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Safety And Health Risks Facing Female Sex Workers In Mombasa And Nairobi

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Abstract: ***Commercial sex work has been and still is illegal in most countries, especially in Africa. As such, the sex workers do not openly report the safety and health issues they face for fear of being victimized by the respective agencies of the state. Failure to report these issues and hence handle them while still at their nascence stage may result into bigger problems in society. This research sought to understand the safety and health risks that the commercial sex workers face in the course of their trade. Due to the nature of their 'business', the researcher used snowballing techniques of sampling. The principal data collection instrument was the semi structured questionnaire supplemented by an interview guide and focus group discussion. The results indicate that there are no marked differences between the hazards that the sex workers are exposed to in the two towns. Little differences however exist in the sexual orientation with more respondents in Nairobi being straight, while Mombasa has more bisexual sex workers. The findings also show that violence against sex workers is rampant in both towns. The study concludes that the sex industry is based on exploitation, abuse and enslavement of young women, leading to a rise in STI/HIV prevalence.***

Keywords: Mombasa, Nairobi, Occupational Safety and Health, Sex work, risk

I. INTRODUCTION

Most women enter the sex industry involuntarily (Omondi, 2003; Langen, 2005). This is because of many socio-economic factors that lead them into choosing sex as a way of earning income (Ndung'u, 2016; Béné & Merten, 2008; Hesketh & Min, 2012; Li, 2007). Some are forced into it either because of abandonment or violence by husbands, or other family problems (Malarek, 2011; Ratcliff & Bogdan, 1988). This makes them vulnerable and easily exposed to risks such as having sex without protection (Gertler, Shah, & Bertozzi, 2005; Goldenberg, Duff, & Krusi, 2015).

Sex work occurs within the context of structural inequality (Deaux, 1985; Martin, 2017) and gender imbalance where one gender takes advantage of the other (Parker & Aggleton, 2003; Sokoloff & Dupont, 2005; Andersen, 2005; Kaur, 2013). This inequality is manifested through advertisements and other platforms that link men with action, power, and ownership, while women are represented as passive, available and as objects to be owned (Omondi, 2003; Kabeer, 2005).

Female sex workers are exposed to many risks in varying degrees depending on where they work from and how they obtain their clients, as well as their economic status and level of education (Ritcher, 2013), and the economic burden is thus disproportionately high among this population (Baral et al., 2014). Those in the Sub-Saharan region are at a greater risk due to limited options because of high poverty levels (Luke, 2008). It has been documented that those who work from the

streets are exposed to more risks compared to those within brothels (Ritcher, 2013; Goldenberg et al., 2015).

The balance between entry into and exit from the commercial sex work depends on socioeconomic factors which encourage the growth and maintenance of the sex industry in many countries (Women's Refugee Commission, 2009). Financial handicap, divorce or separation from husband, unemployment and peer influence are some of the Socio-economic factors that maintain the sex industry, especially in the Sub-Saharan Africa (Akinnawo, 2016).

The concept of Occupational Safety and Health in the sex industry is still relatively new. This concept has until recently been a victim of moral discourses that ignore, devalue, or condemn commercial sex workers or attempt to control health for the benefit of the client rather than the sex worker (Ross, Crisp, Mansson, & Hawkes, 2011). The main aim of this study was to find out the hazards and hence the risks that female sex workers are exposed to in Mombasa, being the main tourist city in Kenya and Nairobi as the Capital city.

To be succeed in keeping the sex workers safe, reducing the rate of entry into the sex industry and eventually getting those already in the industry to leave and start a new life, concerted effort is required to device effective interventions that will reduce the exposure to risks and subsequently reduce the prevalence of STIs among the commercial sex workers and by extension, the general population. This will include involving sex workers as well (Moret, 2014).

