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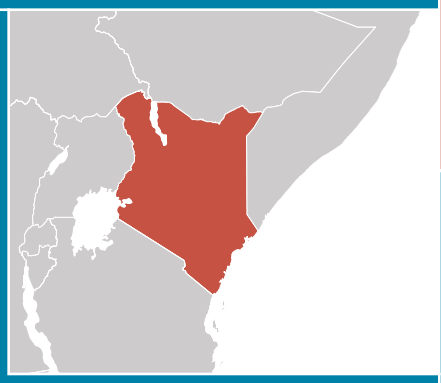
September 2015

IMPACT OF STIGMA ON UTILIZATION OF HEALTH SERVICES AMONG SEX WORKERS IN KENYA



This publication was prepared by Laura Nyblade, David Kuria Mbote, Catherine Barker, Javier Morla, Daniel Mwai, Tom Oneko, Melissa Stockton, Arin Dutta, Caroline Kemunto, Joshua Kimani, Helgar Musyoki, John Mathenge, Peninah Mwangi, Stella Njugana, Thomas Odhiambo, and Martin Sirengo.

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Impact of Stigma on Utilization of Health Services among Sex Workers in Kenya

SEPTEMBER 2015

This publication was prepared by Laura Nyblade,[1] David Kuria Mbote,[2] Catherine Barker,[2] Javier Morla,[1] Daniel Mwai,[2] Tom Oneko,[2] Melissa Stockton,[1] Arin Dutta,[2] Caroline Kemunto,[3] Joshua Kimani,[4] Helgar Musyoki,[5] John Mathenge,[6] Peninah Mwangi,[7] Stella Njugana,[8] Thomas Odhiambo,[9] and Martin Sirengo.[5]

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
FSW	Female Sex Worker
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
HPP	Health Policy Project
HTC	HIV Testing and Counseling
KNCHR	Kenya National Commission on Human Rights
KSh	Kenya Shilling
MOH	Ministry of Health
MSM	Men Who Have Sex With Men
MSW	Male Sex Worker
NACC	National AIDS Control Council
NASCOP	National AIDS & STI Control Programme
OR	Odds Ratio
PLHIV	People Living with HIV
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
RDS	Respondent-Driven Sampling
S&D	Stigma and Discrimination
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS

EXECUTIVE SUMMARY

Stigma is a recognized barrier to accessing HIV services and may have an impact on health outcomes (sustained treatment access, adherence, and viral suppression) for people living with HIV (PLHIV). There is also increased recognition that stigma and discrimination are barriers to controlling the HIV epidemic among key populations most affected by HIV. However, little is known about the experience of stigma among male and female sex workers and how it relates to the utilization of health services. In response, the USAID- and PEPFAR-funded Health Policy Project collaborated with four local civil society organizations—the National AIDS & STI Control Programme (NASCOP), the Kenya Medical Research Institute, and the University of Nairobi—to conduct a cross-sectional study to quantitatively measure four types of HIV-related stigma faced by sex workers and examine these in relation to use of health and HIV services. Questionnaires were delivered by trained data collectors through face-to-face interviews. Specifically, the study sought to answer the following questions:

- What is the prevalence of anticipated, experienced, witnessed, and internalized sex worker stigma among male and female sex workers in Busia, Homa Bay, Kitui, and Nairobi counties?
- What is the prevalence of HIV-stigma among male and female sex workers in the Busia, Homa Bay, Kitui, and Nairobi counties?
- What is the association between the different forms of stigma and sex workers' use of health services?

Below are the highlights of responses obtained from 497 female sex workers (FSWs) and 232 male sex workers (MSWs) who participated in the study.

Summary of Findings

Prevalence of stigma

The study measured the prevalence of four types of stigma (see Box 1). Researchers found that the prevalence of different types of stigma and the frequency with which it is happening is high. Nearly all respondents anticipated (93%, MSWs; 81%, FSWs), witnessed/heard (96%, MSWs; 99%, FSWs), or experienced (95%, MSWs; 97%, FSWs) at least one manifestation of stigma in the 12 months preceding the interview.

Box 1. Defining Stigma

Type of stigma	Definition
Anticipated	Fear or expectation that one will experience stigma and discrimination from others in the future
Witnessed/Heard	Heard stories or witnessed events of how stigmatized individuals have been mistreated
Experienced	Experienced or enacted stigma through interpersonal acts of discrimination
Internalized	Individuals take on (internalize) the stigma they experience or perceive around them and accept it as true and just

Anticipated stigma: Prevalence of anticipated manifestations of stigma ranged from a low of 59 percent (housing discrimination) to a high of 75 percent (exclusion) for FSWs and from 57 percent (rape) to 89 percent (verbal abuse) for MSWs in the 12 months preceding the study. MSWs and FSWs anticipated less stigma from health providers (50% each) than from other sources, such as family (73% for FSWs; 85% for MSWs).

Witnessed/heard stigma: Sex workers reported higher levels of witnessed/heard stigma than any other form of stigma. For instance, almost all sex

workers (93%, MSWs; 95%, FSWs) witnessed or heard about a sex worker being verbally abused by others in the last 12 months preceding the interview.

Experienced stigma: Reported experiences of specific manifestations of stigma in the 12 months preceding the study ranged from a low of 33 percent (disowned by family) to a high of 87 percent (gossip) for FSWs and from 11 percent (disowned by family) to 72 percent (gossip) for MSWs. At least half of MSWs and FSWs had experienced stigma from health providers, the general community, and police. More than half of FSWs and a quarter of MSWs had experienced stigma from family.

Internalized stigma: The majority of males (98%) and females (86%) reported agreeing with at least one of six items that measures internalized stigma.

Healthcare seeking behavior and associations with stigma

Approximately 81 percent of males and 72 percent of females had either avoided or delayed health services when they needed them in the 12 months preceding the study. Of those who either avoided or delayed seeking health services, 70 percent of men and 48 percent of females avoided seeking services for sexually transmitted diseases, sexual and reproductive health, or HIV.

Stigma was associated with participants' avoiding and delaying seeking health services in the 12 months preceding the study. When controlling for multiple factors in logistical regression analyses, this study found a consistent pattern across manifestations and sources of stigma for FSWs. FSWs had significantly higher odds of avoiding or delaying services if they had anticipated, witnessed, or experienced stigma. For MSWs, the results were less consistently significant across manifestations and sources of stigma, but they still suggest a significant association between some manifestations and sources of stigma and avoiding or delaying seeking health services.

For both FSWs and MSWs, experiencing stigma from health providers in the 12 months before the study was significantly related to both the avoidance and delay of seeking needed health services. We estimated odds ratios (ORs)—a measure of association between an exposure and an outcome—through logistical regression analysis. FSWs who experienced health provider stigma were 1.56 (p=.06) more likely to avoid and 1.59 (p=.05) more likely to delay needed health services compared to FSWs who had not experienced it. MSWs who experienced health provider stigma in the 12 months preceding the interview were more than two times as likely to avoid (OR 2.11, p=.03) or delay (OR 2.68, p=.01) needed health services than MSWs who had not. For FSWs, anticipating healthcare stigma had a stronger effect on avoidance (OR 2.25, p=.001) than experienced stigma. This suggests that it may not be necessary to experience stigma to avoid seeking healthcare, but that simply the anticipation of stigma can influence behavior.

These data clearly show that anticipating or experiencing stigma outside the health facility (from family, community, or police) can negatively impact health-seeking behavior. For example, FSWs and MSWs who had experienced stigma from the general community were significantly more likely to delay needed health services. For FSWs, anticipating, witnessing, and experiencing stigma from the police in the 12 months preceding the interview all had significant relationships to both the avoidance and delay of needed health services. For MSWs, both anticipating and witnessing/hearing stigma from the police were significantly related to delay or avoidance.

HIV status and HIV-related stigma

More than one-fifth of respondents (25%, MSWs; 23%, FSWs) self-reported that they were living with HIV. The research team measured how respondents perceive stigma toward PLHIV. Large majorities of both males and females agreed that PLHIV face rejection from their peers (71%, MSWs; 67%, FSWs) and people who are suspected of having HIV lose respect in the community (62%, MSWs; 60%, FSWs).

Among the study respondents, stigma toward PLHIV was relatively low. However, significant minorities of both females (28%) and males (29%) thought that sex workers living with HIV should not be allowed to sell sex. About half of MSWs agreed that most PLHIV have had many sexual partners (46%), and that people who get infected with HIV engage in irresponsible behaviors (48%). Half of FSWs and MSWs reported anticipated HIV-related stigma, reporting they had feared in the 12 months preceding the interview that people would assume they were HIV positive because they were sex workers. For both FSWs and MSWs, holding anticipated HIV-related stigma was significantly associated with delaying or avoiding needed health services.

Other important findings

The study team asked respondents whether others know that they sell sex or have sex with men (men only). MSWs were generally less likely to have disclosed their status as sex workers than FSWs were. Male respondents were also more likely to disclose to others that they have sex with men than that they sell sex.

Sex workers report high levels of social capital and resistance to stigma. For example, the majority of MSWs and FSWs interviewed said they can count on help from other sex workers in dealing with a violent or difficult client, borrowing money, and helping with other issues.

Eighty-nine percent of MSWs and 92 percent of FSWs reported experiencing at least one symptom of depression in the two weeks preceding the survey. Of those who experienced any of the symptoms of depression, the majority of males (64%) and females (74%) found these problems made it difficult to work, take care of things at home, or get along with others.

Key Conclusions and Discussions

To inform the development of interventions that may reduce stigma, it is important to understand the ways in which key populations are stigmatized (manifestations of stigma), as well as who is doing the stigmatizing (sources of stigma). Male and female sex workers in Kenya face high levels of stigma. Anticipating, witnessing/hearing, and experiencing stigma is associated with an increased likelihood of avoiding or delaying seeking needed health services. The results of the study show that sex workers face stigma within and outside of the healthcare system. As a result, HPP recommends the following:

Recommendations for health services

1. Provide participatory stigma and discrimination (S&D)-reduction sensitization training for all health facility staff (medical and nonmedical).
2. Revise the Kenya National Patients' Rights Charter to include provisions that address stigma and discrimination, especially for vulnerable and marginalized groups.
3. Develop, staff, and maintain facility-level systems for complaints, compliments, and redress.
4. Institute and enforce strict confidentiality policies around sex work, men who have sex with men (MSM), and HIV status at the facility level.

Recommendations for police services

1. Promote collaboration between the Ministry of Health (MOH) and the National Police Service to update the Police Service Standing Orders with provisions on S&D sensitivity indicators for vulnerable and marginalized groups.
2. Implement stigma-reduction sensitization training for the police.

Recommendations on structural reforms

1. Reform laws and policies at both the national and county levels to recognize human rights in the design, implementation, monitoring, and evaluation of key population health-related policies and programs and to mitigate S&D-related issues that affect key population healthcare utilization.
2. Promote and advocate legal reforms beyond the HIV and AIDS Prevention and Control Act, 2006, which provides the legal basis to address HIV-related discrimination and access to justice through the establishment of the Equity (HIV&AIDS) Tribunal.
3. Provide a supportive environment for peer support groups, as these are a critical component of health-seeking behavior for sex workers.

Recommendations for further research

1. Collect data on stigma from those perpetrating stigma, in particular health workers and police, to further inform S&D-reduction programs among these groups.
2. Develop, pilot, and evaluate S&D reduction programs, building implementation science around these programs to study how to overcome the challenges caused by cultural and social aspects in the Kenyan context.
3. Conduct research to better understand the reasons for inadequate implementation of guidelines and policies specific to key populations at the facility level and how to strengthen healthcare workers' utilization of guidelines and policies specific to key populations and the implementation of programs targeting key populations.
4. Support additional research to understand and establish mechanisms that create a supportive environment for key populations to access health services and strengthen the linkage to care for key populations living with HIV.

CHAPTER 1: INTRODUCTION

HIV Epidemic and Response in Kenya

Kenya has made significant gains in HIV programming targeting the general population, contributing to the decline in HIV prevalence from 10.5 percent at the peak of the epidemic in 1995–1996 to 5.6 percent in 2012.[1] However, while prevalence had declined, an estimated 106,000 people became newly infected in 2012, indicating the need for the continued scale-up of comprehensive HIV-related prevention, treatment, care, and support services in the country.[2]

Interventions for key populations, such as sex workers, MSM, and people who inject drugs (PWID), are lagging in Kenya.[3] This is against a background of epidemiological and behavioral studies, which continue to show the disproportionate risks of HIV infection among these groups. Key populations account for 33.1 percent of all new HIV infections in Kenya, but represent less than 2 percent of the total national population.[4, 5] HIV prevalence among these groups stands at 18.3 percent for PWID,[6] 18.2 percent for MSM,[6] and 29.3 percent for migrant FSWs.[7, 2]

Many factors lead to increased risk of HIV infection among these groups. High levels of poverty and criminalization of behaviors associated with key populations impact their ability to access targeted and responsive health services.[8, 9]

Stigma and discrimination[1] are also large impediments to HIV service provision and access. According to the Kenya HIV stigma index report of 2014, HIV-related S&D levels are still very high in Kenya, with a score of 45.16 on a composite discrimination index, reflected in the high percent (70%) of people living with HIV (PLHIV) who express fear and concern about disclosing their status.[10]

Kenya has national policies that support stigma reduction and equitable access to care. The *Kenya AIDS Strategic Framework 2014–2019* envisions a Kenya free of HIV infections, stigma, and AIDS-related deaths. One of its four main objectives is to significantly reduce HIV-related S&D.[11] Specifically, the framework hopes to achieve the following results by the year 2019: to reduce self-reported S&D related to HIV and AIDS by 50 percent; reduce levels of sexual and gender-based violence by 50 percent; increase protection of human rights; and improve access to justice and reduce social exclusion for PLHIV, key populations, and other priority groups including women, boys, and girls by 50 percent.[11] Additionally, the Kenya's 2010 Constitution guarantees the right to the highest attainable standard of healthcare as stipulated in Article 43(1), meaning everyone should have access to high-quality, comprehensive, and equitable healthcare.[12]

Significance of Studying Stigma and Discrimination

The negative impact of HIV-related S&D on individuals, communities, and the HIV response is well established. The impacts of S&D inhibit a person's quality of life and right to dignity, and are major barriers to HIV prevention,[13-15] diagnosis,[16] and treatment.[17, 18] As such, HIV-related S&D adversely affects health outcomes, by impeding utilization of HIV testing and counseling (HTC),[18, 16] linkage to care,[17] adherence to treatment,[18] prevention of mother to child transmission (PMTCT),[19, 15] and disclosure of status to partners and health providers.[13, 14] Significant progress has been made over the past two decades in understanding and measuring HIV-related S&D, and in developing programmatic tools and

[1] We use the terms stigma and stigma and discrimination interchangeably throughout the report as we define stigma as a social process with multiple steps that ends in discrimination. We therefore see discrimination as part of (the end point of) the process of stigma.

intervention responses to reduce HIV S&D.[13, 20] Conversely, understanding, measuring, and responding programmatically to key population S&D, the intersection of this form of S&D with HIV stigma, and the role of such S&D in the HIV epidemic have received less attention.

The importance of addressing S&D experienced by key populations and the intersection of this form of S&D with HIV stigma is underscored by HIV prevalence among key populations. Globally, people who are socially marginalized or criminalized carry a higher burden of HIV than the general population. MSM are 19 times more likely to be living with HIV than the general population and HIV prevalence among FSWs is 13.5 times greater than among all women ages 15–49 years.[21, 22] As of 2011, 29.3 percent of all Kenyan FSWs were living with HIV, and HIV prevalence among Kenyan MSM was 18.2 percent.[23] While less information is available on national HIV prevalence among Kenyan MSWs, a 2012 study conducted in Nairobi found baseline HIV prevalence among MSWs to be 40 percent.[24]

Furthermore, the *Gap Report* by the United Nation's Joint Programme on HIV/AIDS included HIV prevalence among MSWs ranging from 13 to 50 percent in three other sub-Saharan African countries.[25] In most African countries, both sex work and same-sex sexual behavior are criminalized; in Kenya, sections 153–156 and 162–165 of the Kenya Penal Code criminalize these two behaviors.[26] In areas where legislation criminalizes prostitution and homosexual activity, sex workers face increased rates of HIV, sexually transmitted infections (STIs), and violence.[27-29] In Kenya, female and male sex workers were also found to be particularly vulnerable to HIV, STIs, police brutality, and sexual and physical violence.[30-33]

In Sub-Saharan Africa, sex workers are not accessing or fully utilizing healthcare services.[25] Furthermore, delivery strategies for existing interventions vary widely, making it difficult to bring such programs to scale.[34, 35] In Kenya, there is a need for proper HIV and STI diagnosis, treatment, and follow up for sex workers.[36] Condom use is low among MSWs[37, 24] and inconsistent among FSWs.[38] Further, FSWs face a high unmet need for contraception.[38] Additionally, a recent study on pre-exposure prophylaxis (PrEP) for FSWs in Kenya found that increased access to PrEP could drastically lower HIV transmission rates.[39] Other studies have highlighted the need for improved access to treatment for violence-related injuries.[32, 27, 36]

There is growing recognition of the importance of reducing key population S&D as a central programmatic response to addressing the HIV epidemic. This is clearly articulated in the World Health Organization's recent *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*[40] and by the new 2030 global target of a 90 percent reduction in S&D faced by PLHIV, vulnerable populations, and key populations. However, a significant gap exists in evidence needed to support programming to reach these target groups effectively.[25] This exploratory study among male and female sex workers in four sites in Kenya seeks to help fill this gap.

Study Objectives

Building both on the strong body of HIV S&D research[13, 41, 20] and nascent work on key population S&D,[21, 22] this study sought to examine the prevalence of stigma and the relationship between different types of stigma (anticipated, witnessed/heard, experienced, and internalized) and seeking health services among female and male sex workers in Kenya. The study contributes to filling a gap in knowledge about the stigma experienced by male and female sex workers and its relationship to the utilization of health services in Kenya, and globally. Stigma is a recognized barrier for accessing health services among PLHIV and there is increasing recognition that stigma is also a barrier for key populations. However, little is known about the experience of stigma among male and female sex workers and how it relates to utilization of health services.

In addition, the issue of HIV stigma within marginalized populations and how that affects HIV testing, disclosure, linkages to HIV care, and treatment adherence by key populations is largely understudied. As different types of stigma are likely to impede male and female sex workers' health-seeking behavior and access to health services to different degrees, this study sought to answer the following questions related to different types of stigma in Kenya:

1. What is the prevalence of anticipated, experienced, witnessed, and internalized sex worker stigma among male and female sex workers in the Busia, Homa Bay, Kitui, and Nairobi counties?
2. What is the prevalence of HIV-related stigma among male and female sex workers in the Busia, Homa Bay, Kitui, and Nairobi counties?
3. What is the association between the different types of stigma and sex workers' utilization of health services?

The study results aim to inform the implementation of Kenya's national HIV/AIDS strategic framework, the *Kenya AIDS Strategic Framework 2014–2019*, and support advocacy efforts for HIV interventions for key populations at both national and county levels of government.

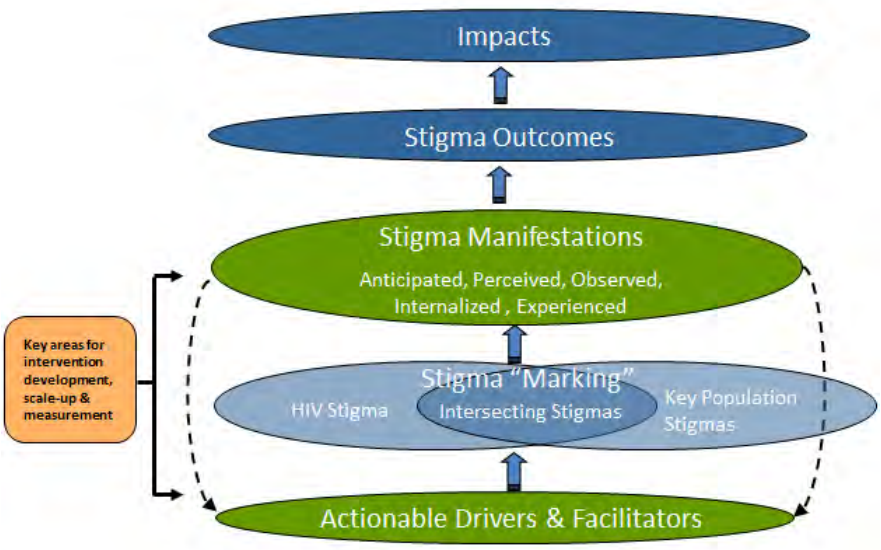
Definitions of Stigma and Discrimination

Stigma and discrimination

Stigma is a complex social process that leads to the social and economic exclusion of individuals or groups and impedes access to health and other services, ultimately fueling the HIV epidemic. Irving Goffman's seminal 1963 study on stigma related to mental illness, physical deformities, and perceived socially "deviant" behaviors describes stigma as "an attribute that is deeply discrediting" and results in the reduction of a person "from a whole and usual person to a tainted, discounted one."[42] Goffman (1963) notes that by regarding "others" negatively, an individual or group confirms their own "normalcy" and legitimizes their devaluation of the "other." Work by Link and Phelan conceptualizes stigma as a social process that includes four main steps: (1) distinguishing and labeling differences; (2) associating negative attributes to those identified differences; and (3) separation and distancing culminating in (4) status loss and discrimination.[43] Discrimination is the end point of the process of stigma, defined by UNAIDS as the unfair and unjust action toward an individual or group on the basis of real or perceived status or attributes, a medical condition (e.g., HIV), socioeconomic status, gender, race, sexual identity, or age.[44] The process of stigma toward key populations leads to a potentially intensifying circle of stigmatization. Stigma heightens vulnerability to HIV, which in turn leads to increased opportunities for HIV-related stigma to be layered on top of existing key population stigma, further intensifying the experience and consequences of stigma.

More recent work on HIV-related stigma lays a framework to guide HIV stigma reduction programming and measurement, illustrating the pathways through which stigma acts to negatively influence key health outcomes and impacts (see Figure 1).[45] The framework depicts factors that facilitate and drive HIV stigma (e.g., fear of HIV transmission, social judgment, prejudice, and stereotyping), which lead to the marking of individuals or groups (e.g., key populations) as socially unacceptable based on behaviors, characteristics, and/or HIV status. This then manifests for individuals and groups in multiple types of stigma (anticipated, observed, internalized, and enacted). These types of stigma influence a range of outcomes, including engaging in risk behaviors and uptake of HIV prevention, care, and treatment services, which ultimately have an impact on quality of life, HIV incidence, and HIV prevalence. This study focused primarily on examining two areas of this framework: the types of stigma sex workers experience and the relationship between stigma and health-seeking behavior. The study also explored perceived HIV stigma among all sex workers, and stigma among sex workers toward PLHIV.

