ORIGINAL RESEARCH ARTICLE

The social dynamics of selling sex in Mombasa, Kenya: a qualitative study contextualizing high risk sexual behaviour

Karen M. Hampanda

Department of Health and Behavioural Sciences, University of Colorado Denver, CO, USA

***For correspondence:** *Email:* karen.hampanda@ucdenver.edu

Abstract

Female sex workers (FSWs) in sub-Saharan Africa have one of the highest HIV seroprevelance rates of any population. Effective safe sex interventions are urgently needed to stop the transmission of HIV during commercial sex. Despite widespread education, counselling, and condom distribution interventions among FSWs, unprotected sexual intercourse remains a large behavioural challenge. Research on this topic has been limited primarily to establishing the frequency of high risk sexual behaviour without a comprehensive analysis of the social environment creating these factors, especially gender inequality. Through qualitative in-depth interviews and focus group discussions with FSWs, this article contextualizes the selling of sex in one large urban city of Kenya. The results of this study indicate that FSWs will never be able to enforce safe sex among male clients in such settings without structural interventions that address gendered socioeconomic power imbalances. Policy implications based on these findings include re-evaluating laws against the selling of sex and prioritizing female education and economic opportunities. (*Afr J Reprod Health 2013; 17[2]: 141-149).*

Résumé

Les femmes prostituées(FP) en Afrique sub-saharienne ont l'un des taux les plus élevés de la séroprévalence du VIH de toute population. Il faut des interventions sexuelles efficaces sûres de toute urgence pour arrêter la transmission du VIH lors des rapports sexuels commerciaux. En dépit de vastes interventions d'éducation, de conseils et de préservatifs parmi les femmes prostituées, les rapports sexuels à haut risque reste un grand défi comportemental. La recherche sur ce sujet a été limitée principalement à établissement de la fréquence des comportements sexuels à risque, sans une analyse complète de l'environnement social qui crée ces facteurs, en particulier les inégalités entre les sexes. A travers des entretiens approfondis et des discussions de groupe avec les femmes prostituées, cet article met en contexte le commerce du sexe dans une grande ville urbaine au Kenya. Les résultats de cette étude indiquent que les femmes prostituées ne seront jamais en mesure d'appliquer le sexe sans risque chez les clients masculins dans de tels contextes, sans des interventions structurelles qui s'occupent des déséquilibres du pouvoir socio-économiques basés sur l'inégalité des sexes. Les implications politiques fondées sur ces résultats comprennent la réévaluation des lois contre la commercialisation du sexe et la hiérarchisation de l'éducation des femmes et des opportunités économiques. (*Afr J Reprod Health 2013); 17[2]: 141-149).*

Keywords: female sex work, sub-Saharan Africa, gender inequality, Kenya, sexual behaviour, HIV/AIDS

Introduction

Women engaging in commercial sex in sub-Saharan Africa are considered one of the highest risk populations for HIV acquisition. Recent empirical data has recorded HIV seroprevalence among female sex workers (FSWs) as high as 66% in Zambia, 71% in Malawi, and over 75% in Kenya[1,2]. The relationship between commercial sex and HIV in sub-Saharan Africa has been examined in numerous research studies over the last several decades. However, the vast majority of current literature has focused on determining the prevalence of commercial sex or the frequency of individual high-risk sexual behaviours among FSWs, such as inconsistent condom use or number of clients[3-13]. There is limited research on *why* FSWs engage in high-risk sexual practices and the

social context in which they are selling sex. In 2011, the World Health Organization (WHO) stated that more research is needed to "disentangle the lack of increase in condom use" among FSWs despite widespread education, counselling, and condom provision[14].

Transactional sex is a common practice among young women throughout many areas of sub-Saharan Africa. It is estimated that between 5 to 80 percent of adolescent girls in this region have exchanged sex for money or other commodities at some point in their lives[15], contributing to the disproportionately high HIV prevalence found in this age group. Although widespread, female sex work (FSW) encompasses a vast range of behavioural practices among women in very different social circumstances. These differing social dynamics among women in sub-Saharan Africa remain poorly understood, limiting effective HIV prevention within these populations. This article contextualizes the selling of sex and the challenges of practicing safe among a group of FSWs in Mombasa, Kenya.

