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COMMUNICATION, CULTURE, AND THE SEXUAL BEHAVIOURS OF FSWS AND MSM: INCONGRUENCE IN HIV/AIDS INTERVENTIONS IN KENYA

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Abstract

Female sex workers (FSWs) and men who have sex with men (MSM) are categorised among the most-at-risk populations (MARPS) in HIV and AIDS interventions. Because of their risky sexual behaviours, the success of HIV and AIDS interventions targeting these MARPS must be largely hinged on the outcomes of behaviour change programmes. Whereas the behaviour change programmes appear effective in promoting the health, rights and general wellbeing of the key populations, the dilemma arises when the messaging in these programmes is inconsistent with and completely negates the values and norms of the general population. Yet, cultural appropriateness is a central pillar in successful health communication interventions. The present study analysed the messages conveyed by the programmers in a variety of interventions targeting FSWs and MSM in Kisii County in Kenya, and also, the responses to the interventions by the target audience and those of the general population and faith-based organisations. These responses were analysed based on the arguments of the Ethnography of Communication. The programmes were deficient in two critical areas: promoting the achievement of long-term outcomes for the key populations and getting the support of all stakeholders by encouraging respect for the rights, norms and values of the general population.

Keywords: FSWs, MSM, culture, behaviour change communication

Introduction

Kenya is described as one of the four high-burden HIV countries in Africa, with about 1.5 million people living with HIV at the end of 2015 (Ministry of Health [MoH], 2016). Most at-risk populations (MARPs) for HIV in Kenya include female sex workers (FSWs) and their clients, men who have sex with men (MSM), prisoners and people who inject drugs (PWID) (MoH, 2010).

Like other MARPs, FSWs are at the highest risk of transmitting and acquiring HIV/STI because of the increased frequency of high-risk sex and drug-related HIV risk behaviours such as unprotected anal and vaginal sex, having multiple sex partners, and engaging in unsafe injection practices (MoH, 2010). In addition, they experience barriers to available HIV services because their behaviours are criminalised and stigmatised, making them marginalised and hard to reach (MoH, 2010). MoH (2016) reported that MSM, FSWs, prisoners and PWIDs contribute a third of all new HIV infections in Kenya.

According to the National AIDS & STI Control Programme (NASCOP, 2014) key populations in HIV and AIDS interventions include FSWs and MSM. The Kenya HIV County Profiles 2016 estimated that there were 4,063 FSWs and 426 MSM in Kisii County (MoH, 2016). The national key population size for each of these was 133, 675 for FSWs and 13,019 for MSM (MoH, 2016). In the mapping of key populations on HIV in 34 selected counties in 2019, Kisii County had an estimated 6,538 FSWs (NASCOP, 2019). This figure shows that the FSWs increased by 2,475 in the three years between 2016-2019, which is 60.91%. The estimated number of MSM in the county during the same period was 462 (NASCOP, 2019). Therefore, MSM increased by 36 between 2016-2019, representing 8.45%.

This study examined the interventions against HIV and AIDS targeting the FSWs and MSM, their objectives, the cultural appropriateness of their programmes and analysing the messaging of these programmes in line with the arguments of the ethnography of communication (EOC). Based on the National Guidelines for HIV/STI Programming with Key Populations (MoH, 2014), the focus was on behavioural interventions; biomedical interventions such as STI screening and treatment; HIV testing and counselling; tuberculosis (TB) screening and referral linkages; HIV-related treatment (for opportunistic infections) and care; promotion, demonstration and distribution of male and female condoms and latex-compatible lubricants; family planning; sexual and reproductive health services; post-abortion care services; cervical cancer screening; emergency contraception; post-rape care and post-exposure prophylaxis; screening and management of Hepatitis B; needle and syringe programme and medically assisted therapy; and structural interventions which address social, economic, political and environmental factors that affect individual or group HIV risk and vulnerability.

Literature Review

Religious and cultural beliefs and values in many societies, especially in Africa, dissuade people from engaging in certain sexual practices and behaviours which pose higher risks to contracting HIV and AIDS. Such practices include commercial sex work by both FSWs and MSM. Based on these beliefs and values against selected sexual behaviours, stigma is widespread among many African communities against FSWs and MSM (Ross et al., 2020).