Figure 1. Stigma Framework



Adapted from: [46]

Experienced stigma

In its most obvious and well-researched form, stigma is experienced or enacted through interpersonal acts of discrimination. Experienced stigma may take the form of gossip, verbal and physical assault, familial ostracism, or social exclusion.[43, 47] In the healthcare setting, healthcare professionals may neglect, deny care to, and breach confidentiality; or verbally abuse patients based on their HIV status, sexual orientation, or occupation. For key populations, experiencing stigma and discrimination often results in a reluctance to seek healthcare services, test for HIV, or reveal occupation or sexual orientation to healthcare professionals when seeking care. Initial research in Kenya has shown that MSM and sex workers face widespread discrimination in the form of public aggression and humiliation, denial of service; discrimination in the workplace; harassment or alienation from friends and family; police harassment; eviction; and verbal, sexual, and physical abuse.[48, 37, 32, 33] Less, however, is known about how this affects healthcare service utilization.

Witnessed/heard, perceived, and anticipated stigma

Stigma does not need to take the form of an overt act of discrimination to adversely affect individuals. For example, women who had never actually experienced discrimination, but who felt stigma was prevalent in their communities, were less likely to access HIV testing services.[49] In fact, stigma is more likely to be witnessed, perceived, or anticipated than actually individually experienced. Witnessed stigma is based on having heard stories or witnessed events of how stigmatized individuals have been mistreated.[50] Perceived stigma consists of one's perceptions of the prevalence of stigmatizing attitudes in the community and among healthcare providers[51, 52, 50, 53] and feeds into anticipated stigma, which refers to the fear or expectation that one will experience S&D from others in the future.[41] Evidence from a multi-country study in Africa found that sex workers felt stigma was very high, and that stigma toward MSWs who have sex with other men was exacerbated by homophobia. Because of this, sex workers were reluctant to disclose their occupation to healthcare providers or to test for HIV.[27]

Internalized stigma

A final type of stigma, internalized stigma, refers to when individuals take on (i.e., internalize) the stigma

they experience or perceive around them and accept it as true and just. Internalized stigma manifests itself in many ways, including low self-esteem, depression, self-hatred, self-isolation, shame, withdrawal from seeking health services, and fear of further ostracization.[42, 54, 53] Studies in Africa found that internalized stigma among PLHIV is associated with depressive symptoms, lower quality of life, and a decreased likelihood of disclosing sero-positivity to others, including primary sexual partners.[55-57] This trend has been reported in Kenya, where internalized stigma is pervasive among PLHIV, particularly among men and those living in rural areas.[58] In fact, a study across five regions in Kenya found PLHIV tend to blame themselves for being HIV positive (50%), have low self-esteem (46%), and feel guilty or ashamed (44%).[59]

There is a paucity of research examining stigma toward PLHIV held by key population groups. A recent survey in Kenya found that sex workers may have elevated levels of stigma toward PLHIV; more than three-quarters of migrant FSWs would hide a family member's HIV-positive status from others, compared with 65 percent of all women.[7] For HIV-positive individuals belonging to a marginalized group, the stigma of living with HIV is layered upon the stigma of being a sex worker or MSM, increasing their risk of experiencing violence, being denied services, or being excluded from family and community.[18, 25] For members of key populations who have been ostracized by their family and communities, their peer networks are a critical, and often the only, source of social support and provide an essential safety net for survival.[60] If HIV stigma is strong within this peer network, or simply perceived to be, then fear of losing this support if one were to be known as HIV positive could be a strong deterrent to being tested for HIV; or for a person with HIV to take action that might disclose his or her positive HIV status, such as receiving antiretroviral therapy (ART).

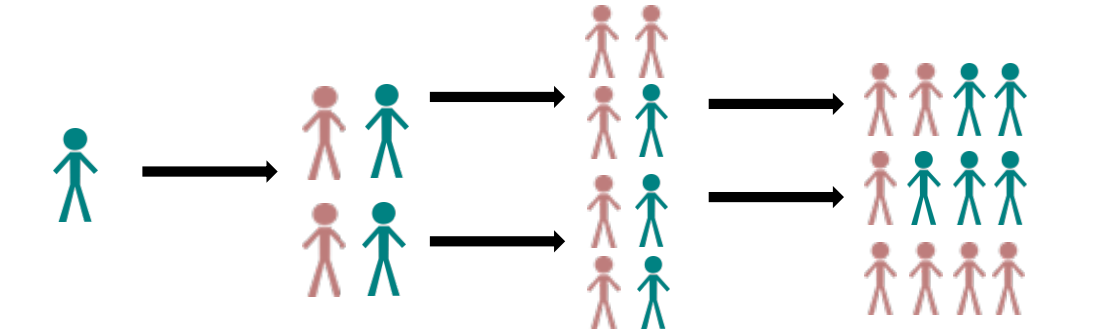
CHAPTER 2: METHODOLOGY

Study Design

This quantitative, cross-sectional study measured the prevalence of anticipated, witnessed/heard, internalized, and experienced sex-worker stigma among male and female sex workers; perceived HIV stigma among all sex workers; and HIV stigma held by sex workers. The study examined utilization of different health services in the 12 months preceding the survey, avoidance or delay in utilization of needed services, and the reasons for avoidance or delay. Any other known factors that could influence utilization of health services were also collected and included as control variables in the study analysis. The study questionnaire also captured potential mediating variables between stigma and utilization of health services: perceived risk of HIV infection; social capital; and resiliency to stigma and discrimination, disclosure, and depression.

Although there is no gold standard for sampling hard-to-reach populations with an unknown sampling frame, respondent driven sampling (RDS) is commonly used for sampling hidden populations, including PWID, MSM, and sex workers. RDS starts with an initial set of nonrandomly selected respondents, known as "seeds." Seeds refer their peers to participate in the study through coupon distribution (Figure 2). RDS differs from snowball sampling, in that the sample is weighted using a mathematical model to compensate for the sample being collected in a nonrandom way. Because the sample is weighted based on personal network size, RDS results may be more representative of sex workers who are hard to recruit or less likely than others to participate in a survey.

Figure 2. Participant Recruitment Diagram



Although this study intended to use RDS and weight the data accordingly for analysis, in the end an alternative method was used. Partnering organizations recruited the seeds at each site, and each participant was supposed to be given four coupons to recruit other participants. The number of coupons chosen was based on previous studies in Kenya and the study timeframe. However, there were unexpectedly high coupon response rates, particularly in Nairobi, which led to limited coupon distribution. The targeted sample size was met within just two recruitment waves. This meant that not all participants were given equal opportunity to recruit others, and shorter referral chains resulted. Therefore, the data presented in this report are not weighted and are analyzed according to a snowball sample.

Study Population and Sites

To be eligible to participate in the study, participants had to be over the age of 18, earn a significant part of their income from sex work, and have been a resident in the location of the study for at least six months prior to the study. Those ineligible for participation included people under the age of 18, people who had not received most of their income through sex work in the past three months, those who have not been residents of the study location for at least six months, and individuals who were unable to provide informed consent. Also ineligible were those visibly under the influence of drugs or alcohol at the time of screening and anyone who admitted to the interviewer that she or he had already participated in the study. Those who admitted to the interviewer that they received the recruitment coupon from a stranger, or who did not have a valid coupon, were excluded from the study, as well. Across all sites, 25 people were deemed ineligible to participate.

Partnering organizations discretely recruited the initial group of participants, through word of mouth. Subsequent respondents were then recruited by the initial peers. Table 1shows the number of people interviewed at each site.

Table 1. Sample Size by Study Location

Site	FSWs	MSWs
Nairobi	183	148
Kitui	76	N/A
Busia	127	28
Homa Bay	111	56
Total	**497**	**232**

The study sites were in four counties: Nairobi, Busia, Kitui, and Homa Bay. These four counties were selected to cover a range of settings—rural, urban, and transit corridors—and included sites that have not been as well-studied as major towns in Kenya. For instance, fewer studies have been conducted in western and eastern Kenya than in Nairobi or Mombasa. Busia County in western Kenya is along the transit corridor to Uganda, Rwanda, and the eastern part of the Democratic Republic of the Congo. The adult HIV prevalence rate in Busia County is estimated to be 7.1 percent.[1] Homa Bay, also in western Kenya, was selected because it has the highest prevalence of HIV in Kenya, at 27.1 percent.[1] Kitui County was selected to represent eastern Kenya. Nairobi was chosen to represent an urban setting with a large estimated sex worker population. With the highest population density in all of Kenya, Nairobi has a total population of 3,445,387.[61, 62] Nairobi County's HIV prevalence rate is 8.6 percent.[1]

The estimated number of FSWs in each study location varied. It is estimated that about 27,620 FSWs reside in Nairobi, with a range of 21,081 to 34,160. On average, there are approximately 794 (561–1,026) FSWs in Kitui, 995 FSWs (774-1,216) in Homa Bay, and 2,474 FSWs (1,854–3,094) in Busia.[63]

Study Procedures

The study's four partnering organizations were responsible for recruiting initial seeds and providing private rooms for interviews: Health Options for Young Men on HIV, AIDS and STIs, Bar Hostess Empowerment & Support Programme, Keeping Alive Society's Hope, and Survivors. Data were collected through face-to-face interviews in a private room at each of the partner organization's offices. Data collection took place in January 2015.

All participants were reimbursed 500 Kenyan shillings (KSh) for their transport and time related to taking the survey. After a participant had passed the screening questions and was deemed eligible to participate in the study, the interviewer initiated the informed consent process. During the informed consent process,

participants were first notified that, if interested, they could receive reimbursement for their time and transport to recruit other participants to also take the survey. Each participant was given 300 KSh for up to four successfully recruited participants.

The data collectors were trained, third-party interviewers rather than peers in order to minimize response bias and protect respondents' confidentiality. Data collectors attended a five-day training on how to properly administer and store the questionnaires; ethical considerations, such as confidentiality and informed consent; the substantive content area of stigma to create a thorough understanding of the different types of stigma, manifestations, and sources; and stigma-reduction to ensure interviewers behaved in a nonstigmatizing manner when delivering the questionnaire. Training included participatory stigma-reduction exercises and practice interviewing.

Ethical Considerations

The Health Media Lab Institutional Review Board in the United States and the Kenya Medical Research Institute Institutional Review Board in Kenya approved the study protocol before implementation. All co-investigators were trained in human subjects research and interviewers signed a confidentiality agreement prior to conducting the study.

Participation in the study was voluntary. This was made clear from the outset, through the consent process and during the interview itself. Participants were advised that they could decide, at any time, to discontinue their participation in the study and that they would not be denied any of the travel reimbursement. Confidentiality was maintained throughout. No personal identifying information was collected on the questionnaire and completed questionnaires with participant IDs and signed consent forms were kept separately from each other in lock boxes. Only members of the research team had access to these documents.

This study required written, signed informed consent. All study staff were trained on the importance of voluntariness, confidentiality, and how to administer the consent process. The informed consent form and questionnaire were translated into Kiswahili and then back-translated into English by an accredited external translator not affiliated with the project. The interviewers read the consent form to the participants in private, in the language the participant felt most comfortable in (English or Kiswahili).

CHAPTER 3: FINDINGS

This chapter describes the key findings, including the prevalence of anticipated, witnessed/heard, experienced, and internalized stigma; and how stigma affects utilization of health services.

Background Variables

Table 2 provides background sociodemographic information on male and female sex workers. While more respondents were in the age group of 25–34 year olds than any other age group for both male and female sex workers, a larger proportion of the male respondents were in the younger age group of 18–24 year olds (43%), compared to female respondents (27%). The majority of FSWs had primary education or less (59%), while the majority of MSWs had secondary (60%) or tertiary (21%) education. Although most male and female sex workers were not married, MSWs were more likely to be married or to have a partner (8% to a woman; 19% to a man) than FSWs (3%).

Table 2. Sociodemographics

Demographic variables	Male sex workers (n=232)	Female sex workers (n=497)
Age		
18-24	43% (100)	27% (136)
25-34	46% (106)	58% (287)
35+	11% (26)	15% (74)
*Education^*		
Primary or less	19% (43)	59% (291)
Secondary	60% (137)	36% (178)
Tertiary	21% (47)	5% (27)
Marital status		
Married/partner with female	8% (18)	N/A
Married/partner with male	19% (45)	3% (17)
Divorced/separated/widowed	19% (45)	44% (216)
Single/never married	53% (123)	53% (261)
Top 3 places where to connect with clients~		
Bar or club	94% (219)	96% (475)
Hotel or guesthouse		82% (410)
Friends	87% (201)	79% (393)
Social media	81% (189)	
Other demographic variables		
Average number of years engaged in sex work	5.9	5.2
Average number of children	1.4	2.2
Average number of clients in a given day	2.2	3.5
Average annual income (KSH)	KSh 327,532	KSh 406,435
Average number of people supported by sex worker	1.7	3.8

^Primary or less includes no education, some primary, and complete primary; secondary includes some and completed secondary; tertiary includes university and technical schools.

~Respondents were allowed to give multiple responses.

Responses may not add to 100% due to rounding.

Both male and female sex workers had been in sex work for roughly the same average number of years (5.9 and 5.2 respectively) at the time of this study. FSWs reported a higher average annual income from sex work than MSWs (KSh 406,435 vs. KSh 327,532). This is a result of FSWs selling sex more days per

week than MSWs (4.8 vs. 3.5), as FSWs typically make less in one day of work than MSWs (KSh 1,647 vs. KSh 1,903). FSWs also had a greater average numbers of clients per working day (3.5 vs 2.2), more children (2.2 vs. 1.4), and more people they supported (3.8 vs. 1.7) than MSWs.

Avoidance and Delay of Health Services

Table 3 details the health-seeking needs and behaviors of the respondents, as well as reasons for **avoiding** or **delaying** seeking health services when needed. Ninety percent of both male and female sex workers reported that they needed health services of some kind in the 12 months preceding the study. Of these respondents, roughly the same percentage of men (48%) and women (49%) reported that they **avoided** health services when needed, while more men (73%) than women (55%) reported **delaying** seeking health services.

Of respondents reporting **avoidance** of health services, 61 percent of men and 63 percent of women reported avoiding services more than once in the 12 months preceding the survey. While the majority of respondents avoided general health services, a significant number both of men and women reported avoiding STI or other sexual and reproductive health (SRH) services (49% men; 35% women), as well as HIV services (29% men; 18% women). Among the reasons given for avoiding services were fear that seeking services could lead to disclosure of sex worker or MSM status to others (e.g., by being seen at the health facility) and fear of being asked to take an HIV test. Other reasons were fear of encountering stigma at the health facility (e.g., discriminatory behavior such as being made to wait longer than others) and nonstigma-related reasons (e.g., lack of money for transport, being too busy, etc.). More than one-fifth of men and women reported that at least one of the reasons they avoided services was stigma-related.

Similar patterns emerged for a **delay** in seeking needed health services. More than half of men (54%) and 61 percent of women reported delaying services more than once over the preceding 12 months. As with avoidance, the majority of respondents reported delaying services for general healthcare, while a significant number reported delaying seeking services for STIs/SRH (47% men; 32% women) and HIV-related services (30% men; 31% women). Roughly the same numbers of men (15%) and women (18%) reported stigma-related reasons as the cause of their delay in seeking health services.

Approximately 81 percent of males and 72 percent of females either avoided or delayed health services when they needed them in the 12 months preceding the study. Of those who either avoided or delayed seeking health services, 70 percent of men and 48 percent of females avoided seeking STI/SRH or HIV-related services.

Table 3. Health-Seeking Behavior

Health-seeking needs and behaviors	Male sex workers (n=232)	Female sex workers (n=497)
Needed health services in the last 12 months	90% (208)	90% (446)
***Avoided** health services among those who needed services*		
Avoided health services in last 12 months among those who needed health services	48% (99)	49% (220)
*Number of times **avoided** services among those who avoided services**		
Once	37% (37)	37% (81)
Twice	30% (30)	34% (74)
At least three times	30% (30)	30% (65)
*Type of services **avoided** among those who avoided services (multiple responses allowed if avoided services more than once)*[†]		

Health-seeking needs and behaviors	Male sex workers (n=232)	Female sex workers (n=497)
General health services^	55% (54)	71% (157)
STI and sexual/reproductive health services	49% (49)	35% (76)
HIV-related services**	29% (29)	18% (40)
Treatment for injury due to violence	1% (1)	2% (5)
Mental health/counseling services	0% (0)	0.5% (1)
Maternal health services	N/A	2% (4)
*Reasons for **avoiding** services among those who avoided services (multiple responses allowed)* [†]~		
Fear of disclosure	26% (26)	22% (48)
Fear of being asked to take an HIV test	6% (6)	6% (14)
Stigma-related quality of services	23% (23)	22% (48)
Reasons not related to stigma	82% (81)	86% (190)
***Delayed** health services among those who needed services*		
Delayed health services in last 12 months among those who needed health services	73% (151)	55% (244)
*Number of times **delayed** services among those who delayed services**		
Once	46% (70)	39% (96)
Twice	30% (45)	25% (62)
At least three times	24% (36)	35% (86)
*Type of services **delayed** among those who delayed services (multiple responses allowed if delayed services more than once)* [†]		
General health services^	50% (76)	68% (166)
STI and sexual/reproductive health services	47% (71)	32% (79)
HIV-related services*	30% (46)	31% (75)
Treatment for injury due to violence	1% (1)	2% (4)
Mental health/counseling services	1% (2)	6% (14)
Maternal health services	N/A	3% (8)
*Reasons for **delaying** services among those who delayed services (multiple responses allowed)* [†] ~		
Fear of disclosure	24% (36)	18% (44)
Fear of being asked to take an HIV test	3% (4)	5% (13)
Stigma-related quality of services	15% (23)	18% (45)
Reasons not related to stigma	85% (128)	86% (211)

*May not add to 100 percent due to rounding or non-response

[†]Unprompted responses

^Includes child health, dental health, general injury, and other general health services (e.g., cold, diarrhea treatment)

**Includes HIV testing and counseling, HIV treatment, post-exposure prophylaxis, and PMTCT services

~Fear of disclosure includes fear of disclosure of selling sex, being MSM, or HIV status; knowing someone/family at the facility; and facility being near home so someone may see sex worker. Stigma-related quality of services includes unfriendly services due to selling sex or being MSM; previous negative experiences (e.g., staff would talk badly because of selling sex or being MSM; having to wait longer than others because of selling sex or being MSM; staff avoiding touching sex worker because of selling sex or being MSM; staff staring or gossiping about sex worker due to selling sex or being MSM). Reasons not related to stigma included inconvenient opening hours or location; no health insurance or high cost; poor-quality services unrelated to patient/provider interaction; wasn't sick enough or can treat themselves; or fear of violence from others.

Respondents who voluntarily admitted avoiding or delaying specific health services answered a follow-up unprompted question about reasons for avoidance or delay (Table 3). However, all respondents were also asked directly whether they had avoided or delayed services in the 12 months preceding the survey for specific stigma-related reasons (Table 4). Approximately half of both male (47%) and female (53%) respondents reported they had delayed or avoided health services for fear that seeking services would lead to disclosure of their status as sex workers, either by health facility staff disclosing their status or someone seeing them seeking services. Approximately the same percentage of males (49%) avoided or delayed seeking services due to fear of disclosure of having sex with men.

Males were asked about fear of stigmatizing treatment at a health facility in general and also specifically for being MSM or selling sex. Slightly more males avoided or delayed services due to fear of stigmatizing treatment due to being MSM (55%) than due to selling sex (48%). For FSWs, 65 percent reported that they had avoided or delayed services for fear of experiencing stigmatizing treatment at the health facility. In addition, a quarter of men and 36 percent of women reported they had avoided or delayed seeking services for fear they would be asked to take an HIV test or would be tested without their consent. A higher proportion of respondents reported delay due to stigma-related reasons when asked specifically about delay due to these reasons than when asked a general, nonspecific question about their reasons for delay or avoidance.

Table 4. Avoided or Delayed Services Due to Fear of Experiencing Stigma (last 12 months)

Avoided or delayed health services in the last 12 months due to fear of...	Male sex workers (n=232)	Female sex workers (n=497)
Disclosure of selling sex~	47% (110)	53% (261)
Disclosure of having sex with men~	49% (113)	N/A
Stigmatizing treatment at the health facility*	N/A	65% (322)
Stigmatizing treatment at the health facility for selling sex^	48%	N/A
Stigmatizing treatment at the health facility for being MSM^	55%	N/A
Stigmatizing treatment at the health facility for any reason+	44%	N/A
You will be asked to be tested for HIV or will be tested without your consent	25% (57)	36% (179)

~Disclosure includes both staff disclosing status without consent or someone learning status

*Stigmatizing treatment includes healthcare provider reacting in a negative way, receiving less care and attention than other patients, waiting longer to be attended to than others, being denied service or being scolded, and being blamed for health conditions

^Stigmatizing treatment includes healthcare provider reacting in a negative way, being denied service or being scolded, and being blamed for health conditions

+Stigmatizing treatment includes receiving less care and attention than other patients and waiting longer to be attended to than others

Difficulties in accessing health services

In addition, both male and female respondents were asked if they had ever had difficulties in accessing health services because they sell sex, and for men because they had sex with men (Table 5). More than a third (36%) of men and close to half of women (46%) reported that they had at some point experienced difficulties accessing services because they sell sex. Of these respondents, the overwhelming majority of both men and women (88% each) reported experiencing stigma from health providers, while close to one-fifth voiced concerns about being seen attending a health facility. About a third of both men and women

(32% each) indicated that their difficulties stemmed from a lack of health facilities and/or health providers with experience in the health needs of sex workers. Male respondents were also asked about difficulties accessing services because they were MSM. Slightly more men (44%) expressed difficulties due to being MSM as opposed to being a sex worker (36%). Reported difficulties were similar to those experienced because of being a sex worker: stigma from health workers (86%), fear of disclosure of MSM status as a result of seeking services (16%), and lack of experience in treating MSM by either the facility or health provider (34%).

Table 5. Difficulties in Accessing Health Services Due to Sex Worker or MSM Status

	Male sex workers (n=232)	Female sex workers (n=497)
Difficulties in accessing health services due to selling sex		
Ever had difficulties in accessing health services because of selling sex	36% (84)	46% (229)
Types of difficulties among those who had difficulties ~		
Stigma from healthcare workers (HCWs)*	88% (74)	88% (201)
Don't want others in your community to see you at a health facility	19% (16)	19% (43)
Lack of facilities specifically for sex workers/ HCWs lack experience working with sex workers	32% (27)	32% (74)
Difficulties in accessing health services due to being MSM		
Ever had difficulties in accessing health services because of being MSM	44% (102)	N/A
Types of difficulties among those who had difficulties~		
Stigma from HCWs	86% (88)	N/A
Don't want others in your community to see you at a health facility	16% (16)	N/A
Lack of facilities specifically for sex workers/ HCWs lack experience working with sex workers	34% (35)	N/A

~Respondent allowed to give multiple responses.

*Stigma from healthcare workers includes healthcare provider refusing service or making sex worker wait longer than others, telling sex work to stop having sex with men (MSWs only), pressuring sex worker to get tested for HIV or other STIs, or gossiping about sex worker.

Health facility preference

Respondents were asked their preferences for type of health facility and their reasons for those preferences (Table 6). Men overwhelming preferred private or specific clinics for sex workers, whereas women were split evenly, with half reporting that they preferred government or public clinics. Reasons for preferring private and sex worker-specific clinics related to the delivery of confidential and stigma-free services for both men and women. Preferences for government/public facilities were related to reasons other than stigma, such as cost, convenient location, and opening hours.