FSWs provide important qualitative information for public policy and civil society interventions to improve the effectiveness of HIV programs. A more comprehensive understanding of the lives and the context of selling sex is essential in order to increase safe sex practices among FSWs and decrease the overall spread of HIV throughout sub-Saharan Africa. This qualitative analysis establishes some of the social determinants that underlie commercial sex and the prevailing issue of inconsistent condom use among FSWs in a large urban setting in Kenya.

Methods

Setting

Women of reproductive age (15-49 years) in Kenya have disproportionately higher HIV seroprevalence with a rate of 8.7%, compared to only 4.6% among their male counterparts[16]. Many women in Kenya sell sex either partially or completely for economic survival at some point in their lives. WHO estimates that 6.6% of urban Kenyan women have received money in exchange for sex in the year preceding the survey[14]. FSWs are considered one of the *core groups* driving the HIV epidemic in Kenya[16]. The HIV seroprevalence among Kenyan FSWs is as high as 75% in some regions and commercial sex is estimated to account for about 14% of the total HIV incidence in this country[1,17,18].

Commercial sex in Kenya is illegal and FSWs are highly stigmatized. However, there is high demand for sex as a commodity in many urban areas, such as Mombasa. Mombasa is Kenya's second largest city with a population of about 1.5 million people and has consistently had a much higher HIV prevalence than the country as a whole. In 2007 when the study was conducted, Kenya had an adult (15-49 years) HIV prevalence between 7.1 and 8.5 percent[18]. Mombasa, on the other hand, had an adult HIV prevalence between 10 and 25 percent[18]. The high amount of commercial sex in this city undoubtedly contributes to disproportionately high HIV seroprevalence. UNAIDS estimates that over 50% of the FSWs in the city of Mombasa are HIV-positive[17,18].

Demand for commercial sex in Mombasa is extremely high and readily available; walk into any disco or bar and one will be witness to the overwhelming presence of FSW. Mombasa attracts tourists from all over the world due to its location on the Indian Ocean, offering many resorts and beaches to travellers. Unfortunately, the city has also become a popular sex tourism location. In addition, Mombasa is a major transit stop along the trans-African highway, bringing many African men on transit through the city every day. There are an estimated 8,000 FSWs on the trans-African highway from Mombasa to Kampala, with about 4,000 new HIV infections occurring annually on this portion of the highway[19].

Recruitment

From April-June 2007, ethnographic methods, including focus group discussions (FGDs) and in-depth interviews, were used to gather data on sexual behaviour and perceptions among FSWs in various locations of Mombasa. Two study sites were selected through a purposive sampling technique, based on their involvement with the

FSW population in Mombasa. One site is a peer education program and the second is a sexual health clinic for high-risk women, including FSWs. Participants in the study were accessed through collaboration with these two organizations. The sampling frame of this project was the female population that these two organizations served. Sampling was done through a convenience approach; FSWs who were at the events/the clinic on the same days as the researcher were invited to participate in an interview or focus group discussion (FGD).

Ethical considerations

Prior to each interview and discussion, the study was explained and informants gave verbal informed consent to voluntarily participate. Written consent was not obtained due to the illegality of commercial sex work. Written consent forms would be intimidating to the informants and limit the accuracy of information they were willing to disclose. All interviews were conducted in private locations and the highest degrees of confidentiality were maintained during and post data collection. IRB exemption (Protocol number 12-0575) was given by the Colorado Multiple Institutional Review Board (COMIRB).

