

The role of intimate partners in harm reduction for HIV positive female sex workers in
Kibera, Nairobi

by

Kimberly Sharpe
B.A., University of Victoria, 2009

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Abstract

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While female sex workers (FSWs) are often the focus of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other sexually transmitted infections (STIs) research in Kenya, little else is known about their lives, including their intimate relationships. This thesis explores the relationships between FSWs and their intimate partners in Kibera, an urban informal settlement in Nairobi, Kenya. As part of the Kenya Free of AIDS (KeFA) project, previous field research found that FSWs with an intimate partner saw over 50% fewer clients per week and were statistically more likely to use a condom with clients. These findings suggested that FSWs' intimate relationships might act as a form of harm and/or use reduction. Sex work harm reduction aims to diminish the occupational harms associated with sex work, such as discrimination, violence and disease, through strategies such as empowerment and education. Use reduction aims to reduce FSWs' frequency of exposure to these occupational risks through a reduction in clients. Specifically, it is proposed that FSW intimate relationships promote harm and/or use reduction in three ways: 1) by reducing the number of clients on a weekly basis, 2) by reducing harm from the virus through adherence to antiretroviral drugs (ARV), and 3) by offering a supportive environment financially, emotionally, and in terms of health and/or childcare.

To test these theories this thesis analyzed interviews with 27 HIV positive FSWs from Kibera. Results showed that HIV was normalized in intimate relationships, whereas sex work was stigmatized. As a result, FSWs in this study were more likely to tell their partners that they were HIV positive than disclose their involvement in sex work.

Therefore, rather than genuine use reduction, client reduction was unintentional and, in reality associated with sex work stigmatization that prevents women from disclosing their occupation. Some intimate partnerships were found to be a source of emotional and

health-related support for Kibera FSWs. Intimate partners provided support for participants' HIV status and adherence to ARV. Overall, this study suggested it would be difficult to include intimate partners in interventions with this particular sample of HIV positive Kibera FSWs because of the considerable, continued stigma surrounding sex work but that intimate relationships could play a positive and/or protective role.

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Chapter 1: Introduction

"Because if I told him, he could not accept me the way I am. You know men; they can't allow a woman who goes just with every man like that. They don't take in any woman like that."

(Karen, age 20, 3 children)

"She says it didn't affect the relationship since the guy is also HIV positive. So then they support each other even when they are going for trainings support HIV." (Janiel, age 39, 5 children, translation)

Karen and Janiel are both female sex workers (FSWs) with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) living in Kibera, a large informal settlement in Nairobi, Kenya. Karen grew up in the Soweto East district of Kibera. She has primary level education and is raising two adopted children. Janiel resides in the Laini Saba district of Kibera and has lived in Kibera over half her life. She has completed primary level education and is responsible for raising five children. In the above quote Karen explains why she keeps her involvement in sex work hidden from her intimate partner. She relies on the financial contributions she receives from her partner to support her family and fears that if her partner finds out about her involvement in sex work she will lose that support. In contrast, when Janiel informed her partner of her HIV positive status her partner was not only supportive but was motivated to disclose his HIV positive status as well. In addition, Janiel later explains that her partner provides emotional support for her HIV status and supplies food for when she takes her HIV medications. These quotes demonstrate the varied nature of Kibera FSWs' intimate relationships. In this thesis, I explore and analyze HIV and sex work disclosure and partner support in the intimate relationships of Kibera HIV positive FSWs.

1.1 Research Background

Sub-Saharan Africa has the highest rate of HIV/AIDS in the world and transmission has largely been through heterosexual sex (UNAIDS, 2012). HIV prevalence in Kenya peaked in the 1990s, when prevalence in cities such as Kisumu reached as high as 19% before declining in recent years to a national average of 6.3% (Cheluget et al., 2006). The Kenyan HIV/AIDS epidemic is considered to be both a generalized epidemic among the general population and a concentrated epidemic prevalent among vulnerable populations (UNAIDS, 2009). FSWs are considered a vulnerable group in the epidemic because they are at greater risk for acquiring HIV and other sexually transmitted infections (STIs) than the general public (Gouws et al., 2006). Commercial sex work has long been considered to play an important role in the HIV epidemic (D'Costa et al., 1985; Ngugi et al., 1988) because of high rates of partner change (Steen and Dallabetta 2003; Cote et al., 2004; Morris et al., 2009) and low frequency of condom use (Luchters et al., 2008; Voeten et al., 2002) that are linked to the risk for HIV/AIDS acquisition and transmission for both sex workers and clients.

Although several studies have illuminated the role sex work plays in the transmission of HIV/AIDS in the Kenyan epidemic (Fonck et al., 2005; Dunkle et al., 2004a), little else is known about Kenyan FSWs, including their intimate relationships. The few studies that have looked at FSWs' intimate partnerships have focussed on physical violence (Maman et al., 2002; Dunkle et al., 2004b) and low levels of condom use with partners (Voeten et al., 2007).

This thesis explores the relationships between FSWs and their intimate partners in Kibera, an urban informal settlement in Nairobi, Kenya. Kibera is one of the largest informal urban settlements in Africa, with an estimated population between 500,000 and 700,000 and is located within Nairobi city boundaries (United Nations Habitat (UN-Habitat), 2011). The settlement is characterized by high levels of poverty, crowding, a lack of sanitation facilities, limited infrastructure and a prevalence of HIV/AIDS more than double the Kenyan national average (Unge et al., 2009).

The research is part of a larger project called *A Kenya Free of AIDS: Harnessing interdisciplinary science for HIV prevention* (KeFA). It is funded by the United States' National Institutes of Health and brings together the University of Washington, USA, the University of Nairobi, Kenya and the University of Victoria, Canada. This collaboration consists of four field-based pilot projects. One project, *Exploration of Kenyan Female Commercial Sex Workers and Their Male Partners – Life Course and Harm Reduction Approaches*, examines the social epidemiology of Kenyan FSWs. The project has completed three field seasons, gathering data on: 1) FSWs and a comparison group of other women working in Kibera; 2) FSWs and their male clients and; 3) FSWs and their intimate partnerships.

In 2009, Phase 1 of the project looked at bar-based FSWs living and working in Kibera and compared them to a sample of Kibera women working in other occupations, including hairdressing and tailoring, and who had never been involved in commercial sex work. One of the most significant findings from the Phase 1 research was that FSWs with an intimate partner saw over 50% fewer clients per week and were statistically more likely to use a condom with clients (Ngugi et al., 2012a). Further examining this relationship, the research found that half of these intimate partners made considerable contributions to household expenses and by doing so may have reduced the need for FSWs to take additional clients or engage in risky sexual practices, such as not using a condom, for which some clients may pay extra money. These findings contrast with the majority of published research on FSWs and their intimate partners, which highlights negative aspects of partnerships; Phase 1 results instead suggest that intimate partners may actually represent a form of harm and/or use reduction for Kibera FSWs by reducing the risk of HIV/AIDS and other STIs and offering economic and social support. The researchers concluded by calling for future research exploring the feasibility of including intimate partners in interventions targeting Kibera FSWs (Ngugi et al., 2012a).

1.2 Research Questions

This thesis explores the harm and/or use reduction potential of intimate relationships for Kibera FSWs and examines the potential for including intimate partners in future sex work interventions. Data for this research come from in-depth interviews conducted in June 2011 with 30 HIV-positive Kibera FSWs. Using a research instrument with closed-and open-ended questions (Johnson & Turner, 2007), this study asked women about their current or past intimate relationships while they have been involved in sex work. For my thesis, I will analyze the resulting data focusing on the following research questions:

- 1) Do the relationships Kibera FSWs form with their intimate partners act as a form of harm and/or use reduction?
- 2) Is it feasible to include intimate partners in interventions targeting FSWs?

1.3 Significance

This thesis contributes to the body of knowledge on FSWs and their intimate partners. Research on the intimate relationships of FSWs in sub-Saharan Africa remains scarce and this thesis looks beyond the traditional focus of partnerships as sources of violence and disease to investigate the potential for more positive aspects. In addition, this thesis documents how FSWs in Kibera negotiate disclosing their HIV status and involvement in sex work to their partners. This information is important as FSWs are considered a vulnerable group in the HIV/AIDS epidemic (D'Costa et al., 1985; Ngugi et al., 1988; Gouws et al., 2006) and have been found to use condoms less with their regular partners than with clients (Voeten et al., 2007; Mgalla & Pool 1997; Outwater et al., 2000). This research also explores the appropriateness of including intimate partners in interventions aimed at FSWs. Because of all the above points this research will be of use aid agencies and policy makers.

In this thesis, I also examine the concept of sex work harm reduction, which has been primarily applied in the context of high-income nations (Rekart, 2005), rather than in resource poor settings such as Kibera. The result is a greater understanding of the role intimate partners play in harm reduction and

the wellbeing of FSWs in Kibera, as well as the specific barriers women in resource poor settings face in participating in harm reduction initiatives.

1.4 Summary of Thesis

In Chapter Two - *Literature Review* - I introduce the Kenyan ethnographic context that may lead women into sex work, including the disruption of traditional Kenyan family linkages and lack of viable economic opportunities. I then examine the social epidemiology of Kenyan FSWs including their vulnerability to HIV/AIDS and present the literature on African FSWs and their intimate partners, which primarily focuses on intimate partner violence and HIV transmission. Finally I introduce the model of harm reduction that will guide my thesis.

In Chapter Three, *Materials and Methods* I begin by describing Kibera, the field site for this thesis. I conclude by outlining the methods used for data collection and data analysis.

In Chapter Four, *Results*, I present the research findings from the interviews. I will first introduce my quantitative results describing the sample, followed by my qualitative analysis. The results will demonstrate the recurring themes and subthemes found within participant responses to the survey instrument.

In Chapter Five, *Discussion and Conclusion*, I summarize the main findings and contextualize the results within the wider body of literature. I then return to and address my research questions. Finally, I include limitations of the study and recommendations for future research and policy implications.

Chapter 2: Literature Review

In this section I contextualize my thesis within the broader literature on HIV/AIDS and FSWs in Kenya. Firstly, I examine changing kinship patterns, economic inequality and a lack of female property rights, lending insight to some of the social and economic determinants of entry into sex work, as well as the poor conditions women face once engaged in sex work. Secondly, I discuss the literature on FSWs and their intimate partners and present the limited literature that examines the potential positive aspects of these relationships. Finally, I introduce the theoretical framework of sex work harm reduction that I use to guide my thesis.

2.1 Ethnographic Context: Women and Kenyan Society

Kenyan women face a lack of economic opportunities that may leave them vulnerable to engagement in sex work. While Kenya's economic performance has improved since the 2003 election of a new government, many Kenyan citizens have not yet benefited, especially those in urban slums (Odek et al., 2009). Kenyan women are located primarily in informal-sector job activities because this allows them to balance their work life with their home life and responsibilities; however these jobs, such as small roadside businesses, can be highly unstable (Wanjale & Were, 2009). Informal employment often leaves women and their families in precarious financial positions for reasons largely outside their control. Female workers in Kenya also often find themselves subjected to sexual exploitation, and are pressured to engage in sexual activities in order to gain or maintain employment (Akeroyd, 2004). In a study on Kenyan migrant women, participants reported that some women obtained jobs at local factories by engaging in sexual activities with the factory's superiors (Mweru, 2008). Akeroyd (2004) argues this is the result of the wider context of sexual harassment and sexual violence in Kenyan society, where customs and law result in unequal gender relationships that give continue to men power over women.

This economic inequality and deprivation may lead some women to engage in sex work to provide for themselves (Robinson & Yeh, 2011; Odek et al., 2009) and, their families as well (Elmore-

Meegan et al., 2004). Chege et al. (2002) argue that sex work is strategic employment by women with dependents when there are significant constraints on formal labour. Heavy economic requirements due to caring for a high number of children may require FSWs to engage in alternative economic activities, such as hairdressing or washing clothes, in addition to sex work (Odek et al., 2009).

Customs and laws also affect women's rights to inherit land in Kenya. Women in Kenya have weak property rights, with land often passed down through patrilineal lines, and widowed or divorced women frequently face land ownership challenges from their husband's family (Henrysson, 2009). However, defending land claims in the court system can be challenging for women who may have less money to spend in the formal court system (Henrysson, 2009). Additionally, most people in Kibera do not own their own land or houses (de Smedt, 2009). This unstable access to land may leave women exposed to even higher levels of poverty, resulting in fewer resources to help support themselves or their families.

However in a study by Gysels et al. (2002) involving Ugandan sex workers, the researchers found that not all economically disadvantaged women entered sex work. Campbell (2000) reported that one of the most important factors for entering sex work was the death of one or both parents. Similarly, Ngugi et al. (2012b) found that women who did not have a male guardian during childhood were four times more likely to engage in sex work compared to women who had at least one male guardian and that a lack of strong kinship support system was a significant factor associated with entry into sex work. This research also noted the importance of traditional child fosterage practices in sub-Saharan Africa.

In Kenya, children historically were raised in large households with intergenerational family members (Catell as cited in Killbride et al., 2000). Weisner argues that these extended families should be seen as "sibling caretaking societies" and family connections, especially among siblings, serve to provide mutual support to family members if the need arises (as cited in Killbride et al., 2000). These reciprocal relationships begin when children are young and they help support their family by supplying

care for younger children (Killbride et al., 2000) or by providing assistance in the form of chores or labour and child care for wealthier extended family members and neighbours (Abebe & Skovdal, 2010). These relationships serve to bolster the concept of fostering, where children are sent to live with aunt or uncles, or less frequently, wealthier relatives or grandparents in reciprocal arrangements that benefit both families (Foster & Williamson, 2000) or as a result of the death of a parent or economic hardships (Oleke et al., 2005; Nyambedha et al., 2003).

The shift to migrant labour, beginning in the colonial era and continuing into the present and bringing rural workers to larger industrial, agricultural and urban areas (Hunt, 1989), has disrupted some of these familial links resulting in an increased number of sibling and female-headed households (Oleke et al., 2005). A lack of access to land and poor rural employment opportunities forces men to migrate in search of employment (Killbride et al., 2000) and migration is often seen as a familial survival method (Young & Ansell, 2003). Men who migrate in search of work often leave their wives and children behind at home, resulting in a split family with women bearing the sole responsibility for the household and childcare (Oppong & Kalipeni, 2004). Young and Ansell (2003) postulate that geographical distances between family members have weakened the ties of the extended family with the result that relatives may be less likely to foster children. Female migration also contributes to traditional kinship erosion, with women living away from their extended families and partners (Dodson, 1998) and migrant women in urban areas often facing high levels of poverty because of low wages and the high cost of living. Consequently, women sometimes live with boyfriends or relatives to cope with financial burdens (Mweru, 2009).

The HIV/AIDS epidemic has also had a significant impact on traditional familial support systems in Kenya. In a study in Western Kenya, Nyambedha et al. (2003) found that the HIV/AIDS epidemic has disrupted traditional fostering practices. While the majority of orphans are still fostered by a surviving parent or patrilineal kin, an increasing number are fostered with grandparents, maternal family or

strangers. Additionally, child-headed households may also form in the case of the death of both parents because relatives are either unable or unwilling to support additional children (Killbride et al., 2000; Foster & Williamson, 2000). In migrant households, children orphaned by HIV/AIDS may be even more at risk because of weaker ties to extended family safety nets (Foster & Williamson 2000).

2.2 Female Sex Workers in Kenya

The exchange of money and goods for sex in sub-Saharan Africa is not limited to commercial sex work. Wojcicki (2002), in a study looking at South African tavern workers, argues that longstanding cultural expectations encourage the exchange of sex in response to money and gifts from men. Conversely, there is also the expectation that male partners must provide their partners with financial resources. However, accepting money, gifts, services or favours in exchange for sex does not necessarily result in women identifying as sex workers (Lowndes et al., 2002). For instance, though many South African tavern workers exchanged sex for monetary gain, they did not self-identify as sex workers because sex work was characterized as something women did publicly and in revealing attire (Wojcicki, 2002). Female bar workers in Tanzania, who exchanged sex for better tips if they were in financial need, also differentiated themselves from FSWs because they were only informally involved in sex work (Mgalla and Pool, 1997). Informal sex work often comes with less social stigma because solicitation is discrete and ambiguous and is therefore not publicly recognizable (Wojcicki, 2002). Involvement in sex work can be fluid, with sex workers participating in other economic activities, such as small roadside businesses, and moving in and out of sex work as needed (Ngugi et al., 1996). Sex work can also act in the place of a social safety net, supplementing income during difficult economic periods.

Sex workers are a highly stigmatized population in Kenya (Ngugi et al., 1996), with sex work associated with 'immoral' activities (Nyblade et al., 2011). The link to immoral activities encourages the belief that FSWs deserve to be punished for their actions (Fida Kenya, 2008). Shame and blame have long been cast on FSWs, which has increased the FSWs' vulnerability and impeded attempts to launch

health initiatives aimed at FSWs (Scambler & Paoli, 2008). Punitive laws surrounding sex work can add another layer of stigma by presenting sex workers not only as morally suspect but as criminals as well and further separate sex work from other forms of legitimate work (Vanwesenbeeck, 2001; Weitzer, 2009). This criminalization can affect FSWs' ability to access health services and education, leading to poorer health outcomes (Blankenship & Koester, 2002). Criminalization also limits FSWs' access to legal protection in instances of sexual and physical violence (Pauw & Brener, 2003). In a study on FSWs in South Africa, Pauw and Brener (2003) noted that law enforcement reinforced the devaluation of FSWs by not taking complaints of abuse and violence seriously or by laying blame on FSWs for their victimization as a result of their involvement in sex work.