Table 6. FSW Facility Preference

Type of facility	Percentage who prefer this facility type	Reasons for preference~		
		Confidential services	Stigma-free services	Other reasons
Female sex workers (n=497)				
Government/public	50% (250)	12% (29)	25% (63)	93% (232)
Private*	30% (149)	38% (56)	76% (113)	68% (102)
Specific clinics for sex workers	20% (97)	36% (35)	90% (87)	79% (77)
Male sex workers (n=232)				
Government/public	23% (54)	19% (10)	44% (24)	89% (48)
Private*	48% (110)	42% (46)	75% (82)	52% (57)
Specific clinics for sex workers	29% (67)	28% (19)	87% (58)	48% (32)

* Private includes facilities run by non-governmental organizations, mission hospitals, and chemists/pharmacists

~Respondents were allowed to give multiple responses. Reasons related to concerns about disclosure were: will not disclose sex worker or HIV status, not knowing anyone at the facility, and facility being further from home. Reasons related to concerns about stigma were: friendly services, previous positive experiences, staff talking nicely, not made to wait longer than others, staff do not avoid touching sex worker, and staff do not stare at or gossip about sex worker. Other reasons were convenient location or opening hours, low cost or free services, and high-quality services.

Stigma

Four types of stigma related to sex work were measured: anticipated (fear of); witnessed/heard; experienced; and internalized. The first three types—anticipated, witnessed/heard, and experienced stigma—were each measured by varying numbers of individual items that captured both a range of manifestations (forms) of stigma (e.g., gossip, verbal harassment, physical abuse, housing discrimination) and the source of that particular manifestation of stigma (e.g., verbal abuse coming from family, health providers, or police). Internalized stigma is measured differently, and so the results are presented separately from the other three types. Data were collected on both the manifestation and source, because it is important to understand both *what* specific forms of stigma are occurring and *who* is inflicting them. Having this level of detail is necessary to design effective S&D-reduction programs and to understand what forms of stigma may be actionable by policy or law, rather than through other mechanisms. The individual items and their frequencies are presented in Annexes A and B.

Anticipated, witnessed/heard, and experienced stigma

For ease of presentation and analysis, several of the individual items used to measure the first three types of stigma—anticipated, witnessed/heard, and experienced stigma—were combined into fewer aggregated variables that capture key manifestations of stigma (e.g., gossip, verbal abuse, physical abuse, and exclusion) and key sources of stigma (e.g., health workers, family, community, and police). Table 7 presents an overall guide to the aggregated variables for anticipated, witnessed/heard, and experienced stigma, detailing which individual items were combined for each of the new aggregated variables. Some manifestations were not aggregated, because (1) they did not fit the aggregated categories conceptually, (2) their gravity, or (3) on their own they might be actionable under law or by policy. These include: rape, housing (e.g., being forced to move or being denied rental), being disowned by family, and blackmail.

Table 7. Key to Aggregations of Manifestations and Sources of Stigma, by Type of Stigma

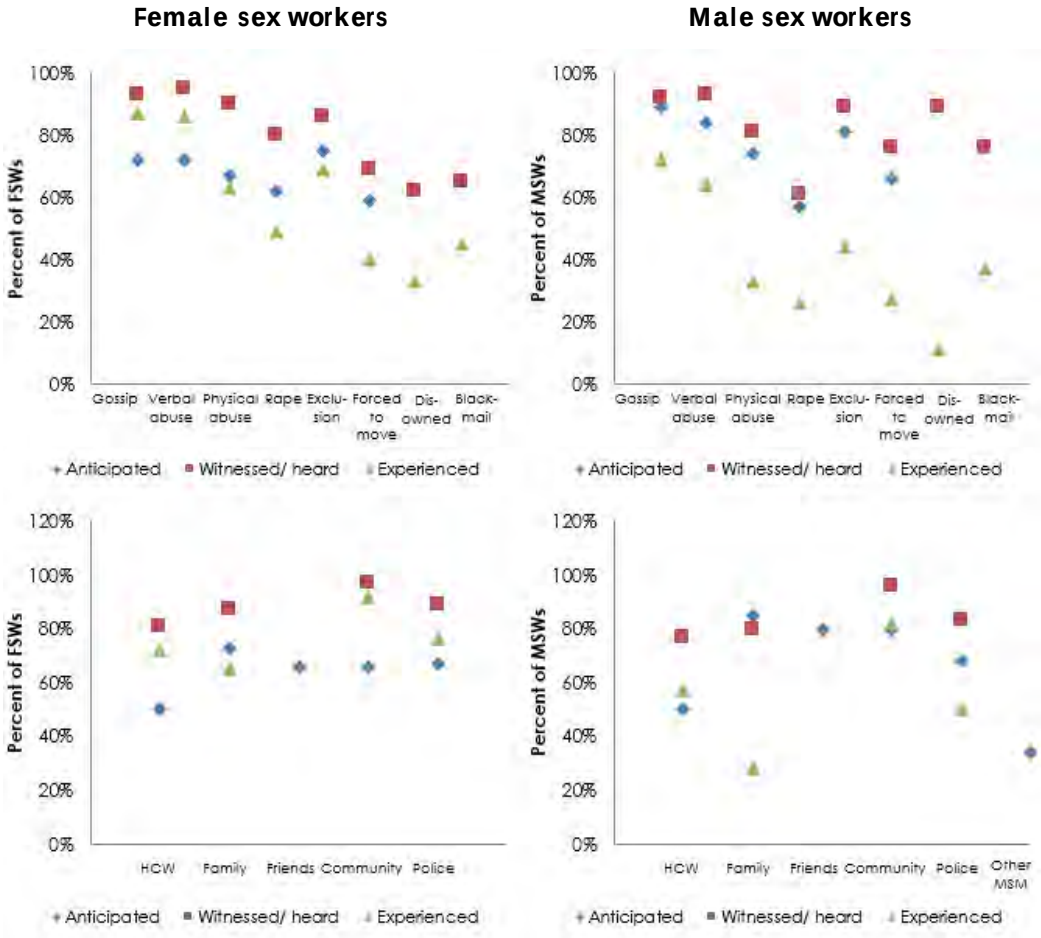
Stigma aggregation	*What is included in aggregation by form of stigma*					
	Anticipated stigma	n*	Witnessed/heard stigma	n*	Experienced stigma	n*
Manifestation						
Gossip	Being gossiped about by family, friends, general community, HCWs, or other MSM*	4/5	Gossip by HCW or general community member	2	Gossip by HCW or general community member	2
Verbal	Being verbally assaulted, harassed, or threatened by family, friends, general community, police, HCWs, or other MSM*	5/6	Verbal assault; harassment; threats by general community, family, or police; or shouted at by HCWs	4	Verbal assault, harassment, or threats by general community, family, or police	3
Physical/ violence	Being physically hurt by family, friends, general community, police, or other MSM*	4/5	Being physically hurt by general community, family, or police	3	Being physically hurt by general community, family, or police	3
Excluded	Being excluded from general community, family, or other MSM* events; forced to change your place of residence	3/4	Refused care by HCW; exclusion from community, religious, or family events; rejection by friends	3	Denied services by HCW; excluded from community, religious, or family events; or rejected by friends	3
Source						
Healthcare providers	Being gossiped about or verbally assaulted by HCWs	2	HCW provided poorer quality care to, shouted at, or made sex worker wait longer; refused to provide care to or gossiped about sex worker; or disclosed sex worker status	6	HCW denied health services, discharged you while still needing care, made you wait longer, did not treat you as well as others, gossiped about you, disclosed that you sell sex or are MSM,* or introduced religious/ morality issues	7/8
Family	Being gossiped about, verbally assaulted, physically hurt, or excluded by family	4	Family excluding, disowning, verbally assaulting, or physically hurting sex worker	4	Family excluded, disowned, verbally assaulted, or physically hurt you	4
Friends	Being gossiped about, verbally assaulted, or physically hurt by friends	3	N/A	N/A	N/A	N/A
Community	Being gossiped about, verbally assaulted, physically hurt, or excluded by general community	4	Community gossiping about, verbally assaulting, physically hurting, excluding, rejecting, blackmailing, or raping sex worker; sex worker forced to change place of residence or sex	9	Community gossiped, verbally assaulted, physically hurt, excluded, rejected, blackmailed, or raped you; you were forced to change place of residence or child was	9

Stigma aggregation	What is included in aggregation by form of stigma					
	Anticipated stigma	n*	Witnessed/heard stigma	n*	Experienced stigma	n*
			workers' children being dismissed from school		dismissed from school	
Police	Being verbally assaulted or physically hurt by police; afraid to carry or take condoms due to fear of getting in trouble with police or *askaris*	6	Police verbally assaulting, physically hurting, arresting, or refusing to protect sex worker; police confiscating/destroying condoms	5	Police verbally assaulted, physically hurt, arrested, or refused to protect you; police confiscated/destroyed your condoms	5
Other MSM*	Being gossiped about, verbally assaulted, physically hurt, or excluded by other MSM	3	N/A	N/A	N/A	N/A

*n refers to the number of items included in the aggregation by manifestation or source. If two numbers are in a cell, the higher number is for MSWs, who were asked additional questions about MSM.

Figure 3 shows the prevalence (frequency) of anticipated, witnessed/heard, and experienced stigma, by manifestation and source. The results show high prevalence of stigma across all three types of stigma, by both manifestation and source. All frequencies by manifestation and source are available in Annex C.

Figure 3. Prevalence of Different Manifestations and Sources of Stigma



The prevalence of anticipated manifestations of stigma ranged from a low of 59 percent (housing discrimination) to a high of 75 percent (exclusion) for FSWs, and from 57 percent (rape) to 89 percent (verbal) for MSWs. Prevalence of the sources of anticipated stigma were also high and ranged from a low of 50 percent (health providers) to a high of 73 percent (family) for FSWs, and from 50 percent (health providers) to 85 percent (family) for MSWs.

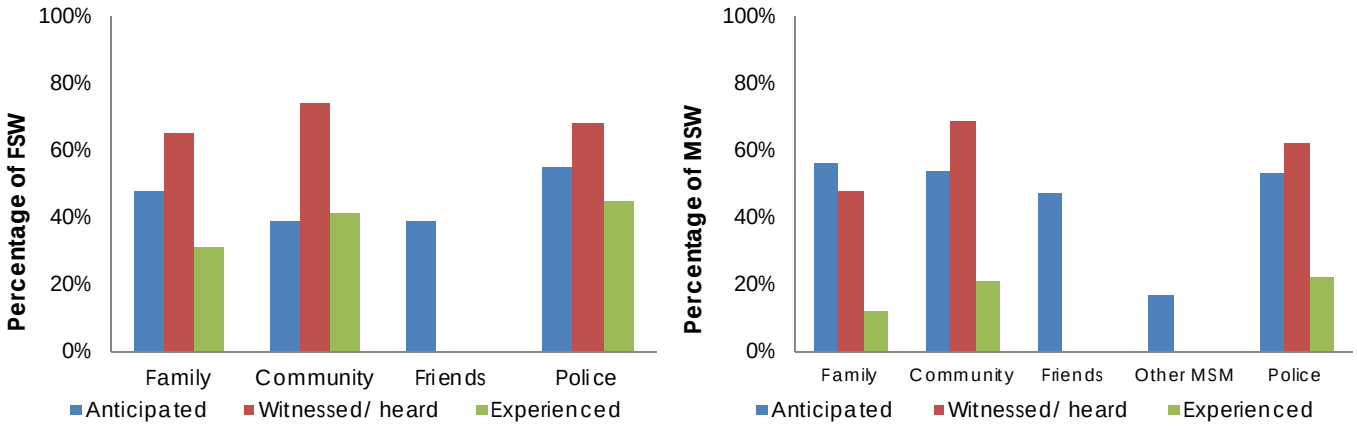
Turning to witnessed/heard stigma, prevalence of the manifestations of stigma ranged from a low of 62 percent (being disowned by family) to a high of 95 percent (verbal abuse) for FSWs, and from 61 percent (rape) to 93 percent (verbal abuse) for MSWs. The sources of these reported manifestations include: healthcare providers (81%, FSWs; 77%, MSWs); family (87%, FSWs; 80%, MSWs); general community (97%, FSWs; 96%, MSWs); and police (89%, FSWs; 83%, MSWs). Last, reported experiences of specific manifestations of stigma in the past 12 months ranged from a low of 33 percent (disowned by family) to a high of 87 percent (gossip) for FSWs, and from 11 percent (disowned by family) to 72 percent (gossip) for MSWs. In examining the sources of this experienced stigma, it is important to note the high prevalence (greater than 50%) across all the sources, with the exception of family for MSM. The sources of experienced stigma were health providers (72%, FSWs; 57%, MSWs); family (65%, FSWs; 28%, MSWs); general community (92%, FSWs; 82%, MSWs); and police (76%, FSWs; 50%, MSWs).

Of these first three types of stigma, witnessed/heard stigma had the highest prevalence, which is not surprising. It is highly likely that respondents were reporting the same cases of witnessed/heard stigma. Given the high levels of witnessed/heard stigma, it is not surprising that there were also high levels of anticipated (fear of) stigma. While experienced stigma was generally lower (except for a few cases) than anticipated or witnessed/heard stigma, it was still high. For example, close to three quarters of female respondents (72%) and more than half of male respondents (57%) reported that they had experienced stigma from healthcare providers in the past 12 months, with similar numbers reporting stigma from police (76%, FSWs; 50%, MSWs). Both FSWs and MSWs had experienced high levels of verbal as well as physical abuse. One in two female respondents (49%) and one in four male respondents (26%) reported having experienced rape in the past 12 months. Women were more likely to report stigma from family than men (65% vs. 28%), but this may be because females' families were more likely than the men's families to know the respondent's sex-worker status. It might also be that men had not disclosed that they have sex with men to their families, or that female respondents were more likely than the male respondents to be in contact with their families.

Not only was the prevalence of stigma high overall but also the frequency with which it happened (see Annexes A and B). If respondents reported that they had experienced a certain manifestation or source of stigma in the past 12 months, they were then asked whether it had happened once, a few times, or often. A general pattern emerged across all manifestations and sources, with the most common response being "often." Stigma was not only prevalent in the 12 months preceding the survey but also frequent.

Given the gravity and magnitude of physical violence reported, this study examined an additional aggregation of this manifestation of stigma, by source (Figure 4). Almost one in two FSWs and one in five MSWs report having experienced violence at the hands of the police in the 12 months preceding the survey. Violence by members of the general community was also high (41%, FSWs; 21%, MSWs). Violence by family members was lower, but still of concern (31%, FSWs; 12 %, MSWs).

Figure 4. Prevalence of Violence (last 12 months)



Internalized stigma

As internalized stigma is an underlying construct (i.e., something felt as opposed to something that happens). It is typically measured through a series of items with Likert-scale response categories (strongly agree, agree, disagree, and strongly disagree), which are then examined together. This study measured internalized stigma through a series of six items (Table 8). Male sex workers were asked a series of questions with regard to both being MSM and to being a sex worker. For this analysis, the categories of agree/strongly agree and disagree/strongly disagree were combined.

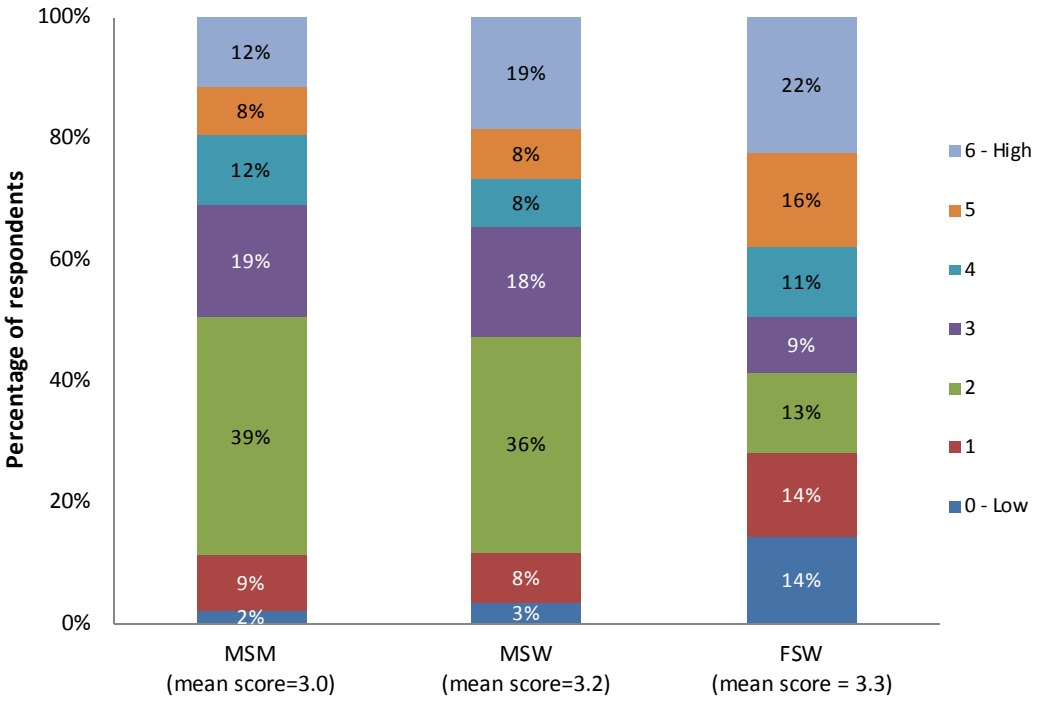
Table 8 shows that the prevalence of internalized stigma was high. Large majorities of MSWs found it difficult to tell people that they sell sex (90%) and are MSM (88%) and most hid the fact that they sell sex (90%) and have sex with men (88%) from their friends and family. While women were less likely than men to report difficulty in telling people that they sell sex (63%) or hide the fact that they sell sex from friends and family (65%), they were more likely to agree that selling sex made them feel dirty (46%), guilty (52%), ashamed (47%), and worthless (53%). The vast majority of respondents (98%, males; 86%, females) agreed with at least one of the internalized stigma measures.

Table 8. Prevalence of Internalized Stigma

Percentage agreeing to the following internalized stigma measures	FSWs (n=497)	MSWs (n=232)	
		Sell sex	Have sex with men
Difficult to tell people that you sell sex/are MSM	63% (312)	90% (209)	88% (204)
	46% (230)	31% (72)	23% (54)
Selling sex/having sex with men makes you feel guilty	52% (257)	34% (79)	34% (79)
	47% (234)	34% (78)	28% (66)
There are times you feel worthless because you sell sex/have sex with men	53% (262)	38% (89)	36% (84)
	65% (325)	90% (209)	88% (205)

Figure 5 displays an index of internalized stigma that reflects the combined responses of each respondent to the six items measured. Each combined score ranges from a low of zero to a high of six. Respondents who agreed/strongly agreed to a statement received a score of 1 for that item; those who disagreed/strongly disagreed received a score of 0. The higher the score, the more internalized stigma a respondent held. The first of the three bars for each score reflects internalized MSM stigma, the second bar internalized MSW stigma, and the last bar internalized stigma for FSWs. The mean score on this internalized stigma index is around 3 for both types of internalized stigma for men and internalized stigma for women. On average, respondents agreed with three of the six internalized stigma statements, reflecting an overall mid-level of internalized stigma across respondents. However, it is important to note that the scores with the highest proportions (i.e., the tallest bar) for FSWs are 5 and 6, indicating a significant proportion of FSWs (38%) with the highest level of internalized stigma. While the highest proportion of male respondents cluster around the combined scores of 2 and 3, there is still a significant proportion of men who reported high levels (5 or 6) of internalized stigma related to being MSM (19%) and MSWs (27%).

Figure 5. Internalized Stigma Index



Index score is based on responses (agree=1, disagree=0) to the following six items: It is difficult to tell people that you sell sex/have sex with men; selling sex/having sex with men makes you feel dirty; selling sex/having sex with men makes you feel ashamed; there are times you feel worthless because you sell sex/have sex with men; and you hide that you sell sex/have sex with men from friends and family.

Stigma and Utilization of Health Services

The study also examined self-reported delay or avoidance of needed health services in the 12 months preceding the survey, together with the different types of stigma (anticipated, witnessed/heard, experienced, and internalized) reported in the 12 months preceding the survey, testing the association between manifestations and sources of stigma and the delay and/or avoidance of health services.

Anticipated (fear of) stigma

Table 9 presents the bivariate results for both delay and avoidance of health services and anticipated stigma (full results are shown in Annex C). For FSWs, all manifestations and sources of anticipated stigma were significantly associated with both delay and avoidance of health services, most at the highly significant level (p-value <=.01), with the strongest associations (p-value < .001) observed between delaying or avoiding health services and anticipated verbal stigma, rape, exclusion, housing discrimination (e.g., being forced to move or not being able to rent housing), and stigma from police. For FSWs, anticipating stigma in the 12 months preceding the survey was clearly associated at the bivariate level with both delaying and avoiding health services when they were needed.

For MSWs, the association between stigma and delay or avoidance of health services was not as consistent as it was for FSWs. However, several manifestations of anticipated stigma were significantly associated with reporting a delay in seeking health services: verbal abuse, physical violence, rape, exclusion, and housing discrimination. Anticipating stigma from the community or police was also significantly associated with MSWs reporting a delay in seeking health services. For avoidance of health

services, manifestations of anticipated stigma with significant associations include rape, exclusion, and housing discrimination. Sources of anticipated stigma were not significantly associated with avoiding healthcare, apart from health providers (p=.08).

Table 9. Association of Anticipated Stigma with Delay and Avoidance of Needed Health Services

Are SWs who anticipate stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
Anticipated stigma by manifestation				
Gossip	0.00	0.00	0.26	0.33
Verbal abuse	0.00	0.00	0.00	0.13
Physical abuse/violence	0.00	0.01	0.02	0.21
Rape	0.00	0.00	0.09	0.01
Exclusion	0.00	0.00	0.02	0.00
Forced to move	0.00	0.00	0.00	0.02
Anticipated stigma by source				
Healthcare workers	0.01	0.00	0.94	0.08
Family	0.02	0.02	0.22	0.31
Friends	0.01	0.00	0.23	0.12
Community	0.02	0.00	0.00	0.25
Police	0.00	0.00	0.01	0.59
Other MSM			.31	.21

Green shading indicates the relationship is significant at 5% (darker green) or 10% (lighter green) level. (This table, unlike Tables 10–15 and Table 17) has no lighter green shading.) This means that the results here are 95% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

Witnessed/heard stigma

Seeing or hearing about stigma may have the potential to influence healthcare-seeking behavior, so respondents were asked if they had personally witnessed or heard of stigma being experienced by other sex workers. Table 10 presents the bivariate associations between the different manifestations and sources of stigma respondents who reported witnessing/hearing of stigma in the 12 months preceding the survey and their own avoidance or delay in seeking needed health services (see Annex C for full bivariate results).

Similar to anticipated stigma, for FSWs, witnessing/hearing about stigma was consistently and significantly associated with delaying services across every manifestation and source of stigma. The same consistent pattern occurs for avoiding health services, with the exception of only two items, where the relationship was non-significant: having been disowned/disinherited by family and witnessing/hearing about stigma perpetrated by healthcare workers toward sex workers.