It is as a result of this stigma that sex work is criminalised in many parts of Africa leading to abuse of the rights of the FSWs and MSM, including being an impediment to HIV service provision and access to health. The People Living with HIV (PLHIV) stigma index 2.0 reported high levels of stigma and discrimination among sex workers on emotional violence at 30.07%, physical violence at 24.94%, blackmail at 18.49% and discriminatory remarks at 23.39% (National Empowerment Network of People Living with HIV in Kenya [NEPHAK], 2021). The report indicates that 1 in 5 sex workers reported having avoided seeking healthcare services due to fear of being identified as sex workers (NEPHAK, 2021).

Human rights violations in HIV and AIDS, as a consequence of the stigma and discrimination against PLHIV both in community and healthcare settings, have the potential to worsen the impact of HIV, increase vulnerability to HIV and undermine responses to the pandemic. Despite the Constitution of Kenya 2010 providing for various rights including the right to the highest attainable standard of health, the right to life, to a package of primary health care services that include reproductive health and other attributes of good health, there are still in existence laws and policies that criminalise sex work and MSM, thus violating their human rights (NASCOP, 2014). FSWs and MSM are often arrested or harassed by police in Kenya.

Aggleton et al. (2004) point out that globally, certain groups of young people are at special risk for HIV and AIDS. Among these groups, Aggleton et al. (2004) list young homeless people, young people who inject drugs, young sex workers, and young men who have sex with men. The authors argue that responses that will be meaningful must have five central points: place the young person and his or her needs and experiences at the centre of the work, ensure meaningful participation in programme and project design and development, commit to protect and promote the rights of young people, presence of gender focus and tackle both societal vulnerability and individual risk in prevention efforts. This study sought to establish the prioritisation of these critical features in the HIV/AIDS interventions targeting FSWs and MSM in Kisii County.

Whereas stakeholders such as the foreign-funded NGOs running HIV and AIDS interventions encourage having fewer partners, regular use of condoms, pre-exposure prophylaxis (PrEP), lubricants and visiting health facilities for frequent check-ups and, when one has contracted HIV and AIDS, being put on treatment early, other stakeholders such as the faith-based organisations encourage abstinence and a complete stop to female sex work and men having sex with men because these practices are inconsistent with the values and norms of the general society. These contradictions bring about tensions between the general population and those involved in HIV and AIDS programmes focusing on FSWs and MSM.

Among the EOC assumptions relevant to this study is that communication is a system of rules where community members make communication choices guided by appropriateness in sociocultural contexts; communication is socially consequential and people bear the consequences of breaches to the normative structures defined by a given society; communication is strategic and conversants can and do artfully use verbal and nonverbal codes as cultural resources within which to achieve individual and group outcomes and finally, communication is not absolutely determined by culture or group as diversity among people in a speech community inspires them to circumvent, challenge and revise communicative patterns (Baillet, 2009). Other assumptions of the EOC are that people are users of symbols and the particular configuration of symbols nestles the structures of sociocultural life; human communication is patterned and largely people's daily lives comprise repetitive communication sequences across contexts; and communication is distinctive (Baillet, 2009).

Research on HIV and AIDS prevention in Kisii County has recently attracted a spate of interest from scholars from diverse disciplines. Mokua et al. (2019) assessed the status and challenges in relation to HIV/AIDS in Kisii County while Maroko et al. (2020) investigating the metaphors engendering HIV and AIDS-related stigma and discrimination. Similar work was undertaken by Nyakundi et al. (2019) who analysed the successes and gaps in the communication strategies used in the management of HIV and AIDS. In other studies, Maroko et al. (2019) evaluated partner notification services as a behaviour change communication strategy in the management of HIV and AIDS while Nyakundi et al. (2020) evaluated stakeholder engagement and management as a determinant of health intervention outcomes through varied messages. Another study focused on Abagusii traditional environmental knowledge in the management of HIV and AIDS and how this information can be used in language teaching (Maroko et al., 2021). Other work on the management of HIV and AIDS in Kisii County has focused on the use of herbal remedies (Mokua et al., 2020) and complementary and alternative medicine (Onyambu et al., 2021). The work reported in this paper will supplement the existing body of knowledge in the management of the HIV and AIDS burden in Kisii County.