People living with HIV/AIDS also face issues of stigma in Kenya. In a study of Kenyan vaccine trial participants, respondents reported that if others perceived them to be HIV positive they would be subjected to gossip and physical and social isolation (Nyblade et al., 2011). Literature on the HIV/AIDS epidemic in sub-Saharan Africa can further stigmatize sex workers by characterizing them as 'reservoirs of disease' (D'Costa et al., 1985, p. 64). Elmore-Meegan et al. (2004, p. 54) argue that this focus has "resulted in prostitution being seen as the cause of the disease rather than the consequence of economic marginalization". Women are then doubly stigmatized when they both engage in sex work and have HIV/AIDS.

As well, a danger in focusing on FSWs as a core group, a sub-population of vulnerable individuals who have higher rates of sexual partners and help maintain rates of STIs at epidemic levels in a population (Ngugi et al., 2012a), is that it often pays little attention to the sexual behaviour of men (Elmore-Meegan et al., 2004). Rather, responsibility for preventing HIV transmission is put solely on women who may lack power in sexual interactions. Consequently, much research focuses on the risk of transmission from FSWs to the general population, rather than strategies to protect sex workers from

disease and abuse. Such research fails to recognize that sex workers are both vulnerable to HIV and yet important partners in preventing its transmission (Elmore-Meegan et al., 2004).

Although HIV/AIDS prevalence in Kenya has declined in recent years, it still remains at 6.3% for adults aged 15-49 years old. Kenyan women are disproportionately affected, with prevalence among women at 8.0% compared to 4.3% among men (Kenya National Bureau of Statistics (KNBS) & ICF Macro, 2010). Because of the increased risk of HIV/AIDS for FSWs compared to the general population (Yadav et al., 2005), the prevalence in this population is even higher. For instance, FSWs in Nairobi were found to have an HIV/AIDS prevalence of three times the Kenyan national rate (Odek et al., 2009). Another study found that sex workers in Kibera have an HIV/AIDS prevalence of 27.2% compared to 11.6% for other working Kibera women (Ngugi et al., 2012a).

These high rates of HIV/AIDS prevalence among FSWs can be attributed partly to higher numbers of clients compared to the general population and low frequency of condom use (Elmore-Meegan et al., 2004; Okal et al., 2011). Additionally, the link between financial instability and risky behaviour for FSWs is well known (Odek et al., 2009) and FSWs may not be financially secure enough to turn down clients who refuse to use condoms or who have visible STIs. One study from Kenya found that in the last month 8% of participants had been with a client who had a visibly infected penis but that FSWs were unable to refuse sex because of financial need or the threat of physical violence (Elmore-Meegan et al., 2004). Conversely, this research found that two-thirds of participants had been treated for an STI in the last six months. In another study, FSWs reported sex was sometimes forced on them when they asked about condoms and that some clients even drugged them with alcohol and other drugs in order to avoid using condoms (Okal et al., 2011).

Physical and sexual violence are common themes in the literature on sub-Saharan Africa FSWs (Chersich et al., 2007; Okal et al., 2011; Elmore-Meegan et al., 2004; Akeroyd, 2004). Elmore-Meegan et al. (2004) found that 35% of FSWs and 17% had been physically assaulted. Alcohol consumption has

been associated with violence, as FSWs who binge drink are more likely to be sexually assaulted by their clients compared to FSWs who do not binge drink (Chersich et al., 2007). Some FSWs reported that they abstain from drinking alcohol with clients in order to recognize potentially risky situations (Okal et al., 2011).

FSWs may also experience high levels of violence from their clients due to the stigma and social connotations attached to sex work. Participants in a study by Okal et al. (2011, p. 614) “drew direct links between violence and the fact that sex work inherently commoditizes sexual exchange and gives men undue advantage” and said their clients often used this advantage to “control” or “endanger” them. One woman explained that sex workers experience physical or sexual violence because the client has spent his money on them and feels he can do what he wants. This objectification of a woman’s body as something that can be bought increases her exposure to harm.

Though physical and sexual violence occur, FSWs are reluctant to seek assistance from the police because of the illegal status of sex work in Kenya. Some women report that the police harass, assault, sexually coerce and threaten to arrest them (Okal et al., 2011; Ferguson & Morris, 2007). Not only does this disrupt the women’s ability to make money but arrest results in them being unable to care for children at home (Okal et al., 2011). Furthermore, police may be clients of FSWs (Ferguson & Morris, 2007), complicating the ability of women to report violence. While much of the literature focuses on the connection between sex work, violence and HIV/AIDS, other facets of FSWs' lives, such as their intimate relationships, remain less well known.

2.3 Female Sex Workers and Their Intimate Partners

There is limited literature concerning the relationships FSWs have with their intimate partners in Africa and the difference between clients and regular or intimate partners is not always clearly delineated. For instance, a client may begin to view a sex worker as an intimate partner as he visits more regularly and begins to provide subsistence assistance, such as food and rent, rather than paying

for each sexual encounter (Ngugi et al., 2002). FSWs may also have more frequent clients that they refer to as "boyfriend" or "lover", rather than "client" (Ngugi et al., 1996). Mgalla and Pool (1997) found that the distinction between client and regular partner was tied most closely to financial support. Regular partners tended to provide more reliable financial support and relative security, such as providing income assistance in times of illness or when school fees for children were due. In contrast, clients were more likely to provide only one time payments for sex acts and could generally not be relied on for support in times of economic hardship. Voeten et al. (2002) also found that financial assistance played a role in defining intimate relationships. For instance, clients drew distinctions between their FSW partners and their partners not in sex work because they believed their partner not involved in sex work would love them even if they were not able to provide regular economic support, whereas they thought their FSW partners were more interested in the economic benefits.

Therefore, for the purpose of obtaining a clearer understanding of the partner literature I include several studies concentrating on the intimate relationships of African women in general, not only those specifically engaged in sex work. Several dominant themes emerge from these works, including the prevalence of interpersonal violence and the risk of HIV/AIDS in these relationships. I also include literature about FSWs' intimate relationships from outside of Africa.

The most common theme for intimate relationships is the association between physical violence and HIV status. In a study involving 520 women at an STI clinic in Nairobi, HIV seropositive women reported nearly twice the amount of physical partner violence as women who were not HIV seropositive (Fonck, et al. 2005). Women using antenatal clinics in Soweto, South Africa also had increased odds of HIV infection with the presence of physical intimate partner violence, even after controlling for factors such as engaging in sex work (Dunkle et al., 2004a). Among HIV seropositive women in Tanzania, the odds of physical partner violence were ten times higher than for seronegative women (Maman et al., 2002). Dunkle et al. (2004b) report an indirect link between intimate partner violence and HIV risk in a

study on women in South Africa. In this study, women who had a history of physical violence in their intimate relationships were more likely to enter sex work, therefore indirectly increasing their risk of acquiring HIV. Although violence is associated with HIV seropositivity, this does not necessarily denote a causal effect. For instance, violence may make women more vulnerable to HIV acquisition (Fonck et al., 2005), but the stigma and discrimination associated with HIV may also make women more vulnerable to violence.

Studies on intimate partnerships also report low levels of condom use within these relationships in Africa (Westercamp et al., 2010; Mgalla & Pool, 1997; Lowndes et al., 2000). A study on FSWs in Nyanza province in Kenya (Voeten et al., 2007) found that FSWs were much less likely to use condoms with their regular or intimate partners than with non-regular clients. FSWs in this study used condoms 25% of the time with intimate partners, compared to 60% of the time with their non-regular clients during a two-week period. Additionally, 40% of FSWs reported not using a condom at all during this same two-week period (Voeten et al., 2007). Sex workers may not use condoms with their intimate partners for a variety of reasons, including sexual pleasure and condom unavailability. In addition, FSWs may say that they trust their intimate partners, though trust appeared to be more connected to material support than fidelity (Westercamp et al., 2010; Mgalla & Pool, 1997). For instance, a study in Tanzania found that FSWs' intimate partners insisted on not using condoms because they provided regular economic support and that the concept of 'trust' for FSWs was related more to ensuring continued material support than faithfulness from their intimate partners, who were often married or seeing other women (Mgalla & Pool, 1997).

The association between violence and HIV and low rates of condom use demonstrates that intimate relationships can be harmful to health, resulting in injury from violence for women and potentially fostering high levels of HIV transmission between women and their partners. While these are

legitimate concerns, there may be the potential for intimate relationships to act in protective and positive ways, as well.

A small number of studies from outside Africa have looked at the potential for intimate relationships to act in a more positive and potentially supportive manner. Jackson et al. (2009), in a study in Nova Scotia, Canada found that intimate partners could be a source of social and emotional support. Some relationships represented a safe haven where women felt comfortable and accepted for whom they were, instead of being seen as women in the sex trade and this fostered a feeling of inclusion. In other instances, women reported that damaging stereotypes about sex workers could be present in intimate relationships, leading to stigma and a sense of exclusion. Similarly Shannon et al. (2008) found that the intimate partnerships FSWs formed were diverse. Some women described their intimate partners as 'glorified pimps' because they held considerable power over the women's work environment and interactions with clients. However, these relationships could also be emotional and economic coping strategies for companionship and acquiring resources, with some women describing their relationships as a source of comfort and trust.

In a study of FSWs working in the border provinces of Vietnam, Thuong et al. (2005) found that having a regular non-paying partner was a protective factor against HIV. They postulated that this might be due to the women having fewer opportunities to meet clients or other partners. As well, in a study that compared Kibera FSWs with women working in other occupations, such as hairdressing, Ngugi et al. (2012a) found that for FSWs, being in a romantic relationship decreased the weekly number of clients by over 50% and increased condom use with clients. The authors found that over half of the intimate partners made significant financial contributions romantic partners to household income and that this likely replaced economic gains from having a higher number of partners and clients paying more for sex without a condom. This financial support from intimate partners is critical as Ngugi et al. (2012b) found

Kibera FSWs had less financial support from their families. In this case, financial support from intimate partners may act as a form of economic security traditionally provided by the extended family.

This evidence demonstrates that there is the potential for FSWs' intimate partners to play a more positive role in FSWs' health and well-being in contrast to the majority of published research that portrays these intimate partnerships as risky and abusive. The potential for intimate relationships to have a negative influence must be considered for an area where poverty, unemployment or underemployment, high HIV rates, stigma and the added responsibilities of dependent children constrain the lives of FSWs. However, this research will go beyond this traditional view and examine how intimate partnerships may have both protective and negative influences in the lives of FSWs.

2.4 Theoretical Framework: Harm Reduction

A wide variety of qualitative theories have been used in sex work research. These theories often examine the structural or intersecting components composing FSWs' lives. The concept of Structural Violence, where violence is exerted systematically or indirectly, such as sexism, gender inequality or unjust trading relationships, and results in adverse outcomes such as illness, death, and subjugation, offers a structural framework with which to examine the structural barriers constraining sex workers' lives (Galtung, 1969, Farmer, 2004). Ecological Systems Theory (Bronfenbrenner, 1989; Dalla, 2002) involves taking into account the entire ecological context in which a sex worker lives, including historical events, environmental factors, cultural history and social relationships. Dalla (2002) argues that social relationships, with other sex workers, clients and partners, may provide valuable information about sex workers' current lives and life trajectories.

Feminist approaches, such as Intersectionality, also provide valuable insights into sex workers' lives. Intersectionality examines how different social, biological and cultural categories, such as race, gender, class and sexual orientation, interact on multiple levels and contribute to systematic social inequality (Crenshaw, 1991; McCall, 2005). The theory of Intersectionality argues that oppression

and discrimination stemming from these categories, such as racism, sexism and homophobia, act interdependently to create a system of oppression that reflects multiple levels of discrimination.

This thesis applies sex work harm reduction, a theoretical framework that seeks to empower, reduce harm and improve sex workers' lives, while acknowledging that exiting sex work can be difficult and even undesirable. Sex work harm reduction is a pragmatic framework that searches for strategies, such as occupational health and safety and improved care, which work to reduce the disproportional harms, such as violence and high levels of STIs, that sex workers experience.

Traditionally applied to substance use, harm reduction is a concept that focuses on reducing the negative consequences of using substances, rather than requiring the elimination of substance use (Riley et al., 2000; Stockwell et al., 2005). Harm reduction may recognize abstinence as an ideal outcome but must promote alternatives that reduce harm for people who continue to use substances (Marlatt, 1996).

Modern incarnations of harm reduction have their roots in the late 1970s and 1980s. The Netherlands was the first country to adopt an explicit harm reduction approach to drugs. The Dutch Model began to take shape as early as 1972, when the Narcotics Working Party released a policy paper calling for drug policy to reflect the risk level of the substance used (Collins et al., 2011). This led to the 1976 Dutch Opium Act, which drew a distinction between 'softer drugs', such as marijuana, and 'harder drugs' such as LSD and heroin. By the 1980s, the Dutch government adopted harm reduction as their official approach to dealing with all substance use (Engelsman, 1989). This policy change, as well as input and advocacy from the drug user group Junkiebond, resulted in the first needle exchange program in 1984 and a pragmatic approach where the harm from criminal proceedings should not outweigh the harm from the substance itself.

Around the same time, the Merseyside or UK Model of harm reduction was forming. The impetus for the development of this model was an influx of cheap heroin into Liverpool in the mid-1980s and the recognition of the link between sharing contaminated injection equipment and acquiring

HIV (O'Hare, 2007). This approach favoured reducing harm from drugs, rather than focusing on reducing drug use, through needle exchange, methadone maintenance and outreach (Marlatt, 1996). It led to the creation of a syringe exchange service in Liverpool in 1986 and interest in the Merseyside approach resulted in the first international conference on the Reduction of Drug Related Harm taking place in Liverpool in 1990. This and subsequent conferences led to the creation of the International Harm Reduction Association in 1996 and were instrumental in spreading the concept of harm reduction worldwide (O'Hare, 2007).

While harm reduction emerged in contrast to promoting abstinence, Lenton and Single (1993, 214) explain that use reduction strategies, such as controlled drinking, can be included in the harm reduction model so long as they are implemented in conjunction with other strategies intended to reduce harm for individuals who continue to use substances. Stockwell et al. (2005: 9) argue that use reduction and harm reduction are not opposing alternatives but rather, that "strategies designed to reduce the harm among continuing drug users should be seen as complimentary to strategies to persuade drug users to use at a lower risk level or abstain altogether." In this thesis, a reduction in weekly clients is considered use reduction.

I adopt this approach in order to apply the principles of harm reduction and use reduction to intimate partnerships of Kibera FSWs but it is important to note that many women in resource-poor areas have few viable economic alternatives to sex work. Income generated from sex work often supports women and their families when there is a lack of alternative or better paying employment opportunities. As well, sex work is an informal occupation with flexible hours that may allow women to balance their work life with their home life and responsibilities, including caring for any children in their household. As a result, abstinence strategies for FSWs may not be possible or even preferable among FSWs in resource-poor areas. Alternatively, FSWs in resource-poor settings face risks they may be unable to avoid through harm reduction due to an imbalance of power relations between FSWs and their

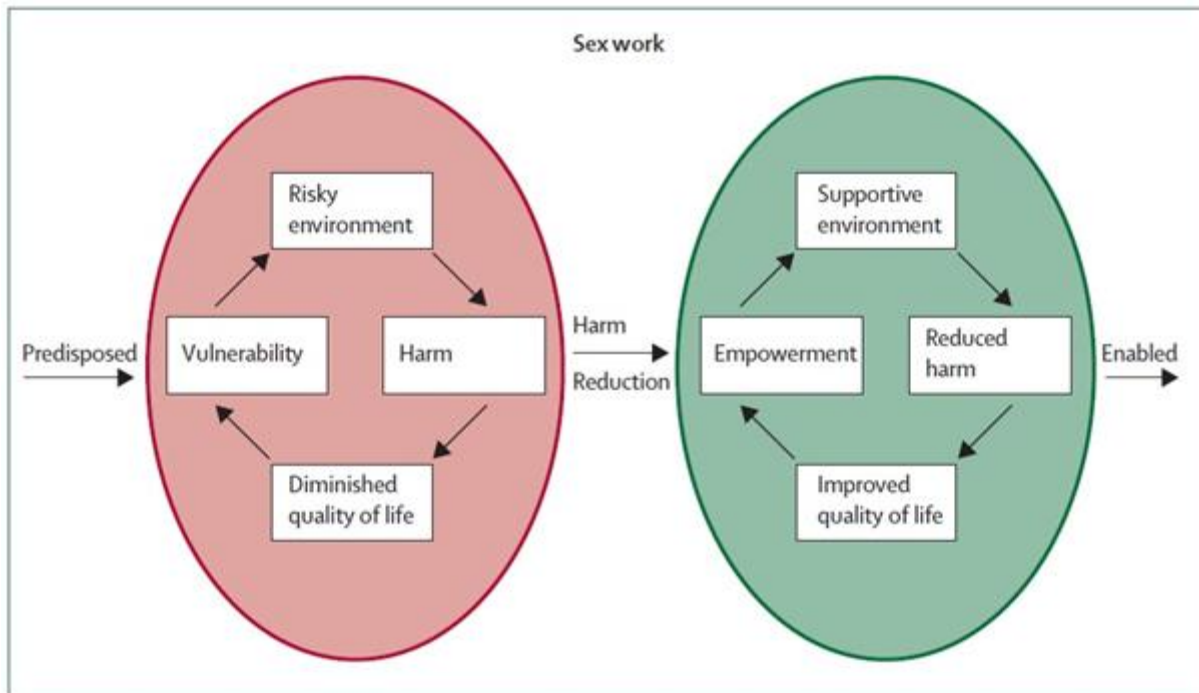
clients (Okal et al., 2011). These risks include physical and sexual violence, STI risk and substance use (Elmore-Meegan et al., 2004; Chersich et al., 2007; Odek et al., 2009; Okal et al., 2011). A reduction in weekly partners, because of partner support, has the potential to be protective by diminishing exposure to these occupational risks. Therefore, while the overarching theory guiding my thesis will be the concept of sex work harm reduction, I will also examine use reduction to reflect the realities of risk for Kibera FSWs.

