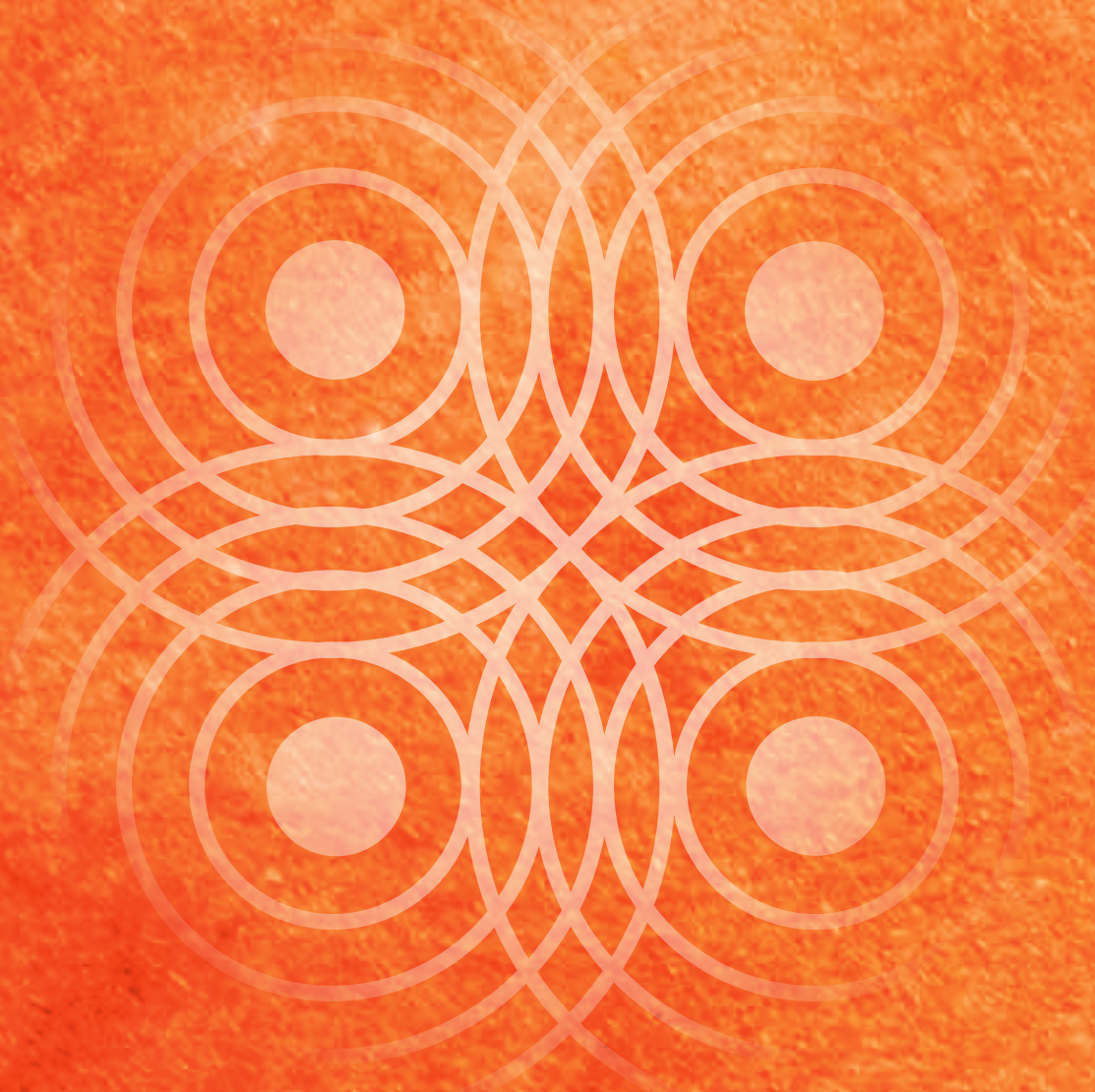


# STRIVE

Tackling the structural drivers of HIV

## Impact of two vulnerability reduction strategies - collectivisation and participation in savings activities - on HIV risk reduction among female sex workers



# **Impact of two vulnerability reduction strategies - collectivisation and participation in savings activities - on HIV risk reduction among female sex workers**

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Impact of two vulnerability reduction strategies - collectivisation and participation in savings activities - on HIV risk reduction among female sex workers

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The views expressed herein are those of the authors and do not reflect the official policy or position of the Bill & Melinda Gates Foundation nor those of the UK Department for International Development.





### **Ethical Approval**

This study was approved by the Institutional Ethical Review Board of the St. John's Medical College and Hospital, Karnataka on 5th September 2009.

### **Contributors**

Priya Pillai, Parinita Bhattacharjee, B.M. Ramesh and Shajy Isac were involved in developing the conceptual framework and study design. B.M. Ramesh and Shajy Isac designed and conducted the IBBA and analysed the results. Priya Pillai designed the study instruments, collected, compiled and analysed qualitative data. Priya Pillai interpreted the findings and wrote the first and final draft of the report. Priya Pillai, Parinita Bhattacharjee, B.M. Ramesh and Shajy Isac all contributed to writing the paper.

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# ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AOR	Adjusted Odds Ratio
CBO	Community Based Organisation
DIC	Drop-In Centre
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
IBBA	Integrated Biological and Behavioural Assessment
KHPT	Karnataka Health Promotion Trust
NGO	Non-governmental Organisation
OR	Odds Ratio
STI	Sexually Transmitted Infection
TI	Targeted Intervention

# EXECUTIVE SUMMARY

The prevalence of HIV/STI is higher among female sex workers (FSWs) than among the general population because of high partner turnover and concurrent sexual partnerships. Mobilisation of the FSW community into groups and training them in savings and income generation activities have emerged as innovative HIV/AIDS prevention strategies. Since 2003, KHPT and its partner NGOs/CBOs have been mobilising FSW community to form CBOs strong and effective enough to challenge power structures and to create an enabling environment for the achievement of outcomes such as improved health, reduced incidence and burden of HIV/AIDS and assertion of rights and dignity by the sex-worker community. Poverty and the need for money are often the main factors pushing women into sex work. A lack of economic power increases the vulnerability of FSWs, reducing their ability to negotiate safe sex or to access care. Efforts to reduce economic vulnerability and improve the sex workers' access to additional sources of income have shown positive impacts such as decreases in client volume and STI, reduced economic dependence on sex work and improved condom use.

## Purpose

The aim of this study was to understand the impact of two vulnerability reduction strategies - collectivisation and participation in savings activities - on HIV risk reduction among female sex workers across three districts in Karnataka - Shimoga, Bellary and Bangalore Urban. The risk reduction behaviours included in the study were consistent condom use and use of clinical services. The study hypothesised that FSWs who benefited from group membership and participation in savings activities would be more likely to adopt safer sex practices. Six sets of factors each were identified as influencing condom usage and clinic access by the FSWs. It was assumed that risk reduction would be higher among members of groups than non-members, due to their positive association with the factors.

## Methods

Multivariate analysis of the data was performed for round 2 of the IBBA data to explore the relationship between membership in a group and safe sex behaviour among FSWs in three districts with three different collectivisation strategies. The primary outcome was defined as collectivisation and condom use in the previous year. Secondary outcomes were HIV/STI prevalence, condom use (with clients and regular partners) and experience of the HIV prevention (contact with a peer educator, and contact with the drop-in centre and the project STI clinic). Odds Ratios (ORs) were used as the measure of association, and the Wald chi-square test was the statistical test used.

Focus group discussions (FGD) were conducted to understand how the set of identified factors influenced condom usage and use of clinical services. Twenty-eight FGDs were conducted with homogenous groups of 6-15 home-based (157) and street-based female sex workers (150). These included both members of groups (159) and non-members (148) in the three districts. Interviews were digitally recorded, transcribed, translated and analysed to examine the influence of group membership and access to micro-savings on use of condoms and clinical services.

## Results

In all the three districts, exposure to programme interventions was much higher among members than non-members. In Shimoga, FSWs who were members were more than 3 times likely to visit a DIC compared to non-members (adjusted OR: 3.14, 95 percent CI: 1.77-5.59,  $p<0.05$ ). Member FSWs in Bellary were more than 4 times likely to visit the NGO sexual health/STI clinic than non-members (adjusted OR: 4.6, 95 percent CI: 1.97-10.64,  $p<0.05$ ). In Bangalore Urban, members were more than 6 times likely to have been contacted by a peer and 2 times likely to have visited a DIC, than non-members (adjusted ORs: 6.43 & 2.53, 95 percent CI: 1.95-21.21 & 1.44-4.47, both  $p<0.05$ ). Also, members were more likely to have received a condom demonstration than non-members (adjusted OR: 3.47, 95 percent CI: 1.92-6.28,  $p<0.05$ ).

Significant association between membership and condom use emerged in Bellary and Bangalore Urban. In Bellary, members were more than 7 times more likely to have used a condom with their last client compared to non-members (adjusted OR: 7.54, 95 percent CI 1.89-30.06,  $p<0.05$ ). In Bangalore Urban, members were 3 times more likely to have used condoms with their last client (adjusted OR: 3, 95 percent CI 1.38-6.57,  $p<0.05$ ) and to have always used a condom with occasional clients (adjusted OR: 1.65, 95 percent CI 0.99-2.75,  $p=0.05$ ) as compared to a non-member. No association was found between membership in a group and condom use for FSWs in Shimoga.

Membership in a group/CBO and access to savings and credit had influenced safe sex practices of the FSWs in Bellary and Bangalore Urban. The pattern of organisation of the FSWs at the field level differed in the three districts. In Shimoga and Bellary, they were organised into affinity support groups while in Bangalore Urban, the drop-in-centre in each zone served as a point of convergence for FSWs in the area. Also, member FSWs in Bellary and Bangalore Urban had access to microfinance facilities through their groups and the credit and savings cooperative, respectively. This was not available for FSWs in Shimoga though they accessed credit from other local microfinance groups.

The comparative success of groups in Bellary and Bangalore Urban as opposed to Shimoga in influencing condom use behaviour among the members shows that community mobilisation activities, which do not address the economic vulnerability of the sex workers may have limited success in ensuring safe sex practices. Access to microfinance had reduced the dependence of member FSWs in Bellary and Bangalore Urban on informal, exploitative sources of credit such as moneylenders and clients. It had enabled the sex workers to better negotiate condom use with their clients and refuse unprotected sex. However, it had been inadequate to help the FSWs to overcome barriers to protected sex with their personal sex partners. The negative symbolism associated with condom use, fear of inadvertent disclosure of sex work and intimacy continued to discourage condom use with non-paying sexual partners.

Further, the Bellary experience made it clear that economic empowerment initiatives, which created alternate supplementary or additional livelihood opportunities, served to increase social interaction and reduce social inequity and stigma. However, the accounts of FSWs from Bangalore Urban and Shimoga amply demonstrate the need for microfinance services for the sex worker community to focus not only on provision of credit, but rather to place equal emphasis on financial discipline, encouraging them to build savings and assets for future needs and to assist in the creation or diversification of livelihood activities. In the absence of such focus, the sex workers would be unable to break free from debt bondage, with the increased credit burden forcing them to engage in risky sexual practices with higher frequency, which could derail the efforts at HIV/AIDS prevention through reduced economic vulnerability.



The relative success of the groups in Bellary in improving use of condoms and clinical services validate the relevance and importance of helping sex workers overcome the fear of stigmatisation and operate in a more enabling environment. FSW groups in Bellary had been able to effect a positive change in the attitudes of the neighbours, fostering a better understanding about the life of sex workers and a more desirable relationship between sex workers and non-sex workers in the community. This created a more enabling environment for the women to access clinics for STI treatment and care. In contrast, sex workers in Bangalore Urban and Shimoga feared negative family and community responses including blame, rejection and loss of accommodation security. In addition, fear for the well-being of their children and the desire to protect them against abuse served to deepen existing stigmatising and discriminatory socio-cultural attitudes towards the sex workers. Better access and utilisation of clinical services among the FSWs in Bellary were influenced by the mutually aiding influences of an improved economic condition and a less stigmatised environment, along with access, availability and a better clinical experience. Bellary experience demonstrates that HIV/AIDS prevention efforts must be channeled to also help the sex workers overcome obstacles to social recognition, participation and inclusion, rather than merely providing access to condoms and clinical services.

Member FSWs also felt better equipped than non-members to negotiate in situations of violence. However, in Bangalore Urban, the clandestine nature of sex work influenced FSWs, who felt too constrained to resist attempts at forced sex. In other words, this increased their susceptibility to violence. The relative success of Bellary groups in dealing with crisis reaffirms the importance of dealing with stigma and throws light on the importance of peer group solidarity in responding more efficiently to crisis. During crisis situations especially with clients, the field level group as an entity formed an immediate, locally available and easily accessible support structure within a short response time. In addition, a group, due to its localised nature, provided a sustained physical presence, which had a symbolic effect on the potentially violent clients, awareness about which inhibited them from harassing the sex worker. Also, as the Shimoga experience demonstrates, until issues of economic disempowerment and stigma remain unaddressed, interventions on violence, access to condoms and clinics, improving knowledge, enhancing self-esteem and positive experiences at the clinic, may not suffice to impact safe sex behaviour.

Finally, the sex worker group, organised to defend the interests and support the collective needs of its members, had also accrued benefits to the non-members and at times to the larger non-sex worker community. Along with the members, non-member sex workers experienced improved availability of condoms and access to quality care at the clinics, better knowledge and awareness about condoms and STI. Interventions by CBO of sex workers to de-stigmatise sex work, change attitudes among government agencies and police, and to reduce violence from clients, police and other players in the sex work circuit have also benefitted non-members.





# BACKGROUND

The state of Karnataka is one of the four southern states in India with an estimated HIV adult prevalence of 0.9 percent in 2008 and contributes to 11 percent of the HIV burden in the country [31]. Unprotected heterosexual sex is the key factor in the spread of the epidemic with overall prevalence among female sex workers in the state being 16.4 percent [47,41,57]. Female sex workers constitute one of the high-risk groups most vulnerable to HIV infection due to multiple sexual partners and sexual practices. They are also considered a core group for HIV transmission due to prevalence of high infection rates and high turnover of sexual partners.

Several reasons determine the entry of women into sex work, such as being forced into sex work through trafficking, death of or alienation by husbands, lack of earning power, debt bondage, absence of alternate employment options and associated lack of earning power or coercion into sex work due to traditions, beliefs and norms<sup>1</sup> [56,4,30,12]. Once in sex work, the complex inter-linkages of socio-cultural and economic factors coupled with hostile policy and institutional arrangements, lead to a low status and life of poverty, with heightened vulnerability to STI and HIV [12]. Poverty and the need for money are the predominant factors that push women into sex work, which is often the only option they have to ensure financial and social security [56, 4, 7, 54]. Located in a context of highly unequal gender relations, economic vulnerability further affects the ability of women to negotiate for and apply knowledge about safe sex practices.

Entry into sex work does not always necessarily guarantee financial autonomy to women and the security that they seek. Instead, multiple reasons converge to exclude women from financial security despite the fact that they support their families and themselves. These include appropriation of their income by third parties like pimps, police or brothel owners, being caught in a cycle of debt or debt bondage to brothel owners who brought them from traffickers, absence of ways to save money for their future or their children and lack of secure options where the income could be deposited. Persistent debt makes it extremely difficult for women to create a financial foundation, which would help plan for and safeguard the future of their children and themselves; reject abusive clients or those who refuse protection; and conceive of other life opportunities [7].

Elsewhere, it has been noted that gender inequalities and the unequal power balance within sexual relationships make it difficult for sex workers to negotiate safe sex with partners [2, 22]. A study conducted among female sex workers in two red light districts of Mumbai showed a positive association between risk behaviour and economic situation [3]. It was found that those who engaged in the profession due to financial difficulty and with financial responsibility of the family had a lesser chance to go in for regular medical examination. Another study exploring women's empowerment and HIV prevention among sex workers in Botswana found women's negotiating power and economic independence as most strongly related to condom use [21]. While education was not found to be a crucial factor, economic independence was found to be most strongly related to the negotiating power of female sex workers [21].

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<sup>1</sup> Endemic to the northern part of Karnataka is the practice of dedicating women to be devadasi, where they are married to a Hindu divinity. It is a form of sex work considered sacred and more acceptable by the local community.



Lack of economic power increased the vulnerability of sex workers, as they are forced to enter into sex work, or form temporary partnerships to barter sex for financial gain, or for survival needs such as food, safety and shelter. Women's economic dependence on their husbands, for survival and support, limits their decision-making and negotiating power, putting them at higher risk. Located as they are in a highly discriminatory and unequal socio-cultural and economic context, the high risk of infection among sex workers arises out of their inability to negotiate condom use, or to conduct their business in a safe environment.

Efforts to address economic vulnerability and improve sex workers' access to additional sources of income have shown positive impacts, such as, decrease in client volume and STI, reduced economic dependence on sex work and improved condom use. A study conducted among 209 sex workers in Nairobi slums found that business-training initiatives resulted in the average number of clients declining by two-thirds for those who continued to engage in sex work [53]. While both, the incidence of STIs and the average income from sex work declined by half, sex workers found additional income from other businesses. In another intervention among female sex workers in Kenya, micro-enterprise services resulted in nearly half the group exiting sex work and a drop in the average number of sexual partners and an increase in consistent condom use among those who continued in sex work [13].

Various strategies are being practiced for the prevention of HIV. These include the use of informal contacts, key informants and 'leaders' to access the population; peer health promotion and education; outreach activities; social marketing and distribution of condoms; care and support for HIV infected sex workers; and provision of accessible sexual health services. Mobilisation of the community into groups and training them in savings and income generation activities have emerged as innovative intervention strategies to tackle HIV/AIDS prevention. Efforts in this area have shown a positive effect of group membership and access to additional/alternative income in terms of dramatic changes in sexual behaviour [29, 32, 24, 50, 36].

Collectivisation has been used and recognized as an effective strategy to empower women and help them deal with the multiple vectors of discrimination. The process enhances their social capital resulting in a change in the public and self-perception of the women's power [29, 24, 36, 55], reflected in their greater agency to decide on issues affecting their lives. In the experience of Saheli HIV/AIDS Karyakarta Sangha, in Pune, India, organising sex workers' collective to enhance self-protection through a sense of togetherness and identity resulted in reported condom usage in upto 95 percent of sexual encounters and resultant stabilisation of HIV [32].

A study conducted among female sex workers in Karnataka, India, to evaluate the role of groups in increasing knowledge and promoting change towards safe sex behaviour found positive relation between the variables [24]. Higher degree of collectivisation was associated with increased knowledge and higher reported condom use. Collectivisation had empowered the FSWs to adopt safe sex practices especially with commercial clients. A study evaluating the behavioural intervention under the West Bengal Sexual Health Project, found that collectivisation and support group formation were the factors that influenced the creation of an enabling environment, effecting and sustaining long term behavioural change [50].

One of the most successful experiments in such an intervention, which has integrated the positive impacts of collectivisation and economic empowerment, has been the Usha Multi-purpose Cooperative Society in Sonagachi red light area of Kolkata. Started by sex workers in 1995, under the aegis of the Durbar Mahila Samiti, a Kolkata-based sex workers' collective, it worked with the strategy of community-led structural intervention wherein the targeted community, i.e. sex workers, led from the front. The programme has been able to create an enabling environment. It provides a secure financial future and also allows for the sex workers to enforce condom use by the client [53, 36, 43]. Lessons from the Sonagachi project show that information and supply of condoms is

insufficient to change the sexual behaviour of sex workers, and that they must value themselves, overcome the fear of losing clients and income to other sex workers, before they take steps to protect their health and enforce condom use by the client. In short, an enabling environment has to be created for them to be able to practice safer sex [53, 36, 43, 9].

HIV interventions have used both risk and vulnerability reduction strategies. Risk reduction strategies include community-led outreach that is differentiated and responsive to community needs [49]. It ensures access to correct knowledge about STI and HIV and services for STI and other health problems among female sex workers, MSM, hijras and their regular partners. Further, it works at developing negotiation skills for sexual encounters, promoting male and female condoms and creating safe spaces. Vulnerability reduction strategies, on the other hand, include developing crisis response systems, advocating with key influencers in the sex work circuit and government, including sensitising police about violence against sex workers [49]. It includes facilitating access to rights and entitlements through provision of basic amenities such as ration card, children's education, so as to reduce economic dependence on sex work. It also works towards building community ownership through enabling participation of key population in the project.

While benefits of risk reduction strategies are evident, the impact of vulnerability reduction strategies is intangible. Two key vulnerability reduction strategies adopted by KHPT and its partners NGOs are:

- (i) Forming sex workers into groups to increase their collective bargaining
- (ii) Encouraging sex workers to save regularly and start income generation projects if they desired.

In short, this study seeks to establish whether membership in a group/CBO<sup>2</sup> along with access to microfinance can be determining factors in impacting behaviour change among female sex workers.

## I. a. Key Concepts

**Collectivisation:** It is a process by which women from the community come together or are organised under a formal or informal institutional structure to facilitate their empowerment - socio-economic, cultural and sexual. In the specific context of sex work, it is 'seen as a means to reduce sex workers' vulnerabilities to achieve a HIV-related end'. Mobilising communities by enlisting grassroots support to form CBOs is perceived to be an effective strategy to increase effective and sustainable outcomes for prevention interventions, bring about changes in practices, policies and laws, and reduce stigma and discrimination [12].

The process is expected to effect a change in individual attitudes and beliefs, build capabilities and develop critical consciousness, leading to collective action resulting in positive transformation. The collective agency can be harnessed to create strong community based organisations and networks. All these are expected to empower women in sex work to challenge power structures, besides creating an enabling environment for accessing their rights [40].

The organisational structure and the primary purpose of mobilisation will differ across contexts. In some areas, women may come together as members of a co-operative structure, while in others they may be organised into small site level affinity support groups further federated at taluka and district levels. All of them address issues important to the community such as violence, financial security, education, advocacy, welfare, cultural arts, etc.

**Savings:** Many of the sex workers' collectives offer access to micro-savings and credit to their members with the aim of empowering them through reduced economic dependence on sex work

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<sup>2</sup> In this report, the terms groups and collectives both denote the same thing. Respondents and different partner organisations use different terms to describe groups of women as 'groups' or 'collectives'. The term CBO is used to denote formal democratic community structures, where field level groups are federated at the taluka and district levels.

and enhanced economic security. Sex workers, more often than not, are unable to access the services offered by formal financial institutions due to their inability to fulfill the required criteria. This forces them to borrow from informal exploitative sources that charge exorbitant rates of interest. In addition, they are also subject to harassment from local goons, police and pimps who extort their money. The women are caught in a perpetual cycle of debt and with very little money for daily sustenance of their families. Microfinance activities within the sex worker group or offered by the collective allow the women to save small amounts of money in a secure environment, earn an interest income on their savings and make them eligible for credit against these savings.

Safe Sex: Condom use at last sex often considered a proxy for safe sex behaviour is not operative at all times since FSWs may not be able to negotiate or enforce condom use due to an urgency to earn money or limited negotiation power among other reasons. Therefore safe sex behaviour is taken to mean consistent condom use with clients. It suggests condom use with all types of partners, including intimate partners such as lovers or husband, as well as in different types of sexual acts (vaginal, anal, oral, etc.).

## I.b. Conceptual framework

The conceptual framework for the study is shown in Figure 1. In this model, collectivisation and participation in micro-savings function as vulnerability reduction strategies that influence risk reduction behaviour among female sex workers. The risk reduction behaviour include consistent condom usage and usage of clinical services<sup>3</sup>, which are also influenced by a set of factors (figure 1).



Figure 1: The role of group membership and participation in micro-savings in influencing condom use and usage of clinical services among female sex workers in Karnataka, India: A conceptual framework for the analysis of empowerment of sex worker women to practice safe sex through collectivisation and allied activities.

<sup>3</sup> NACO guidelines list out different modes of clinical service delivery to the high risk groups. These include: 1. Static Clinic: This is a project linked clinic located in and around the red light area or in the brothel setting where there is a large congregation of HRG population. 2. Preferred private providers: These are private providers who are identified based on a focused group discussion with the target population, who are located in and around the hot spots/ zone of the intervention area and are preferred by the community. 3. Hybrid model: This model is applicable where the target population is scattered as well as concentrated and a single approach cannot provide effective services. This is a mix of the static clinic approach with inclusion of preferred providers so as to improve the access to services. 4. Referral to government health facilities: This model is applicable in the case where the nearest government health facility is the preferred location of accessing services by the HRGs. National STI/RTI Control and Prevention Programme, NACP, Phase III, India.



The conceptual framework suggests that FSWs who benefit from group membership and participation in micro-savings activities would be more likely to adopt safer sex practices, such as, increased and consistent condom usage and regular clinic visits for health check-up. The study assumed that vulnerability reduction strategies would create an enabling environment that would help the FSWs overcome barriers to practicing safe sex and accessing clinical services.

