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Surviving pandemic control measures: The experiences of female sex workers during COVID-19 in Nairobi, Kenya

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ABSTRACT

At the beginning of the COVID-19 pandemic, the Kenya Ministry of Health instituted movement cessation measures and limits on face-to-face meetings. We explore the ways in which female sex workers (FSWs) in Nairobi were affected by the COVID-19 control measures and the ways they coped with the hardships. Forty-seven women were randomly sampled from the Maisha Fiti study, a longitudinal study of 1003 FSWs accessing sexual reproductive health services in Nairobi for an in-depth qualitative interview 4–5 months into the pandemic. We sought to understand the effects of COVID-19 on their lives. Data were transcribed, translated, and coded inductively. The COVID-19 measures disenfranchised FSWs reducing access to healthcare, decreasing income and increasing sexual, physical, and financial abuse by clients and law enforcement. Due to the customer-facing nature of their work, sex workers were hit hard by the COVID-19 restrictions. FSWs experienced poor mental health and strained interpersonal relationships. To cope they skipped meals, reduced alcohol use and smoking, started small businesses to supplement sex work or relocated to their rural homes. Interventions that ensure continuity of access to health services, prevent exploitation, and ensure the social and economic protection of FSWs during times of economic strain are required.

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Background

Most of the female sex workers (FSWs) in Nairobi, Kenya, work in settings such as bars, night clubs, on the streets and in designated rooms in lodges. In the Kenyan context, once negotiations on the terms and payments for sex are done with their clients, sex can happen in the same venues if the bars have lodgings, or other rented spaces, as well as in cars or behind buildings (NASCOP, 2020). The face-to-face nature of their work made FSWs vulnerable to hardship during the COVID-19 pandemic. The Kenyan government instituted COVID-19 preventive measures in line with the recommendation of the World Health Organization from March 2020 to October 2021. The measures

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included a nationwide lockdown, cessation of movement into and out of major cities and towns, a dusk to dawn curfew, mask mandate, and temporary suspension of non-essential businesses.

These COVID-19 regulations made it difficult for sex workers to access health services. In Kenya, the dusk-to-dawn curfew meant that places that offered sexual and reproductive health services (SRH) had fewer operating hours, a situation predicted in a United Nations Population Fund Technical Note on the possible effects of the pandemic on women (UNFPA, 2020). The physical distancing measures reduced the number of patients that health centres could care for at one time, and closure of entertainment facilities such as bars, and physical distancing directives instituted by the Ministry of Health to curb the spread of COVID-19 led to FSWs losing their livelihood (Gichuna et al., 2020; Kimani et al., 2020; Mantell et al., 2021).

Reflections from the Ebola and Severe Acute Respiratory Syndrome (SARS) pandemics show that vulnerable populations, especially women and children, are disproportionately affected due to the underpinning sociocultural contexts (Saalim et al., 2021). This has also been the case during the COVID-19 pandemic (Hassan et al., 2021; Kimani et al., 2020), with evidence from Kenya suggesting that the COVID-19 containment measures may have increased physical, sexual, verbal, and economic violence against FSWs (Mantell et al., 2021). Reports from West Africa suggest that vulnerable people may also have suffered increased inaccessibility of healthcare, exacerbated sexual and domestic violence, economic disruptions, and arbitrary police arrests (Saalim et al., 2021). While the focus was directed towards controlling the pandemic, there were unintended consequences for the vulnerable populations which we set out to document.

In this paper, we focus on the lived experiences of FSWs in Nairobi, Kenya, during the COVID-19 pandemic and describe how individual women were affected. Our longitudinal study captured the experiences of women before the pandemic in the baseline interviews and captured their same experiences at endline as COVID-19 was ongoing. This made it possible to draw a direct comparison of their experiences before and during the pandemic.

Methods

Study setting

Nairobi County is the capital and economic hub of Kenya with many entertainment venues that cater to individuals with disposable income and where sex work thrives. In 2017/2018, Nairobi County had the largest population of sex workers in the country accounting for 25% of the estimated 206,000 women who sell sex on a peak day in the country (NASCOP, 2020). However, COVID-19 containment measures led to a significant reduction/cessation of these activities because women engaged in sex work were left with limited daytime operating hours and could not gather at the places where they usually sought clients.

