upon using condoms. For example, a man approaches me I will insist that he uses a condom. Another one will say that he does not want and another will agree. We want them to ensure that men will not have sex without a condom." HCW participant*

Health education to the male clients will improve the health of the women who practice sex work and even reduce their high prevalence of HIV and STIs, as well as unintended pregnancies.

4.3.4 Need for Spiritual Care

Female sex workers need spiritual guidance during the times they seek healthcare services. Only one participant, acknowledged that she has ever received spiritual care from a health provider. A 26-year-old participant said that the doctor often speaks of biblical inferences when they are testing them at the VCT,

> "*When they are testing you, they talk to you about things from the bible and when I go to the VCT they read the bible for me." Participant 7, 26y, sex worker*

Provision of spiritual care would give the female sex workers a positive perspective on life when stressed and help them take charge of their stressful conditions as reported by one health worker.

> *"It would be better in such a way that if one has stress and you are not gaining much from your business… It is better to know about spiritual matters because one can control her stressful condition and plan … This is how it will help." HCW participant*

4.3.5 Female Sex Workers' Perspective on Whole Person Care Provision

The female sex worker's perspective on how whole person care can influence their health. Such as, a 25-year-old female sex worker affirmed that it will improve her health by reducing her risk for sickness and disease and even improve her ability to plan her family size. This was affirmed by a 33-year-old informant who reported that health can be caused by psychological problems such as stress and addictions to alcohol and cigarettes. Therefore, healthcare that seeks to treat the psychological aspect can improve health.

> *"It will improve my health by not getting sick. I can plan my family better and even prevent my risk for disease" Participant 20, 25 y, sex worker*

> *"When you are stressed even your physical body can have problems, things like alcohol can be a cause of body aches and headaches. Use of cigarettes can harm you therefore you cannot miss stress by the way" Participant 4, 33 y, sex worker*

Most of the sex workers do not have a reliable source of income. A 35-year-old woman said that through the provision of whole-person care, it will provide a way for her to come out of sex work. Through the provision of social services, she would receive support to leave sex work and start a business and would not have to do sex work again.

> *"It will help me stop sex work and start a business that will support me, Then I will not be at risk of getting STIs and become stable… My life will be better." Participant 10, 35y, sex worker*

During the focus group discussion, the female sex worker's perspective on the impact of the provision of whole-person care to their health was pragmatic. One of the participants reported how it would be beneficial in reducing their morbidity for psychological stress and disease.

"It would help the women because there are things that we cannot teach ourselves such as how to reduce the burden of stress and disease" FGD participant 5

However, another participant thought that it would consume their time. This would pose a problem especially if they are called by a client and they have to go through the different steps of whole person care at the scheduled clinic time. Also, the other unpleasant part would be that the doctors would do more tests that one does not approve. This was explained in detail,

"Challenge would be you may not have the time…Yes. One can forfeit going to the hospital because you can get tested even what you did not want to be tested. For other women when they go to the doctor, there can be a client who wants to be served first." FGD participant 8

4.4 Challenges Encountered by Female Sex Workers when Seeking Healthcare Services

Table 7: Showing Thematic Representation for Challenges Faced when Seeking Healthcare

Code	Category	Theme
Stigmatization	Stigma	Stigma
Financial constraints	Economic	Access to health care services
Long-distance Fear of health workers	Structural barrier Fear	
Physical violence Intimate partner violence Violence from law enforcers	Violence	Need for psychological support
Addiction to alcohol and other substances	Substance abuse	
Shame, guilt Morality	Spirituality	Need for spiritual support

4.4.1 Stigma

One of the challenges encountered by female sex workers is stigma from different groups of people, either a group or community as a whole which impacts their health. In this study, stigmatization has been seen in various ways. Female sex workers lack support from the community and often suffer from stigma. They are often considered as lesser persons in the community because of their occupation. One health worker alluded to the fact that the community does not bother about the female sex worker community and seems to alienate them,

"*…The community is a bit skeptical about this population especially here in Bomet but…." HCW participant*

On the other hand, due to the fear of stigmatization in seeking family planning and HIV drugs, this results in low uptake of these services despite being well informed. The health workers' alluded to this fact by saying that very few sex workers present themselves to the facility for fear of being stigmatized by other health care workers.

"*For example, you can reach out to maybe fifty female sex workers and clearly, they need these service they need pre-exposure and post-exposure HIV prophylaxis but out of fifty you can get maybe five who will come for these services." HCW participant*

"Also the stigma against sex work like going for STI screening is still a bit stigmatized." HCW participant

"...The major challenges are stigma and discrimination. For a sex worker, they are required to get STI screening every quarter year, as well as HIV testing and most of the other services. When they present themselves to a facility as often they usually face stigma from the health care workers…" HCW participant

This was confessed by a female sex worker living in Site A who communicated the need for HIV testing services that are easily accessible to the community. She went on explaining that some of the women find it hard to come out and get tested. Also, health workers can consider placing tents where people can be tested. This could provide more privacy and ease of accessing the HIV testing service

"*There is none, only what I had told you that you need to bring a tent where people can be tested- VCT. You can even place it outside here; you know many people find it hard to come out especially the ones who have not understood its*

importance. It is very hard for them to come out." Participant 1, 36 years, sex worker

4.4.2 Access to Healthcare Services

One of the challenges that female sex workers go through is long distances of travel to the facilities where they expect to receive health services as female sex workers. One health worker supported this fact. He said that if the hospital facilities would be shorter distances from where the female sex workers reside, then a larger number of female sex workers can present themselves for health services. Two health workers emphasized this aspect as evidenced by these responses,

"*.. …as much as we reach out to the entire county, we only have one health facility and distance can play a role, maybe if we had closer or more facilities that offer services to sex workers the turnout would be a bit high…." HCW participant*

"…. low economic status also builds up to the distance challenge maybe they would be able to access here if they had the money for transport …" HCW participant

It is of the essence to mention that most female sex workers suffer from a lack of financial resources to purchase the drugs they may need. A 35-year-old participant said that it is a challenge to look for money to purchase drugs for us as sex workers.

"*It's a challenge for us to look for cash and go and by drugs. This is a problem for all sex workers. "Participant 10, 35y, sex worker*

Another challenge that the female sex workers experience is delayed service delivery from the health facilities. Therefore, opt to get drugs from chemists. One participant said that healthcare service providers are not available to serve them. They, therefore, resort to purchasing drugs from local chemists and head home.

"*Sometimes, when you go there, no one attends to you and yet you are feeling unwell….so you decide to go to the chemist get attended to and head home. "Participant 10, 35y, sex worker*

During their visits to the dispensary, the women experience long patient lines and inattentiveness of the health workers which may, in turn, deter them from getting the healthcare service required. They seemed to prefer going to the drop-in a clinic led by I choose Life which is a non- government organization. The following were some of the women's' statements,

"We wait, there are many people" FGD participant 4

"It is not like ICL; the people are many. They stay chatting with each other until midday. When it is lunch they display that they have gone for lunch until 5 pm." FGD participant 3

Other than this, they also reported that their dispensaries only open during day time and they would not access urgent services such as HIV testing before taking post-exposure prophylaxis drugs for HIV or condoms during the night. Due to the nature of their work, they would prefer more flexible clinic opening hours. As explained,

"If the clinic would open at night, it will help us" FGD participant 6

Limited preventive healthcare resources, is another challenge that can limit access to the appropriate health service. One of the peer educators alluded to the fact that at times they are faced with a shortage of condom supply.

"*There is a shortage of condoms offered to female sex workers in our facilities "Health worker 2*

In addition to a lack of condoms, one participant alluded that there is a shortage of drugs at times from the nearest health facilities,

"You can find that drugs are not available." FGD participant 2

Apart from the limited availability of their drugs, it seemed that lubricants and female condoms were scarce. The women reported that they were taught how to use these items but they were not easily available for use. This was expressed by one of the participants,

> *"We are taught about lubricants but it is not available and finding female condoms is hard. You can get them once in a year and they are few." FGD participant 3*

Another challenge that a female sex worker goes through is the fear of seeking counselling services from medical centres. Two of the participants alluded to this fact.

One of the participants said that she fears opening up to the doctor for fear of being judged and harassed,

> "*I have never sought counselling services to the doctor, I fear because I prefer to talk to a person I can easily relate to. Some doctors are too tough as witnessed when we go for family planning services, they harass us" participant 8, 22 years, sex worker*

Therefore, they opt to talk to their friends to seek advice and comfort,

> *"Whenever I experience guilt, I talk to my friends. They give me advice and assist me." Participant 17, 27y, sex worker*

Lack of follow up and low retention in peer-led programs because of their short-lived nature. Sometimes, the female sex workers may feel like another location will help them thrive economically as compared to another. Thus, they may opt to move from their current location into a new location. In this regard, they are not retained in their current support groups and have to join another support group. This movement also plays an important role in loss to follow up at their health facilities especially women who are on HIV care or other chronic diseases.

"*Sex workers are migratory in nature, whenever there is cash influx in that area, they automatically move to that area…"HCW participant*

4.4.3 Need for Psychological Support

4.4.3.1 Violence

Gender-based violence is a challenge that female sex workers often face. Sometimes such cases are addressed nevertheless cases go unnoticed because of under-reporting in this special population. One health worker supported this proposition by saying that cases of violence and assault have been reported to them.

"*.. We get cases of physical assault that the sex workers present with. So we get traumas, blunt force injuries…" HCW participant*

However, a 27-year-old female sex worker, a victim of intimate partner violence, explained how she would be beaten by her frequent male partner but had not reported,

"I am beaten thoroughly almost every day with my frequent male partner with whom I have children, he does not give us any financial support. "Participant 17, 27y, sex worker

A 35-year-old participant said that every so often her male clients refuse to pay her, beat her up and become violent and she ends up not getting paid for the services offered. Due to the illegality of sex work, law enforcers imprison them instead of providing justice and protection.

"*Sometimes a client can refuse to pay for my services and beats me and becomes violent... I face such problems but I am afraid of reporting the person because sex work is illegal. If you go to the police you are put in prison. I fear saying that I am a sex worker because I feel discriminated "Participant 10, 35y, sex worker*

The violence experienced by female sex workers brings about psychological and emotional harms. FSWs are fearful of reporting these cases because of the illegal aspect

of sex work. The healthcare system has the role of increasing the reporting of such cases. This can be done providing safe ways of reporting and creating awareness of these services; intimate partner violence support and gender-based violence.

4.4.3.2 Use of Alcohol and Other Substances

Another challenge that female sex workers face is the abuse of alcohol and other substances that could lead to unhealthy sexual behaviours and mental health disorders such as addiction. Use of alcohol and other substances of abuse can lead to poor judgement on risk reduction from occupation-related illnesses. Upon interviewing, three women of the in-depth interview participants attested to the fact that they abused several drugs. One participant alluded to this fact as evidenced by her response below.

A 33-year participant attested to the fact that she sniffed drugs as well as abused alcohol,

> "*I used this drug for sniffing and I also drink alcohol." Participant 18, 33 y, sex worker*

Another 36-year-old sex worker attested to the fact that many of her colleagues in sex work use alcohol even at day.

> *The problem that is in this area is that people love drinking alcohol. The women become drunk even at day time" Participant 1, 36 y, sex worker*

Because of the effects of these substances, for example, poor judgement and competing financial needs, female sex workers are not able to seek timely healthcare services. This increases their morbidity to diseases and even risk for death. Healthcare workers need to provide psychological support such as counselling and gender-based violence support to improve the general health of this vulnerable population.

4.4.3.3: Lack of HIV Drugs for Their Children

The participants' articulated their concerns for women in sex work who were infected with HIV. They reported that it was hard for women to find their children's drugs. This would force them to continue breastfeeding without any form of preventive medicine. This surmounted to a great deal of psychological anguish for the women,

> "We *lack drugs for children. If a mother is positive, their children do not get their drugs, it is limited" FGD participant 7*
>
> *"...they reach there and they say they do not have drugs for children. One comes and continues breastfeeding their child because they do not have the drugs." FGD participant 5*
>
> *".... sometimes, when they go they don't get ARVs for children, they get stressed. They say if they use drugs and the drugs for children are not there then what shall I do? Should sex worker's not have children? This program does not include small children." FGD participant 8*

4.4.4 Need for Spiritual Support

Another challenge that female sex workers experience is the lack of spiritual care. This is because of the societal condemnation that sex work is considered sinful. Due to their inner conflict of morality, sex workers themselves may go through shame which may hinder them from getting appropriate health services tailored to their health needs. A 35-year-old sex worker who usually visits the government health facility in Site B, explains that in a case where her occupation is required by a health worker she was not ready to disclose. This is because of the shame that comes along sex work.

> *"I cannot tell them because it is shameful being a sex worker" Participant 10, 35y, sex worker*

One health worker attested to this fact by saying that female sex workers have not accepted spirituality. Thus, integration of spiritual care to female sex worker's health package would be difficult,

> "… *Spiritually the sex workers have not accepted…. the whole aspect of morality…." HCW participant*

4.5 Healthcare Services Extended to Female Sex Workers by Healthcare Providers

Table 8: Showing Healthcare Services Extended to FSWs by Health Care Providers

Code	Category	Theme
HIV and STI treatment and prevention	Treatment and Preventive services	Sexual and Reproductive health services
Family Planning Services		
Peer Education	Awareness	Health Education
Community Sensitization Campaigns		
Advocators for human rights		
Support groups		Social support
Orphaned and vulnerable children		
Child abuse		
Addressing Gender Violence		Psychological support and address of gender-based violence
Psychological depression, effects of GBV and substance use	Psychological problems	
Healthcare that meets all aspects of health		Health workers perspective on whole-person care provision

4.5.1 Sexual and Reproductive Health Services

Female sex workers present with occupation and non- occupation-related illnesses. As reported by a clinician working with this population.

"Majorly it is sexually transmitted infections but of course our program runs HIV which is an STI itself. Then, of course, depending on the region for example in this area, we get a lot of upper respiratory tract infections... the gender-based violence that we talked about, we get cases of physical assault that the sex workers present with. traumas, blunt force injuries." HCW participant

The healthcare workers have a package of care for the female sex worker's population which includes their sexual and reproductive health.

"With female sex workers, we offer them a package of care. Which involves behavioral interventions, structural and biomedical. My role is offering these biomedical services. This includes HTS services, HIV testing services and we also offer reproductive health services majorly. With the reproductive health, it involves family planning, STIs screening and treatment" HCW participant

One of the services extended to female sex workers is HIV Testing services and there is at least one facility that provides this kind of service per sub-county. One of the health workers interviewed alluded to this fact.

"*HTS is HIV Testing Services. We offer testing services to the key population and the sex workers……. We have at least one facility per sub-county that we work together in providing this service to female sex workers " HCW participant*

Sex workers are also engaged in HIV preventive programs which are geared to prevent the spread of HIV. One health worker alluded to the fact that the female sex workers in Bomet County are engaged in HIV prevention programs like I Choose Life Africa. In this package, the female sex workers are engaged in peer education, risk reduction behavior like condom distribution, condom demonstration, and intervention measures

like pre-exposure prophylaxis. Further, female sex workers are also offered STI screening and treatment.

> "*The program that we run here is I choose life Africa which is majorly a HIV Preventive Program, that reaches out to female sex hours. We take them through these packages. We have what we call a minimum package, prevention package…I had mentioned HTS, the one is peer education…risk reduction behavior like condom distributions, condom demonstration. We acquire the condoms and distribute them...We also offer post-exposure prophylaxis...We also offer STI screening and treatment." HCW participant*

One of the peer educators who leads a support group of women doing sex work in Site C which is about 2.5 kilometers from Bomet town, also said that through the help of the outreach programmes provided by the non-government organization initiative she can provide lubricants, condoms and teach safe use, family planning methods and preventive HIV drugs.