For MSWs, there was a similarly consistent pattern of significant associations across all manifestations and sources of witnessed/heard stigma with a delay in seeking health services, apart from three items (verbal and physical abuse and stigma from family). Men's decision to delay seeking health services was more strongly associated with having witnessed or heard of stigma than was the decision to avoid seeking health services. For avoiding health services, apart from one item (exclusion, p=.08), the relationships with having witnessed/heard of manifestations or sources of stigma are all non-significant.

Table 10. Association of Witnessed/Heard Stigma with Delay and Avoidance of Needed Health Services

Are sex workers who witnessed/heard of stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
Anticipated stigma by manifestation				
Gossip	0.02	0.03	0.03	0.20
Verbal abuse	0.00	0.00	0.36	0.47
Physical abuse/violence	0.00	0.01	0.20	0.87
Rape	0.07	0.05	0.01	0.50
Exclusion	0.00	0.02	0.02	0.08
Forced to move	0.00	0.01	0.01	0.91
Disowned	0.01	0.85	0.05	0.73
Blackmail	0.00	0.00	0.01	0.97
Anticipated stigma by source				
Healthcare workers	0.03	0.44	0.06	0.91
Family	0.00	0.00	0.93	0.19
Community	0.08	0.00	0.03	0.47
Police	0.00	0.01	0.01	0.87

Green shading indicates relationship is significant at 5% (darker green) or 10% (lighter green) level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

Experienced stigma

Similar to the other two types of stigma, for FSWs there was a consistent pattern of significant associations between experiencing different manifestations and sources of stigma and reporting delaying or avoiding health services, most at the highly significant level ($p <= .01$). However, there were two items where the association was borderline significant (physical violence with avoidance, p=.12; healthcare workers with avoidance, p=.11) and one item with a non-significant relationship with avoidance (being disowned/disinherited by family).

Table 11. Association of Experienced Stigma with Delay and Avoidance of Needed Health Services

Are sex workers who experience stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
Experienced stigma by manifestation				
Gossip	0.00	0.00	0.04	0.82
Verbal abuse	0.00	0.00	0.25	0.89
Physical abuse/violence	0.00	0.12	0.33	0.67
Rape	0.00	0.02	0.34	0.58
Exclusion	0.00	0.00	0.21	0.62
Forced to move	0.10	0.05	0.67	0.05
Disowned	0.01	0.82	0.99	0.47

Are sex workers who experience stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
Blackmail	0.00	0.01	0.15	0.23
Experienced stigma by source				
Health workers	0.00	0.11	0.00	0.01
Family	0.00	0.06	0.62	0.26
Community	0.00	0.01	0.00	0.44
Police	0.00	0.03	0.05	0.72

Green shading indicates relationship is significant at 5% (darker green) or 10% (lighter green) level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

For MSWs, only five of the items showed a significant association with delay or avoidance. However, it is important to note the strength of the significance of the negative association between experiencing stigma from healthcare workers and delay (p=.00) and avoidance (p=.01) of health services. The associations between experiencing stigma from the community or the police and delay of services were also significant. Experiencing gossip and the delay of seeking healthcare was significant, as was experiencing housing discrimination and the avoidance of health services.

Internalized stigma

Internalized stigma was measured differently from the other three types of stigma. Table 12 shows the relationship between different internalized stigma measures and delaying or avoiding needed health services. The results showed that sex workers who hid that they sell sex or have sex with men from their friends and families were significantly more likely to delay and avoid seeking needed health services than those who do not hide their status as sex workers or MSM. Females who reported finding it difficult to tell people they sell sex were also more likely to delay and avoid seeking care than those who do not find it difficult to tell people they sell sex. Feeling worthless or guilty was associated with delaying care and avoiding care, respectively, among women. Men who agreed that selling sex makes them feel guilty, or who find it difficult to tell others they sell sex, were more likely to delay seeking services than men who disagreed with these two statements.

Table 12. Association of Internalized Stigma and Delay and Avoidance of Needed Health Services

Are sex workers who internalize stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
Selling sex				
It is difficult to tell people you sell sex	0.05	0.04	0.09	0.73
Selling sex makes you feel dirty	0.27	0.84	0.88	0.38
Selling sex makes you feel guilty	0.44	0.09	0.98	0.67
Selling sex makes you feel ashamed	0.11	0.57	0.22	0.99
There are times you feel worthless because you sell sex	0.03	0.44	0.95	0.32
You hide that you sell sex from friends and family	0.03	0.08	0.34	0.14
Having sex with men (MSWs only)				

Are sex workers who internalize stigma more likely to delay or avoid seeking health services?	Female sex workers (p-value)		Male sex workers (p-value)	
	Delaying services	Avoiding services	Delaying services	Avoiding services
It is difficult to tell people you have sex with men			0.49	0.89
Having sex with men makes you feel dirty			0.02	0.44
Having sex with men makes you feel guilty			0.44	0.78
Having sex with men makes you feel ashamed			0.90	0.84
There are times you feel worthless because you have sex with men			0.64	0.87
You hide that you have sex with men from friends and family			0.10	0.02

Green shading indicates relationship is significant at 5% (darker green) or 10% (lighter green) level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between internalized stigma and avoiding or delaying services.

Multivariate analysis (logistic regression)

Building on the bivariate analysis that examined the associations between reporting different manifestations or sources of stigma and delay or avoidance of health services, the study team further explored the relationship between stigma and health-seeking behavior through multivariate logistic regression. This analysis allowed us to answer the question, *"Are male and female sex workers who* ***anticipate, witness, experience, or internalize*** *stigma more likely to delay or avoid seeking health services,"* while controlling for other variables that may also influence delay or avoidance of healthcare. In this analysis the study team controlled for:

- Age
- Level of education
- Marital status
- Time spent doing sex work
- Reported annual income
- HIV status
- The wave in which a respondent was recruited into the current study (seed or first or second wave)
- Where (site) they were interviewed
- Level of social capital based on a constructed scale
- Whether or not a person has voluntarily disclosed his or her status as a sex worker (controlled for in anticipated, experienced, and internalized stigma regressions only)
- How often a person has felt down, depressed, or hopeless in the last two weeks (controlled for in internalized stigma regressions only)

The outputs of this initial regression analysis are expressed as log odds ratios and their respective p-values are included in parentheses in Tables 13 through 17.

Anticipated stigma

Table 13 highlights the results from *multivariate logistic regressions* to determine whether male and female sex workers who anticipated specific manifestations of stigma or stigma from specific sources at least once in the past 12 months were more likely to delay or avoid seeking health services, while controlling for other variables.

Table 13. Logistic Regression Results: Anticipated Stigma with Avoidance and Delay in Seeking Health Services

Are sex workers who anticipated stigma more likely to delay or avoid seeking health services?	**Female sex workers**		**Male sex workers**	
	Delayed seeking services n=434	Avoided seeking services n=432	Delayed seeking services n=173	Avoided seeking services n=179
Anticipated stigma by manifestation				
Gossip	1.68 (.03)	1.94 (.01)	1.77 (.37)	1.81 (.60)
Verbal abuse	1.70 (.03)	2.06 (.00)	1.57 (.39)	2.51 (.06)
Physical abuse/violence	1.93 (.01)	2.06 (.00)	2.19 (.08)	2.00 (.09)
Forced to move	2.20 (.00)	2.22 (.00)	2.55 (.03)	2.69 (.01)
Exclusion	2.06 (.00)	2.18 (.00)	1.13 (.79)	4.48 (.00)
Rape	1.56 (.06)	2.14 (.00)	1.05 (.91)	2.60 (.01)
Anticipated stigma by source				
Healthcare workers	1.34 (.18)	2.28 (.00)	0.78 (.53)	1.49 (.24)
Family	1.18 (.51)	1.66 (.04)	1.33 (.60)	2.89 (.05)
Friends	1.33 (.23)	2.40 (.00)	1.57 (.36)	1.32 (.53)
Community	1.15 (.55)	1.80 (.01)	2.22 (.10)	2.07 (.10)
Police	1.64 (.04)	1.97 (.01)	3.64 (.00)	2.25 (.03)
Other MSM			1.51 (.34)	1.32 (.43)

Model includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, wave recruited in current study, the site they were interviewed in, their HIV status, disclosure of sex worker status, and social capital.

Green shading indicates relationship is significant at 5% or 10% level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

For FSWs, these results confirm the significant associations seen between anticipating stigma and the avoidance of seeking needed health services, across all manifestations and sources of stigma. For example, the odds of avoiding health services were two times higher for FSWs who reported anticipating several different manifestations or sources of stigma than they were for FSWs who did not anticipate that manifestation or source of stigma. Specifically, the results were verbal stigma (OR 2.06; p-value = .00); physical abuse or violence (OR 2.06; p-value = 0.00); housing discrimination (OR 2.22; p-value = .00); exclusion (OR 2.18; p-value = .00); rape (OR 2.14; p-value .00); and anticipated stigma from healthcare workers (OR 2.28; p-value = .00) or friends (OR 2.40; p-value =.00). The relationship between different manifestations of stigma and delay of health services was also consistently significant.

Interestingly, when controlling for background factors, the significant associations seen between anticipation of stigma from key sources and delay of health services at the bivariate level disappeared, apart from police. While FSWs who reported anticipating stigma from healthcare workers, family, friends, and community had higher odds of reporting delaying health services, these relationships were

not significant. However, FSWs who anticipated stigma from police had odds that were 1.64 times higher (p=.04) of delaying health services than FSWs who reported not anticipating stigma from police.

For men, the results were less consistently significant, but still suggest that men who anticipated some manifestations or sources of stigma were significantly more likely to delay or avoid seeking health services than those who did not, often to the magnitude of odds that are twice as high. A few differences occurred in which manifestations or sources were significantly associated with avoiding versus delaying health seeking. For example, anticipation of rape (OR 2.60; p-value = .01), exclusion (OR 4.48; p-value = .01), and stigma from family (OR 2.89; p-value = .05) were significant predictors of avoiding health services but not of delaying them. Anticipating physical violence, housing discrimination, and stigma from police were significant predictors of both delay and avoidance of health services.

Witnessed/heard stigma

The multivariate results provide strong evidence that women who witnessed/heard about stigma were more likely to delay or avoid seeking health services (Table 14). The decision to avoid seeking health services was especially sensitive to witnessing or hearing verbal stigma (OR 7.56; p-value = .00) and stigma from the community (OR 10.57; p-value = 0.03). Women who witnessed or heard about police perpetrated stigma were at least three times more likely to avoid (OR 3.84; p=.01) or delay (OR 3.08; p=.01) seeking health services than FSWs who had not. A few items, while showing increased odds of avoiding services, were not statistically significant (being disowned by family and stigma from health providers). Similarly for delay, while the majority of stigma measures showed a significant and negative relationship, a few items showed non-significant relationships (gossip, rape, stigma from the community, and stigma from healthcare workers).

Table 14. Logistic Regression Results: Witnessed/Heard Stigma with Avoidance and Delay in Seeking Health Services

Are sex workers who witnessed/heard of stigma more likely to delay or avoid seeking health services?	**Female sex workers**		**Male sex workers**	
	Delayed seeking services n=433	Avoided seeking services n=432	Delayed seeking services n=173	Avoided seeking services n=179
Witnessed/heard of stigma by manifestation				
Gossip	1.92 (.11)	2.32 (.04)	1.97 (.34)	2.70 (.18)
Verbal abuse	3.22 (.03)	7.56 (.00)	1.60 (.51)	1.92 (.33)
Physical abuse/violence	2.13 (.04)	3.16 (.00)	0.91 (.87)	1.25 (.66)
Rape	1.23 (.45)	1.69 (.06)	2.57 (.02)	1.55 (.24)
Exclusion	1.94 (.04)	2.28 (.01)	1.47 (.57)	2.91 (.14)
Forced to move	2.17 (.00)	1.48 (.09)	1.30 (.62)	1.00 (.99)
Disowned	1.44 (.10)	0.98 (.94)	1.49 (.57)	0.57 (.39)
Blackmail	1.80 (.01)	1.79 (.01)	1.02 (.97)	0.81 (.68)
Witnessed/heard of stigma by source				
Healthcare workers	1.52 (.13)	1.26 (.39)	1.88 (.17)	1.09 (.84)
Family	2.27 (.01)	2.60 (.01)	0.74 (.55)	1.98 (.11)
Community	1.88 (.33)	10.57 (.03)	3.74 (.20)	1.86 (.54)
Police	3.08 (.01)	3.84 (.00)	4.05 (.02)	0.93 (.90)

Model includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, wave recruited in current study, the site they were interviewed in, and their HIV status.

Green shading indicates relationship is significant at 5% or 10% level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

In contrast to the women, the results suggest that, overall, men who witnessed or heard of stigma were not more likely to delay or avoid health services compared to men who had not witnessed or heard of stigma. However, in two cases, men who had witnessed /heard of stigma were more than twice as likely as those who had not to delay seeking health services. Specifically, the men were more likely to delay seeking health services when they witnessed/heard of stigma perpetrated by the police (OR 4.05; p-value = .02), or rape (OR 2.57; p-value = .02).

Experienced stigma

Table 15 provides the results of the multivariate analysis examining the relationship between experienced stigma and avoidance or delay of healthcare seeking by FSWs and MSWs. Similar to the other types of stigma already presented, for FSWs there was a fairly consistent pattern across all manifestations and sources of stigma, with significantly higher odds of FSWs avoiding or delaying services if they had experienced stigma. For example, FSWs who had experienced verbal stigma were more than three times as likely to avoid (OR 3.18; p=.00) or delay (OR 3.68; p = .00) services than FSWs who had not. The only items that did not show significant relationships for avoidance were physical abuse/violence, housing discrimination, being disowned, and stigma from family. Similarly, only housing discrimination had a non-significant relationship with delaying seeking health services.

By contrast, for MSWs, fewer items showed a significant relationship. MSWs who reported experiencing gossip were more than twice as likely to delay seeking healthcare (OR 2.77; p=.03). Of note is that MSWs who experienced stigma from healthcare providers had odds that are twice as high as MSWs who had not, for both avoiding (OR 2.39; p=.02) and delaying (OR 2.33; p=.04) seeking health services.

Table 15. Logistic Regression Results: Experienced Stigma with Avoidance and Delay in Seeking Healthcare

Are sex workers who experienced stigma more likely to delay or avoid seeking health services?	**Female sex workers**		**Male sex workers**	
	Delayed seeking services n=433	Avoided seeking services n=432	Delayed seeking services n=173	Avoided seeking services n=179
Experienced stigma by manifestation				
Gossip	2.31 (.01)	2.68 (.00)	2.77 (.03)	1.25 (.58)
Verbal abuse	3.68 (.00)	3.18 (.00)	1.24 (.63)	1.21 (.62)
Physical abuse/violence	1.68 (.02)	1.33 (.21)	1.15 (.75)	1.73 (.13)
Rape	1.51 (.05)	1.56 (.03)	1.14 (.78)	1.09 (.82)
Exclusion	2.05 (.00)	2.02 (.00)	1.31 (.52)	1.17 (.65)
Forced to move	1.31 (.23)	1.35 (.16)	1.47 (.40)	2.00 (.06)
Disowned	1.56 (.06)	1.07 (.76)	1.14 (.83)	0.45 (.17)
Blackmail	1.66 (.02)	1.61 (.02)	1.79 (.18)	1.62 (.16)
Experienced stigma by source				
Healthcare workers	1.53 (.08)	1.56 (.07)	2.33 (.04)	2.39 (.02)
Family	1.53 (.06)	1.38 (.15)	2.50 (.05)	1.57 (.23)
Community	3.52 (.00)	2.86 (.01)	1.69 (.37)	1.07 (.90)
Police	1.56 (.09)	1.76 (.03)	1.60 (.28)	1.56 (.22)

Model includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, wave recruited in current study, the site they were interviewed in, their HIV status, disclosure of sex worker status, and social capital.

Green shading indicates relationship is significant at 5% or 10% level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between each manifestation/source of stigma and avoiding or delaying services.

Internalized stigma

Tables 16 and 17 show the relationships between specific measures for internalized stigma and avoiding or delaying seeking healthcare services, while controlling for other factors. Female sex workers who found it difficult to tell people they sell sex (OR=1.57; p = .05) had higher odds of avoiding seeking health services than those who did not hide or find it difficult to tell others that they sell sex. There were no significant associations between internalized stigma and delaying healthcare among FSWs when controlling for other factors, such as age and education. For MSWs, those who said selling sex makes them feel ashamed were more than twice (OR=2.42; p = .07) as likely as those who did not to delay seeking health services. MSWs who hide that they sell sex are more than three times (OR=3.30; p = .05) as likely as those who do not to avoid seeking health services.

Table 16. FSW Logistic Regression Results: Internalized Stigma with Avoidance and Delay in Healthcare Seeking

Are FSWs who internalize stigma more likely to delay or avoid seeking health services?	Delayed seeking health services (n=427)	Avoided seeking health services (n=425)
Difficult to tell people that you sell sex	1.19 (0.47)	1.57 (0.05)
Selling sex makes you feel dirty	0.93 (0.76)	0.83 (0.40)
Selling sex makes you feel guilty	0.88 (0.56)	0.57 (0.01)
Selling sex makes you feel ashamed	1.05 (0.82)	0.73 (0.17)
There are times you feel worthless because you sell sex	1.20 (0.41)	1.05 (0.83)
You hide that you sell sex from friends and family	1.21 (0.42)	1.32 (0.23)

Model includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, wave recruited in current study, the site they were interviewed in, their HIV status, depression, social capital, and disclosure of sex worker status.

Green shading indicates relationship is significant at 5% or 10% level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between internalized stigma and avoiding or delaying services.

Table 17. MSW Logistic Regression Results: Internalized Stigma with Avoidance and Delay in Healthcare Seeking

Are MSWs who internalize stigma more likely to delay or avoid seeking health services?	Delayed seeking health services		Avoided seeking health services	
	n=179 MSWs	n=179 MSM	n=179 MSWs	n=179 MSM
Difficult to tell people that you sell sex/are MSM	1.44 (0.60)	1.95 (0.30)	0.73 (0.63)	1.24 (0.71)
Selling sex /having sex with men makes you feel dirty	1.08 (0.86)	0.49 (0.15)	0.75 (0.45)	0.64 (0.32)
Selling sex /having sex with men makes you feel guilty	1.12 (0.81)	0.87 (0.75)	0.90 (0.79)	0.95 (0.88)
Selling sex/having sex with men makes you feel ashamed	2.42 (0.07)	2.04 (0.17)	0.84 (0.64	0.67 (0.35)
There are times you feel worthless because you sell sex/have sex with men	1.45 (0.40)	1.49 (0.36)	0.93 (0.84)	0.88 (0.74)

Are MSWs who internalize stigma more likely to delay or avoid seeking health services?	Delayed seeking health services		Avoided seeking health services	
	n=179 MSWs	n=179 MSM	n=179 MSWs	n=179 MSM
You hide that you sell sex/have sex with men from friends and family	1.30 (0.68)	1.10 (0.88)	1.92 (0.29)	3.30 (0.05)

Model includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, waive recruited in current study, the site they were interviewed in, their HIV status, depression, social capital, and disclosure of sex worker status or status as MSM.

Green shading indicates relationship is significant at 5% or 10% level. This means that the results are 95% or 90% certain in support of rejecting the null hypothesis that there is no relationship or association between internalized stigma and avoiding or delaying services.

Important Related Factors

In addition to the background and key healthcare seeking and stigma variables of interest, data were also collected on three factors that are known to be related to both stigma and healthcare seeking: disclosure, depression, and social capital. The following sections provide basic descriptive results for these three areas.

Disclosure

We asked respondents whether or not specific individuals (e.g., spouse/partner), or groups of individuals (e.g., other family members) knew that they sell sex or have sex with men (men only). Where others had knowledge of either sex work or MSM status, we asked whether disclosure had been voluntary (i.e., they told others themselves or gave someone else permission to tell others) or involuntary (Tables 18 and 19). The results showed that MSWs were generally less likely to report that others knew their status as a sex worker compared with FSWs. For example, 81 percent of MSWs reported that their neighbors or community members did not know that they sell sex, compared with just 23 percent of FSWs. Similarly, males were much less likely to report that their friends and adult family members knew that they sell sex. For both males and females with children, the majority of respondents (79%, females; 95%, males) had not disclosed to their children that they sell sex. There were some similarities between male and female sex workers on whether the decision to disclose to others was voluntary or not. Of those who had disclosed that they sell sex to adult family members or neighbors/community members, both male and female sex workers were more likely to report involuntary rather than voluntary disclosure of their status. The majority of female (72%) and male (84%) sex workers had voluntarily disclosed that they sell sex work to other sex workers. Notably, the majority of males had also voluntarily disclosed they sell sex to healthcare workers (58%) and to other MSM who are not clients (56%).

Table 18. FSW Disclosure Table (n=497)

	SW status not disclosed	SW status disclosed voluntarily	SW status disclosed involuntarily
Your husband/partner (n=17)*	65% (11)	24% (4)	0% (0)
Other adult family members	31% (156)	19% (95)	49% (242)
Your children (n=422)~	79% (332)	7% (29)	13% (54)
Your friends	13% (66)	42% (210)	45% (221)
Other sex workers	2% (10)	72% (359)	26% (127)
Neighbors or community members	23% (113)	10% (48)	67% (335)
Healthcare workers	31% (155)	47% (232)	22% (109)

*n is equal to those who reported being married or having a partner. Totals do not add to 100% due to respondents' selection of "not applicable."

~n is equal to those who reported having children. Totals do not add to 100% due to respondents' nonresponse or selection of "not applicable."

In general, male respondents were slightly more likely to voluntarily disclose to others that they have sex with men than that they sell sex. For example, while 66 percent of MSWs said that they had voluntarily disclosed being MSM to their neighbors or community members, only 3 percent had voluntarily disclosed being sex workers to this same group. However, this pattern is reversed for disclosure to healthcare workers; 58 percent of MSWs had voluntarily disclosed their status as sex workers to healthcare workers compared with just 6 percent who had voluntarily disclosed their MSM status to health providers. Of note is that 18 percent of MSWs reported that their MSM status had been involuntarily disclosed to healthcare workers.

Table 19. MSW Disclosure Table (n=232)

	SW status			MSM status		
	Not disclosed	Disclosed voluntarily	Disclosed involuntarily	Not disclosed	Disclosed voluntarily	Disclosed involuntarily
Your wife/partner (n=63)*	62% (39)	25% (16)	5% (3)	25% (16)	60% (35)	0% (0)
Other adult family members	75% (174)	6% (14)	19% (43)	59% (136)	12% (28)	29% (67)
Your children (n=61)~	95% (58)	2% (1)	2% (1)	92% (56)	0% (0)	5% (3)
Your friends	53% (123)	22% (52)	25% (57)	43% (100)	23% (53)	34% (79)
Other sex workers	5% (11)	84% (196)	11% (25)	5% (11)	85% (197)	10% (24)
Neighbors or community members	81% (187)	3% (8)	16% (37)	28% (64)	66% (154)	6% (14)
Healthcare workers	35% (82)	58% (134)	7% (16)	76% (176)	6% (14)	18% (42)
Other MSM (not clients)	33% (77)	56% (129)	11% (26)	N/A	N/A	N/A

*n is equal to those who report being married or having a partner (male or female). Totals do not add to 100% due to respondents' selection of not applicable or non-response.