Focus group discussions

Three focus group discussions took place with peer educators after their weekly meetings where they discuss safe sex behaviours, HIV testing, and other relevant topics. After the meetings, FSWs who wanted to participate in the discussion were invited to stay. The researcher explained the study to all participants and received verbal consent of their acceptance to participate. Eight to twelve women were present at each FGD. The researcher facilitated the FGDs in English, the official language in Kenya, using a semi-structured guide to allow for a free-flowing conversation regarding the norms, attitudes, and cultural domains of practicing safe sex in this environment[20]. All of the women were fluent in English and if a participant did not understand a question, another participant would translate into Swahili for her and translate back to English for the researcher.

Questions specifically regarding the challenges to practicing safe sex were asked in the FGDs and what the participants felt were the largest barriers to condom use. Safety and legal issues surrounding commercial sex were also frequent topics in the discussions. The discussions were not tape recorded because the researcher felt that this would be intimidating for FSWs and would create social desirability bias in the information that the women shared. Since commercial sex is an illegal activity, the researcher did not want any data that could potentially be linked back to these women. The researcher collected in-depth field notes both throughout and immediately after each discussion.

In-depth interviews

In addition, a total of 28 in-depth interviews were conducted with peer educator FSWs at outreach events and with non-peer educator FSWs at the local sexual health clinic for high-risk women. Twenty-three women were peer educators and 5 women were patients at the health centre. After a peer education event or a woman's health care visit, the researcher approached women, explained the study, and invited them to participate in an interview. If women were interested, they were escorted to the confidential area where the interviews took place (i.e., in a separate room in the facility or outside in a secluded space). There was no compensation for the interviews. The interviews were conducted in English using a semi-structured interview guide with questions regarding individual behaviours and perceptions about selling sex. Questions were asked regarding when and why she began selling sex, the clients that she serves, experiences with violence, price per sex act, condom use, and HIV testing. To avoid intimidation, the interviews were not recorded, but the researcher took extensive field notes.

Data analysis

From May-July 2012, the researcher used critical reflection, thematic analysis, and an inductive matrix analysis to examine the existing qualitative data from FGDs and in-depth interviews. The researcher repeatedly read field notes, grouping statements into categories. Similar categories were

then grouped into themes. The recurring themes from field notes were organized as a set of descriptive terms arranged in rows and columns in a matrix analysis. This analytic method allowed the researcher to relate statements from participants to particular reoccurring theoretical concepts in the data[21].

Although the data was collected in 2007, it is still relevant for current HIV prevention efforts among FSWs in sub-Saharan Africa. In 2010-2011, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS and WHO released reports indicating that there continues to be a lack of inconsistent condom use among FSWs in sub-Saharan Africa, limiting HIV/STI prevention efforts[14,17]. WHO specifically stated the need to explore why there remains this lack of condom use among FSWs[14].

Results

Sample Description

The age range of women was 18 to 45 years, with the majority being between 18-23 years. The age women began selling sex was between 14 to 25 years. One important observation is that 13 of the 28 FSWs began selling sex before age 18, which is considered child prostitution in Kenya. Nineteen of the 28 informants had no other jobs/sources of income besides selling sex at the time of the interview. Fourteen FSWs discussed experiencing physical or sexual violence to varying degrees by a client or a partner. Self-reported consistent condom use over the past month was high with 19 FSWs reporting 100% condom use in the 30 days preceding the interview. This is a similar proportion to what other studies looking at condom use in Mombasa have found [1]. Several women mentioned that they had consistently used condoms with paying clients, but not with boyfriends. HIV testing was very high in the sample; all but one woman reported having had an HIV test and many women stated that they are tested every three months. One woman's response was *"of course I have had an HIV test!"* However, STI screening was much less common and many women mentioned that they only go for STI testing if they are having symptoms. The study did not ask women's HIV status because it was not relevant to the research question and deemed too intrusive.