> "*I teach them about HIV, condom use, safe use of condoms… We further have PEP and PREPS.....for PEP you can't receive them without being tested for STIs or HIV…." HCW participant.*

This was echoed in the focus group discussion where the women who had been taught by the health workers would teach the new sex workers and also test them for HIV infection as reported:

> *"If there is a visitor we teach her how to get help, she is tested for HIV, if she does not have it we teach her ways to prevent herself." FGD participant 5*

There is an established platform of communication and referral systems by healthcare workers. There is one drop-in centre in Bomet County which is run by I choose Life Non-Government Organization. It coordinates healthcare provision to key populations in

Bomet and works alongside the government health facilities and the community itself through outreach programmes. A health worker describes this,

> *"…the DICE is an umbrella that all service provision is done. If a client has come for family planning methods, we do not refer them to other places, they get these services here. Another example is if they present with pulmonary tuberculosis then for this case, they get treatment. Although we do not have the facilities for investigating such a condition, they come here, we get the sample then we take them to Longisa County Referral hospital or Bomet health centre then after the results we refer them to the appropriate health facilities for treatment. Every health service they need; we ensure that they receive these services." HCW participant*

This was approved by one informant who explained that if they were to be referred for other services, ICL would write a formal referral report and even take the client to the hospital of choice.

> *"I took another woman and she had a referral report written and was taken to Longisa by a doctor in ICL." FGD participant 5*

4.5.2 Health Education

It is worth noting that female sex workers receive peer education from health care workers and support fellow female sex care workers through the formation of peer education groups. Three health workers supported this fact by saying that they offer training to peer educators who are identified from the female sex workers' community. The trained peer educators offer intervention education to other sex workers. Further, organizations do regular training in support of HIV Care, clinical care for family planning. This is depicted by the following responses,

"*...we identify peer educators from the sex workers themselves. They form themselves into what we call cohorts, led by a peer educator. We offer training to this peer educator and then the peer educator gives that training to his peers that's how the community helps" HCW participant*

"...Our donor... regularly organizes on HIV care, sometimes it's on clinical services like family planning...." HCW participant

"A peer educator stands for six to eight peers of a given location. We call them hotspots that's where they are found after identifying this sex worker, that peer educator with the help of our outreach workers who ensure that the sex worker remains in the program." HCW participant

Health workers serve as informative health advocators for the female sex workers population. They do this through planning and executing sensitization campaigns in the community for their existence as a key population. This also reduces stigma which in turn mitigates any stigma related challenges when seeking healthcare. Two health workers supported this fact,

"*…. they sometimes invite us to their functions, for example, the chief Baraza where we go and sensitize the community on the existence of the key population." HCW participant*

".... majorly under NASCOP, which is a national program offers training, for example, last year we had a training on key population sensitivity to key population, also retention of the key population on ART…." HCW participant

The peer educator had an important role in the distribution and teaching of key health practices to the female sex workers in the community. Since they are part of the community, they are a bridge between the female sex workers and the healthcare

providers. One peer educator witnessed to this important role of educating the female sex workers.

"I get to educate them on PEPs, PREPs and also what to do in case of gender violence" HCW participant

"*You give someone condoms, tomorrow they tell you that they are burnt with STI and you get to wonder how they use the condoms given. I taught them how to use condoms, they did not know…" HCW participant*

4.5.3 Social Support

Female sex workers with children are offered support through support programs for orphans and vulnerable children's programs. One of the health workers attested to the fact that they have such a support program at Tenwek Hospital,

> "*…. those who have children, we link them to the Orphans and Vulnerable Children (OVC) program at Tenwek and we link them to other services that we don't provide" HCW participant*

Other than supporting the vulnerable and orphaned children of female sex workers, health workers also provide social services and integrate them into their health package. When a clinician was asked, the response was as follows,

> *"but of course social services we integrate those. We also have connections with county social services and in any instance that we need their help they usually provide." HCW participant*

They also provide child abuse services where reporting can be done by the leaders of the female sex workers support group and they take the necessary measures. One participant attested to this,

"If someone leaves their children the whole night or beats them a lot we have child abuse services under the law. There is a doctor in the office who takes these cases for children." FGD participant 3

At the community level, female sex workers group themselves in support groups that are led by peer educators so that they can meet their basic needs without strain. The peer educator attested to the fact that there was a need for the female sex workers to be in a support group besides relying on the sex work alone.

"*Apart from sex work, they can see a way of starting a support group…I also talk to them about embracing self-employment and starting small businesses as opposed to doing sex work for their daily needs. They should be thinking of something else apart from sex work…" HCW participant*

The social support extended by the health workers was beheld by one female sex worker,

"The group has helped… To other women, it has opened new business ventures for them at this moment." FGD participant 5

4.5.4 Psychological Support

Further, female sex workers receive help if they are faced with sexual or gender-based violence. This is because is a particular group of individuals is considered as a vulnerable group in the society. One health workers supported this fact by testifying that they provide legal, counselling and clinical services that they may need in case they are exposed to gender-based or sexual violence,

"…Before we continue, the one crucial service that we offer that I haven't mentioned, the gender-based violence. As we see this key population are vulnerable to sexual gender-based violence. We have experts dedicated to offering those services. They report to us we offer them clinical services and legal services and of course counselling services." HCW participant

Other than gender-based violence, some women who use alcohol and other substances of abuse get psychological support to improve their health. This was alleged by a health worker,

> *"Most women who practice sex work use alcohol, for those who cannot stay without alcohol, we provide counselling services… We advise on the importance of health… encourage them to do their work with a sober mind." HCW participant*

There is a participant who was dependent on alcohol and explained how she was able to talk with a doctor and advised her accordingly.

> *"I talked to the doctor about this and he advised me not to take the strong alcohol, I only take the one that does not make me drunk. "Participant 18, 33 y, sex worker*

4.5.5 Health Worker's Perspective on the Provision of Whole-Person Care

There were mixed views by health workers on the provision of whole-person care especially when spiritual care component was mentioned as part of this entity.

One health provider reported that it would be of benefit to the women,

> *"It would be better… if one has stress, you are not gaining much from your business. You go out and come back with 200 shillings sometimes and you have other needs. They should know about spirituality because sometimes one can control her stressful condition and plan not to have stress. This is how it will help." HCW participant*

Another health worker was supportive of whole-person care apprehensive in the inclusion of spiritual care to the health package for female sex workers,

> "*yes we can treat them physically for the physical symptoms but to help them we need to go one step further to provide this holistic care with the four aspects…*

That's a tough one. Spiritually the sex workers are not accepted as you know, so in our program, we try to stay away from spiritual but of course social services we integrate those." HCW participant

Yet another health worker was concerned on integrating spiritual care in his session because of what the person receiving these services would misrepresent him for a religious person.

"If you are in sex work then I come and start preaching for you and at this time you know what you are doing, who will you take me for?" HCW participant

4.6 Discussion

This chapter covers the discussion of the findings. The findings were aligned with the objectives which were to describe the experiences of female sex workers when receiving healthcare services, determine challenges encountered by female sex workers and an exploration of the healthcare services extended to female sex workers by healthcare providers in Bomet County.

4.6.1 Experiences and Challenges of Female Sex-workers When Utilizing Healthcare Services in Bomet County

The following is a discussion of the emerging themes from the results presented:

4.6.1.1 Socio-Economic Factors

Economic Factors

Female sex workers in this study went to both government and non-government organization led health facilities. They experienced extra charges which came from buying drugs from chemists and transport fee. After visiting the government-led health facilities, there were instances where they were required to buy drugs from outside chemists if the drugs were not available. Due to the financial limitations, this would result in a delay in treatment. Forcing them to buy costlier drugs and raise extra money

for transport if they needed to travel far distances to get appropriate healthcare services. A similar study done in Laos reported that female sex workers in the area faced cost which came from transport fee and cost of medication and it influenced their health-seeking behavior (Phrasisombath, 2012). In comparison to this study, the cost of transport and medications were reasons why women would delay seeking healthcare services resulting to poor health and increase in the transmission of sexually transmitted diseases.

Female sex workers in this study were mostly dependent on sex work as their main source of income. The money they got is distributed amongst their competing needs in daily living. Due to a lack of financial security, they would be involved in unsafe sexual behaviours, such as inconsistent condom uses and hence place their health at risk. Correspondingly, literature has narrated how due to limited finances, women have been driven into sex work thus exposing them to risky sexual behaviours (Parcesepe et al., 2016; Phrasisombath, Faxelid, Sychareun, & Thomsen, 2012; UNAIDS, 2002). In addition to this, according to Morett in 2014, it stated how important it is for health workers' to economically strengthen FSWs so that they can cater to their health needs. Morett, further argued that economic empowerment would not lead them to exploitation by their clients, could foster safe sex practices and even help the women afford health services for their health care needs (Morett, 2014). Lack of economic empowerment led to most women in the study practice unsafe sex, since their lack of basic needs surpassed their need to practice safe sex.

Stigma

The literature on female sex workers over the years has reported on the negative effect of stigma in the lives of the women. In this study, female sex workers experienced stigma from the community, healthcare workers and fellow sex workers. This was not openly

voiced because sex work is done in secrecy or as an alternative form of work. Fear of being stigmatized by the healthcare providers was one factor that steered female sex workers to delay seeking healthcare services in Bomet County. This form of healthcare worker's stigma was mostly experienced in the government health facilities as compared to the health facilities that were private or run by non-government organizations. Some of the female sex workers experienced stigma from health workers in the form of harsh remarks and being ignored which led to anticipatory fear by the rest of the female sex workers. This affected their openness and relationship with healthcare providers. Likewise a study done in Kenya, informed that female sex workers would give false information or minimal information to health providers to acquire certain services, due to fear of stigma and discrimination (Murenga & Faife, 2014). A study done in four African countries reported the same findings where sex workers were discriminated by health worker's especially from the government-led health facilities (Scorgie et al., 2013). Stigma was presented as a factor that led to avoidance or delay to seek medical services. Another study done in Nairobi, Kenya, reported that when FSWs had experienced, witnessed or anticipated stigma from the general community, then they would keep away from seeking healthcare (Nyblade et al., 2015).

Aside from stigma from healthcare workers', stigma by fellow female sex workers was brought out in the study. This form of stigma leads to emotional stress and suspicion among female sex workers. According to this study, fellow sex workers were harsh to one sex worker because she was living with HIV. This form of stigma from co-workers came with psychological tumult and suspicion. This had a negative influence on her health seeking behaviors due to fear of being gossiped by her colleagues. A similar finding was reported in a study where sex work stigma seemed to overlap with HIV related stigma, for those living with HIV stigma. Therefore, women who were in sex

work and living with HIV could be more prone to stigma from the community (Hargreaves, Busza, Mushati, Fearon, & Cowan, 2016). Another study in Mongolia described how female sex workers who experienced stigma had a higher risk of symptoms suggestive of depression (Carlson, et al., 2017). In this study, stigma by fellow female sex workers was brought about by the competing nature of the trade, poverty levels and intertwined by HIV related stigma from the society. This affects female sex workers living with HIV, with psychological problems and places them at a higher risk of acquiring mental disorders such as depression.

4.6.1.2 Sexual and Reproductive Health and Other Healthcare Needs

According to the findings, female sex workers have different healthcare needs. They seek out sexual and reproductive health services and other general health services. One of the top services sought after were family planning methods such as male condoms, emergency pills and injectable contraceptives. A similar study done in Nairobi, Kenya stated that female sex workers had similar sexual and reproductive health needs (Sutherland et al., 2011). It was evident that most female sex workers seek condoms, family planning services as well as emergency pills from the nearby hospitals and this was reported by nineteen of the twenty women interviewed.

They also went for Voluntary Counselling and Testing (VCT) services for HIV and preventive treatment for HIV; pre-exposure and post-exposure prophylaxis. Other services that the women went to receive is STI testing and treatment. Some of the women went to seek testing and treatment for other sexually transmitted diseases such as gonorrhea and syphilis. Similarly, a study done in Kenya reported that most female sex workers living in Nairobi went for HIV testing and recommended routine combined HIV and STI preventive methods (Musyoki et al., 2015).In the study, there was a lack of health awareness for consistent and proper use of male condoms by women who practice

sex work. There seemed to be higher rates of transmission of sexually transmitted infections especially in site A. It was not apparent if the inconsistent use of condoms was with paying or non-paying partners for example spouse or regular sexual partners. A review of literature on the health needs of female sex workers in low and middle-income countries had similar findings to the study. FSWs had inconsistent use of condoms especially with their non-paying partners (Ippoliti et al., 2017). In Kenya, female sex workers have been identified as a key population due to their high risk of transmitting HIV and STI. Therefore, creating awareness of adopting safe sex behaviors such as, consistent use of barrier contraception is necessary to reduce the burden of disease in this population.

Female sex workers also went to seek HIV and STI testing, treatment and prevention health services. HIV testing was available at the Voluntary Counselling and Testing Centres, the drop-in clinic and also by the support group peer educators. FSWs went to seek preventive and treatment HIV services from the drop-in clinic and the nearest health centres. However, access to HIV preventive drugs posed a challenge to FSW in Bomet. In the study, the women either had minimal knowledge of the available preventive drugs such as pre-exposure and post-exposure prophylaxis or they were not able to easily access them from their nearest health facilities. Similarly, a review on HIV in female sex workers' population reported that coverage, equal access of antiretroviral drugs, HIV prevention, treatment and care fell below that of the general population (Shannon et al., 2015). Of note, other preventive services for STIs such as prophylactic and cervical cancer screening were not pursued by FSWs in the study. This was attributed from the fact that they were not aware that these health services were available to them at their nearest health facilities.

From this research study, an unmet health need for sex workers' children emerged. Exposed infant's HIV prophylaxis drugs were limited and this placed breastfeeding mother's vulnerable to transmitting the infection to their infants. It was an indisputable challenge for women. Health facilities that ran programs for female sex workers had not actively enrolled the children of female sex workers for treatment and prevention services. Children of female sex workers have unique risks that are derived from their parent's occupation. They can face stigma and discrimination as well and become marginalized from the general population. This marginalization increases their risk of infection, morbidity and mortality of HIV and STI infection (Beard et al., 2010). This study uncovered children of female's sex workers' vulnerability to HIV infection. This unmet health need requires urgent attention by the health system on the provision of essential maternal and child health services to female sex workers and their children (Willis, Welch, et al., 2016) By doing so, hopefully achieving elimination of HIV and STI pediatric infection will be realized.

The female sex worker's experiences and challenges when seeking sexual and reproductive health services were similar to women in different regions according to the available research. Family planning services, HIV and STI prevention and treatment services were most sought after. Unmet health needs such as lack of HIV and STI prevention services for sex workers and their children, a lack of health awareness on the available health services and matters pertaining access to appropriate health resonated in the growing evidence. The health system needs to look at ways of improving access to sexual and reproductive health care services to female sex workers and their children. As well as integrating counselling services and health education to female sex workers' health care services. Correspondingly, the global network of sex workers project report, stated that coverage and treatment of sexual and reproductive health services were

insufficient in different settings. The disintegrated health system played a part in this inadequacy. Female sex workers ought to get integrated health services by their health care providers (NSWP, 2018).

4.6.1.3 Health Education

There was an expressed need for knowledge of HIV/ STI preventive services, safe use of condoms and screening services by the participants. There was a lack of awareness of the health services that are available to the female sex worker's population. Most of the participants had not heard of pre-exposure prophylaxis (PrEP) for HIV but had ever heard or used the post-exposure prophylaxis (PEP) drugs used for HIV prevention. A similar report was stated in a study done in Western and Nyanza parts of Kenya where apart from the use of condoms, female sex workers were not well conversant with other HIV preventive measures and pointed out that there was an emerging need for peer-led education programmes (Nyagero, Wangila, Kutai, & Olango, 2012). A similar study done in Mombasa, Kenya reported that the level of awareness on PrEP. and PEP was low amongst sex workers but the participants were willing to use PrEP and PEP (Restar et al., 2017).

In the study, other than HIV preventive interventions, female sex workers were also not aware of screening amenities for cervical cancer. Consistently, a study done in Nigeria recognized that the reasons stated by its participants for the low uptake of cervical cancer screening services were lack of interest in addition to the absence of awareness (Ilesanmi & Kehinde, 2018). From literature, a study done in Kenya, reported high prevalence rates of Human Papilloma Virus (HPV) and cervical dysplasia amongst HIV infected female sex workers living in Nairobi, Kenya was higher (Sweet et al., 2020). The progression of cervical cancer is preventable and this can be done through early screening for every sexually active woman. However, there seems to be low utilization of available health

services and this could be due to the female sex workers' level of knowledge on the health services available to them. Through the formation of health awareness on cervical cancer screening service, FSWs morbidity and mortality from cervical cancer can be reduced. The healthcare providers have the responsibility to promote health awareness on pertinent health issues affecting female sex worker.

