KHPT

STRIVE
Tackling the structural drivers of HIV

SAMVEDANA PLUS

REDUCING INTIMATE PARTNER VIOLENCE AGAINST FEMALE SEX WORKERS

Implementation Design

WhatWorks
TO PREVENT VIOLENCE
A Global Programme To Prevent Violence Against Women and Girls

UNITED NATIONS TRUST FUND TO END VIOLENCE AGAINST WOMEN

UNIVERSITY OF MANITOBA

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SUPPORT

Project Samvedana Plus is supported by STRIVE, the UN Trust Fund to End Violence against Women, What Works to Prevent Violence Against Women and Girls Programme, and University of Manitoba. STRIVE, a DFID-funded research consortium at the London School of Hygiene and Tropical Medicine (LSHTM), has partners in India, Tanzania, and South Africa, to investigate and address the structural forces – stigma, gender-based violence, poverty, and alcohol consumption norms, in particular – that combine to amplify vulnerability to HIV and undermine prevention efforts. The plan was prepared with support from STRIVE and funded by UK Aid from the Department for International Development (DFID).

Our partner on the project, Chaitanya AIDS Tadegattuva Mahila Sangha, is a collective of over 4,600 sex workers working to prevent HIV/AIDS and empower sex workers in Bagalkot district, Karnataka.

Samvedana Plus has received funding support from STRIVE/ LHSTM for research, evaluation and related training and from UNTF, University of Manitoba and What Works to Prevent Violence against Women and Girls programme for interventions.

CONTENTS

ABBREVIATIONS

ART	Antiretroviral Therapy
FSW	Female Sex Worker
CBO	Community-based Organisation
CMT	Crisis Management Team
DV	Domestic Violence
GBV	Gender-based Violence
GEMS	Gender Equitable Men Scale
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counselling and Testing Centre
IP	Intimate Partner
IPV	Intimate Partner Violence
LSHTM	London School of Hygiene and Tropical Medicine
PRI	Panchayati Raj Institution
PWID	People Who Inject Drugs
RMC	Routine (or Regular) Medical Checkup
RPC	Research Programme Consortium
SAMRC	South African Medical Research Council
SHG	Self-help Group
STRIVE	Structural Drivers of the HIV Epidemic
TI	Targeted Intervention
UNTF	United Nations Trust Fund to End Violence against Women
WHO	World Health Organisation

EXECUTIVE SUMMARY

The influence of structural factors such as poverty, social norms, alcohol abuse, and criminalisation of high-risk behaviours on HIV risk and vulnerability has led scholars and HIV prevention programmers to regard structural intervention as an essential component of an HIV prevention strategy [1–8]. Structural interventions reduce risk and vulnerability among female sex workers (FSWs) by empowering them with greater control over condom use with clients [9], and reducing violence and stigma against them [10, 11]. However, these interventions have fallen short of addressing the structural factors that increase risk and vulnerability within their intimate relationships, where they adhere to gender norms of male dominance. The failure to address the structural factors in these relationships enables HIV/STIs to persist and spread, impeding control of the epidemic.

To learn more about the influence of structural factors on HIV risk and vulnerability in FSWs' intimate partnerships and to test approaches to address them, the Karnataka Health Promotion Trust (KHPT), in partnership with the Social and Mathematical Epidemiology Group at the London School of Hygiene and Tropical Medicine (LSHTM), the Centre for Global Public Health at the University of Manitoba, What Works to Prevent Violence Against Women and Girls Programme led by the Medical Research Council of South Africa, and the Chaitanya AIDS Tadegatwa Mahila Sangha, is implementing a three-year programme called Project Samvedana Plus in northern Karnataka, India. This document presents the background, rationale, theory of change, implementation design, management structure, and the monitoring and evaluation (M&E) plan for the programme.

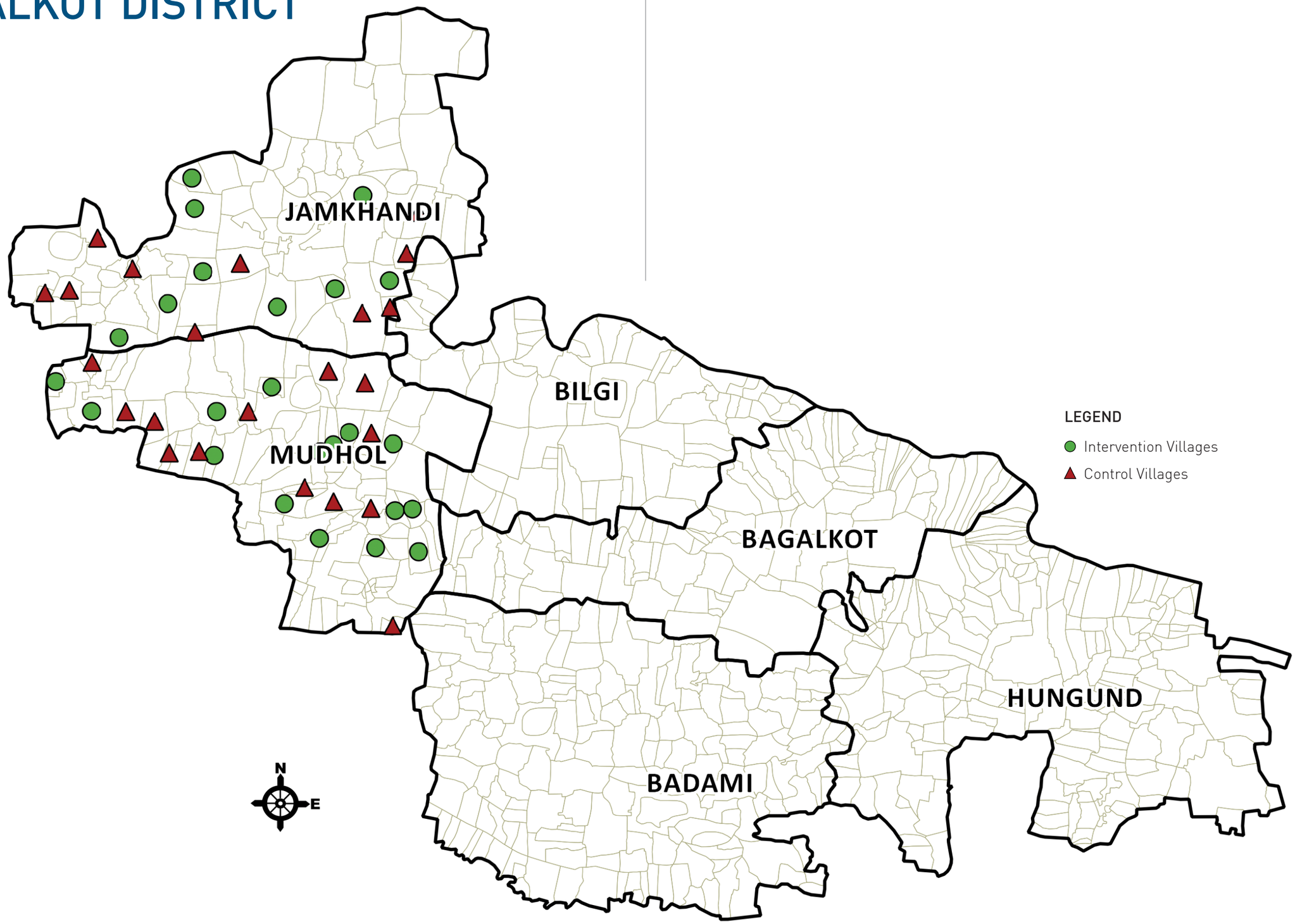
Intimate partner violence (IPV) is influenced by social norms, alcohol consumption, and childhood exposure to similar forms of violence and abuse [12, 13]. KHPT surveys of condom use and violence among FSWs and their intimate partners (IPs) in northern Karnataka reveal that the prevailing gender ideals, power disparity between the sexes, and public acceptance enable IPV. In other words, IPV, gender ideals, and power disparity reduce condom use [14, 15, 16]. Programmes that promote equitable gender norms, such as Stepping Stones [17] and Horizons [18], report a reduction in HIV risk behaviour and violence among men. Furthermore, increased condom use has been reported by FSWs who are members of collectives [9].