Methodology

Kisii County has a total of 161 health facilities with 112 being public health facilities, 3 non-governmental, 17 faith-based and 29 privately owned (MoH, 2015). Antiretroviral Treatment/Therapy (ART) services are offered in 80% of the health facilities available in Kisii County (County Government of Kisii, 2014). Data was collected from 2 of the 17 health facilities which received a high volume of patients. These 2 health facilities were sampled purposively because they had the most consistent programmes targeting FSWs and MSM.

The programmes in these two facilities had enrolled bigger numbers of FSWs and MSM in the county. A total of 59 healthcare personnel in these health facilities were interviewed. These included clinicians, supervisors, heads of section, nurses, lab technologists, records officers, peer navigators and mother mentors. To complement interview data, a focus group discussion which involved 8 FSWs and 1 MSM was conducted. These 9 were active participants in the programme targeting FSWs and MSM. Topics for the focus group discussion centered on the activities of the two groups under study.

In line with the recommended ethical standards, the research proposal, data collection instruments and the informed consent form were reviewed and approved by a registered Institutional Ethics Committee (Approval Number CU/IERC/NCST/18/53). The study was issued with a research permit by the National Commission for Science, Technology & Innovation (NACOSTI). The research permit number was NACOSTI/P/18/50245/24190. Before data collection, all respondents were fully debriefed about the purpose of the study and asked to sign an informed consent form. They were assured of anonymity and confidentiality.

Findings and Discussion

General Situation Regarding FSWs and MSM

FSWs and MSM are frowned upon among the general population in Kisii County. Data obtained from the two hospitals indicated that because of stigma, people referred to FSWs as malaya, Swahili for

prostitute. All the FSWs interviewed asserted that they would intentionally pass HIV and AIDS to the husbands and sons of women who called them malaya (prostitutes). The FSWs were angry with this reference because they knew it referred to a behaviour that violates established social norms (Baillet, 2009).

In Hospital A, it was reported that initially, healthcare workers did not want to provide HIV prevention and treatment services to FSWs. One FSW said, "We threatened to look for the husbands and sons of female healthcare staff who did not want to treat us and infect them with HIV and AIDS. That is when they started treating us." This shows that there is discrimination and stigmatisation of FSWs even in hospital settings and these are barriers to treatment for HIV and AIDS (MoH, 2010). Consistent with the National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010), healthcare staff in the hospital were trained to offer HIV prevention and treatment services to FSWs and a room in the hospital was set aside to offer those services.

Similarly, because of stigma MSM were reported not to go to hospital. Since research has shown that MSM are 19 times more likely to be living with HIV than the general population (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2014) if measures are not put in place to encourage them to engage in responsible sex, the HIV and AIDS infection rates will continue increasing. Furthermore, the MSM who participated in the FGD indicated that MSM partners can even be children. This constitutes a threat to sexual abuse of children.

Linkage and Adherence to Care and Treatment

Of the two hospitals sampled, one, referred in this study as Hospital A had 1021 FSWs and the other, referred as Hospital B had 440 FSWs. Table 1 and Table 2 present the figures of FSWs enrolled, those linked to care and treatment and those active in care and treatment in the two hospitals.

Table 1. Data on FSWs in Hospital A from 2015 - August 2020

Key Population	Number Enrolled
FSWs	1021
No. Tested for HIV	1021
No. Tested Positive for HIV	135
No. Linked to Care and Treatment	100
No. Active in Care and Treatment	76

Table 2. Data on FSWs in Hospital B from 2015 - August 2020

Category	Number of FSWs
FSWs enrolled	440
Number tested for HIV	440
Number positive	48
Number linked to care	41
Number active in care and treatment	39
Number defaulted	2
Number on PrEP	47
Active clients	256

In Hospital A, the FSWs who tested positive for HIV constituted 13.22%. Those linked to care were 100, representing 74.07%, while those active in treatment and care were 76, representing 76%. In Hospital B, the FSWs who tested positive for HIV were 48 out of the enrolled 440, representing 10.9%. Those linked to treatment were 41 representing 85%, while those active in care and treatment were 39, representing 95.12%. This is an indication that the intervention measures put in place to link those who have tested positive with HIV and AIDS to care and treatment do not ensure 100% linkage. Among

other factors that could be the reason for those who tested positive for HIV defaulting on treatment is the fear of stigma that people will know, through informal communication channels, that they have contracted HIV as a consequence of engaging in sex against the confines of social norms (Baillet, 2009). Table 3 and Table 4 present data on MSM enrolled in two of the sampled hospitals.