II. METHODOLOGY

The study used cross-sectional research design, which was taken to ascertain and describe the exposure risks of the Female Sex Workers in areas of the study. A cross-sectional study examines the relationship between a state of affairs and other variables of interest as they exist in a defined population at a single point in time or over a short period of time (Olsen, Marie, & George, 2004). This is particularly suitable for estimating the prevalence of a behaviour or disease in a population (Sedgwick, 2014). Using this approach, sex workers were engaged to provide vital information on their work. This information was key in identifying and classifying the various risks that they face. Focused group discussions and questionnaires were used to establish the different mechanisms through which the sex workers are exposed to health and safety risks. The participants in the study were all above 18 years of age. This was deliberate to ensure the results obtained are reliable and not influenced by coercion or any form of intimidation because one being underage.

III. MAJOR FINDINGS OF THE STUDY

The researcher sought to establish factors that influence the prevalence of sexually-related injuries.

A. SEXUAL ORIENTATION

From the finding, 57% of those reached reported their sexual orientation as 'straight', while 43% were 'bisexual'. Nairobi reported a higher percentage of 'straight' sex workers at 69% compared with Mombasa which had a higher percentage of bisexual sex workers at 76%. Even with these percentages, it needs to be clarified that majority of these sex workers say these are not their natural sexual orientation, but they simply align themselves to any sexual orientation for convenience and to meet the demand of the time.

The significance of these statistics was to identify the risks that each group faces based on their sexual orientation based on studies done by Marceau et al., (2015) and Asamoah (2015) reporting rape cases among same sex at 6.5% compared to the straight woman at 1.2% in 6 months. Conron, Mimiaga, & Landers (2008) reiterates that while gay/lesbian/homosexual adults evidenced poorer health and greater risk than straight/heterosexuals across several health domains, poorer health was observed most often for bisexuals. As MAP (2016) explains, this may be because bisexual people face discrimination from within the LGBT community as well as from non-LGBT people.

B. DURATION IN THE SEX INDUSTRY

The study aimed at establishing whether there is a relationship between the duration one is in the sex work and the exposure to sex hazards and risks. From the responses, 1.5% of the respondents had been in the sex industry since 2008, 0.5% indicated 2009, 0.5% indicated 2011, 1.5% indicated 2012, 10% indicated 2013, 22.5% indicated 2014, 34.5% indicated 2015 and 29% indicated 2016. This shows that majority of the participants have been in the trade for less than 3 years, with the oldest having been in the sex industry for 8 years.

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.963[a]	7	.140
Likelihood Ratio	11.856	7	.105
Linear-by-Linear Association	4.759	1	.029
N of Valid Cases	200		

a. 8 cells (50.0%) have expected count less than 5. The minimum expected count is .50.

Table 1

There was no significant difference between Nairobi and Mombasa regarding the duration of the participants in the trade, as shown in table below:

The findings show that there is a direct relationship between the duration in the sex trade and exposure to health risks associated with sex. For instance, it was observed that people who have been in the trade for more than five years have at some point in their lives faced physical violence, contracted an STD and in some cases, some have had a baby with a client by accident. The table below shows the chi-square test done to establish the relationship between the duration in the sex industry and the use of alcohol as a drug, findings corroborated by Parcesepe et al., (2017) and Prakash et al., (2016).

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	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	33.876[a]	21	.037
Likelihood Ratio	27.531	21	.154
Linear-by-Linear Association	.000	1	.990
N of Valid Cases	200		

a. 22 cells (68.8%) have expected count less than 5. The minimum expected count is .07.

Table 2

This was also confirmed from the focus group discussions.

It should also be noted that exposure to safety and health risks is a factor of many other elements including the level of education. For instance, those who have a higher education seem to know and understand the risks involved in the trade and therefore generally take precautions to stay safer. On the other hand, the participants pointed out during the focus group discussion that they have colleagues who have never gone to school or some have low levels of education, and they have fallen victims in most cases. This is because most of them drop out of school because of lack of fees. They are therefore in the sex business purely as the only means of earning an income. For this reason, majority of them expose themselves to several risks including having unprotected sex in the guise of earning more money. Another aspect to be considered is the duration in the sex industry. The longer one stays in the trade the more exposed to hazards she is. This is true for most of the time. However, those who stay in the trade past a certain level become experienced and therefore can easily identify the frequent hazards and have therefore devised way of coping with certain hazards at work. They also become better negotiators both in terms of safe sex but also for higher rates (Gordon & Charnock, 1991). This was observed across all education levels.