Six sets of factors each were identified as influencing condom usage and clinic access by the FSWs. The factors identified as influencing condom usage were: availability and accessibility of condoms; knowledge about the need for using condoms; benefits of using condoms; risks associated with unsafe sex, ability of the sex worker to negotiate forced sex, or free sex and the rate for their service; economic dependence on sex work; self-esteem; and fear of violence. Factors identified as influencing clinic access were: availability and accessibility of clinics; knowledge about symptoms and treatments for STI; economic dependence on sex work; self-esteem; stigma; and the experience of sex workers at the clinic.

The assumption made on account of each of the six factors influencing condom usage and usage of clinical services is given below.

## **Factors influencing condom usage**

### **Availability of condoms**

Availability of condoms has been advocated and recognised as one of the key structural intervention measures in the ongoing HIV/AIDS prevention efforts [55, 15]. Other prevention strategies lose their potential effectiveness when not coupled with access to condoms [15]. As adequate knowledge of prevention methods does not always ensure the practice of safe sex, it has to be supplemented with mechanisms that ensure sufficient and need based availability of condoms, which help overcome multiple constraints to condom access often faced by female sex workers [55, 15]. This study explored whether membership in a group/CBO and participation in micro savings had bettered the accessibility and availability of condoms for sex workers who were members of groups as opposed to non-members.

### **Knowledge about HIV and AIDS**

Sex workers who have good knowledge on HIV/AIDS are more likely to use condoms with different types of sexual partners [23, 14]. Efforts at educating sex workers about using condoms have found to result in increased use of condoms and refusal of unprotected sex [48, 8]. Lack of knowledge about the risks involved in unsafe sex, irrespective of the status of the sexual partner, was hypothesised to be a barrier to safe sex. Knowledge about the risks involved in unsafe sex was assumed to compel consistency in condom usage and refusal of unprotected sex. The study explored whether members of the group displayed increased awareness and knowledge about safe sex practices and the importance of it in preventing HIV/AIDS, as compared to non-members.

### **Negotiation skills**

Negotiation skills have been found to significantly influence consistent condom use with both regular and non-regular partners [14, 62, 51]. The ability of the sex workers to deal with situations of forced sex from clients leads to a reduction in unprotected sex, thereby reducing the risk of infection. Negotiating to avoid free sex would prevent loss of income, hence improving the financial situation of FSWs. Additionally, it would reduce the sex workers' vulnerability to agree to unprotected sex under compulsion to earn more money. These assume more importance in the event of increased awareness and willingness among sex workers to practice safe sex.

Both these capabilities (to negotiate for consistent condom use and to avoid free sex) were assumed to be developed as a result of their empowering participation in the groups. It was hypothesised that the ability of a sex worker to negotiate - (a) situations of forced sex i.e. unprotected sex under violence, abuse and threat (b) demands for free sex, wherein they are not paid for their service - would reduce their vulnerability and hence, support safe sex practices. The study assumed that sex workers who were members of the group would have an increased awareness about situations of violence and the need for avoiding them, as well as increased confidence and knowledge of strategies for dealing with such situations. It was also expected that member FSWs would be more skillful in negotiating for a better rate and in protecting themselves from being duped.

### **Economic dependency**

Economic dependency is one of the many critical determining factors that push a woman into sex work. For women who enter into sex work, often under extreme financial duress, compulsion to engage in unprotected intercourse for money is high. They find it hard to negotiate for, or insist on, safe sex. A group provides a space for the women to save money that would have otherwise been spent or usurped by exploitative husbands, partners, pimps, goondas and police. Further, savings in the group provide them with greater agency to service or refuse clients. Access to savings also promotes better health seeking behaviour, reduces their dependency on income earned through sex work and on exploitative sources of credit such as moneylenders and clients. The study hypothesised that members in a group who have access to microfinance would have a decreased economic dependency on sex work. This was expected to reduce their vulnerability to unsafe sexual practices as opposed to non-members who did not have the facility to save and avail of credit, and hence, had an increased economic dependence on sex work.

### **Low self-esteem and self-stigmatisation**

One of the key psychosocial factors that influence safe sex behaviour among female sex workers is self-esteem. It has been found to be an important mediating factor between attitudes and beliefs in adopting condom use. Coupled with lack of confidence to access condoms and negotiate its use, low self-esteem increases the FSW's vulnerability to HIV [37]. Low self-esteem leads to self-stigmatisation and has been found to be associated with inconsistent condom use and non-use of prevention services [37, 1, 33]. The link between positive self-esteem and positive condom use attitudes in the target population has been well established [51, 18, 27, 34], wherein FSWs with a positive self-image were found to be more confident in negotiating condom use, with an increased likelihood to insist on safe sex with their sexual partners [53].

A positive self-image enables the sex workers to not unwillingly accept but seek protection or protect themselves against violence and abuse. Groups provide a space for these women to reach out to more of their peers, promote solidarity and facilitate increased knowledge and experience sharing. The support that the sex workers gain from these groups helps them to overcome isolation and marginalisation and the resultant low self-esteem. It was hypothesised that sex workers who were members of the group would have a better self-image and appreciation about themselves, which would in-turn lead to increased confidence and power to negotiate for safe sex.

### **Violence and abuse**

Female sex workers operate in a socio-cultural context, where sex work is stigmatised and considered immoral. Sex work is considered as a non-normative female behaviour and sex workers as vectors of infection, who risk the lives of clients and clients' sexual partners [45]. As a result, sex workers are discriminated against and violence against sex workers gain legitimacy.

Violence against the FSWs increases their vulnerability to HIV/AIDS and other STIs through numerous mechanisms [6, 5, 16, 44]. Women who experience violence are more likely to report inconsistent condom use, less likely to have accessed HIV intervention programmes or visited a sexual health clinic and more likely to be infected with STI [6, 52]. Abused women find it difficult to effectively negotiate sexual matters with their partners, located as they are within unequal heterosexual relationships, thus increasing their risk to STI.

Condom use involves an implicit or explicit agreement between the partners and requires the cooperation or participation of the male partner and is influenced by the power of the women in sexual decision-making [25]. Given the dynamics involved in negotiating safer sex, FSWs need to be enabled to comfortably discuss sexual matters, assert their sexual needs and desires and avoid or refuse to engage in intercourse when a partner refuses to use condoms [38]. The study explored whether members in the group, as compared to non-members, had increased self-efficacy and ability to negotiate situations of violence and insist on safe sex under such circumstances.

## **Factors influencing Usage of Clinical Services**

Various structural and environmental barriers, such as geographical distance, mobility, work limitations and social stigma affect the uptake of clinical services by sex workers [39].

### **Physical proximity of services**

A key factor that could impede FSWs' access to clinical services is the physical proximity of the services and monetary costs involved in accessing them. Non-availability and inadequate accessibility of healthcare service providers can increase the incidence of STIs, and thereby, impede efforts towards HIV prevention [46, 26, 63, 61]. For instance, high cost of travel to access a health clinic may negatively influence the decision of FSWs to visit the clinic. The study hypothesised that utilisation of clinical services was better for members as compared to non-members. In this regard, it attempted to explore - the convenience of the FSWs in accessing clinical services for STI treatment, the difference in utilisation of services between members and non-members and whether membership in a group facilitated FSWs to better access and avail of the clinical services.

### **Awareness and knowledge**

Awareness and knowledge about STI and the modes of its transmission, recognition of symptoms, taking appropriate treatments and necessary precautions, are important for controlling the spread of STI among target communities. Insufficient knowledge and awareness could lead to delays in symptom recognition and seeking care [61, 35, 17], subsequently thwarting the efforts at STI control. Membership in a group was assumed to increase the knowledge and awareness about STI and its treatment, and in turn expected to motivate FSWs to seek prompt treatment and care when infected.

### **Economic dependency**

Economic survival is one of the many reasons for women being in sex work. This dependence on sex work often encourages risky behaviours – agreeing to unsafe sex for money, or compromising on treatment and health check-up to service a client. Risky behaviours in turn increase their vulnerability to HIV and impede prevention and care efforts. Increased awareness about the importance of regular health checks supported by buffer savings were assumed to reduce their economic dependence on sex work, which would, in turn, enable the sex workers to prioritise clinic visits over servicing a client, if faced with such a situation. The study explored whether membership in a group, with the facility to save, had impacted the choice made by FSWs – between visiting a clinic or servicing a client.



### **Low self-esteem, stigma and discrimination**

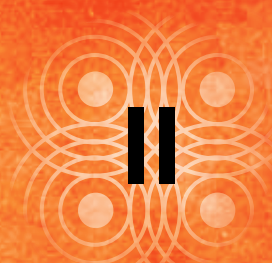
Low self-esteem coupled with stigma and discrimination greatly influences care seeking behaviour of the female sex workers [61, 35, 17, 28, 58]. Fear of being exposed, leading to shame, loss of respect and resultant discrimination by the family and community act as coercive deterrents to access to clinical services by sex workers [17, 58]. Sex workers with low self-esteem and who fear stigma and discrimination, are less likely to adopt preventive strategies such as: seeking treatment for sexually transmitted infections, getting counselled/tested, or returning for results, accessing health care professionals for treatment, disclosing their HIV status, or adhering to treatment. The study hypothesised that being a member of a group would help sex workers: (a) to deal with issues of low self-esteem and (b) to improve relationships with the larger community through raising awareness among them about the sex worker population, thereby addressing issues of stigma.

The study explored whether members and non-members, experienced themselves and their relations with the larger community differently. It further explored the influences of these experiences, if any, on the FSWs' compliance to health service and care seeking behaviours.

### **Negative experiences with service providers**

Lack of confidentiality, discrimination, negative attitudes of health care providers, and fear of exposure also impact FSWs' access to sexual health services. A key factor among these is the FSWs' previous experiences with the service providers. Impersonal treatment at the clinic, indifference and harassment by the doctor, exploitation – being charged for free services and being charged higher than normal because they are sex workers, unofficial payments to clinic staff in order to receive treatment, long waits to see the doctor, lack of trained staff, breach of confidentiality, poor communication, disrespectful and judgemental behaviour of the service providers - all act as barriers to seeking sexual health services [61, 17, 58, 42]. The study explored the concerns of sex workers with regard to the service providers – their reasons for visiting the clinic and aspects they liked and disliked about their experience at the clinic. The study hypothesised that as a result of their membership in the group, members had better experiences at the clinics than non-members.

# METHODS



## II. a. Purpose of the study

The purpose of this study was to understand the relationship between vulnerability reduction strategies, that is, membership in a group and participation in savings activities, and safe sex behaviour among the female sex workers (FSWs) in three districts of Karnataka: Bangalore Urban, Bellary and Shimoga.

## II. b. Objectives

**Objectives of the study were:**

1. To explore the relationship between membership in a group and safe sex behaviour among FSWs in districts with different collectivisation strategies.
2. To explore the mechanisms through which the membership in a group influences safe sex behaviour among FSWs.

## II. c. Study design and methods

For the first objective, the data collected in the second round of Integrated Biological and Behavioural Assessments (IBBA) among the FSWs in the three study districts was analysed. The IBBA was carried out as part of an evaluation of a large-scale HIV prevention programme in the state. The second objective was addressed through a set of focus group discussions.

### Integrated Biological and Behavioural Assessments (IBBA)

To evaluate the impact of HIV prevention programme, IBBA were conducted at baseline and follow-up stages, on random samples of FSWs in five selected districts – Belgaum, Mysore, Bellary, Shimoga and Bangalore Urban - in Karnataka. HIV prevention programmes were initiated in these four districts between January 2004 and April 2005, with baseline IBBA conducted 7-19 months after the initiation of the programme. Follow-up surveys were completed 28-37 months after the baseline surveys. Details of the IBBA methodology are described elsewhere<sup>4</sup>. The data from Bellary, Bangalore Urban and Shimoga were used in the current study.

The target sample under this study was fixed at 400 each for Shimoga and Bellary, and 800 in Bangalore urban. A two stage sampling method was used - selection of sites where FSWs solicit in the first stage, and selection of respondents in the second stage. Conventional cluster sampling was used to select home-based sites/ clusters. Time-location cluster sampling method was used for the selection of street-based sites/ clusters. A total of 80 clusters, with additional five for contingencies, were selected in the districts of Bellary and Shimoga, and number of clusters selected in Bangalore was 190 so as to provide separate estimates for public place based FSWs and others. The number of completed interviews with at least one biological sample was fixed at 5 per cluster. From each of the selected sites, FSWs were selected at random for interviews. If the number was not achieved

<sup>4</sup> Ramesh BM, Beattie TSH, Isac S, Washington R, Jagannathan L, Reza-Paul S, Blanchard JF, Moses S. Changes in risk behaviours and STI prevalence following HIV preventive interventions among female sex workers in five districts in Karnataka state, south India. Sex Transm Inf 2010; 86 (Suppl 1):i17-24.

within a site, the balance was covered in subsequent clusters. In sites where there were five or less FSWs, all were interviewed.

The following table show the completed interviews in the second round of IBBA and the response rate.

**Table 1: Number of completed interviews in second round IBBA**

District	Number of completed interviews	Response rate (In %)
Bellary	410	95
Shimoga	406	99
Bangalore	750	94

All statistical analyses were performed using survey data analysis techniques in STATA version 10.0. For the IBBA data, appropriate weights were used to account for the differential recruitment of FSWs by typology within districts, differential non-response rates, and differential probabilities of selection across districts. The primary outcome was defined as collectivisation and condom use in the previous year. Secondary outcomes were HIV/STI prevalence, condom use (clients and regular partners) and experience of the HIV prevention programme (contact with a peer educator, and contact with the drop-in centre and the project STI clinic). Odds ratios (ORs) were used as the measure of association, and the Wald Chi-Square test was the statistical test used. In the multivariate models, age was included as a potential confounding variable. Other potential demographic confounders were added to the model using a stepwise approach. Those that caused the ORs of the independent variables to change  $\geq 10$  percent were included in the final model. Multivariate analyses were performed for IBBA data.

### Focus Group Discussion (FGD)

Focus Group Discussions (FGD) were conducted with homogenous groups of 6-15 FSWs, both members and non-members of a group, in the three selected districts. Participants gave individual informed consent before the focus group commenced and each session followed the same format.

Each FGD was facilitated by the primary researcher, following guidelines developed for this study. Groups discussed barriers to condom and clinic usage. On condom usage, the discussions centered on availability and accessibility of condoms, knowledge about the need to use condoms, skills in using condoms, negotiation ability and influence of violence and fear in practicing safe sex. On accessing clinical services, the discussions were around availability and accessibility of clinics, knowledge about STI, stigma and fear of doctors. The groups also discussed how economic dependence on sex work and self-esteem influenced their safe sex behaviour and willingness to use clinical services for treatment of STI.

Three categories of sex workers were sampled for the study: (i) members of a group or CBO (ii) members of a group or CBO, also participating in savings activities and (iii) non-members. Information (the registration id of each sex worker and typology) about the three categories of sex workers was collected from the partner NGOs. In each FGD a stratified (home- and street-based FSWs) random sample of sex workers was chosen from the registered sex workers in each district, based on their registration number and typology.

Each FGD was conducted in Kannada and recorded using a digital recorder. Following each FGD, a translator transcribed the discussions in English. Transcribed manuscripts of FGDs were coded under different categories. For condom usage, the categories included: availability/accessibility of

condoms, knowledge and awareness, negotiation ability, economic dependence, self-esteem and presence of violence and fear. For usage of clinical services, the categories included: availability and accessibility of clinical services, knowledge about STI, economic dependence, self-esteem, stigma and experience at the clinic. The responses in FGD were compared across groups, typology and districts using the analysis method of scheme and sub-theme.

A total of 28 FGDs were conducted with 307 FSWs from the 3 selected districts in Karnataka (Shimoga, Bellary and Bangalore Urban). They included 157 home-based and 150 street-based FSWs. A little more than half (159) FSWs who participated in the FGDs were members of a group and the remaining (148) were not members of any group.

**Table 2: Sample of FSWs participating in FGDs**

District	Member in a group		Non-member	
	Home	Street	Home	Street
Bangalore Urban	29	26	27	21
Shimoga	23	23	20	20
Bellary	28	30	30	30
Total	80	79	77	71



### III. a. Introduction<sup>5</sup>

With a total population of 16.4 lakhs, district Shimoga is the 14th largest district in the state in terms of population. As per 2001 Census of India, it has 9 towns, 1443 villages and is administratively divided into 7 talukas. Shimoga town is the administrative headquarters of the district. The district had a sex ratio of 978 females per 1000 males in 2001. The literacy rate is 75 percent with the proportion of literate being higher among males than females (82 percent compared with 67 percent) and higher in urban areas than rural (84 percent compared with 70 percent). Agriculture and animal husbandry are the major contributors to the economy of Shimoga district. The network of public health services in the district includes 1 district hospital, 2 community health centres (CHCs), 65 primary health centres (PHCs), and 336 sub-centres.

For HIV related services, in 2009, there were 23 integrated counseling and testing centres (ICTCs), 22 prevention of parent to child transmission (PPTCT) centres, 7 government-recognised blood banks and 5 clinics for sexually transmitted diseases (STD) in the district. There are 2 community care centres (CCCs), 1 anti-retroviral therapy (ART) centre, and 1 PLHIV network.

Among the high-risk groups, the estimated size of FSWs in urban and rural areas of the district is 2,854, with 34 percent in the rural areas. 82 percent of the estimated FSWs in the district are spread across 4 talukas: Bhadravati (33 percent), Shimoga (26 percent), Shikaripur (12 percent) and Sagar (11 percent). The total number of FSWs in the urban areas of the district is 1,882, with 64 percent in two talukas of the district – Bhadravati (35 percent) and Shimoga (29 percent). Overall, there were 5.69 FSWs per 1,000 adult population in urban areas of the district and 1.6 FSWs per 1,000 adult populations in the rural areas of the district. Most of the urban FSWs are home-based (64 percent), followed by street-based (29 percent). 41 percent of the FSWs are either widowed, divorced, separated or deserted, 20 percent are high-volume, entertaining 10+ clients a week, 18 percent are under age 25 years, 53 percent are illiterate and 19 percent are new to sex work with less than 2 years since they started sex work. The HIV prevalence among FSWs in the district is moderate at, 8.96 percent (IBBA-FSW, 2008).

ActionAid has been implementing the Sankalp/Abhaya<sup>6</sup> programme in all the 9 cities/towns of the district since February 2004, with the funding from KHPT/Avahan.

In 2009, there were two targeted interventions in the district, one each for FSWs and MSM-T. Out of the estimated number of 1,588 FSWs in the district, a total of 1,889 were covered by the TI, with 65 percent of the FSWs being contacted in a month. The reported condom use among FSWs in 2009 was quite high in the last sex with occasional clients (51 percent), regular clients (72 percent), lovers (63 percent) and husbands (45 percent). From IBBA, the condom use among FSWs, both with occasional and regular clients, was found to have increased over the period 2003 to 2008.

<sup>5</sup> From India Health Action Trust, 'HIV/AIDS Situation and Response in Shimoga District: Epidemiological Appraisal Using Data Triangulation', July 2010.

<sup>6</sup> Abhaya is the name of the district HIV/AIDS prevention programme.

An average of 793 FSWs, which is about 42 percent of the FSWs covered by the TI in the district, received STI consultation in a month.

### **III. b. Institutional design**

In the district, FSWs are organised into site level groups called Support Groups. The bases for organising the groups are:

- i. Typology – support groups of sex workers from the same typology are formed, specifically in the case of street-based sex workers, who are organised around a particular site.
- ii. Geographical proximity – sex workers living close to each other form a group and the groups are constituted by mixed typology of sex workers. In Shimoga, most support groups are formed of home based sex workers.

Each peer worker, under a TI, has five sites under her responsibility. Peer workers form groups in these sites under the supervision of an outreach worker. The CBO has a three-tier structure with support groups at the level of sites and committees at the levels of taluka and district. Each support group at the site has 10-15 members and meets once a month. About fifty to sixty percent of the members regularly attend these meetings. The support groups select or elect a Convener and/or Co-convener to the taluka Committee. One member from each taluka is elected to the district committee. The district committee has a President, Secretary and a Treasurer who is elected once in two years. There are a total of 77 site level groups in Shimoga.

The groups in Shimoga do not undertake savings or credit activities as yet<sup>7</sup>. The groups are primarily organised around issues of health. Discussions in the groups are centered on issues of health, self-respect, and understanding of one's life situation and acceptance of sex work as a profession.

### **III. c. Member and non-member profile**

#### **Socio-demographic characteristics**

Table 3 (see Annex) summarizes the socio-demographic characteristics of member and non-member FSW in Shimoga. Among the total registered sex workers, majority were aged above 40 years (24 percent) and a minority were under 25 years (11 percent). Non-members had more FSW under 25 years of age (12 percent) than members (8 percent). Overall, member FSW tend to be younger than non-member FSW: while 29 percent FSW members were between 25-29 years 26 percent FSW non-members were aged 40 years and above. Majority of both, members and non-members, were not literate, lived near the area of solicitation and were non-migrants. Half of the total sex workers were currently married, separated/divorced or widowed. This was true for both members and non-members. Almost equal proportions of FSWs were cohabiting with a regular partner (husband, boyfriend or lover) among members and non-members. Approximately, 81 percent of the non-members and 78 percent of the members had sources of income outside of sex work. The age of sexual debut was lower among members, with 41 percent being less than 15 years of age at first sex, compared to 37 percent for non-members.

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<sup>7</sup> In interviews with programme coordinators and CBO representatives, it was mentioned that the decision to exclude microfinance transactions from these groups emerged from the FSWs themselves. The women felt that introduction of savings and credit facilities would divert the focus from matters of health. Additionally, most of them were already part of other local microfinance groups where they saved money and accessed credit from. The high mobility of sex workers, where they shifted their base every six-month was also not conducive to operate a savings and credit programme.

## History, pattern and environment of sex work

As shown in Table 4 (see Annex), majority of the total FSWs were more likely to solicit and entertain clients at home than in public places (parks, streets, markets, etc.). This was true for both members and non-members. The proportion of FSWs who practiced sex work at home was slightly higher among members than non-members (67 percent versus 61 percent). A majority of members (35 percent) have been in sex work for 5-9 years while a majority of the non-members (42 percent) have been in sex work for 10 years and more. Almost equal proportion of members and non-members has been in sex work for less than a year. Half of the members and little over half of non-members (54 percent) had a client volume of 10 and more in a week. A significantly higher proportion of non-members than members (64 percent versus 50 percent) serviced more than 5 new clients in a week. An almost equal proportion of both members and non-members earned a monthly income of ₹ 1,500 and more. More members than non-members received more than ₹ 100 per sexual act.

## Exposure to programme according to membership in a group

Almost all members and non-members had been contacted by a peer and an equal proportion (94 percent) of both the groups had received a condom demonstration. However, overall exposure to programme intervention was much lower among non-members than members (see Table 5). There were significant differences between members and non-members (85 percent and 65 percent respectively) with respect to ever having visited a drop-in centre.

Multivariate analyses were carried out looking at intervention exposure of members and non-members. After adjusting for confounding variables, strong associations remained between membership in a group and visit to a DIC in Shimoga. Member FSWs were more than 3 times likely to visit a DIC compared to non-members (adjusted OR: 3.14, 95 percent CI: 1.77-5.59,  $p < 0.05$ ).

## III. d. Membership and condom use

There was not much difference in the proportion of members and non-members who reported unprotected sex (21 percent and 23 percent respectively) and condom use with last client (74 percent and 77 percent respectively) among the FSWs in Shimoga (Table 4). Similarly, 81 percent of the members reported condom use in last sex with repeat client compared to 84 percent of the non-members. An equal proportion (77 percent) of both members and non-members always used a condom with repeat client. A higher proportion of non-members than members (71 percent versus 65 percent) always used condom with an occasional client. Reported condom use in last sex and consistent condom use with partner was lower among members than non-members (19.3 percent and 10.4 percent members & 23.6 percent and 14.3 percent non-members, respectively).

Proportion of non-members with only chlamydia (3.5 percent) and chlamydia and/or gonorrhea (5 percent) was significantly higher as compared to members (0.8 percent with chlamydia and chlamydia and/or gonorrhea). HIV prevalence was higher among non-members than members (9.3 percent versus 8 percent) while those who tested positive for syphilis were higher among members (5.3 percent) than non-members (3.3 percent).

Multivariate analyses were carried out looking at membership in a group and condom use. No association was seen between condom use and membership in a group in Shimoga.

## Availability and accessibility

Both members and non-members expressed satisfaction with the availability and accessibility of condoms. Multiple sources that ensured access to condoms included peers, NGO office, hospital, medical shops and vending machines. Constraints to condom access remained despite these factors. Membership in a group did not seem to have aided sex workers to better access and avail of condoms.

Access to condoms was difficult due to the presence of family members at home or when clients were serviced outdoors. Particularly in the case of home-based sex workers, presence of family members at home prevented them from stocking condoms at home for fear of it being discovered by their husband or other family members.

“Sometimes it is ok to utter a hundred lies in order to conduct a marriage and in our case it is ok if we utter a few lies to safeguard our health.”

(home-based FSW, member, Shimoga)

The women worked their way around these constraints. They stocked condoms at their neighbour’s, or friend’s place and made excuses or lied to their family to access condoms during such instances.