Table 3. Data on MSM enrolled in Hospital A from 2016 - 2020

Category	Number of MSM
MSM enrolled	75
Number tested for HIV	75
Number positive	46
Number linked to care	38
Number active in care and treatment	13
Number of defaulters	25

Table 4. Data on MSM enrolled in Hospital B from 2016 - 2020

Category	Number of MSM
MSM enrolled	40
Number tested for HIV	40
Number positive	27
Number linked to care	24
Number active in care and treatment	11
Number of defaulters	9

The percentage of the MSM who tested positive for HIV in Hospital A was 61.33% while the percentage linked to care was 82%. However, those active in care and treatment were 34.21%. In Hospital B, those who tested positive for HIV constituted 67.5%. Those linked to care and treatment constituted 89%. However, those active in care and treatment were 46%. The percentage of MSM who tested positive for HIV is higher compared to that of FSWs. Further, the percentage of FSWs who were active in care and treatment was higher than that of MSM in both hospitals.

These findings are consistent with World Health Organization reports (WHO, 2017; 2018) which note a high HIV incidence rate among male sex workers and higher levels of stigma from medical personnel, the family, community and in the workplace towards MSM. Though both FSWs and MSM are subjected to stigma within the community in which this study was conducted, MSM are the recipients of much of this stigma because in the community, men are culturally not supposed to have sexual relationships with other men, and sex for money is also frowned upon. Consistent with the assumption that communication is socially consequential and people bear the consequences of breaches to the normative structures defined by a given society, MSM face the consequence of stigmatisation in the community in this study because of their sexual behaviours that are a breach to the social norms defined by the society (Baillet, 2009).

The Mode of Operation of FSWs and the Influence of EOC

To guide HIV prevention efforts, programmers define typologies within each key population based on common traits presenting distinct levels of risk and vulnerability and therefore guiding programme prevention and outreach strategies specifically and appropriately for the risks and vulnerabilities associated with each strategy (KHPT, 2012). In the two hospitals sampled, FSWs were categorised as operating from different locations. Table 5 and Table 6 indicate the locations and the number of FSWs from each location.

Table 5. Location where FSWs operate from in Hospital A

Location where FSWs Operate From	Number of FSWs
Hot spot	852
One's House	57
Streets	112
Total	1,021

Table 6. Location where FSWs operate from in Hospital B

Location where FSWs Operate From	Number of FSWs
Hot spot	322
One's House	32
Streets	86
Total	440

The choice of location of operation for the FSWs is a form of communication through which users attempt to either conform fully or partially to set communicative patterns and social norms or defy them so long as one is able to achieve individual or group outcomes (Baillet, 2009). This data implies that activities targeting FSWs should be intensified in hotspots which include bars, guest houses, sex dens, uninhabited buildings, casino, club, strip club, massage parlour/barbershop/salon, park, beach, bush (NASCOP, 2019) where the majority operate from and can be reached. Indeed, HIV services are supposed to be located in places that are convenient to the sex workers (MoH, 2010). Data obtained indicated that FSWs link healthcare staff to hotspots where more FSWs and their clients can be found. Furthermore, FSWs and MSM provide information in hotspots.

Whereas the FSWs operating from hot spots and streets can be traced easily because of their regular locations, those at home may be harder to reach because they may not always want to be known to be engaged in the sex trade. Programmes targeting them should therefore be designed to take more time to gather information about their engagement in sex trade and how to take the required commodities and services to them. Table 7 and Table 8 indicate the cases of GBV among FSWs reported in two of the sampled hospitals.