~n is equal to those who report having children. Totals do not add to 100% due to nonresponse.

Social capital and resistance

Respondents were asked a series of questions related to social capital associated with other sex workers, to participation in groups, knowledge of an organization that could help with S&D, and resistance to stigma (Table 20). Respondents were asked a series of seven questions about being able to rely on other sex workers for various kinds of support (e.g., to borrow money) and participation in groups. The mean score on the social capital index was 5.2 for MSWs and 5 for FSWs, on a scale of 0-7, with higher scores indicating stronger social capital. The mean on the index for participation in a range of social groups was 3.9 both for MSWs and FSWs, out of a range of possible scores of 0–10. The most commonly reported type of group participation was religious.

While more FSWs (82%) than MSWs (47%) had confronted or challenged someone who was stigmatizing them for selling sex, the results show that both FSWs and MSWs had clearly challenged stigma. More than 60 percent of both male and female respondents knew of an organization where they could seek help if they experienced S&D for selling sex.

Table 20. Social Capital and Resistance to Stigma

	Male sex workers (n=232)	Female sex workers (n=497)
Social capital		
Know an organization that can help you if you experience stigma or discrimination for selling sex	68% (158)	61% (301)
Agree that you can count on other sex workers...		
If you need to borrow money	83% (193)	80% (399)
To accompany you to the doctor or hospital	82% (191)	85% (424)
If you need to talk about your problems	90% (208)	86% (428)
If you need somewhere to stay	85% (197)	80% (400)
To help deal with a violent or difficult client	92% (212)	89% (442)
To help you find clients	87% (201)	79% (393)
Mean index score*	5.2 (1.2 std. dev.[1])	5.0 (1.4 std. dev.)
Participation in a group		
Participates in, actively participates in, or leads...		
Church or other religious groups	69% (161)	69% (345)
Clubs (sports, student groups)	47% (110)	37% (183)
Art and cultural activities (dance, music, etc.)	43% (100)	44% (220)
Social activities in society	58% (135)	62% (306)
Mean index score^	3.9 (2.5 std. dev.)	3.9 (2.1 std. dev.)
Resistance to stigma		
Ever confronted or challenged someone who was stigmatizing or discriminating against you because you sell sex	47% (109)	82% (406)

[1]std. dev. = standard deviation

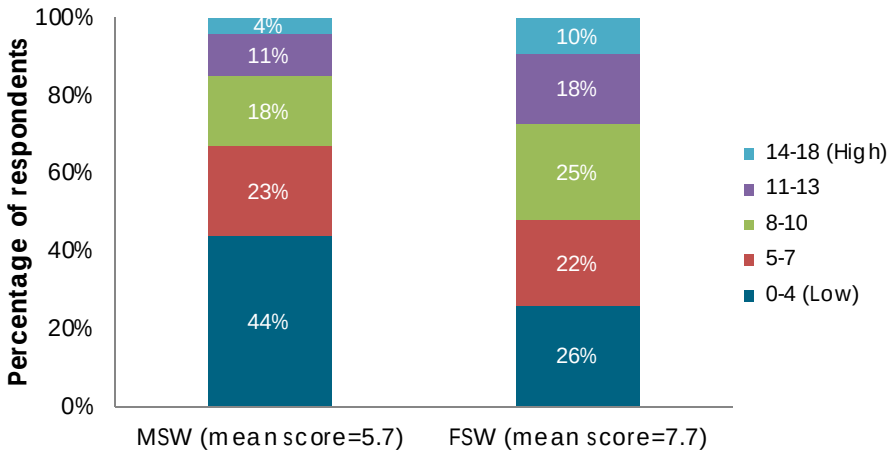
*Index ranges from 0 to 7 based on 7 statements and on agreeing (1) or disagreeing (0) w being able to count on other sex workers for: borrowing money, accompaniment to a health facility, to talk about problems, for somewhere to stay, to help deal with a violent or difficult client, to help find clients.

^Index ranges from 0 to 10 and is based on not participating (0), participating (1), or actively participating/leading (2) in 5 types of organizations/group: church/other religious, clubs (sports, student groups), art and cultural activities, social activities in society, sex worker support networks.

Depression

Depression was measured using the validated P9-Patient Health Questionnaire,[64, 65] which consists of nine items. Figure 6 shows the scores across a depression index from 0–18, where respondents were scored based on how often they experienced an item in the past two weeks (not at all=0, several days=1, or more than half the days or nearly every day=2). The mean score for MSWs was 5.7 and 7.7 for FSWs, with more women than men expressing higher levels of depression (see Annex C for full frequencies).

Figure 6. Depression Index Score



Index ranges from 0 to 18 and is based on how often in the last two weeks (not at all=0, several days=1, or more than half the days or nearly every day=2) respondent had experienced the following: felt little interest or pleasure in doing things; feeling down, depressed, or hopeless; either trouble falling or staying asleep or sleeping too much; feeling tired or having little energy; either poor appetite or overeating; feeling bad about yourself; trouble concentrating on things; either moving or speaking slowly or being fidgety or restless; thoughts that you would be better off dead or hurting yourself in some way.

More than half of FSWs reported having experienced symptoms of depression over the last two weeks before the survey for eight of the nine items measured. For example, most FSWs (81%) felt tired or had little energy at least several days in the preceding two weeks. The only symptom of depression reported by less than half of FSWs within the last two weeks was having thoughts of being better off dead or hurting oneself (37%). Responses from MSWs followed similar patterns, with roughly 50 percent or more reporting symptoms of six of the nine items in the previous two weeks. Less than half of MSWs reported occurrences of three symptoms in the preceding two weeks: thoughts of being better off dead or hurting oneself (25%), trouble concentrating on things (37%), and moving or speaking slowly or being fidgety and restless (39%). For both FSWs and MSWs, the percentage of respondents reporting they had experienced a given symptom in the past two weeks never fell below a quarter.

Eighty-nine percent of male and 92 percent of female sex workers reported having experienced at least one symptom of depression in the preceding two weeks. Of those, the majority of males (64%) and females (74%) found that these problems made it difficult to work, take care of things at home, or get along with others. Six percent of males and 8 percent of females reported that depression symptoms made it *extremely* difficult to do these things.

HIV Status and HIV-related Stigma

HIV status and risk perception

In terms of HIV risk behavior, just more than half of MSWs (55%) and FSWs (58%) reported that they always used a condom during sex in the preceding 12 months (Table 21). Thirty-nine percent of both MSWs and FSWs reported that they or a partner had injected an illicit drug during the same period. Reflecting on these risk behaviors, 60 percent of males and 52 percent of females believed they were at some risk of contracting HIV due to their behavior.

Slightly more females (82%) than males (72%) had been tested for HIV in the preceding 12 months. Also during that period, a majority of respondents said they had received both pre- and post-test counseling when tested for HIV, with slightly more females (76%) than males (63%) receiving this counseling. A quarter of male and 23 percent of female respondents self-reported that they were living with HIV. Of those who self-reported they were HIV negative, 6 percent of males and 24 percent of females had been worried about contracting HIV in the last 12 months and believed they could be living with HIV.

Table 21. HIV Risk, Testing, and Status

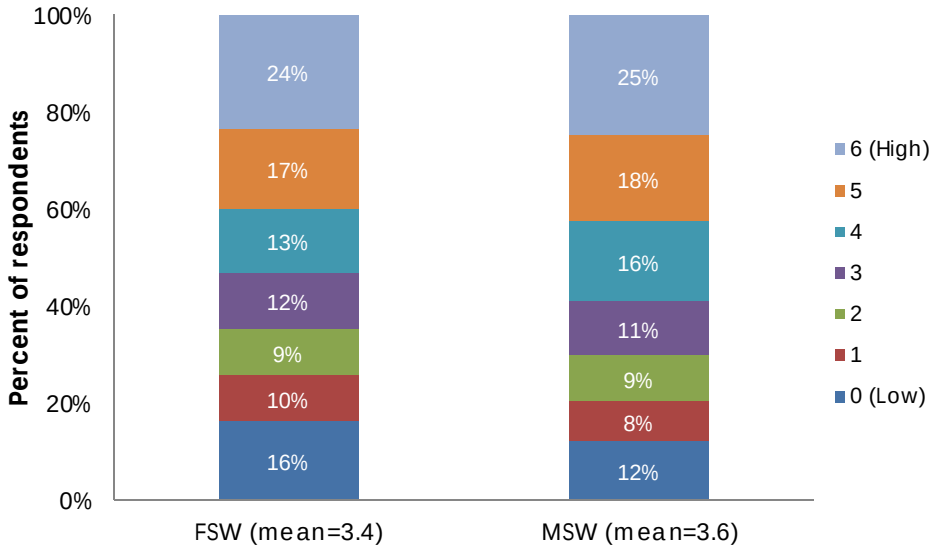
	Male sex workers (n=232)	Female sex workers (n=497)
HIV risk behavior and perception		
Always used condom during sex in the last 12 months	55% (128)	58% (287)
Injected or partner injected illicit drugs in last 12 months	39% (90)	39% (196)
Percentage of respondents who believe they are at risk of HIV based on their sexual behavior in the last month	60% (139)	52% (257)
HIV testing		
Tested for HIV in last 12 months	72% (168)	82% (409)
Tested for HIV without consent in last 12 months	4% (10)	5% (26)
Received both pre- and post-HIV test counselling (of those tested for HIV in last 12 months)	63% (106)	76% (309)
*HIV status**		
HIV positive	25% (57)	23% (115)
HIV negative	54% (125)	72% (359)
Percent of HIV negative people who believe they have HIV	6% (11)	24% (92)

*Does not add to 100% due to nonresponse.

Perceived stigma toward PLHIV

The study team measured how respondents perceived stigma toward PLHIV across five items and built an index score ranging from 0 to 5 based on whether or not the respondent agreed (1) or disagreed (0) with each of the five statements. The mean score was 2.7 for FSWs and 2.9 for MSWs (Figure 7). The range of responses indicates that there were wide variations in how respondents perceived stigma toward PLHIV in their communities and society. However, large majorities of both males and females agreed that PLHIV face rejection from their peers (71%, MSWs; 67%, FSWs) and people who are suspected of having HIV lose respect in the community (62%, MSWs; 60%, FSWs). More than 40 percent of both male and female respondents reported the highest levels (a score of 5 or 6) of perceived stigma.

Figure 7. Perceived Stigma toward PLHIV

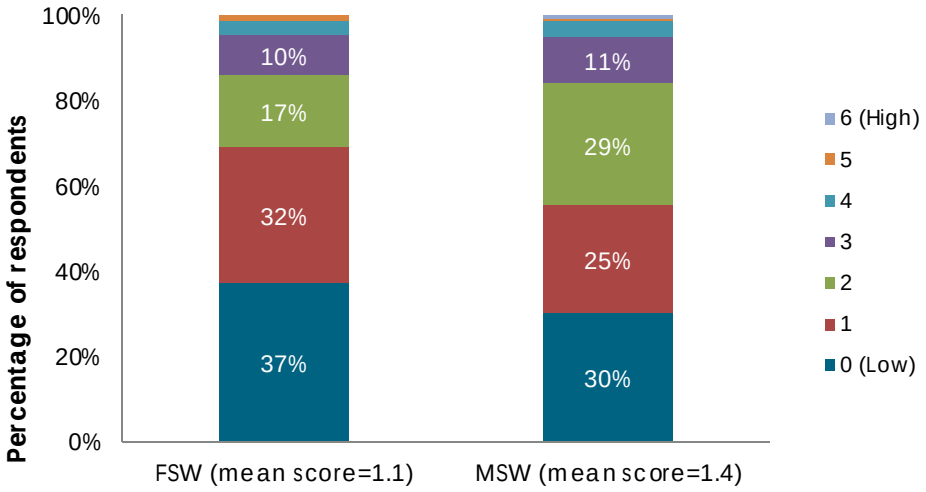


Index ranges from 0 to 6 and is based on whether or not a respondent agreed (1) or disagreed (0) with the following statements: PLHIV face neglect from their family, PLHIV face physical abuse, PLHIV face ejection from their homes by their families, people suspected of having HIV lose respect in the community, PLHIV face verbal abuse, and PLHIV face rejection from their peers.

Stigma toward PLHIV

The study team created an index score for stigma toward PLHIV based on eight items measured in the study. The index score ranges from 0 to 8, where 0 indicates the lowest levels of stigma and 8 is the highest level of stigma toward PLHIV. The mean scores for males and females were 1.4 and 1.1, respectively, suggesting very low levels of stigma toward PLHIV (Figure 8). In fact, 37 percent of females and 30 percent of males had a score of 0, and no respondents had a score above 6. The low levels of stigma toward PLHIV may be due to the fact that nearly every respondent reported knowing a person living with HIV (95%, MSWs; 96%, FSWs). However, there were still some indications of stigma toward PLHIV among respondents. Significant minorities of both females (28%) and males (29%) did not think sex workers living with HIV should be allowed to sell sex. Males were more likely than females to agree that most PLHIV have had many sexual partners (46%,MSWs; 33%, FSWs) and that people who acquire HIV engage in irresponsible behaviors (48%, MSWs; 29%, FSWs).

Figure 8. Stigma toward PLHIV



Index ranges from 0 to 8 and is based on whether or not a respondent agreed (1) or disagreed (0) with the following statements: PLHIV should be ashamed of themselves, people who have HIV are cursed, it is reasonable for an employer to fire a person living with HIV, you would not buy vegetables from a shopkeeper or food seller whom you knew had HIV, you think children living with HIV should not be allowed to attend school with other children who are HIV negative, sex workers living with HIV should not be allowed to sell sex, most people living with HIV have had many sexual partners, and people get infected with HIV because they engage in irresponsible behaviors.

HIV-related stigma and healthcare seeking behavior

In addition to asking questions on perceptions of stigma toward PLHIV and sex workers' own attitudes toward PLHIV, researchers asked if sex workers anticipated being assumed to have HIV due to being a sex worker or MSM. Table 22 shows that males and females who feared being assumed to have HIV in the 12 months preceding the survey because they sold sex or were MSM were more likely to delay or avoid seeking health services, compared to those who did not fear being assumed to have HIV for these reasons (see Annex C for full bivariate results).

Table 22. Association of Anticipated HIV-related Stigma with Delay and Avoidance of Needed Health Services

Are sex workers who anticipate HIV-related stigma more likely to delay or avoid seeking health services?	Delayed seeking health services	Avoided seeking health services
Female sex workers (n=497)		
Assumed to have HIV because SW	0.03	0.04
Male sex workers (n=232)		
Assumed to have HIV because MSM	0.00	0.01
Assumed to have HIV because SW	0.01	0.00

Green shading indicates relationship is significant at 5% or 10% level.

Table 23 shows the logistic regression results for anticipated HIV-related stigma and avoiding or delaying seeking healthcare. The logistic regression controls for other factors that may influence avoiding or delaying healthcare services, such as age, education, and income. For both males and females, those who anticipated being assumed to have HIV because they sell sex had higher odds of delaying and avoiding healthcare than those who did not anticipate this. Similarly, MSWs who feared others would assume they have HIV because they are MSM had significantly higher odds of delaying (OR 2.14; p=0.02) or avoiding

(OR 3.68; p=0.00) seeking health services than those who did not fear being assumed to have HIV due to being MSM.

Table 23. Logistic Regression Results: Anticipated HIV-related Stigma with Avoidance and Delay in Seeking Health

Are sex workers who anticipate HIV-related stigma more likely to delay or avoid seeking health services?	Delayed seeking health services	Avoided seeking health services
Female sex workers	*n=435*	*n=434*
Assumed to have HIV because sex worker	1.55 (.03)	1.59 (.02)
Male sex workers	*n=204*	*n=173*
Assumed to have HIV because MSM	3.10 (.00)	3.68 (.00)
Assumed to have HIV because sex worker	2.72 (.00)	2.64 (.02)

Includes control variables for age, level of education, marital status, time (in years) spent doing sex work, reported annual income, wave recruited in current study, HIV status, and the site they were interviewed in.
Green shading indicates relationship is significant at 5% or 10% level.

CHAPTER 4. DISCUSSION AND STUDY LIMITATIONS

Discussion

This study sought to add to the limited knowledge, both in Kenya and globally, on sex worker stigma by quantitatively measuring four types of stigma and examining their relationship to the utilization of health services. Evidence shows how HIV-related S&D undermines HIV testing, entry into care, and treatment adherence.[17, 18, 16] Further, there is increasing recognition that key population stigma is also a strong deterrent to HIV prevention, treatment, and care.[25, 66] However, quantitative data documenting the experience of stigma among key populations, including sex workers, and the relationship between stigma and utilization of health services, are limited.

Prevalence and frequency of stigma

The data from this study paint a grim picture both for male and female sex workers of lives filled with stigma. Study respondents are anticipating, witnessing/hearing of, experiencing, and internalizing multiple manifestations of stigma coming from several sources: their families, the community, healthcare workers, and police. Although qualitative research has revealed that sex workers face S&D,[67, 27, 68-73] there remains a dearth of quantitative research measuring S&D among this population, particularly among male sex workers.[9] The findings of this study add to that limited body of knowledge, and while often not directly comparable because of differences in measures and timeframes, they confirm that Kenya sex workers experience similarly high levels of stigma as documented in other studies.[74, 75]

For example, a study in Swaziland found that 87.7 percent of FSWs reported perceived stigma and 72.9 percent reported any experienced event of stigma in the preceding 12 months.[75] Another study conducted in Brazil found 83.3 percent of male sex workers reported psychological abuse due to homophobia in the past year.[74] Similarly high levels of stigma were found in this study (see Figure 3 and Annex C):

- 72 percent of FSWs and 84 percent of MSWs reported anticipating verbal abuse in the past 12 months and 86 percent of FSWs and 64 percent of MSWs reported having experienced it
- 86 percent of FSWs and 89 percent of MSWs reported witnessing/hearing about exclusion and 69 percent of FSWs and 44 percent of MSWs reported experiencing exclusion themselves

The study revealed both a high prevalence and a high frequency of stigma across the study population. Respondents who indicated they had experienced a specific manifestation of stigma in the 12 months preceding the survey were most likely to report that it happened often. For example, of the respondents who reported experiencing verbal harassment in the past 12 months, the majority reported that it happened often (63%), with a lesser number of respondents responding that it happened a few times (28%), or once (9%). While all manifestations of stigma measured in this study were alarmingly high, of particular concern were the anticipated, witnessed, and experienced levels of physical violence and rape; 90 percent of FSWs and 81 percent of MSWs reported witnessing/hearing of physical violence, and 63 percent of FSWs and 33 percent of MSWs reported experiencing it in the past 12 months. FSWs are experiencing violence at a rate more than twice as high as that experienced by the general population of women. According to the Kenya Demographic and Health Survey 2008-09,[*, 76] 24 percent of women ages 15–49 reported experiencing physical violence in the last year; 63 percent of FSWs in this study did so. A study in northern Ethiopia found that 45.6 percent of FSWs reported physical harm in their lives.[77] A

[*] The 2014 Kenya Demographic and Health Survey report has made available only data on domestic violence against ever-married women, 22.7 of whom reported experiencing physical violence from their husbands or partners in the last year.

recent global review of violence (that includes Kenya) against female or transgender sex workers reports a high burden of violence, concluding that "large gaps in epidemiological data support the need for research and structural interventions to better document and respond to the contextual factors shaping this violence."[78] Research on physical violence against MSWs is even more limited. However, one Brazilian study on both sex worker and non-sex worker MSM found that 48.5 percent of MSWs experienced physical abuse over the previous 12 months due to homophobia, compared to 17.8 percent of the MSM, non-sex worker population.[74]

Rape was also alarmingly high. The majority of both FSWs and MSWs reported that they had anticipated rape in the 12 months preceding the survey. A higher proportion of respondents reported witnessing/hearing about rape and almost half (49%) of women and more than a quarter (26%) of men reported experiencing rape in the past 12 months. In comparison to the general population of Kenyan women, FSWs were much more likely to experience rape. Sixty-six percent of FSWs reported ever experiencing rape (49% in the past 12 months), compared to nearly a fifth of women ages 15-49 from the general population who report ever having experienced sexual violence in 2008-9.[*, 76] Other studies in sub-Saharan Africa have revealed similar findings. A study in Swaziland found that rape was very common, with nearly 40 percent of FSWs reporting rape in the past year,[75] while a study in northern Ethiopia found that 75.6 percent of FSWs reported having experienced any form of sexual violence in their lives.[77] Another study conducted in Uganda found that 49 percent of FSWs had been raped at least once in their lives, while a study conducted in Togo and Burkina Faso found that 33 percent of FSWs reported forced sex at least once in their lives.[79] Research on rape or forced sex among MSWs is extremely limited. However, one Thai study of forced sex among MSM, MSWs, and transgender people notes that 12.2 percent of MSWs have experienced forced sex at least once in their lives.[80]

In addition to the physical and psychological harm caused to the individual and the human rights violations implicit in any form of physical and sexual violence, the rates of violence documented in this study have implications for controlling the HIV epidemic. A recently published modeling paper estimates that elimination of sexual violence alone could avert 17 percent of HIV infections in Kenya among FSWs and their clients in the next decade.[81]

It is also important to note that both MSWs and FSWs reported high levels of experienced stigma from healthcare providers. Almost three quarters of FSWs (72%) and more than half (57%) of MSWs experienced S&D from healthcare providers in the 12 months preceding the study. These results resonate with a qualitative study conducted in Kenya, Zimbabwe, Uganda, and South Africa, which found that female, male, and transgender sex workers faced high levels of discrimination from healthcare providers, including the denial of treatment for injuries following physical assault or rape.[72] Another qualitative study conducted in Zimbabwe found that FSWs faced considerable discrimination from healthcare providers, including being demeaned and humiliated, a reflection of broader social stigma surrounding their work.[69] While not specific to MSWs, but still relevant, several studies have also documented healthcare stigma toward MSM. Two qualitative studies in South Africa describe verbal harassment[82] as well as discrimination and negative attitudes[83] by health providers toward MSM, while in a study in Swaziland, 61.7 percent of MSM respondents reported fear of seeking healthcare.[84]

Stigma from police is also high with 76 percent of FSWs and 50 percent of MSWs reporting police as a source of S&D in the 12 months preceding the survey. The pervasiveness of stigma from the police is documented in a multi-country qualitative study that took place in sub-Saharan Africa, which found that

[*] The 2014 Kenya Demographic and Health Survey report has made available only data on sexual violence against ever-married women, 9.8% of whom reported experiencing sexual violence from their husbands or partners in the last year.

physical and sexual abuse at the hands of the police were disturbingly common.[85] Other qualitative studies conducted in sub-Saharan Africa found that FSWs commonly reported physical and sexual violence and other forms of harassment and abuse from the police.[71, 73, 86] One study that examined the experiences of six MSWs in Nigeria also revealed experiences of physical and sexual violence from policeman and other forms of police harassment.[70]

In addition to anticipated, witnessed/heard of, and experienced stigma, the study measured internalized stigma. Internalized stigma has been linked to poor health outcomes, in particular mental health conditions and HIV.[87] For example, a South African study found that internalized homophobia was significantly associated with a reduced likelihood of having recently been tested for HIV,[88] while in the Dominican Republic, internalized stigma related to HIV and to being a female sex worker were significantly associated with ART interruption.[89] Internalized stigma was relatively high in this study, though higher for FSWs than MSWs. Around half of FSWs and a quarter of MSWs either agreed or strongly agreed with the six items interviewers asked in order to capture internalized stigma. For example, 52.7 percent of FSWs and 26.2 percent of MSWs agreed or strongly agreed with the statement, "There are times you feel worthless because you sell sex." For men, the study team measured internalized stigma related both to sex work and to having sex with other men.