“Sometimes while my husband or family members are at home, I am not able to get condoms and it is during these times that I feel I need it to be more accessible.”

(home-based FSW, member, Shimoga)

The respondents seem to have internalised the importance of safe sex. Constraints to access were not economic rather they emerged from a sense of discomfort or fear of being identified as a sex worker. FSWs expressed their readiness to buy condoms from medical shops if it were not available free of cost. However, not all were willing to buy it in person and depended on their clients to purchase it for them. The presence of familiar female salesperson in the medical shops was an enabling factor for those buying condoms themselves.

“We are shy to directly go to the shop and buy it.”

(street-based FSW, non-member, Shimoga)

The respondents specially mentioned the role of Abhaya Action Aid (NGO), whose involvement aided and ensured the community’s access to condoms. Further, peers emerged as the most depended upon source for getting condoms for both members and non-members.

“If Abhaya had not got involved with our community it would have been difficult to get even a condom as we are shy to go and buy it from a shop.”

“We have never faced that problem because when we are running out of stock the peer will come and give us some more.”

(home-based FSWs, members, Shimoga)

FSWs, especially street-based, demanded for an increase in the number of condom vending machines in public places for better accessibility and availability.

“There should be vending boxes in every locality.”

“There shouldn’t be a position where our client has to go to the medical shop to get a condom.”

(street-based FSWs, non-member, Shimoga)

Respondents expressed their dissatisfaction with the quality of condoms supplied by the office and preferred those bought from the medical shop. They also suggested that existing multiple channels for distribution of condoms be maintained.



“Condoms bought from the medical shop are good and doesn’t break open during sex.”  
(street-based FSW, non-member, Shimoga)

In summary, membership in a group did not differently impact members and non-member FSW, with respect to accessibility and availability of condoms. Overall, both members and non-members expressed satisfaction with the existing system. A key factor that ensured consistent and need based condom availability for all sex workers was the network of peers. However, constraints to access - shared by all the sex workers – remained, irrespective of their membership status.

## Knowledge and awareness

All sex workers, both home and street-based, members and non-members, underscored the importance of condom usage in every sexual encounter with each sexual partner. FSWs received information about condoms from the NGO office, peers, government hospital and ICTC. However, this did not always translate into safe sex practice with multiple sexual partners.

Various reasons prompted insistence of consistent condom use by the FSW. These include fear of contracting sexually transmitted diseases such as HIV and other STIs, negative health and social consequences of such outcomes, experiencing death of family member due to HIV, the desire to stay healthy to provide for their children and the need to prioritise good health over pleasure.

“I have seen a woman infected with HIV suddenly lose weight, get boils on her tongue and mouth”.

“We are in this profession because we want to give our children a bright future. If we get infected, our children will be on the roads”.

(home-based FSWs, member, Shimoga)

“To stop infections from spreading from one person to another”

(street-based FSW, non-member, Shimoga)

Despite knowledge and awareness about using condoms, majority of FSWs cited their inability to use condoms with their husband. Reasons for not being able to ensure safe sex with husband included the fear of being exposed as a sex worker, trust in his loyalty towards their relationship and an inability to convince the husband to use condoms. The main concern was raising suspicion that could subsequently lead to marital discord, which was often abusive and could result in desertion of the woman by the family.

“He will ask me where I got that condom from and we may end up in a police station after a fight.”  
(home-based FSW, member, Shimoga)

Some respondents stressed the importance of using condoms even with their husbands to avoid infections. Lack of trust in their husband’s fidelity, husband’s willingness to use condoms and ability to convince the husband about the positive health outcomes of using condoms, aided the use of condoms with their husbands. Respondents also suggested counselling as a way to get their husbands to agree to use condoms.

“Our husband goes out and we cannot trust him to the level where we can forego the use of a condom during sex.”

(home-based FSW, non-member, Shimoga)

On using condoms with sexual partners other than the spouse, typology-wise differences emerged. While home-based sex workers, both members and non-members, reported consistent use of condom with their lovers, street-based sex workers at times found it difficult to negotiate safe sex with lovers and partners. For home-based workers, lack of trust in their lover’s fidelity was the primary reason why they used condoms with lovers and partners. For street-based sex workers, barriers to using condoms with lovers and partners included issues related to intimacy and trust and their inability to convince them to use condoms. However, all FSWs denied unprotected sex with their clients.

“It is most important that we use it with our lover because they may go to someone else.”

(home-based FSW, non-member, Shimoga)

“I try to convince my lover but if he does not listen I have sex with him without a condom. If it is a client I will send him back.”

(street-based FSW, member, Shimoga)

In some instances, respondents reported that lovers’ meeting sessions had been effective in convincing the lovers to use condoms.

“Some lovers understand the importance of using a condom when they come here for the lover’s meeting and agree to use it. Some don’t use it because they do not get pleasure during sex.”

(street-based FSW, member, Shimoga)

Most respondents, regardless of typology and membership status, feared being infected with HIV despite consistent use of condoms. Unprotected sex with husbands and breakage of condom during sex were reported as the main reasons behind this fear.

“My husband even though he goes to other women does not reveal it to me out of the fear that I will leave him. When I have sex with him without a condom I get infected.”

(home-based FSW, member, Shimoga)

“Sometimes the condom will fail and at such times I have the fear of HIV.”

(home-based FSW, non-member, Shimoga)

In addition to condom breakage and unprotected sex with their sexual partners, street-based non-member sex workers, also cited oral sex and used syringes in the hospital as a cause for worry with respect to being infected with HIV.

However, condom breakage was the most cited cause for fear of HIV. Poor quality of condoms and sabotage of condoms by the clients were two reported causes of condom breakage. Respondents stated using multiple condoms in one sexual act as a precaution to safeguard their health during such instances. Some of them reported consuming alcohol before undergoing clinical examination to cope with the fear of HIV.

“We have the fear because of oral sex. Most of our clients want to kiss us.”

“Some men are rough during sex and there is a chance the condom may get damaged. So we use more than one condom.”

(street-based FSWs, non-member, Shimoga)

There is greater awareness among members about the possibility of infection due to unsafe sex than among non-members. The latter tend to rely on husband's loyalty as a safeguard against infection, despite not using condoms with them.

“We do not use a condom with our husband but we are confident he is faithful to us.”

(home-based FSW, non-member, Shimoga)

In summary, membership of FSWs in a group did not have a differential impact on the knowledge and awareness about the importance of protected sex and its translation into actual practice of safe sex. Negotiating safe sex with intimate sexual partners continued to be difficult for both members and non-members. However, the increased awareness had led to improved condom use pattern with clients for both the groups.

## Ability to negotiate

### **Forced sex**

In Shimoga, members displayed more confidence than non-members in dealing with situations of forced sex. Their ability to counsel and convince clients and the mutual support from FSWs in the area were cited as reasons for this confidence. While members used community networks to inform their peers of a bad client and garnered its support in the event of violence, non-members clearly lacked this support system.

Of the two typologies, home-based sex workers were better enabled than street-based sex workers to negotiate to prevent forced sex. Home-based sex workers employed unique strategies to deal with possible situations of abuse and forced sex. These included, being absent from home during visit by a violent client, threatening violent clients with immediate arrival of family members, not entertaining strangers and entertaining only those new clients introduced by their regular clients.

“If he does not listen I will tell him my husband will come anytime now and out of fear of my husband he will go away.”

(home-based FSW, member, Shimoga)

Although there have been instances where street-based member FSW have convinced client to use condoms, situational compulsions forced them into unprotected sex. They were unable to deal with situations of forced sex when outside the usual area of work.

“In our area we will resist any such attempt because we have other women for support. When we are taken out we are helpless and we will have to succumb and our main aim is to get out of there alive.”

“I am from a village and I am an agricultural laborer. Sometimes we are forced to have sex with some other workers there and at such times we are not able to use a condom.”

(street-based FSWs, member, Shimoga)



Although generally confident, non-members among home-based sex workers found it difficult to deal with situations of forced sex, especially when in closed room with multiple violent and drunk clients. Street-based non-member sex workers were confident of fighting back if there were just one or two men but not if they were in a group. They expressed being particularly vulnerable when they practiced sex work in a place of client's choice.

"There are two dangers in that situation. One is sex without condoms and the other is violence from those clients."

(home-based FSW, non-member, Shimoga)

"Three years back I was bundled into an auto and was taken to a lonely place and I was forced to have sex with 8 men. I found it difficult to walk back in the morning. Now I am HIV positive."

(street-based FSW, non-member, Shimoga)

### **Free sex**

Member FSWs negotiated situations of free sex better than non-members. However, home-based sex workers were better equipped than street-based sex workers as the latter practiced sex work in less secure environments, such as open spaces, streets, lodges, public toilets, bus stands, etc.

Home-based member sex workers protected themselves against free sex by taking money beforehand. The community network was also used to inform other members about a non-paying client. There were mixed responses to fixing the rate for their services. While most FSWs negotiated a mutually agreeable rate with the client, some accepted the rate offered by the client without negotiating. The reasons for not negotiating included fear that the client could expose their identity as sex worker to her family/community, dislike of negotiating for money, or the client's refusal to pay what the sex worker demanded.

For street-based sex workers, who were members of the group, the place of sex work determined their ability to deal with demands for free sex. They expressed inability to deal with it while stranded in a public place or a lodge. Very few took money beforehand to avoid being duped. Interestingly, they were able to command a rate without any negotiation from the client, as the demand for sex work was very high.

"It has happened and since we practice sex work in a lodge we cannot come out and create a scene because people will call the police."

(street-based FSW, member, Shimoga)

Home-based sex workers, who were not members of the group, stated their inability to deal with free sex. However, they managed to negotiate with client for a mutually agreeable rate.

"There are clients who will not give us money even for bus charge and some won't even give us our clothes."

(home-based FSW, non-member, Shimoga)

In contrast, street-based non-members were more effective in negotiating situations of free sex. They negotiated the rates over the phone. They took the money from new clients before sex and with regular clients after sex. The rates were decided by themselves or through negotiation.

“The contact is made over the phone and we also negotiate over the phone. We ask for a certain price but finally even if we do not get that rate we will at least get a satisfactory amount.”

(street-based FSW, non-member, Shimoga)

In short, membership in a group had influenced the ability of the sex worker to better negotiate situations of forced and free sex. Members used the community network to inform each other of bad clients and sought out the support of peers when in trouble. Non-members clearly lacked this support system.

## Economic dependence

In Shimoga, the sex worker groups did not offer microfinance facilities and hence, the sex workers did not save in these groups. However, these women were part of other local microfinance groups in which they saved and accessed credit

Member and non-member sex workers continued to engage in unprotected sex under financial duress and borrow from moneylenders and clients. In addition, membership in multiple microfinance groups increased their credit burden subsequently leading to more sex work and unprotected sex to repay the debt.

Sex work was the main source of livelihood for most of the FSWs except for few among the home-based sex workers, for whom it constituted a supplementary source of income. While home-based sex workers voiced strong preference for work other than sex work, street-based sex workers had visible increased financial benefits from sex work as compared to other livelihood options.

“I am able to earn ₹ 500 per day from sex work whereas ₹ 120 per day from working as a coolie. So, most of us prefer sex work to some other profession.”

(street-based FSW, non-member, Shimoga)

All respondents had multiple sources of credit that they depended on during shortage of money. These included credit from the employer, moneylender, lover, savings and credit from the local microfinance groups, pawning ornaments, and loans from chit funds, neighbour's, clients and shopkeepers near cruising points and from where they bought provisions.

Economic dependence on sex work continued to be significant for most sex workers. They agreed to unprotected sex for money during emergencies, such as when their child is ill or to meet other needs at home.

“My child was ill and my husband was away. I needed money and agreed to have sex without condoms because he would have gone away if I had insisted.”

(home-based FSW, member, Shimoga)

The persistent need for money coupled with the presence of long term and continuous relationships with some of their clients, also led to situations of unprotected sex. Along with the need for money, comfort and intimacy with the regular client, often led FSWs to have unprotected sex with those clients, even when there was no emergency.

“I get a client from Bengaluru who comes once a month and will pay me ₹ 2000 but won't use a condom. We have sex twice and he leaves in the evening. I have no problem with it because I need the money and he is a regular.”

(street-based FSW, non-member, Shimoga)

A more discomfoting finding was that enhanced debt burden of the sex workers due to membership in more than one microfinance groups increased their vulnerability to unprotected sex. The need to generate money for the compulsory weekly saving deposits in these groups, along with other personal and familial demands, often led the FSWs to engage in sex without condoms.

“There are many sanghas and our women are members of at least three of them. If they pay ₹ 250 each into each of them and with a drunkard for a husband, there are bound to be money problems at home. We also do not get loans easily outside. We are forced to agree in situations like this.”

(home-based FSW, member, Shimoga)

Another form of exploitation is being asked for free sex, when the women are unable to repay the money borrowed. In a context of highly unequal and exploitative gender relations, women, especially those in sex work are often asked to agree to unpaid sex to repay credit.

However, majority of the respondents reported having rejected such propositions. Multiple steps have been taken by respondents to avoid free sexual services for unreturned money. These included seeking more time for repayment, rescheduling the repayment, borrowing mostly from women, avoiding credit from men who might ask for such favors and paying an increased interest rate. Even so, unpaid sex with clients to whom they are indebted continued to happen.

Most FSWs stated having control over the money they earned. Decisions on ways to use the money earned were made by the women themselves. Some of them did not inform the family about their income or hid the money earned, for fear of it being taken away by their husbands or lovers. Overall, FSWs were assertive about their right over the money earned.

“We buy the household essentials, non-vegetarian food, pay school fees, and buy liquor for the husband if he asks for it. We decide on it and also pay for it.”

(home-based FSW, member, Shimoga)

Few among the street-based sex workers expressed inability to exert control over the income earned and being subjected to abuse from the spouse if they did not comply with his terms and conditions.

“I give the money I earn to my husband because he will torture me. He gives me ₹ 200 while I leave home in the morning and when I get back home I have to give all my earnings to him or else he will beat me up.”

“I don’t have the capacity to stop my husband from taking a decision on my behalf.”

(street-based FSWs, member, Shimoga)

In summary, membership in a group had not differentially impacted the economic vulnerability of FSWs. Even though FSW groups in Shimoga do not offer microfinance facilities, sex workers were accessing the same through other groups. Easier access to credit, instead of reducing the sex workers’ vulnerability to unprotected sex under financial duress, had increased their debt burden. It led FSWs to engage in unprotected and unpaid sex to repay debt.

## Self-esteem

Self-esteem related issues seemed similar for both members and non-members in Shimoga. Neither would identify themselves as sex workers.

All respondents chose only to identify their alternate profession. They tend to describe their identity in terms of their families and place of origin.

"I will tell I am a respectable woman and I have a husband and children, I am from this town, I am living in a rented or own house but we won't talk about this profession."

(home-based FSW, non-member, Shimoga)

Fear was the most compelling reason why FSWs hid their sex worker identity. Fear of loss of respect from others, conflicts at home and adverse consequences for the family and the fear of being exposed as a sex worker emerged as the main reasons why FSWs hid their sex worker identity.

"How can I say openly that I am a sex worker? It is not possible. If I say openly I am a sex worker, tomorrow there are chances there will be fight in front of my house."

(home-based FSW, member, Shimoga)

"I am worried my children won't be respected if I openly say that I am a sex worker."

(street-based FSW, non-member, Shimoga)

Most respondents reported feeling guilty and dejected and perceived themselves as bad persons. They felt shy and scared to reveal their sex worker identity. They harboured a constant sense of resentment about being forced into sex work because of circumstantial compulsions. FSWs shared that they coped with these feelings by reasoning that they entered sex work so they could take care of their children and families.

"I feel I am a bad person but am forced to continue in this profession."

(home-based FSW, member, Shimoga)

"If our men would have taken good care of our family there was no need for us to sleep with other men to earn a living."

(street-based FSW, member, Shimoga)

Respondents were asked whether it was okay for them to be abused by others because they were sex workers. Responses differed on the basis of typology and status of membership. Almost all home-based members felt that family, friends and regular clients had a right to abuse them, since they were sex workers. They feared violent retaliation if they resisted abuse and believed that if they were not sex workers, they would not have been subjected to abuse. However, they did not think it was all right for strangers to abuse them.

"It would not have happened if we were not in this profession."

"It is ok if it is done by our family members or our friends but not by a stranger."

(home-based FSWs, member, Shimoga)



More self-assertive voices emerged from the non-members. Most of them vehemently opposed the idea that anyone, including family, had the right to abuse them.

"I am doing it for my own compulsions and reasons. A third person won't come to my aid and solve my problems and so he does not have a right to abuse me."

(home-based FSW, non-members, Shimoga)

The response of street-based sex workers was different. They strongly stated that it was not acceptable for anyone other than their spouse to abuse them because they were sex workers. They did not think they were doing anything immoral or bad and considered sex work just like any other profession. They did not perceive violence from their spouses as an affront to their dignity.

"People give us money because we have sex with them. That does not mean they can abuse us."

(street-based FSW, member, Shimoga)

"We are not depending on anyone and we are not committing a crime. Our family does not take care of us. Normal professions do not give us enough money. That is the reason why we are in this profession and so we also have a right to a dignified life."

(street-based FSW, non-member, Shimoga)

"Our husband has the right because we are married to him and we turn to him for everything."

(street-based FSW, member, Shimoga)

Even though street-based FSWs said that they had the right to lead a dignified life, they did not seem to have internalised it. They believed they had the right to lead a dignified life because they were forced into sex work out of compulsion and had not willingly taken it up. Some others rationalised that they had the right to dignity because their sex work did not inconvenience others.

"I have the right because I am also doing a profession and I am a human being like everyone else."

(street-based FSW, member, Shimoga)

"I have a husband who is out of work. I have four children and my in-laws staying with me. If I work as a coolie, I earn ₹ 120 and it is not enough to take care of my family. So I am forced to do sex work. I conduct myself with dignity in my family life and do this profession clandestinely."

(street-based FSW, non-member, Shimoga)

There were a few others who desired to quit sex work and those who felt they had lost their dignity when they entered this profession.

"I had the right before I joined this profession but now even if I pay money no one will respect me."

"I have seen children who do not respect their mother because she is a sex worker. How should I expect the general public to respect us?"

(street-based FSW, member, Shimoga)

The respondents affirmed their right to say no to unprotected sex. The belief stemmed from: (a) concern for their health, and (b) increased awareness as part of being a member of the support group.

“This (awareness about their right to say no to unprotected sex) is a recent phenomenon and something we did not know before the formation of the support group. Before the formation of the support group we faced a lot of problems.”

(street-based FSW, member, Shimoga)

In summary, in terms of self-esteem of FSWs, their typology played a more influencing role than membership in groups. Typology wise differences emerged with respect to feelings of guilt and being open to abuse on account of being in sex work. Home-based sex workers reported an increased sense of guilt and displayed higher tolerance to abuse from family and others compared to street-based sex workers. Among home-based sex workers, members consented to abuse more than non-members.

However, none of the sex workers were willing to reveal their sex worker identity. All harboured a deep sense of dejection and discomfort with their sex worker identity.

### Presence of violence and fear

Members dealt better with situations of violence than non-members. Street-based sex workers faced more instances of violence than home-based.

While home-based member sex workers reported fear of violence from clients who were drunk, street-based sex workers reported an increased frequency of violence from clients during holidays. Most respondents, from both typologies, expressed confidence in facing situations of assault.

Presence of other female sex workers, self-confidence, the ability to gather cues about a client's behaviour, the capability to counsel clients and the possibility of seeking help from the NGO office were (listed as) factors that enabled the respondents to address situations of assault. The respondents did not fear repercussions of their resistance to violence. Lodging a police complaint immediately after the incident, support from the NGO office and loss of interest from the client's side all contributed to this confidence.

“If we are subjected to assault we can always come to the office and lodge a complaint and they will solve the problem.”

(home-based FSW, member, Shimoga)

“We can read a client when we see him and do not entertain them if we feel they will be violent.”

(street-based FSW, member, Shimoga)

However, members, especially street-based sex workers, expressed their helplessness to deal with police violence. Half of the street-based FSWs expressed their helplessness in dealing with police violence. Many of them, with their work site away from their place of residence, found it hard to face police brutality. Once arrested and sent to the remand home, more often than not, they found it difficult to secure a release as only family members are permitted to post bail.

“We can face problems from the clients and rowdies but we cannot face problems created by the police. The female inspector who has come here now beats us up for no mistake of ours and I have marks on my body to show for it.”

(street-based FSW, member, Shimoga)

Compared to members, non-members found it more difficult to handle drunken clients or multiple client scenarios. Here too, the nature and frequency of violence reported by street-based sex workers were much higher than that reported by home-based sex workers. They found it difficult to deal with violence in public places or in a location of client's choice.

"At that point of time we do not mind losing all our belongings as long as they let us get out of there alive."

(home-based FSW, non-member, Shimoga)

"Clients who take us outdoors for sex create a lot of problems if we don't satisfy their demands... It is very difficult to run away from that situation. We have to agree to their conditions and make sure that we come out of there alive."

(street-based FSW, non-member, Shimoga)

As an exception, few of the home-based non-member sex workers reported a change in their situation from the past. They reported that their interactions with the NGO Abhaya Action Aid empowered them to face situations of violence.

"We never used to come out in the open before and we had to face assaults then. But now after coming to this office (NGO) and with information and knowledge we are empowered to avoid such problems and if it still happens we are confident of facing it."

(home-based FSW, non-member, Shimoga)

In summary, sex workers in Shimoga, who are members of the group, expressed more confidence in dealing with violence compared to non-members. They expressed better ability to gather cues about a client, sought help from the NGO and were better networked with their peers, all of which helped in times of need.

### **III. e. Membership in a group and usage of clinical services**

The IBBA analysis showed that approximately 94 percent of the members and 90 percent of the non-members had ever visited the sexual health/STI clinic run by the NGO. Of the women visiting the STI clinics, a significantly higher proportion of members than non-members (63.5 percent versus 53 percent) had ever received a grey pack.

#### **Availability and accessibility**

In Shimoga, majority of the sex workers accessed clinical services regularly. Membership in a group did not emerge as a determining factor for accessing services as both members and non-members experienced similar challenges and had sought solutions for it from the NGO.

Majority of the sex workers were well aware that in order to maintain good health, they needed to regularly visit the clinic for STI check-up and not just make occasional visits when plagued by an illness.

"Some STI is visible but some are invisible and it is better we go to the clinic for a check-up."

(home-based FSW, non-member, Shimoga)

"Some clients kiss, bite, pinch, etc., and it is better we go regularly for a check-up."

(street-based FSW, member, Shimoga)

Distance to the clinic continued to be a barrier to access. Most respondents expressed the need for the clinic to be at a closer and a more convenient location. For sex workers from the villages, long distances to the clinic increased the travelling costs incurred for visiting clinics. Also, often long distance meant that they would not reach the clinic in time to see the doctor who would have left by the time they reached the clinic. Some of the street-based sex workers said they would prefer to have clinics near their cruising points.

“It would have been better if there were STI clinics in the same way as private clinics.”

(home-based FSW, non-member, Shimoga)

“Sometimes we won’t have money for bus charge. The doctor would have left for the day by the time we adjust money for bus charge and reach the hospital.”

(street-based FSW, member, Shimoga)

Some respondents shared that the NGO provided them with cash support for transportation costs. Except for street-based non-member sex workers, all respondents expressed the need for easier access to the clinic.

However, home-based member sex workers were satisfied with the accessibility of the clinic and did not want the clinic to be closer. Most of the home-based member sex workers visited the clinic when affected with a health problem. Some of them reported visiting the clinic twice a month.

Home-based sex workers preferred the clinics to be away from their homes so as to avoid the consequences of family, neighbours and the larger community discovering about their visits. They reported the present central location of the clinic to be convenient for the women from different villages to attend.

“In Shiralkoppa, we spent Rs.4 on bus charge one way, to get to the government hospital and we do not have any issues with the distance since we can always tell them we are going to the town and then visit the clinic.”

“We can manage the questions posed by our family members but answering our neighbours is a serious problem. All of this can be avoided if the clinic is at a distance from our home.”

(home-based FSWs, member, Shimoga)

The women especially mentioned membership in the CBO and the active involvement of peers, as factors which ensured that they receive treatment at the right time.

“Peers when they come on field visits usually enquire about our health and if we tell them we have a problem they will take us to the clinic for treatment.”

“It’s been five years since I got married and I did not have a child even after three years due to STI. After I came here I went to the clinic and got treatment and I had a child the very next year.”

(home-based FSWs, member, Shimoga)

Except for home-based member FSWs, majority of the respondents reported distance as a barrier to access. Home-based member sex workers seem to have benefited from membership in the group and were reached better by the peers to ensure that they received clinical services as and when needed.



## Knowledge about STI

Majority of the sex workers, from both typologies and irrespective of membership status, reported good knowledge about the symptoms, treatments and precautions for the prevention of STI. Though most of the respondents could list symptoms correctly, there were a few who could not.

“Stomach Ache, Cold.”