There was a raised concern from the noticeable rise of sexually transmitted illnesses around the community and this was as a result of the unsafe sex practices by their male clients. A similar study done in Nyanza province, Kenya, reported unsafe sex practices by male clients of female sex workers. More than 40% of the male clients were inconsistently using condoms with the female sex workers (Voeten, Egesah, Ondiege, Varkevisser, & Habbema, 2002) Creating awareness of HIV testing and treatments as well as consistent use of condoms to male clients of female sex workers' can improve the overall risk of HIV/STI infection amongst female sex workers and the general population.

4.6.1.4 Psychological Support

Other than stigma, female sex workers face various psychological issues. Female sex workers in this study experienced violence as gender-based violence, intimate partner violence and violence from law enforcers which resulted in physical, psychological and emotional trauma. However, due to the sensitivity of some of these forms of violence, the women were silent on this matter. This made it hard for them to utilize counselling services from the health services and get justice when their human rights' are violated. The participants received psychological support from each other, their peer educators or close family and friends.Several studies reported on the occurrence of violence; sexual and physical violence experienced by female sex workers from their clients and pimps, gender-based violence and violence from the police

(Elmore-Meegan et al., 2004; Ippoliti et al., 2017; Parcesepe et al., 2016). According to Jeal and Sallisbury (2006), it was observed that FSWs often face violence from their clients. Sometimes they suffer from rape, use of weapons to coerce them to offer their services and chain saws. This poses a risk to physical harm and hence the need for their protection from violence. In Kampala, Uganda, there was a reported high prevalence rate of violence in its study population. 82% of the respondent's had experienced gender-based violence from their clients and almost half, 49% had ever been sexually assaulted in their lifetime (Schwitters et al., 2015).

In comparison to this study, female sex workers are faced with two forms of violence; from their clients and law enforcers which are inextricable. A study done in Kenya supported legal networks in protecting the women from violence (Okal et al., 2011). In this study, female sex workers who experienced violence shied away from utilizing GBV and IPV health services and had different coping strategies for example talking about their experiences with a close friend or family. This was similar to a study done in Mombasa, Kenya which reported that uptake of medical treatment following sexual violence was low (Lafort et al., 2017). In comparison, a study done in South Africa, female sex workers had to cope on their own after experiencing violence from clients. This is because they did not know where they could get medical help from (Fick, 2005). In this study, the women found it more comforting to talk to their family or close friends rather than going to seek medical help. This was because of the anticipated stigma they would receive for the reason that sex work is shameful and illegal. There is a need for psychological support and even protection against violence that is yet to be met by female sex workers.

4.6.1.5 Spiritual Support

Dealing with difficulties of life and conflict on morality are some factors that can support the necessity of integrating spiritual care in healthcare service provision to female sex workers. In this study, some female sex workers received some form of spiritual care such as counselling in keeping with spiritual matters from healthcare providers. However, this was not experienced by most of the participants. Religion and spirituality has been shown to assist people living with HIV, a minority group, coping with the chronic illness, related stigma and discrimination and were less likely to be depressed (Yi, Mrus, Wade et al., 2006). With spiritual care and support, the women in this study learned how to cope with their life stressors which improved their health.

The healthcare workers were hesitant on integrating spirituality in their clinical encounters with female sex workers. Incorporating spirituality in patient care has been shown to give health care providers a deeper insight into their patient illness and the establishment of a trust-filled relationship (Brémault-phillips et al., 2015). Health in totality includes the spiritual aspect of a person, therefore integrating spiritual care in healthcare services extended to female sex works is paramount in improving their wellbeing.

4.6.2 Healthcare Services Extended to Female Sex Workers by Health Care Providers

The role of the health worker in provision of whole person care is to provide health services that aim to improve a patients' health while keeping the sight of the whole while building effective communication and trust between the provider and the patient. Health workers in Bomet provide various health services to female sex workers operating in the county. These health services can be classified as sexual and reproductive health (SRH) services, health education, social support and psychological support. The sexual health

services provided include behavioural interventions, HIV testing, preventive strategies and treatment services. Reproductive health services involve family planning and STI testing and treatment. There is only one non-government led drop-in clinic which provides specialized health services catered for female sex workers. The other health facilities provide health services to the general population as well as female sex workers. Specific services tailored for FSWs are made available to the community of FSWs through peer-led programs which are run by the non-government organization partnering with the government. This peer-led outreach program increases the utilization of SRH services. The HIV prevention programs provided are risk reduction, condom distribution, condom demonstrations and provision of prophylactic drugs.

Other than health workers meeting the physical needs of FSWs, they also give psychological support to the women through counselling services. These services are provided to victims of gender-based violence and those dependent on alcohol and other substance of abuse. Health workers also coordinate healthcare provision to female sex workers for example by providing timely referral services to health facilities that have the necessary health resources. In addition to offering sexual and reproductive health services and coordination of care, health care workers make available, health awareness to the female sex workers' community. Some of the activities they are involved in are community sensitization, organization of peer-led education programs, educating female sex workers on safe sex practices and utilization of gender-based violence. Dissemination of health information is made possible through the peer-led programs that are implemented by peer educators in the support groups.

The support groups consist of women from the same region and a peer is elected to lead, organize training and educate the group members on health issues. These support groups also empower women economically through micro-financing. The support group

members register the support group into a microfinance institution that can provide short term loans to its members. They benefit from this by opening businesses, educating their children and even managing their household which improves their overall economic status. Besides, healthcare providers extend social support to children of female sex workers who are orphaned and vulnerable. They refer and enroll the children in programs that can cater to their healthcare needs. For example, medication and food. Additionally, the health workers have connections with Bomet county social service which offer social support such as food security to the female sex workers.

Social support has been integrated into the healthcare package to FSWs as described by the study findings. This was done with the organization of peer-led support groups that empower the FSWs economically, provide food security and cater to the needs of the vulnerable children of FSWs. On the contrast, a systematic review that looked into health care service provision to female sex workers in Africa reported that health services focus was more towards the provision of HIV and STI interventions rather than other broader sexual and reproductive health needs. The HIV interventions were: condom distribution and demonstration, HIV testing and counselling services, provision of HIV care that includes providing antiretroviral drugs, pre-exposure prophylaxis drugs and prevention of mother to child transmission. Other STI interventions were screening and treatment of STIs and educating the sex workers on STIs. The unmet needs highlighted in the study was limited access to family planning methods and antiretroviral drugs, gender-based violence and cervical cancer screening services (Dhana et al., 2014). In comparison to this review, health workers in Bomet have gone a step further in including psychological support for gender-based violence, substance addiction and integrated social services in their healthcare package.

4.6.3 Female Sex Workers and Health Worker's Perspective of Whole-person Care

Female sex workers perceive that whole-person care will improve their overall health. Through this, they will learn how to prevent themselves from diseases, plan their families better and even find ways to exit from sex work. Similarly, health workers perceive that whole-person care would help them go one step further to offer services that meet the other three aspects of health which includes psychological, social and spiritual care. It will provide psychological support and teach FSWs how to control their stressful conditions. However, the health workers were hesitant to integrate spiritual care in the health package for female sex workers.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This final chapter includes a summary of the findings, the conclusion based on the results of the study. It also includes proposed policy recommendations and interventions that can be implemented and recommendations for future research.

5.2 Summary

This qualitative study objective was to understand the experiences and challenges faced by female sex workers when seeking healthcare and also finding out the healthcare practices extended to female sex workers by healthcare workers in Bomet County.

Understanding one's experiences, one needs to familiarize with the individual and their context. Therefore, for this study to understand the experiences and challenges that female sex workers face when seeking healthcare, it was prudent to know more about their background. Female sex workers living in Bomet County, a rural part of Kenya, are faced with the harsh reality of poverty, stigma from the community and a lack of awareness of best health practices.

These women face stigma from the community, from fellow sex workers as well as from the health workers. This stigma coupled with other factors that limit access to the appropriate health services has an impact on their general health. Factors such as limited finances, distance to the drop-in clinic, non-flexible opening hours, limited supply of drugs and other preventive health services in the government and private health facilities. This makes access to sexual and reproductive health services a challenge. However, the

health workers have played a key role through the outreach programmes in providing healthcare at their doorstep.

The health workers package of healthcare to female sex workers meets some of the needs of FSWs in Bomet County. Health needs such as HIV/ STI testing and treatment, family planning services, screening services, social support, community sensitization against stigma and partly psychological support. Nevertheless, health services extended to their children such as the provision of medication for prevention and treatment of illnesses which can cause psychological and emotional distress to FSWs, has been overlooked and needs to be urgently addressed. Also, spiritual care has been placed aside with the fear of rejection by the female sex worker's. Such a response could be fear-driven in that through the integration of spiritual care in female sex worker's health package, it could compromise the physician-patient relationship. It was evident that there was a knowledge gap by the female sex workers on the health services that are available to them. Services such as preventive services, screening services as well as gender-based violence services and legal services. The whole person care was perceived positively by female sex workers as a hope of improving their overall health and even changing their lifestyle towards safe sexual behaviours and good health practices.

5.3 Conclusion

Female sex workers are a vulnerable population that is at a higher risk of morbidity and mortality than women in the general population. They are faced with unique challenges that influence their health and the way they receive healthcare services. Issues such as stigma, abuse and a lack of awareness of the available health services are some of the limitations to better health. Therefore, healthcare workers have a responsibility of integrating all aspects of health, the physical, psychological, social and spiritual domains in their health service provision. In addition to this, place effective programs that provide

health services tailored to their health needs and up to date health information at the doorsteps of the female sex workers.

5.4 Recommendations

5.4.1 Policy Recommendations

National Level

i. The government should ensure that all health facilities offering services to women who practice sex work have a package of care that includes both preventive and treatment services for sexual and reproductive health. As well as include mental health, spiritual care and even social support that is extended to them and their dependents.

ii. Develop policies that will support and advocate for legislation that protect the human rights of female sex workers.

Health Facility Level

i. Adopt whole person care approach to meet the unmet health needs of female sex workers living in Bomet, more so the psychosocial and spiritual aspect of health.

ii. Consider offering flexible clinic opening hours and improve the access of health services to female sex workers. All health facilities, public and private, should have a health package of care that meets the four aspect of FSWs health needs. This will reduce delayed treatment and improve their general health.

iii. Consider including children of FSWs when delivering health services to female sex workers, especially, children who are exposed or infected with HIV/AIDs.

iv. Enhance health worker's sensitization against stigma and discrimination towards female sex workers.

v. Health workers need to engage in activities that create health awareness to female sex workers. This can be done through peer-led education programmes working

with female sex workers. All FSWs need to be aware of the preventive services that are available to them. For example, HIV and STI prophylactic drugs, cervical cancer screening and human rights that protect against violence amongst women.

Community Level

i. Formulate policies that will sensitize the community against stigma and discrimination towards female sex workers.
ii. Foster social support to female sex workers by encouraging formation of support groups of female sex workers in the different sub-counties of Bomet. These support groups can be used as platforms to empower women economically, be a bridge between female sex workers and healthcare providers and link the women to subsidiary services such as legal support.
iii. Involve female sex workers in organizing developing and managing health programs designed to meet their health needs.
iv. Empower community leaders and gatekeepers to support female sex workers who get discriminated and stigmatized in the community.

5.4.2 Recommendations for Future Studies

i. Research on whole-person care and its impact on the health of female sex workers and other vulnerable populations
ii. A larger study that will assess health services provided to female sex workers by both government and non- government led health facilities.
iii. A study on the effectiveness of peer-led support groups in providing opportunities for safe sex behavior changes, economic, social and legal empowerment to female sex worker.
iv. A study to determine the impact of streamlining health service delivery and inclusion of spiritual care and support for key populations and vulnerable populations

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APPENDICES

Appendix I: Research Instruments

Consent Form

This informed Consent Form is for Female sex workers in Bomet County Kenya whom we are inviting to participate in the research titled "Towards Whole Person Health Care for Female Sex Workers in Bomet County, Kenya: identifying the unmet health need".

Name of Principal Investigator: Joy Sinkeet

Name of Organization: Student at Kabarak University

Name of Sponsor: Self-sponsored

Name of Project: "Towards Whole Person Health Care for Female Sex Workers in Bomet County, Kenya: identifying the unmet health needs".

This Informed Consent Form will also be in Kiswahili and Kipsigis language

It has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for your signature if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

I am a student pursuing a master's degree in Family Medicine at Kabarak University, I am researching on meeting the unmet needs in a whole-person care approach for Female Sex Workers' in Bomet County, Kenya. Feedback will be given to you once the research is complete. I invite you to be part of this study. You are free to discuss this study with anyone you are comfortable with and you can take time to think through and reflect on whether you would like to participate or not.

This consent form may contain words that you do not understand. Please ask me/ the research assistant to stop as we go through each section and we will take time to explain. If you have any questions afterwards, you can ask at any time.

Purpose of the research

Quality health should be enjoyed by all Kenyans most of all those who are more vulnerable to illness. Whole person care involves physical, psychological, social and spiritual domains of an individual during the provision of healthcare. We want to explore female sex workers in Bomet health needs, any unmet needs and if the unmet needs can be met through a whole-person care approach during the provision of health services. This will inform policymakers to incorporate care for the unmet needs in the sexual and reproductive health package in a more holistic manner, for female sex workers in Bomet County, to improve the health of women in this community.

Type of Research Intervention

This research will involve your participation in a face to face interview or a focus group discussion with the principal investigator. The interview will take about twenty to thirty minutes of your time while the focus group discussions will take thirty to forty-five minutes.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a female sex worker can contribute much to our understanding and knowledge on this topic.

Voluntary Participation

Participation in this study is fully voluntary. You are free to choose whether to participate or not. If you choose not to participate, there will be no further effect to your occupation and if you were to participate in a focus group discussion you will continue receiving the same health services provided, nothing will change.

Procedures

We are asking you to help us learn more about your health needs, find out if these health needs are met by health providers if a whole-person care approach would meet the unmet needs and suggestions on ways to improve health services provided to you. If you accept this request you will be asked to partake in this interview or focus group discussion.

Interviews

During the interview, I and a research assistant will sit down with you in a comfortable place at the Centre. For convenience, the interview can take place at your chosen

location. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The expected time for the in-depth interviews is forty minutes. The information, audio recorded is confidential, and no one else except my research supervisor and I will have access to the information documented during your interview. The entire interview will be audio-recorded, but any traces of name or voice will be removed. The tape will be kept in a safe cabinet under lock and key. The information recorded is confidential, and no one else will have access to the tapes. The tapes will not be destroyed in case any information is needed to be retrieved.

Focus group discussions

You will take part in a discussion with 7-8 other persons with similar experiences. This discussion will be guided by the research assistant or myself. The group discussion will start with me, or the focus group moderator making sure that you are comfortable. We can also answer questions about the research that you might have. We will ask you questions concerning your health needs, your unmet needs by the health providers, find out if the whole person approach will meet your health needs and your suggestions on ways to improve the health systems. Some of the questions may be sensitive therefore it will be your voluntary choice to share. If you are not comfortable in sharing during those discussions, we will not ask you to share your knowledge.

The discussion will take place in [TO BE SPECIFIED ONCE THE PARTICIPANT AGREES] and no one else but the people who take part in the discussion and guide or me will be present during this discussion. The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept [explain how the tape will be stored]. The information recorded is confidential, and no one else except [name of the person(s)] will have access to the tapes. The tapes will not be destroyed but will be stored safely under lock and key.

Duration

The research takes place over two months in total. Each interview will last about half an hour each. The group discussion will be held once and will take about forty-five minutes.

Risks

There is a risk that you may share some confidential information if at any time you do not feel comfortable in responding to any question, you do not need to give us any reason. However, we do not wish for this to happen.

Benefits

Your participation in this study may bring benefits to you as the information shared will inform the policymaker to include services that will meet the health needs of female sex workers. This will eventually improve your health and that of each woman in this occupation.

Reimbursements

You will not be provided with an incentive to take part in the research. However, we will give you reimbursement for your travel expense if this will be encountered.

Confidentiality

The research team will maintain the confidentiality of the information provided and your identity throughout the study. However, confidentiality will only be bridged if the information provided has the potential to harm you, someone else especially a minor. Your participation may attract the attention of members of the community and there is a risk of being identified as a sex worker. We ensure that within the limits of this research your identity will be anonymous and no information provided will be traced to you without your knowledge. If you will participate in a focus group discussion, we will ask you and others in the group not to talk to people outside the group about what was said in the group. We will ask each of you to keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing information that should be confidential.