Internalized stigma related specifically to being a sex worker has scarcely been researched or measured among sex worker populations, particularly in Africa. A small exploratory study of MSWs in Beirut found that respondents frequently raised issues of internalized stigma.[90] Internalized stigma was also measured in a study on adherence for HIV-positive FSWs in the Dominican Republic.[89] Internalized homophobia among MSM is a little more commonly assessed.[9] While not directly comparable due to the use of different measures, this study's results are similar to those of a Nigerian study, where nearly a third of MSM respondents reported internalized homophobia.[91]

Relationship between stigma and seeking healthcare

Given the high prevalence and frequency of stigma, it is perhaps unsurprising that this study's findings demonstrate a relationship between stigma and delaying or avoiding healthcare. When asked about this issue directly, more than half of MSWs and FSWs reported that they either had avoided or delayed health services in the 12 months preceding the survey due to anticipation of stigma within the health service. For example, 58 percent of MSWs and 65 percent of FSWs indicated that they avoided or delayed needed health services, because they feared they would experience stigma from health providers (e.g., being denied services, scolded, blamed, and made to wait longer).

In addition to these direct questions on how stigma affects health seeking, the study also collected information on health-seeking behavior and stigma separately from each other and then examined the association between them. Health-seeking behavior was measured by asking participants about both the delay and avoidance of any type of needed health services during the 12 months preceding the study. The need for health services in the past 12 months was high, with 90 percent of male and female respondents reporting need. Of these respondents, just about half of MSWs (48%) and FSWs (49%) reported that they avoided health services when needed, and an even higher proportion reported that they delayed seeking needed health services (73%, men; 55%, women). Literature on avoidance or delay in general health seeking among FSWs and MSWs is limited. However, one qualitative study conducted in Hong Kong found that FSWs delayed seeking healthcare, self-medicated, or traveled to China (a distance) to seek care.[68] While not among MSWs, a qualitative study conducted in Nairobi found that MSM participants delayed seeking treatment for STIs for fear of "possible embarrassment and stigmatization because of their evident non-normative sexual behavior."[92]

The findings from this study show a strong and consistent negative relationship between health-seeking behavior (as measured by delay or avoidance of needed services in the past 12 months) and stigma for FSWs. Female respondents who reported that they anticipated, witnessed/heard of, or experienced stigma, no matter the manifestation (e.g., verbal, physical, exclusion) or the source (e.g., from family, health providers, police), were consistently more likely to report delay or avoidance of health services than were FSWs who did not. For MSWs, stigma was also negatively related to health seeking, though less consistently across manifestation and source of stigma than for FSWs.

Stigma was also more frequently related to delay than avoidance of services for MSWs, while for FSWs it was related to both. To the best of the authors' knowledge, no other published quantitative studies look specifically at the relationship between different types of stigma (and within those, both manifestations and sources) and general health-seeking behavior among MSWs and FSWs. However, a qualitative study among female, male, and transgender sex workers in Kenya, South Africa, Uganda, and Zimbabwe found that stigma pervades the sex worker community, delaying access to HIV testing, services, and treatment and preventing status disclosure.[72] A few studies, including one in Kenya,[92] focused on MSM show relationships between experiencing S&D and fear of seeking health services.[93]

Although the overall picture is that stigma is generally related to avoidance and delay of needed health services, especially for FSWs, it is important from a policy and programmatic perspective to highlight the relationship of healthcare provider stigma, as well as the influence of stigma from outside a health facility on health-seeking behavior—in particular, the role of the police. For both FSWs and MSWs, experiencing stigma from healthcare providers in 12 months preceding the study was significantly related to both avoidance and delay of seeking needed health services. FSWs who experienced health provider stigma were 1.56 (p=.06) more likely to avoid and 1.59 (p=.05) more likely to delay needed health services, compared to FSWs who had not experienced it. For MSWs, the relationship is larger and stronger. MSWs who had experienced health provider stigma in the preceding 12 months were more than two times as likely to avoid (OR 2.11, p=.03) or delay (OR 2.68, p=.01) needed health services than MSWs who had not. For FSWs, anticipating healthcare stigma had a stronger effect on avoidance (OR 2.25, p=.001) than experienced stigma did, indicating that simply anticipating stigma can influence behavior. While there are no quantitative studies of FSWs and MSWs directly comparable to this study, a multi-country qualitative study of MSWs, FSWs, and transgender sex workers describes the experiences of health worker stigma, with respondents calling for sensitization and training of healthcare providers.[72] A few studies also document the experience of MSM with healthcare stigma. A study in Swaziland found that among MSM, fear of seeking healthcare was significantly associated with having been denied healthcare (OR 8.3, p=.05).[84]

Less expected, perhaps, is the relationship between stigma from outside a health facility and its relationship to delay or avoidance of needed health services. This data clearly show that anticipating or experiencing stigma outside a health facility (from family, community, or police) can have a negative relationship to health-seeking behavior. For example, FSWs who have experienced stigma from the general community were significantly more likely to delay (OR 3.37, p=.001) or avoid (OR 2.91, p=.01) needed health services, while MSWs who had experienced community stigma were more than three times as likely to delay seeking health services (OR 3.18, p=.03). While studies on the influence of stigma outside health facilities on health seeking are limited, a quantitative study in Kenya on stigma and PMTCT has documented how anticipated stigma from husbands can impede pregnant women from taking an HIV test, even while lack of disclosure of HIV status undermines delivery in a facility.[19, 15] A qualitative study in India of the barriers FSWs face in accessing free ART services found that stigma at the family and social levels impeded access to proper healthcare and ART services. Specifically, FSWs in the study feared adverse consequences from unwanted disclosure (including fear of domestic violence, eviction, or rejection by family) and lack of family support.[67]

Beyond the effects of community and family, this study shows a strong negative relationship between police stigma and use of health services by FSWs and MSWs. For FSWs, anticipating, witnessing/hearing of, and experiencing police stigma in the 12 months preceding the study all had significant relationships both to avoidance and delay. For example, FSWs who witnessed/heard about police stigma were more than three times as likely to avoid (OR 3.9, p=.001) or delay (OR 3.09, p=.001) seeking needed health services. For MSWs, both anticipating and witnessing/hearing of police stigma were significantly related to delay or avoidance. For example, MSWs who anticipated police stigma were more than two times as likely to avoid (OR 2.19, p=.04) and three times as likely to delay (OR 3.10, p=.001) needed health services than MSWs who had not. A qualitative Senegalese study found that criminalization of same sex practice and increased police persecution increased stigma toward MSM, and decreased the provision of HIV prevention services and the uptake of HIV prevention services.[94] A quantitative study conducted in China found that fear of arrest among FSWs was negatively associated with accessing HIV prevention services.[95]

Disclosure

Disclosure is closely linked to stigma and healthcare in multiple ways and therefore important to understand. Because of S&D, sex workers may not disclose to others that they are SW, MSM, or—if living with HIV—that they are HIV positive. Controlling who knows about one's status is a defense and coping mechanism against S&D. If people do not know a person's status, they are less likely to stigmatize or discriminate against that person. However, disclosure, particularly to sexual partners and healthcare providers, is essential to preventing HIV and STIs and to receiving appropriate medical care. Respondents in this study were asked who knew about their sex work status (and for MSWs, their MSM status) and whether the disclosure had been voluntary or not. FSWs were more likely to report that their status as sex workers was known by adult family members (besides their spouses), friends, and neighbors than MSWs were.

However, of note is the large proportion both of FSWs and MSWs who reported that disclosure—particularly to adult family members, friends, and neighbors or community members—was not voluntary. Only a small proportion of FSWs and MSWs were married. Of these, close to two thirds of FSWs (65%) and MSWs (62%) had not disclosed to their spouses that they engaged in sex work. Close to a third of FSWs (31%) and MSWs (35%) had not disclosed to healthcare providers that they engaged in sex work, and 76 percent of MSWs had not disclosed that they engaged in sex with men. This is not surprising, given respondents' reports of anticipated, witnessed, and experienced stigma toward sex workers by healthcare providers. However, it does point to a challenge both in providing and receiving appropriate preventive and curative healthcare related to the specific health issues faced by FSWs and MSWs.

Fear of HIV stigma and utilization of health services

Sex workers not only face stigma related to being sex workers or MSM but also the risk of experiencing stigma associated with HIV, either because of the assumption that FSWs and MSWs are HIV positive or because they are living with HIV. More than 50 percent of FSWs and MSWs reported that in the 12 months before the survey, they had feared being assumed to be HIV positive, because they were sex workers. More than two-fifths (44.8%) of MSWs reported they had feared being assumed to be HIV positive, because they were MSM. More important, both the bivariate and multivariate analyses showed a significant relationship between the fear of being assumed to be HIV positive and the delay and avoidance of health services. FSWs who feared they would be assumed to be HIV positive were 1.59 times more likely (p=.02) to delay services than those who did not, and 1.43 times more likely to avoid services (p=.08. MSWs who feared assumptions about HIV status due to being sex workers were more than twice as likely to delay (OR 2.64, p=.02) or avoid (OR 2.10, p=.03) health services than those who did not. This relationship was even stronger with respect to being MSM. MSWs who feared being assumed to be HIV positive because they are MSM were more than three times as likely (OR 3.68, p=.001) to delay needed health services as those who did not, and the odds of their avoiding seeking healthcare were more than

two times as high (OR 2.10, p=.03). One qualitative study, conducted in India with FSWs, MSM, and transgender persons, found that fear of the psychological impact of a positive HIV test result and the perceived repercussions of being seen accessing HIV services constituted key personal and interpersonal barriers to HIV service utilization.[96]

Study Limitations

This study has several limitations. One is its design. Cross-sectional designs lead to an inability to determine directionality in observed relationships or trends over time that longitudinal study designs provide. However, cross-sectional studies have the advantage of providing results more quickly and are able to determine associations. In addition, the study relied on participant self-reports, both of their utilization of health services and experiences of stigma, which could be influenced by poor recall, sensitivity of the questions, and social desirability bias (for example, with the questions about stigma toward PLHIV). The study recruited participants through partner organizations serving MSWs and FSWs, and as with any study enrolling hard to reach populations, the study may have been limited in its ability to reach male and female sex workers who are potentially most vulnerable to stigma simply because they may not participate in networks or be connected to people who do participate in networks. It is not possible to know if this was indeed the case. However, it should be noted that both MSW and FSW respondents reported very high levels of stigma, so if those who are most vulnerable to stigma were indeed not reached, it can be concluded that their experience of stigma is likely to be even higher.

To try to mitigate this issue, the study design used the RDS methodology. The initial recruitment of participants (the seeds) was conducted through partner organizations serving sex workers. These initial respondents (seeds) were then asked to recruit up to four other respondents. The number of initial seeds and then number of coupons given out to each participant were based on the coupon return rate experience of a previous study among migrant FSWs in Nairobi of 35.6 percent.[7] However, there was a higher coupon return rate than anticipated: 43 percent across all sites, and 80 percent across sites in Nairobi, where most of the study sample lived. This resulted in reaching the target sample size within only two waves of recruitment, and an uneven opportunity for each respondent to recruit the same number of respondents. As a result, while the study design was set up for RDS weighting, the data analysis was not conducted using RDS weighting, but was instead analyzed as a snowball sample. Since study participants were not selected randomly and we did not weight the data to adjust for this, our results may not be generalizable to all sex workers in these four sites or to other contexts within Kenya. However, the study results do provide compelling pictures of the experiences of stigma among MSWs and FSWs in these sites and of the association between stigma and utilization of health services.

Last, the study team was only able to collect data from the perspective of those experiencing and not from those perpetrating S&D. To get a fully comprehensive picture, and to shape stronger stigma-reduction interventions, it will be important to collect data from those perpetrating stigma, in particular healthcare workers and police. Understanding their perspectives on S&D toward male and female sex workers, including their perceptions of the manifestations, prevalence, and causes of stigma, is important in designing effective S&D-reduction programs.

CHAPTER 5. RECOMMENDATIONS

Protecting human rights is at the core of several policies in Kenya. The realization of fundamental human rights, including the right to health as enshrined in the 2010 Kenya Constitution, is one of two key obligations of health in the draft *Kenya Health Policy*, a framework to guide the health sector from 2014 to 2030. Article 43 (a) of the Constitution states that every person in Kenya is entitled to "the highest attainable standard of health, which includes the right to health care services, including reproductive health care." Furthermore, the Constitution states that the state shall put in place affirmative action programs designed to ensure that minorities and marginalized groups have reasonable access to health services. Therefore, provision of comprehensive, nonstigmatizing healthcare services for key populations is not only critical in the national HIV response but also in upholding Kenyans' constitutional right to healthcare.

An understanding of the ways in which key populations are stigmatized and the various stigmatizing agents/sources is needed to inform the development of interventions that may reduce stigma. This study showed an association between anticipating, witnessing/hearing of, or experiencing stigma in the past twelve months and delaying or avoiding seeking needed health services by both male and female sex workers. Sex workers who anticipated, witnessed/heard of, or experienced various manifestations of stigma were more likely to delay, and often avoided, health services when needed. Health objectives enumerated in the country's different policies and guidelines will not be realized unless the Government of Kenya, through its program implementation, works to address the underlying factors that lead sex workers to delay or entirely avoid health services. Delays or avoidance of needed health services negatively affect the health of the individual, through poorer health outcomes, and the overall population, by increasing health sector costs and undermining investments in health services. For example, if individuals most vulnerable to HIV are not able to access available HIV prevention and treatment services for fear of stigma, then investments in those services are underutilized and the broader HIV response is less efficient and less effective in the long run.

In addition, the results of this study point to a need not only to address stigma within the health system but also to recognize and address the environment outside the health system that influences access to health services. It is not enough to make services available; barriers that reduce uptake of services by stigmatized populations also must be removed. Therefore, this study makes the following recommendations.

Recommendations for health services

The study findings clearly show that MSWs and FSWs are experiencing stigma in health facilities and that stigma is a barrier to accessing timely healthcare and to achieving a constitutional right to health. Global best practices, as well as recent work in Kenya, show that it is feasible to reduce S&D within health facilities. Thus, this study recommends the following:

1. **The MOH should provide participatory S&D-reduction sensitization training** for all health facility staff (medical and nonmedical), using standardized and tested approaches and tools for addressing both HIV and key population S&D in health facilities; these are available and easily adaptable.[97-99] Training can be tailored and flexible to meet the busy schedules of health facility staff. One successful approach is to have health facility staff develop their own codes of conduct based on understanding built during the training, and to post these codes of conduct throughout health facilities. A model for scaling up this kind of training could include piloting and refining adapted approaches and tools in selected health facilities in the regions where this study was conducted. Global best practice indicates the need for a total-facility approach. Because S&D often begins at the gate or door of health facilities, such an approach should include sensitization

training for all staff, development of codes of practice, and institutionalization of S&D-reduction through development and enforcement of facility-level nondiscrimination policies.

2. **The MOH should revise the Kenya National Patients' Rights Charter to include provisions on S&D**, especially for vulnerable and marginalized groups. The charter states that every person, patient, or client has a right to all that is listed within the charter, including two factors related to S&D: the right to be treated with dignity and respect and the right to receive confidential care. The study findings, however, demonstrate clearly that sex workers are often not treated with dignity or respect, and their confidentiality can be breached in many ways. There is a need to revise this charter to state the ministry's deliberate intention to address S&D in healthcare settings, on behalf of all populations. This could include language that specifies that stigma-free and nondiscriminatory care will be provided to all clients irrespective of gender, age, income, marital status, source of income, and sexual orientation. These messages can be conveyed to clients using clear and highly visible S&D-free signs (similar to no-smoking signs) to reassure stigmatized populations that all facilities are stigma- and discrimination-free.

3. **The Kenya National Commission on Human Rights (KNCHR), in its human rights oversight role, should develop, staff, and maintain facility-level systems for complaints, compliments, and redress.** The KNCHR should consider learning from Ghana's Commission on Human Rights and Administrative Justice and adopt the commission's complaint mechanism, which documents the nature and extent of S&D on the basis of HIV status, sources of income, gender identity, or sexual orientation with a view to informing national policy and programming priorities. Ghana's online complaint form and process100 is more detailed than KNCHR's current form101 and provides a learning opportunity for KNCHR to provide redress to female and male sex workers unable to realize the right to health as articulated in Article 43(a) of the Constitution.

4. **The MOH should institute and enforce strict confidentiality policies around sex work, MSM, and HIV status at the facility level.** Fear of disclosure of status is a concern for sex workers, both within a health facility and outside of it. Instituting facility-level policies and, most important, enforcing them with strong penalties for contravention would reassure sex workers that they can safely utilize health services.

Recommendations for police services

The study's findings demonstrate that S&D experienced outside the health system can affect health-seeking behavior and, therefore, health outcomes. In particular, the results point to the influence of the police and other law enforcement agencies as barriers to sex workers seeking to access health services. Even though the MOH and agencies such as NACC and NASCOP have progressive service guidelines for sex workers, addressing S&D within the health system alone is insufficient. This study associated anticipating, witnessing/hearing of, or experiencing stigma from police with delays in seeking health services. Therefore, addressing S&D beyond the health sector, and within the police and other law enforcement agencies, is also important.

1. **The MOH should work with the National Police Service to update the Police Service Standing Orders**, with provisions on S&D sensitivity indicators for vulnerable and marginalized groups. This will help to ensure that health services for male and female sex workers are not negatively affected by law enforcement activities.[102]

2. **The MOH and the National Police Service should implement stigma-reduction sensitization training for the police.** For example, participatory sensitization training is a potentially powerful structural intervention to educate police on S&D and may reduce stigma. The police force should be offered participatory training that focuses on creating awareness and a deeper understanding of S&D, particularly in law enforcement settings, and how S&D can negatively affect health outcomes. In addition, training will address underlying fears and attitudes that drive S&D by police toward key

populations. Such training can use vignettes and case studies to help the police understand some of the S&D challenges that key populations face. Initial training should be followed up with periodic refresher training and should be part of training new recruits as they come into the police force.

Recommendations on structural reforms

UNAIDS notes that "legal reforms that are significantly associated with HIV (such as decriminalizing HIV transmission; removing laws that are barriers to the uptake of HIV services, such as in the context of sex work; and decriminalizing sex between men) are critical enablers of utilization of health services."

The World Health Organization, in a report entitled *Sexual health, human rights and the law*, also produced evidence confirming that "stigmatization, discrimination, and legal, economic and social marginalization and exclusion impede their [sex workers'] access to necessities such as appropriate and good quality healthcare, social welfare, housing, education and employment."[104]

It is imperative for the Government of Kenya, through its lead agencies in the MOH, National Law Reform Commission, and the Attorney General's office among others, to address with urgency these structural factors that engender and perpetuate stigma against female and male sex workers. This study recommends that:

1. **The government should reform laws and policies at both the national and county levels** to recognize human rights in the design, implementation, and monitoring and evaluation of key population health-related policies and programs and mitigate S&D-related issues that affect healthcare utilization by key populations.
2. **The government should promote and advocate legal reforms beyond** the HIV and AIDS Prevention and Control Act, 2006, which provides the legal basis to address HIV-related discrimination and access to justice through the establishment of the Equity (HIV&AIDS) Tribunal. Even though this tribunal exists at the national level, it is unknown by the majority of the population. Further, the tribunal should be represented at the subcounty level. Legal reforms should ideally include decriminalization of sex work.
3. **The government should provide a supportive environment for peer support groups**, because they provide a critical component of health-seeking behavior for sex workers. Peers are in a unique position to identify, reach out to, and support sex workers who may be experiencing barriers to healthcare due to S&D.

Recommendations for further research

This exploratory study on stigma and utilization of health services among male and female sex workers raises many critical issues that need further investigation. The study demonstrates the need to address the different types of S&D at multiple levels and with different groups to improve health outcomes and to uphold human rights. Yet, additional research is needed on how to address S&D toward sex workers, both in programs and through policy. Implementing such studies requires the following:

1. **Researchers should collect data on stigma from those perpetrating stigma, in particular health workers and police**, to further inform S&D-reduction programs for these groups. A standardized questionnaire for measuring stigma in health facilities, which was tested globally and in Kenya, is already available and could readily be adapted for law enforcement.[105]
2. **Researchers should develop, pilot, and evaluate S&D reduction programs**, building implementation science around these programs to study how to overcome the challenges caused by cultural and social aspects in the Kenyan context. Kenya needs to research and prioritize

relevant stigma reduction approaches to guarantee a robust HIV response in the country's HIV planning process.

3. **Researchers should conduct research to better understand the reasons for inadequate implementation of guidelines and policies specific to key populations at the facility level** and how to strengthen healthcare workers' utilization of guidelines and policies specific to key populations and the implementation of programs targeting key populations.
4. **Researchers should support additional research to understand and establish mechanisms that create a supportive environment for key populations to access health** services and strengthen the linkage to care for key populations living with HIV.