Sex workers in Nairobi access HIV prevention and care services from, among others, seven standalone Sex Workers Outreach Programme (SWOP) clinics, funded by the CDC-PEPFAR. These clinics are strategically located throughout Nairobi County and serve as safe spaces for at least 33,000 FSWs. One clinic is located in downtown Nairobi while the others are within informal settlements, to take the services closer to where the majority of sex workers live, and to cover different key sub-counties within Nairobi. All clinics provide comprehensive and accessible HIV prevention and treatment services to key populations (Female Sex Workers and Men who have Sex with Men).

Sampling and data collection

Our findings come from interviews with FSWs residing in Nairobi, Kenya, collected as part of the Maisha Fiti study, a three-year mixed-methods longitudinal study that began in 2019 and enrolled a random sample of 1003 FSWs who access HIV prevention and treatment services from SWOP clinics. The overarching Maisha Fiti study aim was to explore risk factors for genital inflammation

and antiretroviral (ARV) uptake and adherence among FSWs in Nairobi. From a sample of all women aged 18–45 years who had attended a SWOP clinic in the 12 months prior to the start of the study (n = 10,292), 1003 were randomly selected. Participants met the study inclusion criteria if they (i) were assigned female sex at birth, (ii) had accessed SWOP services within 12 months prior to contact with the study, (iii) did not have pre-existing health conditions (other than HIV) which would affect their immunology, and (iv) were willing to give written consent to participate in the study. In phase 1 (June-December 2019), in-depth interviews (IDIs) were conducted with a random sample of 40 of these 1003 participants. Sex workers under 25 years of age were unintentionally underrepresented in the qualitative interviews at baseline. In phase two (June 2020-March 2021), follow-up qualitative interviews were conducted with the initial 40, along with an additional 7 women aged <25. The same female interviewer interviewed the same woman at each time-point. The baseline qualitative interviews aimed to understand the interpretation and experiences of women on violence, mental health, alcohol and substance use, and how they relate to HIV risk behaviours. In these follow-up interviews, we re-visited these themes and explored how COVID-19 had impacted their lives. This current analysis uses qualitative in-depth interview data collected from 47 women in phase 2 of the study (July-August 2020), 4–5 months after COVID-19 lockdown measures had been implemented in Nairobi.

Qualitative interviews were conducted by two social scientists. Following informed consent procedures, women were asked to provide a detailed overview of their daily life, narrating specific events or aspects of their lives, including sex work, violence experiences, and how these relate to mental health, alcohol and substance use, and adherence to pre / post-exposure prophylaxis (PrEP / PEP) and anti-retroviral therapy adherence in the context of COVID-19.

All interviews were conducted in Swahili or English. Most were conducted face-to-face while some were conducted remotely by mobile phone, in order to reach FSWs who had left Nairobi since their baseline interview. During the consent process, the interviewer and participants agreed on a safe word/phrase that would alert the interviewer if the participant faced interference, such as someone walking into the room where she was answering the call. For in-person and remote interviews, after each interview, the interviewers wrote a detailed script that described the interview, including nuances that would not have been captured on audio tape (such as the woman's mood and demeanour). When women consented, the interview was also audio-recorded and subsequently transcribed and translated. For in-person interviews, both participants and interviewers wore face masks in a well-ventilated room and sat a sufficient distance apart to ensure compliance with government guidelines.

Ethical approvals and considerations

Ethical approval for this study was obtained from the ethics boards at the Kenyatta National Hospital/University of Nairobi (KNH/UoN), the London School of Hygiene and Tropical Medicine, UK, and the University of Toronto, Canada. A National Commission of Science, Technology and Innovation (NACOSTI) permit was also obtained. For follow-up interviews, only participants who had consented to be contacted again by the study were invited to participate. The follow-up interviews included some additional questions on how women handled the pandemic and some interviews were conducted via the phone. Additional ethical approval was obtained from boards at the University of Nairobi, London School of Hygiene & Tropical Medicine and the University of Toronto, as due to the nature of the interviews, we needed to ensure women's safety was not compromised through taking part in a remote interview (Bhatia et al., 2022).

At baseline and at each subsequent study visit, study participants were informed about the study through a detailed participant information sheet that was provided in a written format and read aloud to participants in English or Swahili, before participants gave their written informed consent. For follow-up remote qualitative interviews, oral consent was sought, recorded, and stored in a separate password-protected file. The audio-recorded data were uploaded to a secure server after each interview and deleted from the recording device. All data were stored using unique identifiers on a

password-protected server to maintain confidentiality. All participants received around 500KSH (5 USD) for their time and transport or air-time costs, were treated for any presenting illness, and were referred to a study counsellor for on-site or remote tele-counselling if they needed additional support.