During the focus group discussions, respondents were asked to indicate some of the risks they face where they indicated rape by clients, pimps, police harassment asking for money or sex. They also indicated that when they seek medical help medical staff don't understand them and keep asking them 'silly questions' just to humiliate them, and at times end up not attending to them. They also indicated that pimps drain them dry, ask for too much money and sometimes they demand to have sex for free.

The respondents indicated that some clients are abusive, attempt new styles that are torturous and painful, some have psychotic tendencies that freak them out during sex. Some narrated that at one point a client ran way with their clothes. Other frequent complaints included failure for the clients to pay their dues, bad breath from clients, infections through inhalation e.g. flu, risk of fights and other encounters with the partners of the clients if they are caught in their house and emotional attachment by clients to the workers which makes them obsessed and even violent if they find these girls with other men.

Another factor noted in the findings was unsafe working conditions for the sex workers. This was found to increase the chances of contracting HIV/AIDS and STIs and had a mean of 4.62 with a standard deviation of 0.546. As CPHA (2014) "sex work is often characterized by a power relationship between the buyer and the seller". Several studies on sex work have shown that the lifetime prevalence of physical or sexual violence, either in the workplace or outside of it, ranged from 45% to 75% for sex workers (Deering et al., 2014; Ellsberg & Heise, 2013). The criminalization and policing of outdoor sex work has also proven to be detrimental to the safety of sex workers, as encounters with clients may become rushed, take place in isolated areas, and often limits any control the sex worker may have over the situation (CPHA, 2014a). Sex workers working in such conditions may forgo condom use in order to obtain higher payment or to avoid violence, thus increasing the chances of infections.

Similar reasons were attributed to their inability to negotiate for consistency for condom use. This leaves them at risk of getting HIV/AIDS and STIs and had a mean of 4.68 with a standard deviation of 0.530. Some of the studies that corroborate this finding are Ngure et al., (2012), Callegari et al., (2008), Martin et al., (1999), and Laga, et al., (2001). In addition, because of high levels of poverty among the population, sometimes the risk of AIDS-related illness later on may seem less important than the immediate need for money, leading some people to sell sex in in ways that leave them vulnerable and susceptible to injuries and sexually-related diseases. These are similar findings from the study done by (Peters, 2015). The economic situation in most cases dictate their safety and exposure to sex and other hazards.

Furthermore, it was found that there are frequent fights among sex workers who compete for clients. These fights increase the probability of contracting STIs among other hazards. This makes them vulnerable to rape by clients and at times by the pimps themselves.

IV. COPING MECHANISMS

During the focus group discussion, the respondents also discussed ways they use to cope with some of the challenges they face during their work in relation to health and safety hazards. Most of them indicated that they have only one client for a weekend. some have adopted this as a mechanism for limiting the risk of exposure to HIV and other risks that come with the involvement in the trade. This is especially the case with sex workers in Mombasa. Their strategy is to get a client, who is willing to hang out with them for a whole weekend, and their pay is much better, and the risks are lower.

They also indicated that they attend classes once in a month. Most of those who took part in the focus group discussion have done at least one foreign language. Majority of them prefer studying Italian. This gives them an edge over their counterparts especially during peak season of tourism in Mombasa. The respondents also indicated that they consult with doctors at Ganjoni medical clinic. Doctors in the clinic have established some rapport with the sex workers and created a sense of trust. So the workers are more open to them and they are advised accordingly. They are issued with a clinic card which is marked every time they visit the facility and they are attended to.

The respondents further indicated that they have friends that keep in touch with them. This helps them to forget about

the issues of the trade. They have formed a group of sex workers (a network) that they use to educate themselves. They also invite a nurse to talk to them on regular basis to ensure they are safe. They pay pimps/managers/security guards at the hotel/bar/club to provide them with protection. Their plan is usually to identify a few city *askaris* (senior in rank) to ensure even if they are arrested, they will be released immediately. They also pay a retainer fee to the places where they operate to ensure the hotel management looks after them. Sometimes they might go for a month without paying, but due to the trust they have built with the facility owners, they can go on using the facility and pay later.