The location (i.e., beach, club, bar or street) where FSWs met their clients emerged as an important aspect regarding many factors, such as types of clients, price per sex act, condom use, and violence. These categories are not exclusive. Ten FSWs reported meeting potential clients at clubs; 14 FSWs reported bars; 7 reported the beach; and 6 reported on the street. The discussions revealed that in this sample, FSWs typically regard the street to be the worst location to meet clients, as depicted in the flowing statements: *"working on the street is the most dangerous because there are lots of thugs and police harassment"*; *"the street is the most dangerous place to meet clients because there is no market and little money, rape is very common."*

Clients of FSWs were both local Kenyans and tourists as one FSW explained: *"I sleep with a mix of clients, as long as they have money."* Some women discussed older men being better clients: *"I go for older men because they have money. Young men want to have sex but can't pay for it. Old men have money. Sex for money is better than just sex."* Age disparate and intergenerational sexual relationships are known risk factors for the spread of HIV [22] and appear to be common among the FSWs interviewed in this study. Some FSWs stated that they prefer local African men, but most women sought tourists, because *"whites pay more money and are more likely to wear condoms* [than local Kenyan men] *because they are scared of HIV."*

Power and Agency

Some authors have argued that young women hold considerable agency in transactional sexual relationships in African settings[23,24]. However, the experiences of the FSWs interviewed in this study in Mombasa are quite different. Trading sex for money was perceived by the informants of this study as one of the few ways they can make money due to their lack of agency and power. One FSW observed that this area is *"worse than other places to sell sex because there is no* [other] *work for us and high levels of poverty, all aspects of life are worse."* For example, *"men set the price. I*

will take whatever they give me." Another woman explained:

> *"I had lots of problems. There was no way for me to make money. I experienced severe violence from the man that gave me HIV. I took him to the police many times. They did nothing so finally I left him. I don't have a man right now. I haven't had a man the past month because I have been sick. I am HIV positive."*

In the context of this sample, these women are without a doubt engaging in "survival sex work" because their behaviours are almost exclusively motivated by extreme poverty and lack of alternative options to meet economic needs.

By far the most discussed reason for starting sex work was a lack of money and need for basic resources. Many women began selling sex to feed their families: *"I have a baby that I need to feed, but I have no job"; "I need money for food for my children"; "I have no job and need to take care of my baby."* Another recurring statement was either that parents or their husband could not provide for them: *"I had no money, my father was poor. My husband beat me, so I left him."* One FSW needed money to pay for school: *"my parents had no business. I couldn't pay for school; I didn't have anything I could do."*

Recurring concepts that emerged during the group discussions include: the dangers of being a Sex workers; a lack of other options to make an income; mistreatment from clients and the police; and problems negotiating condoms. Women discussed that there are *"many difficulties of being a sex worker*." For example, *"men agree to wear a condom and then they do not want to, and beat you when you refuse to have sex with them without a condom"; "Men say that they are going to make their money go far so they will have sex with you and then beat you"; "There is a lot of violence against sex workers here"; "Men become violent if they don't want to pay for sex when you demand money";* and, *"If men want anal sex and you refuse, they will beat you."*

One hindering factor for FSWs' agency in sexual relationships that emerged in this study is the stigma attached to selling sex. As one FSW explained, *"the public talks about us and we are ostracized."* The giving of gifts in sexual relationships is typically not stigmatized; on the contrary, it is expected in many African cultures [6]. However, the formalized version of transactional sex (i.e., a one-time fee for some sexual favour) is highly stigmatized in societies such as Mombasa. One participant explained that *"there is a negative opinion of us* [FSWs] *because women are not supposed to sell their bodies… mothers will not even let their children talk to us."* Stigma describes a level of inferiority and accounts for the dangers an individual represents to society, often rationalizing animosity based on other differences, such as those of social class or gender [25]. The high level of stigma towards FSWs in Mombasa is most likely attributable to a combination of factors: gender, low social class, and the illegality of sex work.

The criminalization of commercial sex work in Kenya additionally limits FSWs' ability to have control over their lives and sexual practices. Women in Kenya are already socially and economically oppressed and the illegality of FSW even further marginalizes this population. Police harassment, fear of imprisonment, and lack of legal protection from violence were recurring concepts in the interviews and FGDs. One FGD participant stated that *"[police] look in your purse and if they find condoms, they put you in jail, but clients are released."* Carrying condoms in Mombasa is evidence of selling sex and women can be jailed for up to 6 months for this offense. There is no law, however, criminalizing the purchasing of sex by male clients.