Table 7. GBV cases in Hospital A from 2017 - August 2020

Number of GBV Cases Reported	190
Number of GBV Cases Successfully Prosecuted	60

Table 8. GBV cases in Hospital B from 2018 - 2020

Number of GBV Cases Reported	190
Number of GBV Cases on Psychosocial Support	60

Response to Gender Based Violence among FSWs

Because of the criminalisation of sex work, the number of FSWs subjected to gender-based violence (GBV) is high (WHO, 2017). The respondents in the HIV programmes in the two hospitals reported that GBV among FSWs was categorised into physical, emotional, sexual and economic. The FSWs and MSM were trained on what to do after rape and they in turn trained others. They reported that once a case of GBV had been reported, the healthcare providers filled in a violence form and GBV register. Management of victims of GBV was based on the degree of violation. The FSWs who had been subjected to GBV underwent counselling. Besides, each of the two hospitals had one of the FSWs

trained on GBV and human rights in order to provide paralegal services to the other FSWs and MSM. These FSWs were also sponsored for refresher courses on paralegal training and they were evaluated. They were included in the Technical Working Group and reported to the hospital monthly. Provision of legal services to FSWs who have been subjected to GBV is in accordance to the MoH (2010) guidelines meant to ensure their human and health rights are protected.

Strategies Used to Reach FSWs

Because of higher stigma against MSM than FSWs, data obtained indicated that the outreach strategies in the two hospitals targeted FSWs more than MSM. The strategies used to reach the FSWs in the health facilities with programmes targeting them were:

1. **Mobilisation meetings**:
   These meetings were used in Hospital A. The meetings were conducted in hotels where the FSWs were given health talks on the risks of contracting HIV and AIDS as a result of the work they were doing, proper use of condoms, use of PrEP, the importance of testing for HIV and AIDS and cervical cancer. The FSWs were also taught about adherence to treatment once one had tested positive for HIV. Data obtained from the healthcare personnel in the hospital and the FSWs indicated that these mobilisation meetings were quite effective as many FSWs used to attend them. During two consecutive meetings, data indicated that 103 and 117 FSWs attended respectively. Those who attended were reported to have started using condoms effectively and regularly, they also reported using PrEP, having regular HIV and AIDS tests and being screened for cervical cancer.
2. **Moonlight testing**:
   Moonlight testing involved testing FSWs for HIV and AIDS at night. This was done to target those FSWs who do not want to go to a health facility for testing for HIV and AIDS during the day due to stigma. They would not want to be seen going for the test as people would start saying that they are positive for HIV as a consequence of their sexual behaviours which are a violation of social norms (Baillet, 2009). This strategy was being used in the two hospitals. Data obtained from the healthcare personnel and FSWs indicated that the strategy was effective as FSWs who could not go for the HIV tests during the day could do so at night. Table 9 and Table 10 show the number of FSWs tested for HIV during the moonlight tests.

Table 9. Moonlight testing in Hospital A

Month	Number Tested
September	23
October	14
November	27
December	46

Table 10. Moonlight testing in Hospital B

Month	Number Tested
September	27
October	19
November	29
December	41

3. **Peer education and outreach**:
   The respondents reported that peer education and outreach programmes involved the selection and training of peer educators among FSWs enrolled in programmes in the two hospitals. The peer educators had to be sex workers who had adhered to treatment, literate and willing to share their experiences with others. Upon selection, the peer educators were trained to modify the

knowledge, attitudes, beliefs or behaviours of their peers, through small group or one-on-one interpersonal interactions in line with the National Guidelines for HIV/STI Programs for Sex Workers (MoH, 2010).

Data indicated that in each of the two hospitals, the number of peer educators had continued increasing from previous years. In Hospital A, there were 22 peer educators while in Hospital B they were 18. The data indicated that the roles of the peer educators included organising for outreaches targeting new participants, as outlined in the National Guidelines for HIV and STI Programming with Key Populations (NASCOP, 2014); following up on positive clients who did not adhere to clinic appointments; following up negative clients and offering self-test kits for retest after 3 months of initial test; giving health talks to FSWs on PrEP; encouraging FSWs to undergo cancer screening and being on family planning; and working with the clinician to ensure that those with STI receive proper treatment.