Sharing the Results

The information shared with us today will not be shared by anyone outside the research team. If interested, the knowledge we get will be shared to you in private and the female sex worker's community before it is available to the public. After sharing this information, we hope that we publish the findings of this research so that other interested people may also learn from the research.

Right to Refuse or Withdraw

It is your voluntary choice to participate in this research. Choosing to participate in this research, your identity will not be affected in any way. You may stop participating in the interview or focus group discussion at any time that you may wish. At the end of the interview or focus group discussion, I will allow you to review your comments, you may modify or remove any part.

Who to Contact

If you have any questions, you can ask them now or later. If later, you can contact the principal investigator through this contact _____

_____

This proposal has been reviewed and approved by the Ethics Research Committee at Kabarak University. This is a committee that protects the participants from any harm during the research. If you wish to find more about the ERC, contact_____

_____

You can ask me any questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I_____ have read the information, or it has been read out to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Initials of Participant_____

Signature of Participant _____

Date _____

Day/month/year

If un-schooled

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.

2.

3.

I confirm that the participant was allowed to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

Appendix II: Kipsigis Translation

This informed Consent Form is for Female sex workers in Bomet County Kenya whom we are inviting to participate in the research titled "Towards Whole Person Health Care for Female Sex Workers in Bomet County, Kenya: the health unmet needs".

Sirutichu bo koyonjinet kobo kwonyikab town eng Bomet County Kenya che kitooche koek kebeberta eng chikilisiet ne kiguren "Keityi ribetab chametabgei nebo chito tugul eng kwonyikab town eng Bomet County, Kenya: Magutik che tomo keityi eng chametabgei nebo borto".

Name of Principle Investigator: Joy Sinkeet
Name of Organization: Student at Kabarak University
Name of Sponsor: Self sponsored
Name of Project: "Towards Whole Person Health Care for Female Sex Workers in Bomet County, Kenya: the health unmet needs".

Chikilindet neo: Joy Sinkeet
Kainetab sukulit: Kabarak University
Kainetab ne libanchin: Libanchingei inegei
Kainetab Chikilisiet: "Keityi ribetab chametabgei nebo borto tugul eng kwonyikab town eng Bomet County, Kenya: Magutik che tomo keityi eng chametabgei nebo borto"
This Informed Consent Form has two parts:

- Information Sheet (to share information about the study with you)
- Certificate of Consent (for your signature if you choose to participate)

You will be given a copy of the full Informed Consent Form

Sirutichu bo koyonjinet kotinyei kebeberwek aeng:

- Kartasit ne aroru agobo chikiliset (arorun nito agobo chikilisiet)
- Certificate nebo koyonjinet (indei sein angot iyan iegu kebeberta eng chikilisionito)

Kigonin copy nebo kartasinito bo koyonjinet

Part I: Information Sheet

Introduction

I am a student pursuing a master's degree in Family Medicine at Kabarak University, I am undertaking a research on meeting the unmet needs in a whole person care approach for Female Sex Workers' in Bomet County, Kenya. Feedback will be given to you once the research is complete. I invite you to be part of this study. You are free to discuss this study with anyone you are comfortable with and you can take time to think through and reflect on whether you would like to participate or not.

This consent form may contain words that you do not understand. Please ask me/ the research assistant to stop as we go through each section and we will take time to explain. If you have any questions afterwards, you can ask at any time.

Kebebertab 1: Ngalek cheiyororu

Taunet

A kipsomaniat ne somanchin Masters (Masters eng Kerichek che tinyegei ak kapchi eng Sukulitab barak nebo Kabarak University, Ayoe chikilisiet netinyegei ak magutik che tomo keityi eng ribetab chametabgei nebo borto eng chito katugul eng kwonyikab town eng Bomet County Kenya. Kigonin wolutik chebo chikilisinito ye kakobataita. Atachin iegu kebeberta eng somanani.Ityagat ingalalen somanani ak chi age tugul ne itin'ge katyagnatet ak imuchi iib kasarta ibwat angot ichame iegu kebeberta eng somananito.

Kartasini bo koyonjinet komuch kotinyei ngelek che megiutosi. Kaikai tebenan anan iteben netoretisiei eng somanani koib kasarta koarorun. Angot itinye tebut imuchi iteb eng kasarta age tugul.

Purpose of the research

Quality health should be enjoyed by all Kenyans most of all those who are more vulnerable to illness. Whole person care involves physical, psychological, social and spiritual domains of an individual during provision of healthcare. We want to explore female sex workers in Bomet health needs, any unmet needs and if the unmet needs can be met through a whole person care approach during provision of health services. This will inform policy makers to incorporate care for the unmet needs in the sexual and reproductive health package in a more holistic manner, for female sex workers in Bomet County, with an aim of improving the health of women in this community.

Tokchinetabgei nebo chikilisionito

Chametabgei ne nin nebo borto konyolu koboiboenchi bik tugul eng Kenya, ne siirei ko biik che abokora konyumyum konyor mianwek. Chametabgei nebo borto tugul, koboto borto, kabwatutik, yamdaet ak tomirmiriet eng kasarta ne kikoitoi konyoiset. Kimache kiguiye agobo kwonyikab town eng bomet, magutikwak ak magutik che tomo keityi ago ngot kotomo keityi komukaksei keityi eng oret nebo ripsetab chito katugul eng kogoitoetab konyoiset nebo chametabgei eng borto. Nitok kotoreti bik che ngatei ngatutik kogeer kole kakitesta magutik che tomo keityi eng ngalekab sigisiet eng oret nebo katugul eng kwonyikab town eng Bomet county. Toreti nito kekanapta chametabkei eng kwonyik eng kokwotinwek.

Type of Research Intervention

This research will involve your participation in a face to face interview or a focus group discussion with the principal investigator. The interview will take about twenty to thirty minutes of your time while the focus group discussions will take thirty to forty five minutes.

Chigilisiet ne kitokyingei

Chikilisoini koibe ngalalet ne kingolole tokoch eng tokoch anan ko ngalalet ne kingolole ak kweanet anan kirubit ak chikilindet neo. Ngalalani koibe dakikosiek tiptem agoi sosom, ago ngalalet nebo kweanet anan kirubit koibei dakikosiek sosom agoi artam ak mut.

Participant Selection

You are being invited to take part in this research because we feel that your experience as a female sex worker can contribute much to our understanding and knowledge on this topic.

Lewenetab icheget che egu kebeberta eng chikilisiet

Kitoochin iegu kebeberta eng chikilisiet amu kiyani kele ingen kot agobo sobetab kwonyikab town ak imuchi imwa ngolyo ne toreti kesich naet ak kaguiyet eng ngolyondonito.

Voluntary Participation

Participation in this study is fully voluntary. You are free to choose whether to participate or not. If you choose not to participate, there will be no further effect to your occupation and if you were to participate in a focus group discussion you will continue receiving the same health services provided, nothing will change.

Iyae boisini eng chamengung

Iegu kebeberta eng chikilisioni ko eng chamengung. Imuchi ilewen itestai anan iistegei. Angot ilewen iistegei komomi kit newoloksei eng boisiengung nebo kotugul, ago angot ilewen iegu kebeberta eng ngalalet nebo kirubit komomitei kit age tugul newoloksei.

Procedures

We are asking you to help us learn more about your health needs, find out if these health needs are met by health providers, if a whole person care approach would meet the unmet needs and suggestions on ways to improve health services provided to you. If you accept this request you will be asked to partake in this interview or focus group discussion.

Ole kiyoitoi

Kisoomin itoretech kiguiye agobo magutiguk chebo chametabgei nebo borto, angot inyoru magutichuto yon kewe kinyain, angot komuchi konyoiset nebo chito katugul koityi magutik che tomo keityi ak kabwatutikab biik agobo olekiriptoi chametabgei nebo borto eng konyoiset. Angot iyan somenyon, kesomin iiegu kebeberta eng tepset anan eng ngalalet ne tinyei tokyin eng kirubit.

Interviews

During the interview, I and a research assistant will sit down with you in a comfortable place at the Centre. For convenience, the interview can take place at your chosen location. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The expected time for the in-depth interviews is forty minutes. The information, audio recorded is confidential, and no one else except my research supervisor and I will have access to the information documented during your interview. The entire interview will be audio-

recorded, but any traces of name or voice will be removed. The tape will be kept in a safe cabinet under lock and key. The information recorded is confidential, and no one else will have access to the tapes. The tapes will not be destroyed in case any information is needed to be retrieved.

Tepset

Eng kasarta nebo tepset kiburi tuwan eng ole kecham kiburen. Asikomaiimin, keyoe tepset eng ole kelewen keyaen. Angot ko memache iwolu tebut age tugul eng kasarta nebo tepset ityagat imwochi inendet ne tebei tebutik asi kobiit kosiptogei kwo tebutiet age. Mami chi age kobaten inendet ne tebei tebutik eng kasarta nebo tepset, iyia kityo ichamchi inyegei chi age komi kobootok. Kasarta ne ibei tepset ko dakikosiek artam. Logoiwek chekitoe kobo ungat ago mami chi age ne imuchi konai kobaten anendet ak konetindenyu.Kasarta tugul nebo tepset ketoe tuget, ago kiistoi kainoutik ak kewal tuget. Kigonori logoiwek che kakita eng ole kikere ak kibulit. Logoiwek che kakita kobo ungat ak maami chi age neimuchi konem. Makin'gemei tepit nekokitochi logoiwek amun kimuch kemokyigei logoiwechoto eng kasarta ne nyonei.

Focus group discussions

You will take part in a discussion with 7-8 other persons with similar experiences. This discussion will be guided by the research assistant or myself.

The group discussion will start with me, or the focus group moderator (……) making sure that you are comfortable. We can also answer questions about the research that you might have.

We will ask you questions concerning your health needs, your unmet needs by the health providers, find out if the whole person approach will meet your health needs and your suggestions on ways to improve the health systems. Some of the questions may be sensitive therefore it will be your voluntary choice to share. If you are not comfortable in sharing during those discussions, we will not ask you to share your knowledge.

The discussion will take place in [……)], and no one else but the people who take part in the discussion and guide or myself will be present during this discussion. The entire discussion will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept [explain how the tape will be stored]. The information recorded is confidential, and no one else except [name of

person(s)] will have access to the tapes. The tapes will not be destroyed but will be stored safely under lock and key.

Ngalalet ne tinyei tokyin eng kirubit

Kimokchin gei oyai ngololutik ak bik Alak 7- 8 che tinyei naet ne kergei. Ngololutik chuton ko toretisiei rubeiywotab chikilindet anan ko anendet.

Ngololutik chuton bo kirubit kotounei ane, anan ko ne tononchin kirubit noto,ak koger kole miten en boiboyet chi age tugul. Kimuchi kora kewolun tebutik che otinye akobo chikilisiet.

Kitebenok tebutik agobo mogutik chebo chametabgei nebo borto, mogutik che tomo keityi, bik che gonu mogutik choton, kegeer angot ko oret ne bo bik tugul koitchin mogutikwok che bo chamet ab kei nebo borto ak kereet ne ngwong agobo ortinwek che kiboisien kekanapta chametabgei ne bo biik.Tebutik alak komuchei ko n'goi, kou noton ko tiengei chamet nengung angot imoche iwolu.. Angot ko metyagat imwa kiy age tugul eng kasarta ne bo kirubit eng ngololutik choton, ko mokilenjin imwa naengung agobo choton.

Ngololutik chuton ko tun ko yooksei en[……)], ago mogichomchin chi age ne mo okwek ko testai eng ngololutik choton che bo kirubit ago ane ne tun miten ak atononji kirubisiek choton.Ngalalanito tugul ketoei eng tepit ago makimwoei chi kaina eng tepit.Kikonori tepinito(aroru ole kikonorto tepit). Logoiwek che kakita kobo ungat ago mamuchi konyor chi age kobaten(Chikilindet neo ak tononjinindenyi/supervisor). Makingemei tepisiek kobate kikonori eng ole ripotin.

Duration

The research takes place over __three_____months in total. Each interview will last about half an hour each. The group discussion will be held once and will take about forty five minutes.

Kasarta neibei

Chikilisioni keyaei eng kasarta nebo arowek __ somok. Ngalalet age tugul koibei dakikosiek sosom. Ngalalet nebo kweanet keyoei konyil eng kirubit ak koibei kasarta nebo dakikosiek artam ak muut.

Risks

There is a risk that you may share some confidential information, if at any time you do not feel comfortable in responding to any question, you do not need to give us any reason. However we do not wish for this to happen.

Bichiinwek

Mi bichiinwek kele imuch imwa ngalek che ungotin, angot igase kometyagaat iwolu tebutiet anum. Komoyochei iaroruech amune.

Agot angandaan unotok komokimache koyaak kiy ne u noto. .

Benefits

Your participation in this study may bring benefits to you as the information shared will inform policy maker to include services that will meet the health needs of female sex workers. This will eventually improve your health and that of each woman in this occupation.

Kelchin

Imuch itoretoke ye iegu kebeberta eng chikilisiani amun eng logoiwek che kinyorunen chikilisiet kotoreti bik che ngatei ngatutik kotes konyoiset ne toreti magutik che tinyegei ak chametabgei nebo borto eng kwonyikab town. Eng let kotoreti nito kotes komieit chametabgei nebo borto eng inye ak eng kwondo age tugul neyoei boisionito.

Reimbursements

You will not be provided any incentive to take part in the research. However, we will give you kshs. 100 for your time, and travel expense if this will be encountered.

Kit ne kiwegu

Momi kit ne kegonin kabaten silingisiek 100/- ye iegu kebeberta eng che yoei chikilisianito. Kigonin silingisiek chu 100/- amun eng kasartangung ak kegonin chekilibanen kariit angot koyochei ibunu karit.

Confidentiality

The research team will maintain confidentiality of information provided and your identity throughout the study. However, confidentiality will only be bridged if the information provided has the potential to harm you, someone else especially a minor. Your participation may attract the attention of members of the community and there is risk of being identified as a sex worker. We ensure that within the limits of this research

your identity will be anonymous and no information provided will be traced to you without your knowledge.

If you will participate in a focus group discussion, we will ask you and others in the group not to talk to people outside the group about what was said in the group. We will, ask each of you to keep what was said in the group confidential. You should know, however, that we cannot stop or prevent participants who were in the group from sharing information that should be confidential.

Logoiwek chebo ungat

Biik che yoei chikilisiani koribei logoiwek chebo ungat che kemwachi ama ibortoi kainautiguk eng chikilisiet tugul. Angandan unotok komuch komokirib logoiwek chebo ungat angot komuchi kondein ngoiyondit anan konde ngoiyondit chi age, missing ko lagok che mengechen. Ye iegu kebeberta nebo chikilisiet komuchi koyai biik komach konain missing ak komuch kosiktoen ichek kole I agenge eng kwonyiak town. Eng kiwotosiekab chikilisioni ko makibortoi kainautiguk anan ko logoiwek alak tugul che kepchei kobaten kokakemwaun. Angot iegu kebeberta eng ngalalet nebo kirupit ne tinyei tokchin, ketebenen inye ak bik cho kirubit komatomwochi bik alak che momiten kirubit tuguk che kakingalalen, ngalek chebo kirubit kobo ungat. Nyolu inai ile makimuchi keter chi eng kirubit komamwaita ngalekab unga.

Sharing the Results

The information shared with us today will not be shared by anyone outside the research team. If interested, the knowledge we get will be shared to you in private and the female sex workers community before it is available to the public. After sharing this information, it is our hope that we publish the findings of this research so that other interested people may also learn from the research.

Sharing the Results

Logoiwek che kakipchei raini komakimwochin chi age kobaten timit ab chikilindet. Angot imache naet ne kinyorunen chikilisioni, kemwaun inyegei ak kwonyikab town komakimwachi bik alak. Ko kakepcheiwok logoiwek agobo chikilisioni, kimangu kesir naet ne kokinyoru si komuch konetengei bik alak che yaei chikilisiet.

Right to Refuse or Withdraw

It is your voluntary choice to participate in this research. Choosing to participate in this research, your identity will not be affected in any way. You may stop participating in the

interview or focus group discussion at any time that you may wish. At the end of the interview or focus group discussion I will give you an opportunity to review your comments, you may modify or remove any part.