Data analysis

Prior to each follow-up interview, the qualitative interviewer re-read the transcript and script from baseline to re-familiarise themselves with women's stories before the interview. The research team (comprising TB, JS, JK, HB, RK, MK, EN, JL, JP, AB, and PS) had previously been involved in the analysis of the baseline quantitative and qualitative data and were familiar with the setting and findings from baseline (pre-pandemic). During the follow-up interview, the research team met virtually after every two in-depth interviews to discuss the interviews as they progressed. During these meetings, the interview script notes were read and discussed to first identify, then refine, and define the themes and subthemes and to develop a codebook. When all interviews had been completed, the research team members randomly chose an interview script which they all separately coded. The team then met and discussed line by line the coded interview to check whether the codebook was understood uniformly by all members. The codebook was then amended and finalised and the 47 scripts and transcripts were divided amongst the team members who coded them independently. They were then analysed by the research team thematically, using Nvivo software to manage the coding.

We used the themes generated to describe the experiences of FSWs in Nairobi during the COVID-19 pandemic. The themes included: violence, stigma, discrimination, social exclusion, access & utilisation of healthcare services, condom use/safe sex negotiation, mental health, IPV and relationships with children, and client sourcing. The interviews illustrated how broad societal factors including the criminalisation of sex work, the communities in which sex workers live, their relationships with peers, family, and partners; and individual factors such as age, income, and education interacted to create realities for the sex workers in Nairobi.

Results and discussion

The women's ages at baseline ranged from 18 to 45 years, with most of the women being aged in their early thirties. Most of these women had some years of schooling and four of these women had tertiary-level education. Before entering sex work, 43 of the 47 women had at least one child. Providing for their children was the main reason women joined sex work. The majority of women first sold sex when they were 18–24 years old. At the time of contact with the study for the follow-up interview, most of the participants were residing in Nairobi County and its environs, while a few had relocated to other towns or returned to their rural homes. All participants expressed increased risks and challenges due to the pandemic. Some had quit sex work and had entered other income-generating activities such as selling masks and tailoring, as relying on sex work had become challenging. Those who still sold sex reported having changed the areas where they sold sex and the number of clients. Although finding alternative sources of income can be presented as a positive coping mechanism, it is likely to be short-term as they cited the money was less than what they made in sex work. To set the scene for analysis of our data on women's experiences we present the narratives provided by one FSW, Summer (all names are pseudonyms), on how the COVID-19 pandemic affected her life and how she coped.

Summer was 29 years old at the time of the baseline interview and a year older at follow-up. She lived in an informal settlement in Nairobi. When COVID-19 restrictions were instituted, Summer, like other sex workers, lost her main source of income. As a community health worker, Summer would receive a stipend of 2500KSH (25 USD) per month, but that was barely enough to feed her children, who were at home because schools were closed too. Summer's parents were also dependent on her income after retiring from their business of brewing illicit liquor.

Summer ended up selling household items, skipping meals, taking loans, and failing to pay rent. This, she reported, led to developing mental health problems. She commented:

> I have accumulated debts because I'm hardly earning any money yet I have rent to pay. I have children to feed and I am a single parent. I think I might have been depressed because of these. I have not paid rent since March (four months prior to the interview). I pay 500KSH (5 USD) per month and I easily managed that before COVID-19. Right now, I have arrears amounting to 150 USD. I have been paying in small instalments of about 15 USD. Sometimes the property owner has been so impatient with me.

Summer had lost her five regular clients and reported instances where new clients refused to pay the agreed amount for sex. Although Summer had registered for the government's economic relief programme, she did not receive any help. Additionally, she was unable to get a job with a government project that hired low-income people, as she did not have the necessary connections.

Physical and financial violence from her clients was the norm. Clients were in the habit of reversing payments made by post/online transfer, paying less, or even assaulting sex workers like her after sex. Summer recounted how she had had to run from the police one time when she was breaking the curfew in order to work. Life became hard for her and she would end up scolding her children whenever they asked for food and other necessities. She also said that despite people going through a lot of stress and needing to talk about it with others, they could not because they were stopped from meeting other people.