KHPT's hypothesis is that social norms linked to inconsistent condom use and IPV may be changed by: (a) conducting group reflection workshops and providing intensive support for FSWs and their partners; (b) training FSW CBOs to respond to and reduce IPV; (c) recruiting and training prominent local leaders to speak against IPV; and (d) staging public performances that promote intolerance for IPV.

M&E of the programme's implementation for effectiveness, impact, and outcomes, will be conducted with quantitative baseline and end-line assessments, qualitative studies and process documentation, and detailed measurements of the exposure of each target group to intervention components.

PROJECT SAMVEDANA PLUS

BAGALKOT DISTRICT



1 INTRODUCTION

The HIV epidemic in India has been considerably curtailed by intensive interventions targeting groups at high risk of HIV/STI transmission – FSWs, transgender sex workers, men who have sex with men (MSM), and people who inject drugs (PWIDs) [19–22]. Interventions with FSWs were designed to reduce their risk in encounters with clients, police, and anti-social elements, primarily by distributing condoms and promoting their use. They upgrade medical services to diagnose and treat STIs and HIV, and engage in advocacy and community mobilisation to reduce violence against FSWs. Fear of violence and harassment discourages FSWs from carrying condoms and insisting their clients use them [10, 23, 24], and physical and sexual violence increase their risk of acquiring HIV or STIs [25–27]. Advocacy with the police has reduced harassment, allowing FSWs to carry condoms without fear of the police regarding this as cause for detention or extortion of money or sexual favours; social mobilisation has empowered them to insist on condoms in each encounter with their clients [10, 28–30]. Consequently, the rate of condom use by their clients has increased [20, 31–36], and there are fewer instances of violence against them [11, 28].

However, interactions with clients are driven by commercial gain [14] and are those of parties in a business deal. In their intimate relationships, violence is common and condom use infrequent, impeding efforts to eradicate the pandemic [14, 16, 36–40]. Intervention tactics that reduce violence and increase condom use have been less successful in this context because the causes of vulnerability differ from those in their work environment. Condom use is uncommon as these relationships are driven by emotion, aspiration, expectation, dependency, and gender roles associated with marriage. The hope of appearing more attractive to their IPs and fear that he will end their relationship drives them to adhere to culturally scripted gender roles that afford greater power to men, including with regard to condom use, thereby ceding control over their lives and safety to their IPs [41–43]. Consequently, their vulnerability is due at least in part to their aspirations to: (a) the social approval accorded to a wife; (b) domestic stability, emotional support, and security provided by a male spouse; and (c) a father for existing or future children [14]. Their vulnerability and risk is compounded by the expectations and attitudes that their IPs commonly bring to these relationships – a sense of entitlement to unprotected sex on demand, unwavering compliance, and sexual fidelity.

HIV prevention interventions need to be specially calibrated to address these distinct structural sources of vulnerability and risk in intimate relationships. Samvedana Plus, whose implementation plan is presented in this document, integrates research and interventions to address these structural factors. Specifically, this three-year programme, which will cover approximately 800 FSWs and their IPs in 47 villages in two talukas of Bagalkot district in northern Karnataka, will examine how factors that contribute to violence and impede condom use in these relationships can be effectively addressed.

1.1 CONDOM USE AND VIOLENCE IN FSWs' INTIMATE PARTNERSHIPS

In 2009, a survey of 3,225 FSWs in Andhra Pradesh found that 74.8 per cent had non-commercial partnerships with a non-paying, intimate male partner they regarded as a lover, boyfriend, or husband. [44]. Another in northern Karnataka found that 96 per cent of the FSWs there had an IP, and 26 per cent had more than one concurrently [15]. Dandona et al. [45] report that of 2,582 non-brothel based FSWs who said they had engaged in penetrative sex with regular, non-commercial sex partners in the previous week, 94 per cent had not used condoms. A study of clients and partners of FSWs in brothels in Pune found that condoms were used consistently in only 10 per cent of long-term or *rakhel* relationships [37]. Only 10 per cent of FSWs surveyed in three districts in Karnataka reported using condoms with their IPs [39]. Other studies in northern Karnataka reveal that 38 per cent had used a condom during their most recent encounter with their primary partner [16], and 61.2 per cent used condoms inconsistently [15].

Violence is another common feature of FSWs intimate relationships. Shaw and Pillai found in a survey that 23 per cent of FSWs in northern Karnataka had faced physical violence and nine per cent experienced sexual violence from their primary non-paying partner. The findings of another study in northern Karnataka reveal that 41 per cent had been subjected to IPV in the preceding 12 months [15].