“When we visit the STI clinic the doctor knows about the symptoms”

(home-based FSWs, member, Shimoga)

Respondents reported that they stopped following native treatments for STI cure after joining the group. Once the NGO clinic started, respondents stopped taking other treatments, or visiting other clinics. They only trusted the treatment provided by the NGO clinic.

“Before joining Abhaya, I have tried native medicine like eating white hibiscus. All these treatments did not help in curing STI.”

(home-based FSW, member, Shimoga)

“After our clinic was set up we have stopped going elsewhere for treatment. Here we can openly discuss our health problems and get proper treatment.”

(street-based FSW, Member, Shimoga)

Respondents were aware that having unprotected sex while having an STI increased their risk of contracting HIV. They emphasized the importance of safe sex practices and regular health check-up for preventing STI.

“We can prevent STI by wearing a condom during sex.”

“We have to have regular health check-ups.”

(home-based FSWs, member, Shimoga)

Respondents were unanimous in reporting that they reject unsafe sex with any person showing symptoms of STI, unless it was a situation of forced sex. They refused sex with persons with STI even if they faced financial compulsions or were offered incentives.

“Even if he gives me Rs.2000 I won’t have sex with him.”

“I cannot resist once we go into a room and I am forced to have sex with him.”

(home-based FSWs, member, Shimoga)

Respondents reported having noticed STI symptoms in their clients. They reported only safe sex with such clients. Few of them reported having refused sex with someone who had STI even with condoms and counselling infected person for treatment. At times, the sex workers accompanied clients to hospitals for treatment.

“I have seen clients with STI symptoms and I only have sex with them if they agree to use a condom.”

(home-based FSW, non-member, Shimoga)

“We will tell him about STI and counsel him to go in for a blood test and treatment. If possible we will accompany him to the clinic.”

(street-based FSW, member, Shimoga)

Street-based, non-member sex workers were an exception, with comparatively lower levels of awareness about STI. Majority of them could not identify symptoms of STI. However, they reported using one or more condoms, as a precautionary measure.

“We won’t know if he has STI and to be on the safer side we use a condom.”

(street-based FSW, non-member, Shimoga)

Few of the participants reported having noticed symptoms in their clients, providing them with information about STI, advising them to get treatment and agreeing to having sex with them only if they used a condom.

“We counsel him to get treatment and have sex with him using a condom.”

(street-based FSW, non-member, Shimoga)

Some respondents however reported that they have agreed to have sex with someone who had an STI. Sometimes, the conditions in which sex took place, such as in the dark without lights, prevented the sex workers from noticing STI symptoms of the clients.

“Most of the times, the lights are off and where will I know if he has STI or not?”

(street-based FSW, non-member, Shimoga)

Most respondents stated that treatment at the clinic was the best way to cure an STI, and only one respondent suggested native treatment as a cure for STI.

“One of the remedies is to eat white hibiscus with sugar first thing in the morning.”

(street-based FSW, non-member, Shimoga)

In summary, though knowledge around STI symptoms varied among the respondents, all of them were aware that unprotected sex with STI increased the risk of HIV. Membership in a group did not emerge as a factor that influenced knowledge of STI and its prevention.

## Economic dependence

Economic dependence on sex work continued to be high, as most sex workers in Shimoga expressed reluctance in prioritising a clinic visit over servicing a client. This factor did not differentiate between members and non-members. The only exceptions were home-based member sex workers who were comfortable with losing a client. This may be because for most home-based sex workers, sex work was a supplementary source of income.

Majority sex workers, with the exception of home-based member sex workers, prioritised servicing a client over visiting the clinic. They preferred to entertain the client first as there was a possibility of losing him as a client if he was refused. They also felt that while clinical services could be accessed at a later time, or day client loss could not be replaced.

“We will entertain the client and if there is no time to go to the clinic we will visit the clinic the next week.”

(home-based FSW, non-member, Shimoga)

“I cannot leave him because he will go to someone else.”

(street-based FSW, member, Shimoga)

Home-based member sex workers, on the other hand, prioritised their health over servicing client. There was a shared understanding about the importance of being in good health so as to be able to continue working.

“I will go to the clinic first because if I am healthy I can service him even tomorrow.”

(home-based FSW, member, Shimoga)

In summary, membership in a group had not positively influenced the sex workers ability to prioritise a clinic visit over servicing a client. As it emerged from earlier discussions, sex workers’ dependence on income from sex work continued to remain an impeding factor. In fact, their dependence on sex work had increased over the years with the multiple memberships in microfinance groups. Hence, the economic situation of sex workers was not conducive for them to choose a clinic visit over a client.

### Self-esteem and stigma

Almost all the sex workers, from both typologies and irrespective of their membership status, experienced high levels of stigmatisation. They practiced sex work clandestinely. They visited the clinic under the pretext of other reasons.

FSWs feared abuse, rejection and destitution if their husbands and/or families discovered that they were sex workers. They feared discrimination and ostracisation by neighbours and extended community, if they were exposed as sex workers. There was also a strong fear of their children being discriminated against

“He (husband) will chop me up.”

(home-based FSW, non-member, Shimoga)

“We have to worry about these things because we do not want our children to grow up and find out that their mother is a sex worker.”

(street-based FSW, member, Shimoga)

“No one will let us rent houses.”

(street-based FSW, non-member, Shimoga)

Respondents shared that they would visit clinic under the pretext of some other reason and never disclosed STI treatment as the reason for clinic visits.

“Once in a while I can tell them I am going to the clinic but not every month.”

(home-based FSW, member, Shimoga)

“Even if they come to know about it we will give them some reason.”

(street-based FSW, non-member, Shimoga)

However, in spite of these fears, the women visited the clinic as they gave importance to good health.

“We do not mind lying in order to visit the clinic.”

(home-based FSW, member, Shimoga)

“We cannot stop visiting the clinic because someone else will shun us.”

(street-based FSW, member, Shimoga)

Membership in a group did not influence the frequency of stigmatisation faced by sex workers nor did it help them deal with it better.

### Experience at the clinic

Majority of the sex workers, from both typologies, irrespective of membership status, expressed satisfaction with the services available and treatment meted out to them at the referral clinic.

The respondents were happy to visit the clinic as it provided them with a space to openly discuss their health problems without being stigmatised. The women especially mentioned the role of Abhaya Action Aid, in helping them overcome their hesitation to openly discuss their health problems. Respondents shared that they overcame their hesitation in talking about condom use patterns and sexual relations with the doctors, after joining the group.

“I am from Bhadrawati and before joining Abhaya I used to feel shy to discuss my health problems with the doctor but not anymore.”

(home-based FSW, member, Shimoga)

Various aspects of the clinic appealed to the sex workers: enquiries by clinic staff about their condom use behaviour and health issues; encouragement from the staff to freely discuss their health problems; good communication from the staff; jovial atmosphere; provision of free services; provision of information and guidance; receiving health reports; satisfaction of knowing about positive health results; and receiving effective treatment.

“We are healthy now because we openly discuss our health problems with the doctor and get good treatment.”

(home-based FSW, member, Shimoga)

“They crack jokes.”

(home-based FSW, non-member, Shimoga)

“We are at peace when peers come and tell us our test reports are all fine.”

(street-based FSW, member, Shimoga)

“The doctors don’t discriminate because we are sex workers.”

(street-based FSW, non-member, Shimoga)

Respondents stated their preference for government clinics over private ones. This was because at a private clinic they are required to disclose and explain their sex work history but at the government clinic, where the doctors are aware of their identity as sex workers, they did not need to explain. Also, respondents found that doctors at the private clinic had a callous attitude towards them while staff at the government clinic showed concern and understanding.



“We have to explain our case history if we go for treatment elsewhere and it can get embarrassing. But here there are trained doctors and we will get the right treatment.”

(home-based FSW, non-member, Shimoga)

While most sex workers reported positive staff attitudes and visited the clinic either accompanied by a peer or an office staff or alone, home-based member sex workers were apprehensive about ill treatment at the clinic if they went unaccompanied. They feared discrimination, such as being deliberately made to wait longer and neglected, and as a result, always visited the clinic in a group, accompanied by a peer.

“We are given treatment only if we are accompanied by our committee members. If we are not accompanied by peers they will think we are not members of Abhaya action aid.”

(home-based FSW, member, Shimoga)

Street-based member sex workers also reported preferential and speedy treatment when accompanied by a peer or an office staff. However, this did not determine or influence their clinic visits, as it did for home-based member sex workers.

“When we go in a group the doctor will take one hour to see our group and then attend to other patients.”

(street-based FSW, member, Shimoga)

Among all respondents, a considerable number of street-based non-member sex workers expressed adverse experiences at the government hospital. They stated not visiting the government clinics for STI treatment.

“They don’t treat us well when we go there for common ailments then will they do it if we go there for STI treatment?”

(street-based FSW, non-member, Shimoga)

They reported negative experiences at the clinic: discriminatory staff attitudes; staff expressing fear in approaching them because they are sex workers; ill treatment by the doctors if their identity as sex worker is revealed; being made to wait for long; and treated with contempt and verbal abuse.

Problems such as not being able to communicate well with the staff, and having to bribe the nurses for being treated with care were also reported.

“They are scared to come near us and even if they do, they wear long gloves before touching us.”

“They not only treat us with disdain but also abuse us verbally.”

(street-based FSW, non-member, Shimoga)

The respondents were also concerned about the quality of medical practice at the clinic, such as reuse of used syringes and prescription of ineffective and expensive medicine.

“We have to bribe the nurse if we want a painless injection in government hospitals.”

(street-based FSW, non-member, Shimoga)

The respondents voiced their preference for private clinic over government clinic despite the higher costs involved in availing treatment from the former.

“The medicine they give there is not effective. Most of the time, they give us a red, white and yellow colored tablet. The medicines they prescribe cost Rs.200-300 when we buy it in a medical shop.”

(street-based FSW, non-member, Shimoga)

Majority sex workers reported positive staff attitudes and were happy to visit the government clinic. However, most of them reported that they received better and preferential treatment if a peer or an NGO staff accompanied them. The only exceptions to this positive experience were street-based non-member sex workers who reported adverse experiences at the referral clinic.

“The doctor in the government hospital is not very communicative but we get a good response when we go to a private hospital.”

(street-based FSW, non-member, Shimoga)

## RESULTS - BELLARY

### IV. a. Introduction<sup>8</sup>

District Bellary has a total population of 20 lakhs and is the 6th largest district in the state in terms of population. As per 2001 Census of India, it has 11 towns, 524 villages and is administratively divided into 7 talukas. Bellary town is the administrative headquarters of the district. The district had a sex ratio of 969 females per 1000 males in 2001. The literacy rate is 57 percent with the proportion of literates being higher among males than females (69 percent compared with 45 percent) and higher in urban than the rural areas (70 percent compared with 50 percent).

The network of public health services in the district includes 1 district hospital, 5 community health centres (CHCs), 55 primary health centres (PHCs), and 301 sub-centres. For HIV related services, in 2009, there were 35 integrated counselling and testing centres (ICTCs), 44 prevention of parent to child transmission (PPTCT) centres, 6 government-recognised blood banks and 3 clinics for sexually transmitted diseases in the district. There are 2 community care centres (CCCs), 1 anti-retroviral therapy (ART) centre plus 3 Link ART centres, 1 drop-in centre (DIC) for people living with HIV (PLHIV) and 1 PLHIV network.

Among high-risk groups, the estimated size of FSWs in urban and rural areas of the district is a total of 8,981, with 50 percent in the rural areas. 70 percent of the estimated FSWs in the districts are in 4 of the 7 talukas: Hospet (24 percent), Bellary (17 percent), and 15 percent each in Kudligi and Siruguppa. The total number of FSWs in the urban areas of the district is 4,468, with 77 percent in four talukas of the district – 30 percent in Hospet, 17 percent in Kudligi, 16 percent in Siruguppa and 15 percent in Bellary. Overall, there were 11.54 FSWs per 1,000 adult population in urban areas of the district and 7.05 FSWs per 1,000 adult populations in the rural areas of the district. Majority of the registered FSWs under TIs are home-based (59 percent) or Devadasis (58 percent), 23 percent are either widowed, divorced, separated or deserted, 20 percent are high-volume entertaining 10+ clients a week, 22 percent are under age 25 years, 73 percent are illiterate and 10 percent are new to sex work with less than 2 years since they started sex work.

HIV prevalence among FSWs in the district is high at 14.12 percent (IBBA-FSW, 2008). An important feature of Bellary district with a bearing on HIV is the Devadasi tradition, wherein families follow the tradition of dedicating one of their daughters to Goddess Yellamma as a means of propitiating the Gods for helping them through difficult times. In additions to performing the traditional roles of performing temple specific tasks, Devadasis were also expected to provide sexual gratification to the main priest (considered a part of the deity) and live as concubines with men who protected them financially and physically. With commercialisation of the system, Devadasis increasingly operate as FSWs and the associated religious and social sanction has resulted in an increasing number of non-Devadasi women dedicating their daughters as means of earning income for the family.

<sup>8</sup> From India Health Action Trust, 'HIV/AIDS Situation and Response in Bellary District: Epidemiological Appraisal Using Data Triangulation', July 2010.

Since 2003, MYRADA, an NGO, has been implementing TIs for FSWs and MSM-T (only in urban areas) in the district with support from KHPT's Sankalp project. The project is funded by Avahan. MYRADA is also implementing the Link Worker programme in 256 selected villages with the support of KHPT's Samastha project, funded by the United States Agency for International Development (USAID).

Out of the estimated 8,598 FSWs in 2009, a total of 7,037 (82 percent) were covered by TI, with 91 percent of the FSWs being regularly contacted, once a month. The reported condom use among FSWs in PBS 2009 was quite high for the last sex with occasional clients (74 percent), regular clients (81 percent), lovers (77 percent) and husbands (57 percent). In condom distribution, 80 percent of the condom requirement in the urban areas and 71 percent in the rural areas were met by the TIs. As per the IBBA, condom use among FSWs, both with the occasional and regular clients, has increased during the period 2003 to 2008. An average of 1,594 FSWs received STI consultation in a month, which is about 23 percent of the FSWs covered by the TIs in the district.

#### **IV. b. Institutional design**

In Bellary district, sex workers are organised at the site level into Soukhya groups comprising of 8-15 members each. Soukhya groups work with the mission of 'safe sex, without oppression or harassment'. In addition, the groups undertake internal savings and credit activities. All the Soukhya group members undergo a ten-module<sup>9</sup> training in Institutional Capacity Building, over a period of 16-24 months. The groups serve multiple functions: encourage other FSWs to join Soukhya groups; ensure access and regular supply of condoms; promote social marketing of condoms; monitor the health seeking behaviour of its members such as regular health check up every 3 months and annual HIV and syphilis testing; conduct regular discussions on issues of harassment, legal issues; provide linkages to loans and access to entitlements to take action; and respond to crises. There are a total of 168 site level Soukhya groups in Bellary.

The site level groups are federated at the taluka level called Soukhya Okootas. The Okootas have both members from existing Soukhya groups and FSWs who are not in groups. Every sex worker site is represented in the federation by 2 members, one from the Soukhya group and the other from the non Soukhya group sex workers. The members are selected at a site level community meeting. Each Okoota has around 25 members, with an elected President, Vice President, Treasurer and Secretary. The Okootas have also formed sub-committees that address issues of health, crisis and social entitlements. The Soukhya Okootas are conceived as a common platform and network to help protect and advance the interests of the sex workers. In addition to monitoring the Soukhya groups and assisting them to achieve their mandate, the Okootas conduct outreach activities such as fortnightly meetings of non Soukhya sex workers, conducting sex workers' conventions, registering new FSWs and monitoring young sex workers and HIV positive workers. They also work towards creating an enabling environment by responding to crises situations, building linkages with line departments, recommending entrepreneurship development programmes and skills training for group members.

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<sup>9</sup> From, The MYRADA Soukhya/Sankalp Experience: HIV AIDS and HIGH RISK GROUP - Strategies for Sustainable Interventions. The 10 module training includes the following: 1st module – introduction to the program; group concepts; aims and objectives of group; common health problems of women; 2nd module – how to conduct meeting; unity and affinity in action; rules and regulations; responsibilities of Soukhya members; gender and HIV; 3rd module – leadership; self-esteem; communication and conflict resolution; 4th module – book keeping, savings and credits; common fund and management; HIV and RCH services; 5th module – Soukhya level vision building; 6th module – credit linkage; book keeping; social entitlements; other departments; IGP and EDP; 7th module – legal issue and HIV crisis management; 8th module – HIV AIDS prevention care and support for HIV positive persons; 9th module – collective decision making; Okoota concept; stigma and discrimination; 10th module – Soukhya group family level approach and community level approach; group grading.



The Okootas are further federated at the district level into Soukhya Samudhaya Samasthe (SSS) with two persons from each taluka Okoota nominated as member of the SSS. It has a governing board with a President, Vice President, Secretary and a Treasurer. The SSS was formed to address a felt need for a district level body that could effectively link with external institutions and access various government programmes. The site level Soukhya groups are members of the SSS and pay an annual membership fee collected through the contributions of the members to their respective groups. To be more inclusive, FSWs not in groups can also register as a member if a local Soukhya group endorses their membership. The SSS focuses on larger issues such as fund raising, higher-level advocacy and organising mass media programmes, among others.

FSWs who are not members of the Soukhya groups are represented at the taluka and district level committees managed by the CBO. They are provided access to microfinance through linkages with a microfinance organisation (MFO), Sanghamitra Rural Financial Services (SRFS)<sup>10</sup>. Sex workers who are not in Soukhya groups can access credit from this MFO through the CBO of sex workers. The CBO provides guarantee to enable these sex workers to get credit. The site level groups and the federated structures are separate institutions with annually audited bank accounts. They hold regular meetings on a fixed day and time schedule. They have systematic programme MIS, finance management and promote livelihood strategies. They also conduct compulsory capacity building for all members.

## IV. c. Member and non-member profile

### Socio-demographic characteristics

Table 7 (see Annex) summarises the socio-demographic characteristics of members and non-members FSW population in Bellary. Overall, of the total registered sex workers, a majority of 25 percent was under the age of 25. However, the proportion sex workers under the age of 25 was much lower among members (16 percent) as compared to non-members (29 percent). Majority of both members and non-members were not literate, lived near the area of solicitation and were non-migrants. A large proportion of the total sample was currently married, separated/divorced or widowed. Among members, however, most FSWs were currently married and Devadasis. The proportion of Devadasis among members was significantly higher as compared to non-members (34 percent versus 11.4 percent). A significantly greater proportion, (67 percent) of members, as compared to non-members (47 percent) was cohabiting with a regular partner (husband, boyfriend or lover). Majority of both members and non-members had sources of income outside of sex work, with a higher proportion (68 percent) among members than non-members (59 percent). The age of sexual debut was lower among non-members, with 47 percent being under 15 years of age at the time of first instance of sex work, compared to 40 percent for members.

### History, pattern and environment of sex work

As shown in Table 8, majority of the FSWs were more likely to solicit and entertain clients at home (50 percent) than in public places and brothels (35 percent and 15 percent respectively). The trend is similar among members and non-members. However, FSWs who practice sex work at home were significantly higher in proportion among members (63 percent) than non-members (44 percent). Also, FSWs who entertain clients in a brothel, lodge or dhabha<sup>11</sup> were not part of the group in Bellary.

<sup>10</sup> SRFS is a not-for-profit, non-banking financial institution promoted by MYRADA, which operates independently of MYRADA and lends to SHGs formed by MYRADA and other NGOs. As MYRADA is not a microfinance institution, it was persuaded to promote a microfinance institution when it realized that bank linkages of SHGs was not happening at the desired pace.

<sup>11</sup> Dhabha: small modest restaurants dotted throughout cities, local towns, and along highways in India, akin to a 'dive'.

Significantly higher proportions of the members (50 percent) were new sex workers, while 33 percent of non-members had been involved in sex work for less than a year. Majority of both members (68 percent) and non-members (73 percent) had a weekly client volume of 10 clients and more. A higher proportion of non-members than members (81 percent versus 77 percent) serviced more than 5 new clients in a week. A higher proportion of non-members than members earned a monthly income of Rs.1500 or more. An almost equal proportion of members and non-members received more than Rs.100 per client.

### **Exposure to programme according to membership in a group**

Overall, exposure to programme was much higher among members than non-members (Table 9). All members and almost all non-members (97 percent) had been contacted by a peer. 99 percent of members and 92 percent of non-members had ever witnessed a condom demonstration. A higher proportion of members than non-members (78 percent versus 63 percent) had ever visited a drop-in-centre.

### **IV. d. Membership in a group and condom use**

Almost equal proportion of members and non-members reported unprotected sex. Likewise, equal proportion reported having used a condom with occasional client (Table 10). Condom use reported with last client was higher among members than non-members (98 percent versus 90 percent). A lower proportion of members than non-members (80 percent and 87 percent, respectively) reported always using a condom with repeat clients. However, equal proportion of both members and non-members (approximately 93 percent) reported condom use during last sex with a repeat client. Reported condom use with partners was higher among members than non-members. A significantly higher proportion of members than non-members reported condom use during last sex with partner (51 percent versus 33.4 percent). Similarly, more members than non-members reported always using condoms with partners (36.7 percent versus 24 percent).

HIV prevalence was equal among both members and non-members (approximately 14 percent) while those who tested positive for syphilis was marginally higher among non-members as compared to members (8 percent and 7 percent, respectively). Proportion of those with only gonorrhea, only chlamydia and with both chlamydia and gonorrhea was significantly higher among non-members than members (5.2 percent versus 0.6 percent; 6.2 percent versus 1.6 percent and 9 percent versus 2.2 percent, respectively).

Multivariate analyses were carried out looking at membership in a group and condom use. Strong associations remained between condom use with the last client and membership in a group. Members were more than 7 times more likely to have used a condom with their last client compared to non-members (adjusted OR: 7.54, 95 percent CI 1.89-30.06,  $p < 0.05$ ).

### **Availability and accessibility**

All respondents, from both typologies and irrespective of membership status, expressed satisfaction with the availability and accessibility of condoms. Sources ensuring ease of access and availability included the NGO office, outlet box, government hospital, medical shop and peers. A few participants voiced the need for more outlet boxes and faster restocking of the existing boxes.

“More outlet boxes near petty shops.”

(home-based FSW, member, Bellary)

The respondents expressed willingness to buy condoms if they were not available free of cost. Some of the FSWs, at the time of the study, had been purchasing socially marketed Masti condoms and condoms from the medical shops.

Inhibitions in buying condoms in person from the medical shops persisted among a minority of the respondents. The reluctance was not due to fear but an embarrassment associated with asking for condoms from male salesperson, or in the presence of other male or female customers. However, since field-workers were supplying condoms respondents did not need to buy condoms from shops.

“We are not scared but since the sales men in the shop are men we feel shy to ask them for condoms.”

(street-based FSW, member, Bellary)

Interestingly, non-members from both typologies expressed more readiness to buy it in person, stating better awareness about condoms among the general public created by media campaigns as having aided in a more conducive situation to openly ask for condoms. They also prioritised the importance of condom usage for good health. Further, the participants saw no value in being shy as they were already in the profession of sex work.

“Condoms are advertised now on TV and even children know about it. So why should we be shy?”

(home-based FSW, non-member, Bellary)

“We are doing sex work and there is no point feeling shy about buying condoms from a shop.”

(street-based FSW, non-member, Bellary)

However, few of the participants voiced their concerns for the future.

“MYRADA is telling us that they won’t be working with us after a few years so we want it to be available even after they leave.”

(street-based FSW, member, Bellary)

Membership in a group had not differentially impacted the availability and accessibility of condoms. Both, members and non-members were satisfied with the existing infrastructure network that ensured sufficient availability of condoms, as and when required.

## Knowledge and awareness

All respondents, from both typologies and irrespective of their membership status, displayed good knowledge and awareness about the importance of consistent condom use with multiple sexual partners. They received information about condoms from the NGO office, government hospital, anganwadi, ICTC and peers.

Majority of the respondents, from all groups, reported consistent condom usage with all, including the husband. Factors enabling condom use with the husband included the ability of the sex worker to impress upon the husband the need to use condoms and better awareness among themselves and the sexual partners about the importance of safe sex.

"He asks me but I convince him because his job takes him away from home for weeks on end and I don't know where he goes during that time. So to be on the safer side I use a condom with him."

(home-based FSW, member, Bellary)

"The clients are also sufficiently educated now through TV and other advertisements."

(street-based FSW, member, Bellary)

Other factors aiding consistent condom use with multiple sexual partners were: sex workers' concern for good health and for preventing the spread of infection from multiple sexual partners; and the lack of trust in the fidelity of intimate sexual partners. Having witnessed the death of their peers due to HIV also led FSWs to insist on and adhere to safe sex practices.

"While the Belaku project was on, we used to come here, take information and go away. But, for the last two years, we are serious about using it. We also saw women who died of HIV. So we became serious about using condoms regularly."

(street-based FSW, non-member, Bellary)

Responses from FSWs indicate influence of the Soukhya groups in ensuring safe sex behaviour. Respondents expressed that after MYRADA started working with them, there has been an increased awareness about the importance of safe sex and increased confidence in their good health. Respondents stated that unprotected sex has become rare after the formation of the groups.