While harm reduction principles are applied most often to drug use, harm reduction for sex work is not new. Harm reduction organizations and sex worker organizations have advocated for and applied harm reduction principles for some time (see Wotton, 2007; Scarlet Alliance, 1999; Rickard & Growney, 2001). However, Cusick (2007) contends that harm reduction programmes often neglect sex workers who are not drug users, and the issues specific to sex work are not addressed. She also argues that while some harms associated with sex work are introduced through the exchange of sex for money, such as increased risk of STIs including HIV, other harms, such as violence and stigma, are the result of the conditions in which sex workers operate. Cusick (2007) found that poor conditions and vulnerability most often were found in open unregulated sex markets, where women may lack power in interactions with clients.

Rekart (2005) argues that harm reduction principles can be applied to sex work, and that sex work harm reduction should be viewed as a new paradigm that can help improve FSWs lives. He identifies several harms associated with sex work, such as disease, debt, violence and discrimination, and suggests several strategies for sex work harm reduction. These include education, empowerment, prevention, care, occupational health and safety, decriminalization of sex work, rights-based approaches (Rekart, 2005: 2125). Figure 2-1 demonstrates Rekart's (2005) conceptualization of sex work harm reduction. In this framework, sex workers are exposed to a risky environment, harms, vulnerability and a diminished quality of life. Harm reduction approaches would ideally allow sex workers to move from a

cycle of harm to a more supportive environment, with reduced harm, empowerment and improved quality of life.

Figure 1. A framework for how sex work harm reduction (Rekart, 2005, p. 2130).



Although Rekart (2005) does not specifically address intimate relationships in his conceptualization of harm reduction, my thesis adopts the sex work harm reduction model to examine two ways in which such relationships may play a role: 1) reducing harm and 2) offering a more supportive environment, which could then lead to an improved quality of life.

In addition to this individualistic model, this thesis examines the potential for intimate partnerships to act as a source of use reduction for Kibera FSWs. Intimate partners may play a role in use reduction by providing financial support, which potentially allows FSWs to take on fewer partners. This financial support may be critical as previous research by Ngugi et al, (2012b), shown in Table 2-1, suggested that FSWs often have less contact and support from their family, compared to other Kibera women who never engaged in sex work.

Table 1. Measure of family contact: Kibera FSWs and other Kibera working women (Ngugi et al., 2012b, p. 400).

Questions	Female sex workers n = 161	Kibera working women in other occupations n=159
How many family members, including aunts uncles and siblings, did you see on a weekly basis when you were 15 years of age?	M = 8.85 SD = 8.21	M = 10.15 SD = 6.14
How many family member, including aunts uncles and siblings, do you see on a weekly basis now?	M = 2.66 SD = 3.06	M = 3.86 SD = 4.77
How many male guardians (father, step-father or other) have you ever live with?	M = 0.86 SD = 0.69	M = 1.11 SD = 0.54
How many female guardians (mother** have you ever lived with?	M = 1.36 SD = 0.62	M = 1.40 SD = 0.63
Age at last contact with male guardian with whom you lived the longest?	M = 14.60 SD = 5.76	M = 17.01 SD = 5.01
Age at last contact with female guardian with whom you lived the longest?	M = 16.78 SD = 4.37	M = 18.06 SD = 4.31

Notes: M = mean, SD = standard deviation

By seeing fewer partners Kibera FSWs have less risk of client-related sexual and physical violence and risky alcohol use. A decrease in clients could also decrease the risk of Kibera FSWs contracting other STIs and HIV reinfection. Seropositivity compromises individuals' immunity, leaving them more susceptible to other STI infections (McCoy et al., 2009; Cohen 2009). Compromised immunity makes co-occurring STIs harder to treat and, as a result, symptoms can linger (Kalichman, 2011). As well, viral STIs may play a role, beyond immune suppression, in increasing the pathogenesis and accelerating the progression of HIV (White, 2006). Decreased STI infection would also help prevent transmission of HIV and other STIs to FSWs' intimate partners and clients, especially as co-occurring

STIs increase viral shedding and thus the risk of transmitting HIV (Fleming & Wasserheit, 1999).

HIV reinfection, also called a superinfection, occurs when an HIV positive individual is infected with a different strain of HIV. Reinfected individuals may acquire new resistance to antiretroviral drugs (ARV), with negative consequences for disease progression and vulnerability to STIs.

Intimate partnerships could also reduce harm for HIV positive FSWs in Kibera. For example, the intimate partners may help facilitate ARV adherence. ARV adherence improves immune functions, fighting off opportunistic infections and delaying the progression to AIDS (Autran et al., 1999 Hogg et al., 1999). Partners could play a role in reducing virus-related harms by helping women get to the clinic or encouraging them to take their medications on time and according to instructions. Adhering to ARV would also help reduce harm to intimate partners and clients, as this reduces viral load and therefore decreases the chances of transmission (Fang et al., 2004; Montaner et al., 2010).

Intimate partners may also foster a supportive environment for HIV-positive FSWs in Kibera by providing emotional, health and childcare support. Emotional support is likely to be especially important for HIV positive sex workers in Kenya, as involvement in sex work and being HIV-positive have been associated with double stigmatization (Nyblade et al., 2011). As well, Chege et al. (2002) found Kibera FSWs often locked their children inside their homes when they went out to perform sex work, so childcare could be another particularly vital contribution.

If intimate relationships act to reduce both harm and use and offer support then the next, logical question is whether including intimate partners in interventions would be feasible? In the following section, this thesis addresses this question with specific respect to Kibera sex workers.

2.5 Chapter Summary

Kenyan women are economically disadvantaged due to a lack of economic opportunities and weak property rights. The majority work in the informal sector where employment more unstable and may leave women more vulnerable to entering sex work; however, informal employment is more

flexible, allowing women to balance work life with home life and responsibilities. Not all economically disadvantaged women enter sex work and research has suggested that the death of one or both parents or lack of a male guardian plays a role. Kenya's traditional fostering practices, where children would be fostered with their paternal family, have weakened because of migrant labour and HIV/AIDS. The result is that fewer culturally acceptable family members, such as uncles, are able to foster children, and greater number of grandparent, women and child-headed households are forming.

In Kenya, sex work is stigmatized and associated with immoral activities. Punitive laws add layers of stigma and separate sex work from other legitimatise forms of work. FSWs have been the focus of much HIV/AIDS literature as a core group, potentially resulting in sex workers being seen as the cause of the disease, rather than as a vulnerable population. Kenyan FSWs are especially vulnerable to HIV/AIDS and this is reflected in their high prevalence rate that has been found in some studies to be more than double the Kenyan national rate. FSWs also experience high levels of physical and sexual violence from their clients but are reluctant to report it to the police because they fear police harassment.

There is limited literature on the intimate relationships of FSWs, both in Africa and worldwide. However, data from intimate relationships of women not in sex work suggest that there is an association between physical violence and vulnerability to HIV infection within relationships. Research also shows that condoms are used less frequently in intimate relationships. In the worldwide literature, there are a small number of studies that examine FSWs' intimate relationship and these studies have found that relationships are diverse, with positive and negative aspects. Some research suggests that intimate relationships are protective against HIV/AIDS, with one study finding that intimate relationships resulted in more condom use and fewer clients.

Applying the theoretical framework of sex work harm reduction, this research further explores the potential for intimate relationships to play a protective role for FSWs. Sex work harm reduction identifies several harms associated with sex work, such as disease and discrimination, and suggests

several strategies for harm reduction, such as empowerment and health care. This thesis uses sex work harm reduction to examine how partners may reduce harm from the virus through adherence to ARV and provide a supportive environment for FSWs. This thesis also draws on use reduction, in this case a reduction in the number of weekly clients as a result of intimate partners' material support.

The next chapter describes the field site, Kibera, as well as the sampling, data analysis and theoretical methodology of sex work harm reduction that is used in this thesis.

Chapter 3: Methodology & Methods

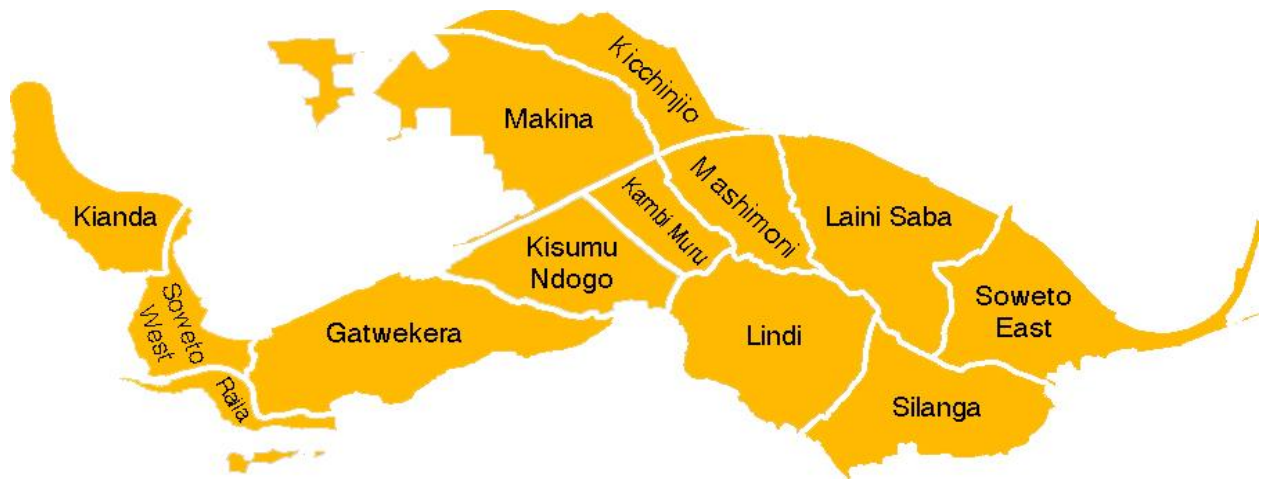
In this chapter, I provide a description of the research site, materials and methods. The methods our research employed included in-depth interviews and an open-ended interview instrument. I begin this chapter by providing information about Kibera, the research site, followed by a description of the materials used in the field and concluding with a detailed description of the methods. This thesis relies on mixed methods research integrated during planning, data collection and analysis (Tashakorri & Teddli, 2003).

3.1 Kibera: Research Site

In Kenya, 71% of the urban population resides in informal settlements (Davis, 2006). Informal settlements are characterized by inadequate access to water, sanitation, quality housing and suffer from overcrowding (UN-Habitat, 2003). These settlements also feature a lack of secure residential status, with housing constructed on land in which the residents have no legal claim. In Nairobi, over 60% of the city's population lives in 'slums' or informal settlements, which account for only 5% of land usage in the city (UN-Habitat 2011). The largest informal settlement in Nairobi is Kibera, located only five kilometers southwest of the city centre. It is one of the most widely known and researched informal settlements in Nairobi and regularly attracts national and international media attention because of its living conditions and size. Kibera is divided into 10 villages, which are often made up of specific ethnic identities and, as such, has been referred to as "Kenya in a microcosm" because all members of Kenya's ethnic groups are represented (De Smedt 2009).

Estimates on the population of Kibera vary. For instance, UN-Habitat (2011) reported that Kibera has between 500,000 to 700,000 people, while the Kibera Map Project conducted a census in 2008 and concluded that Kibera contained between 235,000 and 270,000 people. Even at the lowest population estimate, the population of Kibera is still contained within only 220 hectares of land, resulting in extremely crowded conditions.

Figure 2. Map of Kibera "Villages"



Kibera originated when Nubian soldiers returning from World War I were given land to settle on by the British colonial government as a reward for their military service (Bendiksen 2007). Since then other tribes and ethnicities have moved into Kibera and have mostly rented their land from Nubian and Kikuyu landlords (de Smedt, 2009). This housing situation is tenuous, as ethnic clashes, exacerbated by rental prices, between the members of the Luo ethnic group, who reside in Kibera primarily as renters, and their Nubis and Kikuyu landlords have erupted on several occasions. These violent clashes often result in the loss of property, either through fire or through intentional property damage (de Smedt, 2009).

Formal deeds for the land were never granted and Kibera has been largely excluded from urban planning and infrastructure initiatives. Consequently, Kibera is not recognized or serviced by public services, including health, education, electricity and garbage collection. As a result, Kibera, like other informal settlements, lacks potable water, proper sanitation, safe housing structures, and garbage collection services (UN-Habitat, 2003). It also has high levels of crowding and poverty. Many residents use communal pit latrines and the ground is littered with refuse. Dwellings are often a single room, made of tin or mud, and can house entire families (Dodoo et al., 2007). Clean water is scarce and expensive and Kibera residents lack public sewage disposal, often using communal pit latrines.

Poor health is an issue in Kibera, due to these unfavourable conditions and a lack of proper health services. In these settlements, malnutrition rates remain high and residents carry a heavy disease load (Bocquier et al., 2011; David et al. 2010). Tuberculosis and HIV/AIDS are the leading causes of death for Kibera residents over the age of five (Kyobutungi, 2008). The HIV/AIDS prevalence for adults aged 15-49 in Kibera is 12% compared to the national average of 6.3% (Unge et al., 2009; KNBS & ICF Macro, 2010). Kyobutungi et al. (2008) suggest that residents of Nairobi's informal settlements are more severely affected by HIV/AIDS than any other population in sub-Saharan Africa, with HIV/AIDS and tuberculosis accounting for 50% of the mortality burden. For populations labeled most-at-risk, the prevalence is even more disproportionate. For example, in Phase 1 of this project, researchers found the HIV/AIDS prevalence for Kibera FSWs was 27.2% (Ngugi et al., 2012a).

Kibera has also been the site of several violent clashes. Many of these clashes involved disputes over rental prices and have resulted in deaths and property destruction (de Smedt, 2009). The most recent outbreak of violence was during the 2008 Presidential election, when incumbent President Mwai Kibaki was declared the winner over Opposition leader Raila Odinga in an election tainted with irregularities. The post-election violence resulted in 1,500 deaths and over 350,000 displaced persons within Kenya (Human Rights Watch, 2008). One of the largest concentrations of violence occurred in Kibera which is located within Odinga's electoral riding. Clashes between Luos and Kikuyus broke out, resulting in a number of beatings, murders and acts of rape. However, the main form of violence during this time was looting (de Smedt, 2009). Acts of vandalism also occurred during this time. For instance, several hundred men who supported Odinga destroyed the railway tracks running through Kibera that connect Uganda to the port of Mombasa in response to rumours that Uganda's President Museveni had helped rig the election (Osborn, 2008).

However, Kibera's positive aspects can be overlooked. It is frequently the first stop of people migrating to the cities and is a source of cheap rent relative to the rest of Nairobi. Kibera is also the site

of many small businesses run by local residents. These businesses offer informal employment to people who are largely excluded from formal avenues of employment in Kenya. Kibera also has many community-based organizations that work toward creating a more positive living space. For instance, Pamoja (meaning "together in Kiswahili") FM is a local community radio station that broadcasts to Kibera's youth. Formed during the 2007/2008 election violence, the radio station aims to empower youth and form community bonds. Kibera also has several organizations who work to improve living standards. One such organization, Maji na Ufanisi, focuses on water and sanitation issues to help rally the community to address wider socio-economic issues related to poverty and encourage community mobilization.