1.2 IPV AND INCONSISTENT CONDOM USE AS PUBLIC HEALTH PROBLEMS

IPV has long been recognised as a significant public health problem [12, 46-49] because it inhibits women from successfully negotiating condom use [51-53], and can cause condom breakage [50] and injuries that facilitate HIV/STI transmission [27], as detailed below.

a. **Violent partners are more likely to pose other risks:** These include multiple concurrent sexual partners, STI infections, condom aversion, and alcohol abuse [54-56]. In a review of studies of the relationship between IPV and HIV/STI infection, WHO, LSHTM, and SAMRC [57] found that the "best estimates of association between IPV and HIV/STIs are odds ratio (OR) = 1.52 (95% CI = 1.03 to 2.23) for HIV [58]; adjusted odds ratio (AOR) = 1.61 (95% CI = 1.24 to 2.08) for syphilis [59], and OR = 1.81 (95% CI = 0.90 to 3.63) for chlamydia or gonorrhea" [60].

b. **Inconsistent condom use increases risk:** Unprotected sex is one of the primary mechanisms for HIV [61, 62]. According to Shaw and Pillai [16], 76 per cent of non-paying partners of FSWs surveyed in Karnataka were married, and eight per cent had sexual relations with at least one other FSW. Prabhughate et al. [15] found that 88 per cent of partners were married. A survey by Deering et al. involving 988 FSWs in four districts in the state [38] found that 41.1 per cent of the husbands or cohabitating partners of the FSWs, and 70.2 per cent of their most recent non-paying partners had sexual relationships with other women. FSWs, wives and others are all put at risk when the men are married or have concurrent sexual partners with whom they also have unprotected sex [63–66].

1.3 CAUSES OF IPV AND INCONSISTENT CONDOM USE

Heise proposes an integrated 'ecological framework' (Figure 1.1) that suggests an interplay of personal, situational, and sociocultural factors in IPV [67]. In a recent review, he reiterates that IPV is caused by the interaction of multiple factors at different levels of society.

IPV and inconsistent condom use share common structural causes and are linked by the threat of violence that intimidates women from suggesting condom use [68] with partners prone to aggression [14] for fear that it might be perceived as a sign of mistrust, infection, or infidelity.

It must be noted that the literature distinguishes between causes and triggers of violence – childhood abuse or exposure to violence, and gender norms that associate aggression and dominance with masculinity [13] may cause violence, whereas jealousy, inebriation, suspicion, frustration, or mundane domestic disagreements may trigger it [14, 69]. These are discussed in more detail below.

a. **Childhood abuse or exposure to domestic violence as a child:** These are associated with IPV by adult men, and with becoming victims of IPV among women [12, 13, 76]. Exposure to violence between parents during childhood is known to interfere with the development of the growing brain, particularly with regard to threat perception and response, predisposing children to "anxiety and depression, and [compromising] their ability to empathise, trust, and build healthy relationships" [13]. Children raised in a violent environment grow to believe that violence is a permissible and effective means of getting their way [77, 78] and are less likely to learn non-violent ways to express themselves and fulfill their needs [13; 79].

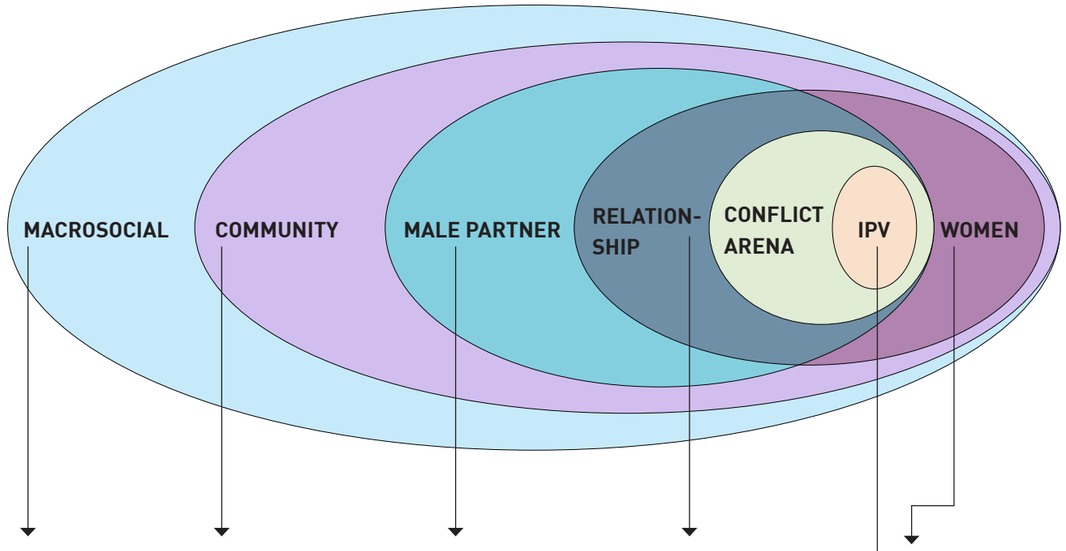
b. **Traditional gender norms:** These have been found to contribute to IPV and inconsistent condom use and thereby increase HIV risk [12, 52, 63, 70]. Hegemonic ideals of masculinity lead many men to adopt attitudes and behaviours that increase both their own as well as their partners' risk and vulnerability [71]. A study using the Gender Equitable Men Scale (GEMS) found that Brazilian men with rigid views of masculinity were more likely to engage violently with a partner, have had an STI, and abuse substances [72]. Studies of men's ideals of masculinity in India found that "violent behaviours were an integral component of describing a 'real man' and 'manliness'" [73], as were sexual promiscuity [63, 74], and a sense of entitlement to unprotected sex [63]. In a study of young men in rural areas, Verma et al. [18] found that "there was a significant association ($p < .05$) between support for inequitable norms and reporting at least one symptom of poor sexual health, partner violence, and sex with more than one partner".

A survey exploring the attitudes of men in India found that 81 per cent agreed or partially agreed that "a man should have the final word about decisions in his home," 68 per cent agreed or partially agreed that "a woman should tolerate violence in order to keep her family together", 65 per cent agreed or partially agreed that "there are times when a woman deserves to be beaten," and 47 per cent agreed or partially agreed that they "would be outraged if (their) wife asked (them) to use a condom" [75].

Verma and Mahendra [73] state that the socialisation of Indian boys encourages a sense of ownership and control over women – they are often raised to safeguard the family honour by controlling and restricting their sisters' liberty. As adults, the authors state that boys continue to control and restrict women, especially their wives and lovers. They further find that " the dynamics of power relationships between husband and wife which are based on the stereotyped gender roles create an interrelationship among extramarital sex, marital violence, and forced sex" [73]. These dynamics are evident in FSWs' intimate relationships, where their partners "use violence to demonstrate their power and keep (them) in constant submission" [14].

c. **Alcohol:** FSWs and their IPs listed alcohol as a cause of IPV in a study in northern Karnataka [14]. Evidence suggests that its consumption may aggravate the severity of violence [13, 80]. Data from India's National Family Health Survey indicates that women whose husbands drink experience significantly higher rates of violence than those whose husbands do not drink at all [81].