"It has happened before but not after joining the group."

(street-based FSW, member, Bellary)

However, few of them reported not using condoms with their husbands in order to avoid suspicion. Others reported unsafe sex with permanent partners.

"I don't use a condom with my husband because I trust him and also because if I tell him to use one he will ask me several questions and I don't want that to happen."

(home-based FSW, member, Bellary)

Majority of the respondents did not fear HIV as they used condoms regularly and have been testing for HIV every six months.

"We carry condoms with us all the time."

(street-based FSW, non-member, Bellary)

"We regularly use a condom and a HIV test every 6 months and so there is no fear."

(home-based FSW, member, Bellary)

Those who feared HIV did so because of condom breakage and used syringes in the hospital.

"We have the fear of the condom failing."

(home-based FSW, member, Bellary)

"When there is a rush in the hospital they may use one needle for more than one person."

(street-based FSW, member, Bellary)

In summary, membership in a group did not have a differential impact on the knowledge and awareness about condom use among the respondents. Both members and non-members displayed a good understanding about the importance of safe sex practices for ensuring good health. The institutional presence seems to have aided both, members of the group and non-members, in practicing consistent condom use with multiple sexual partners, including intimate partners, such as husbands and lovers.

## Ability to negotiate

### *Forced sex*

In Bellary, all the respondents, irrespective of the typology and membership status, reported being confident in dealing with situations of forced sex, except in multiple client scenarios. Various sources of strength include: (a) ability to convince the clients about the importance of safe sex practices (b) support of MYRADA and (c) support of friends and other sex workers around.

“Even if the clients are drunk when they come to us we are capable of cooling them down. If convincing them doesn’t work, we tell them about MYRADA.”

(home-based FSW, non-member, Bellary)

“...we can phone up our friends and tell them to come for our support. We will also give him a warning that there are more community women around.”

(street-based FSW, member, Bellary)

Interestingly, both members and non-member seem to have benefited from sex workers being organised into groups, in terms of increased awareness and confidence to deal with situations of violence and forced sex.

### *Free sex*

Respondents in Bellary, irrespective of their membership status and typology reported being able to deal with demands for free sex by taking money before the service was offered.

Membership in the group did not have a differential impact on the ability of sex workers in Bellary to negotiate situations of forced or free sex. Both members and non-members were well networked with their peers and actively sought the help of MYRADA to better deal with such instances.

## Economic dependence

In Bellary, sex work was the main source of livelihood for all the respondents, both members and non-members of the group. The income from sex work was supplemented by earnings from other work, including agriculture labour, tailoring, and construction labour among others.

In case of shortage of money, FSWs borrowed from multiple sources. They took on loans from neighbours, groups, and chit funds and/or took advance payment from employers. For these women, money saved in the group formed the most important source of credit in times of need. The maximum credit limit for a member being ₹ 10,000, it usually met the credit needs of the respondents. The women felt confident and secure with their earnings from the different sources, as well as with the possibility of borrowing from the group.

“Even if we are short of money we can always use the money saved in the group.”

(home-based FSW, member, Bellary)



Other sources of credit included – other women, neighbours and permanent partners. These sources also protected them from having to agree to unpaid sex during times of default. The respondents refused unprotected sex for money, even in times of urgent need. Savings in the group and neighbours emerged as the most favoured and depended upon sources during emergencies. Respondents did not borrow from private moneylenders due to the exorbitant interest rates charged.

Borrowing from clients evoked mixed responses from the group. Some have borrowed money from clients when the requirement exceeded ₹ 10, 000, while others rejected clients as a source of credit. The possibility of having to agree to the unreasonable demands of the client was a deterrent to borrowing from clients. Respondents would rather pay penalty for default on loan than resort to unpaid sex.

“We will pay penal interest but not free sex.”

(street-based FSW, member, Bellary)

The women reported that they had control over their earnings and made their own decisions on how the money would be used.

Alternate sources of income and credit had enabled these women to refuse unprotected sex. Among the various sources, savings in the group emerged as a key source that served two purposes: (a) reduced their dependency on local private financiers, thereby helping them move out of the permanent debt trap (b) provided them with the confidence to refuse unprotected sex even in emergencies. A significant measure, as it directly cuts down the vulnerability of women to unprotected sex for money.

Though non-members also reported positive influences from the institutional presence, clients and private moneylenders continued to be a source of credit for them, during emergencies. While home-based non-member sex workers did not borrow from clients unless all other options were closed, street based non-members reported borrowing from clients and private moneylenders during emergencies.

“We can borrow from our clients but then we will have to listen to everything that they say including sex without condoms and free sex. So we only borrow from them when we are in dire need of money.”

(home-based FSW, non-member, Bellary)

Chit funds emerged as the most desired source of credit, as its credit limit was ₹ 20,000 and it could be availed of easily by satisfying a minimum set of requirements.

Sex work was the main source of livelihood for street-based non-member sex workers. Only recently have they started learning skills for alternate sources of income.

With regard to unpaid sex and unprotected sex for money, the respondents reported a marked difference in the situation over the years.

“We would have gone two years back but not now. In those days even getting ₹ 100 was difficult but now ₹ 1000 is no problem.”

“Five years back we were forced to give free sex to police and auto drivers. But now all that has stopped and we have them in our control.”

(street-based FSWs, non-member, Bellary)

Intervention from NGO (MYRADA) was credited for improvement in the situation of the FSWs to a large extent.

“After MYRADA came here, there has been more cooperation between community members and we are ready to help each other. Those days we used to poach clients not anymore.”

(street-based FSW, non-member, Bellary)

In addition, increased cooperation between the community members and willingness to help each other, as well as, increased demand and rates for their services were the key factors that have helped reduce their vulnerability to unprotected and unpaid sex.

In Bellary, membership in a group did appear to reduce the dependence of FSWs on exploitative sources of credit. While members of the group no longer depend on private moneylenders and clients for credit, non-members continued to depend on them as sources of credit during emergencies.

### Self-esteem

Mixed responses emerge on the question of self-esteem, in Bellary, based on an additional classification among FSWs: Devadasi and non-Devadasi.

Overall, non-Devadasi FSWs reported that they would not disclose their identity as sex workers despite their families and neighbours knowing about it. Fear of discrimination and stigmatisation by the wider community was the main deterrent. This was not the case with Devadasis, since their identity has socio-cultural acceptance.

“We are not comfortable about openly telling others that I am a sex worker. Other people will then point a finger at us and call us sex workers.”

(home-based FSW, member, Bellary)

The respondents neither expressed guilt nor perceived themselves as immoral on account of being a sex worker. They reported convincing others about sex work being a profession like any other in times of trouble. While some respondents rationalised that sex work helped them take care of their families, others did not feel the need to rationalise it.

“Our parents decided we should be in this profession. Now there is no point in feeling bad about ourselves and nothing is going to change.”

(street-based FSW, non-member, Bellary)

“We don’t feel bad because we are doing it to make a living.”

(home-based FSW, non-member, Bellary)

Responses from street-based, non-member sex workers in Bellary were different from those of other groups. They said they would describe themselves as sex workers. The group had both Devadasis and non-Devadasis. However, their sense of disappointment and desire for better life were very evident. The Devadasi women were comparatively more comfortable with their self, identity and life.

“We will say we are Devadasis and we are sex workers”

(street-based FSW, Devadasi, non-member, Bellary)

All FSWs strongly disapproved any abuse against them. They asserted their right to live a life of their choice by selling their body and disagreed with the argument that they were involved in an unacceptable profession. They were forceful in refuting claims that people had the right to abuse them. They also reported strong resistance to such attempts.

“Good or bad, they are not going to help us in our times of need.”

(home-based FSW, non-member, Bellary)

“It is our life and our decision.”

(street-based FSW, member, Bellary)

FSWs, both members and non-members, believed in their right to say no to unprotected sex. They considered good health an asset for their profession.

“Our health is our confidence because our profession depends on our health.”

(home-based FSW, member, Bellary)

FSWs reported using the space of the group to discuss and overcome feelings of dejection. They share about unpleasant experiences with clients or discrimination from strangers, with each other and discuss ways to deal with them.

“We have a support network of our community members and we will share our problems and sadness with them.”

(street-based FSW, member, Bellary)

With the exception of Devadasis, majority of the respondents refused to reveal their sex worker identity despite their family being aware of it. They feared stigmatisation and discrimination from the wider community. However, both members and non-members reported not feeling guilty or considering themselves immoral on account of their being sex workers and asserted their right to practice sex work for a living.

### **Presence of violence and fear**

In Bellary, except for home-based member sex workers, all the other respondents reported facing violence from clients and fearing violence. However, all the sex workers, irrespective of their typology and membership status expressed confidence in dealing with situations of violence. They reported seeking help from MYRADA. Further, member sex workers cited the group as their support system.

For home-based sex workers, who were members in the group, several factors affected their experience of violence. For Devadasis the presence of family members at home deterred clients from being violent. Interventions from neighbours in the event of violence from clients, only servicing familiar clients and clients who seek them out instead of soliciting clients were all listed as factors that protected them from violence. In case the women practiced sex work outside their home, their friends would be informed well in advance about the location, so that they had a group

looking out for them when they went out to do sex work. In case of any unwarranted situations, the group would know where they went and if the sex worker called for help, they could immediately take steps to help her.

“If we have gone out then we would have informed our friends and we will be in contact.”

“If there are loud voices our neighbours will come to our help.”

(home-based FSWs, member, Bellary)

Other respondents (home-based non-members and street-based members and non-members) reported facing violence and that drunk and new client posed the maximum threat. However, they expressed confidence in dealing with it. Multiple factors contributed to this confidence: support from MYRADA, sex workers' group and police. In addition, they refused to entertain a violent client more than once and said that they had the ability to make a violent client calm down. The clients' fear of intervention from MYRADA acted as a deterrent.

“If convincing them doesn't work we tell them about MYRADA.”

(home-based FSW, non-member, Bellary)

FSWs reported reduction in the incidence of violence against them after they joined the group. They expressed an increase in their self-confidence.

“We have faced problems before we joined the group but not anymore.”

(street-based FSW, member, Bellary)

Respondents expressed an improvement in the situation within the last two years. Not only did they experience less violence, they felt better equipped to deal with situations of violence. Their ability to calm the clients, presence of MYRADA and their access to mobile phones that facilitated immediate communication, were listed as factors contributing to this change.

“Two years back we used to be scared but now all of us have phones and we can communicate immediately.”

“Two years back we faced a lot of problems of violence....we could not do anything about it. But after MYRADA has come here we feel confident of facing and overcoming it. Now we have got information and support from MYRADA.”

(street-based FSWs, non-member, Bellary)

Female sex workers from both typologies and membership status reported a reduction in instances of violence and a significant change in their ability to deal with it as and when faced with it. Increased confidence, presence of MYRADA and the group and a smarter choice of clients were factors that aided this change.

#### **IV. e. Membership in a group and usage of clinical services**

According to the IBBA a significantly higher proportion of members (95 percent) than non-members (77 percent) had ever visited the NGO sexual health/STI clinic. Of the FSWs visiting STI clinics, while 76 percent among members received a grey pack, among non-members a lower proportion (59 percent) received the grey pack.

In multivariate analysis, after adjusting for confounding variables, it was found that members were four times more likely than non-members to visit the NGO sexual health/STI clinic (adjusted OR: 4.6, 95 percent CI: 1.97-10.64,  $p < 0.05$ ). The odds of having visited an NGO sexual health/STI clinic were found to be the same among members and non-members.

### Accessibility and availability

Majority FSWs were satisfied with the availability and accessibility of clinical services. They regularly visited the clinic.

However, with the exception of street-based member sex workers, all FSW wanted the clinic to be nearer so they would not lose time travelling to clinic and miss servicing clients.

Both members and non-members have requested MYRADA to move the clinic closer but there has not been any action on this so far.

“We have told MYRADA about it but nothing has been done about it. Here they are only concerned about STI care. They do not treat us for any other ailment.”

(home-based FSW, non-member, Bellary)

Hence, while both members and non-members were satisfied with the availability and accessibility of the clinic, most respondents wish that the clinic would move closer to them. However, distance to the clinic did not emerge as a barrier to accessing it.

### Knowledge of STI

All respondents are well aware of STI and reported accessing the clinic for STI treatment. Respondents reported that they no longer resorted to native treatments for STI.

Respondents refuse sex with clients who have an STI, or used a condom or deferred sex until after treatment. A few were not willing to have sex with an STI infected client even with a condom and offered sexual services only after treatment.

“We may have problems if our skins touch.”

(home-based FSW, member, Bellary)

The respondents reported having noticed symptoms in lovers and clients and then accompanying them for partner treatment.

“I took my lover who had those symptoms to the clinic for treatment.”

(street-based FSW, member, Bellary)

The respondents expressed better awareness about STI now, than two years ago. They reported no longer engaging in unprotected sex with someone who has STI.

“Two years back we would have had sex but not now.”

(street-based FSW, non-member, Bellary)



All participants were aware that having unprotected sex with an STI infected person increased the risk of HIV transmission. They were also aware that consistent use of condom prevented STI.

In summary, membership in a group did not have a differential impact on the knowledge of STI among sex workers. Both members and non-members displayed good knowledge about the symptoms of STI, its treatment and the importance of protected sex in preventing the spread of infection. Encouragingly, non-member sex workers in Bellary showed an increased awareness due to the presence of the NGO.

### Economic dependence

Majority respondents prioritised a clinic visit over servicing a client. In addition to the concern for good health, increased demand for sex work was also a factor that influenced their choice in favour of clinic visit.

“We can entertain 10 more clients if we are healthy.”

(street-based FSW, member, Bellary)

The respondents were confident that their clients would not leave, if asked to wait until clinic visits. Alternatively, if they were sure about losing the client, they would change their appointment at the clinic so as to be able to service the client. The respondents reported that they make best attempts to accommodate the client.

“If the doctor is going to be there till the evening we will go with the client and if the client says he wants to spend a lot of time with me I will leave him and go to the clinic.”

(home-based FSW, member, Bellary)

“We will go to the clinic and tell them that we will come later and go with the client.”

(home-based FSW, non-member, Bellary)

In summary, member and non-member response to the choice between a clinic visit and client did not differ. Most of the respondents from both the groups reported prioritising clinic visit over servicing a client.

### Self-esteem and stigma

Non-members, especially among home-based sex workers, feared stigmatisation and discrimination if their sex worker identity were to be revealed to the wider community.

However, members did not report fears of stigmatisation or discrimination. They derived confidence from the fact that their family and neighbours were already aware of their line of work, they had good relationships with their neighbours and they were willing to admit to their identity if exposed. They reported that neighbours no longer ill-treated them, or spoke ill of them.

“We have confronted them and so they have stopped it now.”

“We will own up if they come to know but won’t voluntarily go to them and say that we are sex workers.”

(street-based FSWs, member, Bellary)

However, non-Devadasi sex workers reported a higher level of stigma compared to Devadasis, whose family and neighbours knew about their profession. For some, while the husbands knew about them being in sex work, neighbours did not.

“We counsel them also to come for a check-up”

(home-based FSW, non-member, Devadasi, Bellary)

Fear of their sex worker identity being discovered by family and the wider community prevailed among non-Devadasi, non-member sex workers. These women feared abuse and visited the clinic under the pretext of some other reason.

“Since I sell flowers I will tell them I am going to buy flowers and then will visit the clinic.”

(home-based FSW, non-member, non-Devadasi, Bellary)

The respondents reported a positive change in the attitude of neighbours and relationships with them after the groups were formed.

“Before these groups were formed they used to talk about us but not anymore. If there is a problem all the group members go there and solve the problem.”

(street-based FSW, member, Bellary)

Non-members, though they still faced some forms of discrimination, such as being ‘badly spoken about’ and landlords being instigated against them, reported a marked difference from before the formation of sex worker groups. Also, since their families and neighbours were aware of their profession, they did not need to keep their clinic visits confidential.

“Two years back they used to discriminate against us but now they know we have our own organisation and don’t harass us anymore.”

(street-based FSW, non-member, Bellary)

Most respondents reported a decrease in instances of harassment, abuse and discrimination after the group was formed. They also reported improved relationships with neighbours on account of their improved economic situation.

“Now we have money and everyone comes to us.”

(street-based FSW, non-member, Bellary)

There has thus been a marginal influence of membership in a group in the ability of FSWs to deal with stigmatisation and discrimination. Both Devadasis and street-based member sex workers reported a decrease in stigmatisation and discrimination and an improvement in relationships with neighbours after the groups were formed. The Devadasis also reported counselling the neighbours for STI care. On the other hand, non-members continued to face discrimination in the form of taunts and threats of eviction from their homes.

However, both members and non-members reported a significant change in their relationship with families and neighbours after the formation of groups. There was an increased acceptance

of sex work as a profession and a decrease in harassment, abuse and discrimination due to the influence of the group. Sex workers also attributed improved relationships with neighbours to their enhanced economic condition where others were now approaching them for financial support in times of need.

### Experience at the clinic

In Bellary, sex workers from both typologies and membership status reported positive experiences at the government clinic. They either visited the clinic alone, or in a group, or with a peer. The respondents did not report any discriminatory treatment.

Positive attitude of and respectful treatment by the clinic staff and good quality treatment provided to them, despite their identity as sex workers, contributed to their positive experience at the government clinic. They accessed treatment for infections and were satisfied with its success when they received positive health reports. In addition, they were provided with health related information and the clinic responded to and clarified any doubts they had. They also received condoms from the clinic.

“We can get our infections treated there if any.”

(home-based FSW, member, Bellary)

“They don’t treat us differently because we are sex workers.”

(street-based FSW, non-member, Bellary)

Respondents were confident about solving any problems they may face at the government clinic and credited the intervention from NGO (MYRADA) for improvement in services provided at the clinic.

“If there is a problem in the government hospital we have the confidence that we will take our madam and go there and correct the situation.”

“They didn’t treat us well before MYRADA came here. We were also not very serious about our clinic visits but all that has changed in the last two years.”

(street-based FSWs, non-member, Bellary)

In summary, membership in a group did not differentially impact the FSWs’ experiences at the clinic. Both members and non-members reported positive staff attitudes, an open environment to discuss their problems and satisfaction of knowing about their health status, as incentives for clinic visits.

### V. a. Introduction<sup>12</sup>

Bangalore Urban is the largest district in the state of Karnataka and has a population of 65.3 lakh. As per the 2001 Census of India, the district has 19 towns, 668 villages and is divided into 16 administrative zones. The district had a sex ratio of 978 females per 1000 males in 2001 and 88 percent of the population lived in cities/towns and the remaining 12 percent in villages. The literacy rate was 83 percent with the proportion of literate being substantially higher among males than females (88 percent compared with 77 percent). The district is a hub for information technology, biotechnology, aerospace, floriculture and key knowledge based industries<sup>13</sup>. The network of public health services in the district includes 8 community health centres (CHCs), 75 primary health centres (PHCs), and 285 sub-centres.

For HIV related services, in 2009, there were 61 integrated counselling and testing centres (ICTCs), 50 prevention of parent to child transmission (PPTCT) centres, 74 government-recognised blood banks and 5 clinics for sexually transmitted diseases (STD) in the district. There are 6 community care centres (CCCs), 5 anti-retroviral therapy (ART) centres, 1 drop-in centre (DIC) for people living with HIV (PLHIV) and 1 network of PLHIV.

There are two sets of data related to high-risk groups in Bangalore Urban- one relates to the distribution of FSW in different zones in the district (2002) and one related to coverage of TI (2009). The data set from 2002, estimated that among high-risk groups, the total number of FSWs in the district was 19,002, with 5.48 FSWs per 1000 adult urban populations. Two-thirds of the estimated FSWs are in 4 of the 7 zones: zone 5 (21 percent), zone 2 (19 percent), zone 4 (15 percent) and zone 6 (14 percent). Most of the FSWs are home-based (48 percent), 34 percent are either widowed, divorced, separated or deserted, 30 percent are high-volume, entertaining 10+ clients a week, 27 percent are under age 25 years, 45 percent are illiterate and 25 percent are new to sex work with less than 2 years since they started sex work. HIV prevalence is moderate among the FSWs at 8.02 percent (FSWs, IBBA, 2009).

The data set from 2009 indicates that there were an estimated 21,621 FSWs in the district, of which 19,222 (89 percent) were covered by the TI<sup>14</sup>. An average of 14,399 FSWs had been contacted in a month, which is 75 percent of the FSWs covered by the TIs in the district. In 2009, the reported condom use during last sex with occasional clients (84 percent), regular clients (75 percent), lovers (66 percent) and husbands (50 percent). There has been no change since 2005

<sup>12</sup> From India Health Action Trust, 'HIV/AIDS Situation and Response in Bangalore Urban district: Epidemiological Appraisal Using Data Triangulation', July 2010.

<sup>13</sup> Bangalore Urban District Profile - [http://pppinindia.com/pdf/karnataka/District\\_percent20Profiles/Bangalore\\_percent20Urban.pdf](http://pppinindia.com/pdf/karnataka/District_percent20Profiles/Bangalore_percent20Urban.pdf)

<sup>14</sup> KSAPS as well as KHPT's Sankalp project funded by Avahan are supporting the targeted interventions (TI) in the district. The Sankalp project is implemented by Pragati among the FSWs in select zones (1, 3, 4 and 6) and by Sangama among the MSM-T. The targeted interventions for FSW supported by KSAPS are implemented by Bhoruka Charitable trust (BCT), Jyoti Mahila Sangha, Society for People Action for Development (SPAD), Swathi Mahila Sangha, and Vijaya Mahila Sangha.

in the percentage of FSWs reporting condom use during last sex with occasional clients, regular clients, lovers, and husbands, as well as, during the last sexual intercourse (PBS, 2006-2009). An average of 3,303 FSWs received STI consultation in a month, which is about 17 percent of the FSWs covered by the TIs in the district. 24 percent of the FSWs received STI consultation in a month in the KHPT-supported TIs.

## **V. b. Institutional design**

Female sex workers in the district are organised under a CBO Swathi Mahila Sangha (SMS) established in the year 2003. The CBO works in four zones of Bangalore Urban, with the vision of achieving overall empowerment of women in sex work and by 2010 had a membership of 6900 FSWs.

Proportional representatives from the four zones are elected to the zonal committee and currently there are 62 members in this committee. A zonal board comprising a President, a Vice President, a Secretary and a Treasurer are elected from this committee. From the zonal committees representatives are elected to the SMS Central Level Board, which has a total of 15 members. The board has a President, a Vice President, a Secretary and a Treasurer. Two vulnerable FSWs (HIV+, homeless and poor), from each of the four zones are selected to represent at the SMS Central Level Board. This is a built-in mechanism to ensure that the voices and concerns of the most vulnerable from the community are heard in the CBO. The roles and responsibilities for each of the board members at the zonal and central levels are very clearly defined. Elections to the committees are held every two years. The Annual General Body Meeting is held once a year and is attended by all the SMS members.

The CBO organises bi-monthly events, which are attended by the FSWs in each of the zones. The FSWs who attend these meetings are formed into small groups and are asked to express the needs they expect the CBO to address. These are further communicated to the zonal and district level committees, which take a decision on the provision of these needs and the mode of implementation.

The SMS has two programme focus areas – sexual health, including reproductive health, and empowerment. Under the empowerment programme, SMS focuses on social entitlements, credit and savings cooperative for the members of SMS, action against violence and legal empowerment and education.

The credit and savings cooperative, Swathi Jyothi Mahila Vividdodesha Souharda Sahakari Niyamita was registered in December 2007 under the Karnataka Souharda Sahakari Act of 1987. The cooperative is formed under the CBO Swathi Mahila Sangha. Membership in the CBO is a compulsory criterion for membership in the cooperative. Out of the total number of FSWs in Bangalore Urban, 23 percent are members of the cooperative. Intervention among sex workers is ongoing in four zones of Bangalore – zone one, three, four and six.

The cooperative has a two-tier structure with zonal level groups and a board with representation from each zone. There is a zonal manager who is a staff of the NGO Swasthi and field coordinator - a community member - for each zone. They are responsible for the day-to-day functioning of the zonal level activities. Two members from each zone are elected to the board and are entrusted with the responsibility of the zone that they represent. The board comprises of nine members and the President and Vice President are elected from among them. The President has the overall responsibility of all the four zones. From among the member sex workers, those who have carried out a transaction of ₹ 1000, or made an interest payment of ₹ 500 in the previous two years constitute the general body. There is a board meeting on the last Saturday and a monthly review meeting on the first Monday of every month. The general body meets once a year.



The cooperative society offers two savings services to its members – Swathi RD, a recurring deposit scheme and Swathi Sarala, a savings account facility. There are modalities to be fulfilled for members to access these services. While the savings account permits a sex worker to deposit and withdraw money on the same day, from the recurring deposit, withdrawal is permitted only after a period of six months. The minimum size of the deposit is ₹ 10 in the savings account and ₹ 50 in the recurring deposit account. Interest is paid on both the accounts.