3.2 Methods:

3.2.1 Participant Recruitment

Women in this study were recruited through the FSW peer-leader system facilitated by the Centre for HIV Prevention and Research. Participants were deemed eligible if they self-identified as current sex workers in Kibera, were HIV positive, and between the ages of 18 and 45 years of age. In order to ensure that the sample included a range of women in that age group, we stratified the sample by age, with ten women in each of the three age categories: 1) 18-24; 2) 25-34; 3) 35-45. Peer leaders from each of Kibera's ten culturally distinct villages recruited women in order to get varied responses from different cultural backgrounds. Women were not required to have a current intimate partner to participate in our study but were informed of the purpose of our study before they agreed to take part. Out of the 30 women recruited, only three had not ever had an intimate partner while they were in sex work.

Recruitment was organized by the staff at the Centre for HIV Prevention and Research at the University of Nairobi. The director of this centre, Dr. Elizabeth Ngugi, a researcher based at the University of Nairobi and the co-investigator of the project was the recipient of the 2004 United Nations

Kenya Person of the Year. Dr. Ngugi also directs two NGOs in Kenya called Kenya Voluntary Women's Rehabilitation Centre and the Society for Women and AIDS in Kenya and has worked with FSWs in Kenya for over twenty years. Anne Gikuni, also based at the Centre for HIV Prevention and Research, was instrumental in organizing participant recruitment in the field. She has over twenty-five years of experience working with FSWs in Kenya and participating in community oriented research and education.

There were some limitations to the recruitment process. Firstly, participants were not randomly selected but were purposively selected by peer leaders in Kibera's different districts and therefore the sample is not random. Secondly, some participants had previously been interviewed, sometimes more than once, for KeFA and other projects led by Dr. Ngugi.

3.2.2 Data Collection - Interview Instrument

Interviews were conducted using a concurrent mixed-methods approach and included open and closed-ended questions in the same research instrument (see Appendix A) (Tashakorri & Teddli, 2003). The research instrument was developed so that the quantitative and qualitative questions would complement each other. For instance, the number of quantitative questions, such as number of children and weekly income, provided context into the participants' financial situation, while qualitative questions, such as those asking about familial support, may demonstrate the importance of partners' financial support.

Canadian researchers, including my supervisor Dr. Eric Roth, and thesis committee member Dr. Cecilia Benoit, research assistants and Kenyan research assistants worked together in a group setting at the University of Nairobi to develop a culturally sensitive, relevant instrument. Each night the Canadian researchers and research assistants took the interview instrument back to their hotel to finalize the edits made throughout the day by the group. The instrument was then presented to the entire group the next day to test the cultural applicability and to check for errors. Important terms, such as intimate or intimate

partner, were discussed at great length so that Kenyan research assistants, who also acted as translators in the field, would have a common understanding of key terms. The group then split into teams of two or three and performed mock interviews over the course of 3 days. Refining the instrument together and performing mock interviews made the group more familiar with the material and helped to identify discrepancies or culturally inappropriate material. For instance, our Kenyan colleagues were quick to point out that several of our questions did not make sense to them and they made alternative suggestions. It also allowed the interviewers to get a better understanding of the overall goals of the research project before going out into the field.

After the English version of the questionnaire was finalized, Kenyan research assistants also translated the questionnaire into Kiswahili, so that both English and Kiswahili copies were available for the interview. This allowed the interviewers to conduct Kiswahili interviews with more focus, as they would not have to translate the questionnaire during their interviews. The questionnaire was approved by the University of Nairobi, University of Washington and University of Victoria institutional ethics committees.

3.2.3 Data Collection - Interviews

Using a mixed-method instrument consisting of both closed and open-ended questions, we conducted interviews over the course of 3 days in July 2011. Participants met the research team at the Salvation Army church of Kibera, a site jointly chosen by the Centre for HIV Prevention and Research staff and the peer leaders. The Salvation Army church was one of the first religious organizations in Kibera to open its doors to FSWs and several participants reported that they felt comfortable at the church because it had been welcoming to them over the years.

The interviewers consisted of three teams of two women. Each team had one Kenyan research assistant and one Canadian researcher (Dr. Benoit) or research assistant (either myself or the other RA). Each day the Kenyan research assistants were paired with a different Canadian research assistant or

researcher. This helped reduce the potential for interviewer bias. Before the interview began, the Kenyan research assistant introduced the Canadian team member and got permission for the member to stay. One major concern during data collection was our identities as outsiders interviewing a vulnerable population with a history of colonialism. Kovach (2009, p.112) urges researchers to remember that “critically reflective self-location is a strategy to keep us aware of the power dynamics flowing back and forth between researcher and participant.” We took precautions to ensure that participants did not feel pressured to have the Canadian researchers present during the interview. None of the woman declined our request and many told us they felt that we had a common bond in talking about intimate partnerships because of our status as women. A common phrase when talking about their intimate partners or children was “well, you understand, we’re all women.” I felt that this assisted in forming a rapport and developing a level of comfort among the women with our presence.

Before the interview began, participants had the choice of conducting their interview in English or Kiswahili. The informed consent form was read aloud and we offered each participant a copy to keep. The participants could opt out of the interview at any time. The interview only proceeded when the women acknowledged they understood and accepted the informed consent form. The Kenyan research assistants conducted the interviews, which were recorded, and the Canadian researcher or research assistant wrote their responses on the interview instrument. The Canadian researcher or research assistant took field notes to increase reliability and to act as backup in case our tapes were damaged in transit or our recorders malfunctioned.

For those interviews conducted in Kiswahili, the Kenyan interviewer translated participants’ responses at the time of the interview. A disadvantage to this approach is that responses may have been paraphrased at times, especially when participants gave a long answer and the interviewers were charged with relaying it to the Canadian researcher and assistants. This to some extent affected our ability to collect direct quotes. On the other hand, translating while the interview was in progress meant that the

interviewers were able to discuss and confirm with the participant that they were accurately translating what the participant had said into English. This may have resulted in a more accurate representation of the participants' responses in some cases. This method also allowed the Canadian researcher or research assistant to more actively engage participants who were speaking Kiswahili.

The interviews took from half an hour to an hour and a half to complete. The shortest interviews were women who had never had an intimate partner while they were sex workers. In this case, we gathered demographic information and only asked the final question in the instrument about ideal partnerships. Interviewers made efforts to expand on any responses that seemed unclear during the interview with prompts. At the end of the interview, the Kenyan research assistant asked the Canadian researcher or research assistant if they had any further questions or if anything was unclear.

At the interview, conclusion participants were able to ask questions about the study or interviewers, and an honorarium of 500 Kenyan shillings was provided to demonstrate appreciation of their time and knowledge shared. During the interview, we provided participants with snacks and soda, both for themselves and to take home for their children.

3.3.3 Transcription

The interviews were recorded using tape-based audio equipment. Once we returned to Canada, a fellow Social Dimensions of Health graduate student based at the Centre for Addictions Research BC (CARBC), and I jointly transcribed the tapes into Microsoft Word documents. Quality issues emerged when we discovered the audio equipment produced poor quality recordings for some interviews. The majority of the transcriptions were carried out using tape-based transcription machines, however due to quality issues I had to digitize and enhance several interviews on the computer. Other interviews with sound quality issues were transcribed once and then reviewed a second or third time to try to fix inaudible sections. The text we wrote in the field helped supplement and clarify some responses that

could not be understood. The result was that despite sound quality issues, all interviews used for this thesis had full responses.

3.3.4 Data Analysis

I identified several criteria to assist in addressing my research questions and analyzed specific questions from the interview instrument (Appendix A). The specific criteria and interview questions pertaining to the research questions are as follows:

1) Do the relationships Kibera FSWs form with their intimate partners act as a form of harm and/or use reduction?

- *Do intimate partnerships function as a form of use reduction for FSWs by providing financial support, which potentially allows FSWs to take on fewer partners?* To address this question, we asked participants if they had told their partners they were involved in sex work, how this affected their relationship and if having an intimate partner increased or decreased the number of clients they saw on a weekly basis (Question 1, part IV; Question 2, part IV). To determine if financial support was associated with seeing fewer partners, we also asked the participants if their partners offered financial support (Question 1, part V).

- *Do intimate partners may reduce harm through assisting with adherence to ARV?* We asked women if they had told their partners about their HIV positive status and if their intimate partners helped them take their ARV medication, took them to the clinic for checkups or helped them with their medication in any other ways (Question 3, part IV; Question 5, part IV).

- *Do FSWs' intimate partners play a role in harm reduction by offering a supportive environment?* In section five of the questionnaire, we asked the women if their partners provided emotional and childcare support (Questions 2, 3, 4 &5, part V). To contextualize the importance of this support, we asked participants if they had other people in their lives who provide this kind of support (Question 6, part V). In section four, we asked the women if they had told their partners about their

serostatus and sex work occupation (Question 1 & 3, part IV). To follow up, if a participant answered that they had not informed their partners, they were asked why they decided not to and if they had, how it affected their relationship (Question 1, part IV). These questions will help demonstrate if intimate partners are able to provide a supportive environment in terms of support for their status and their occupation.

2) Is there a potential to include intimate partners in future HIV interventions?

- *Have participants disclosed their HIV status and told their partners about their occupation?* In order for partners to be included in HIV interventions targeting FSWs, intimate partners should be aware that their partners are HIV positive and involved in sex work. We asked participants whether they had informed their partners about their HIV status and their occupation (Question 1 & 3, part IV).

- *How long do Kibera FSWs' intimate relationships last?* As well, to investigate the potential for these relationships to act as potential harm and/or use reduction in the long term, we asked participants to tell us about their future plans with their partners (Question 6, section IV).

For the quantitative data, only interviews where the participant was currently or had ever been in a relationship were included. The qualitative analysis used a smaller subset of 15 interviews for a more in-depth analysis. The fifteen interviews were chosen so that each Kenyan interviewer and Canadian researcher or research assistant combination was represented in the sample in order to minimize potential interview bias arising from particular Canadian-Kenyan pairings. Care was also taken to ensure that different Kenyan interviewers were represented for each of the three interview days.

I analyzed the qualitative and quantitative data for this thesis concurrently. Some of my quantitative results informed the direction of my qualitative analysis, while my qualitative results led me to look at the quantitative data set in different ways. For instance, when I examined the quantitative results for level of emotional support, I found that a high number of participants who responded yes to "Does your partner support you financially?" This encouraged me to examine the qualitative results

where I found that many participants reported that they did receive support but that it was minimal or infrequent. This type of back and forth analysis happened frequently during the initial stages of data analysis.

Quantitative data from all were entered into SPSS (IBM Corporation) 17.0 and descriptive and inferential (Fisher's test) statistics were generated (Field, 2010). Descriptive statistics were used to present demographic data about the women, such as their age, number of children in their household, years in sex work and income, and information regarding their intimate relationships, such as intimate partner gender and relationship length. For inferential statistics, Fisher's exact test (Field, 2010) was performed to examine the relationship between participants telling an intimate partner that they were HIV positive and telling an intimate partner they were a sex worker.

Qualitative data were transcribed into Microsoft Excel and analyzed using thematic analysis. Thematic analysis is a flexible method used for identifying themes in a data set that is "not wed to any pre-existing theoretical framework, and so it can be used within different theoretical frameworks" (Braun & Clarke, 2006, p.9). This independence makes thematic analysis a good fit for a mixed-methods approach because it is not constrained by particular theoretical and epistemological assumptions. Thematic analysis involves actively discovering patterns and meanings of interest and "involves a constant moving back and forward between the entire data set, the coded extracts of data that you are analyzing and the analysis of the data that you are producing" (Braun & Clarke, 2006, p.15).

We constructed the coding manual and we began by reading through all 15 interviews separately without taking notes. This was to get a feeling for the individual women's' stories. Reading the interviews for a second time, we started independently identifying overall themes. We then entered the relevant questions into separate Microsoft Excel sheets and began coding question by question. We began forming a tentative coding manual derived from recurring themes and sub-themes but also took note of unique responses. This coding manual contained sections relevant to each of the selected

interview questions. Some themes emerged from responses to direct questions such as "does having a partner increase or decrease the number of clients you see in an average week?" Other themes emerged more inductively by observing connections between questions, responses and life chances and histories. We used a combined system of colour-coding recurring themes and assigning lettered codes to responses.

We then met and compared our codes and types of responses they applied to and refined our coding system. When only one of us had created a certain code for a theme we explained why we created it and why we believed it applied. My initial coding manual contained 87 themes and sub-themes, while the other graduate student's contained 96 themes and sub-themes. We then jointly decided if we should keep that code or use an alternative code instead. We applied the newly refined codes to the data once again and we met a final time to finalize the coding manual. The final manual contains 52 codes. This process progressed over the course of one month. During this time, we met with my supervisory team, including Dr. Eric Roth and Dr. Cecilia Benoit, to discuss the emerging codes and themes. The supervisory team offered reviewed the codes and offered suggestions on how to organize and interpret them. The coding manual and a subset of six interviews were then sent to another graduate student in the Social Dimensions of Health program. This graduate student applied our codes to a subset of interviews and then met with me to discuss the results. In the majority of cases, we applied the codes in the same areas. Where we did not agree, we discussed our differences and this discussion resulted in changes to two of the codes.

3.3.5 Ethics

The University of Nairobi, University of Washington and University of Victoria institutional ethics committees approved this research. Participants were assured of their confidentiality and to protect their anonymity each participant was assigned a code based on the interviewing Kenyan research assistants' first two initials, the date and the interview number. As well, we reminded participants that

should they feel uncomfortable they could decline answering questions or discontinue the interview at any time without losing their honorarium. Interview data remain in a locked cabinet at the Centre for Addictions Research BC at the University of Victoria.

3.4 Chapter Summary

Kibera is an informal settlement located five kilometers from Nairobi's centre that is characterized by inadequate access to water, sanitation and quality housing. Population estimates for Kibera vary from between 235,000 to 7000,000 people and it has been called Kenya in a microcosm because of the vast representation of Kenya's different ethnic groups. Formal deeds have never been granted for Kibera and as a result it has been largely excluded from urban planning initiatives. Kibera residents are disproportionately affected by diseases such as tuberculosis and HIV/AIDS. However, Kibera is the site of several vibrant community organizations that work toward creating more positive living spaces and improving health outcomes.

Participants were recruited through a peer-leader system led by the Centre for HIV Prevention and Research. Thirty participants were recruited between the ages of 18-45. Participants were not required to have an intimate partner to take part but only three had never had an intimate partner while they were in sex work. Interviews were conducted over three days at the Salvation Army church in Kibera using a mixed-method instrument. The tapes were brought back to the Centre for Research Addictions of BC where they were transcribed.

Data was analyzed concurrently, with qualitative and quantitative analysis often informing each other. Quantitative data were entered into SPSS and descriptive and inferential statistics were generated. Qualitative data was analyzed in MS Excel using thematic analysis. The codebook was discussed Dr. Roth and Dr. Benoit as themes emerged. The final coding manual was developed with a fellow graduate student and a second graduate student applied the codes to a smaller subset of interviews.

In the next chapter I present the results from the quantitative and qualitative analysis.

Chapter 4: Results

In this chapter I present the results of my quantitative and qualitative analyses. The quantitative results consist of descriptive statistics for the 27 women who had intimate partners while they were in sex work, including information about FSWs' highest level of education, average income and number of children in the household as well as information about FSWs' intimate relationships, including current relationship status and partner gender. Qualitative results will further explore the main themes that emerged from the quantitative results including, stigmatization of sex work, normalization of HIV and varying levels of partner support.

4.1 Quantitative Results:

4.1.1 Sample Description

Descriptive statistics for the study participants are presented in Table, 1 along with the corresponding questions from the interview instrument. Results show that the majority of participants had completed some formal schooling. While 40.7% completed primary school and 44.4% completed secondary school, post-secondary education completion was rare at 3.7%. Just over half the participants were never married, while five women were divorced or separated and three were widows. Participants had an average of four children living in their household. One woman had 10 children living in her household, while other participants had between one and six children.

Participants were involved in sex work for an average of 6.25 years ($SD = 5.30$). Participants' involvement in sex work ranged from six months to 25 years; however 81.5% of the sample had been involved in sex work for under 10 years. All participants identified sex work as their primary occupation and averaged 1788.33 shillings per week from sex work ($SD = 2838.76$), with only four women making over 2000 shillings per week and almost 45% earning less than 1000 shillings per week. In total, 16 participants held secondary employment, such as cleaning laundry or working as hair stylists, which

contributed an average of 634.62 (SD = 485.36) shillings per week to their household income. Of these women, seven earned 400 shillings per week or less in their secondary occupation.

Table 2. Descriptive statistics of Kibera female sex workers, mean (M) and standard deviations (SD).

Questions	Female sex workers n = 27	
How long (years) have you been involved in commercial sex work?		M = 6.24 SD = 5.30
In an average week, what is your income in Kenyan shillings?	Sex work:	M = 1957.41 SD = 2947.58
	Other Occupation:	M = 634.62 SD = 485.36
How many children currently live in your household?		M = 3.78 SD = 2.12
What is your current marital status?	Single/Never Married:	16 (59.3%)
	Divorced/Separated:	5 (18.5%)
	Widowed:	3 (22.2%)
What is the highest level of education you ever attained?	None:	3 (11.1%)
	Primary:	11 (40.7%)
	Secondary:	12 (44.4%)
	Post-Secondary:	1 (3.7%)

Interviews also provided information about participants' intimate relationships. Table 2 shows that that 55.6% of the participants were currently in an intimate relationship. The majority of participants were in relationships with men; however, four participants were in relationships with female intimate partners and, in one instance, the female intimate partner was also a sex worker. The average length of intimate relationships was 18.59 months (SD = 19.53). The length of intimate relationships ranged from one month to seven years, though only five women reported relationships that exceeded 24 months while 11 intimate relationships were less than two years.