Imuchi iesie anan anan iistegei

Iegu kebeberta eng chikilisioni kotiengei chamengung. Angot Iegu kebeberta eng chikilisie, ko mowolei ole isoptoi eng or age tugul. Imuchi iistegei eng ngalalet nebo kirubit eng sait age tugul ne kecham.Eng let ne bo tepset anan ngalalet nebo kirubit agonin kasarta iwekchigei logoiwek che kepchei ak imuchi iwal kit ne kan imwa anan iiste kiy ne kan imwa.

Who to Contact

If you have any questions, you can ask them now or later. If later, you can contact the principal investigator through this contact _____

_____

This proposal has been reviewed and approved by the Ethics Research Committee at Kabarak University. This a committee that protects the participants from any harm during the research. If you wish to find more about the ERC, contact_____

_____

You can ask me any questions about any part of the research study, if you wish to. Do you have any questions?

Who to Contact

If you have any questions, you can ask them now or later. If later, you can contact the principal investigator through this contact _____

_____

This proposal has been reviewed and approved by the Ethics Research Committee at Kabarak University. This a committee that protects the participants from any harm during the research. If you wish to find more about the ERC, contact_____

_____

You can ask me any questions about any part of the research study, if you wish to. Do you have any questions?

Chito ne nyolu iteben kiy

Angot itinye tebut, imuchi itebnguni anan iteb eng kasarta age. Angot itebe eng kasarta age konyolu iteben chikilindet neo iboisien simet nambaisiechu_____

Somet nebo chikilisiet ko kakigochi chomchinet Ethics Research Committee eng Kabarak University. Inoni ko committee ne ribei bik che egu kebeberta eng chikilisiet asi monyor bichiindo age tugul eng kasarta nebo chikilisiet.

Angot imache inai che chang agobo nito (ERC) imuchi ibirchi simet eng nambaisiechu,

_____

Imuchi itebenan tebut age tugul agobo kebeberta age tugul eng chikilisioni. Itinye tebut i?

Imuchi itebenan tebut age tugul kotinygei ak kebeberta age tugul nebo somanani bo chigilisiet angot imache iteb. Itinye tebut age tugul i?

Part II: Certificate of Consent

I_____ have read the information, or it has been read out to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Initials of Participant_____

Signature of Participant _____

Date _____

Day/month/year

Kebebertab 2: Certificate nebo koyonjinet

Ane_____ karasoman sirutichu , anan kakesomanwon. Kanyoru kasarta ateb tebutik agobo nito ago tebutik che kakitebenan kokarawolu kou ye kaamuch. Karayan eng chamenyu aeg kebeberta eng somananito.

Kainet eng nwogindo/initials_____

Sein nebo chito ne kebeberta eng chikilisiet _____

Trikit _____

Betut/arawet/kenyit

If un-schooled

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness_____ Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Ngot ko mangen kosoman

Karabaorian ale kakisomanji sitrutikab koyonjinet inendet ne wendi koegu kebeberta eng chigilisiet ago kakigochi inendet kasarta koteeb tebutik. Abaoriani ale kagoyan komakigikyi.

Sir kainetab baoriat_____Siyet nebo chito ne kebeberta eng chigilisiet.

Sein nebo baoriat _____

Tarikit _____

Betut/arawet/kenyit

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1.

2.

3.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly **and to** the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

Ngolyot nebo chikilindet /inendet neibei koyonchinet

Karasomanji ne nyolu koek kebeberta eng chikilisiet ngalek chebo arorunet eng oret neiguitos ak eng kamugenyu kokaager ale kaguiyo kole kiyoe tuguk cheisubi:

1.
2.
3.

Abaorini ale kogigochiinendet ne egu kebeberta eng chikilisiet kasarta koteeb tebutik che tinyegei ak chikilisiet ago kakiwolji tebutik tugul eng oret ne nin ak eng kamugenyu. Abaoriani ale mokigikyi inendet koib koyonjinet ago kayan inegei eng katyagnatet ak eng chamet.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent_____

Signature of Researcher /person taking the consent_____

Date _____

Day/month/year

Copy nebo kartasit nebo koyonjinet ko kokikochi chito ne koek kebeberta eng chigilisiet.

Sir kainetab chikilindet/chito neibei koyonjinet_____

Sein nebo chikilindet /chito neibei konyonjinet_____

Tarikit _____

Betut/Arawet/Kenyit

Appendix III: In-Depth Interview Guide

I would want to appreciate you for participating in this in-depth interview. The purpose of this interview is to understand your experiences and challenges when utilizing healthcare services to improve your health.

Introduction

- ✓ Greet the interviewee and thank her for giving an appointment for an interview.
- ✓ Introduce yourself and the research assistant.
- ✓ Explain about confidentiality and use of the study outcomes.
- ✓ Introduce the consent form.
- ✓ Ask for consent to an audio recording

Biodata

Initials:

1. How old are you?
2. Where do you live?
3. What is your level of education?
4. Where do you operate from?
5. How long have you been in sex work?
6. Do you have any dependents (for example children and family members) please tell me more on this?
7. Please tell me more about the your income sources other than sex work?
8. Please tell me more about the number of clients you see in a day?
9. Please tell me more about the amount of money you make in a day?
10. Please tell me more on the stated substances: alcohol, cigarettes, tobacco, any other drugs that you use?

TOPIC	Guiding Questions	Possible follow up questions
Introduction	• So tell me more on how a normal working day/ night is for you? • Please tell me more on how you started sex work? • Tell me more about, the last time you felt bad about how someone treated you because of sex work.	• How many sexual partners a day/night? • Has anyone treated you differently because of sex work? • Who was the person? What was the situation? How did that situation make you feel thereafter? • Who did you talk to and what

		did you do next? • **Probe more about the areas of interest**
Experiences when utilizing health services and health needs	• Tell me more about the reasons would make you seek healthcare services? • Suppose you are unwell, where would you get help/ treatment? Tell me more on this • I am curious, what were your experiences when you last received healthcare services for an occupation related illness? • If you find yourself in a position where your occupation is required by the health provider how does this make you feel? Please tell me more about this? • Were you satisfied with the healthcare services you received during the illness? If yes, please expound on this. If not also eplain why you were not satisfied/ • Apart from physical illness have you ever gone to a health provider for other health services? Tell me more on this. • There are health services that prevent someone from getting an illness or the progression of a disease, have you ever gone to a health facility to receive such service? Please explain what services these were. • Have you ever felt the need to talk to someone because of an emotional or psychological issue, for	• Why do you choose to receive healthcare service there? • How do you get to the health facility? • What has been your experience when getting help from the health provider? • Why does this make you feel in this particular way? • How did you feel about these experiences? • If satisfied, please explain why? • If not, which service did not please you? • If you have ever received, what type of preventive service was it? • Where did you get information on these preventive health services? • Who did you talk to? • Did talking to this person help? • Have you ever felt the need to go to a professional health worker to talk about this issue? • Please explain your experience when getting help? • Have you ever discussed these feelings with a healthcare worker? • Have you ever had any discussions with your health

	example, depression or substance use? Please tell me more on how you went about this. • Please tell me more on who you talk to when afraid or with guilt?	provider on matters concerning spiritual care and practices?
Challenges faced when seeking healthcare services	• Tell me more if there were there any challenges faced when you last used healthcare services?	• How did those challenges affect your general health? • Are these challenges similar to other women in sex work?
Development of whole-person care	Please tell me more on how the health providers would best address the health needs of female sex workers in Bomet County. What services could have helped ensure your health needs are addressed adequately? (If yes, explain more on this. If no, also explain why you gave this answer)	• Would healthcare that looks at the physical, psychological, social and spiritual aspect of your health address your health needs?
Summary	Thank you for taking the time to tell me more about your experiences and challenges you face when utilizing health services, is there anything else you think I should know?	

Appendix IV: Focus Group Discussion

Introduction

- ✓ Welcome all participants and allow each person to give an introduction.
- ✓ The interviewer and the research assistant need to specify their roles in the interview.
- ✓ Copies of informed consent and confidentiality forms should be provided to each participant and read-aloud for the benefit of those who cannot read.
- ✓ Participants should be provided with an opportunity to ask any questions.

More on the guide

We will ask more about your experiences during the utilization of healthcare services in Bomet County and explore the challenges you face as female sex workers when seeking healthcare. Some questions will establish your knowledge on the health services for female sex workers available in Bomet and the healthcare practices. It is most preferred to ask the questions according to the order given below but it is more important to maintain the flow of discussion. Find suggested probes included below the questions to get clarity in the information provided.

Rules to follow

There are no right or wrong answers in this discussion. We are interested in knowing what you think, feel free to be open, honest and to share your point of view. It is important to hear your opinion. Information shared in this discussion should not be shared to persons who were not present in this group

You will be allowed to keep silent or walk out if you feel uncomfortable with the subject being discussed

1. Please tell me more what are the health needs of female sex workers that is to be discussed?
2. Please tell me more what reasons made you seek health services?

-(Was it for treatment or prevention of illness or illness due to a sexual and reproductive illness or did you decide to seek this health service?) For any of the repsonses prompt further.

3. Please tell me more on the health care services for female sex workers, conveniently available to you?

- If not, what are the reasons that make them inconvenient?

4. Please tell me more on your experiences when receiving health care services here in Bomet?

-Which health facilities were this? (Government/ non-government organizations)

-I am curious, why did you choose this health facility?

- Please explain how you felt when receiving health services there. (Probe further on areas of interest).

5. How did the health workers respond to your health needs at the time?

(please tell me more if they were aware of your occupation?)

- Was there a time that you may have felt that you were treated unfairly? Please explain what made you feel that way.

- I would like to know if the treatment given was appropriate? If yes/no, please explain further

- If unwell, would you return to this health facility? Please explain why you would or would not return to the health facility.

5. Please tell me more about the preventive services available to you in the health facilities in Bomet County?

- I would like to know more if you are aware about PrEP (pre-exposure prophylaxis drugs for HIV)? Where and how do you get these drugs?

- Please tell me more if you have ever gone for screening for sexually transmitted illnesses and reproductive tract cancers? Is this routinely done in the health facilities?

- I am interested to know more on how you access barrier methods of contraception?

- Pease tell me more on your awareness of vaccines that are available in Kenya that can prevent sexually transmitted diseases? Is vaccination routinely done for female sex workers in the health facilities?

6. Please tell me more if you have ever been referred to another health facility for healthcare services?

- How did the referral process look like?

- How soon were you able to get the healthcare service?

7. Tell me more on the challenges you face when seeking healthcare and using healthcare services for female sex workers?

-Probes: What changes can be done by health providers to improve these challenges?

8. Other than physical illness, Illness can also be caused by the psychological, social and spiritual aspects of an individual. Have you ever suffered from illness caused by these three other aspects of health? This includes:

- Psychological: mood disorder, post-traumatic stress disorder, anxiety disorder

- Social: isolation from society secondary to discrimination and stigma
- Spiritual: fear, shame and guilt

- How did this make you feel?
- Where did you get help from?
- Was the help effective?

8. Please tell me if there are support groups amongst female sex workers living in Bomet? If yes, tell me more on how these support groups improve the health of female sex workers in this community?

9. Discuss, what if the healthcare you receive from health providers could address the physical, psychological and social and spiritual aspects of well-being would it improve your health?

- What is the good side of it?

-What is the bad side of it?

10. Are you satisfied with the health services available in Bomet County (focusing on female sex workers)? (If yes/ no please explain more on this)

Appendix V: Health Workers Interview Guide

This interview is to gain more knowledge on the health practices of health providers about healthcare for female sex workers in Bomet County. The study is designed to understand the health needs of female sex workers and if these health needs are met by the healthcare system in Bomet

Introduction

- ✓ Greet the interviewee and thank him/her for giving an appointment for an interview.
- ✓ Introduce yourself (interviewer), if the interviewee is not already familiar with you.
- ✓ Introduce Kabarak University
- ✓ Provide the interviewee with the leaflet on the study design and briefly explain the study.
- ✓ Establish credibility and explain about confidentiality and knowledge translation of the study outcomes.
- ✓ Assure the interviewee that their cooperation is important during the collection of data
- ✓ Introduce the consent form and get written consent.
- ✓ Ask for consent to an audio recording

Topic	**Guiding Questions**	**Possible Follow Up Questions**
Role in health service delivery	• Please tell me more on the position you hold? • Could you describe your role in the provision of healthcare services to female sex workers?	• How long have you worked with female sex workers?
Health practices in Bomet County	• How many health facilities do we have in Bomet County that offer services to female sex workers? • What programs are available for female sex workers in Bomet County? • From your experience, could you describe the health services available for female sex workers in these facilities? • From your experience, are these health	• Are the majority of the health facilities funded by the government or non-government organization's? • Are these programmes led by the government or non-government organizations? How is the community involved in these programmes? - Curative - Preventive

	services utilized by female sex workers? • From your experience, what illnesses do female sex workers commonly present within the health facilities? • Tell me more about the level of training of health providers who work with female sex workers	- Mental health - Spiritual assistance •How often do healthcare providers get training on improving healthcare for female sex workers?
Continuity and coordination	• Tell me more on how you ensure that the clients who have been registered in the clinics come for follow up? • I am curious, what is the current structure of the referral system for health services for female sex workers? • From your experience, should 'subsidiary services' such as social services, counselling services, spiritual care be given a priority in the health service delivery to female sex workers?	• By your estimation how many female sex workers are retained in these health facilities? • What is the process of the referral system, for example, clients who may have a mental disorder such as substance dependence? • Are you aware of any social services available for female sex workers here in Bomet? • How does the health systems in Bomet coordinate care for female sex workers?
Health care delivery	• Working with a group of women with complex health needs, in your experience, what could be the challenges when receiving healthcare been like? • Please tell me more, if the health services available to female sex workers address their health needs? • From your experience, what are the health needs of female sex workers in Bomet County? • Tell me more on the possible changes that can be made in the health delivery system to improve the health outcomes of female sex workers in Bomet?	• What factors would you consider as barriers to their access to healthcare? • What kind of health services would address their health needs? • Are these health needs similar to all female sex workers elsewhere or unique to women living in Bomet County?
Development of whole-person care	• We would like to know,from your experience, could a whole-person care model (where the four aspects of health are taken into account during healthcare provision) address the health needs of female sex workers in Bomet County?	• If yes/ no please explain why?

Summary	• Thank you for taking the time and participating in this interview. Is there anything you ink I should know? • Can I get back to you for any clarifications or further information? • Thank the respondent for their participation	

Appendix VI: Karatasi ya Habari Za Mshiriki

Mada ya Utafiti: Kuhusiana na Huduma ya Afya Bora kwa Mtu Binafsi Anayeshiriki kwa Ngono kama Njia Ya Kupata Mapato katika Kaunti ya Bomet nchini Kenya: Kutambua Mahitaji ya afya yasiyoweza kushughulikiwa.

Kuhusu Utafiti

Utafiti utalenga kuelewa uzoefu na changamoto za wanawake wanaoshiriki kwenye ngono ili wapate mapato wanapotafuta huduma za afya bora zinazotolewa kwao katika Kaunti ya Bomet.

Lengo la utafiti ni kuelewa na kufafanua mahitaji ya afya bora yasiyoshughulikiwa kwa wanawake wanaoshiriki kwenye ngono na wanaishi katika Kaunti ya Bomet.

Maswali Unayoweza kuwa nayo kuhusu Utafiti

Je, ni kwa nini umeniuliza nishiriki kwa utafiti na nini nitatakiwa kufanya ?

Ombi hili limeelekezwa kwako kwa lengo la kupata maoni kupitia uzoefu na changamoto zako unapotafuta huduma za afya katika mahojiano na kwa vikundi vinavyosisitiza mazungumzo pamoja na wanachama wengine.

Tunashukuru kwa uaminifu wako kwa maoni na ushirikiano katika utafiti.

Ikiwa sitaki kushiriki au kubadili mawazo yangu wakati wa Utafiti?

Ushirikiano wako katika utafiti si wa kulazimishwa. Utapewa hiari ya kujiondoa kutoka kwa utafiti wakati wowote na hakuna maelezo zaidi yataweza kutafutwa baadaye.