FIGURE 1.1: REVISED CONCEPTUAL FRAMEWORK FOR IPV



Gender Order
- Lack of economic rights & entitlements for women
- Discriminatory family law
- Ease of divorce for women
- Composite measures of gender inequality

Cultural factors
- Collectivist versus individual cultural orientation
- Emphasis on women's purity & family honour

Economic factors
- Level of development
- Women's access to formal wage employment

Norms
- Acceptance of wife beating
- Male right to discipline/control female behaviour
- Tolerance of harsh physical punishment of children
- Stigma for divorced or single women
- Norms linking male honour to female purity
- Family privacy

Lack of sanctions
- Lack of legal or moral sanction for violence
- Others do not intervene

Neighbourhood
- Community violence
- High unemployment
- Low social capital
- Poverty

Violence in childhood
- Harsh physical punishment
- Witnessing parental violence
- Other childhood traumas
- Psychological dysfunction
- Antisocial behaviour
- Adult attachment issues

Attitudes
- Accepting of violence as a means to resolve conflict
- Acceptance of partner violence
- Gender hierarchical or transitional attitudes
- **Alcohol Abuse**
- **Gender role conflict**
- **Delinquent peers**
- **Sociodemographic**
- Young
- Low educational level

Interaction
- Non-equalitarian decision making
- Poor communication
- High relationship conflict

Conflict arena

Situational triggers
- Sex/ infidelity
- Money/ distribution of family resources
- Children or in-laws
- Division of labor
- Male drinking

Patriarchal triggers
- Female challenge to male authority
- Failure to meet gender role expectations
- Assertions of female autonomy

Childhood violence
- Child sexual abuse
- Other childhood traumas
- Witnessing mother being beaten

Attitudes
- Tolerance of wife beating
- Socio-demographic
-Young age (for current violence)
- High educational attainment (protective)
- **Low social support**

Factors that operate differently in different settings:
- Women's employment
- Participation in credit schemes or other development programs
- Asset ownership

Source:
Lori L. Heise. 2011. *What works to Prevent Partner Violence*: An Evidence Overview. STRIVE. London School of Hygiene and Tropical Medicine.

1.4 CAUSES OF INCONSISTENT CONDOM USE IN INTIMATE RELATIONSHIPS

As with IPV, several factors contribute to inconsistent condom use in sex workers' intimate relationships.

These include:

a. Violence or the threat of violence [14, 73] from the IP [14, 53].
b. Alcohol [53, 82–86].
c. Expectations and power disparities in gender norms [14, 52, 53, 63, 73, 85, 87–90].
d. A sense of intimacy, trust, and romance [14].
e. The desire to procreate [14].
f. The male partner's belief that condom use interferes with spontaneity, convenience, and cleanliness [14].
g. Dependence on the IP for financial and emotional support [14].
h. Lack of awareness about HIV risk and vulnerability [91].

SUMMARY

Studies of FSWs in northern Karnataka as well as elsewhere reveal that most have relationships with non-paying IPs – most of who are married [15,16] – in addition to their clients [15, 38, 44]. Condom use is inconsistent, often rare, in these partnerships, and violence common [14, 16, 32, 36, 38–40]. Violent partners tend to exhibit other behaviours and conditions that increase the risk of HIV/ STI transmission, such as alcohol abuse, STIs, and multiple concurrent sexual partners [38, 54–56, 92, 93]. Culturally sanctioned gender norms, power disparities, and dependence on the IP also contribute to high-risk behaviour [63] that threatens the health of both partners [14].

Although inconsistent condom use and IPV create ideal conditions for HIV/STI transmission, targeted prevention interventions seldom address these problems explicitly [38]. Samvedana Plus aims to reduce IPV and increase condom use in intimate partnerships in Bagalkot district.

The literature differentiates between drivers and triggers of IPV. Drivers of IPV tend to be structural, whereas its triggers are emotional in nature, arising when the woman acts in ways that might be perceived as defiant, suspicious or unfaithful. Similarly, several factors, such as gender norms, alcohol abuse and IPV, reduce condom use. Furthermore, inexperience reduces the efficacy of organisations such as FSW CBOs working to increase condom use and reduce IPV.

2 RATIONALE

This section presents the rationale for interventions to address the problem of IPV among FSWs and increase condom use in their intimate relationships, and the strategies that have been effective in achieving change.

2.1 ADDRESSING IPV AND INCREASING CONDOM USE

Less violence has been found to correlate with a reduction in new HIV infections both among FSWs and in the wider population in generalised as well as concentrated epidemics [38]. Condom use has been found to reduce the incidence of HIV/STIs [20, 31, 32, 36, 94, 95]. Therefore, Samvedana Plus is grounded in the belief that reducing IPV and increasing condom usage in FSWs' intimate relationships will help curtail the spread of HIV/STI. Furthermore, since childhood exposure to domestic violence is strongly associated with perpetrating violence as an adult, reducing the prevalence of IPV is critical to protect the children of sex workers from growing up believing that violence is a permissible or effective form of expression.

Few interventions have focused explicitly on decreasing IPV and increasing condom usage among FSWs. However, targeted structural interventions to prevent the transmission of HIV have had some success in decreasing violence and increasing condom use with clients, and, to an extent, their IPs. Evidence also indicates that programmes promoting equitable gender norms alter men's gender ideals to promote safer sex. We believe in the efficacy of the strategies employed by these interventions, as detailed below, particularly as they relate to empowerment.

a. **Empowering FSWs through community mobilisation and economic independence:** As power influences condom use [96], correcting the power imbalance that prevents women from asserting and protecting themselves is central to reducing HIV risk and vulnerability. A survey of FSWs in Andhra Pradesh [9] found that "FSWs who do not feel they can control the type of sex they have with a client (are) less able to insist on condom use". Mobilising communities is one tactic used to empower FSWs [9-11, 97, 98]. Studies of the impact of targeted interventions that included mobilisation of FSWs in Maharashtra and Karnataka for condom use and violence indicate that those who are collectivised are more likely to report self-dealing with crises [99]. In Andhra Pradesh, FSWs exposed to HIV prevention programmes with a high degree of collective agency were found to be 2.5 more likely to report consistent condom use than other FSWs [9]. This indicates that collective agency may increase the ability to insist on condom use. Blanchard et al. [101] also report an association between FSWs' collective empowerment through community mobilisation and "'social transformation' variables, including higher autonomy and reduced violence and coercion". Blankenship et al. [9] found that economic independence was significantly associated with consistent condom use.

b. **Creating an enabling environment with advocacy, sensitisation, and community mobilisation:** Beattie et al. [28], Gurnani et al. [10], and Reza-Paul et al. [11] observe that violence against FSWs decreases where structural interventions combine policy-level advocacy, direct engagement to generate awareness and empathy among violent partners, and mobilisation to enable FSWs to collectively address violence, undertake advocacy, and respond to crises.