Table 3. Descriptive statistics for intimate partners of Kibera female sex workers

Questions	Female sex workers n = 27	
Are you currently in an intimate relationship?	Yes:	15 (55.6%)
	No:	12 (44.4%)
What is (or was) the gender of your intimate partner?	Male:	23 (85.2%)
	Female:	4 (14.8%)
How many months have you been or were you in this intimate relationship?	M = 18.59 SD = 19.53	
What is the highest level of schooling that your partner attained?	None:	0 (0.0%)
	Primary:	6 (22.2%)
	Secondary:	15 (55.6%)
	College:	3 (11.1%)
	University:	3 (11.1%)
Does (did) your partner work to earn money?	Yes:	22 (81.5%)
	No:	5 (18.5%)

Notes: M = mean, SD = standard deviation

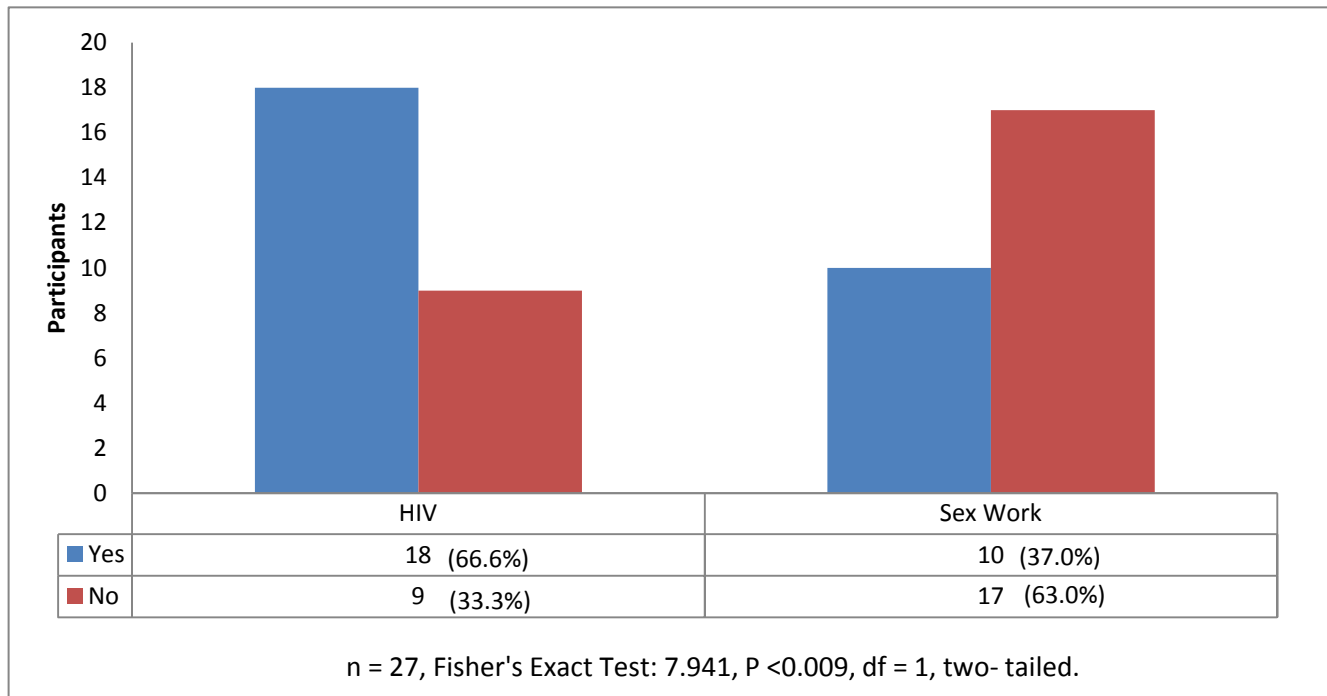
According to participants, all intimate partners completed some form of formal schooling. Intimate partners had higher levels of education, with 55.6% of partners having completed secondary education compared with FSWs at 44.4%. Similarly, it was reported that 22.2% of partners had completed college or university education, while one participant completed post-secondary education. Results showed that 81.5% of intimate partners were employed in the work force, either formally or informally. While there was a wide range of occupations, participants most frequently reported that their partners were mechanics or manual labourers. Six participants reported that their intimate partner was married to another person. Of these intimate partners, five were male and one was female.

4.1.2 HIV and Sex Work Disclosure in Intimate Relationships

One of the most significant findings of the quantitative analysis was that while the majority of women disclosed their HIV status to their intimate partners, 17 did not tell their partners that they were

sex workers. However, three out of four FSWs in intimate relationships with women told their partners they were involved in sex work. Fisher's exact test (Field, 2010) was performed to examine the relationship between participants telling an intimate partner that they were HIV positive and telling an intimate partner they were a sex worker.

Figure 3. HIV status and sex work disclosure



The statistically significant result (7.941, P <0.009, df = 1, two- tailed), presented in Figure 1, indicates that FSWs were more likely to disclose to their intimate partners that they were HIV positive than that they were involved in sex work.

As Table 4 demonstrates, being in an intimate relationship also affected the majority of participants' involvement in sex work. Average weekly client numbers were reduced for 17 women when they were in intimate relationships, while one participant reported that her average weekly client numbers increased during an intimate relationship. For nine participants having an intimate partner did not reduce or increase the number of clients they saw each week. For FSWs in intimate relationships

with women, one participant reported a decrease in weekly clients, while three reported neither an increase nor decrease in weekly clients.

Table 4. Intimate relationships and sex work

Questions	Female sex workers n = 27		
Does having an intimate partner increase or decrease the number of clients you see (saw) in an average week?	Increase:	1 (3.7%)	
	Decrease:	17 (63.0%)	
	No change:	9 (33.3%)	
		<i>Currently in Relationship:</i>	<i>Not Currently in Relationship:</i>
In an average week what is your income in Kenyan shillings from each work activity?	SW:	1656.67 (SD = 2111.01)	2333.33 (SD = 3819.17)
	OE:	505.56 (SD = 462.63)	925.00 (SD = 457.35)

Notes: M = mean, SD = standard deviation, SW = sex work, OE = other employment

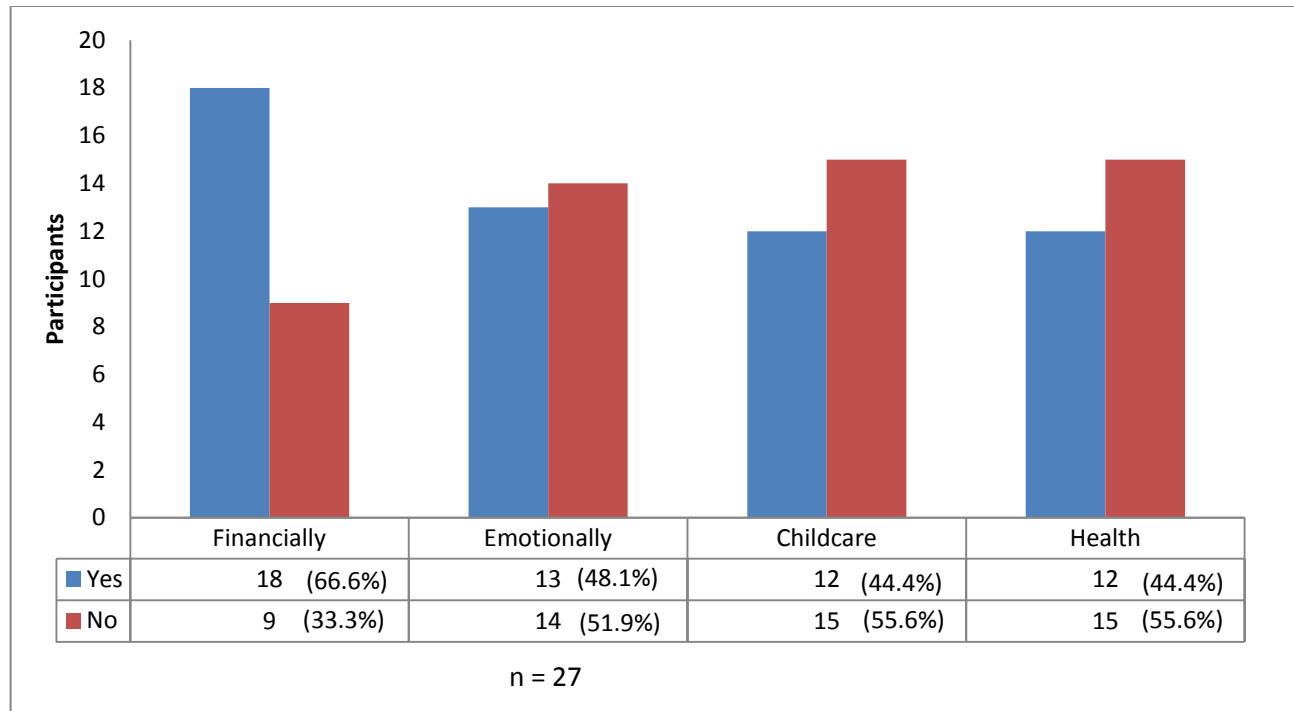
A comparison between the weekly income for FSWs currently in a relationship and FSWs not currently in a relationship demonstrates how a reduction of clients affects FSWs' income levels. Participants currently in a relationship on average earned 1656.67 shillings per week compared to 2333.33 shillings per week for women not currently in an intimate relationship.

4.1.3 Intimate Partner Support

Intimate partners also offered varying levels of support. Financial support was most common, with 66.6% of participants reporting they received some form of financial assistance. Almost half of participants said that their intimate partners supported them emotionally and almost 45% had partners who provided childcare support. Just over 44%, including 75% of FSWs in relationships with women, of

participants reported that their partners provided health-related support, such as assistance when participants' were sick or helping with HIV medications.

Figure 4. Support in FSWs' intimate relationships



4.2 Qualitative Results:

The following qualitative results expand upon the quantitative data presented above. I explore the reasons why participants chose or did not chose to disclose their HIV status and their involvement in sex work to their intimate partners and the effect this had on their relationships. I next examine the kinds of support participants received in their intimate relationships, including financial, emotional childcare and health-related support. I also investigate the kinds of support participants received from their friends and family in order to contextualize the importance of intimate partner support. Finally, I present data on the future plans FSWs made with their intimate partners. Responses to these questions address whether intimate relationships act as a form of harm and/or use reduction for Kibera FSWs and delineate the kinds and levels of support FSWs receive from their partners. Overall, responses will also help determine the feasibility of including intimate partners in interventions for HIV positive FSWs in

Kibera. All participants are identified by a pseudonym, their age and the number of children in their household.

4.2.1 HIV/AIDS Normalized:

In Kibera FSWs' intimate relationships, HIV/AIDS was more accepted and normalized than involvement in sex work. Normalization is when a phenomenon loses its extraordinary status and becomes familiar or customary (Rosenbrock et al., 2000). In this research, the majority of women interviewed reporting that their intimate partners knew about their HIV status. In many instances, participants had intimate partners who were also HIV positive and two women had partners who knew about their HIV status before their relationship began. For instance, Violet, age 35 with 1 child, met her partner at a clinic:

Kenyan Interviewer: Did it affect your relationship with him?

Violet: No, because he's also HIV positive.

Kenyan Interviewer: So to him, he didn't feel like affected or...

Violet: Yeah, actually met him there, at the hospital, yeah...

Kenyan Interviewer: When you were going for a check-up or...

Violet: Yeah.

Janiel's intimate partner also knew her status before their relationship began. She and her partner were able to provide mutual support for their HIV positive statuses:

She says it didn't affect the relationship since the guy is also HIV positive. So then they support each other even when they are going for trainings support HIV. The other reason why it didn't affect their relationship is the guy knew her status even before (age 39 with 5 children, translation).

Three participants told their partners about their HIV positive status only to have their partners reveal that they were also HIV positive. Susan, age 35 with 2 children, discussed how revealing her HIV status encouraged her partner to disclose his status: "Okay fine, to me it did affect because after a while he himself, he himself would decide to tell me the truth about him. He was also...yeah, he disclosed to me. He was also HIV." In another instance, Maria, age 25 with 5 children, explained that her partner actually revealed his HIV positive status first, prompting Maria to disclose her status. Eva, age 19 with 4

children, and her partner found out they were HIV positive together after taking their young child to a clinic:

He also has the virus but the child that she has with him, but the child is negative. So – they realized that—they realized that she was positive after they went to take the child to the clinic because you can't get treated without getting tested so after getting tested that's when they realized that they were—they were positive (translation).

For four participants, disclosing encouraged their intimate partners to get tested for HIV at local clinics. Sue, age 36 with 1 child, reported that her disclosure prompted her partner to get HIV tested: "She told him, it did not affect the relationship. He also went and got tested and found that he also has the virus but they still use condoms (translation)." When Mary, age 21 with 5 children, disclosed her HIV positive status, her partner was tested and found to be HIV negative: "She says when she told her about her status it didn't affect their relationship. Instead it made her to have the courage to go and have the test (translation)." Angy, age 37 with 2 children, revealed her HIV status because her partner had a family:

She told him that she's HIV positive mostly because he has a wife and children. But he didn't believe it at first, so they went and got tested and after getting tested he still wants to be with her because he still loves her (translation).

However, one participant reported that her intimate relationship ended because of her disclosure. Grace, age 20 with 3 children, and her partner separated shortly after she informed her partner she was HIV positive: "She told him. It affected the relationship in that he (inaudible) only left her cause he was afraid she would infect him (translation)." In addition, there were several participants who did not reveal their HIV statuses to their partners. One participant reported that she did not inform her partner because they always used condoms:

She didn't inform him about her status. She says she didn't see any reason to, any need to because they always used protection, they always used condoms. So she didn't see the risk in or the reason as to why she would tell him (Serah, age 24, 4 children, translation).

Some women worried that their partners would leave them if they disclosed their status: "She doesn't because if she tells him he might leave (Catherine, age 37 with 6 children, translation)." Emily, age 33 with 6 children, believed that she was better off not telling her partner: " Um, she said that if she told him that she has the virus, he would deny her, like flee from her, so she decided it was better not to tell him (translation)."

4.2.2 Sex Work Stigmatized

While some women informed their partners about their involvement in sex work, the majority of women felt that sex work was too stigmatizing to reveal to their partners. Stigma is "...an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one" (Goffman, 1963, pg. 3). Stigma against sex work can appear in intimate relationships when intimate partners' views reflect and reinforce the community perception that sex work is associated with immoral activities (Nyblade et al., 2011; Jackson et al., 2009).

Three participants described how they felt their partners could not accept their involvement in sex work. For instance, Violet, age 35 with 1 child, explained: "I decided not to tell him because —okay, you can't tell a man that you've been out with someone like that. So I just do it as secret." Karen, age 20 with 2 children, discussed how she felt her partner could not accept her as a sex worker: "Because if I told him, he could not accept me the way I am. You know men; they can't allow a woman who goes just with every man like that. They don't take in any woman like that." One woman, Eva, 19 with 4 children, did not tell her intimate partner because he believed that they were a monogamous couple: "She hasn't told him because she wouldn't want him to know she has other men as well cause according to him it's just him and her, nobody else. So she hasn't told him because of that (translation)."

Concern that their partner would end their relationship and that this would result in a loss of financial support was reported by three women. Janiel, age 39 with 5 children stated that she kept her

involvement in sex work a secret because her partner provided her with support that would be difficult to replace if he left her:

She says she didn't tell him because she's afraid. If she tells, the guy will pack off and maybe she would have any source of income, even after she has told him. She says the support she's getting from the guy, she thought once she tells him it would be hard for her to afford all the support he's offering (translation).

Similarly Catherine, a 36 year old mother caring for 6 children, reported that she did not tell her partner because he would assist her when she was under financial constraints: "She says no because if she lets him know then he'll leave and withdraw support because at times he supports her maybe financially. Like if she doesn't have money he comes and steps in (translation)."

Participants also described how they feared the reaction they would get from their partners if they told them about their involvement in sex work. Angy, age 37 with 2 children, explained that she feared her partner's judgement: "She's afraid if she tells him he might get disgusted. So she's never told him, she's afraid he might get disgusted (translation)." Another woman stated that her intimate partner's drinking made her hesitant to reveal her occupation:

She was afraid to tell him because when she found him he was drunk. So she— eventually she never told him because most of the time he would come home drunk and he would make noise at her. So she decided it was better off never telling him. So she would go out there and just do her work and not tell him (Anne, age 32 with 4 children, translation).

Two participants kept their involvement in sex work hidden from their partners because they did not believe the relationship was permanent. Karen, age 20 with 2 children explained: "I knew we were not going anywhere so why was I going to tell him anything?" Sharleen, age 31 with 3 children, explained that she kept her involvement in sex work hidden because her partner made it clear she was not his primary partner: "When he comes, or when we meet he just gives me some, like 2000, then he tells me, you know you're not my real wife and I'm just assisting you."