Access to sexual reproductive health services (SRH) was also affected by COVID-19 regulations. The SWOP clinic, where Summer accesses her SRH services, was closed for a short time. Fortunately, Summer had her supply of Antiretrovirals (ARVs) and condoms and continued to use both. However, Summer mentioned that she skipped her ARV medication whenever she did not have food.

To cope with COVID-19 itself, Summer said she used sanitiser and wore masks. However, she reported that she never wore masks while having sex with clients. She kept her distance from her neighbours and limited the amount of time her children stayed outside the house. Summer said that she started to source her food supplies from a cheaper market and reduced her use of bhang (marijuana) intake. She said:

> Bhang would cost me 50ksh (0.50 USD), which right now goes to food. I also do not drink [alcohol] unless I find a friend drinking and I join in. I would like to think that I am reforming and I have become wiser. Even when things come back to normal, I do not think I will be spending as much money on Bhang as I did before. I was misusing money. I used to spend 300ksh (3 USD) on alcohol and bhang in a day and nowadays I go a week without getting as much. It has been truly eye-opening.

She said that she considered sending her children to their father in the village to reduce her expenses, but neither she nor their father could raise the necessary fare.

Effects of COVID-19 on sex workers at the individual, community and societal levels

Violence (sexual, physical, financial)

As Summer's account illustrates, FSWs were often unable to observe COVID-19 control measures such as physical distancing and isolation and therefore were profiled as 'COVID-19 spreaders' by the community. As a result, FSWs were frequently unfairly targeted by punitive COVID-19 prevention measures (UNAIDS, 2020a), and stigma and violence from community members (Reuters, 2020). Cases of police harassment and violence towards FSWs, such as forceful quarantine due to breaking curfew rules, social distancing measures, being in venues that were supposed to be closed, money and sex solicitation, and physical violence, were reported by women in our study. While this is a continuous experience by FSWs in Kenya due to the criminalisation of sex work, the participants reported this to have escalated during this period, a finding corroborated by others (Kimani et al., 2020). Although most of the respondents attempted to adapt to changes in the

operation of sex work (due to COVID-19 restrictions), for example, by contacting clients online and sleeping in clients' homes, some recounted additional risks of violence from clients, police and the community at large, mostly attributed to the context of the COVID-19 pandemic. However, it is not unusual for sex workers in Kenya to report experiencing various forms of violence from their clients, law enforcement, and the public (Beattie et al., 2023; Mbote et al., 2020). The increased risks of violence during the COVID-19 pandemic reported in our qualitative interviews could be attributed to restriction measures. We were told by the women that the few clients that they found would frequently take advantage of the curfew and the desperate need of women for money, to lure them – for example to their homes until the curfew began so women were forced to stay overnight – and subsequently violate the agreed terms and conditions of sex.

Stigma, discrimination, and social exclusion

Due to the criminalised nature of sex work, African countries tended to exclude sex workers from safety nets during the COVID-19 pandemic, including economic relief (Adebisi et al., 2020). Two of the women in our study reported being removed from the list of social support beneficiaries offered to single parents by the government as part of the COVID-19 relief. They said that their removal was because they were known to be sex workers in the localities where they lived. Even in countries with higher incomes such as the United States and Germany, the government required the beneficiaries of COVID-19 relief services to provide proof of loss of employment or reduced income from a business, which was a challenge for sex workers (Platt et al., 2020).

In addition to the absence of financial support, the enforcement of COVID-19 control measures in Nairobi subjected FSWs to arbitrary arrests, violence, and extortion from the police, worsening their already precarious financial position at the height of COVID-19 infections (Kimani et al., 2020).

Sex workers also reported stigma from the local community, more so because they now performed sex work during the day (due to the dawn-to-dusk curfew) and so were more visible to their communities. In our interviews, they said they had been accused of teaching immorality to children in the neighbourhood, plotting to steal husbands, and spreading COVID-19. In Summer's narrative, she talked about hiding from the police. Another respondent recounted how the police frequently beat and harassed her in broad daylight for selling sex because they knew she was a sex worker; her community called her a bad influence.