The respondents indicated that they negotiate with the client for safe sex even before they take their money. This is to manage their expectations. There will be less resistance this way. They also send some of their colleagues to other joints to see if there is anything new in terms of pricing, trends in customer choices among other emerging issues in the trade. others have create a security code such that if one senses danger, she can easily and quickly let the security team know. This includes a particular orgasmic scream that will make the client feel she is enjoying sex, only to see the security personnel storm into the room. Young girls make friends with the older ones who tell them safe joints, areas to avoid, what to do with men when you sense danger, who to talk to if you are arrested, which hospitals/ clinics to go for checkups and general protection. The young girls in turn show them respect, at times look for clients for them (share clients) to ensure they don't go home empty handed.

The interviewees also gave history of living in non-formal settlements, including slums. The reason for this was that the rent in such houses was less than in formal housing units. They are also able to blend into the crowds without raising suspicions as to the nature of the work that they do unlike in formal settlements. Here the sex workers go to places frequented by potential clients in the hope that they will attract one.

The interviewees also indicated that they use contraceptives. The high prevalence of contraception use was due to fear of having an unplanned pregnancy, which would result in strain on the home economy. The male condom was the most commonly used method followed by injectable hormonal contraception. One interesting observation made was that while the sex workers in Nairobi used condoms to protect themselves from contracting diseases, those in Mombasa did the same but to prevent unplanned pregnancies.

V. CONCLUSION

The study concludes that the sex industry is often based on exploitation, abuse and enslavement of young women. Sex workers interact with security officers, owners of sex establishments, managers, clients, intimate partners and law enforcement authorities, all of whom often have control over sex workers daily lives. They usually exert control by dictating the amount of money a sex worker will charge a client for services such that their share is included in the rates; determine the number of clients that sex workers can have in a shift; and in some cases even determine whether a sex worker can or cannot insist on condom use. These third-party players also exert their control through obvious means such as threat of or actual sexual and physical violence, physical isolation and threat of handing sex worker over to legal authorities, and forced drug and alcohol use.

Knowledge about STI/HIV and their transmission was poor. The prevalence of HIV was still relatively low compared to other towns such as Homa Bay with 37% HIV prevalence, but given the high prevalence of STDs and the fact that STD may facilitate the sexual transmission of HIV, the potential for the further spread of HIV is clearly present.

VI. RECOMMENDATION

The results obtained from the study indicate that violence against female sex workers was rampant. Sex workers are prone to violence by their clients as well as members of the public. This includes cases where sex workers are jeered and belittled, at times they are directly physically attacked. The study recommends that commercial sex workers should be educated on how to avoid and protect themselves from violence, followed by public enlightenment to reduce the perpetration of violence to sex workers. Just as observed by Fawole & Dagunduro (2014), Yadav et al. (2013) and Atteraya, Kimm, & Song, (2014), initiatives which address parental care or supervision to avoid child sexual abuse, law enforcement training on dealing with sex workers, and societal norms towards women in general will be crucial to stemming violence against female sex workers.

It is necessary to address the social and economic challenges that encourage sex work by providing education on sexual and reproductive health. This should aim at discouraging prostitution, encouraging values clarification and inculcating conflict resolution skills. Parents need to take the leading role in providing an example to the children and guide them in virtue and truth. As Cannold (2003) points out, the first responsibility of a parent is to the child.

During the focus group discussion as well as the filled questionnaires, it was noted that the sex workers sometimes fail to use condoms because of pressure from their clients. In other cases, they find themselves using them wrongly hence reducing their effectiveness. Similar to a study done Mondal et al., (2008), this study therefore recommends that special training for commercial sex workers is needed so that they learn to use female condoms appropriately; this along with sex education, knowledge about healthy sexual behaviour, and instruction about correct use of male condoms would substantially reduce the risk of health complications and greatly reduce the spread of STIs. Local organizations involved in sex education can play a critical role to this end.

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