Ni nini itatendeka kwa takwimu za utafiti?

Ikiwa utashiriki na ukaweza kuwa na wasiwasi kuhusu habari zilizotolewa, utaruhusiwa kuomba takwimu iweze kuharirwa .

Ikiwa hii itafanyika unaweza kuwasiliana na kiongozi wa utafiti kupitia nambari ya simu iliyotolewa wakati wa kukusanya takwimu. Takwimu zote zitakazokusanywa hazitakuwa na majina na hakuna habari zitakazolinganishwa na wewe binafsi. Habari zitakazo kusanywa zitahifadhiwa kwa kanda iliyorekodiwa na kuwekwa vizuri chini ya kufuli na ufunguo. Kiongozi wa Utafiti na msimamizi moja watakuwa na ruhusa kuingilia takwimu zilizokusanywa.

Je, utafiti utaripotiwa aje?

Punde tu takwimu zikikusanywa na kuchanganuliwa, matokeo ya utafiti yatawasilishwa kwako kupitia baraza la kikundi kinachosisitiza mazungumzo. Habari kuhusu lini hiki kitatendeka utapewa kwa mwisho wa kukusanya takwimu pahali pengine pa kukutania patakuwepo katika utangazaji wa somo la utafiti pale ambapo wahudumu wa afya na mtu yeyote atakayevutiwa atakuwa na uwezo wa kuingilia.

Nitawezaje kupata habari zaidi?

Tafadhali wasiliana na mtafiti moja kwa moja kupitia barua pepe
muragejoy@yahoo.com

Ulinzi

Ikiwa utaniambia kuhusu kitu kitakachodhihirisha hatari za athari nzito kwako mwenyewe au kwa watu wengine labda sitaweza kuweka hatari hii iwe siri na nitazungumza nawe hatua gani nitazichukua.

Ikiwa ninataka kulalamika kuhusu utafiti

Mwanzoni, ikiwa hii itafanyika unaweza kuwasiliana na mtafiti moja kwa moja .
Aidha, ikiwa hutosheki au kutamani, kulalamika zaidi kupitia malalamishi rasmi, unaweza kuwasiliana na mmoja wa wasimamizi wa utafiti jina lake ni Professor Wesley Too, Chuo Kikuu cha Kabarak Nakuru.
Ikiwa ume pitia kwa kuusoma utafiti huu na kukubali ombi hili la ushirikiano shukrani!
Ikiwa una maoni tafadhali wasiliana na mtafiti kupitia barua
pepemuragejoy@yahoo.com

Kiambatisho II: Fomu Ya Utoaji Idhini

Fomu hii ya utoaji idhini ni ya wanawake wanaoshiriki kwenye ngono ili kupata mapato yao ya kila siku katika Kaunti ya Bomet nchini Kenya. Wanawake hawa tumewakaribisha kushiriki katika utafiti wenye mada "Kuhusiana na Huduma ya Afya kwa Mtu Binafsi Anayeshiriki Ngono Kama Njia ya Kupata Mapato katika Kaunti ya Bomet nchini Kenya : Kutambua Mahitaji ya afya Yasiyoshughulikika.

Jina la Mtafiti Mkuu : Joy Sinkeet.

Jina la Mfumo : Mwanafunzi kutoka chuo kikuu cha Kabarak.

Jina la Mfadhili : Mfadhili mbinafsi.

Jina la Muundo Msingi : "Kuhusiana na Huduma ya Afya kwa Mtu Binafsi Anayeshiriki kwa Ngono kama Njia ya Kupata Mapato katika Kaunti ya Bomet Nchini Kenya "Kutambua Mahitaji ya Afya Yasiyoshughulikika."

Fomu hii ya utoaji idhini itakuwa kwa lugha ya kiswahili na Kpsigis

Fomu hii ina sehemu mbili.

- ✓ Karatasi ya kutoa habari (kukueleza habari kuhusu somo hili kwako)
- ✓ Hati ya uthibitisho wa utoaji idhini (Kwa ajili ya sahihi yako ikiwa utakubali kuchagua kushiriki)

Utapewa nakala mzima ya Fomu ya utoaji Idhini.

Sehemu ya kwanza : Karatasi ya kutoa Habari.

Utangulizi.

Mimi ni mwanafunzi anayesomea shahada ya pili katika Dawa ya Familia chuo kikuu cha Kabarak, mimi ninafanya utafiti kwa kupata mahitaji yasiyoshughulikika kwa afya ya mtu binafsi kwa ajili ya wanawake wanaoshiriki kwa ngono ili kupata mapato katika kaunti ya Bomet nchini Kenya. Utapewa majibu pindi tu utafiti utakamilika . Ninakukaribisha kushiriki kwa somo hili . Uko huru kujadiliana utafiti huu na mtu yeyote unayemuamini na unaweza kuchukua muda wa kutosha kufikiria na kukata shauri ikiwa utapenda kushiriki au la.

Fomu hii ya utoaji idhini inaweza kuwa na maneno ambayo yataweza kuwa magumu kwako kuelewa . Tafadhali uniulize au umuulize msaidizi wa utafiti ili tukome

tunapoendelea kupitia kila sehemu na tutachukua muda kuelezea. Ikiwa utakuwa na maswali baadaye, unaweza kuuliza wakati wowote .

Kusudi la Utafiti.

Afya bora ni haki kwa Wakenya wote, wengi wao ni wale wasiolindwa kutokana na magonjwa . Huduma ya afya kwa mtu binafsi inajumuisha mwili, nafsi, ushirikiano na jamii ,na mahitaji ya kiroho kwa mtu binafsi wakati wa utoaji huduma za afya. Tunataka kuchunguza kwa makini wanawake wanaoshiriki kwenye ngono ili kupata mapato katika Bomet hasa kwa mahitaji ya afya, hitaji lolote lililokosa kushughulikiwa na ikiwa mahitaji haya hayakushughulikiwa yataweza kushughulikiwa kupitia huduma kwa mtu binafsi anayeshirikishwa wakati wa utoaji wa huduma za afya. Hii itashirikishwa wanaochangia kwa kuunda sera zitakazounganisha mahitaji yasiyoshughulikiwa na huduma kamili ya uzazi kwa njia inayofaa hasa kwa wanawake wanaoshiriki kwa ngono ili kupata mapato yao kwa Kaunti ya Bomet kwa lengo la kuendeleza afya bora kwa wanawake wa jamii hii.

Aina za Kuingilia Kati Kwenye Utafiti.

Utafiti huu utahusisha ushirikiano wako wa mahojiano ana kwa ana au kwa kikundi kinachosisitiza mazungumzo pamoja na kiongozi mkuu wa utafiti. Mahojiano utachukua muda kama dakika ishirini hadi nusu saa kwa wakati wako katika kikundi kinachosisitiza mazungumzo watachukua dakika arobaini hadi dakika arubaini na tano.

Uteuzi wa Washiriki.

Unakaribishwa kushiriki kwa utafiti huu kwa sababu tunahisi kwamba uzoefu wako kama mwamamke anayeshiriki kwenye ngono ili kupata mapato unaweza kuchangia zaidi kwa kuelewa kwetu na ufahamu wa mada huu.

Kushiriki kwa Kujitolea.

Kushiriki katika somo hili ni wa kujitolea kabisa. Uko huru kuchagua ikiwa unataka kushiriki au la. Ikiwa utachagua kutoshiriki , hakutakuwepo na maana wowote kwako kukaa na ikiwa ungeshiriki kwenye kikundi kinachosisitiza mazungumzo , utaendelea kupokea huduma sawa za afya zitakazotolewa , hakuna kitu kitakachobadilika.

Utaratibu

Tunakuomba utusaidie tujue zaidi kuhusu mahitaji yako kiafya , tugundue ikiwa mahitaji haya yanashughulikiwa na wale wanaotoa huduma ya afya , ikiwa mtazamo wa

afya ya mtu mbinafsi unahusisha mahitaji yasiyoweza kushughulikiwa na maono ya njia zitakazoendeleza huduma za afya zinazotolewa kwako . Ikiwa utakubali hili, utaulizwa kushiriki kwenye mahojiano haya au kwenye kikundi kinachosisitiza mazungumzo.

Mahojiano.

Wakati wa mahojiano , mimi na msaidizi wa utafiti tutaketi pamoja nawe kwa pahali pa starehe kwa katikati. Kwa hali inayofaa , mahojiano yatatekelezwa kwa pahali ambapo umepachagua . Ikiwa hautarajii kujibu swali lolote katika maswali wakati wa mahojiano , unaweza kusema na anayekuuliza maswali atasonga kuuliza swali linalofuata. Hakuna mtu mwingine tena lakini anayeuliza maswali ndiye atakayeyeuliza na labda tu ungependa mtu fulani kuwepo. Wakati unaodhamiriwa kwa mahojiano ya ndani utachukua muda wa dakika arubaini . Habari, rekodi za kusikiliza zitakuwa siri,hakuna mtu mwingine isipokuwa msimamizi wa utafiti wangu na mimi tu tutapata uwezo wa kuingilia habari zilizohifadhiwa wakati wa mahojiano . Mahojiano yote yatarekodiwa kwenye kwenye rekodi ya kusikiliza lakini dalili zozote za jina au sauti zitatolewa . Kinasa sauti kitawekwa kabati salama yenye kufuli na ufunguo. Habari zilizorekodiwa ni siri na hakuna mtu mwingine ataweza kuingilia kinasa sauti. Kinasa sauti havitaharibiwa ikiwa habari zozote zitahitajika kupatikana tena.

Kikundi cha Kusisitiza Mazungumzo.

Utashiriki kwa mazungumzo pamoja na watu wengine saba hadi nane ambao wana uzoefu sawa wa kazi hii. Mazungumzo haya yataongozwa na msaidizi wa utafiti au mimi binafsi.

Mazungumzo kwa kikundi yataanza pamoja na mimi au msimamizi wa kikundi cha kusisitiza mazungumzo. (_____) kuhakikisha kwamba hautakuwa na wasiwasi, tunaweza pia kujibu maswali kuhusu utafiti ambao unaweza kuwa nao.

Tutakuuliza maswali yanayoshughulisha mahitaji yako ya kiafya, mahitaji yako yasiyoweza kushughulikiwa ipasavyo na wale wanaotoa huduma za kiafya , kutambua ikiwa kushughulikia mtu mbinafsi kwa makini itaweza kuleta umuhimu kwa mahitaji yako ya kiafya na maoni yako kwa njia zinazoweza kuendeleza mifumo ya afya . Maswali machache yataweza kuwa nyeti hivyo itakuwa maamuzi yako kwa kujitoa ambayo yataweza kuwasilishwa. Ikiwa utakuwa na wasiwasi utakapotoa habari zako wakati wa mazungumzo, hatutakuuliza ushiriki katika mazungumzo.

(_____) na hakuna mtu yeyote isipokuwa watu watakaoshiriki kwenye mazungumzo na msimamizi.

Mazungumzo yatatekelezwa kwa au mimi mwenyewe watakaokuwa wakati wa mazungumzo haya . Mazungumzo yote yatarekodiwa kwa kanda ya kusikiliza bali hakuna mtu yeyote ataweza kutambulishwa kwa jina kwenye kanda. Kanda itawekwa (eleza jinsi kanda itahifadhiwa). Habari zitakazorekodiwa zitawekwa kwa siri na hakuna hata mmoja isipokuwa (majina ya watu ambao wana kibali kuingilia kanda . Kanda hazitaharibiwa bali zitawekwa pahali pa usalama chini ya kufuli na ufunguo.

Utafiti utatekelezwa kwa muda wa miezi mitatu na zaidi kwa jumla. Kila mahojiano yatachukua karibu muda wa nusu saa .Kikundi cha mazungumzo kitatekelezwa kwa mara moja kwa na itachukua muda wa dakika arobaini na tano.

Hatari.

Kuna athari ya kwamba utaweza kutoa habari chache za siri, ikiwa kwa wakati wowote utakuwa na wasiwasi kwa kujibu maswali yoyote, hautahitajika kutupa sababu yoyote. Hata hivyo ,hatutarajii hiki kutokea.

Manufaa.

Kushiriki kwako katika utafiti huu kutaweza kuleta manufaa kwako kwa sababu habari utakazozitoa zitajulisha anayechangia katika uundaji wa sera ili kujumuisha huduma zitakazoshughulisha mahitaji ya afya kwa wanawake wanaoshiriki kwenye ngono ili kupata mapato. Hakika hii hatimaye itaweza kuendeleza afya yako na ile ya kila mwanamke anayefanya kazi ya kushiriki kwenye ngono ili apate mapato.

Malipo.

Hutalipwa kitu chochote cha kukusisimua ili uweze kushiriki kwa utafiti.Aidha, tutakupa shilingi mia moja kwa wakati wako na iwe nauli ikiwa utahitaji kusafiri.

Uaminifu.

Kikundi cha utafiti wataweka siri ya habari zilizotolewa na utambulisho wako katika utafiti wote. Hata hivyo , siri yako itazibwa ikiwa habari zilizotolewa zitakuwa na uwezo wa kukuathiri na kuathiri mtu yeyote hasa mtoto mdogo kushiriki kwako kutaweza kuvutia hisia za wanajamii na kuna hatari za kujulikana kwamba wewe unafanya kazi ya kushiriki kwenye ngono ili upate mapato. Tunahakikisha kwamba upeo wa utafiti huu hautataja jina lako na hakuna habari zinazotolewa zitakuwa na dalili ya kuwa wewe ni mshiriki bila fahamu zako.

Ikiwa utashiriki katika kikundi cha kusisitiza tutakuuliza wewe na wengine katika kikundi msiwaongeleshe watu nje ya kikundi kuhusu kinachozungumziwa kwenye kikundi. Tutauliza kila mmoja kwenye kikundi kuweka sirini kinachozungumziwa. Unahitaji kujua aidha kwamba hatutakomesha au kuzuia washirika waliokuwa katika kikundi kuwasilisha habari zinazohitaji kuwa siri.

Kuwasiliana Kuhusu Matokeo

Habari zilizowasilishwa kwetu leo hazitawasilishwa kwa mtu yeyote nje ya kikundi cha utafiti. Ikiwa ungependa maarifa tutakazopata zitawasilishwa kwako kwa siri na jamii ya wanawake wanaoshiriki kwenye ngono ili kupata mapato kabla habari hazijawekwa zipatikane kwa uma.

Baada ya kuwasilisha habari ni tumaini letu kuwatangazia matokeo ya utafiti huu ili watu watakaovutiwa wataweza pia kujifunza kitu kupitia kwa utafiti.

Haki ya Kukataa au Kujiondoa.

Ni chaguo lako la kibinafsi kushiriki katika utafiti huu. Kuchagua kushiriki katika kikundi hiki, utambulisho wako hautaathirika kwa njia yoyote. Unaweza kukoma kwa kushiriki kwa mahojiano au kwa kikundi kinachosisitiza mazungumzo kwa wakati wowote unavyotaka. Kwa mwisho wa mahojiano au kikundi cha kusisitiza mazungumzo, nitakupa fursa kurudia maoni yako, unaweza kuongeza maoni au kuondoa maoni mengine.

Nani wa Kuwasiliana Naye

Ikiwa una maswali yoyote unaweza kuuliza sasa au baadaye. Ikiwa ni baadaye unaweza kuwasiliana na mtafiti mkuu kupitia nambari yake ya mawasiliano_____

Pendekezo hili limekaguliwa rasmi na kuthibitishwa na Wanakamati wa Mfumo wa Maadili katika Utafiti wa Chuo Kikuu cha Kabarak.Wanakamati hawa hulinda wanaoshiriki kutokana na athari zozote wakati wa utafiti.

Ikiwa unataka kujua zaidi kuhusu Wanakamati wa Mfumo wa Maadili,

wasiliana na _____

Unaweza kuniuliza maswali yoyote kuhusu sehemu yoyote ya utafiti ikiwa ungependa.

Je, una maswali yoyote?

Sehemu ya Pili: Hati ya Utoaji Idhini.

Mimi_____nimesoma habari, au nimesomewa habari. Nimekuwa na fursa kuuliza maswali kuihusu na maswali yoyote niliyoulizwa yamejibiwa yapasavyo. Ninaidhinisha bila kulazimishwa kuwa mshirika katika utafiti huu.