In total, six women told their intimate partners that they were sex workers. For two women, this revelation did not negatively affect their relationship. Sue, age 36 with 1 child recounted how disclosing her occupation did not affect the relationship because they were not married: "She told him she's in the sex work and it did not affect the relationship because he hasn't still taken dowry to her home. He still hasn't taken dowry to her home and they haven't gotten married yet (translation)."

Three out of the four FSWs who were in intimate relationships with women reported that telling their intimate partners about their involvement in sex work did not negatively affect their relationship. Another participant did not tell her female partner not because she was concerned about her partner's judgment; rather she was worried her partner would want to join her in sex work, leaving the participant without childcare. Mary, age 21 with 5 children, explained to her female partner, who later also became a sex worker, that she was involved in sex work because of her difficulties in finding alternative employment:

It didn't affect the relationship since she was able to explain to her the problems why she's doing the sex work business ... She realized it was hard to get a job and doing the sex work it's a bit easy other than when you go out for a job (translation).

One participant reported that her partner knew about her involvement in sex work before their relationship began because she had met him in a local club:

Ok to me to be honest, it didn't because this person wanted to know more about me. He was just like, what made you decide to do this job? I was so open, as I just told you. To me it was so many problems. Then he just listened to me—he just felt so sorry for me. I know because he was asking—he was asking me, it was like "Now what are your plans?" I was just like, my plans—my plans are (inaudible) else. I was just moving. Even if it is a business or to get a job (Susan, age 35, 2 children).

While Susan's partner was supportive and understood the problems that led to her involvement in sex work he was still uncomfortable living in her house because of her clients:

Okay, to me...I can't explain that because to him I think he was not very comfortable. He was so afraid, living in my house. He was just like, maybe I can just—if I stay here, and maybe somebody else can come in there and stay a week, another month (inaudible). Something like that. So, he was not so comfortable (Susan, age 35, 2 children).

Similarly, Grace's partner was also not comfortable with her involvement in sex work and terminated the relationship when she informed him (age 20, 3 children).

4.2.3 Intimate Partnerships and Number of Clients

For the majority of women having an intimate partner resulted in a decrease in the average number of clients seen on a weekly basis. For nine of the participants, their occupation had not been disclosed and therefore experienced difficulties meeting clients when they were spending time their intimate partners. For instance, Eva, age 19 with 4 children, reported:

It decreased. It decreased because like on Saturdays or on Sundays when she spends some time with her boyfriend or with her intimate partner she can't see other clients and a client called her and she can't avail herself he would get angry and go look for someone else that way she has no client (translation).

Anne, age 32 with 4 children, explained that her average number of clients reduced because partner would not allow her to speak to other men:

It reduced the number of clients she could get because she wouldn't talk to any other men when he was around. In as much as she found him in the same place as she goes for sex work, he wouldn't allow her to talk to any other people (translation).

For Serah, age 24 with 4 children, having restrictions on visiting clients was a disadvantage because it resulted in less money: "Yes, decreased because you can't meet other clients when you're with him. And that's a disadvantage because the ones who are out there are many more who'd provide much more than he did (translation)."

However, Susan, age 35 with 2 children, described the situation as positive:

Yeah, it affected because, you know, now when you are with him you can't go out. So you couldn't go meet other clients. So to me, it affected, but in other words I think it was so good. Because even made myself, I got some rested time. I got

some time having—I got some good time with my baby. So to me I think it wasn't so bad.

For six participants, the number of clients they saw on a weekly basis stayed the same. Emily, age 33 with 6 children, explained that her intimate relationship did not affect the number of clients she had because she met with them while her intimate partner was working. Another woman explained: "She says it doesn't affect—doesn't increase or decrease because she's already told him what she does and she's already told him that he can't meet her needs" (Maria, age 25 with 5 children, translation). Similarly, Angy, age 37 with 2 children stated that her client numbers did not decrease because even though she had an intimate partner she still had to work to meet her financial obligations.

Having a female intimate partner did not result in a decrease in weekly clients, except in one case where the partner encouraged the participant to exit sex work. For Mary, age 21 with 5 children, her average number of clients did not decline because her partner also became a sex worker: "She says, it didn't decrease or increase simply because even her later, she joined her to the sex work business (translation)."

4.2.4 Financial Support:

The majority of participants reported some form of financial support from their intimate partners. Catherine, age 35 with 6 children, explained that her partner steps in to support her when she is under financially constraints. Similarly, Janiel, age 39 with 5 children, stated that her partner helped when she had financial problems. Two partners supported financially by paying school fees for the children in the participants' household. Eva, 19 with 4 children, explained: "Yeah, has a sister who's still in school. So, when the children are away from school he tries his best to get the school fees balanced so that they get back to school (translation)." Maria, age 25 with 3 children, also reported that her partner paid the school fees for her children. Three participants reported their partners supported financially by providing food. For instance, Anne, age 32 with 4 children, mentioned that her partner provided financial support in the form of food, rather than money, and Emily, age 33 with 6 children, elaborated that her partner supplied

the family with flour for making *ugali*, a traditional dish made of maize flour and cooked to a dough-like consistency.

However, 11 of the participants described the support from their intimate partners as minimal or "not enough." Violet, age 35 with 1 child, explained that her partner's support was "not to my standard." Sharleen, age 31 with 3 children, explained that while her partner did contribute financially, it was not enough: "No. You know, no. Sometimes he gives it, like that only comes like once a week. He gives me even 1000. That is not—it's not helping—it's not helping me." Serah, age 24 with 4 children, said that the small amount of support her partner offered was rare: "That was yes but rarely. So she says yes but very little. You know like 100 shillings which is very little because it can't support her and her children (translation)." Catherine, age 37 with 6 children, explained that while her partner contributed financially, it was rare and she was the major provider of household expenses.

For five of the participants, being in a relationship with a partner who was married to someone else reduced the financial support they received. Maria, age 25 with 5 children, described how when her partner became angry over her involvement in sex work she told him that he does not provide enough support for her to leave:

Like he resists. But she explains that whatever he provides for her is not enough. Because she says he's a married man, he has his family so like when he gets his salary he has to split it between his family and her and she's more (inaudible) now (translation).

Another woman, Sharleen, age 31 with 3 children, described how her partner reminded her that she was not "his real wife" and that he was only assisting her. She explained that the financial support he provides was not enough to help her.

Being in an intimate relationship often resulted in reduced client numbers and three women explained that their intimate partners did not always compensate for lost income with financial support. Violet, age 35 with 1 child, explained: "Because maybe, yeah there are disadvantages because the intimate partner always wants you close to him. Maybe like now he doesn't support me and wants me to

be there." For Grace, age 20 with 3 children, the financial support her intimate partner provided did not offset the reduction in income that resulted from seeing fewer clients: "Didn't really help much. The only thing he'd do is he'd buy food but nothing else (translation)." In another instance, Janiel, age 39 with 5 children, lamented that she had less of her own money when she was with an intimate partner:

She says about the money she would get from the intimate partner, sometimes the person might not have any money and maybe he doesn't have anything to offer. But once he has the money he'll be there and he'll give her the money that she needs. So that affects because if she was to go out every day with different clients she would have her own money, she doesn't have to go him (translation).

Emily, age 33 with 6 children, replied that in addition to seeing fewer clients, her intimate partner did not contribute financially: "He never used to help her in any other ways. Without her working in the sex trade, she wouldn't get any other help for her (translation)."

4.2.5 Health Support - HIV Medication:

When intimate partners knew the participants' HIV status the majority assisted with HIV medications in some way. Three participants spoke about how their partners reminded them to take the medication on time: "... He helps her especially when she's not feeling very well - he reminds her to take her medication (Angy, age 37 with 2 children, translation)." Mary, age 21 with 5 children, reported that her partner not only helped her take her medication on time but also reminded her of upcoming clinic appointments. Another participant, Violet, age 31 with 1 child, explained that her intimate partner provided financial assistance for her medications: " Maybe he just brings me what I need like he's,—if I go to the hospital, and maybe I'm prescribed a drug, can buy for me. Yeah, he helps me." Intimate partners also assisted with medications in other ways. For instance, Janiel, age 39 with 1 child, reported that her partner sometimes provided fruit to take with her HIV medication.

4.2.6 Health Support - General Health:

Four women reported that their partners encouraged healthy living. Eva, age 19 with 4 children, described how her partner advised her to make positive health choices: "He advises, and this is for that

(pointing out which question), he advises her on how to live positively. And this is by eating good food and avoiding stress. So he gives her advice (translation)." Another participant, Sue, age 36 with 1 child, explained that her partner encouraged her to exercise and eat healthy food. For Violet, age 35 with 1 child, her partner helped reduce her alcohol consumption: "Yeah, he's helped me stop taking alcohol. Ok, I've not stopped but I've reduced."

One intimate partner helped Susan, age 35 with 2 children, with her co-occurring tuberculosis infection:

Yeah, yes, by that time I remember, uh, I was once affected with TB so I was so down and I was very weak. So one day I decided to call him and tell him that and I told him that I'm supposed to go to the clinic to take my, ah—my—TB drugs. Then, he asked me, what do you want me to help? I told him that, in fact I'm so weak that I can't just go alone. And, ah, for me, I can't just tell my son to take me because, to be honest, my son—my son is 14 old—14 years old.

4.2.7 Emotional Support:

A number of women reported that their intimate partners support them emotionally. For three women intimate partners provided emotional support for the participants' HIV status. Maria, age 25 with 5 children, explained that her partner encouraged her when her health was compromised: "She says that he also helps her a lot with whenever she's sick he really encourages her that she's not alone that there are many other sick people and there's more to life than that (translation)." Janiel, age 39 with 5 children, had an intimate partner who helped her work through emotional challenges and issues related to her positive status and who also helped educate her about HIV.

Intimate partners also contributed to supportive environments by providing advice. Mary's partner assisted by giving her childcare advice when Mary was sick and Mary noted that when she had a problem, she could confide in her intimate partner. For Grace, age 20 with 3 children, her partner helped guide her when she had issues: "Yes, she used to help her maybe when she went through hard times she could consult her (translations)." Similarly, Catherine's, age 37 with 6 children, partner provided comfort when she was "stressed" from financial or health problems.

However, not all intimate partners contributed to a supportive environment. Seven participants reported that their intimate partners did not provide any form of emotional support. Even relationships that offered some emotional support could still be a source of stress. For instance, Catherine's stated that her partner was a source a comfort, he was also occasionally a source of stress: "Yeah, stress. Mentally, emotionally, physically stressful, like if he gets violent (translation)." For Susan, age 35 with 2 children, stress was a result of quarrels in her relationship:

Okay, to me, I know this because, when I was just alone I was so happy at least because nobody's quarreling with me, as you know being HIV and AIDS, being positive, you're not supposed to be having stress most of the times. So to me, it was not so good to me having an intimate because at the end of the day he just come and quarrel with me, he's drunk, maybe he wants to fight with you, so it's just like no, let me just be alone.

Additionally, three participants reported that their intimate partners were controlling, resulting in a loss of autonomy. Emily, age 33 with 6 children, responded that "having an intimate partner is bad because he takes charge over your body and he over protects you, he becomes possessive". Maria, age 25 with 5 children, explained that her partner sometimes forces her to do things:

She says at times she is forced to do what she don't wants because like at times probably wants to sleep with her and she just doesn't feel like. So even if she gives in she gives in when, even when in anger (translation).

4.2.8 Childcare Support:

Six women stated that their partners provided some form of childcare support. For instance, Mary, age 21 with 5 children reported that her partner, also a sex worker, cared for her children:

If the partner is not going to go sex business she's left with her kids for just looking after them now that she has the adopted kids who are a bit older . On childcare there is taking care of them, cooking for them. (translation).

Another participant, Sharleen, age 31 with 3 children, discussed how her partner would not provide childcare but would act as a mentor to her children. While he did not provide physical childcare, he provided the children with a form of male guardianship:

So in terms of children he also advises them, like they should come from school and go home straight always to avoid getting into mix up with strangers so (inaudible) give her advice on how to take care of the children (translation).

However, nine women reported that their partners did not provide any form of childcare support.

Emily, age 33 with 6 children, explained that her partner does not play a role in childcare: "No babysitting – she doesn't leave her children with him ... Basically he doesn't buy clothing for them or babysit them for her (translation)." Karen, age 20 with 2 children, elaborated, stating that her partner was not involved in childcare because the children were not his own. One participant, Age, age 32 with 4 children, responded that her partner was abusive towards her children, including an incident where he put washing powder in their drinking water, and that had resulted in the end of the relationship:

Washing powder, like laundry soap, in the drinking water, so the children drank the water and got sick. And so she had to terminate the relationship because (inaudible) in the water. Then most of the time he would come home and insist on having sex, even when the children are there when he was drunk. So she said forget it and terminated the relationship because it affects the children (translation).

4.2.9 Support from Other Family Members:

More than half the women stated that they had nobody else in their lives who provided support.

Susan, age 35 with 2 children, explained that after she revealed her HIV positive status to her family, they broke off contact:

To me, no. It is only me. First to be honest, after my family knew that I was positive, they chased me away because it is something that is so tricky. I myself, I come from a mostly religious, and coming from a mostly religious, they don't believe in HIV and AIDS. They believe in witchcraft. So when you come and tell them that I am HIV, they just look at me like I'm cast out. So to me they took me like a cast out, so nobody cares about me.

Sharleen also replied that her family was not a source of support: "No. Family, they just criticize you.

They tell you, now because you've decided to have work sex working and now you've become sick, you just go away with your kids, we don't want to even (inaudible)."

For Grace, age 20 with 3 children, lacking a social support system meant that her children were often left alone in her home: "The children she leaves them in the house, no one looks after them. She doesn't have any others that will help." Emily, age 33 with 6 children, explained that: "There is no one else to support the weight of her needs. She doesn't even have her parents. No one helps her out; everyone has to carry their own burden. Even the sisters she has never (translation)."

However, four participants did have family that offered financial support. Most often this was one family member on whom they could rely on. For instance, Violet, age 35 with 1 child, stated that her mother would pay her rent. Similarly, Eva, 19 with 4 children, discussed how her Uncle occasionally provided rent for her household:

In other ways, she says there's an uncle of hers who lives in Kayole. At times sends rent for the house. So when the boyfriend didn't have rent money she can use it for shopping. Apart from her uncle and boyfriend, no one else (translation).

Similarly, Serah, age 24 with 4 children, had a brother and cousin who sometimes supported her:

Her brother would offer a kind support – mainly food. She says support group they did—they had but it broke. So not—no one else really, except the cousin she lives with is a bit older, so – the cousin she lives with at least also takes care of the children and does child care when she's not there.

For three women friends were a source of support. Anne, age 32 with 4 children, described how her friend provided emotional support: "There is a woman friend of hers who used to come and counsel her, especially when she was too tired or feeling sick. So she used to come and counsel her about the (inaudible) that she needed (translation)." Sharleen also had a friend who provided support when she was sick:

You know, sometimes I can come—I can become sick then I go to my friends. I tell them—not all the friends but I have specific friend. A lady, I go to tell like that sister. I can go and tell her my problems then she assists me...

4.2.10 Future Plans:

In five interviews participants discussed future plans with their partner including starting a business, living together or getting married. Several participants spoke of their aspirations to leave sex

work. For those participants, discussing plans with their intimate partners gave them an opportunity to think of a different future. Sue, age 35 with 1 child, and her partner talked about starting a business making beads. Similarly, Mary, age 21 with 5 children, explained that she and her partner were attempting to find funding to help them start a business selling children's clothing.

Another participant, Violet, age 35 with 1 child, responded that she and her partner had plans to move in together in the near future. One participant had plans to marry her partner after finding out they were both HIV positive, however his family objected:

Yeah, we had some plans. It was after getting that he was HIV and also I was HIV, we decided that now we are going to get married. But the problem came that when he went to our mothers' and their parents. So after sharing with the parents, the parents—the parents knew that their son was HIV. And now when we went there and it was so open and they, my mum is so open, telling the parent that want to marry—he wants to marry me. The parents decided no. You can't marry this lady. I was just like, why? The mother said that, you can't marry this lady because you don't have any future. Because, like you yourself, as my son, you will die next minute. And this lady will just die next minute. If you get children, they're just going to leave us – you're just going to leave children here. So, we are not ready to take someone who's HIV. So I was just like, no, if your parent doesn't want me to be your wife then I'll just go my way. And that is how we parted.

However, 10 participants reported that they did not believe there was a future with their partners.

Karen, age 20 with 2 children, for instance felt that her partner's drinking interfered with their relationship:

Kenyan Interviewer: And did you have any plans...

Karen: I would go to his place or he would come to my place. We had plans but no you see this man he would just drink and every day, every day, so...just...

Kenyan Interviewer: He drank every day?

Karen: Yeah. So there's no future there. So it is better I do my work and concentrate on my things and leave him alone.