Access & utilisation of health care services

The COVID-19 pandemic over-burdened the healthcare system resulting in resources being redirected, including the supply chain of medical supplies (Haleem et al., 2020; Iversen et al., 2020). When cessation of movement was implemented, we found that sex workers who had temporarily travelled from Nairobi were locked out, so they could not access their specific health needs, including access to HIV medicines. Furthermore, as reported by other researchers, some sex workers in Nairobi did not have the bus fare to go to their health centres due to financial stress related to COVID-19 (Gichuna et al., 2020) In Nairobi, and elsewhere globally, COVID-19 may have undermined the huge progress made in HIV prevention and treatment, by disrupting the access of key populations to HIV antiretroviral drugs, viral load monitoring, HIV pre and post-exposure drugs, STI testing and treatment, and condom distribution (Iversen et al., 2020)

However, despite the challenges mentioned above, some study participants reported being able to access these services from SWOP clinics. SWOP clinics closed only for a short period (3 weeks) as clinical services were considered essential by the Ministry of Health. SWOP services included condom provisions, Post Exposure Prophylaxis (PEP), STI screening, ARV refills, telemedicine, and counselling, among others. From the interviews, those who accessed these services reported

being happy that the clinics were operational despite the strict restriction measures that were aimed at reducing COVID-19 infections.

However, a significant number of sex workers who we interviewed reported non-adherence to ARVs, PEP, and PrEP due to a reduced number of clients, the temporary cessation of sex work, and the side effects of taking the pills when hungry. Women reported frequently missing meals due to lack of money and that their stomachs could not handle the pills when empty. Poor ARV adherence during COVID-19 due to lack of food was also reported among the general population in Kenya, especially among economically vulnerable persons (Muhula et al., 2021).

Condoms use & negotiation for safe sex

Sex workers reported accepting lower pay than usual from their clients, as Summer explained in her narrative, due to economic hardships in the country. In Kenya in general, it has been reported that sex workers took less than 75% of their normal income (The Global Fund, 2020). The lockdown, quarantine, and curfew measures enacted by most countries left sex workers economically vulnerable, as well as their clients self-isolated (UNAIDS, 2020b). Night curfews and bar and hotel closures significantly reduced the places where sexual activity was requested, therefore causing an income loss (Kimani et al., 2020). In Kenya, 81% of places where sex workers seek sex are venues, such as streets, bars, lodgings and hotels. 74% of these venues are open late at night and some all night (NASCOP, 2020). The COVID-19 regulations in Kenya – closure of bars, restaurants, hotels, and night curfew starting as early as 7 pm meant few to no clients for sex workers in Kenya (Mantell et al., 2021). The decreased prospects of generating regular income from sex work due to the economic downturn may have put sex workers in a vulnerable position in terms of compromising their sexual and physical safety. Most women reported low negotiation power for both condom use and the amount charged for services. They said they often felt that clients took advantage of their economic vulnerability to demand sex without condoms.

Mental health

Experiences of stigma and social exclusion among sex workers have been associated elsewhere with poorer mental health (Stockton et al., 2020). Most of the our study participants said they felt lonely and isolated during the pandemic, as the places where they would meet while performing sex work were closed. The closure of public gathering places, such as bars, during the pandemic, increased their social isolation, which had an impact on their physical and mental health, as has also been found in the U.S.A. (Callander et al., 2020).

Women told us that coping with the challenges of sex work, as well as COVID-19, meant that mental health problems were reported due to stress. Stressors included a lack of money to provide for their children, stigma from the community, as they had to change operating hours and venues due to curfew, as well as increased violence. Some described how they found it difficult to eat or sleep. Others reported having friends who were sex workers committing suicide due to mental health problems resulting from a lack of money. There were additional health issues for sex workers living with HIV, that gave them the fear of getting COVID-19. Globally it has been reported that they could have faced increased mental health problems from stress and isolation, as well as, challenges in accessing care (Rana, 2020; Waterfield et al., 2021).

However, our quantitative and qualitative findings suggested a significant reduction in substance use during the COVID-19 period – indeed, this is illustrated by Summer, who reported her reduced use of marijuana in her narrative above (Beksinska et al., 2022). Many of the women told us that they could no longer afford alcohol and other recreational drugs. These findings are consistent with those conducted in Latin America among the general population during the COVID-19 pandemic, where lower income and reduced disposable income were associated with lower alcohol consumption (Garcia-Cerde et al., 2021)

Effects of the COVID-19 pandemic on personal relationships

IPV and relationships with children

During and after the pandemic, women (not just FSWs) in Kenya experienced increased sexual, physical, emotional, and economic abuse compared to men (Kimani et al., 2020).