Herufi za Majina ya Mshiriki_____

Sahihi ya Mshiriki_____

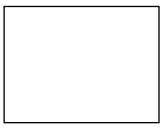
Tarehe_____

Siku/Mwezi/ Mwaka

Ikiwa hawezi kusoma na kuandika;

Nimeweza kushuhudia kusomwa kwa makini fomu ya utoaji idhini kwa uwezo wa mshiriki na mtu binafsi amekuwa na fursa wa kuuliza maswali. Ninahakikisha kwamba mtu binafsi amepewa idhini bure.

Chapisha jina la Mshahidi_____sehemu ya sahihi ya kidole ya gumba

Sahihi ya mshahidi_____ 

Tarehe_____

Siku/Mwezi/Mwaka

Kauli ya Mtafiti / Mtu anayechukua idhini

Nimesoma kwa makini karatasi ya habari kwa uwezo wa mshiriki, na kwa uwezo wangu wote nimehakikisha kwamba mshiriki anaelewa kuwa yafuatayo yatafanywa:

1.
2.
3.

Ninahakikisha kwamba mshiriki alipewa fursa kuuliza maswali kuhusu utafiti, na maswali yote yaliyoulizwa na mshiriki yamejibiwa ipasavyo na kwa uwezo wangu wote. Ninahakikisha kuwa mtu binafsi hajashurutishwa kwa utoaji idhini, na idhini imetolewa bure na kwa kujitolea.

Nakala ya ICF imepewa mshiriki.

Chapisha jina la mtafiti/ Mtu anayechukua idhini_____

Sahihi ya Mtafiti /Mtu anayechukua idhini_____

Tarehe_____

Siku/Mwezi/ Mwaka

Kiambatisho III : Mwongozo Wa Mahojiano Wa Kina

Ningependa kuhushukuru kwa kushiriki katika mahojiano haya kwa kina. Lengo la mahojiano haya ni kuelewa mambo ambayo umepitia na changamoto katika huduma za afya bora zinapotumika vizuri kwa lengo la kuendeleza afya yako.

Utangulizi

- ✓ Umsalimie mhojiwa na umshukuru kwa kumpa miadi ya mahojiano.
- ✓ Ujitambulishe na umtambulishe msaidizi wa utafiti.
- ✓ Eleza kuhusu uaminifu na matumizi ya matokeo ya utafiti.
- ✓ Utangulize fomu ya utoaji idhini.
- ✓ Uliza kuhusu idhini ya rekodi ya kusikiliza.

Takwimu za Uhai.

Herufi:

Una miaka mingapi?

Unaishi wapi?

Ulifikia kiwango kipi kwa elimu yako?

Elimu ya juu: Chuo /Chuo kikuu

Shule ya Upili .

Shule ya Msingi.

Hujui kusoma wala kuandika.

Unafanya kazi wapi?

Kwa mitaa?

Kwa baa/ hoteli na vyumba vya kupanga

Kwa danguro.

Mengine.

Umefanya kazi ya kushiriki ngono kwa muda gani?

Mwaka moja hadi miaka mitano.

Miaka sita hadi miaka kumi.

Miaka kumi na moja hadi kumi na tano

Zaidi ya miaka kumi na mitano.

Je, una watu wa kukutegemea kwa mfano watoto au jamaa?

Je, una njia zingine za mapato isipokuwa kazi ya kushiriki kwenye ngono?

Je, una wateja wangapi wa kuwahudumia kwa siku?

Kwa takriban, je unatengeneza pesa ngapi kwa siku?

Je, unatumia madawa ya kulevya kama ; pombe sigara, tumbako, madawa?

Mada	**Maswali ya Miongozo**	**Maswali Yanayoweza Kufuatiliwa**
Mahitaji ya Afya	• Basi uniambie, mchana/usiku ni kawaida kwako kufanya kazi? • Je, ulianza aje kazi ya kushiriki kwenye ngono? • Uniambie zaidi kuhusu wakati wa mwisho ulipohisi vibaya kuhusu mtu aliyekudhuru kwa sababu ya kazi ya kushiriki kwenye ngono.	• Je, una wenzi (Patna) wangapi kwa mchana au usiku? • Mtu huyo alikuwa nani? Je, nini kilikuwa kimefanyika? Je kitendo hicho kilikufanya uhisi aje baadaye? Je ,ulimuongelesha nani na nini ulifanya baadaye?
Mambo unayopitia wakati wa matumizi ya huduma za afya	• Kama wewe uko mgonjwa, Je, ni nini umepitia unapopokea matibabu ya magonjwa yanayohusiana na kushiriki kwa pahali ambapo kazi yako inahitajika na mhudumu wa afya utahisi vipi? • Ninataka kujua zaidi, ni mambo gani uliyopitia ulipopokea huduma za afya kwa magonjwa yanayohusiana na kazi yako? • Je, ulitosheka kwa huduma za afya bora ulizopokea wakati wa kuugua kwako? • Kuna huduma za afya ambazo zinamzuia mtu fulani kwa kupata magonjwa au ugonjwa kuzidi kuendelea kuwa,	• Ni Kwa nini ulichagua kupokea huduma za afya pale? • Je, unaendaje pahali pa kupokea huduma za afya? • Kwa nini hii itakufanya uhisi hivi? • Ulihisi aje kuhusu mambo uliyopitia? • Ikiwa ulitosheka, tafadhali eleza ni kwa nini. • Ikiwa haukutosheka huduma gani hazikukupendeza? • Ikiwa umewahi kupokea, ni aina gani za huduma za kukinga magonjwa uliweza kupokea? • Je, ulipata habari hizi za kukinga magonjwa wapi? • Je, mliongea na nani? • Je, kuongea na mtu huyu

	Je, umewahi kuenda kwa kituo cha afya kupata huduma hizi? • Ikiwa una ugonjwa donda ndugu ni mambo gani unayopitia wakati wa kupokea huduma za afya bora? • Umewahi kuhisi umuhimu wa kuongea na mtu fulani kwa sababu ya masuala ya hisia au saikolojia kwa mfano mawazo au matumizi ya madawa ya kulevya? Unapohofu au kuhisi kuwa na hatia, Je, ni nani wa kuongea naye?	kulisaidia? • Umewahi kuhisi kuwepo na umuhimu kuenda kwa mtaalamu wa huduma za afya kuhusu suala hili? • Tafadhali eleza mambo uliyopitia ulipopokea usaidizi. • Je, umewahi kuzungumzia hisia hizi ukiwa na mhudumu wa afya bora?
Changamoto	**Je, kulikuwepo na**	**Je, ni vipi**
Zinazoweza kukumba unapotafuta huduma za afya bora.	Changamoto zozote zilizokukumba mara yako ya mwisho ulipotumia huduma za afya bora? Tungependa kujua jinsi ya kushughulikia mahitaji ya afya kwa wanawake wanaoshiriki kwa kazi ya kushiriki ngono katika kaunti ya Bomet. Je, ni nini ingeweza kukuzaidia kuhakikisha mahitaji yako ya kiafya yanashughulikiwa ipasavyo?	Changamoto hizo ziliathiri afya yako kwa jumla? • Je, changamoto hizi zinafanana na za wanawake wengine wanaoshiriki kwenye kazi ya ngono?
Maendeleo ya huduma ya afya bora kwa mtu mbinafsi	Tungependa kujua jinsi ya kushughulikia mahitaji ya afya kwa wanawake wanaoshiriki ngono katika kaunti ya Bomet. Je, ni nini ingeweza kusaidia kuhakikisha mahitaji yako ya kiafya yanashughulikiwa ipasavyo?	• Je, huduma za afya bora inashughulikia saikolojia, ushirikiano na jamii na hali yako ya kiroho itaweza kukimu mahitaji yako ya kiafya?

Muhtasari	Asante kwa kuchukua muda wako kuniambia zaidi kuhusu mapito yako na changamoto zako ulizopitia ulipotumia hudumu za afya, • Je, kuna kitu chochote unafikiria ni vizuri nijue?	

Kiambitisho IV :Mazungumzo Ya Kikundi Kinachosisitiza Majadiliano.

- ✓ Ukaribishe washiriki wote na uwape fursa kila mmoja kujitambulisha.
- ✓ Mhojaji na msaidizi wa mtafiti wanahitaji kueleza kwa bayana kazi zao katika mahojiano.
- ✓ Nakala za utoaji idhini na fomu za uaminifu zitapewa kila mshiriki ni zisomwe kusoma ni lazima washiriki wapewe fursa ya kuuliza maswali yoyote.

Vitu Vingi Zaidi Kwenye Mwongozo

Tutauliza maswali zaidi kuhusu mapito yako wakati wa matumizi ya huduma za afya bora katika Kaunti ya Bomet na kuangazia changamoto ambazo zinakukumba kama mfanyikazi wa kushiriki kwenye ngono unapotafuta huduma za afya. Maswali machache yataimarisha kuelewa kwako katika huduma za afya za wanawake wanaofanya kazi ya kushiriki ngono zinazopatikana kwa Bomet na utekelezaji wa huduma za afya bora. Ni kitu cha kusisitiza kuuliza maswali kufuatia mpangilio uliotolewa lakini ni muhimu zaidi kuchunga mtiririko wa majadiliano. Utambue uchunguzi zilizopendekezwa chini ya maswali ili upate maelezo kamili ya habari zilizotolewa.

Amri za Kufuatwa

Hakutakuwepo na majibu sahihi au majibu yasiyosahihi kwa mazungumzo haya sisi tunataka sana kujua unachofikiria, uwe huru kufungua roho yako, mwaminifu kwa kuwasilisha maoni yako.

Habari zitakazowasilishwa siziwasilishwe kwa watu wengine ambao hawakuwepo kwenye hiki kikundi.

Hutaruhisiwa kunyamaza au kutoka nje ovyo ikiwa hautahisi vizuri kwa mada linalozungumziwa.

1 .Je unafikiria nini kuhusu mahitaji ya kiafya kwa wanawake wanaofanya kazi ya kushiriki ngono? Je, hilo ni jambo linaloweza kujadiliwa?

2 .Je, ni sababu zipi zilikufanya ukatafuta huduma za afya?

- Je, ilikuwa matibabu au kukinga magonjwa?
- Je, magonjwa haya yalikuwa sababu ya ngono au magonjwa ya uzazi?
- Je, ni kwa nini uliamua kutafuta huduma hii ya afya?

3. Je, huduma za afya kwa wanawake wanaofanya kazi ya kushiriki ngono zinapatikana kwa urahisi?

4. Je, mapato yako yamekuwaje unapopokea huduma za afya bora hapa Bomet?

- Je hivi ni vituo gani vya afya ? (Serikali au Mashirika Yasiyokuwa ya Serikali)
- Ni kwa nini uchague vituo hivi vya afya?
- Tafadhali eleza ulivyohisi ulipopokea huduma za afya pale?

5. Je , wahudumu wa afya walishughuliaje mahitaji yako ya afya wakati moja hadi nyingine?

- Je, walijua kazi unayofanya?
- Je, kuna wakati ulihisi kana kwamba ulitekelezwa ulipotibiwa? Tafadhali eleza ni nini kilichokufanya uhisi hivyo.
- Je, matibabu yalikuwa bora?
- Ikiwa unahisi vibaya, utaweza kurudi kwa kituo hiki cha afya? Tafadhali eleza ni kwa nini utarudi au ni kwa nini hautarudi kwenye kituo hiki

6.Je, ni huduma gani za kukinga zinazoweza kupatikana kwenye vituo vya afya katika Kaunti ya Bomet?

- Je , unazo fahamu kuhusu (madawa ya ukimwi pre-exposure prophylaxis?) Ni wapi na jinsi gani unaweza kupata madawa hizi?
- Je, unaenda kupimwa kutokana na magonjwa yanayosambazwa kupitia ngono na saratani ya njia ya uzazi? Je , hii inatekelezwa kila mara kwa vituo vya afya?
- Je unapataje aina ya madawa ya kujikinga wakati wa kushiriki kwenye ngono?
- Je unajua ni chanjo gani zinapatikana kwa Kenya ambazo zinaweza kuzuia magonjwa ya sinaa? Je chanjo zinafanywa kila mara kwa wanawake wanaoshiriki ngono katika vituo vya afya?

6. Je , wameweza kukutuma uende hospitali nyingine kwa sababu ya huduma za afya!

- Je, njia zilizotumika kwa kukutuma zilikuaje?
- Je, ilichukua muda gani kwako kupata huduma za afya?

7. Ni changamoto gani unapitia unapotafuta huduma za afya na matumizi ya vituo vya afya kwa wanawake wanaoshiriki kwa kazi ya ngono?

- Je , ni mabadiliko gani yataweza kufanywa na wahudumu wa afya ili kushughulikia changamoto hizi?

8. Mbali na magonjwa ya kawaida, magonjwa yanaweza kuanzishwa kupitia saikolojia , ushirikiano na jamii na hali ya kiroho kwa mtu binafsi .

- Je, umeweza kuathirika kutokana na magonjwa yanayoletwa na hali hizi tatu za afya?

Hii inahusisha:

- Saikolojia : hali ya akili iliyovurukika , kiwewe cha baadaye kinachosababishwa na akili iliyovurugika,hali ya wasiwasi.
- Ushirikiano na jamii : kujitenga kutoka kwa jamii inayofuatwa na kubaguliwa pamoja na stigma.
- Hali ya kiroho, woga, fedheha na kuhisi kuhukumiwa.

- Je, hii ilikufanya uhisi aje?
- Je, uliweza kupata msaada kutoka wapi?
- Je, msaada ulikuwa bora?

8. Je, mna vikundi vya kusaidia miongoni mwa wanawake wanaoshiriki kwa kazi ya kufanya ngono katika Bomet? Ikiwa jibu ni ndiyo, je ,vikundi hivi vya kusaidia vitaweza kuendeleza vipi afya ya wanawake wanaoshiriki kwenye kazi ya ngono kwa jamii hii?

9. Eleza, ikiwa huduma za afya unazopokea kutoka kwa wahudumu wa afya yataweza kushughulukia maumbile ya mwili, saikolojia , ushirikiano na jamii pamoja na hali za kiroho za afya bora na vipi itaendeleza afya yako?

- Je , umuhimu yako ni nini?
- Je, ubaya wake ni nini?

10. Je, unatosheka kutokana na huduma za afya zinazopatikana katika kaunti ya Bomet (kwa kuangazia wanawake wanaofanya kazi ya kushiriki kwa ngono ili kupata mapato).

KIAMBATISHO V: MWONGOZO WA MAHOJIANO YA MTOA HABARI.

Mahojiano haya ni ya kupata fahamu zaidi kwa shughuli za afya za wahudumu wa afya ikilinganishwa na huduma ya afya bora ya wanawake wanaoshiriki kazi ya ngono katika Kaunti ya Bomet. Utafiti huu imebuniwa kuelewa mahitaji ya afya ya wanawake

wanaofanya kazi ya kushiriki kwenye ngono na ikiwa mahitaji haya ya afya zinaweza kushughulikiwa na mfumo wa huduma za afya katika Bomet.

Utangulizi

- Umsalimie mhojiwa na umshukuru kwa kumpa miadi audhurie mahojiano .
- Ujitambulishe (mhoji), ikiwa mhojiwa hajaweza kukufahamu.
- Utambulishe Chuo Kikuu cha Kabarak.
- Umpe mhojiwa karatasi ya utafiti uliobuniwa na kwa ufupi ueleze yanayokuwa kwenye utafiti.
- Uweke imara sifa njema ya utafiti na ueleze kuhusu uaminifu na fahamu za utafsiri wa matokeo ya utafiti.
- Hakikisha mhojiwa kwamba ushirikiano wao ni wa umuhimu wakati wa kukusanya takwimu.
- Utangulize fomu ya utoaji idhini- na uwe na utoaji idhini ulioandikwa.
- Uulizie utoaji idhini unaoelekezwa kwenye rekodi ya kusikiliza.