In addition to the administrative requirements the members, have to form a Common Interest Group (CIG) to avail any of the credit services. A CIG is a three-member group, formation of which is a necessary condition for any member to avail of a loan. The life span of a CIG is from the day of availing the loan to the day of its closure by a member. Any three members who know each other can form the group. The group has to save for three months before the members can apply for a loan. All the three members can apply for a loan at the same time. Depending on the savings in both the accounts of the member and the repayment capacity of the group, loans are granted or denied. This also serves as a monitoring mechanism whereby the members ensure each other's diligence in loan repayment.

## **V. c. Member and non-member profile**

### **Socio-demographic characteristics**

Table 11 (see Annex) summarises the socio-demographic characteristics of the member and non-member population in Bangalore Urban. Majority of the FSWs (28 percent) were under the age of 25. This was also true for non-members. However, the proportion of young sex workers, below the age of 25, was significantly lower among members (12.5 percent) than non-members (28 percent). The proportion of literates was higher among members than non-members. The majority of the FSWs were local (residents) and not migrants. A large proportion of the total sample of FSWs was currently married, separated/divorced or widowed. However, non-members had fewer currently married FSWs than members. A higher proportion of members than non-members (70 percent versus 61 percent) were cohabiting with a regular partner (husband, boyfriend or lover). Majority of both members and non-members had sources of income outside of sex work. The age of sexual debut was bit lower among non-members, with 39 percent being under 15 years of age during their first sexual encounter, compared to 30 percent of members.

### **History, pattern and environment of sex work**

As shown in Table 12 (Annex), majority FSWs were likely to solicit and entertain clients in public places (parks, streets, markets, etc.) than in their homes or in brothels. This was true for both members and non-members. However, a higher proportion of non-members than members (61 percent versus 52 percent) entertained clients in public places. Also, 12 percent of the members as opposed to 6 percent among non-members were brothel-based FSWs. A significantly higher proportion of members than non-members (43 percent versus 30 percent) had been in sex work for 10 years and more. The proportion of new sex workers (less than one year) among members (9 percent) was much lower compared to non-members (15 percent). Majority non-members had a weekly client volume of 10 and more, while among members most of them entertained 5 to 9 clients in a week. The proportion of FSWs with a weekly client volume of less than 5 clients was higher among members than non-members (32 percent versus 26 percent). About 72 percent of the members serviced more than 5 new clients in a week as opposed to 64 percent of the non-members. An almost equal proportion of both members and non-members received more than ₹ 100 per client and had a monthly income of ₹ 1500 and more.

## Exposure to programme according to membership in a group

Overall, exposure to programme interventions was much higher for members than non-members (Table 13, Annex). A significantly higher proportion of members than non-members were ever contacted by a peer (97 percent and 83 percent, respectively) and had ever witnessed a condom demonstration (90 percent versus 71 percent). There were significant differences between members and non-members with respect to ever having visited a drop-in centre (82 percent and 65 percent of members and non-members, respectively).

Multivariate analyses were carried out to measure exposure to intervention. Members were more than 6 times and 2 times more likely to have been contacted by a peer and to have visited a DIC, respectively, than non-members (adjusted ORs: 6.43 & 2.53, 95 percent CI: 1.95-21.21 & 1.44-4.47, both  $p < 0.05$ ). Likewise, they were more likely to have received a condom demonstration than non-members (adjusted OR: 3.47, 95 percent CI: 1.92-6.28,  $p < 0.05$ ).

## V. d. Membership in a group and condom use

Table 14 (Annex) shows the influence of membership in a group on condom use. The proportion of FSWs who reported unprotected sex was higher among members than non-members (26 percent versus 21 percent). A significantly higher proportion of members (92 percent) than non-members (83.4 percent) used condom with the last client and always used condom with the occasional client (83 percent members and 76 percent non-members, respectively). Almost similar proportion of members as compared to non-members reported condom use during last sex with a repeat client (82 percent and 84.3 percent respectively). Condom use with a repeat client was lower among members (74 percent) than non-members (80 percent). A slightly higher proportion of members than non-members (25 percent versus 22 percent) reported using condom during last sex with partner and an equal proportion of both members and non-members (15 percent) always used condom with their partner.

Prevalence of HIV and syphilis was equal among both members and non-members. Proportion of FSWs who had chlamydia only and those who had chlamydia and/or gonorrhea was lower among members as compared to non-members (9 percent and 13 percent and 10 percent and 14 percent, respectively).

Multivariate analyses were carried out looking at membership in a group and condom use. Members were 3 times more likely to have used condoms with their last client as compared to a non-member (adjusted OR: 3, 95 percent CI 1.38-6.57,  $p < 0.05$ ). Likewise, it was more likely for members to always use a condom with occasional clients (adjusted OR: 1.65, 95 percent CI 0.99-2.75,  $p = 0.05$ ).

## Availability and accessibility

Majority of the respondents expressed satisfaction with the current availability and accessibility of condoms. They accessed condoms at the drop-in-centre of the NGO (Swathi Mane), and from peers, outlet boxes and medical shops.

Respondents said that they were willing to buy condoms if they were not available for free. However, most of them expressed their unwillingness to buy it in person. The fear of being exposed as a sex worker, being ill spoken of and the associated embarrassment were reported as reasons that prevented them from purchasing condoms from shops.

“We don’t feel like going to a shop. The salesmen there look at us strangely when we go to a shop for condoms.”

(home-based FSW, member, Bangalore Urban)

“It is OK if the client brings it but bringing it ourselves may lead to a loss of respect.”

(home-based FSWs, non-member, Bangalore Urban)

They also considered buying condoms as unnecessary since they receive sufficient condoms through existing sources.

“I have not gone because I am shy. Moreover we get enough condoms in outlet boxes and so there is no need to buy.”

(street-based FSW, member, Bangalore Urban)

Few respondents said they were willing to buy condoms from the shop in person. Importance of good health and the presence of female salespersons were listed as factors that aided their confidence in buying condoms from the shops.

“It is better than getting infected and seeing the doctor.”

(home-based FSW, members, Bangalore Urban)

Requests for better accessibility, better quality and different types of condoms and more condom boxes were made by a minority of non-members.

“Sometimes we have to go some distance to get condoms from an outlet box.”

(home-based FSW, non-member, Bangalore Urban)

“There should be more condom boxes in the toilets, where we have privacy.”

(street-based FSW, non-member, Bangalore Urban)

Both members of a group and non-members were satisfied with the existing availability and accessibility of condoms. They expressed readiness to spend money to buy condoms in the absence of availability of free condoms. However, irrespective of membership status, majority of them expressed their unwillingness to buy condoms from the medical shops in person.

## Knowledge and awareness

The respondents, both members of a group and non-members, displayed good awareness about the importance of safe sex and knowledge about the adverse effects of unprotected sex.

“We are doing this to overcome our problems and if we don’t use a condom and fall ill all our efforts will be wasted.”

(street-based FSW, member, Bangalore Urban)

FSWs received information about condoms from the drop-in-centre and field workers. However, this failed to ensure protected sexual intercourse with their various sexual partners, including clients.

Majority of the respondents expressed inability to use condoms with their spouses, lovers, or permanent partners. Believing that protected sex is a mistake, trusting their husband and fear of conflicts in the relationship were the reasons that prevented them from practicing safe sex with their intimate sexual partners.

“There are chances a family may break up if we insist our husband wear a condom during sex.”  
(home-based FSW, non-members, Bangalore Urban)

“It is a mistake to use condoms with our husband. If we use a condom with our husband we won’t have children.”  
(street-based FSW, member, Bangalore Urban)

With lovers and partners, intimacy in the relationship did not permit insistence on safe sex. Fear of desertion by the partner if condom use was insisted upon, also emerged as a deterrent.

“We would have chosen our lover and after some time he would have become very close to us and so we cannot force him to wear a condom.”  
(home-based FSW, member Bangalore Urban)

“We have sex with our permanent partner without a condom. We have doubts about him but he will leave us if we confront him about it.”  
(street-based FSW, non-member, Bangalore Urban)

However, unprotected sex for money was reported only by street-based non-member sex workers.

“We succumb to clients who pay more money for sex without condoms.”  
(street-based FSW, non-member, Bangalore Urban)

Some respondents did report using condoms with their husbands since they wanted to protect themselves against infections. Husband’s willingness to use a condom and FSWs’ insistence on safe sex promoted condom use with husbands.

“Husbands also go to other women and so they voluntarily use condoms so as to not hurt our health.”  
(home-based FSW, members, Bangalore Urban)

Majority respondents feared contracting of HIV on account of unprotected sex with the husbands, lovers or partners; sabotage of condoms by clients during sex, including removal of condoms during sex, and breakage of condom during sexual intercourse.

“We go to many clients and there are chances that the condom we use may be defective. That is the reason we are scared of getting HIV.”  
(home-based FSW, non-member, Bangalore Urban)

“Some clients damage the condom on purpose.”  
(street-based FSW, member, Bangalore Urban)

In contrast, those respondents who were also members of Swathi Jyothi, in addition to being members of Swathi Mahila Sangha, expressed confidence in their good health and did not fear contracting of HIV. Even though this category of respondents reported engaging in unprotected sex with their husbands, lovers and partners, they were confident that they would not contract HIV. This confidence was attributed to their trust in their husbands and consistent use of condoms with their clients.

“My husband won’t go to any other woman.”

“If there is a doubt that the condom may have broken we immediately come here and have a check-up.”

(street-based FSW, members, Bangalore Urban)

In summary, membership in a group did not influence use of condoms by FSW. All participants were well aware of the need to wear condoms with each sexual partner, in every sexual encounter, to safeguard their health. Respondents listed the need to protect themselves from HIV and STI, to lead a healthy life and to take care of their families as reasons why condoms should be used consistently.

However, majority respondents cited inability to negotiate condom use with their husbands and in other intimate relationships. The women feared that insistence on using condoms with the husbands would be perceived as a sign of mistrust and infidelity. For the FSWs, this could lead to desertion and breakdown of their marriage.

Although participants were well informed about the need to use condoms with every client, barriers to safe sex with clients existed among both members and non-members. These included sex with multiple clients at a time, sabotage of condoms by clients during sex and compulsion to earn more money. However, only non-members agreed to unprotected sex with clients for money.

Majority of the respondents feared being susceptible to HIV, due to unprotected sex with various sexual partners, breakage of poor quality condoms, and sabotage of condom by clients during sexual act.

## Ability to negotiate

### **Forced sex**

In Bangalore Urban, home-based and street-based sex workers who were members of the group said that the presence of Swathi Nyaya Sanjeevani, increased their confidence in dealing with situations of forced sex. Despite this, more often than not, they found it difficult to protect themselves from forced sex.

Home-based members, found it particularly difficult to refuse forced sex in situations of multiple clients and with new clients. Practicing sex work without the knowledge of the family and the larger community increased their vulnerability to succumb to forced unprotected sex. Dealing with situations of forced sex was also difficult because either clients threatened to inform their family, or the landowner who in turn could evict them, or wrongful accusations by clients to the police or because they feared clients would taunt their children.

“We stay in rented houses and they threaten to inform our landowner. If that happens we will be on the road in no time.”

(home-based FSW, member, Bangalore Urban)

“Clients forcibly make us drink alcohol and then manage to have sex with us without condoms. It is difficult to insist at that moment as we fear for our life. If we insist they are also ready to hit us.”

(home-based FSW, member, Bangalore Urban)

Street-based members could not protect themselves in situations of forced sex if they practiced sex work outdoors, or in a location of client’s choice or when there were multiple clients at a time.



“Some of them go to a room and then call their friends and we are forced to have sex with all of them.”

(street-based FSW, member, Bangalore Urban)

Non-members, both home-based and street-based, suggested that they lacked confidence in dealing with situations of forced sex. Negotiating forced unprotected sex became particularly difficult with drunken clients or when a client called in other men once he was in the room with the sex worker. Being compelled to yield to the demands of the client under the threat of their sex worker identity being exposed was also common. For street-based non-members, negotiating forced unprotected sex was difficult when it was outside their place of choice.

“We are scared to talk too much because we fear for our life.”

(home-based FSW, non-member, Bangalore Urban)

### **Free sex**

In Bangalore Urban, most sex workers reported that they often faced demands for free sex. Comparatively, members dealt better with it than non-members and street-based member sex workers felt more confident to deal with it than home-based members. Majority FSWs said they were unable to deal with such situations. Home-based sex workers were particularly vulnerable, as clients often threatened them with disclosure of their sex worker identity to the family and the larger community.

Demands for free sex included: being forced into free sex through blackmail; clients refusing to pay for services before sex; being duped by the clients by delaying payment for sex for another day; and demand for free sex in exchange for credit. Some respondents said they were duped into free sex through sentimentality. They also reported being forced into free sex with multiple men.

“There are situations where we have sex with one person and when we ask for our money they will invite one more person and tell us we will get our money if we have sex with the other person. We are blackmailed if we insist on the payment.”

(home-based FSW, member, Bangalore Urban)

In addition to not being paid for sex, respondents shared their experiences of being robbed of clothes, money and mobile phones. They reported desertion by the clients when the police arrived. Not being paid for their service was cited to be more frequent with clients who were drunk. Home-based FSWs did not seem to have found any effective way to deal with such situations. Most of them thought about it as a wasted effort or a mistake and said they would not entertain that client again.

“We will ask him but if he refuses to pay us we cannot do anything.”

(home-based FSW, non-member, Bangalore Urban)

Street-based members reported that they dealt effectively with such situations by taking the money beforehand and negotiating a rate favorable to them for the services offered. Only few of them reported being duped into free sex.

“We first take money and sex later.”

(street-based FSW, member, Bangalore Urban)

In contrast, most street-based non-members reported being unable to deal with situations of free sex. Interestingly, some non-members reported having fought for their money with the clients, drawing upon the support of Swathi Mane.

“We are helpless.”

(street-based FSW, non-member, Bangalore Urban)

In summary, sex workers from Bangalore Urban, while acknowledging the role of Swathi Nyaya Sanjeevani in boosting their confidence reported an inability to deal with situations of forced sex or demands for free sex. Home-based sex workers were vulnerable to blackmail and street-based sex workers, were more vulnerable when servicing outside their usual area of practice or in a location of client’s choice. For all of them, negotiating forced unprotected sex with drunken clients and a group of men was difficult.

### Economic dependence

Bangalore Urban had two groups of members – sex workers with membership in only Swathi Mahila Sangha and others, who were also part of Swathi Jyothi. Initially, only those who were members of Swathi Mahila Sangha could avail of the credit and savings facilities in Swathi Jyothi. However, at the time of the study, it was found that a sex worker could avail of the facilities irrespective of her membership status. Hence, the study also came across non-members who were saving in Swathi Jyothi.

For all the respondents, sex work was the main source of livelihood.

“We do other jobs as a front for sex work. We get more money from sex work.”

(home-based FSW, member, Bangalore Urban)

Income from sex work was supplemented with the income from other sources of livelihood. Most times, the income was reported to be insufficient to meet their needs. When in need, the FSWs borrowed from multiple sources – Swathi Jyothi, private financiers/moneylenders, employers, neighbours, and against pawning of jewelry. Taking on more clients/ more sex work was also cited as a source of immediate extra income. Borrowing from clients was reported as rare.

Respondents, who were also members of Swathi Jyothi, did not cite private moneylenders as a source for money. They had also stopped borrowing from chit funds, calling them exploitative.

“In chit funds the interest is more and if we do not pay on time they will abuse us.”

(home-based FSW, member, Bangalore Urban)

Members of Swathi Jyothi also avoided borrowing from clients to prevent possible abuse. The money that the client was willing to loan was not always sufficient to meet their need.

“They will torture us if we take a loan from them. They will start calling us on phone at all times.”

(street based FSW, members, Bangalore Urban)

However, FSWs also stated that they found it difficult to repay their loans on time and often resorted to taking on more sex work or providing sex for free as repayment for loans. Some members also reported that the facility to borrow from Swathi Jyothi helped them refuse demands for unprotected and unpaid sex.

“...we have created fresh problems for us trying to repay the money on time. We take a loan in Swathi Jyothi and repay the loan outside.”

(home-based FSW, member, Bangalore Urban)

More non-members than members depended on exploitative sources of credit such as private moneylenders, clients and chit funds. Also, non-members reported engaging in unprotected sex for money while members depended on Swathi Jyothi and refused unprotected sex. Non-members have also had to provide free sex in lieu of unreturned money.

“...money problem at home...when we have enough money we have refused to have sex with a client who is refusing to wear a condom”.

(home-based FSW, non-member, Bangalore Urban)

“We succumb to clients who pay more money for sex without condoms.”

(street-based FSW, non-member, Bangalore Urban)

However, non-members who availed of the facilities of the savings and credit cooperative had stopped borrowing from clients and moneylenders.

Majority of the respondents had control over the income they earned. They did not feel secure handing over their incomes to spouses or lovers or partners who would not prioritise the needs of the family and instead spend the money on themselves. The FSWs made their own decisions regarding utilisation of their income.

“If we give the money to our husband or partner, they will spend it on liquor and my children and I will have to go to bed hungry.”

(home-based FSW, non-member, Bangalore Urban)

In summary, membership in a group had reduced the economic vulnerability of the sex workers. For majority of the FSWs, although sex work was the main source of income, it was supplemented by other sources to meet their needs. Alternate livelihood sources mostly included agriculture and non-agricultural labor. Even small entrepreneurial activities, such as vegetable and flower vending or dairying, earned them much less in comparison to sex work.

All FSWs depended on multiple sources of credit in times of need. Pawning jewellery or utensils, borrowing from neighbours, friends and employers were common across categories, as sources of borrowing. Moneylenders and chit funds continued to be sources of credit.

However, borrowing from moneylenders and clients was more common among non-members than members. Those non-members who availed the services of the savings and credit cooperative had reduced their dependence on exploitative sources of credit.

## Self-esteem

None of the respondents, regardless of their membership status, were willing to reveal their sex worker identity for a number of reasons: fear of ostracism from family and wider community, fear of being called Sule, adverse effects on their children and threat to accommodation security. Home-based sex workers also feared that clients would seek them out directly at home if they were open about their sex worker identity.

Though few of the respondents expressed dislike for themselves, most FSWs did not feel any guilt, or perceive of themselves as immoral on account of being in this profession. They rationalised the need for them to be in sex workers in order to care for their families and themselves.

“We look after four to five people in our family, so even if I am doing a wrong it is fine.”

(home-based FSW, member, Bangalore Urban)

Further, the fact that they were not practicing sex work for pleasure and that adverse circumstances compelled them into sex work were also cited as rationale for being in the profession. Regarding sex work as just another profession also provided legitimacy to their sex worker identity.

“We are also doing a work like everyone else.”

(street-based FSW, member, Bangalore Urban)

Most respondents, however, shared the sense of dejection and disappointment with their lives. They strongly condemned abuse by anyone, including family, because of their identity as sex workers. When faced with any kind of abuse, they reported instances of abuse to Swathi Nyaya Sanjeevani, or the police.

“Family or not, the problem has to be confronted right in the beginning. Otherwise everyone will start beating and abusing us.”

(street-based FSW, member, Bangalore Urban)

“I ask the police when they abuse me because even they do not have the right to abuse us.”

(street-based FSW, non-member, Bangalore Urban)

They believed they had the right to lead a dignified life and say no to unprotected sex.

In contrast to the members, non-members would not outright refuse unprotected sex. Instead, they would try and convince the clients to wear a condom.

In summary, while most women denied feeling guilty or perceiving themselves as immoral, a deep sense of dejection and disappointment prevailed among all respondents. They strongly refuted others’ right to abuse them because of their sex worker identity. All of them believed they had a right to lead a dignified life despite being sex workers.

While members expressed that they had the right to refuse demands for unprotected sex, non-members did not. Non-members expressed reluctance to refuse demands for unsafe sex. They will try to convince the clients. If he is not convinced, they will agree to sex without condoms.

### Presence of violence and fear

Compared to the other two districts, the brutality and frequency of violence reported was much higher in Bangalore Urban.

A distinguishing feature was the experience of police violence, which the sex workers found very difficult to deal with. They reported being forcibly taken to the police station, beaten, tortured and threatened with arrest and confinement if they resisted the demands of the police.

"I urgently needed money because my children are in a hostel. I asked a male friend for money and he took me to the Majestic area. There a policeman stopped us and accused my friend of forcibly bringing me there. He then forcibly had sex with me and stole my mobile phone. My male friend did not have sex with me. The policeman then forcibly took ₹ 350 from my friend and left both of us with no money."

(home-based FSW, member, Bangalore Urban)

"We are routinely troubled by police. They even take our money."

(street-based FSW, non-member, Bangalore Urban)

However, they reported that police violence has reduced in recent times.

The sex workers also reported fear of violence from a new client, from drunken clients and in multiple client scenarios. The FSW reported both physical and verbal abuse from clients especially when they disagreed to repeated sex and insisted on using a condom. Violence from drunken clients was very common. Respondents faced violence of various kinds such as being forced to remove clothes, use of foul language, being cut with blades and burnt with cigarettes.

"If we don't stay more time with some clients they will hit us."

(street-based FSW, member, Bangalore Urban)

"They expect us to do their bidding since they have paid us money."

(home-based FSW, non-member, Bangalore Urban)

Violence from spouses was only reported by non-members. Husbands reportedly abused them when neighbours talked ill of the FSWs. Most of them expressed their inability to deal with violence and only a few approached Swathi Mane for help.

Members expressed more confidence in dealing with situations of violence than non-members. For street-based sex workers, the ability to deal with violence depended on the place of sex work. They felt confident in a lodge as they could count on the support from staff of the lodge.

Members from both typologies sought the assistance from Swathi Nyaya Sanjeevani, and the support of other community members to deal with situations of violence. They also relied on their ability to convince the clients to stop/prevent the violence. All members have been given a card with a contact number, which they can use anytime (24/7) to seek help when in trouble.

"Before we joined Swathi it was difficult but now we inform SNS and the team comes and solves the problem."

(home-based FSW, members, Bangalore Urban)

Members of the group, from both typologies, were more confident in dealing with situations of violence than non-members. They seem to use the facilities of the legal cell at, Swathi Nyaya Sanjeevani, and the help of other community members to handle crisis situations. A few among the home-based non-members cited seeking help from Swathi Mane. As they were not collectivised, non-members did not have the support of their peers to handle crisis situations.



## V. e. Membership in a group and usage of clinical services

The IBBA analysis showed that approximately 82 percent of the members as compared to 73 percent of the non-members had ever visited the NGO run clinic for sexual health/STI. Of the women visiting the STI clinics, only 50 percent members and 40 percent non-members had ever received a grey pack.

### Accessibility and availability

Majority sex workers were satisfied with the accessibility and availability of clinical services. Street based member sex workers and home and street based non-member sex workers reported that their request for the clinic to be moved closer was heeded to. Referral clinics were set up for those for whom Swathi Mane was too far to visit. Respondents visited the clinic for regular monthly check-ups.

The only exception was home-based member sex workers who expressed the need for the clinic to be closer. They reported that distance to the clinic was a deterrent for some of their peers to access treatment.

“When we try to bring some other community women they do not come because it is far.”

(home-based FSW, member, Bangalore Urban)

Yet other home-based sex workers found the distance to be contributing factor since they could visit it discreetly without the knowledge of their neighbours.

“It is better if it far because otherwise our neighbours will know about our visit.”

(home-based FSW, member, Bangalore Urban)

In short, majority respondents were satisfied with the availability and accessibility of clinical services. Membership in a group did not emerge as a factor that influenced this.

### Knowledge about STI

Majority respondents could list the symptoms of STI correctly and were aware of the importance of safe sex in preventing STI. However, levels of knowledge varied according to typology. Street-based sex workers – both members and non-members – displayed better knowledge compared to home-based sex workers.

Most home-based sex workers could not list the symptoms of STI. They suspected STI when they experienced a sudden change in health. They accessed the NGO clinic or the referral clinic for treatment.

“When there is a sudden change in our health we realize we have a problem and we visit the clinic immediately.”

(home-based FSW, member, Bangalore Urban)

Majority respondents accessed the clinic for treatment. They reported not having noticed any symptoms of STI in clients or other sexual partners. However, most of the participants said they would advise their sexual partners to get treated at the clinic if they noticed STI symptoms. Only a few respondents reported noticing symptoms in their clients, counseling them for treatment and accompanying them for treatment at the clinic. All of them stressed the importance of using condoms consistently in order to prevent the transmission of STI.

“When a client comes to us we won’t know if he is infected with STI or not. The safest thing is to use a condom during sex with everybody.”

(home-based FSW, member, Bangalore Urban)

Most FSWs reported that they would not agree to have sex with an infected person, even with a condom. This was particularly true in the case of members who saved in Swathi Jyothi. Members who did not save were reported having sex with clients who had STI after using two condoms.

“There may be other complications so it is better to stay away from them.”

(home-based FSWs, member-SMS only, Bangalore Urban)

“We can wear a condom as we need the money.”

(home-based FSW, member – Swathi Jyothi, Bangalore Urban)

This must be understood along with earlier admissions, where members of Swathi Jyothi reported increased debt burden as a result of increased access to credit. FSWs with increased debt burden reported undertaking more sex work to repay the debt. In this instance, their ability to reject sex with an STI infected client seems to have been compromised on account of financial compulsions.