c. **Promoting equitable gender attitudes through education and community programmes:** Interventions that educate men about HIV risk, and encourage them to critically reflect on their attitudes and behaviour toward women, have been found to foster more equitable gender ideals. Conversely, equitable gender attitudes are reported to be associated with a decrease in risky behaviour such as violence and inconsistent condom use. Among the projects that have reported success in altering gender norms are Stepping Stones [17, 102, 103], which works with small, single-sex groups of men and women and occasionally with mixed groups, and Horizons' Yaari Dosti [18], which works with groups of young men, and conducts community programmes through a lifestyle social marketing campaign. An evaluation of the RISHTA project in Mumbai also points to a reduction in alcohol abuse and HIV risk behaviour among men, and an increase in gender equitable attitudes [80].

d. **Addressing alcohol abuse through counselling, decreasing access, and support systems:** Interventions to address alcohol abuse fall into four categories [13]: (a) brief interventions in the form of advice or counselling by medical staff when drinking begins at an early stage [104]; (b) structural interventions that increase the cost of alcohol [104] or decrease access to it [106]; (c) community-based interventions [80]; and (d) treatment and support groups such as Alcoholics Anonymous [107].

2.2 RECOMMENDATIONS FOR INTERVENTIONS TO REDUCE IPV

In a review of strategies to prevent IPV, Heise's recommends that "researchers and practitioners collaborate on designing and implementing pilot projects that implement and evaluate overlapping strategies that integrate the following: shifting norms around the acceptability of beating as a form of 'discipline', challenging gender roles that grant men authority over women, reducing harmful drinking, and working with both men and women as well as girls and boys to encourage new models of relationships and more flexible gender roles" [13].

Abramsky et al. [13] analysed data from 10 countries included in the WHO Multi-Country Study on Women's Health and Domestic Violence to identify factors consistently associated with IPV. Based on their findings, they advise that IPV prevention programmes work to transform gender norms and attitudes, address child abuse and childhood exposure to domestic violence, support children exposed to marital violence, and moderate alcohol consumption. Several studies of IPV acknowledge the importance of engaging men in efforts to reduce violence and HIV risk [38, 85, 108–112]. These include Horizons [18], Stepping Stones[1] [17, 103, 113] and the We Can campaign [114, 115].

1 Stepping Stones is a training package on HIV/AIDS, gender, communication and relationship skills designed both for use in existing HIV/AIDS projects, written by Alice Welbourne.

3 THEORY OF CHANGE

3.1 PROBLEM AND IMPACT

The project's theory of change recognises that HIV transmission persists within FSWs' intimate relationships because structural factors that increase risk and vulnerability in these relationships are not well understood and fall beyond the purview of existing prevention interventions. Recognising the problem enables us to define the impact we intend to achieve. We have identified structural barriers that reduce condom use with IPs and cause IPV. This has helped us envision the preconditions for impact in the medium- and long-term, as well as indicators of these outcomes. Identifying the barriers and preconditions has enabled us to clarify the type and purpose of the interventions required, the groups with whom they would be appropriate, and the essential outputs.

3.2 SCOPE

Workshops and surveys of FSWs and their partners reveal that it is imperative to intervene with violent male partners, abused female partners, and society in general to reconstruct the gender concepts from which the underlying attitudes, expectations, and behavioural norms emerge. However, due to time and resources constraints this project focuses specifically on social norms and the women's individual and collective self-protection capacities. We believe that reducing IPV against the women will reduce their children's exposure to violence and thus decrease their odds of becoming perpetrators or victims of violence as adults. Therefore, even though alcohol is associated with IPV, reducing alcohol abuse is not one of Samvedana Plus's explicit objectives. Counselling sessions and gender sensitivity workshops organised by the programme, however, do encourage men to recognise how drinking affects their behaviour and to moderate their consumption.

3.3 BARRIERS

Samvedana Plus focuses on the following factors that cause and enable IPV and impede condom use:

a. FSWs' acceptance of patriarchal gender norms and violence.
b. Normative ideals of masculinity that give rise to sexual entitlement and control issues in relationships.
c. Power disparities in intimate relationships, compounded by women's emotional and financial dependence.
d. Expectations that the female partner demonstrate fidelity and trust.
e. Institutional inexperience with designing and managing interventions to reduce HIV risk in this context.
f. Social attitudes towards IPV as a mundane domestic concern.
g. Current response mechanism to IPV for general women does not address the needs of the FSWs.
h. Social perceptions of sex work as immoral and of sex workers as deserving of punishment.