For Anne, age 32 with 4 children, her partner's drinking coupled with the abuse he directed towards her children, resulting in the decision that "she'd be better if she made no plans to be with him (translation)."

Three participants believed that their relationships did not have a future because their intimate partner was using them. Susan, age 35 with 2 children, explained:

Okay, to me what if I just say, I couldn't just take it to be a help. To me, I just take it to be—he was just using me. Because, when it comes in this way, I was just like, no, we are going for an out. Why couldn't he just buy food for in the house? He was just like, no, me I can't buy food for the house. So that is why to me I can't say that he helped me because I can't—he can't buy food in the house and eat with me, eat with my child. So to me, I thought that he was just using me.

Serah, age 24 with 4 children, also replied that she believed her partner was using her: "He was to start up a business for her, sell second-hand clothes but he never seemed serious about that. He always—like he was only interested in sleeping with her so he never supported that way."

The five participants who were in relationships with married intimate partners reported that their relationship did not have a future because their partner was married. Sharleen, age 31 with 3 children, responded:

Sharleen: We don't talk about our future. You know, that man is married. And to me here, I'm not married.
 Kenyan Interviewer: Oh.
 Sharleen: Yeah. And I don't hold my hope to that man.

Conversely, Emily, age 33 with 6 children, explained that she and her partner had not made any plans for the future because he was married. Maria, age 25 with 5 children, elaborated: "Okay so for this she says they don't have any long-term plans because, you know he's married, so she knows even if they having plans it can be short-term. It can end at any time (translation)."

Two women explained that their main priority was caring for the children in their household. When talking about potential future plans to live together, Mary, age 21 with 5 children, replied: "She says they cannot live together. She says staying together is not possible now she has some orphans she's taking care of. She would rather be alone and take care of the kids (translation)." Eva, age 19 with 4 children also discussed how her childcare responsibilities made future plans difficult:

He would like them to live together, maybe in the future. Start a business, but for her she wouldn't want that at the moment because she has to take care of her

sisters. And when she's married to him she can't carry her sisters to (inaudible) so according to her at the moment she'd prefer if he just leaves her quietly then after her sisters have grown up then maybe they can get married and stop having (inaudible) together (translation).

Finally, three women believed that if their partner was not supportive then they were better off alone. Serah, age 24 with 4 children, stated: "Because she says they if they don't do anything to help you, just rather stay alone (translation)." Karen, age 20 with 2 children, also felt that her intimate partner support was important in her relationship replying: "Yeah. If he can't support you're going to— financially, emotionally—it is better if you stay like that."

Chapter 5: Summary, Discussion & Conclusion

In this chapter, I discuss and contextualize the research findings and provide answers to the research questions. Firstly, I present a summary of the results in order to draw out the most important findings and then I situate these findings within the greater body of existing literature. Secondly, I return to the research questions posed at the beginning of my thesis and apply the research results in order to answer them. Finally, I present my conclusion, limitations and future recommendations.

5.1 Summary of Research Findings

One of the most important findings of this research was that compared to sex work, HIV was more normalized in intimate relationships. The majority of participants in the study reported that they had disclosed their HIV status to their intimate partners. In the qualitative data, common themes included partners knowing about participants' HIV positive status prior to the relationship, intimate partners revealing their HIV positive status in turn and participants' disclosure acting as a catalyst for intimate partners to also get tested for HIV. Participants largely reported that disclosing their HIV positive status either did not negatively affect their relationships or had a positive influence on support offered by their intimate partners. However, HIV stigma was still felt by some women, and five participants were hesitant to disclose their HIV status because they feared their partner would terminate the relationship. One woman reported that her partner left her after she disclosed her status.

By contrast, the majority of women did not inform their partners about their involvement in sex work and the qualitative data revealed that participants often felt that they would be stigmatized if they revealed their occupation to their partners. Three participants discussed how their partners would not accept their occupation, while two worried that their partner would react with judgement or anger. Participants were also concerned that their partners would terminate the relationship and they would lose

financial support. Finally, two participants did not disclose their occupation because they believed the relationship was only temporary.

In total, five participants informed their partners that they were sex workers. For three of these women disclosure of their occupation did not result in a negative reaction, such as the termination of the relationship, but the stigma of sex work was still visible. For instance for Sue, informing her partner that she was a sex worker was not an issue because her partner had not proposed marriage and, therefore, a long term commitment. Similarly, while Susan's partner was open and supportive about her involvement initially, he eventually felt uncomfortable about being in Susan's house because of her work. However, for one woman, disclosure resulted in her intimate partner terminating the relationship.

As a result of their intimate relationship, 17 participants reported that they had a reduction in the number of clients they saw weekly, while nine participants did not report a reduction of clients. In the qualitative data, the majority of women explained that they could not meet with clients when their partner was around, either because their partner was unaware of their involvement in sex work and as a result they needed to keep it a secret or because it made their partner uncomfortable. Additionally, three women expressly reported that having fewer clients resulted in reduced weekly incomes. One participant lamented that even though her intimate partner supported her financially, this forced her to rely on him rather than being able to control her own money. Three participants reported that they did not see a decrease in clients because they met clients while their partners were working or away. Finally, two women reported that their client numbers had not gone down because they had informed their partners that they still needed to work to meet their financial obligations.

Turning to intimate partners support, this study demonstrated that they provided varying levels of HIV medication, financial and emotional support and childcare. The majority of intimate partners provided some financial support. The most common financial support identified in the qualitative data was: offering money when participants were financially constrained; paying children's school fees; and

providing food. In contrast, 11 women talked about how the support they received was minimal and often limited. For instance, one participant reported that her intimate partner only provided financial support in the form of flour for food and another clarified that her partner would not offer financial support but would provide support if she went to him for assistance. Three women explained that their partner's financial support was not enough to replace the income they lost through a reduction in clients. Five participants reported that their partners could not provide adequate support because they had a wife and a family and therefore had to split their income.

The majority of women also reported that when their partners knew about their positive status they often helped participants manage their HIV-related health. For instance, partners supported participants in taking their medications on time; reminded them of clinic appointments; acquired medications for them from the clinic; or provided food to take with the medications. In the qualitative data, participants reported that intimate partners also assisted with participants' general health, including encouraging participants to make positive health choices, like eating well, avoiding stress, exercising and reducing alcohol intake, and one woman's partner supported her by buying medications when she had a concurrent tuberculosis infection.

Almost half of the intimate partners also provided participants with emotional support, such as acting as a confidant and giving comfort when participants felt stressed. Three participants in the qualitative data noted that their partners gave them advice and comfort when they were stressed about financial or health issues. For three participants, their intimate partners provided emotional support for their HIV status. This included encouraging participants when they were sick and reaffirming that they were not alone in their fight against HIV/AIDS. However, 14 partners did not provide any emotional support and three participants in the qualitative data described their partners as controlling.

Six women reported that their partners offered any form of childcare. Support was mainly in the form of advice or acting as a mentor to the children, rather than physical childcare. Only one partner in

the qualitative data, also a sex worker, provided physical childcare. Nine women reported that their partner did not provide any form of childcare. One participant, explained that her intimate partner did not provide childcare support because the children were not his own.

More than half of participants did not have other avenues of support available to them, making intimate partner support particularly important. Only four participants reported some form of familial support. When family did provide support it was often only a single family member, such as a mother or cousin, and was primarily financial support. For three women, friends were also a source of emotional support, often in the form of advice and comfort.

For five women, intimate relationships offered participants a chance to think about their future plans outside sex work. These women discussed starting a business, moving in together and getting married with their partner. Ten women believed their relationship did not have a future because: 1) abuse directed towards their children, 2) their partners were married or, 3) their partners' drinking habits. One recurring theme was the idea that intimate partners were only using the participants for sex. Two women, while not criticizing their relationships, spoke of the need to raise the children in their care before they committed to long- term relationships.

5.1.1 Contextualizing the Findings: HIV Normalization and Sex Work Stigmatization

An important theme emerging from the findings is that HIV is normalized in HIV positive Kibera FSWs' intimate relationships. In contrast, involvement in sex work remains highly stigmatized. Normalization is a " ...process in which a phenomenon that was previously considered extraordinary ... loses this status and returns to the world of the familiar and customary in terms of perception and action" (Rosenbrock et al., 2000, pg. 1613). The theory of normalization has traditionally been applied to disability (Thomas & Woods, 2003) and drug research (Erickson & Hathaway, 2010; Brochu et al., 2011). Stigma is theory defined by Goffman (1963, pg. 3) as "...an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one."

There are several reasons why HIV/AIDS may be more normalized in Kibera FSWs' intimate relationships. The first is that all women we interviewed reported currently receiving ARV. The introduction of ARV in sub-Saharan Africa has changed the nature of the disease and its progression (Mall et al., 2012). For instance, Ashforth & Natrass (2005, pg. 292) discuss how HIV/AIDS was once "tantamount to saying a person is already dead" before ARV and that "as long as treatment is successful the patient will seem healthy and the risk of pollution to others from contact with those 'already dead' will diminish along with the 'stigma' related to this." Castro and Farmer (2005, pg. 56) further argue that improvements in clinical services can spark a "virtuous social cycle" in which "access to proper HIV care can transform a disfiguring and consumptive disease into a manageable condition that is invisible to one's consociates." By reducing this vision of HIV/AIDS through the uptake of ARV, the disease is re-conceptualized as manageable. In a study in South Africa, Gilbert et al. (2010) found that treatment alleviated public signs of disease and therefore allowed HIV positive individuals to return to a more normal life. Additionally, participants who realize that HIV is not a death sentence may become advocates for other HIV positive people, further reducing stigma and contributing to normalization (Zuch & Lurie, 2012).

Zuch and Laurie (2012), in a study on HIV disclosure in South Africa, also argue that ARV enables the establishment of new spaces for social support. Indeed, several participants in their research found relationships while attending the clinic and they found that HIV was both the catalyst for the relationship and a source of continued mutual support. Similarly, in a study by Medley et al. (2009) in Uganda several women met their partners at HIV support groups and these partners became a source of emotional and financial support. Our research found this too, with several women reporting that they formed relationships with men they met while receiving treatment. These kinds of relationships could be mutually advantageous as both individual are aware of their partners' status from the beginning and can provide a measure of mutual understand toward HIV-related challenges. This research also found that

two women met their partners at a clinic while receiving treatment. These women reported mutual support and understanding in regards to their HIV positive status.

Secondly, attaining increased support may be a motivating factor in HIV disclosure. Material support was a motivating factor for women disclosing their HIV status to partners in Nairobi (Miller et al., 2007). Shamos et al. (2009) also reported that male partners often provided financial support after their female partners had disclosed their status. For half of these women, their male partners immediately supported them, while other women were offered support after some time had elapsed. In this research, 12 of the 18 participants who disclosed their status reported some form of continued financial support. In some studies participants were also offered emotional support after they disclosed. For instance, two studies reported an increase in kindness and emotional support after disclosure (Medley et al., 2009; King et al., 2008). In this research, the majority of participants who disclosed their HIV status reported that their partners offered support, often in the form of ARV and health assistance. In Tanzania, over 80% of women responded that their partner reacted supportively to their disclosure, while less than 5% reacted negatively (Maman et al., 2003). This research supports these findings as only one participant reported that her partner had reacted negatively.

These normalizing factors in intimate relationships led to high disclosure rates in some studies, including this thesis. A small number of studies examined disclosure between intimate partners in sub-Saharan Africa. In Tanzania, 64% of HIV positive women told their HIV results to their intimate partner within 3 months of the test. In Nairobi, Miller et al. (2007) reported that two-thirds of participants told at least one of their partners that they were HIV positive and for 41% of participants their partners were the first person they informed. These findings suggest that disclosure rates for FSWs' intimate relationships are similar to other intimate relationships in sub-Saharan Africa.

By contrast, some Kibera FSWs' intimate relationships continue to reflect stigma surrounding sex work. Link and Phelan (2001) explain that stigma involves labeling, stereotyping, separating, status

loss and discrimination that occur with the exercise of control. Stigma can be enacted, which involves direct discrimination by others, or it can take the form of felt stigma, where individuals internalize a sense of shame (Scambler & Paoli, 2008). Felt stigma can sometimes result in a disabling fear of being discriminated against.

Sex work may be stigmatized for several reasons. Firstly, sex work is stigmatized because of its link to immoral activities (Nyblade et al., 2011). As a result, many Kenyans believe that FSWs deserve to be punished for their actions (Fida Kenya, 2008). The illegality of sex work in Kenya also contributes to this stigma. In Kenya, the current laws allow police to target and arrest women on the street on the basis of how they dress, being out too late or walking in particular areas (Fida Kenya, 2008). Weitzer (2009) notes that criminalization separates sex work from other forms of legitimate work and further stigmatizes sex workers. This stigmatization often results in the social ostracism of FSWs (Ngugi et al., 1996) who then try to hide their occupation from their partners, family and the community (Raingruber, 2011).

Secondly, sex workers have been stigmatized as carrying the main responsibility for spreading HIV/AIDS in sub-Saharan Africa. Scambler (2007, pg. 1080) argues that narratives focus on sex workers as "vectors of disease" and a "source of transmission into the respectable community of heterosexual families of sexually transmitted infections (STI), including, latterly, HIV/AIDS." The focus on FSWs as a core group puts the main responsibility of HIV prevention only on the women and often ignores the sexual behaviour of men or the power differentials between a FSW and her client (Elmore-Meegan et al., 2004). Elmore-Meegan et al. (2004) further argue that this strategy concentrates on the risk of transmission of FSWs to the general population, while doing little to protect FSWs from physical and sexual abuse and disease. Consequently, the community associates HIV with sex work and sex worker becomes a highly stigmatizing label (Nyblade et al., 2011).

In this study stigma, often internalized by women who felt their partners would be disgusted by their occupation, prevented many participants from informing their partners about their involvement in sex work. As a result, participants were at greater risk of abandonment or violence if their partners were to find out and they experienced stress related to keeping their occupation a secret. This put participants in an even more tenuous position as they are unable to approach their partners for assistance with occupational risks such as physical or sexual violence. A further consequence is that FSWs have fewer clients because they are not able to engage in sex work when they spending time with their intimate partners. This finding supports a study by Thuong et al. (2005), of FSWs working in the border provinces of Vietnam, which found having regular non-paying partners was protective against HIV. They also postulated that this may be due to FSWs having fewer opportunities to meet clients or other partners as a result of being engaged with their intimate partners.

5.1.2 Contextualizing the Findings: Intimate Partner Support

While physical and sexual abuse has been documented within FSWs' intimate relationships, this research helps lend support to several studies which found both positive and negative aspects of partnerships. Previous research by Ngugi et al. (2012a) found evidence that Kibera FSWs with intimate partners had a lower personal income than FSWs not in an intimate relationship and that half of FSWs' made significant financial contributions to household income. They also found that women in intimate partnerships saw fewer clients than FSWs not in intimate relationships. The authors theorized that financial support replaced economic gains from having a higher number of partners and therefore FSWs could take on fewer clients. This research confirmed that Kibera FSWs currently in a relationship had lower personal incomes than FSWs not currently in a relationship. Participants also confirmed that intimate partners often provide financial support, with over half of the participants reporting some financial support. This support ranged from paying school fees for participants' children to buying food. However, this research does not demonstrate that financial contributions participants allowed FSWs to

take on fewer clients. Rather, participants reported that they had fewer partners because they were not able to meet with clients when they were with their partners.

As well, these reduced incomes meant that FSWs had less money of their own to manage, prompting them to rely on their partners' financial support. Several participants reported not telling their partners about their involvement because they feared losing financial support, even though they often described this as minimal or infrequent. This financial reliance both reflects and reinforces the gendered inequality many Kenyan women face in their relationships (Akeroyd, 2004), where they remain largely excluded from formal employment (Wanjale & Were, 2009) and have weaker property rights (Henrysson, 2009), and therefore more constrained life choices, than their male intimate partners. This situation is exacerbated by the increase in female-led households (Oppong & Kalipeni, 2004), in which women are often responsible for not only their own children but fostered children as well.

Despite these drawbacks, intimate partners' financial support was still significant for Kibera FSWs. Though it was not the impetus behind taking on fewer clients, it allowed participants to gain back some of the financial losses they incurred from being unable to meet with clients. This financial support was even more important, as only a small number of participants reported that their kinship networks or friends helped financially support them.

Studies by Jackson et al. (2009), who examined FSWs' intimate relationships in Nova Scotia, Canada and Shannon et al. (2008), in a study with FSWs in Vancouver, British Columbia, reported that FSWs' intimate relationships were varied and complex. Jackson et al. (2009) found that intimate partners sometimes acted as an important source of social and emotional support but could also contribute to stigma and a sense of exclusion. Shannon et al., (2008) found that some partners held power over their FSWs' sex work interactions and controlled their access to resources, while other partners were sources of emotional support and companionship. Similarly, this research found that some partners could be a source of support, especially for the participants' HIV positive status by emotional support by providing

comfort when participants were worried and stressed or by providing advice. Some intimate partners also provided support for participants' health by ensuring participants took their medications according to instructions, attended their clinic appointments, ate well and exercised, reduced stress and alcohol intake. However, some participants reported that their intimate partners did not provide any emotional support and discussed how their partners were controlling or that the relationship itself was stressful because of quarrels or abuse.