Mada	**Maswali Yanayokuwa Mwongozo**	**Maswali Yanayoweza Kufuatiliwa.**
Wajibu wa Kutekeleza Huduma za Afya.	• Unachukua nafasi gani? • Je, unaweza kueleza wajibu wako katika utoaji wa huduma za afya bora kwa wanawake wanaoshiriki kwenye kazi ya ngono?	• Je umefanya kazi ya kushiriki ngono kwa muda gani?
Shughuli za Huduma za Afya Bora katika Kaunti ya Bomet.	• Je , tuna vituo vingapi vya afya katika Kaunti ya Bomet vinavyotoa huduma kwa wanawake wanaoshiriki kwenye kazi ya ngono? • Mipango ya wanawake wanaoshiriki kwenye ngono ni gani katika Kaunti ya Bomet? Unaweza kueleza huduma za afya zinazopatikana kwa wanawake wanaoshiriki kwenye kazi ya ngono kwa vituo hivi vya afya? • Kwa maoni yako, je vituo hivi vya afya vinatumika na wanawake wanaofanya kazi ya kushiriki kwenye ngono? • Je , ni magonjwa gani wanawake wanaoshiriki kwenye kazi ya ngono wanaweza kuwa	• Je, wingi wa vituo vya afya vinagharimiwa na serikali au mashirika yasiyokuwa ya serikali? • Je, mipango hii inaongozwa na serikali au mashirika yasiyokuwa ya serikali? • Je jamii imehusishwa vipi kwa hii mipango? • Ni mara ngapi wahudumu wa afya wanapata mafundisho kwa kuendeleza huduma ya afya kwa wanawake wanaoshiriki kwenye kazi ya ngono? • Kwa makadirio yako, je ni wanawake wangapi wanaoshiriki kwenye kazi ya ngono wanaweza kulazwa kwa vituo vya afya? • Je ,utaratibu wa mifumo ya marejeleo ni gani, kwa mfano wateja ambao wamepata shida ya akili kama kutegemea matumizi ya madawa ya kulevya? • Je, unazo ufahamu wa huduma zozote za ushirikiano na jamii zinazopatikana kwa wanawake wanaoshiriki kwenye kazi ya ngono hapa Bomet? Je , mifumo ya afya katika Bomet

	nayo katika vituo vya afya? • Uniambie zaidi kuhusu kiwango cha mafundisho ya wanaotoa huduma za afya na wanahudumia wanawake wanaoshiriki kwenye kazi ya ngono.	inaratibishaje afya ya wanawake wanaofanya kazi ya kushiriki ngono?
Mwendelezo na makubaliano.	• Je ,unahakikishaje wateja wako ambao wamesajiliwa kwa kliniki watarudi kliniki kwa ajili ya kufanyiwa uchunguzi kila mara? • Ninataka kujua zaidi, je ,muundo wa kisasa wa mifumo za marejeleo ya huduma za afya kwa wanawake wanaoshiriki kwenye ngono ni gani? Kwa maoni yako , je "huduma za kutoa misaada" kama vile huduma za ushirikiano na jamii, huduma za hali ya kiroho yapewe kipau mbele katika utoaji wa huduma za afya kwa wanawake wanaoshiriki kwenye kazi ya ngono?	
Uwasilishaji wa Huduma za Afva	• Kwa kufanya kazi pamoja na kikundi cha	• Ni hali zipi utaziangazia kama vizuizi kwao kupata huduma za afya?

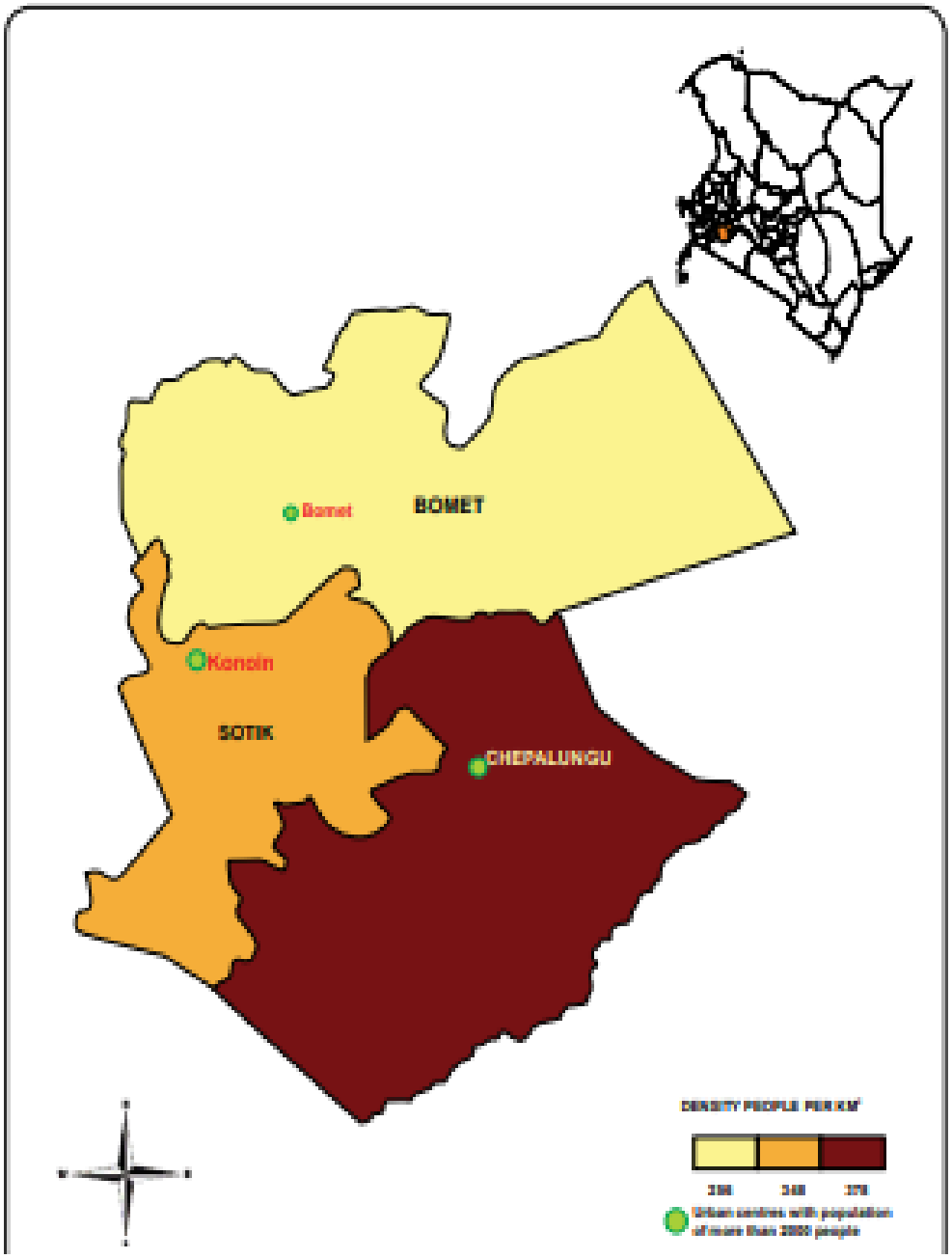
	wanawake wanaokuwa na mahitaji ya afya yasiyoelezeka kwa urahisi, kupitia uzoefu wako, je ni changamoto zipi wanazopata wanapopokea huduma za afya? • Kwa maoni yako , je unafikiria kuwa huduma za afya zinazopatikana kwao zinashughulikia mahitaji yao ya afya? • Kwa maoni yako ni mahitaji gani ya afya bora kwa wanawake wanaoshiriki kwenye kazi ya ngono yanaweza kuangaziwa kwa Kaunti ya Bomet?	• Je mahitaji haya ya afya yanafanana na mahitaji ya afya kwa wanawake wengine wanaofanya kazi kama hii au si hali ya kawaida kwa wanawake wanaoshi Kaunti ya Bomet?
Uwasilishaji wa Huduma za Afya	• Ni mabadiliko gani yanaweza kutekelezwa katika uwasilishaji wa mifumo ya afya kwa matokeo ya huduma za afya kwa wanawake wanaofanya kazi ya ushiriki kwenye ngono katika Bomet?	• Ni hali zipi utaziangazia kama vizuizi kwao kupata huduma za afya? • Je mahitaji haya ya afya yanafanana na mahitaji ya afya kwa wanawake wengine wanaofanya kazi kama hii ausi hali ya kawaida kwa wanawake wanaoshi kaunti ya Bomet?
Maendeleo ya Huduma ya Afya kwa mtu binafsi	Tungependa kujua, je huduma za afya kwa mtu binafsi zinaweza kuundwa (pale ambapo hali nne zote za huduma za afya yanazingatiwa wakati wa	

	utoaji wa huduma za afya) kuonyesha mahitaji ya afya ya wanawake wanaoshiriki kwa kazi ya ngono kwa Kaunti ya Bomet?	
Muhtasari	• Shukrani kwa kuchukua muda wako na kushiriki katika mahojiano haya. Je kuna kitu chochote unafikiria ni vizuri nijue? • Ninaweza kuwasiliana na wewe kwa kueleza wazi maoni yako au kwa kutoa habari zaidi? • Uwashukuru wahojiwa kwa kushiriki kwao.	

Appendix VII: Work Plan

Proposal writing: Research Question May 2018	Thesis proposal Defense 2019	Approval of the research proposal by IREC January 2020	Data Collection and Analysis February 2020- March 2020	Thesis Report writing 20th April 2020	Final thesis Defense 11th November 2020
✓	✓	✓	✓	✓	✓

Appendix VIII: Map of Bomet



Appendix IX: Access Population Introduction Letter: County Aids And Sti Coordinator

1st November 2018,

The Human Resource Manager,

I Choose Life,

Bomet County.

Dear Madam/Sir

Re**: Introduction letter of Dr. Joy Sinkeet, a Family Medicine resident intending to conduct a research in Bomet County.**

Greetings from CASCO offices.

The above named person is a family medicine resident at Kabarak University and aspires to do a research among female sex workers in Bomet County. Her research topic is **'Towards whole person healthcare for female sex workers in Bomet county, Kenya: identify the unmet health needs'**. She will work closely with you and this women group. Any introduction and assistance required for the purpose of collecting data is permitted.

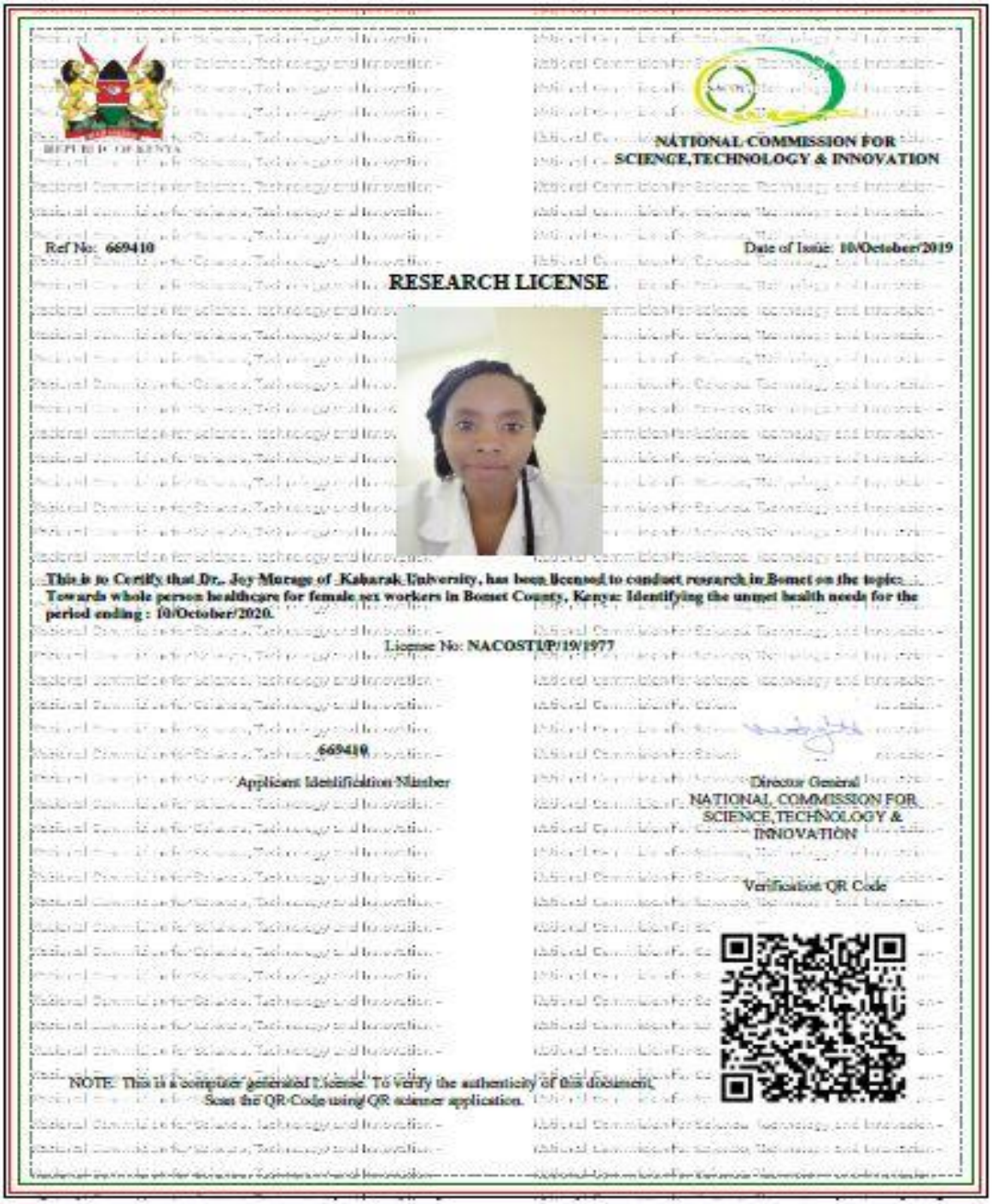
Any support and guidance provided to her will be highly appreciate.

Yours faithfully

Sir. Andrew Koech,

CASCO office

APPENDIX X: NACOSTI PERMIT FOR DATA COLLECTION



REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 669410

Date of Issue: 10/October/2019

RESEARCH LICENSE

This is to Certify that Dr.. Joy Murage of Kabarak University, has been licensed to conduct research in Bomet on the topic: Towards whole person healthcare for female sex workers in Bomet County, Kenya: Identifying the unmet health needs for the period ending : 10/October/2020.

License No: NACOSTI/P/19/1977

669410

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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APPENDIX XI: KABARAK IPGS LETTER

KABARAK UNIVERSITY

INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

P.O. Private Bag – 20157 Kabarak M: +254 724 887 431 F: +254 51 343529

www.kabarak.ac.ke/irecsecretariat.html E: irecsecretariat@kabarak.ac.ke

22nd Jan 2020

Reference: KABU01/IREC/016/VoL1/2020

Formal Approval Number: KABU/IREC/016

Dr **Joy Murage** GMMF/M/1359/09/16, Department of Medicine (Family Medicine) School of Medicine and Health Sciences, Kabarak University

KABARAK UNIVERSITY
INSTITUTIONAL RESEARCH & ETHICS COMMITTEE
22 JAN 2020
APPROVED
P.O. PRIVATE BAG - 20157, KABARAK

Dear **Dr Murage,**

FORMAL APPROVAL OF RESEARCH PROPOSAL

The Institutional Research and Ethics Committee reviewed your research proposal on 7th October 2019 titled:

"Towards Whole Person Healthcare for Female Sex Workers in Bomet County, Kenya: Identifying the unmet health needs."

You have addressed all concerns raised and now I am pleased to inform you that your proposal has been granted a Formal Approval Number: **KABU/IREC/016** on 17th January 2020. You are therefore permitted to start your study.

Note that this approval is for 1 year; it will thus expire on 21st January 2021. If it is necessary to continue with this research beyond the expiry date, a formal request for continuation should be made in writing to KABU IREC secretariat two months prior to the expiry date.

You are required to submit progress report(s) regularly as dictated by your proposal. Furthermore, you MUST notify the committee of any proposal change(s) or amendment(s), serious or unexpected outcomes related to the conduct of the study, or study termination for any reason. The committee expects to receive a final report at the end of the study.

Yours faithfully,

for

Prof. Wesley Too, PhD, MPH

Chairman,Institutional Research and Ethics Committee.

Cc Registrar- Academic Affairs and Research
Dean School of Medicine and Health Sciences
Director, Institute of Post Graduate Studies

Kabarak University Moral Code

As members of Kabarak University family, we purpose at all times and in all places, to set apart in one's heart, Jesus as Lord. (1 Peter 3:15)

Kabarak University is ISO 9001:2015 Certified