ANNEX A. FSW INDIVIDUAL FREQUENCIES OF DIFFERENT FORMS OF STIGMA

Table A.1. Anticipated, Witnessed/Heard of, and Experienced Stigma

Question	Response (n=497)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
Anticipated stigma: Have you ever been fearful of...						
Being gossiped about by family	23% (115)	3% (16)	18% (91)	43% (214)	12% (61)	0% (0)
Being gossiped about by friends	33% (164)	3% (17)	18% (91)	33% (164)	12% (61)	0% (0)
Being gossiped about by neighbors and the general community	31% (153)	5% (24)	15% (73)	36% (180)	13% (67)	0% (0)
Being gossiped about by healthcare workers	49% (244)	4% (22)	15% (76)	24% (120)	7% (35)	0% (0)
Being verbally insulted, harassed, or threatened by family	26% (128)	6% (28)	13% (65)	42% (211)	13% (65)	0% (0)
Being verbally insulted, harassed, or threatened by friends	34% (170)	3% (17)	18% (91)	33% (163)	11% (56)	0% (0)
Being verbally insulted, harassed, or threatened by neighbors and general community	33% (166)	6% (30)	13% (67)	34% (67)	13% (66)	0% (0)
Being verbally insulted, harassed, or threatened by police	40% (201)	4% (21)	13% (63)	33% (166)	9% (46)	0% (0)
Being verbally insulted, harassed, or threatened by healthcare workers	51% (249)	6% (29)	12% (58)	24% (116)	8% (40)	1% (5)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by family	43% (213)	5% (27)	14% (70)	29% (142)	9% (45)	0% (0)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by friends	57% (284)	4% (22)	14% (68)	21% (103)	4% (20)	0% (0)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by neighbors or community members	58% (286)	5% (26)	13% (63)	22% (107)	3% (15)	0% (0)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by police	38% (188)	4% (19)	14% (69)	38% (187)	7% (34)	0% (0)
Being excluded from family gatherings	34% (169)	5% (25)	17% (83)	36% (180)	8% (40)	0% (0)
Being excluded from community events, such as weddings, parties, or funerals	44% (221)	6% (32)	17% (86)	26% (131)	5% (27)	0% (0)
Being rejected by friends	39% (196)	4% (22)	17% (84)	27% (136)	12% (59)	0% (0)
Being forced to have sex when you did not want to	31% (155)	4% (21)	23% (116)	34% (170)	7% (35)	0% (0)
Being forced to change your place of	41%	8%	19%	26%	7%	0%

Question	Response (n=497)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
residence or being unable to rent accommodation	(204)	(38)	(94)	(128)	(33)	(0)
Carrying condoms, because you were afraid that they might get you in trouble with the police	75% (374)	3% (15)	6% (32)	12% (60)	3% (16)	0% (0)
Carrying condoms, because you were afraid that they might get you in trouble with city/town council *askaris*	77% (383)	3% (16)	7% (35)	10% (49)	3% (14)	0% (0)
Taking condoms from an outreach worker, because you were afraid they might get you in trouble with the police	79% (392)	3% (15)	6% (28)	11% (56)	1% (6)	0% (0)
Taking condoms from an outreach worker, because you were afraid they might get you in trouble with city/town council *askaris*	80% (399)	2% (10)	6% (32)	10% (50)	1% (6)	0% (0)
Being assumed to have HIV because you sell sex	39% (195)	4% (20)	15% (77)	33% (166)	7% (36)	1% (3)
Witnessed and heard stigma: Have you ever witnessed or heard about…						
A healthcare provider providing poorer quality care to FSWs than to other patients	41% (206)	10% (48)	21% (104)	26% (128)	2% (11)	0% (0)
A healthcare provider shouted at or scolded a female sex worker	38% (191)	12% (59)	19% (95)	29% (143)	2% (9)	0% (0)
A healthcare provider made a female sex worker wait longer than others	36% (181)	7% (36)	13% (63)	42% (209)	2% (8)	0% (0)
A healthcare provider refused to provide care to a female sex worker	57% (284)	10% (49)	14% (69)	18% (88)	1% (7)	0% (0)
A healthcare provider gossiped about a female sex worker	37% (185)	10% (50)	14% (68)	38% (187)	1% (7)	0% (0)
A healthcare provider disclosed without the person's permission that a female sex worker sells sex	47% (232)	10% (49)	15% (74)	27% (135)	1% (7)	0% (0)
Someone talking badly or gossiping about FSWs	8% (42)	3% (15)	16% (77)	72% (357)	1% (5)	0% (1)
FSWs being verbally assaulted, harassed, or threatened	8% (42)	6% (30)	22% (111)	63% (310)	1% (3)	0% (1)
FSWs being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt)	23% (114)	11% (54)	27% (134)	36% (180)	3% (14)	0% (1)
FSWs being excluded from community events, such as weddings or funerals	42% (210)	11% (54)	20% (100)	25% (126)	1% (6)	0% (1)
FSWs being excluded from religious activities or places of worship	54% (268)	7% (34)	15% (73)	22% (109)	2% (12)	0% (1)
FSWs being rejected by their friends	23% (113)	10% (49)	28% (137)	38% (186)	2% (11)	0% (1)
Someone blackmailing a female sex worker	33% (166)	11% (56)	23% (115)	30% (151)	2% (8)	0% (1)
FSWs being raped (being forced to	17%	9%	25%	46%	3%	0%

Question	Response (n=497)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
have sex when they did not want to)	(85)	(46)	(123)	(226)	(16)	(1)
FSWs being forced to change their places of residence or being unable to rent accommodation	28% (139)	15% (74)	22% (107)	32% (161)	3% (15)	0% (1)
The children of a female sex worker being dismissed, suspended, or prevented from attending an educational institution	71% (353)	6% (31)	9% (45)	12% (61)	1% (6)	0% (1)
A female sex worker being excluded from family gatherings (e.g., cooking, eating together, weddings, funeral)	33% (163)	10% (51)	26% (129)	29% (142)	2% (11)	0% (1)
A female sex worker being disowned by or lost inheritance from her family	34% (171)	13% (64)	22% (108)	27% (135)	4% (18)	0% (1)
A female sex worker being verbally assaulted, harassed, or threatened by family members	17% (83)	11% (54)	27% (136)	43% (213)	2% (10)	0% (1)
A female sex worker being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by family members	33% (164)	11% (53)	21% (104)	33% (164)	2% (11)	0% (1)
A female sex worker being verbally assaulted, harassed, or threatened by police	24% (119)	4% (22)	16% (80)	53% (263)	2% (12)	0% (1)
A female sex worker being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by police	29% (145)	4% (18)	17% (84)	48% (237)	2% (12)	0% (1)
Police confiscating or destroying condoms held by a female sex worker	49% (245)	7% (35)	13% (62)	30% (150)	1% (4)	0% (1)
A female sex worker being arrested for selling sex	14% (71)	4% (20)	11% (57)	69% (342)	1% (6)	0% (1)
A police worker refusing to protect or take a statement from a female sex worker	41% (205)	10% (51)	17% (86)	28% (141)	3% (13)	0% (1)
Experienced stigma: Have you ever had the following happen to you?						
You were denied health services	69% (345)	8% (42)	10% (52)	9% (45)	3% (3)	0% (0)
You were discharged or asked to leave while still needing care	71% (353)	11% (53)	9% (47)	7% (33)	2% (11)	0% (0)
At the hospital/clinic, you were made to wait longer than other patients	43% (212)	7% (37)	16% (80)	31% (154)	3% (14)	0% (0)
You were not treated as well compared to patients who were not sex workers	53% (261)	9% (47)	15% (76)	19% (94)	4% (19)	0% (0)
A healthcare worker gossiped or spoke badly about you	49% (245)	9% (43)	16% (79)	23% (115)	3% (15)	0% (0)
A healthcare worker disclosed without your consent that you sell sex	57% (285)	8% (40)	14% (68)	18% (91)	3% (13)	0% (0)
A healthcare worker introduced religious or morality issues	51% (255)	8% (40)	17% (86)	20% (101)	3% (14)	0% (0)

Question	Response (n=497)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
Someone spoke badly or gossiped about you	13% (66)	4% (19)	15% (77)	65% (325)	2% (10)	0% (0)
You were verbally assaulted, harassed, or threatened	20% (101)	7% (33)	22% (108)	48% (240)	3% (15)	0% (0)
You were physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt)	56% (280)	8% (41)	13% (67)	19% (95)	3% (14)	0% (0)
You were excluded from community events, such as weddings or funerals	60% (299)	9% (43)	13% (66)	16% (80)	2% (9)	0% (0)
You were excluded from religious activities or places of worship	69% (342)	5% (27)	10% (48)	13% (63)	3% (16)	0% (1)
You were rejected by friends	36% (177)	9% (43)	20% (101)	25% (124)	10% (52)	0% (0)
You were blackmailed	49% (243)	10% (50)	15% (77)	19% (96)	6% (31)	0% (0)
You were raped (forced to have sex when you did not want to)	44% (220)	13% (66)	22% (108)	14% (69)	7% (34)	0% (0)
You were forced to change your place of residence or were unable to rent accommodation	55% (271)	13% (64)	11% (55)	16% (81)	5% (26)	0% (0)
Your child was dismissed, suspended, or prevented from attending an educational institution	86% (411)	3% (12)	5% (24)	4% (19)	3% (14)	4% (17)
You were excluded from family gatherings (e.g., cooking, eating together, sleeping in the same room)	54% (266)	8% (38)	14% (68)	19% (92)	7% (33)	0% (0)
You were disowned by or lost inheritance from family members	59% (291)	7% (36)	7% (37)	18% (89)	9% (44)	0% (0)
You were verbally assaulted, harassed, or threatened by family members	35% (173)	7% (35)	17% (85)	33% (162)	8% (42)	0% (0)
You were physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by family	63% (314)	8% (41)	9% (44)	14% (71)	5% (27)	0% (0)
You were verbally assaulted, harassed, or threatened by police	37% (182)	5% (24)	18% (90)	36% (179)	4% (22)	0% (0)
You were physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by police	52% (259)	6% (29)	15% (74)	25% (122)	3% (13)	0% (0)
Police confiscated or destroyed your condoms	64% (320)	6% (29)	11% (53)	17% (84)	2% (11)	0% (0)
You were arrested for selling sex	31% (155)	10% (52)	17% (84)	35% (174)	6% (32)	0% (0)
A police worker refused to protect you or take a statement from you	56% (280)	12% (60)	11% (55)	17% (84)	3% (17)	0% (1)

Values may not add to 100% due to rounding.

Table A.2. Internalized Stigma

Measures of internalized stigma	Response (n=497)				
	Strongly agree	Agree	Disagree	Strongly disagree	Refuse to answer
It is difficult to tell people that you sell sex	38% (190)	25% (122)	18% (91)	19% (94)	0% (0)
Selling sex makes you feel dirty	15% (76)	31% (154)	26% (130)	28% (137)	0% (0)
Selling sex makes you feel guilty	19% (95)	33% (162)	24% (121)	24% (119)	0% (0)
Selling sex makes you feel ashamed	17% (83)	30% (151)	26% (129)	27% (134)	0% (0)
There are times you feel worthless because you sell sex	20% (97)	33% (165)	23% (113)	25% (122)	0% (0)
You hide that you sell sex from friends and family	36% (179)	29% (146)	18% (88)	17% (84)	0% (0)

Values may not add to 100% due to rounding.

ANNEX B. MSW INDIVIDUAL FREQUENCIES OF DIFFERENT FORMS OF STIGMA

Table B.1. Anticipated, Witnessed/Heard of, and Experienced Stigma

Question	Response (n=232)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
Anticipated stigma: Have you ever been fearful of...						
Being gossiped about by family	14% (33)	2% (4)	14% (32)	63% (147)	7% (16)	0% (0)
Being gossiped about by friends	22% (52)	2% (5)	14% (33)	55% (128)	6% (14)	0% (0)
Being gossiped about by neighbors and the general community	22% (50)	1% (3)	16% (36)	57% (133)	4% (10)	0% (0)
Being gossiped about by other MSM	74% (172)	3% (6)	9% (21)	13% (29)	1% (3)	0% (1)
Being gossiped about by healthcare workers	41% (96)	6% (14)	14% (33)	25% (59)	13% (29)	0% (1)
Being verbally insulted, harassed, or threatened by family	24% (55)	2% (5)	11% (26)	56% (129)	7% (17)	0% (0)
Being verbally insulted, harassed, or threatened by friends	32% (75)	2% (4)	14% (33)	48% (111)	4% (9)	0% (0)
Being verbally insulted, harassed, or threatened by neighbors and general community	24% (56)	1% (3)	13% (29)	57% (132)	5% (12)	0% (0)
Being verbally insulted, harassed, or threatened by police	44% (101)	0%(1)	13%(31)	37% (86)	3% (8)	2% (5)
Being verbally insulted, harassed, or threatened by healthcare workers	79% (184)	1% (2)	6% (13)	11% (26)	2% (5)	1% (2)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physical hurt) by family	56% (130)	4% (10)	10% (23)	13% (31)	6% (14)	10% (24)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physical hurt) by friends	40% (92)	1% (2)	14% (32)	41% (95)	5% (11)	0% (0)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physical hurt) by neighbors and general community	48% (112)	2% (5)	10% (23)	35% (81)	5% (11)	0% (0)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physical hurt) by police	41% (95)	2% (4)	12% (27)	41% (95)	4% (10)	0% (1)
Being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physical hurt) by MSM	42% (96)	3% (8)	13% (30)	37% (86)	4% (10)	1% (2)
Being excluded from family gatherings	30% (69)	4% (9)	15% (34)	44% (102)	8% (18)	0% (0)

Question	Response (n=232)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
Being excluded from community events such as weddings, parties or funerals	45% (104)	3% (7)	13% (30)	34% (78)	5% (12)	0% (1)
Being excluded from MSM social groups or gatherings	86% (199)	2% (4)	7% (17)	5% (11)	0% (1)	0% (0)
Being rejected by your friends	38% (87)	4% (10)	13% (31)	39% (90)	6% (13)	0% (1)
Being forced to have sex when you did not want to	38% (87)	3% (7)	19% (44)	34% (80)	5% (12)	1% (2)
Being forced to change your place of residence or being unable to rent accommodation	34% (79)	6% (15)	15% (35)	39% (90)	5% (12)	0% (1)
Carrying condoms and lubricant, because you were afraid that they might get you in trouble with the police	65% (151)	1% (2)	9% (20)	18% (41)	7% (17)	0% (1)
Carrying condoms and lubricant, because you were afraid that they might get you in trouble with city/town council *askaris*	69% (160)	0% (1)	8% (19)	15% (35)	7% (17)	0% (0)
Taking condoms and lubricant from an outreach worker, because you were afraid they might get you in trouble with the police	75% (174)	2% (5)	5% (11)	12% (27)	6% (15)	0% (0)
Taking condoms and lubricant from an outreach worker, because you were afraid they might get you in trouble with city/town council *askaris*	77% (178)	1% (3)	5% (11)	11% (25)	6% (15)	0% (0)
Being assumed to have HIV because you sell sex	46% (106)	6% (15)	14% (33)	29% (68)	4% (10)	0% (0)
Being assumed to HIV because you have sex with men	50% (117)	4% (9)	13% (29)	28% (66)	5% (11)	0% (0)
Witnessed and heard stigma: Have you ever heard about or seen the following…						
A healthcare provider provided poorer quality care to a male sex worker than to other patients	41% (95)	9% (21)	23% (53)	21% (48)	6% (15)	0% (0)
A healthcare provider shouted at or scolded a male sex worker	51% (118)	7% (16)	16% (37)	22% (51)	4% (10)	0% (0)
A healthcare provider made MSWs wait longer than others	43% (99)	6% (15)	19% (45)	28% (66)	3% (7)	0% (0)
A healthcare provider refused to provide care to a male sex worker	51% (118)	13% (29)	16% (36)	15% (35)	6% (14)	0% (0)
A healthcare provider gossiped about a male sex worker	34% (78)	12% (28)	15% (35)	36% (84)	3% (7)	0% (0)
A healthcare provider disclosed a male sex worker's status as a sex worker or MSM without the person's permission	50% (115)	11% (25)	14% (32)	23% (54)	3% (6)	0% (0)
Witnessed and heard stigma: Have you ever witnessed or hear about…						

Question	Response (n=232)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
Someone talking badly or gossiping about MSWs	9% (22)	3% (8)	17% (40)	69% (161)	0% (1)	0% (0)
A male sex worker being verbally assaulted, harassed, or threatened	13% (30)	7% (17)	16% (37)	63% (146)	1% (2)	0% (0)
A male sex worker being physically hurt (pushed, shoved, slapped, hit kicked, choked, or otherwise physically hurt)	28% (64)	11% (25)	21% (49)	38% (87)	3% (7)	0% (0)
MSWs being excluded from community events, such as weddings or funerals	45% (105)	9% (20)	19% (44)	23% (54)	4% (9)	0% (0)
MSWs being excluded from religious activities or places of worship	49% (114)	12% (27)	13% (30)	22% (52)	4% (9)	0% (0)
MSWs being rejected by their friends	22% (50)	9% (20)	26% (60)	41% (94)	3% (8)	0% (0)
MSWs being excluded from MSM groups or gatherings	86% (199)	2% (4)	7% (17)	5% (11)	0% (1)	0% (0)
Someone blackmailing a male sex worker	24% (55)	6% (13)	22% (51)	48% (112)	0% (1)	0% (0)
MSWs being raped (being forced to have sex when they did not want to)	34% (78)	14% (32)	25% (59)	22% (51)	5% (12)	0% (0)
MSWs being forced to change their place of residence or being unable to rent accommodation	20% (46)	10% (24)	28% (66)	38% (87)	4% (9)	0% (0)
The children of MSM being dismissed, suspended, or prevented from attending an educational institution	87% (202)	4% (9)	3% (6)	5% (12)	1%(3)	0% (0)
A male sex worker being excluded from family gatherings (e.g., cooking, eating together, weddings, funeral)	35% (82)	13% (29)	24% (56)	21% (49)	7% (16)	0% (0)
A male sex worker being disowned by or lost inheritance from his family	36% (83)	16% (38)	20% (47)	19% (45)	8% (19)	0% (0)
A male sex worker being verbally assaulted, harassed, or threatened by family members	25% (59)	12% (27)	24% (55)	34% (79)	5% (12)	0% (0)
A male sex worker being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by family members	47% (110)	9% (21)	19% (45)	19% (45)	5% (11)	0% (0)
A male sex worker being verbally assaulted, harassed, or threatened by police	28% (64)	6% (14)	22% (51)	41% (96)	3% (7)	0% (0)
A male sex worker being physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by police	35% (81)	11% (25)	17% (39)	34% (80)	3% (7)	0% (0)
Police confiscating or destroying condoms and lubricants held by a male sex worker	58% (134)	10% (24)	9% (22)	21% (49)	1% (3)	0% (0)

Question	Response (n=232)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
A male sex worker being arrested for selling sex	27% (63)	10% (24)	21% (48)	38% (89)	3% (8)	0% (0)
A police worker refusing to protect or take a statement from a male sex worker	52% (121)	10% (24)	14% (33)	21% (49)	2% (5)	0% (0)
Experienced stigma: Have you ever had the following happen to you?						
You were denied health services	77% (179)	6% (14)	6% (14)	3% (8)	7% (17)	0% (0)
You were discharged or asked to leave while still needing care	87% (201)	4% (9)	2% (4)	3% (7)	5% (11)	0% (0)
You were made to wait longer than other patients	59% (138)	11% (26)	13% (30)	10% (24)	6% (14)	0% (0)
You were not treated as well compared to other patients	64% (149)	10% (23)	13% (30)	8% (18)	5% (12)	0% (0)
A healthcare provider gossiped or spoke badly about you	66% (152)	7% (16)	9% (22)	13% (29)	6% (13)	0% (0)
A healthcare worker disclosed without your consent that you have sex with men	72% (168)	9% (21)	6% (13)	7% (16)	5% (12)	0% (2)
A healthcare worker disclosed without your consent that you sell sex	81% (188)	4% (10)	4% (10)	6% (15)	3% (7)	0% (2)
A healthcare worker introduced religious or morality issues	69% (159)	10% (23)	6% (14)	10% (23)	5% (12)	0% (1)
Someone spoke badly or gossiped about you	26% (61)	9% (20)	25% (57)	37% (85)	4% (9)	0% (0)
You were verbally assaulted, harassed, or threatened	46% (105)	8% (18)	15% (34)	26% (60)	6% (13)	0% (2)
You were physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt)	73% (169)	7% (17)	6% (15)	7% (16)	6% (15)	0% (0)
You were excluded from community events, such as weddings or funerals	82% (191)	5% (12)	3% (6)	7% (16)	3% (7)	0% (0)
You were excluded from religious activities or places of worship	83% (193)	6% (14)	3% (6)	6% (14)	2% (5)	0% (0)
You were rejected by your friends	62% (144)	7% (16)	14% (32)	14% (33)	3% (7)	0% (0)
You were blackmailed	56% (130)	16% (38)	10% (24)	9% (22)	7% (16)	1% (2)
You were raped (forced to have sex when you did not want to)	68% (158)	13% (29)	10% (22)	3% (8)	6% (13)	0% (2)
You were forced to change your place of residence or unable to rent accommodation	66% (152)	15% (34)	8% (19)	4% (10)	7% (16)	0% (1)
(if has children) Your child was dismissed, suspended, or prevented from attending an educational institution (N=96)	94% (90)	0% (0)	0% (0)	1% (1)	4% (4)	1% (1)

Question	Response (n=232)					
	Never	Once in last 12 months	A few times in last 12 months	Often in last 12 months	Not in last 12 months, but have before	Refuse to answer
You were excluded from family gatherings (e.g., cooking, eating together, sleeping in the same room)	80% (184)	5% (12)	2% (5)	6% (14)	7% (16)	0% (1)
You were disowned by or lost inheritance from family members	86% (199)	5% (11)	2% (5)	4% (10)	3% (7)	0% (0)
You were verbally assaulted, harassed, or threatened by family	70% (163)	6% (14)	6% (15)	11% (25)	6% (15)	0% (0)
You were physically hurt (pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt) by family members	87% (202)	4% (10)	4% (10)	3% (7)	1% (3)	0% (0)
You were verbally assaulted, harassed, or threatened by police	59% (136)	14% (33)	10% (24)	15% (34)	2% (4)	0% (1)
You were physically hurt (pushed, shoved, slapped, hit kicked, choked, or otherwise physically hurt) by police	76% (175)	9% (21)	8% (18)	5% (11)	3% (6)	0% (1)
Police confiscated or destroyed your condoms and lubricants	77% (177)	8% (19)	6% (14)	6% (15)	3% (6)	0% (1)
You were arrested for selling sex	69% (160)	10% (22)	9% (20)	9% (20)	4% (9)	0% (1)
You were arrested for having sex with a man	78% (181)	7% (16)	8% (18)	5% (11)	2% (4)	1% (2)
A police worker refused to protect you or take a statement from you	79% (184)	8% (18)	6% (14)	5% (11)	2% (5)	0% (0)

Values may not add to 100% due to rounding

ANNEX C. DESCRIPTIVE TABLES

Table C.1. Prevalence of Different Manifestations and Sources of Stigma

Stigma aggregation	FSWs (n=497)			MSWs (n=232)		
	Anticipated	Witnessed/ heard of	Experienced	Anticipated	Witnessed/ heard of	Experienced
Manifestation						
Gossip	72% (356)	93% (461)	87% (430)	89% (207)	92% (213)	72% (168)
Verbal	72% (360)	95% (474)	86% (425)	84% (196)	93% (215)	64% (149)
Physical/ violence	67% (337)	90% (446)	63% (312)	74% (172)	81% (187)	33% (76)
Rape	62% (307)	80% (395)	49% (243)	57% (131)	61% (142)	26% (59)
Exclusion	75% (373)	86% (426)	69% (343)	81% (188)	89% (207)	44% (103)
Forced to move	59% (293)	69% (342)	40% (200)	66% (152)	76% (177)	27% (63)
Disowned	N/A	62% (307)	33% (162)	N/A	89% (200)	11% (26)
Blackmail	N/A	65% (322)	45% (223)	N/A	76% (176)	37% (84)
Source						
Healthcare providers	50% (250)	81% (404)	72% (360)	50% (115)	77% (178)	57% (133)
Family	73% (363)	87% (432)	65% (322)	85% (197)	80% (185)	28% (65)
Friends	66% (330)	N/A	N/A	80% (185)	N/A	N/A
Community	66% (326)	97% (482)	92% (457)	80% (185)	96% (222)	82% (191)
Police	67% (333)	89% (444)	76% (378)	68% (157)	83% (192)	50% (117)
Other MSM*	N/A	N/A	N/A	34% (78)	N/A	N/A

*MSWs only
Note: Includes once, a few times, or often in the past 12 months.