3.4 PRECONDITIONS

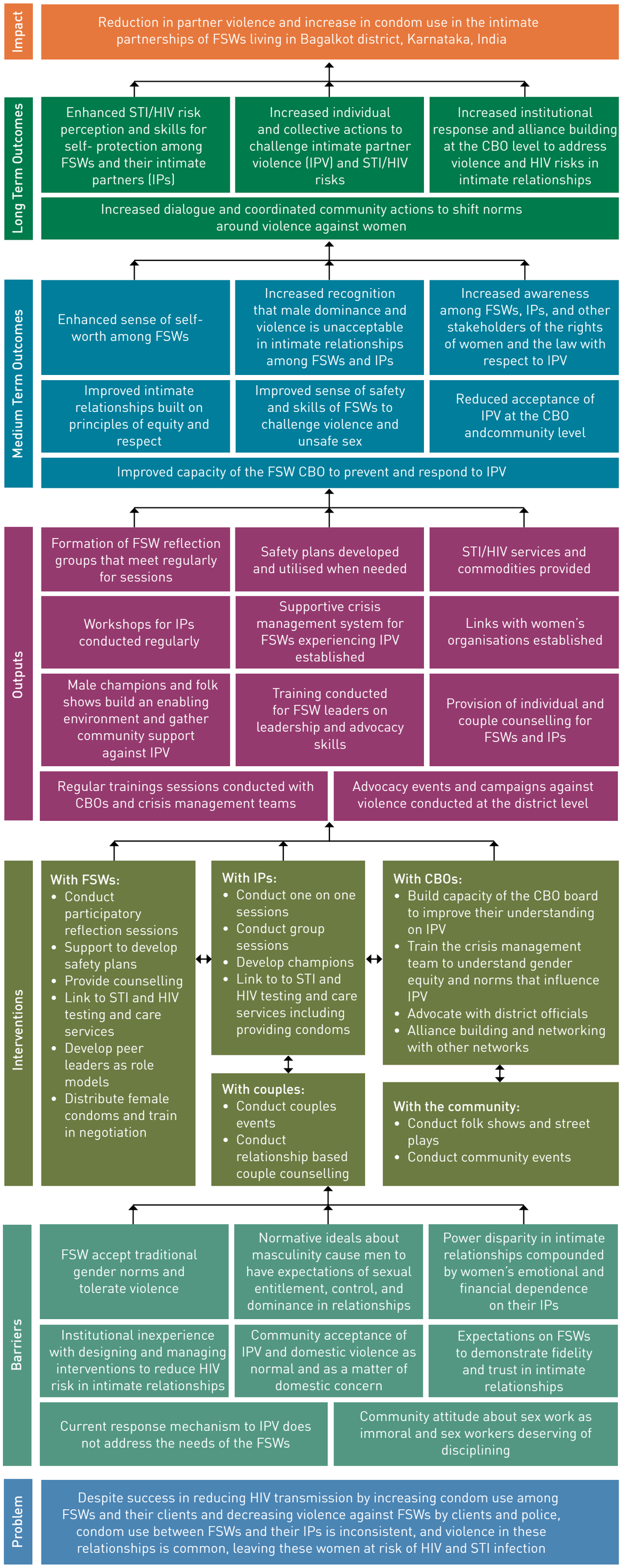
3.4.1 Long-term outcomes

The barriers indicate that reducing violence and increasing condom use in this context requires change at the individual, relationship, community and larger society levels. Samvedana Plus aims to bring about change that, if well coordinated, will propel a shift from social norms that legitimise and perpetuate gender disparity and violence against women to those that promote gender parity, respect, and safety for women. At the individual level, FSWs and their IPs must develop a better understanding of their HIV/STI risk and be able to protect themselves from risk. There must also be an increase in personal and collective processes and actions to reduce IPV and HIV/STI risk. At the community and society levels, there must be greater support for dialogue and action.

Examples of indicators of expected outcomes include:

a. The FSWs and their IPs are more aware of the impact of IPV and STI/HIV risk.
b. Increased individual and collective action against IPV and STI/HIV risks.

SAMVEDANA PLUS - THEORY OF CHANGE



c. Better institutional response and alliances at the CBO level to address violence and HIV risk in intimate relationships.
d. Increased dialogue and coordinated community action to alter how violence against women is viewed.

3.4.2 Medium-term outcomes

While preconditions for long-term outcomes include positive change in attitudes and the ability to work collectively, medium-term changes include better self-worth, greater individual and collective efficacy among the FSWs, increased recognition of HIV/STI risks in the context of intimate partnerships, greater awareness among the stakeholders about women's rights and the law with regard to IPV, the ability to think critically about these issues, a sense of safety and well-being among the FSWs, less acceptance of violence, and better understanding of the normative ideals that shape male behaviour and risk-taking attitudes in intimate relationships.

3.5 OUTPUTS

Samvedana Plus's outputs will lay the foundation for change by inviting stakeholders to learn, discuss, and reflect upon prevailing attitudes, circumstances, and behaviours, and plan action thereafter. This emerges from our belief that new norms can only be architected when communities come to realise that social norms are merely social constructs.

The outputs of the project include:

a. Counselling on risk and violence reduction for individuals and couples
b. Awareness workshops to equip the FSWs and their IPs to initiate and manage change
c. Crisis management teams (CMTs) trained to respond to episodes of violence
d. New relationships between FSW CBOs and women's organisations with experience in addressing IPV
e. Condom distribution
f. Public events and performances to generate disapproval of violence against women

Examples of the indicators of these outputs include:

a. Number of FSW reflection groups formed and number of FSWs attending the group sessions
b. Number of FSWs and IPs met individually and as couples
c. Number of FSWs with safety plans
d. Number of female condoms distributed

3.6 INTERVENTIONS

The outcome framework and barriers identified in our theory of change make it clear that intervention is required with four groups to affect change:

a. With the FSWs: To empower and enable them to protect themselves from HIV risk and IPV
b. With the IPs: To replace norms that perpetuate aggression, conflict, and domination in relationships with those that encourage cooperation, affection, and non-violent communication
c. With CBOs: To capacitate them to reduce HIV/STI risk and IPV against the FSWs
d. With public and other leaders: To promote disapproval of violence against women thereby creating an enabling environment for women

3.7 ASSUMPTIONS

We assume the following:

a. Condom use and violence are influenced by social norms.
b. By altering social norms we can increase condom use and reduce IPV.
c. FSW CBOs will welcome action to reduce IPV and increase condom use in intimate partnerships.
d. Even though the perpetrators are male, the intervention must engage women and the wider community.

3.8 GENDER ANALYSIS

According to Rao and Kelleher [116], "In order to bring about gender equality, change must occur both at the personal level and at the social level. It must occur in formal and informal relations". The key activities of the Samvedana Plus intervention fit into all four quadrants of the Rao and Kelleher model, as shown below (Table 3.1: Domain of change in gender power).

TABLE 3.1: DOMAIN OF CHANGE IN GENDER POWER

	INDIVIDUAL CHANGE	
INFORMAL	**Quadrant 1: Awareness** • Group sessions for the FSWs and their IPs • Counselling: Individual and couple • Special events	**Quadrant 2: Access and control** • Health services (HIV/STI testing, care) • Access to female condoms • Access to legal services • Linkages and referrals
	Quadrant 4: Cultural norms and practices • Group sessions for the FSWs and their IPs • Gender training for staff • Male champions programmes • Community events/ campaigns	**Quadrant 3: Law and policy** • Involving SACS TI programmes • Linkages with womens' organisation to mainstream IPV among sex workers • Strengthening CBOs to address IPV
	SYSTEMIC CHANGE	FORMAL

4 INTERVENTIONS

4.1 COVERAGE AND TIMEFRAME

Samvedana Plus
- 36 months
- 47 villages
- 800 FSWs and their IPs

The intervention, which began in April 2014, is proposed for a period of three years. It will cover 800 FSWs and their IPs in 47 villages in Bagalkot district of northern Karnataka. Twenty-four of these villages will receive intervention with 412 FSWs and their IPs for 24 months. The remaining 23 will receive intervention for a year beginning in the twenty-fifth month, covering an additional 388 FSWs (Table 4.1: Coverage and time frame).

TABLE 4.1: COVERAGE AND TIME FRAME

Months 1-24	Months 25-36
Group 1: 24 villages 412 FSWs	Group 2: 23 villages 388 FSWs

4.2 LEVELS OF INTERVENTION

The intervention aims to reduce vulnerability among FSWs by reducing partner violence and promoting consistent condom use within intimate relationships. Its innovations are aimed at three levels:

a. Individual FSWs and their IPs;
b. board members, staff, and crisis management teams of FSW CBOs; and
c. the wider community where FSWs and their partners live (village and community leaders, neighbours, Panchayati Raj institutions and SHGs).