While there was variation in the supportive nature of each relationship, with some intimate partners offering more support than others, there was also variation within each relationship. For instance, a number of intimate partners offered financial support but did not support emotionally or provide childcare. Similarly, intimate partners were more supportive towards FSWs' HIV positive status than they were for their involvement in sex work. This evidence lends support to the argument that FSWs' intimate relationships are varied and complex, with both positive and negative aspects, much like relationships in the general population.

Finally, previous research by Ngugi et al. (2012b) demonstrated the importance of having a male guardian for children in Kibera. In their study girls were significantly more at risk of entering sex work if they lacked a male guardian or had weak kinship networks. Although few partners offered physical childcare, partners sometimes mentored participants' children or assisted keeping them in school through financial support. This mentorship and financial assistance may be especially important for children without male guardians or an extended kinship network that act as a safety net.

5.2 Returning to the Research Questions

At the beginning of this study two major research questions were posed. I identified specific criteria to address these research questions and to conclude this study I return to these criteria and attempt to summarize the results which address my research questions:

1) Do the relationships Kibera FSWs form with their intimate partners act as a form of harm and/or use reduction?

- *Do intimate partnerships function as a form of use reduction for FSWs by providing financial support, which potentially allows FSWs to take on fewer partners?* Previous research (Ngugi et al. 2012a) theorized intimate partners could function as a form of use reduction because financial contributions from intimate partners reduced the number of male clients needed to support FSWs and their families. This research found that while the number of clients was reduced, this was because women were unable to meet with clients when their intimate partners were around. It also found that many participants did not disclose their involvement in sex work to their intimate partners because of the stigma surrounding sex work. Therefore, client reduction is unintentional and, in reality, associated with sex work stigmatization that prevents women from disclosing their occupation, rather than genuine use reduction.

- *Do intimate partners reduce harm through assisting with adherence to ARV?* This research found that many partners did provide ARV support for participants. Intimate partners reminded participants of their clinic dates, to take their medications according to instructions and provided healthy food to take with their medications. Some intimate partners also offered emotional support for participants' HIV status, which may have positively contributed to the feeling that they could manage their status and medications. This support may play a protective role, as HIV positive FSWs who adhere to their medications likely have better personal health outcomes and less risk of transmission than FSWs who do not.

- *Do FSWs' intimate partners play a role in harm reduction by offering a supportive environment?* This research found varied levels of support between and within FSWs' intimate relationships. Overall, many intimate partnerships were a source of emotional and health-related support for Kibera FSWs. In particular, some participants reported that their partners provided advice and

comfort when they were stressed and offered emotional support for their HIV status. Some participants explained that their partners helped them accept and learn about their HIV status. Other participants explained that their partners did not provide them with any form of emotional support. Only a few participants reported that their intimate partners supported them in their occupation, with one supportive intimate partner also engaging in sex work. Low levels of support for FSWs' occupation often resulted from either realized or felt stigma, where participants feared telling their partners about their occupation and therefore partners were unaware and unable to give support and from enacted stigma against participants' occupation, such as terminating the relationship. Intimate partner support was found to be particularly significant, as few women reported strong family support systems.

2) Is it feasible to include intimate partners in interventions targeting Kibera FSWs?

- *Have participants disclosed their HIV status and told their partners about their occupation?*

The findings in this study suggest that it would be difficult to include intimate partners in interventions targeting this particular sample of HIV positive Kibera FSWs because the majority of participants had not informed their intimate partners about their occupation and there was still considerable felt and actualized stigma surrounding sex work. However, these data do support previous research showing that intimate partnerships in Kenya can be useful avenues of support for HIV positive FSWs. Many participants reported supportive environments for their HIV status and for adhering to their ARV regimens, attending HIV clinic appointments and eating healthy foods with their medications. This support was sometimes reciprocal, with participants explaining that they offered mutual support and gained knowledge about their status together as a couple. These relationships often provided a safer space against HIV stigma in Kenya that, while diminished in recent years, still affects HIV positive individuals.

- *How long do Kibera FSWs' intimate relationships last?* Similarly, interventions that include intimate partners would be the most beneficial if the relationships were likely to be long term. The

majority of relationships were under 24 months, while only five were reported to be longer. Many participants expressed concern that their relationships did not have a future because their partners were using them for sex; were married; abused their children; and had risky drinking habits. However, several participants talked about plans to start businesses, move in together or get married. Future research with a more robust and diversified sample is needed to concretely answer whether intimate partners can be included in interventions targeting FSWs.

5.3 Conclusion

There is scant research on FSWs' intimate relationships world-wide. The few studies that have examined these relationships in Kenya focused on the low level of condom use (Voeten et al., 2007) and high levels of physical violence (Maman et al., 2002; Dunkle et al., 2004b) in these relationships, as well as the risk of HIV transmission (Fonck et al., 2005). Building on research from a previous field season of the Kenya Free of AIDS project (Ngugi et al., 2012a), this thesis explored whether Kibera FSWs' intimate relationships acted as a form of harm and/or use reduction and if it was feasible to include FSWs' intimate partners in targeted interventions.

This thesis used applied a harm and/or use reduction model to examine these intimate relationships. Analyses found that participants were more likely to tell their partners they were HIV positive than disclose their involvement in sex work. In this study, HIV was found to be more normalized, while intimate relationships reflected sex work stigma. HIV normalization in Kibera FSWs' intimate relationships is the result of several factors. Firstly, the introduction of widespread ARV has changed HIV/AIDS from a disease that used to be a death sentence to a disease that is more manageable (Ashforth & Natrass, 2005; Mall et al., 2012). Secondly, ARV has created new spaces of social support, such as clinics, for HIV positive individuals (Zuch & Lurie, 2012). Thirdly, it has also been reported that male partners often provided financial support after their female partners had disclosed their status in other sub-Saharan intimate relationships (Shamos et al., 2009). Additionally, comparing the findings of

this thesis with previous research suggests that the rates of disclosure in this research are similar to rates of disclosure in other sub-Saharan intimate relationships.

Previous research suggests that sex work was stigmatized largely because of its association with immoral activities (Nyblade et al., 2011; Fida Kenya, 2008). Sex work is criminalized in Kenya, which separates it from other forms of legitimate and legal work, further stigmatizing and applying moral worth to the occupation (Weitzer, 2009). FSWs have also been stigmatized as carrying the main responsibility for spreading HIV/AIDS in sub-Saharan Africa (Scambler, 2007; Elmoore-Meegan et al., 2004) and this has contributed to the general population associating HIV/AIDS with sex work (Nyblade et al., 2011).

Stigma surrounding sex work resulted in fewer participants disclosing their involvement in sex work to their intimate partners, similar to previous research (Raingruber, 2011). By hiding their involvement in sex work, many participants experienced a reduction in weekly clients because they could not meet with clients while their partner was visiting. This resulted in reduced personal incomes, making participants more reliant on the financial support their partners provided, and leaving them with less control over their resources. Even though financial support was often characterized as minimal or infrequent, this support was still important for participants for two reasons: 1) their partners often assisted them financially when they were in acute need, and 2) few participants reported that their kinship networks or friends assisted them.

This research found that it would be difficult to include FSWs' intimate partners in targeted interventions for this particular sample because the majority of participants did not tell their partners about their involvement in sex work. However, intimate partners have the potential to play a positive and protective role by encouraging Kibera FSWs to adhere to ARV, which not only improves FSWs' health status but reduces the risk of transmission to clients, other sex workers and the general public, as

well. Additionally, intimate partners also offered emotional support for FSWs regarding their HIV status by providing comfort, advice and encouragement.

This research further supports previous studies by Jackson et al. (2009) and Shannon et al. (2008) that FSWs' intimate relationships are diverse, with varying kinds of support. This thesis found that there was not only variation between different relationships but within relationships as well. For instance, some intimate partners provided financial, emotional and health support and childcare, while other intimate partners were controlling, abusive and did not provide financial support. Some intimate partners supported financially but did not support participants emotionally, while others offered emotional and health support but only offered financial support infrequently. This thesis argues that FSWs' intimate relationships should be conceptualized as varied and complex, rather than one dimensional and overwhelmingly negative, with the potential to act as positive and/or protective influences.

Finally, applying Rekart's (2005) model of harm reduction was a useful tool for examining FSWs' intimate relationships. In his model, Rekart argues for more education, empowerment, prevention, care, occupational health and safety, decriminalization of sex work and rights-based approaches. These suggestions are vital and relevant but the ability to implement them may be hindered by conditions in developing nations. There exists a need for a model for community leaders and development organizations working with FSWs in resource-poor areas that comprehensively addresses the structural inequalities FSWs in developing nations encounter: such as exclusion from formal economies (Wanjale & Were, 2009); sexual exploitation in the workplace (Akeroyd, 2004; Mweru, 2008); weak property rights (Henrysson, 2009) and structural gendered inequality that is often coded in customs and laws (Akeroyd, 2004). As well, local and national governments looking to target high rates of HIV/AIDS among FSWs would also benefit from a more in-depth understanding of the challenges facing the implementation of harm reduction initiatives for FSWs in resource-poor locales.

5.3.1 Limitations of the Study

This study may be limited by several factors. Firstly, this study did not include intimate partners and therefore only examined intimate relationships from the view of FSWs. Secondly, statistical analyses for factors such as comparing income level or number of clients between those who told their partners they were HIV positive or involved in sex work and those who did not, were limited because of the small (n=30) sample size. Thirdly, participants were recruited through peer leader purposive sampling and therefore the sample was not random. Fourthly, despite previous research finding that FSWs in intimate relationships used condoms more frequently with clients, this study did not include a mechanism to further explore that connection. Finally, although participants repeatedly reported that their partners did not provide enough monetary support, this study did not examine how much support the partners actually contributed.

5.3.2 Areas for Future Research

This research provides insight into patterns of HIV and sex work disclosure in Kibera FSWs' intimate relationships, and the consequences of disclosing or not on intimate partner's financial, health and child care support. Results demonstrate that HIV is largely normalized while sex work remains stigmatized. Future research should further explore HIV disclosure and support among FSWs and their partners as it remains a vastly under researched topic. Exploring HIV disclosure is particularly important as FSWs, their partners and clients are considered central populations in the HIV/AIDS epidemic in Kenya and FSWs experience an inequitable prevalence of HIV/AIDS and other STIs. Future research is also needed into the effect sex work stigmatization has on FSWs' intimate relationships and on FSWs' well-being. This research should undertake to explore ways to reduce sex work stigmatization in intimate relationships and among the general public. Studies should also be undertaken further exploring FSWs' intimate relationships, as this thesis demonstrates that they are varied and complex and that the current concentration on violence and disease does not necessarily accurately represent them. Of particular interest are FSWs' female intimate partners, who in this research

largely understood and supported participants' involvement in sex work. Finally, there is a need for research looking at FSWs' children, who are often at increased risk due to poverty and absence of male guardians, in order to improve their health status and life outcomes.

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Appendix A

A KENYA FREE OF AIDS: HARNESSING INTERDISCIPLINARY SCIENCE FOR HIV PREVENTION:

PROJECT 4, PHASE 3:

INTERVIEW GUIDE

HIV- POSITIVE FEMALE SEX WORKERS

KENYA FREE OF AIDS

Date: _____ Interviewer Name: _____

Time Started: _____ Time Ended: _____

Study Identification Number _____

Did you participate in the previous KEFA survey in 2009? Yes__ No__

PART I. INTRODUCTION. To begin, I would like to learn about you and your family's history.

1. Where were your parents born? (District level)

Mother:

Father:

2. In what part of Kibera do you live? _____

3. How long have you lived in Nairobi? _____

4. When were you born? _____ (year) _____ (month)

5. What is the highest level of education you ever attained?

1. None
2. Primary
3. Post-Primary/Vocational
4. Secondary /A Level
5. College Middle Level
6. University

6. Do you have any other training?

1. Yes (specify, length and completion)

2. No

7. How many biological/adopted children have you ever had?

Total Number: _____ Biological _____ Adopted _____

8. How many children currently live in your household?

Number: _____

9. Are you pregnant?

1. Yes

2. No

10. What are your current work titles? Please list in order of work earnings and tell me if the work is full-time or part-time.

	FULL-TIME	PART-TIME	
1. _____	1		2
2. _____	1		2
3. _____	1		2

11. In an average week, what is your income in shillings from each work activity?

1. _____ per week

2. _____ per week

3. _____ per week

12. What is your current marital status?*

1. Single/never married
2. Divorced/separated
3. Married
4. Widowed

PART II. SEX WORK HISTORY. In this section I would like to ask you a few questions about your involvement in commercial sex work.

1. How long have you been involved in commercial sex work?

Years _____ Months _____

2. Do you have access to free condoms?

1. Yes
2. No

3. How many different clients have you had sex with in the past week?

Number _____

4. How many of these different clients did you use condoms with in the past week?

Number _____

5. How many different clients have you had sex with in the past month?

Number _____

6. How many of these different clients did you use condoms with in the past month?

Number ____

7. Those times that you didn't use condoms please tell me why not.

Notes:

8. Do you tell your clients that you are HIV+?

1. Yes
2. No

9. Please tell me why you do or don't tell your clients that you are HIV+ .

PART III. INTIMATE PARTNERS - My next set of questions has to do with your intimate partner. If you currently have multiple intimate partners, please tell me about the one you feel closest to.

1. Are you now in an intimate relationship?

1. Yes (If yes, go to question 3).
2. No (If no, go to question 2).

2. Have you ever been in an intimate relationship while you were a commercial sex worker?

1. Yes, please answer the next questions about your last intimate relationship while you were a commercial sex worker.

2. No skip to last page, question 8

3. What is (was) the gender of your intimate partner?

1. Male
2. Female
3. Other

4. How many months have you been or were you in this intimate relationship?

Number: _____ (zero indicates less than one month)

5. In an average week, how many days of the week does (did) your partner live in the same household as you? ____Days

6. When did you begin living together? Year_____ Month _____Never _____

7. What is the highest level of schooling that your partner attained?

0. None
1. Primary

2. Post-Primary/Vocational
3. Secondary /A Level
4. College Middle Level
5. University
6. Other. Specify_____

CHECK TAPE RECORDER

8. Does (did) your partner work to earn money?

1. Yes
2. No

9. What is (was) your partner's usual occupation(s)?

10. Please give a short description of your partner's work. What is (was) your partner's day-to-day work activity?

IV. IN THIS SECTION I WOULD LIKE TO ASK YOU ABOUT YOUR SEX WORK, HIV STATUS, AND PLANS WITH YOUR CURRENT/PAST INTIMATE PARTNER.

1. Did you tell your partner that you are involved in sex work?

If yes, please tell me how this affected your relationship.

If no, can you please tell me why you decided not to?

3. Does (did) having an intimate partner increase or decrease the number of clients you see (saw) in an average week?

3. Did you tell your partner that you are HIV-positive?

If yes, can you please tell me how this affected your relationship?

If no, can you please tell me why you decided not to?

4. Are you now taking HIV medication?

1. Yes (Go to question 5)
 2. No (please tell me why you decided not to take it) Skip to question 6.
-
-

5. If yes, does your intimate partner help you:

a. take your medication according to instructions?

1. Yes
2. No

b. Take you to the clinic for checkups?

1. Yes
2. No

c. Help you with your medication in other ways?

1. Yes
2. No

If yes, please explain.

**6. Could you please tell me what are (were) your long-term plans with your intimate partner?
(PROBES: Living together, getting married, starting up a business)**

7. Does (did) your partner plan to have children with you?

1. Yes
2. No

8. Do (did) you plan to have children with your partner?

1. Yes
2. No

9. How often do you drink alcohol?

Never Rarely Sometimes Frequently Always

(if never, go to question 12)

10. In the average month, how many times do you take the following in one sitting:

One drink: _____

Two drinks: _____

Three drinks _____

Four drinks _____

Five or more _____

11. In the average month, how many times do (did) your intimate partner drink alcohol at one sitting:

One drink: _____

Two drinks: _____

Three drinks _____

Four drinks _____

Five or more _____

12. In the average month how many times do (did) you and your intimate partner have fun together?

Never Rarely Sometimes Frequently Always

13. How often does (did) your intimate partner emotionally hurt you? (i.e. put you down in front of others)

Never Rarely Sometimes Frequently Always

14. How often does or did your intimate partner physically hurt you?

Never Rarely Sometimes Frequently Always

15. How often does or did your intimate partner sexually hurt you?

Never Rarely Sometimes Frequently Always

SECTION V: INTIMATE PARTNER SUPPORT**Does (did) your partner support you?****1. Financially**

1. Yes

2. No

2. Emotionally

1. Yes

2. No

3. In terms of your health and safety

1. Yes

2. No

4. Childcare

1. Yes

2. No

5. Any other ways?

6. Who else provides (or provided) these supports?

7. Are there disadvantages, to having an intimate partner?

Please discuss.

In conclusion:

8. What does an ideal intimate relationship look like to you?

1. Thank you very much for your time.

2. Do you have any questions for me?

3. ASK mentor if we've missed anything.