FSW peer educators were issued with a comprehensive monthly reporting tool for client follow-up and mobilisation. The tool contained details such as the facility name, the year, the number of hotspots assigned to a peer educator, the number of hotspots visited in the month, and the number of FSWs assigned to a peer educator. In addition, the peer educators were expected to report on the number of FSWs given services at hotspots, the number of new FSWs identified, the number of those given health education, those reporting GBV, those offered risk reduction counselling, those referred to the clinic, and those who visited the clinic. The peer educators were also expected to report on the number of condoms and lubricants required, and those distributed. Finally, the peer educators also reported on the number of group sessions held, the number of participants in the session, the topics discussed in the groups and the dates the group sessions were held.

Outreach entails actively delivering information, products and services to existing or potential service users in locations where they typically spend time, rather than relying on them to come to programme sites (NASCOP, 2014). Outreach was documented as it occurred and these records were analysed to plan, monitor and assess programme implementation and performance. Outreach activities were conducted in hotspots for purposes of convenience to FSWs (NASCOP, 2014). These outreach activities were increased during seasons when tea and wheat farmers earned their annual income. During this period, FSWs migrated to look for sex partners in tea growing and wheat farming areas, thus posing a challenge in retention to treatment.

Peer educators and outreach activities were reported to be very effective in supporting the programme because peer educators knew their colleagues and due to the mutual experiences and understanding, they persuaded them to join the programme and utilise the HIV services available for them. As a result, the respondents indicated that the FSWs who were reached by peer educators gained more knowledge of HIV and AIDS, they started increasing their use of condoms during sexual encounters, and the number of FSWs accessing HIV prevention and treatment services increased. This was in line with the findings of MoH (2010) about the impact of peer education and outreach programmes.

4. **Songs**:

FSWs and the healthcare staff serving them used songs to encourage behaviour change. One of the songs sung in Swahili by the sex workers and the healthcare personnel serving them was:

Ni nani atakaye tetea kuma (Who will protect the vagina)

Ni condom itakayo tetea kuma (It is a condom that will protect the vagina)

The respondents reported that these songs helped promote openness about discussions on sex as well as encouraging sex workers to practice safe sex by using condoms. However, the plain reference to the vagina and condom are culturally inappropriate among members of the Gusii community, the major inhabitants in Kisii County. By encouraging condom use as the surest way of avoiding contracting HIV and AIDS, the song is also encouraging engaging in sex work. Though the content of the songs violates one of the assumptions of the EOC that communication is a system of rules whose appropriateness is determined by sociocultural context, the theory agrees with the fact that some members in a speech community can circumvent, challenge or revise communicative patterns (Baillet, 2009).

5. **Slogans**:
   One of the slogans used in one health facility was borrowed from religious settings. The slogan went thus:

   Health worker: Sex is good.
   Commercial sex workers (Chorus): All the time.
   Health worker: And all the time.
   Commercial sex workers (Chorus): Sex is good. That is why we are all products of sex.
   In the religious settings, the slogan went thus,
   One faithful: God is good.
   Congregation (Chorus): All the time.
   One faithful: And all the time.
   Congregation (Chorus): God is good and that is His nature.

   The respondents concurred that through the use of these slogans, FSWs were encouraged to accept their trade and fight off the stigma against sex work. The use of slogans was reported to be effective in encouraging certain behaviour changes such as mobilising commercial sex workers to accept their trade and talk proudly about it, embracing condom use during sex, having regular HIV tests, undergoing cancer screening and persuading their male partners to be tested for HIV.

   However, some of these slogans could be seen as sacrilegious among members of the local community who are religious and use similar slogans in church settings. Though, on one hand, this is inappropriate to the general population in Gusii as observed by the EOC, on the other hand the FSWs also comprising a speech community, have the freedom to create their own communicative patterns (Baillet, 2009). Further, the adoption of the slogan from religious settings (Baillet, 2009) observes that communication is strategic and conversants can and do artfully use verbal and nonverbal codes as cultural resources within which to achieve individual and group outcomes.

Biomedical and Structural Interventions

In line with the National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010), condom use was promoted among the FSWs, their correct use was demonstrated often and the condoms were distributed to FSWs freely. Through interpersonal communication, sex workers who had already enrolled in the programme persuaded other sex workers to enrol. In one hospital, bar owners were involved in sensitisation on HIV and AIDS and to persuade FSWs to be tested for HIV and be linked to treatment if they tested positive.