4.2.1 Interventions with FSWs and their intimate partners

The main focus of the intervention is FSWs and their IPs. The objectives of working with FSWs are to:

i. *build self-worth and collective efficacy;*
ii. *develop skills* to change norms of violence and negotiate safer sex;
iii. *inform* them about protective laws;
iv. *empower* them to identify solutions and support mechanisms; and
v. *act* against violent and risky relationships.

a. The project will engage FSWs in the following ways:

i. P***articipatory reflection sessions*** at workshops with a structured curriculum led by the eight female facilitators, for FSWs from the same village. KHPT has successfully implemented Stepping Stones with men and women in the region before. It has used the lessons from this experience to develop a curriculum for group reflection in the context of sex work. A participatory approach and adult learning principles are used. The curriculum includes learning through discussion, analysing personal experiences, and considering alternative outcomes, rehearsed with a safe, supportive peer group. Like Stepping Stones, this package comprises theme-based workshops suitable for populations where literacy is a challenge. While several activities are adapted from the Stepping Stones module, other training packages that address gender inequality, relationship issues and domestic violence have also been adapted.

The curriculum, which was piloted with FSWs and their IPs, comprises eight group modules, where each module is about three to four hours. The groups will meet 15-16 times each for two-hourly sessions that include structured reflection. As sessions will be held once every fortnight per village, they will take five to six months to complete. The purpose of spreading the curriculum into small, manageable sessions over a six-month time frame is to give the women adequate time to reflect, discuss what they have learnt with their friends and IPs, practice their newly-acquired skills in their daily lives, and bring back real life issues and challenges to their group. 412 FSWs in the 24 villages will undergo this group reflection process. Each facilitator will manage three groups simultaneously in three villages.

WORKSHOP CURRICULUM: FSWs

Module 1: Build trust and meaningful communication
Appreciate the value of team support, trust, and cooperation; understand the importance of listening and communicating feelings with others.

Module 2: Explore perceptions of 'ideal man/ woman'
Examine self-image, build self-esteem, and try to be less judgmental about others.

Module 3: Understand relationships
Discuss what loving relationships mean, expectations and abusive behaviours between lovers, and explanations for such behaviours.

Module 4: Risk and the human body
Learn about HIV-related risks and how to reduce them in the context of intimate relationships.

Module 5: Intimate partner violence
Learn to recognise the signs, types and effects of IPV on women, families and the community; consider why women endure violence and commit to not tolerating it any more.

Module 6: Laws and rights
Understand the legal implications of domestic violence and the rights of the abused; how to react to a violent partner without antagonising him further. Explore why women stay in abusive relationships and whether a violence-free existence is possible.

Module 7: Support and solidarity
Consider the need for solidarity among women; learn how to prepare personal safety plans, identify allies and map a support network; pledge to support each other.

Module 8: Action plans
Examine the new understanding acquired during the workshops. Envision a violence-free life, discuss how it may be brought about, devise a detailed action plan for change.

ii. ***Help develop practical safety plans*** with a quick response rate should violence occur. These include identifying allies close to home, keeping the crisis management helpline number handy and seeking legal support, if necessary. Experience has shown that a visible support structure tends to deter IPV by sending a signal that the violence is no longer a private matter and that the woman has support.

iii. ***Counselling support*** for women who prefer one-to-one counselling will be provided by the facilitators when sought by individual FSWs. This barefoot counselling will provide a safe space for a woman to share her intimate problems, consider her options and identify her course of action. Counselling will follow the principles and themes discussed in the group sessions. It will also demonstrate condom use, discuss how to make it more appealing to IPs, and the advantages of non-penetrative sexual practices.

iv. ***Linkages to services and commodities*** with regard to HIV/ STI testing and care will be provided by the CBO as required. The CBO runs these clinics under various other projects. Male condoms, provided free by the government, will be distributed by the project. Demand for female condoms has increased in the context of intimate relationships but these are not currently available through the other interventions. This project will provide female condoms and train FSWs to use them.

v. ***Two large special events*** will be organised after the women complete their reflection sessions to enable them to meet and build solidarity with FSWs from other villages. Successful attempts to violence and the challenges involved will be discussed. Experience shows that such forums build strong bonds and a sense of collective agency, both essential in the fight against violence.

vi. ***Leadership building*** for two FSWs per village, who will be selected for their leadership qualities after the six-month reflection process. Their leadership skills will be honed to advocate

for violence against FSWs. Having such spokeswomen in each village will attract more attention to the issue, and help and motivate other FSWs to fight the problem. The project will conduct two three-day leadership training sessions every 18 months to train 48 FSWs to become leaders.

vii. ***A crisis management system*** will be provided through a 24-hour violence hotline. After the group sessions, the women may challenge their IPs' behaviour more often. As this could lead to more violence in the beginning, there must be a system that can respond immediately. A sex worker or her friend can call the hotline and a violence response team will be available within 24 hours. This system already exists at the CBO to respond to violence by non-intimate partners (such as clients and the police) but is not currently equipped to handle IPV. This project will strengthen the crisis management system to support FSWs who experience IPV. It will also link them with medical, legal and other psycho-social support.

b. **The project will work with the IPs of FSWs through four male facilitators. Those who live outside the 24 intervention villages will be reached through the FSWs. Activities with the IPs will include the following:**

i. ***Regular one-to-one sessions*** with the four facilitators, who will engage the IPs upon the FSWs' recommendations. The facilitators will discuss gender, equity, respect and responsibility along with violence and condom use. They will inform the IPs about the law against domestic violence and help them improve their communication and anger management skills. This one-to-one interaction will help encourage the IPs to participate in the group reflection sessions. The facilitators will attempt to engage 80 per cent of the IPs through counselling.

ii. ***Group sessions*** with similar principles as those for the FSWs but different modalities. During the pilot, it was evident that the men would not attend two-hourly sessions for six months – they prefer full day workshops to short sessions. Hence, they will have one full-day session every month for three months.

WORKSHOP CURRICULUM: INTIMATE PARTNERS

The five-module workshop series for men will cover HIV risk, women's rights, and laws relating to violence. The participants will share experiences, and discuss their ideals of masculine norms and behaviour. They will be encouraged to practice cooperation and communication rather than confrontation and coercion.