Often, police will take advantage of these sexist polices, requiring FSWs to provide sexual favours as bribes. FSWs are also unable to seek help or protection from sexual violence, which increases the risk of HIV transmission. Police officers are often perpetrators themselves, since these women have "*no one to go to*" to report offenses. Public policy in countries like Kenya would greatly benefit from using an evidence-based approach to HIV-prevention instead of moral judgment in the case of FSW.

Synergy of Gender Inequality and Poverty

Gender inequality and extreme poverty converge among FSWs in Mombasa, making safe sex a difficult task. As one woman described: *"men*

misuse you because you are poor and a woman." High-risk sexual behaviours among FSWs in this sample were not a reflection of lack of knowledge or motivation; in almost all situations it is a lack of control and economic materialism that motivates unsafe sex. As one FSW stated: *"we don't use condoms because we are not informed, it is because of poverty and need for money."* The gendered hegemonic culture in Mombasa allows underprivileged women few options for economic survival, constraining free choice regarding sexual behaviours that place them at risk for HIV. Interventions that leave behaviour change up to the individual — the basis of most programs — are not going to be successful in these populations because FSWs do not have control over choices regarding their sexual behaviour.

The commodification of sex in Kenya has resulted in a "sexual market" in which more risky sexual activities are more highly compensated[15]. Based on the interviews and FDGs, male clients in Mombasa will pay on average about 7 times more money for unprotected sex (about $5 with a condom, $35 without a condom). Many FSWs explained their inconsistent use of condoms because *"we get more [money] without a condom."* Throughout the interviews, it became apparent that women weigh decisions regarding their health against the need for economic profit. A FGD participant explained: *"I am very worried about HIV, but because I need money, I will be unsafe."* Other FSWs stated: *"money is everything!"* and *"it is a very dangerous way of making money."* The unfortunate reality is that sex is often the currency that impoverished women in Mombasa are forced to use either completely or partially to meet their material needs.

Twenty-three of the 28 FSWs interviewed were trained as safe sex peer-educators. They have extensive knowledge about HIV and safe sex, yet six of the 23 peer educators admitted to inconsistent condom use during the month preceding the interviews. This number is most likely also underreported due to social desirability bias, but still high none-the-less. The economic power imbalance between FSWs and their clients gives them little authority to demand condom use, despite their knowledge of safe sex, STIs, HIV, and their access to free condoms. FSWs in the peer education program explained: *"it is difficult to get men to wear condoms because they do not like the feeling"* and *"clients don't want to use condoms because they are drunk and don't want to deal with them; they also do not like them."* FSWs are not able to consistently practice safe sex because they are at the mercy of their client's money. It is apparent that women are also at risk of sexual or physical violence if they insist on condom use, as highlighted in the following quote: *"when the client does not want to wear a condom he will beat you if you demand he wears."*

Peer Education

The FGDs and in-depth interviews indicate that peer education programs have a positive impact on the lives of FSWs, even if there is not 100% condom use. Women were very glad to be empowered with knowledge, social support, and some supplemental income (about $7 per month) for being a peer educator. One woman explained:

> *"the program is good because it teaches us to take care of ourselves, always use protection during sex, know your status and your partner's status, and educate our peers. We are now strict about condom use, even with boyfriends. We have become more respected higher class and learned the importance of protection. The program has taught us to leave a client if he won't use protection, be assertive about condom use, always use condoms, get tested for HIV every 3 months and get tested for STIs if you notice any abnormality."*

The data illustrates that after becoming a peer educator many women had positive behaviour changes. HIV testing was almost universal among peer educators and many women stated they have reduced their number of sexual partners. For example, one woman explained that before becoming a peer educator she had 20 to 30 clients per week, but now she has found another job in a salon and only has 2 clients that she consistently sleeps with and she would like to stop doing sex work altogether and have only one long-term sexual partner. Another woman stated that before becoming a peer educator she did not know how to use a condom or why they should be used. After her peer education training, however, she uses

condoms with every client and tells her peers to do the same.