The FSWs were accorded special attention as they did not queue when they went to hospital for HIV services. They had a clinician assigned to attend to them. Respondents reported that these measures were effective in reaching FSWs and retaining them in the programme. However, the Faith Sector Response to HIV and AIDS in Kenya Action Plan 2015/2016-2019/2020 does not talk about FSWs and MSM or the use of condoms for protection (National AIDS Control Council [NACC], 2015). It only talks of HIV prevalence among children, adolescents and young people and adults (NACC, 2015). The avoidance of these issues is in line with the ethnography of communication on appropriateness of some topics in given sociocultural contexts (Baillet, 2009).

As spelt out in the National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010) emergency contraceptives were being given to FSWs in Kisii County to avoid unwanted pregnancies. Information was provided on the benefits and limitations of emergency contraceptives and eligibility for emergency contraceptives was determined in terms of type and time (MoH, 2010). All the respondents agreed that the use of emergency contraceptives had largely served its purpose. However, the use of these emergency contraceptives was not agreeable to the norms and values of the general population and the Faith-based organisations (Baillet, 2009) thus falling short of ensuring harmony among all stakeholders in the HIV/AIDS response.

All FSWs in the two facilities sampled received cervical cancer screening at no cost in the hospitals with programmes targeting them as is recommended by the MoH (2010) because they were at a greater risk of acquiring HPV, increasing the risk of progression to cervical cancer. In addition, the FSWs were

provided with information on causes, prevention, screening and treatment of cervical cancer. They were also taught about using Kenya's national medical cover, the National Hospital Insurance Fund (NHIF), to cater for their health needs and those of their families. These interventions were said to have worked effectively.

Some interventions, though contained in the National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010) were not in force. For instance, the guidelines stipulate that FSWs need family and social services such as food, shelter, and education. However, data obtained indicated that none of this was done in the hospitals offering HIV prevention and treatment services to FSWs in Kisii County.

Post-abortion care was not being offered for the FSWs in the two hospitals from which data was collected as outlined in the National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010). With data indicating that 23% of FSWs in Kenya had procured an abortion in their lifetime, and the majority reporting carrying them out on their own (NACC, 2009), this service is essential. However, abortion is illegal in Kenya and post-abortion care is only found in selected services (MoH, 2018). Furthermore, abortion and post-abortion care are inconsistent with the values and norms of the general population and the Faith-based organisations (Baillet, 2009).

Services Provided to FSWs and their Influence towards Behaviour Change

Baral et al. (2012) estimated that 37% of sex workers in sub-Saharan Africa are infected with HIV. This is due to a number of factors, common among them high rate of change of sexual partners, infrequent condom use, use of injectable drugs and harmful consumption of alcohol (Baral et al., 2007; Chersich et al., 2014; Bengtson et al., 2014; Mbonye et al., 2014).

In Hospital A, FSWs who participated in the focus group discussions reported a number of behaviour changes with the first being condom use. The sex workers interviewed reported that they regularly picked condoms and lubricants from the health facility and used them during sex after enrolling in the programme. NASCOP (2014) identified promotion of condoms and lubricants as information needs among female sex workers. Previously they were not using these commodities and they were therefore exposing themselves and their clients to HIV and AIDS.

The second behaviour change that the FSWs reported was having regular tests for HIV and AIDS and other sexually transmitted infections (STIs). They visited the health facility regularly for these tests. They had also been trained on using HIV and AIDS self-testing kits.

The third behaviour change that was reported among the sex workers was reduction in alcohol intake. Alcohol intake was cited as one of the barriers to HIV prevention (NASCOP, 2014).

In a 2012/2013 assessment of the HIV-related communication and information needs of three key populations, namely: FSWs, people who inject drugs (PWID), and MSM, the National AIDS and STI Control Programme (NASCOP) found that perception of self-risk was due, among other factors, to high prevalence of alcohol and drug use among female sex workers (NASCOP, 2014). All the sex workers who participated in the study reported to have reduced the amount and frequency of alcohol intake. This enabled them to make the right decisions to ensure they and their clients used condoms during sexual encounters. The programme also taught them how to negotiate for safe sex and payment with their clients.