In our study, some women reported experiencing violence from their intimate partners, which was often the result of disagreements about finances and how to meet other needs. They said that male partners often felt pressured because of their lack of income and took it out on women. Most of the participants also said that the relationship with their children was strained by the pandemic. The expectations from their children to provide food and other necessities often left the women feeling helpless, and some reported taking it out on their children; Summer talked about scolding her children more than usual, in her narrative.

An increase in violence has been reported during other pandemics. For example, after the Ebola outbreak in West Africa, there was a spike in cases of violence, rape, and sexual assault among women and girls, with teenage pregnancies increasing by 65% (Seema Yasmin, 2016). In March 2020, a few months after the outbreak of the COVID-19 pandemic, countries such as Brazil, Australia, the United States of America, and China recorded increased reports of violence against women (Bradbury-Jones & Isham, 2020; Usher et al., 2020). Quarantines and social isolation measures may expose women to exploitative relationships because they may be temporarily unable to escape abusive partners, and are exposed to coercion, violence, or victimisation in response effort (Peterman et al., 2020).

Client sourcing

Most of the participants expressed difficulties in making money due to the closure of venues, cessation of movement, and night curfew. Potential clients who had also lost jobs due to depressed economic activities also had no disposable income.

Women in our study reported how the dynamics of sex work changed during the pandemic, where the venues often used for both soliciting and sex were/are closed because of containment measures. The domino effect of this was a reduced number of clients, reduced income, diminished negotiation power, and economic or physical violence. The results of our study are consistent with a study with sex workers in western Kenya where participants also reported loss of income and increased violence experiences (Mantell et al., 2021). On the Kenyan coast and in Kampala, Uganda, FSWs faced similar situations where the safety net of the regular venues/locations was replaced by underground sex work, which was more dangerous for women (Zuma et al., 2021).

Taken together, the COVID-19 control measures in Kenya did not consider sex workers, placing them in a more vulnerable economic, health and safety position. Sex workers – who are already marginalised due to criminalisation, stigma and discrimination – experienced exacerbated levels of economic, verbal and physical violence; stigma, discrimination, and social seclusion; poorer mental health outcomes; reduced accessibility to sexual and reproductive health services; and deterioration of their personal relationships including with their children. This shows that in a pandemic response, vulnerable groups may also be denied access to social protection and other essential services if mitigation measures do not take into account their peculiar vulnerabilities.

Strengths and limitations

The follow-up interviews in our study were building on previous interviews and analyses, with same themes explored at both time points. COVID-19 pandemic took place when our study was ongoing, and due to the longitudinal design of our study, we were able to capture the acute effects of the pandemic on this marginalised community without the risk of recall bias. Finally,

interviews at both baseline and endline were conducted by female interviewers who had already established relationships with interviewees and were familiar with their stories from baseline interviews.

Our study had limitations; for instance, the interviews were conducted when the pandemic was ongoing and the covered period three-four months after lockdown measures began included a time when the effects were acute. Additional research is needed to understand how FSWs were affected in the long-term by the effects of both the COVID-19 containment measures as well as infection with COVID-19.

The study was not initially designed to assess the effects of COVID-19 and the interview guides were adapted rapidly, before we had much experience of this pandemic. Thus, we may have missed some key issues, such as the impact of school closures on FSWs ability to work while their children were not at school.

While there was no formal help or social protection from the government, there were self-help groups and community-based organisations that offered help to the very needy. However, we were not able to explore and formerly document these in this study.

Conclusions

Pandemics such as COVID-19 negatively affect customer-facing businesses, which include sex work. Interventions to curb the spread of infection and mitigate these effects should be designed for and with FSWs and other marginalised populations in mind, given the disproportionate burden and economic disenfranchisement, they experience. Maintaining continuity of HIV care, as well as social and mental health support systems during a pandemic, is important for the well-being of sex workers and their families. Policies to help protect sex workers from severe economic shocks should be put in place for current and future pandemics. This, however, can only be achieved if the legal framework changes and decriminalises sex work. Decriminalisation may also help reduce the stigma, discrimination and violence that was exacerbated by the pandemic. More research with FSWs (and with women in general) is needed on how pandemics affect their relationships with partners and children at the household level.

Ethics approval and consent to participate

The Maisha Fiti study was ethically approved by the Kenyatta National Hospital – University of Nairobi Ethics Review Committee (KNH ERC P778/11/2018), the Research Ethics Committees at the London School of Hygiene and Tropical Medicine (Approval number: 16229) and the University of Toronto (Approval number: 37046).

Consent for publication

Not Applicable.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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