Peer education also had a positive impact on the social capital and social support among FSWs in the program. It was described as creating a protection and support network for the women in the areas where they work. However, many women expressed a need to find other opportunities to make money: *"we like the program, it helps, but we wish that we had other ways of making money."* Ultimately, even peer educators' ability to practice safe sex is determined by their male partners' willingness to use condoms. Several FSWs suggested the need for more programs aimed at male clients, which is a large gap in HIV interventions throughout sub-Saharan Africa.

Discussions

Gender inequality contributes to women's lack of economic opportunities and social mobility, increasing reliance on FSW and temptation to engage in unprotected sex. In many societies within sub-Saharan Africa women do not have equal access to education or jobs. Governments in sub-Saharan Africa need to prioritize the education of girls and if necessary, establish incentives for parents to keep *both* girls and boys in school. In the fight against HIV, it is essential that young girls be able to finish school and have other options for income besides commercial sex. In addition to female education, African governments should also address gender inequality by allotting more spaces in government positions to women and ensuring equal pay for both genders throughout the public and private sectors.

In civil society and non-governmental organizations, increased community mobilization and activism in needed. Researchers have found that 'perceived citizen power' is one of the most influential aspects of health-enhancing behaviour[27]. Empowering FSWs through peer education, cooperative groups, condom negotiation skills, income generation, and available safe healthcare services would ultimately result in a decrease of HIV rates among FSWs and an improvement in the quality of their lives overall. More private and governmental global funding should be dedicated to women's empowerment, including women who may sell sex.

Lastly, at the policy level, there is strong evidence that the criminalization of sex work is health *hindering* because women are not able to access sexual health services, carry condoms, or protect themselves from sexual and physical violence due to fear of legal repercussions. The FSWs in this study unanimously called for a re-evaluation of laws against the selling of sex. Criminalizing sexual behaviour is an unnecessary and oppressive policy, which increases stigma and adds additional barriers to practicing safe sex. Many of these laws are sexist in nature, or in their enforcement, by only punishing FSWs and not the male clients. If we are to expect FSWs to be sexually responsible (i.e., use condoms), there needs to be the necessary social and legal structures in place that enable them to do so by protecting their rights as citizens.

Conclusions

The results of this study indicate the need to tailor HIV interventions among FSWs to match the multifaceted dynamics of their lives, including gender inequality and access to education and employment. High-risk sexual behaviours among the FSWs in this study were not a reflection of poor knowledge; it is lack of control and economic materialism that motivates unsafe sex. Education and counselling among FSWs are no doubt positive interventions, but would be dramatically enhanced by community, institutional, and public policy interventions that address the social critical determinants of health[26]. In many settings across sub-Saharan Africa, most sex work takes place in high-risk environments filled with intense social marginalization where FSWs have little or no control over client's sexual behaviour. Unfortunately, the most widely or only available safe sex method is the *male* condom. Marginalized women will never be able to enforce the use of this safe sex method because of the gendered socioeconomic imbalances that currently exist in these sexual relationships throughout sub-Saharan Africa.

Limitations

The sample in this study included FSW peer educators and FSWs at a health clinic for high-risk women. However, this leaves out the most vulnerable women: those who are not accessing social and health services at all. Since experiences were all self-reported, there may be social acceptability bias in the reporting of condom use and HIV testing. However, this would not change the ultimate findings and conclusions of the study. Males or transgendered sex workers were not interviewed and will most likely have very different experiences than FSWs. The data was collected in 2007, however, as stated previously, there is likely to be few discrepancies in the experiences of FSWs in 2007 and now considering that consistent condom use remains low and no major policy changes regarding sex work have occurred.

Contribution of Authors

Karen M. Hampanda conceived and designed the study, conducted all interviews and FGDs, analysed the data, and prepared the manuscript. Karen M. Hampanda approves the publication of this manuscript. The author declares no competing interets.

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