While most participants suggested using a condom to prevent STI, few of them reported taking tablets as a prevention measure. All of them were aware that unprotected sex with STI infected person increased their risk of HIV.

In summary, more than membership, typology emerged as an influencing factor with regard to knowledge of STI. While, both members and non-members from street-based sex workers displayed good knowledge about the symptoms, only few among the home-based sex workers did. However, irrespective of membership status and typology, all respondents were aware of the importance of protected sex to prevent STI.

### **Economic dependence**

All sex workers, regardless of typology and membership status, expressed their preference for servicing a client over clinic visit. Those who chose clinic visit would do so only if they were able to convince the client to wait. Most of them reported delaying clinic visit to a later time or date in favour of servicing a client when they were in need of money.

“We will go with the client and visit the clinic the next day.”

(home-based FSW, member, Bangalore Urban)

“Swathi Mane and the clinic will wait for us but not the client.”

(street-based FSW, non-member, Bangalore Urban)

In summary, the clear dependence of the FSWs on sex work for their livelihood emerged from their prioritisation of servicing a client over clinic visit. Membership in a group did not influence this choice differently, with both members and non-members, from both typologies, making explicit their need for money from sex work. They reported their unwillingness to prioritise clinic visit over servicing a client.

## Self-esteem and stigma

There was a pervading fear of stigmatisation and discrimination from family, neighbours, landlords and adverse consequence for their children, among home-based members and non-members in Bangalore Urban. Street-based members and non-members shared similar fears of abuse, desertion and rejection by family and neighbours, discrimination by landlords and adverse consequences for their children.

The respondents feared conflicts, rejection and abuse from the immediate and extended family. They also feared being 'taunted' or 'looked down' by neighbours.

"They will instigate our husband who will then come and beat us and torture us."

(home-based FSW, SMS & SJ member, Bangalore Urban)

"They will call us a 'Sule'."

(home-based FSW, SMS & SJ member, Bangalore Urban)

"Most of us stay in rented houses and we will have to vacate our houses there."

(street-based FSW, SMS & SJ member, Bangalore Urban)

"We are scared our children will be targeted if they come to know about it."

(home-based FSW, non-member, Bangalore Urban)

All the participants reported doing sex work and visiting the clinic on the sly, to avoid negative outcomes.

"We give them some excuse and come here."

(street-based FSW, non-member, Bangalore Urban)

Compared to the NGO clinic, referral clinic emerged as an option that may not invite stigmatisation and discrimination due to its more general profile. It was much easier to maintain confidentiality about one's sex worker identity with a visit to the referral clinic than with a visit to the NGO clinic. This is because referral clinic catered not just to the sex worker population but also to the general public. Hence, a visit to the referral clinic raised fewer doubts among neighbours and family.

"We don't have to be scared about going to the referral clinic because it is in a hospital and there are patients there for all kinds of ailments."

(street-based FSW, SMS & SJ member, Bangalore Urban)

In summary, sex workers of both typologies, irrespective of their membership status had a pervading fear of stigmatisation and discrimination from family, neighbours and the extended community. Most of them would not disclose their profession and practiced sex work in secrecy. Their visits to the STI clinic were also clandestine in nature.

## Experience at the clinic

Majority of the respondents from both typologies and regardless of membership status reported satisfaction with the treatment they received at the government clinic. They did not report any discrimination from the staff.

"They respect us a lot there."

(street-based FSW, non-member, Bangalore Urban)

The respondents reported positive experiences at the clinic and favorable attitude of the clinic staff.

“We can freely express our problems to the doctor here.”

(street-based FSW, member, Bangalore Urban)

Some respondents said that they had to remain healthy to be able to care for their children. They considered the clinic as a factor that helped them maintain their good health.

“We have to be healthy for the sake of our children.”

(street-based FSW, member, Bangalore Urban)

Few reported easy accessibility and privacy as reasons for liking the clinic.

“We have privacy as it is situated inside the government hospital.”

(home-based FSW, member, Bangalore Urban)

Respondents, including non-members, stated the influence of the CBO, Swathi Mahila Sangha institutional influence as having impacted on their ability to communicate their health issues without inhibitions.

“Initially we found it difficult to communicate our health issues with the doctor. But now after four years we do not have any such problems.”

(home-based FSW, non-member, Bangalore Urban)

The respondents also reported that the CBO intervention had improved the attitude of the staff at the clinic.

“The doctors in the referral clinic are also first counseled by SMS and so they treat us well.”

(street-based FSW, member, Bangalore Urban)

However, a few respondents reported facing discrimination at the clinic.

“The doctor there discriminates against us.”

(street-based FSW, member, Bangalore Urban)

Some reported that they have to pay for treatment in the government clinic, if they visited the clinic alone. They were treated free of cost if accompanied by a jeevika.

“We have to give money to doctors even in government hospital. If the jeevika accompanies us, it is free.”

(street-based FSW, member, Bangalore Urban)

In summary, membership in a group did not influence the sex workers’ experience at the clinic. Sex workers from both typologies, irrespective of their membership status, reported to have benefited from the CBO presence. The CBO interventions helped them discuss their health issues more openly and also ensured positive attitudes of the clinic staff towards them.

This study conducted with FSWs in three districts of Karnataka, aimed to explore the influence, if any, of collectivisation and participation in micro-savings on safe sex behaviour. Socio-demographic and sex work characteristics of FSWs, who were members and non-members of the group, were examined and described for the three districts. Additionally, associations for reported condom usage among various partner types and reported exposure to interventions, among members and non-members in the three districts were investigated.

The study identified six factors each that influenced the use of condoms and clinical services. It explored how group membership and access to microfinance services within the sex worker groups had influenced these factors. Participants described ways in which institutional intervention had impacted changes in their behaviour and the larger environment that effectively helped them practice safe sex.

Exposure to interventions was greater for members than non-members in all the three districts. Female sex workers, who were members in a group, were more likely to have visited the drop-in-centre in both Shimoga and Bangalore Urban. Likewise, members in Bangalore Urban were more likely to have been contacted by a peer as well as to witness a condom demonstration. In Bellary, members were more likely than non-members to visit an NGO sexual health/STI clinic. In two of the three districts (Bellary and Bangalore Urban), membership in a group and access to savings and credit, did indeed influence safe sex practices among respondent FSWs.

### VI. a. Condom Use

The results show that membership in a group had clearly influenced condom use behaviour among FSWs in both Bellary and Bangalore Urban. Condom use with the last client was higher among members than non-members, in both these districts. Further, FSWs who were members in a group in Bangalore Urban were more likely to use condoms with occasional clients than non-members. Compared to these two districts, membership in a group had not influenced condom use among FSWs in Shimoga.

A key finding from the focus group discussions was that access to microfinance for FSWs in Bellary and Bangalore Urban had substantially influenced their ability to practice safe sex with clients. Member sex workers negotiated condom use with their clients more effectively than non-members. A significant feature of the sex worker groups in these two districts has been the provision of microfinance facilities<sup>15</sup>, with an active micro-savings component for the members. This assumes increased value in the sex work context, as financial pressures weaken the most effective prevention messages because the women are often incapacitated to exert control over sexual practices under extreme economic duress. Hence, even when effective messages reach the women, the economic pressure discourages them from practicing safe sex.

<sup>15</sup> Through internal lending and bank linkages for MYRADA Soukhya groups in Bellary and through Swathi Jyothi Credit and Savings Cooperative in Bangalore Urban.



Compulsion to generate income to meet basic needs enhance the vulnerability of FSWs to exploitation and harassment at home, work or in the marketplace. In the absence of formal institutional lending, the gap in the credit space is filled by local moneylenders and clients. This creates an environment conducive for exploitative lending arrangements by these sources, including high interest rates, unfavourable terms of lending and demands for unprotected and free sex in return. Access to micro-savings helps these women break free from the grinding cycle of debt with exploitative sources and enter into non-abusive creditor-debtor relationships. Sex workers' groups that also promote micro-savings are valuable since they are readily accessible, non-exploitative, positively biased towards women and allow the FSWs to participate in economic transactions on equal and favourable terms.

A critical outcome, of the access to credit and savings for FSWs in Bellary and Bangalore Urban, has been the reduced dependence of FSWs on local moneylenders and clients to meet their credit requirements. In Bellary, sex workers who were members of the group did not borrow from moneylenders and clients, denied unprotected and free sex and had control over the money they earned. The community camaraderie evolved as a result of belonging to the same group fostered better cooperation among the FSWs. They stopped poaching of clients and had an increased readiness to help one another in need. They used group solidarity to their benefit. All these, along with an increased demand for and improved rates for sex work, have substantially lessened their vulnerability to unprotected and unpaid sex.

Suggesting the influence of a rural-urban divide on individuals, female sex workers in Bangalore Urban found the income earned to be insufficient to meet their needs. However, the FSWs who accessed credit from Swathi Jyothi savings and credit cooperative had stopped borrowing from moneylenders and chit funds. The dependence on clients as a credit source had also considerably reduced. Non-members on the other hand, continued to depend on moneylenders and clients as sources of credit, and engaged in unprotected, unpaid sex and more sex work to meet their credit burdens. However, even among those non-members who had started accessing the Swathi Jyothi facilities, there was reduced their dependence on private moneylenders for credit<sup>16</sup>.

Despite these positive outcomes, the members experienced an increasing debt burden with the increase in the number of credit sources now available. In Bangalore Urban, though Swathi Jyothi helped FSWs refuse demands for unprotected sex, their over-indebtedness resulted in more sex work and at times, led them to succumb to demands for free sex to repay debt. Over-indebtedness was reported by the FSWs in Shimoga as well. Even though the sex worker's group in Shimoga did not offer microfinance as part of its programme, FSWs accessed credit from other microfinance groups in the region. FSWs are part of more than one group and borrowed from multiple groups at the same time. This has increased their debt burden, which in turn has heightened their vulnerability to unprotected and unpaid sex. Further, multiple sources for credit in Shimoga did not reduce the dependence of FSWs on clients for credit.

Group membership and access to microfinance have been inadequate in helping FSWs overcome obstacles to condom use with their intimate partners. Sex workers continue to engage in unprotected sexual intercourse with their non-paying intimate partners - husbands, lovers and permanent partners. Since condoms have been associated with disease, infidelity and mistrust, it has been difficult for the FSWs to insist on condom use with their husbands [59, 60]. The predominant reason for not negotiating safe sex with the husband was the fear of inadvertent disclosure of sex work, which in turn could lead to marital discord that was often abusive and result

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<sup>16</sup> For a sex worker in Bangalore Urban, though membership in Swathi Mahila Sangha was mandatory to join Swathi Jyothi and avail its services, at the time of the study, it was found that the facilities were also being extended to those who were not members of Swathi Mahila Sangha

in desertion of the woman by the family. With lovers and partners, intimacy in the relationship discouraged the women from using condoms. Compared to the other two districts awareness about the importance of safe sex among husbands and the ability of the sex workers to convince their husbands helped ensure condom use among FSWs in Bellary.

In Shimoga, among the factors identified as influencing condom use, members reported a better ability to negotiate forced sex and demands for free sex and dealt more effectively with violence from clients. As compared to the non-members, sex workers who were members of the groups were well networked with their peers and used it to inform each other of bad clients. They were able to counsel the clients, sought help from their peers and NGO office and no longer feared retaliation on account of resisting violence from clients. They had evolved easy, workable strategies such as being absent from home or threatening the clients with the immediate arrival of family members, to protect themselves from violence. They also took money beforehand to avoid being duped by the clients.

However, sex workers' ability to resist or avoid forced sex and demands for free sex, or violent clients seemed to have been insufficient to effect a change in their condom use behaviour. Membership in a group did not have a significant association with condom use in the Shimoga. Factors such as availability/accessibility of condoms, knowledge about condoms and importance of safe sex, economic dependence and self-esteem did not differentiate between a member and a non-member. This suggests that capability to negotiate forced sex and demands for free sex alone was insufficient to impact on safe sex behaviour. Other detriments need to be better addressed to ensure practice of positive safe sex behaviour by FSWs in Shimoga.

Negotiating violence was another aspect, where members emerge better equipped than non-members in all the three districts. Though violence from spouse, clients and police continue to exist, respondents reported a drastic reduction from before the start of the programme intervention period. FSWs in the groups felt better equipped to deal with violence due to multiple reasons. The multi-layered violence intervention strategy involving policy makers, secondary stakeholders (police, lawyers, media) and primary stakeholders (FSWs), to arrest and address violence against the sex worker community [6] showed considerable impact in all the three districts.

Violence intervention efforts have been successful in helping FSWs approach government departments and officials with less inhibition, to report against violence and harassment and to demand for their rights. Sensitisation efforts with the police have noticeably changed police attitudes towards sex workers and reduced incidences of police violence except in Bangalore Urban. Community mobilisation efforts have addressed, to a considerable extent, the sense of isolation and powerlessness and the experience of stigmatisation and discrimination. It has also enabled action against violence and harassment. The twenty-four hour crisis management teams comprising peer educators, lawyers and NGO staff, which provided immediate response in the event of a violent attack, wrongful arrest or sexual assault, have increased the confidence of the sex workers. They no longer feared retaliation if the violence was resisted, as they had an entity to advocate on their behalf in the event of being subjected to violence. Better cohesion and strengthened network among community members helped them seek immediate support and share information about the clients with each other. Their improved ability to gather cues about a client's behaviour and to counsel the clients with confidence have also helped them deal with situations of violence.

However, notwithstanding a very responsive twenty-four hour crisis management team, FSWs in Bangalore Urban reported a lesser ability to deal with violence and forced sex with clients, compared to the other two districts. First of all, the clandestine nature of the sex work practice increased the home-based sex workers' susceptibility to violence. They felt unable to resist attempts of forced sex,

as they often operated under threats to their accommodation, anonymity and children's safety. For street-based sex workers, multiple client scenarios and sex work in a location of client's choice and outdoors increased their vulnerability to unprotected sex under violence, abuse and threat.

Secondly, in Bangalore Urban, FSWs are not organised into field level groups as is the case in Shimoga and Bellary<sup>17,18</sup>. The only point of convergence for member FSW in Bangalore Urban is the drop-in-centre. FSWs in Shimoga and Bellary have a stronger degree of association and a higher frequency of contact with the peers owing to their membership in field-level groups that tend to be smaller (only 10-15 members per group) and more closely knit. In Bangalore Urban however, FSWs are only members of a larger zonal level body (on an average, a zone has about 4800 member FSWs). Therefore, the affinities that FSWs in Bangalore Urban would form are likely to be less definite and their networks may not be as wide or cohesive as those in Shimoga and Bellary. During crisis situations, especially with clients, field-level groups serve as an immediate, locally available and easily accessible support structure with a shorter response time, as compared to a zonal/taluka level committee. Further, due to its localised nature, field-level groups provide a sustained physical presence, which has a symbolic effect on the potentially violent clients, awareness about which inhibits or prevents them from harassing the sex workers<sup>19</sup>.

Additionally, the type and frequency of violence reported by street-based sex workers were much higher than home-based sex workers. As compared to violence from clients, police and others in the sex work circuit, FSWs were open to violence from their spouses<sup>20</sup>. The acceptance of domestic violence by the FSWs should be considered seriously, since spousal violence has been found to be a causal factor for STI [11]. Faced with a choice between the immediate threat of violence and the possibility of contracting HIV, women surrender to sexual demands and indiscretions that may increase their risk of HIV acquisition [20]. Furthermore, negotiating condom use becomes difficult in the context of a violent intimate relationship, thus increasing their risk of HIV/STI infection [5, 16, 44].

Even though non-members accessed the facilities of the crisis management cells, they did not receive the same extent of help as members did. Unlike the members, majority of the non-members did not feel confident about standing up to the perpetrators of violence and were unable to find ways to negotiate in such instances. They were clearly less networked than the members and hence, lacked the beneficial outcomes that the members received as a result of being part of the group, such as the confidence in the solidarity of their fellow sex workers.

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<sup>17</sup> In Bangalore Urban, the FSWs were first organised into SHGs with a size of 15-20 members per group. Self-help groups entailed that they had to meet weekly and decisions of the group be made only with the consent of the majority (quorum as fixed by the group) of the members, especially for credit transactions. However, the urban characteristic and geographical expanse of the district made it difficult for the members of a group to attend meetings regularly. The attendance in these meetings was very low (3-4 members) and financial transactions became impossible due to lack of quorum. To overcome this limitation, a cooperative structure was formed where FSWs had individual accounts. The financial transaction, especially credit was primarily given based on the repayment capacity of the individual sex worker and not a group.

<sup>18</sup> They are similar to self-help groups (SHGs) with a size of 8-15 members in a group, and are self-managed units led by representatives elected (on a rotational basis) from the group.

<sup>19</sup> FSWs from both Shimoga and Bellary reported that the clients knew that the 'group was behind them' which effectively prevented the mistreatment.

<sup>20</sup> FSWs in Shimoga were accepting of spousal violence, as they did not consider that as an affront to their dignity. The women did not perceive it as victimization and considered it justifiable as the husband provided for the needs of the family. However, all sex workers in Bellary and street-based FSWs in Bangalore Urban rejected and resisted violence from the husband.

## Other factors influencing condom use

In terms of other factors that impacted condom use, members and non-members have been similarly influenced, either positively or negatively, in all the three districts.

## Availability/accessibility and knowledge

Across the three districts, sex workers from both typologies, irrespective of their membership status expressed satisfaction with the existing infrastructure that ensured availability and accessibility of condoms. The network of peers, NGO, government hospital, medical shops and vending boxes ensured condom availability, as and when needed. However, concerns regarding anonymity, confidentiality of their sex worker identity and fear of being ridiculed emerged as disincentives to openly access condoms from medical shops, for most FSWs.

FSWs exhibited high levels of awareness about the importance of consistent use of condoms to prevent transmission of HIV. Levels of knowledge did not vary much between members of a group and non-members in any of the three districts. While the perceived susceptibility to a sex-based infection [10] prompted condom use with clients, it did not always translate into protected sexual intercourse with their non-paying sexual partners, due to reasons of trust, fidelity and intimacy.

## Self-esteem

Low self-esteem of sex workers has been found to be associated with inconsistent condom usage. Sex workers with a low self-esteem were found to engage in self-stigmatisation [1], which increased the likelihood of them engaging in unprotected sexual intercourse.

Across the three districts, irrespective of typology or membership status, majority sex workers were not willing to reveal their sex worker identity. FSWs in Bellary were more open about their identity than those in Shimoga and Bangalore Urban. The FSWs preferred to describe themselves in terms of their alternate profession, families and the places they were from. They operated under intense fear of stigmatisation and discrimination of their family and themselves, if exposed as a sex worker. However, majority respondents from three districts rejected the idea that anyone, including their family members, has the right to abuse them because they were sex workers. As an exception, FSWs in Shimoga accepted spousal violence, as they did not perceive it as a threat to their dignity.

In general, most FSWs denied feeling guilty and did not consider themselves as immoral. They reported feeling guilty and bad about themselves when abused or discriminated against. A deep sense of dejection and disappointment prevailed across all typologies. However, all respondents believed they had the right to lead a dignified life despite being sex workers.

Overall, member FSWs in all three districts were positively influenced towards safe sex, drew strength from their collective identity, and used the shared space to deal with the trauma of dejection and abuse. However, while membership in a group influenced safe sex behaviour among FSWs in Bellary and Bangalore Urban, it did not do so for in Shimoga. For the FSWs in Bellary and Bangalore Urban, access to micro-savings and credit from the sex worker groups provided an alternate source of income. This reduced their dependence on exploitative sources of credit and enabled better negotiation of condom use with clients. Members in all three districts also used the crisis response mechanisms and the groups to deal better with situations of violence. In Shimoga, membership in a group had not influenced condom use among the FSWs. They were not as successful in influencing safe sex behaviour from clients since they were not able to avoid situations of forced sex and demands for free sex.

## VI. b. Usage of clinical services

Out of the three districts, positive association between membership in a group and usage of clinical services for STI only emerged in Bellary. In Bellary, members were more likely than non-members, to have visited the NGO run clinic for sexual health/STI. Since Soukhya groups in Bellary were able to change the attitudes of the neighbours, foster a better understanding about the life of sex workers and developed a better relationship between sex workers and non-sex workers in the community, they were able to visit the clinics more freely. In some cases, they even accompanied non-sex workers to the clinics if they presented with STI symptoms. However, home-based sex workers, and among them non-Devadasi, non-member sex workers, experienced greater stigmatisation compared to others, continued to operate under fear and were secretive about their visits to the clinic.

The positive influence of the Soukhya groups in facilitating greater access and use of clinical services in Bellary has been due to the mutually aiding influences of an improved economic condition and a less stigmatised environment, along with ensured access, availability and a better experience at the clinic. Groups in Shimoga and Bangalore Urban, with respect to use of clinical services, had been effective in ensuring availability and accessibility, increased knowledge among the sex workers and a favorable clinical environment. However, in both the districts, success of the groups in reducing economic dependence on sex work and facilitating a less discriminatory and stigmatised social space has been limited. These then signify and determine the difference in effectiveness of the interventions in the three districts vis-à-vis the usage of clinical services.

Even though FSWs in Bangalore Urban had access to credit and savings facilities they expressed strong reluctance to choosing clinic visit over a servicing a client, if it entailed a loss of income. The multiplicity of sources to borrow from and save in had increased the debt burden of FSWs in both Shimoga and Bangalore Urban. This is a matter of concern, as the women continued to remain in the cycle of debt, borrowing from one micro-credit group to meet obligations of another. For example, FSWs in Bangalore Urban reported using the easily accessible and less expensive credit from Swathi Jyothi to meet their debt burden from more taxing sources. It worked against the objective of a reduced vulnerability due to decreased economic dependence on sex work, as the women were pushed into increased, unprotected and free sex situations under financial pressure. This trend indicates an urgent need for the microfinance programmes for sex workers to provide sound financial education and management skills to the member FSW, in addition to providing savings and credit services.

Further, it would be useful to measure the success of these programmes from the borrowers' position, wherein, the purpose of utilisation of credit is evaluated. In Bellary, many of the FSWs used credit from the Soukhya groups to start micro-enterprises<sup>21</sup> that had a ripple effect in terms of increased income, reduced client volume and a better social standing among the local community. This in turn served the programme objective of improved prevention and health seeking behaviour among these women. Running local business enterprises has had an indirect, additional benefit of a reformed image for the sex worker<sup>22</sup>. It provided the sex workers with an identity, outside of sex work, associated with an acceptable profession that helped the non-sex worker community to relate to them with ease and comfort. Also, it created avenues for increased interaction between

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<sup>21</sup> In the pilot phase, the study met with randomly selected individual sex workers from all the three districts. Each of them in Bellary had used the loan from the group to start individual enterprises such as a petty shop, a cycle shop that rents out cycles and repairs them, tailoring shop, a grocery shop and a catering business.

<sup>22</sup> "After I got loan from the group and began my shop, people also began to respect me as I was doing something other than sex work." Hanumakka, street-based sex worker, Bellary.

the sex worker and non-sex worker community, as the businesses serviced the needs of the local community. Thus, effective utilisation of savings and credit had resulted, not just in enhanced economic freedom, but also in reducing experiences of stigmatisation and discrimination.

In contrast, groups in Bangalore Urban and Shimoga have been less successful in encouraging positive perceptions about FSWs and sex work as a profession within the family and the local community. In these two districts, the success of the group has been confined to mobilising the sex workers to challenge and resist discrimination and lobby more effectively with the government agencies, police and lawmakers. Hence, the FSWs were more empowered to voice their needs fearlessly, demand for their rights and social entitlements and seek a more meaningful engagement with the state. They have also been successful in addressing issues of ‘internalised stigma’<sup>23</sup> [45], resulting in improved self-esteem of the FSWs that helped them value themselves better. Though this had enabled the women to overcome the social barriers to access health care services, they did so under fear.

The Soukhya groups in Bellary differed from the other two districts in their success with helping the FSWs deal with the outcomes of ‘secondary stigmatisation’<sup>24</sup> [45] and stigma from within the family. In the other two districts, sex workers feared negative family and community responses that included blame, rejection and loss of accommodation security. In addition, fear for the well-being of their children and the desire to protect them against abuse, served to abet the existing stigmatised and discriminatory socio-cultural attitudes towards the sex workers.

### **Other factors influencing usage of clinical services**

In terms of other factors that impacted usage of clinical services, members and non-members have been similarly influenced, either positively or negatively, in all the three districts.

### **Availability and accessibility of clinics and knowledge about STI**

Availability/accessibility of clinics and knowledge about STI were not influenced by membership in a group. Majority of the sex workers, both members and non-members, accessed the services regularly. Though access barriers such as long distance to the clinic were frequently reported from the three districts, it had not prevented the FSWs from visiting the clinic. Membership in a group did not evolve as a determining factor for service access, as both members and non-members had shared their difficulties with the respective NGOs. Similarly, no marked difference in knowledge about STI emerged between members and non-members. The FSWs displayed good awareness about the symptoms and treatments for STI and engaged in protected sex or refused sex with clients presenting with STI and advised them to go for. Respondents cited peer and the interventions of the NGO/CBO in having facilitated the increased awareness.