Table C.2. Prevalence of Violence (Last 12 Months)

Source of violence	FSWs (n=497)			MSWs (n=232)		
	Anticipated	Witnessed/ heard of	Experienced	Anticipated	Witnessed/ heard of	Experienced
Family	48% (239)	65% (321)	31% (156)	56% (129)	48% (111)	12% (27)
Community	39% (196)	74% (368)	41% (203)	54% (126)	69% (161)	21% (48)
Friends	39% (193)	N/A	N/A	47% (109)	N/A	N/A
Other MSM	N/A	N/A	N/A	17% (40)	N/A	N/A
Police	55% (275)	68% (339)	45% (225)	53% (124)	62% (144)	22% (50)

Table C.3. Association of Anticipated Stigma with Delay and Avoidance of Needed Health Services for FSWs

Are FSWs who anticipate stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Anticipated stigma by manifestation							
Gossip	Never or not in past 12 months	58% (73)	42% (52)	**.00**	62% (77)	38% (47)	**.00**
	At least once in past 12 months	40% (129)	60% (192)		46% (147)	54% (173)	
Verbal	Never or not in past 12 months	59% (70)	41% (49)	**.00**	64% (75)	36% (43)	**.00**
	At least once in past 12 months	40% (132)	60% (195)		46% (149)	54% (177)	
Physical/ Violence	Never or not in past 12 months	59% (85)	41% (58)	**.00**	60% (85)	40% (57)	**.01**
	At least once in past 12 months	39% (117)	61% (186)		46% (139)	54% (163)	
Rape	Never or not in past 12 months	57% (92)	43% (69)	**.00**	61% (98)	39% (62)	**.00**
	At least once in past 12 months	39% (110)	61% (175)		44% (126)	56% (158)	
Exclusion	Never or not in past 12 months	65% (66)	35% (35)	**.00**	67% (68)	33% (33)	**.00**
	At least once in past 12 months	39% (136)	61% (209)		45% (156)	55% (187)	
Forced to move	Never or not in past 12 months	57% (99)	43% (74)	**.00**	63% (109)	37% (63)	**.00**
	At least once in past 12 months	38% (103)	62% (170)		42% (115)	58% (157)	
Anticipated stigma by source							
Health workers	Never or not in past 12 months	52% (115)	48% (108)	**.01**	61% (135)	39% (87)	**.00**
	At least once in past 12 months	39% (87)	61% (136)		40% (89)	60% (133)	
Family	Never or not in past 12 months	54% (65)	46% (55)	**.02**	60% (71)	40% (48)	**.02**
	At least once in past 12 months	42% (137)	58% (189)		47% (153)	53% (172)	
Friends	Never or not in past 12 months	54% (80)	46% (68)	**.01**	63% (92)	37% (55)	**.00**
	At least once in past 12 months	41% (122)	59% (176)		44% (132)	56% (165)	
Community	Never or not in past 12 months	53% (81)	47% (73)	**.02**	60% (92)	40% (61)	**.00**
	At least once in past 12 months	41% (121)	59% (178)		45% (132)	55% (154)	
Police	At least once in past 12 months	59% (83)	41% (58)	**.00**	60% (84)	40% (56)	**.00**
	At least once in past 12 months	39% (119)	61% (160)		46% (140)	54% (164)	

Table C.4. Association of Anticipated Stigma with Delay and Avoidance of Needed Health Services for MSWs

Are MSWs who anticipate stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Anticipated stigma by manifestation							
Gossip	Never or not in past 12 months	42% (5)	58% (7)	.26	67% (8)	33% (4)	.33
	At least once in past 12 months	27% (52)	73% (144)		52% (101)	48% (93)	
Verbal	Never or not in past 12 months	55% (12)	45% (10)	**.00**	68% (15)	32% (7)	.13

Are MSWs who anticipate stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
	At least once in past 12 months	24% (45)	76% (141)		51% (94)	49% (90)	
Physical/ violence	Never or not in past 12 months	40% (21)	60% (32)	**.02**	60% (32)	40% (21)	.21
	At least once in past 12 months	23% (36)	77% (119)		50% (77)	50% (76)	
Rape	Never or not in past 12 months	34% (28)	66% (54)	**.09**	65% (53)	35% (29)	**.01**
	At least once in past 12 months	23% (29)	77% (96)		46% (56)	54% (66)	
Exclusion	Never or not in past 12 months	44% (15)	56% (19)	**.02**	76% (26)	24% (8)	**.00**
	At least once in past 12 months	24% (42)	76% (132)		48% (83)	52% (89)	
Forced to move	Never or not in past 12 months	41% (26)	59% (38)	**.00**	66% (42)	34% (21)	**.02**
	At least once in past 12 months	22% (31)	78% (113)		47% (67)	53% (76)	
Anticipated stigma by source							
Health workers	Never or not in past 12 months	27% (28)	73% (75)	.94	57% (81)	43% (61)	**.08**
	At least once in past 12 months	28% (29)	72% (76)		44% (28)	56% (36)	
Family	Never or not in past 12 months	37% (11)	63% (19)	.22	65% (11)	35% (6)	.31
	At least once in past 12 months	26% (46)	74% (132)		52% (98)	48% (91)	
Friends	Never or not in past 12 months	35% (14)	65% (26)	.23	64% (25)	36% (14)	.12
	At least once in past 12 months	26% (43)	74% (125)		50% (84)	50% (83)	
Community	Never or not in past 12 months	43% (17)	58% (23)	**.00**	61% (19)	39% (12)	.25
	At least once in past 12 months	24% (40)	76% (128)		51% (90)	49% (85)	
Police	Never or not in past 12 months	39% (25)	61% (39)	**.01**	56% (27)	44% (21)	.59
	At least once in past 12 months	22% (32)	78% (112)		52% (82)	48% (76)	
	Never or not in past 12 months	30% (38)	70% (29)		56% (71)	44% (55)	

Items in bold are significant at the 5% or 10% significance level.

Table C.5. Association of Witnessed/Heard of Stigma with Delay and Avoidance of Needed Health Services for FSWs

Are FSWs who witnessed/heard of stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Witnessed/heard of stigma by manifestation							
Gossip	Never or not in past 12 months	66% (21)	34% (11)	**0.02**	86% (18)	14% (3)	**0.03**
	At least once in past 12 months	44% (181)	56% (233)		49% (206)	51% (217)	
Verbal	Never or not in past 12 months	76% (16)	24% (5)	**0.00**	86% (18)	14% (3)	**0.00**
	At least once in past 12 months	44% (186)	56% (239)		49% (206)	51% (217)	
Physical/ violence	Never or not in past 12 months	67% (29)	33% (14)	**0.00**	69% (29)	31% (13)	**0.01**
	At least once in past 12 months	43% (173)	57% (230)		49% (195)	51% (207)	
Rape	Never or not in past 12 months	54% (43)	46% (36)	**0.07**	60% (47)	40% (31)	**0.05**

Are FSWs who witnessed/heard of stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
	At least once in past 12 months	43% (158)	57% (208)		48% (176)	52% (189)	
	Never or not in past 12 months	64% (36)	36% (20)	**0.00**	65% (36)	35% (19)	**0.02**
	At least once in past 12 months	43% (166)	57% (224)		48% (188)	52% (201)	
	Never or not in past 12 months	59% (77)	41% (54)	**0.00**	60% (77)	40% (52)	**0.01**
	At least once in past 12 months	39% (124)	61% (190)		46% (146)	54% (168	
	Never or not in past 12 months	54% (88)	46% (76)	**0.01**	51% (83)	49% (80)	0.85
	At least once in past 12 months	40% (113)	60% (168)		50% (14)	50% (140)	
	Never or not in past 12 months	58% (81)	42% (59)	**0.00**	61% (84)	39% (54)	**0.00**
	At least once in past 12 months	39% (120)	61% (185)		46% (139)	54% (166)	
	Never or not in past 12 months	56% (46)	44% (36)	**0.03**	54% (44)	46% (37)	0.44
	At least once in past 12 months	43% (156)	57% (208)		50% (180)	50% (183)	
	Never or not in past 12 months	68% (36)	32% (17)	**0.00**	69% (36)	31% (16)	**0.00**
	At least once in past 12 months	42% (166)	58% (227)		48% (188)	52% (204)	
	Never or not in past 12 months	69% (9)	31% (4)	**0.08**	92% (12)	8% (1)	**0.00**
	At least once in past 12 months	45% (193)	55% (240)		49% (212)	51% (219)	
	Never or not in past 12 months	71% (29)	29% (12)	**0.00**	70% (28)	30% (12)	**0.01**

Items in bold are significant at the 5% or 10% significance level.

Table C.6. Association of Witnessed/Heard of Stigma with Delay and Avoidance of Needed Health Services for MSWs

Are MSWs who witnessed/heard of stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Witnessed/heard of stigma by manifestation							
Gossip	Never or not in past 12 months	54% (7)	46% (6)	**0.03**	69% (9)	31% (4)	0.20
	At least once in past 12 months	26% (50)	74% (145)		52% (100)	48% (93)	
Verbal	Never or not in past 12 months	38% (5)	62% (8)	0.36	62% (8)	38% (5)	0.47
	At least once in past 12 months	27% (52)	73% (143)		52% (101)	48% (92)	
Physical/ violence	Never or not in past 12 months	36% (13)	64% (23)	0.20	53% (19)	47% (17)	0.87
	At least once in past 12 months	26% (44)	74% (128)		53% (90)	47% (80)	
Rape	Never or not in past 12 months	39% (29)	61% (46)	**0.01**	55% (41)	45% (34)	0.50
	At least once in past 12 months	21% (28)	79% (105)		52% (68)	48% (63)	
Exclusion	Never or not in past 12 months	50% (9)	50% (9)	**0.02**	72% (13)	28% (5)	0.08
	At least once in past 12 months	25% (48)	75% (142)		51% (96)	49% (92)	
Forced to move	Never or not in past 12 months	43% (19)	57% (25)	**0.01**	52% (23)	48% (21)	0.91
	At least once in past 12 months	23% (38)	77% (126)		53% (86)	47% (76)	
Disowned	Never or not in past 12 months	47% (8)	53% (9)	**0.05**	47% (8)	53% (9)	0.73

Are MSWs who witnessed/heard of stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
	At least once in past 12 months	25% (46)	75% (138)		53% (97)	47% (85)	
Blackmail	Never or not in past 12 months	44% (19)	56% (24)	**0.01**	51% (22)	49% (21)	0.97
	At least once in past 12 months	23% (38)	77% (127)		53% (87)	47% (76)	
Witnessed/heard of stigma by source							
Health workers	Never or not in past 12 months	39% (17)	61% (27)	**0.06**	52% (23)	48% (21)	0.91
	At least once in past 12 months	24% (40)	76% (124)		53% (86)	47% (76)	
Family	Never or not in past 12 months	27% (11)	73% (30)	0.93	65% (26)	35% (14)	0.19
	At least once in past 12 months	28% (46)	72% (121)		50% (83)	50% (83)	
Community	Never or not in past 12 months	67% (4)	33% (2)	**0.03**	67% (4)	33% (2)	0.47
	At least once in past 12 months	26% (53)	74% (149)		53% (105)	48% (95)	
Police	Never or not in past 12 months	47% (15)	53% (17)	**0.01**	50% (16)	50% (16)	0.87
	At least once in past 12 months	24% (42)	76% (134)		53% (93)	47% (81)	

Items in bold are significant at the 5% or 10% significance level.

Table C.7. Association of Experienced Stigma and Delay and Avoidance of Needed Health Services for FSWs

Are FSWs who experienced stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Experienced stigma by manifestation							
Gossip	Never or not in past 12 months	64% (37)	36% (21)	**0.00**	70% (40)	30% (17)	**0.00**
	At least once in past 12 months	43% (165)	57% (223)		48% (184)	52% (203)	
Verbal	Never or not in past 12 months	75% (44)	25% (15)	**0.00**	74% (43)	26% (15)	**0.00**
	At least once in past 12 months	41% (158)	59% (229)		47% (181)	53% (205)	
Physical/ violence	Never or not in past 12 months	57% (91)	43% (69)	**0.00**	55% (88)	45% (71)	0.12
	At least once in past 12 months	39% (111)	61% (175)		48% (136)	52% (149)	
Rape	Never or not in past 12 months	52% (113)	48% (103)	**0.00**	56% (121)	44% (94)	**0.02**
	At least once in past 12 months	39% (89)	61% (141)		45% (103)	55% (126)	
Exclusion	Never or not in past 12 months	60% (78)	40% (52)	**0.00**	63% (81)	37% (48)	**0.00**
	At least once in past 12 months	39% (124)	61% (192)		45% (143)	55% (172)	
Housing discrimination	Never or not in past 12 months	48% (129)	52% (137)	**0.10**	54% (144)	46% (121)	**0.05**
	At least once in past 12 months	41% (73)	38% (107)		45% (80)	55% (99)	
Disowned	Never or not in past 12 months	50% (150)	50% (153)	**0.01**	51% (153)	49% (148)	0.82
	At least once in past 12 months	36% (52)	64% (91)		50% (71)	50% (72)	
Blackmail	Never or not in past 12 months	53% (126)	47% (113)	**0.00**	57% (134)	43% (103)	**0.01**

Are FSWs who experienced stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
	At least once in past 12 months	37% (76)	63% (131)		43% (90)	57% (117)	
Experienced stigma by source							
Health workers	Never or not in past 12 months	58% (68)	42% (49)	**0.00**	57% (66)	43% (50)	0.11
	At least once in past 12 months	41% (134)	59% (195)		48% (158)	52% (170)	
Family	Never or not in past 12 months	56% (85)	44% (68)	**0.00**	57% (86)	43% (66)	**0.06**
	At least once in past 12 months	40% (117)	60% (176)		47% (138)	53% (154)	
Community	Never or not in past 12 months	74% (25)	26% (9)	**0.00**	73% (24)	27% (9)	**0.01**
	At least once in past 12 months	43% (177)	57% (235)		49% (200)	51% (211)	
	Never or not in past 12 months	58% (57)	42% (41)		60% (58)	40% (38)	

Items in bold are significant at the 5% or 10% significance level.

Table C.8. Association of Experienced Stigma and Delay and Avoidance of Needed Health Services for MSWs

Are MSWs who experienced stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Experienced stigma by manifestation							
Gossip	Never or not in past 12 months	38% (20)	62% (32)	**0.04**	53% (27)	47% (24)	0.82
	At least once in past 12 months	24% (37)	76% (119)		53% (82)	47% (73)	
Verbal	Never or not in past 12 months	32% (23)	68% (48)	0.25	54% (38)	46% (32)	0.89
	At least once in past 12 months	25% (34)	75% (103)		52% (71)	48% (65)	
Physical/ violence	Never or not in past 12 months	30% (40)	70% (95)	0.33	55% (73)	45% (60)	0.67
	At least once in past 12 months	23% (17)	77% (56)		49% (36)	50% (37)	
Rape	Never or not in past 12 months	29% (43)	71% (105)	0.34	54% (79)	46% (68)	0.58
	At least once in past 12 months	22% (13)	78% (45)		51% (29)	49% (28)	
Exclusion	Never or not in past 12 months	31% (35)	69% (78)	0.21	56% (62)	44% (49)	0.62
	At least once in past 12 months	23% (22)	77% (73)		49% (47)	51% (48)	
Housing discrimination	Never or not in past 12 months	28% (41)	72% (106)	0.67	57% (83)	43% (63)	**0.05**
	At least once in past 12 months	25% (15)	75% (45)		42% (25)	58% (34)	
Disowned	Never or not in past 12 months	27% (51)	73% (135)	0.99	52% (96)	48% (88)	0.47
	At least once in past 12 months	27% (6)	73% (16)		59% (13)	41% (9)	
Blackmail	Never or not in past 12 months	31% (40)	69% (89)	0.15	57% (73)	43% (54)	0.23
	At least once in past 12 months	22% (17)	78% (61)		46% (36)	54% (42)	
Experienced stigma by source							

Are MSWs who experienced stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Health workers	Never or not in past 12 months	39% (32)	61% (50)	**0.00**	63% (52)	37% (30)	**0.01**
	At least once in past 12 months	20% (25)	80% (101)		46% (57)	54% (67)	
Family	Never or not in past 12 months	28% (42)	72% (106)	0.62	56% (82)	44% (64)	0.26
	At least once in past 12 months	25% (15)	75% (45)		45% (27)	55% (33)	
Community	Never or not in past 12 months	48% (15)	52% (16)	**0.00**	58% (18)	42% (13)	0.44
	At least once in past 12 months	24% (42)	76% (135)		52% (91)	48% (84)	
Police	Never or not in past 12 months	34% (32)	66% (62)	**0.05**	53% (49)	47% (43)	0.72
	At least once in past 12 months	22% (25)	78% (89)		53% (60)	47% (54)	

Items in bold are significant at the 5% or 10% significance level.

Table C.9. Association of Internalized Stigma and Delay and Avoidance of Needed Health Services for FSWs

Are FSWs who internalize stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
It is difficult to tell people you sell sex	Disagree	51% (85)	49% (81)	**0.05**	57% (94)	43% (72)	**0.04**
	Agree	42% (117)	58% (163)		47% (130)	53% (148)	
Selling sex makes you feel dirty	Disagree	48% (115)	52% (126)	0.27	50% (120)	50% (120)	0.84
	Agree	42% (87)	58% (118)		51% (104)	49% (100)	
Selling sex makes you feel guilty	Disagree	47% (101)	53% (113)	0.44	46% (98)	54% (114)	**0.09**
	Agree	44% (101)	56% (131)		54% (126)	46% (106)	
Selling sex makes you feel ashamed	Disagree	49% (113)	51% (118)	0.11	49% (113)	51% (117)	0.57
	Agree	41% (89)	59% (126)		52% (111)	48% (103)	
There are times you feel worthless because you sell sex	Disagree	51% (106)	49% (103)	**0.03**	52% (109)	48% (99)	0.44
	Agree	41% (96)	59% (141)		49% (115)	51% (121)	
You hide that you sell sex from friends and family	Disagree	53% (79)	47% (71)	**0.03**	56% (84)	44% (65)	**0.08**
	Agree	42% (123)	58% (173)		47% (140)	53% (155)	

Items in bold are significant at the 5% or 10% significance level.

Table C.10. Association of Internalized Stigma and Delay and Avoidance of Needed Health Services for MSWs

Are MSWs who internalize stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Selling sex							
It is difficult to tell people you sell sex	Disagree	44% (8)	56% (10)	0.09	56% (10)	44% (8)	0.73
	Agree	26% (49)	74% (141)		52% (99)	47% (89)	
Selling sex makes you feel dirty	Disagree	27% (39)	73% (105)	0.88	51% (73)	48% (69)	0.38
	Agree	28% (18)	72% (46)		56% (36)	44% (28)	
Selling sex makes you feel guilty	Disagree	27% (38)	73% (101)	0.98	54% (75)	45% (62)	0.67
	Agree	28% (19)	72% (50)		49% (34)	51% (35)	
Selling sex makes you feel ashamed	Disagree	30% (41)	70% (95)	0.22	53% (72)	46% (62)	0.99
	Agree	22% (16)	78% (56)		51% (37)	49% (35)	
There are times you feel worthless because you sell sex	Disagree	28% (35)	72% (92)	0.95	56% (71)	43% (54)	0.32
	Agree	27% (22)	73% (59)		47% (38)	53% (43)	
You hide that you sell sex from friends and family	Disagree	37% (7)	63% (12)	0.34	68% (13)	32% (6)	0.14
	Agree	26% (50)	74% (139)		51% (96)	48% (91)	
Having sex with men							
It is difficult to tell people you have sex with men	Disagree	33% (8)	67% (16)	0.49	50% (12)	50% (12)	0.89
	Agree	27% (49)	73% (135)		53% (97)	46% (85)	
Having sex with men makes you feel dirty	Disagree	24% (39)	76% (125)	0.02	51% (84)	48% (78)	0.44
	Agree	41% (18)	59% (26)		57% (25)	43% (19)	
Having sex with men makes you feel guilty	Disagree	26% (36)	74% (104)	0.44	54% (75)	45% (63)	0.78
	Agree	31% (21)	69% (47)		50% (34)	50% (34)	
Having sex with men makes you feel ashamed	Disagree	27% (41)	73% (110)	0.90	53% (79)	47% (70)	0.84
	Agree	28% (16)	72% (41)		53% (30)	47% (27)	
There are times you feel worthless because you have sex with men	Disagree	26% (35)	74% (98)	0.64	54% (71)	46% (60)	0.87
	Agree	29% (22)	71% (53)		51% (38)	49% (37)	
You hide that you have sex with men from friends and family	Disagree	42% (10)	58% (14)	0.10	75% (18)	25% (6)	0.02
	Agree	26% (47)	74% (137)		50% (91)	50% (91)	

Items in bold are significant at the 5% or 10% significance level.

Table C.11. Frequency of Depression (last two weeks)

% who have been bothered in the last 2 weeks by the following:	Female sex workers (n=497)	Male sex workers (n=232)
Little interest or pleasure in doing things	75% (375)	62% (143)
Feeling down, depressed (sad), or hopeless	76% (376)	63% (147)
Either trouble falling or staying asleep OR sleeping too much	64% (320)	56% (131)
Feeling tired or having little energy	81% (403)	66% (152)

% who have been bothered in the last 2 weeks by the following:	Female sex workers (n=497)	Male sex workers (n=232)
Either poor appetite OR overeating	68% (336)	56% (131)
Feeling bad about yourself –or that you are a failure or have let yourself or your family down	60% (299)	46% (106)
Trouble concentrating on things, such as reading the newspaper or watching TV	52% (258)	37% (87)
Either moving or speaking so slowly that other people could have noticed OR being so fidgety or restless that you have been moving around a lot more than usual	51% (254)	39% (91)
Thoughts that you would be better off dead, or of hurting yourself in some way	37% (183)	25% (59)

Table C.12. Association between HIV-related Stigma and Avoiding or Delaying Seeking Health Services

Are sex workers who anticipate HIV-related stigma more likely to delay or avoid seeking health services?		Delayed seeking health services			Avoided seeking health services		
		Did not delay (n)	Delayed (n)	p-value	Did not avoid (n)	Avoided (n)	p-value
Female sex workers (n=497)							
Assumed to have HIV because SW	Never or not in past 12 months	52% (90)	48% (84)	**.03**	57% (98)	43% (75)	**.04**
	At least once in past 12 months	41% (112)	59% (160)		46% (126)	54% (145)	
Male sex workers (n=232)							
Assumed to have HIV because SW	Never or not in past 12 months	38% (35)	62% (57)	**.00**	52% (57)	48% (53)	**.01**
	At least once in past 12 months	19% (22)	81% (94)		48% (52)	52% (56)	
Assumed to have HIV because MSM	Never or not in past 12 months	35% (36)	65% (66)	**.01**	63% (63)	37% (37)	**.00**
	At least once in past 12 months	20% (21)	80% (85)		43% (46)	57% (60)	

Items in bold are significant at the 5% or 10% significance level.

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