The sex workers who took part in the study also reported that as a result of enrolling in the programme, they had reduced the number of sexual partners they had. This also reduced the frequency of their sexual encounters as well as the exposure to HIV and AIDS. In Hospital B, there was no FSW trained on alternative skills to earn a living. However, 3 FSWs were reported to have found alternative employment. The National Guidelines for HIV and STI Programs for Sex Workers (MoH, 2010) include support to expand choices beyond sex work. This includes the provision of alternative employment and livelihood opportunities including income-generating activities, financing and alternative livelihood skills training; assistance in obtaining family and social services such as school fees for children; provision of education for life including literacy classes, vocational and skills training; and comprehensive assistance for HIV positive sex workers including access to HIV care and treatment, food supplements among others (MoH, 2010). In Hospital A, data obtained indicated that some FSWs started other businesses with the intention of quitting commercial sex work while other FSWs reported starting businesses to supplement the income they got from sex work.

The last form of behaviour change reported among FSWs in Hospital A was starting their own families. Some FSWs reported that they had children whom they were now paying more attention to. This enabled them to start thinking of life after sex work. To emphasise these behaviour changes, one sex worker reported,

> *'I started with 7 partners. Now I have 3. I have taken my children to school. One has finished Form Four. I go to church and I have stopped drinking alcohol.'*

The FSWs in Hospital A also explained that they collaborated with bar hostesses and the police to rescue underage girls from sex work. They reported that whenever bar hostesses could spot a man with an underage girl in a bar or a lodge, they could report to the FSWs who could storm the bar or lodge, rescue the girl and hand over the man to the police. However, there was no support from the donors, the Ministry of Health or even the county authorities in programmes to rescue underage girls from sex work. The local community was also not involved in any clear way.

Therefore, the protection of underage girls from engaging in sex work, or rescuing those who have already started engaging in sex work is not coordinated, consistent and sustainable. Yet, estimates show that 52% of women in Kenya who sell sex in hot spots frequented by adult sex workers are below the age of 24 years (NASCOP, 2017). NASCOP (2014) in its findings on an assessment of the HIV-related communication and information needs of key populations outlined facilitators for HIV prevention as having dependents and an alternative source of income.

Among MSM, data collected from Hospital A indicated that behaviour change included stopping or reducing drug abuse, using condoms and being economically empowered. One MSM who participated in the FGD indicated that,

> *'I started MSM in high school. I thought it was fun. After school, I started doing it for commercial purposes.'*

Conclusions

HIV and AIDS interventions targeting FSWs and MSM in Kisii County put great emphasis on correct and consistent use of condoms during sexual encounters, use of lubricants, PrEP, being screened for cervical cancer, being tested for HIV and AIDS regularly and putting in place measures to address the problem of GBV. Those infected with HIV and AIDS are put on treatment and adequate measures are put in place to ensure they adhere to treatment and management. All the intervention measures have been brought closer to the FSWs and MSM to ensure that many are reached. According to the data collected, all these measures were fruitful in reaching FSWs and MSM with the required services.

However, these measures are ineffective in several ways. First, they are ineffective in bringing down the number of FSWs and MSM in the county. The number of FSWs is rising rapidly in the county and this increases vulnerability to HIV infections. Secondly, the measures cannot effectively address the challenge of stigma against FSWs and MSM when these sexual practices are inconsistent with the values and norms of the general population. The existence of such stigma, always evident in the communication practices of FSWs, MSM and the general population, is consistent with the arguments of the ethnography of communication.

Furthermore, harmony among all stakeholders in interventions targeting FSWs and MSM against HIV and AIDS will not be achieved because of the differences in values and norms. Therefore, the messages communicated by different stakeholders on this subject will vary. The messages of the donors, programme implementers, FSWs and MSM will not be consistent with those of the general population and Faith-based organisations in the local community. With such contradictions and tensions among different stakeholders in the interventions against HIV and AIDS, long-term and appropriate behaviour change that will bring down the rates of HIV infections and promote adherence to treatment and care will not be achieved.

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