### **Experience at the clinic**

The importance of ‘prevention-care synergy’<sup>25</sup> for effective STI treatment has been well established. Successful STI prevention and care service should possess accessibility, acceptability, affordability and quality as its main features [56]. The awareness and sensitisation efforts by the respective NGOs

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<sup>23</sup> In highly stigmatised contexts, fear of stigma and discrimination cause individuals to isolate themselves to the extent that they no longer feel part of the civil society and are unable to gain access to the services and support they need (Daniel and Parker, 1993).

<sup>24</sup> Secondary stigmatization and discrimination is where stigma and discrimination has been extended to family, neighbours and friends of the individual thereby creating and reinforcing social isolation of those related such as children and partners.

<sup>25</sup> ‘Prevention-Care synergy’ involves delivery of good quality, non-judgmental curative services along with prevention messages that results in individuals being more receptive to condom use.



in the districts were successful in converting the government clinics into a more welcoming space for the sex workers. Home and street-based sex workers in the three districts, both members and non-members, were satisfied with the services at the government clinic. Multiple reasons prompted the sex workers to visit the clinics: being treated with dignity, an environment that facilitated open discussion about health issues, better communication from the staff, availability of free and effective treatment, being provided with reports after treatment/ check-ups, being provided with information about methods of prevention and care, positive staff attitudes and friendly relations with the doctor and the nursing staff. The FSWs' association with the respective NGOs in the districts facilitated preferential treatment for them at the clinics<sup>26</sup>. Overall, majority of the sex workers were satisfied with the experience at the clinics and only a few non-members reported adverse experiences<sup>27</sup>.

### **VI. c. Study limitations**

A critical issue in this study is the social desirability bias in terms of the responses. Female sex workers selected for the study had been members of the group for at least a period of two years. It is likely that they have been asked similar behavioural questions by earlier researchers or interviewers and were aware of desirable responses. Some of the FGD groups had peer FSWs as a member, which may have constrained and influenced the other participants in the sharing of information. It is difficult to control for the dynamics of sex trade in the three districts chosen for the study. Also, the influences of other unmeasured factors in the FSW environment that impact on STI/HIV/AIDS risk reduction may remain unaccounted for [24].

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<sup>26</sup> This was specially so in the case of home and street-based member FSWs in Shimoga who reported speedy and preferential treatment when accompanied by a peer.

<sup>27</sup> Street-based non-member FSWs in Shimoga reported negative and discriminatory staff attitudes reflecting stigma, ineffective treatment and having to bribe the staff for free services.

In all the three districts, community mobilisation of female sex workers has led to increased knowledge about condoms, STI and the risks involved in unprotected sex, enhanced perception of self and enabled a positive clinical environment and experience. However, differences remain in the ability of the members and non-members to negotiate in situations of forced sex and demands for free sex, deal with violence, resist stigma and discrimination and reduce vulnerability due to economic dependence on sex work. The intervention model and processes in the three districts offer key insights for collectivisation and participation in savings activities to be considered as effective strategies in reducing risk behaviour among female sex workers.

The comparative success of groups in Bellary and Bangalore Urban in influencing condom use behaviour among the members, shows that community mobilisation activities, which do not address the economic vulnerability of the sex workers, may have limited success in ensuring safe sex practices. In the sex work context, where negotiating condom use has economic consequences, it is important for interventions with the female sex worker community to address environmental barriers based on economic exclusion, vulnerability and insecurity. Further, from the Bellary experience, it is clear that economic empowerment initiatives, which create supplementary livelihood opportunities, serve to increase social interaction and reduce social inequity and stigma. This facilitates a more enabling environment for sex work and empowers sex workers to protect their health as it effectively addresses the inter-personal and structural factors that limit their capability to practice safe sex.

However, the accounts of the FSWs from Bangalore Urban and Shimoga caution and amply demonstrate, the need for microfinance services for sex workers to not only focus on provision of credit, but to place equal emphasis on financial discipline, encouraging them to build savings and assets for future needs and to assist in the creation or diversification of livelihood activities. In the absence of such focus, the sex workers will be unable to break free from the debt cycle, with the increased credit burden forcing them to engage in risky sexual practices with higher frequency. This in effect will fail to serve the larger purpose of HIV/AIDS prevention through reduced economic vulnerability.

The relative success of the Soukhya groups in Bellary, in improving both condom use and utilisation of clinical services, validates the relevance and importance of helping the sex workers overcome the fear of stigmatisation and be able to operate in a more enabling environment. Stigmatisation and discrimination can demotivate the sex workers to adopt preventive measures, get tested and seek treatment. Hence, intervention efforts must be channeled to help sex workers overcome obstacles to social recognition, participation and inclusion, along with provision of services for competent HIV/AIDS prevention.

It is clear that community mobilisation efforts, though with varying degree of success, resulted in the creation of social capital<sup>28</sup> with positive externalities<sup>29</sup>, such as reduction of health risks, in all the three districts. The sex worker group/CBO, organised to defend the interests and support collective needs of its members, had also accrued benefits to the non-members and at times to the larger non-sex worker community<sup>30</sup>. Along with the members, non-member sex workers experienced improved availability of condoms and access to quality care at the clinics, as well as, gained better knowledge and awareness about condom use and the need to access treatment and care. They also benefited from the interventions of the sex worker CBO to de-stigmatise sex work and the resultant changes in attitudes among the state actors such as government agencies and police, and reduction in violence from clients, police and other players in the sex work circuit. However, since one outcome of community mobilisation initiatives is to increase community ownership of the programmes and ensure sustainability of the efforts after withdrawal of the external agency<sup>31</sup>, it would be prudent to evaluate the strength, capabilities and effectiveness of the sex worker CBOs.

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<sup>28</sup> Robert Putnam defines social capital as those features of social organisation, such as networks of individuals or households, and the associated norms and values, that creates externalities for the community as a whole. The benefits from social capital include several related features such as information sharing, collective action and decision-making and reduction of opportunistic behaviour (67).

<sup>29</sup> In economics, an externality (or transaction spillover) is a cost or benefit, not transmitted through prices, incurred by a party who did not agree to the action causing the cost or benefit. A benefit in this case is called a positive externality or external benefit, while a cost is called a negative externality or external cost. In public health initiatives, it may reduce the health risks and costs for third parties for such things as transmittable diseases.

<sup>30</sup> In Bellary, member sex workers reported non-sex worker women approaching them with STI related issues and accompanying them to the clinics for treatment.

<sup>31</sup> In interviews with programme coordinators in Shimoga, a common concern emerged about the sustainability of the intervention programme once the NGO partner withdraws. They felt that the community needed more time to internalize the importance of being part of the sex worker collective and taking ownership of the same. Compared to Bellary, as both districts have group based structures federated at taluka and district levels, groups in Shimoga were reported as recording lesser attendance, met less frequently and also were evidently less effective in impacting outcomes.

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# APPENDIX 1: TABLES

**Table 3:**  
**Comparison of socio-demographic characteristics of member and non-member FSWs in Shimoga**

		Shimoga		
		Members	Non-Members	Total
Socio-demographic Characteristics	Age Group			
	< 25	8	12	11
	25 to 29	29	18.5	21.4
	30 to 34	23	19	20
	35 to 39	20	24	23
	40 and above	20	26	24
	Literacy			
	Illiterate	52	58	56.5
	Literate	48	42	43.5
	Marital Status			
	Never Married	2.5	2.7	2.6
	Co-habiting	1	0.4	0.6
	Currently Married	49	50.6	50
	Others	48	46.4	47
	Devadasi			
	Source of Income			
	Sex work the only source	22.5	19	20
	Has other sources	77.6	81	80
	Residency			
	Non-local	7.6	11	10
	Local	92.4	89	90
	Migrant Status			
	Non-migrant	92.4	93.3	93
	Migrant	7.6	6.7	7
	Age at Sexual Debut			
	<15 years	41	37	38
	More than equal to 15years	59	63	62
	Regular Partner			
	No	39	38	38
	Yes	61	62	62

**Table 4:**  
**Comparison of patterns of sex work between members and non-members in Shimoga**

		Shimoga	
		Members	Non-Members
Sex Work History, Pattern and Environment	Duration in Sex Work		
	Less than equal to 1yr	9	8
	2 to 4 years	28	24
	5 to 9 years	35	26
	10 years and more	28	42
	Typology		
	Home	67	61
	Brothel/Lodge/Dhaba	0	0
	Public Places	33	39
	Rate for Service		
	Less than equal to 100	33	39
	More than 100	67	61
	Client Group		
	Less than 5 clients	21	17
	5 to 9 clients	29	29
	10 clients and more	50	54
	New Clients		
	At least 5 out of 10 new clients in a week	50	36
	More than 5 new clients in a week	50	64
	Income Group		
	Less than equal to Rs.500 per month	18	13
	Rs.501 to Rs.1500	34	40
	Rs.1500 and more	48	47

**Table 5:**  
**Associations between reported exposure to intervention among members and non-members in Shimoga**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Contacted by Peer	99.2	99.3	1.83	0.804	0.84	0.886
DIC Visit	85	65	3.14	0	2.93	0
Clinic Visit	94.2	90	2.16	0.097	1.83	0.159
Grey Pack	63.5	53	1.48	0.123	1.56	0.077
Condom Demonstration	94	94	1.06	0.91	1.04	0.931

**Table 6:**  
**Associations between condom use among members and non-members in Shimoga**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Unprotected Sex	21	23	1.22	0.54	1.13	0.7
Condom Use with Last Client	74	77	0.69	0.25	0.84	0.53
Always Use Condom with Occasional Client	65	71.4	0.66	0.18	0.75	0.28
Last Time Condom Use with Repeat Client	81.4	84	0.85	0.68	0.86	0.66
Always Use Condom with Repeat Client	77	77	1.08	0.82	1	0.98
Condom Use in Last Sex with Partner	19.3	23.6	0.71	0.42	0.77	0.48
Always Use Condom with Partner	10.4	14.3	0.71	0.53	0.69	0.43
HIV Prevalence	8.1	9.3	0.79	0.56	0.86	0.7
Active Syphilis	5.3	3.3	1.32	0.67	1.65	0.35
High Titre Syphilis	1.7	2	0.39	0.51	0.83	0.79
Chlamydia and/or Gonorrhea	0.8	5	0.17	0.14	0.16	0.09
Chlamydia Only	0.8	3.5	0.19	0.18	0.23	0.18
Gonorrhea Only	0	1.8	-	-	-	-



**Table 7:**  
**Comparison of socio-demographic characteristics of member and non-member FSWs in Bellary**

		Bellary		
		Members	Non-Members	Total
Socio-demographic Characteristics	Age Group			
	< 25	16	29	24.5
	25 to 29	17.4	20.5	19.4
	30 to 34	17.5	15	16
	35 to 39	24	15	18
	40 and above	25	21	22
	Literacy			
	Illiterate	80	75	77
	Literate	20	25	23
	Marital Status			
	Never Married	3.6	18	13
	Co-habiting	2.4	2.6	2.6
	Currently Married	42	38.5	40
	Others	18	30	26
	Devadasi	34	11.4	19
	Source of Income			
	Sex work the only source	31.6	41	37.6
	Has other sources	68	59	62.5
	Residency			
	Non-local	1	1	1
	Local	99	99	99
	Migrant Status			
	Non-migrant	91.5	90	89
	Migrant	8.5	10	11
	Age at Sexual Debut			
	<15 years	40	47	44
	More than equal to 15years	60	53	56
	Regular Partner			
	No	35	53	47
	Yes	65	47	53

**Table 8:**  
**Comparison of patterns of sex work between members and non-members in Bellary**

		Bellary	
		Members	Non-Members
Sex Work History, Pattern and Environment	Duration in Sex Work		
	Less than equal to 1yr	50	33
	2 to 4 years	20	25
	5 to 9 years	10	20
	10 years and more	20	22
	Typology		
	Home	63	44
	Brothel/Lodge/Dhaba	0	23
	Public Places	37	33
	Rate for Service		
	Less than equal to 100	44	46
	More than 100	56	54
	Client Group		
	Less than 5 clients	7	8
	5 to 9 clients	25	19
	10 clients and more	68	73
	New Clients		
	At least 5 out of 10 new clients in a week	23	19
	More than 5 new clients in a week	77	81
	Income Group		
	Less than equal to Rs.500 per month	13	8
	Rs.501 to Rs.1500	32	33
	Rs.1500 and more	55	59

**Table 9:**  
**Associations between reported exposure to intervention among members and non-members in Bellary**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Contacted by Peer	100	96.5	-	-	-	-
DIC Visit	78	63	1	0.996	2.04	0.016
Clinic Visit	95	77	4.6	0.001	5.31	0.001
Grey Pack	76.2	58.5	1.54	0.182	2.27	0.007
Condom Demonstration	99.4	92.3	6.6	0.06	13.8	0.012

**Table 10:**  
**Associations between condom use among members and non-members in Bellary**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Unprotected Sex	15	16	1.17	0.6	1.04	0.91
Condom Use with Last Client	97.6	90	7.54	0.01	4.6	0.01
Always Use Condom with Occasional Client	85.6	85.5	1.3	0.49	1	0.99
Last Time Condom Use with Repeat Client	93.3	92.3	1.36	0.54	1.16	0.78
Always Use Condom with Repeat Client	80	87	0.7	0.33	0.59	0.1
Condom Use in Last Sex with Partner	50.8	33.4	1.96	0.08	2.05	0.02
Always Use Condom with Partner	36.7	24.1	1.72	0.15	1.83	0.034
HIV Prevalence	13.9	14.2	1.04	0.93	0.97	0.95
Active Syphilis	6.9	8.2	0.67	0.34	0.82	0.73
High Titre Syphilis	4.9	4.7	0.94	0.91	1.05	0.94
Chlamydia and/or Gonorrhea	2.2	9	0.79	0.77	0.23	0.03
Chlamydia Only	1.6	6.2	0.71	0.7	0.25	0.09
Gonorrhea Only	0.6	5.2	0.34	0.39	0.11	0.043

**Table 11:**  
**Comparison of socio-demographic characteristics of member and non-member FSWs in Bangalore Urban**

Socio-demographic Characteristics		Bangalore Urban		
		Members	Non-Members	Total
	Age Group			
	< 25	12.5	28	25
	25 to 29	21	21.5	21.5
	30 to 34	17.6	18.5	18.4
	35 to 39	28	20	22
	40 and above	21	12	13.4
	Literacy			
	Illiterate	50.4	49.4	49.6
	Literate	49.6	50.5	50.4
	Marital Status			
	Never Married	2.6	8.6	7.5
	Co-habiting	0.5	0.9	0.8
	Currently Married	68.5	57.6	59.6
	Others	28.4	33	32
	Devadasi			
	Source of Income			
	Sex work the only source	45.4	49	48
	Has other sources	54.6	51	52
	Residency			
	Non-local	0	0	0
	Local	100	100	100
	Migrant Status			
	Non-migrant	87	90	89
	Migrant	13	10	11
	Age at Sexual Debut			
	<15 years	28	32	32
More than equal to 15years	72	68	68	
Regular Partner				
No	30	39	37	
Yes	70	61	63	

**Table 12:****Comparison of patterns of sex work between members and non-members in Bangalore Urban**

Sex Work History, Pattern and Environment		Bangalore Urban	
		Members	Non-Members
	Duration in Sex Work		
	Less than equal to 1 year	9	15
	2 to 4 years	22	28
	5 to 9 years	26	27
	10 years and more	43	30
	Typology		
	Home	36	33
	Brothel/Lodge/Dhaba	12	6
	Public Places	52	61
	Rate for Service		
	Less than equal to 100	5	7
	More than 100	95	93
	Client Group		
	Less than 5 clients	32	26
	5 to 9 clients	35	35
	10 clients and more	33	39
	New Clients		
	At least 5 out of 10 new clients in a week	28	36
	More than 5 new clients in a week	72	64
	Income Group		
	Less than equal to Rs.500 per month	8	7
Rs.501 to Rs.1500	20	23	
Rs.1500 and more	72	70	



**Table 13:**  
**Associations between reported exposure to intervention among members and non-members in Bangalore Urban**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Contacted by Peer	97	83	6.43	0.002	6.2	1.85
DIC Visit	82	65	2.53	0.002	2.4	0.003
Clinic Visit	81.7	73.4	1.62	0.115	1.62	0.125
Grey Pack	49.7	40	1.44	0.113	1.5	0.064
Condom Demonstration	89.7	70.7	3.47	0	3.6	0

**Table 14:**  
**Associations between condom use among members and non-members in Bangalore Urban**

	Members	Non-Members	Adjusted Odds Ratio	p-value	Unadjusted Odds Ratio	p-value
Unprotected Sex	25.7	21.2	0.78	0.25	0.78	0.22
Condom Use with Last Client	92	83.4	3	0.006	2.27	0.022
Always Use Condom with Occasional Client	83	76.5	1.65	0.054	1.49	0.099
Last Time Condom Use with Repeat Client	82	84.3	0.92	0.77	0.85	0.547
Always Use Condom with Repeat Client	74	80	0.73	0.212	0.69	0.147
Condom Use in Last Sex with Partner	25	22	1.41	0.282	1.22	0.462
Always Use Condom with Partner	15	15	1.24	0.54	1.02	0.959
HIV Prevalence	8	8	1.23	0.564	1.02	0.949
Active Syphilis	10	10	0.86	0.691	1.02	0.953
High Titre Syphilis	6	4	1.61	0.417	1.44	0.419
Chlamydia and/or Gonorrhea	10	14	0.94	0.844	0.66	0.193
Chlamydia Only	9	13	0.93	0.841	0.65	0.201
Gonorrhea Only	4	3	2.16	0.227	1.23	0.696

## APPENDIX 2: FGD GUIDELINES

CONDOM USE		ACCESSING CLINICS	
1	<b>Availability/Accessibility</b> Have you seen condoms? From where do you get them? Is it free or do you buy them? From where could you buy them? Do you get condoms as per your need? Can you get it on your own? Is it easy or difficult to get them as and when you need it? What makes it easy or difficult? What are some of the instances where it has been difficult to get them? Have actions been taken to handle those situations? What are some of the actions taken to ensure availability/accessibility? If it's easy, what are the factors that make it easily available and accessible? Is there anything that needs to be done to make it more available/accessibility?		<b>Availability/Accessibility</b> Where do you all go for sti care? Why do you go there? Is it free or do you have to pay? Are you able to go to the clinics regularly? If yes or no, what are the reasons? Is the clinic at an accessible distance? If far, have you been able to do anything about it? What have been done about it? What factors have helped? Do you always get the required treatment at the clinic? If no, what are the reasons for not getting the treatment? Have you been able to do anything to ensure getting the required treatments at the right time? What factors have helped?
	<b>2 Knowledge &amp; skills</b> Do you know what condoms are? Should one use condoms during sex? Why? How frequently should one use condoms? Does it have to be used with everyone? Why? Do you use condom with your lover/husband/permanent partner? Why do you have to use it with them? What will happen if you don't use condoms? Where do you get the information about condoms from? If you had to buy condoms, would you buy them? Do you think you are at the risk of getting hiv?		<b>Knowledge</b> Have you heard of sti (local term)? What are the symptoms of sti? Where can you go for treatment of sti? Are there other treatments that will help you deal with sti? What are they? Do you think going to the clinic will harm you in anyway? If yes, how? Have you noticed sti symptoms in your regular partners? Do you advice them to go to the clinic when you notice the symptoms? Is it ok to have sex with someone who has sti? Can you prevent sti? How can you prevent sti? Do you think having sti increases the risk of getting hiv? Why should you go to the clinic regularly?

<p><b>3</b></p>	<p><b>Negotiation ability</b></p> <p>Do you use condoms with everyone you have sex with?</p> <p>Won't you lose business if you insist on using condoms?</p> <p>If yes, why do you insist?</p> <p>Have there been instances where you have not been able to use condoms? Enumerate some of those instances.</p> <p>Do you feel confident to deal with situations where you are forced to have sex with condoms?</p> <p>What gives you the confidence?</p> <p>Have you been forced to or had to give free sex in any instance?</p> <p>If yes, what are those instances?</p> <p>Are you able to deal with such situations? How?</p> <p>Do you feel confident that you can deal with situations where you are forced to give free sex?</p> <p>What gives you that confidence?</p> <p>Who decides on the rate for your service?</p> <p>If you do, how is it done?</p>	<p><b>Economic dependence</b></p> <p>What is your main source of livelihood?</p> <p>Is that sufficient to meet all your needs – personal and family?</p> <p>What do you do when it's insufficient?</p> <p>Do you borrow money?</p> <p>Where do you borrow money from? From whom all do you borrow money from?</p> <p>Are you always able to repay in time?</p> <p>What happens in situations where you are unable to repay?</p> <p>Are there any other sources of income? What are they?</p> <p>If yes, do they help you personally and professionally? How?</p> <p>Do you think it's better to earn money than waste time visiting clinics?</p>
<p><b>4</b></p>	<p><b>Economic dependence</b></p> <p>What is your main source of livelihood?</p> <p>Is there any other work that you do in addition to sex work?</p> <p>Is that sufficient to meet all your needs – personal and family?</p> <p>What do you do when it's insufficient?</p> <p>Do you borrow money?</p> <p>Where do you borrow money from? From whom all do you borrow money from?</p> <p>Are you always able to repay in time?</p> <p>What happens in situations where you are unable to repay?</p> <p>Are there any other sources of income? What are they?</p> <p>If yes, do they help you personally and professionally? How?</p> <p>Do you have control (decide on its usage) over your own money?</p> <p>Do you think you should take care of your health? Why?</p> <p>Is it your responsibility or someone else's?</p>	<p><b>Self esteem</b></p> <p>How would you describe yourself?</p> <p>Why do you describe yourself on that basis?</p> <p>How do others describe you?</p> <p>What basis do they describe you in that manner?</p> <p>What do you think about yourself?</p> <p>(Immoral, bad character, guilty, lower status)</p> <p>How do others treat you?</p> <p>(Family, general population, own community)</p> <p>Do people around you know that you are a sex worker?</p> <p>What do you do if others abuse you – physically, verbally?</p> <p>Why shouldn't they abuse you?</p> <p>Do you think you have a right to lead a dignified life? Why?</p>

<p><b>5</b></p>	<p><b>Self esteem</b></p> <p>How would you describe yourself?</p> <p>Why do you describe yourself on that basis?</p> <p>How do others describe you?</p> <p>What basis do they describe you in that manner?</p> <p>What do you think about yourself?</p> <p>(Immoral, bad character, guilty, lower status)</p> <p>What do others think of you?</p> <p>How do others treat you?</p> <p>(Family, general population, own community)</p> <p>Do people around you know that you are a sex worker?</p> <p>What do you do if others abuse you – physically, verbally?</p> <p>Why shouldn't they abuse you?</p> <p>Do you think you have a right to lead a dignified life? Why?</p> <p>Do you feel shy or scared to say that you are a sex worker? If yes, why?</p> <p>Do you think you have a right to say no to sex without condoms? Why?</p>	<p><b>Stigma</b></p> <p>Do you feel shy or scared to say that you are a sex worker? If yes, why?</p> <p>Do family, local community/friends know that you are a sex worker?</p> <p>Do they mistreat you because of that?</p> <p>How do you deal/cope with such situations?</p> <p>Do your family/neighbours/friends know that you visit clinics?</p> <p>If no, are you scared of them getting to know about it? Why?</p> <p>Are you scared or shy to visit clinics?</p> <p>Are you scared of your peers knowing that you visit clinics?</p> <p>What about it scares you?</p> <p>Do you fear being shunned by the community/family if they come to know about it?</p> <p>If yes, then why do you go to the clinic?</p>
<p><b>6</b></p>	<p><b>Presence of violence &amp; fear</b></p> <p>Do you fear being physically assaulted by your clients/partners/lovers/husbands?</p> <p>How often are you subject to physical assault?</p> <p>Do you fear being sexually assaulted? Who assaults you physically?</p> <p>What are the reasons for which you are physically and sexually assaulted?</p> <p>Does anyone other than lovers, clients, partners, and husbands assault you physically and sexually? Who?</p> <p>What is the nature of assaults that you are subjected to?</p> <p>Do you think you can resist these?</p> <p>Have you been able to resist these?</p> <p>How have you been able to resist these?</p> <p>Are you not scared of repercussions while resisting the assaults?</p> <p>What factors give you the confidence to deal with them?</p>	<p><b>Fear of doctor</b></p> <p>Do you go to the clinic?</p> <p>Do you like going to the clinic?</p> <p>What do you like or not like about it?</p> <p>Do you go alone or does someone accompany you? If no, why don't you go alone?</p> <p>Do you feel comfortable meeting the doctor and the staff? What makes you comfortable or uncomfortable in the clinic?</p> <p>How are you treated in the clinic?</p> <p>Do you feel confident that you can deal with them if not treated well?</p> <p>Do you feel confident that they will give you the right treatment?</p> <p>Do you think they will not treat you well because you are a sex worker?</p> <p>Can you enumerate such instances? What factors helped you deal with such situations?</p>