Module 1: Building trust and meaningful communication

Module 2: Gender ideals and notions of masculinity

Module 3: Unsafe sex and reducing risk

Module 4: Understanding violence and men's role in stopping it

Module 5: Creating a safe and responsible future

Their curriculum has five modules conducted over three full days. Gaps between the three workshops leave them enough time to reflect and practice the skills they have learnt. Since only 30-50 per cent of the partners are expected to attend the workshops, around 10 groups of 20 IPs each will be formed. Each group will undergo three workshops each.

iii. ***Training champions*** – selected from the IPs who have changed because of the intervention – to advocate locally for violence-free relationships. Fifteen men will be identified and trained as champions.

iv. ***Linkage to services and commodities*** such as HIV/STI testing and care services, as needed. These services are provided by the CBO through other programmes. The facilitators will also distribute condoms regularly.

v. ***Couples activities*** will be conducted to encourage loving and responsible relationships without risk or violence. These include the following:

- ***Couples events*** organised once every three months to enable couples to interact with other couples and enjoy leisure time with their partners. Through activities and games, the project will reinforce the message of violence- and risk-free relationships.
- ***Couple counselling*** as needed to help resolve relationship issues. The FSWs requested this service to help them address issues of trust, risk, violence and condom use with their IPs. In these sessions, facilitators will work with both partners to help them resolve their issues while promoting equity and a positive outcome for the FSW. It must be noted that this service is not equivalent to professional counselling by a qualified psychologist.

c. **Intervention outcome indicators at the FSW and IP level are described below (Table 4.2: Outcome indicators at the FSW and IP levels).**

TABLE 4.2: OUTCOME INDICATORS AT THE FSW AND IP LEVELS

Outcome level	Indicators
Long-term outcomes	• Greater acceptance of the negative impact of IPV and HIV/STI risk in intimate relationships by FSWs and their IPs. • Increased individual and collective action by the FSWs to challenge IPV and HIV/STI risk.
Medium-term outcomes	• Increased self-worth among the FSWs. • Increased recognition that male dominance and violence is unacceptable. • Increased awareness among stakeholders about the rights of women and the legal ramifications of IPV. • More equitable intimate relationships based on mutual respect. • Greater safety of the FSWs now equipped with the skills to challenge violence and unsafe sex practices.

d. **Outputs, activities, indicators, means of verification and targets are described below (Table 4.3: Outputs and Activities at FSW and IP level).**

TABLE 4.3: OUTPUTS AND ACTIVITIES AT FSW AND IP LEVEL

Outputs		• Formation of FSW reflection groups; group sessions conducted and attended regularly by FSWs. • Safety plans developed and utilised as required. • HIV/STI services and commodities provided. • Workshops conducted and regularly attended by the IPs. • Supportive crisis management system for the FSWs experiencing IPV established. • Training on leadership and advocacy skills for the FSW leaders. • Individual and couple counselling conducted for the FSWs and their IPs.		
No.	**Activity**	**Indicators**	**Means of verification**	**Target**
Activities with the FSWs				
1	Contact/ outreach/ follow-up	• Number of FSWs contacted/ outreached or followed up for services.	• Line list • Outreach reporting format	• 320 in Years 1 and 2 and another 300 in Year 3.
2	Conduct group participatory reflection sessions with the FSWs.	• Number of FSW groups formed. • Number of sessions conducted with the FSWs. • Number of FSWs attending at least half the total number of sessions.	• Session reports • Attendance register • Monthly progress report	• 32 FSW groups formed in Year 1 and continued in Year 2. 28 new groups formed in Year 3. • 500 sessions for 32 FSW groups in Years 1and 2 and 28 groups in Year 3. • 350 FSWs covered through these sessions in Years 1 and 2 and 300 in Year 3. • 300 FSWs in Years 1 and 2 and 250 in Year 3 attend at least half the total number of workshops.
3	Assist the sex workers to prepare safety plans.	• No of FSWs who have prepared safety plans.	• Line list	• 412 in Years 1 and 2 and another 388 in Year 3.
4	Provide counselling services to the sex workers.	• Number of FSWs who received individual counselling after facing IPV.	• Counselling reports • Outreach reporting format • Line list	• 165 FSWs in Years 1 and 2 and 150 in Year 3 receive individual counselling.
5	Provide services and commodities to sex workers.	• Number of male/ female condoms distributed. • Number of FSWs accessing services (STI, ICTC and ART).	• Outreach reporting format • Clinical records • Line list	• 13,000 male condoms and 4,000 female condoms distributed monthly to FSWs in Years 1 and 2. • 400 FSWs visit the clinic every quarter for STI screening and ICTC if eligible. • All the eligible FSWs given ART.
6	Support the sex workers during incidents of IPV.	• Number of FSWs experiencing IPV. • Number of FSWs supported following IPV.	• Crisis reporting format • Outreach reporting format	• All the FSWs who experience IPV are supported.
7	Conduct special events for the FSWs.	• Number of special events conducted for the FSWs. • Number of FSWs who participate in the events.	• Events register	• 2 special events conducted annually • 240 FSWs participate annually.
8	Identify leaders and conduct training.	• Number of leaders identified and trained. • Number of leadership training sessions conducted.	• Workshop reports • Training reports	• 48 leaders in Years 1 and 2 and another 46 leaders in year 3 identified and trained • 2 leadership training sessions conducted.

Activities for the intimate partners				
1	Conduct one-to-one sessions with the IPs.	• Number of IPs contacted/ outreached or followed up for services.	• Line list • Outreach reporting format	• 400 in Years 1 and 2 and another 380 in Year 3.
2	Conduct group participatory reflection sessions with the IPs.	• Number of IP groups formed. • Number of sessions conducted with the IPs. • Number of IPs attending at least two third the total number of the sessions.	• Workshop reports • Attendance register • Monthly progress report	• 10 IP groups formed in Years 1 and 2 and another 9 in Year 3. • 300 full-day sessions in Years 1 and 2 and 270 full- day sessions in Year 3. • The workshops cover 200 IPs in Years 1 and 2 and 180 IPs in Year 3. • 150 IPs in Years 1 and 2 and 130 IPs in Year 3 complete two third the total number of sessions.
3	Identify and train champions among the IPs.	• Number of champions identified and trained. • Number of champion training sessions conducted.	• Workshop reports • Training reports	• 15 champions identified and trained in Years 1 and 2 and another 15 in Year 3. • 1 champion training session conducted annually.
4	Provide services and commodities to the IPs.	• Number of male condoms distributed. • Number of IPs accessing services (STI, ICTC and ART).	• Outreach reporting format • Clinical records • Line list	• 4,000 male condoms distributed monthly to the IPs. • 50 IPs visit the clinic every quarter for STI screening and ICTC, if eligible. • All the eligible IPs provided ART.

Activities for couples				
1	Conduct events with couples.	• Number of special events conducted for couples. • Number of participating couples.	• Events register	• 4 special events conducted for couples annually. • 20 couples participate in the special events annually.
2	Provide relationship counselling to the couples.	• Number of couples who received couple counselling after facing IPV.	• Counselling reports • Outreach reporting format • Line list	• 100 couples in Years 1 and 2 and 100 couples in Year 3 receive couple counselling.

d. **The timeline for the intervention at the FSW and IP level are described below (Table 4.4: Timeline – FSWs and IPs)**

TABLE 4.4: TIMELINE – FSWs AND IPs LEVEL ACTIVITIES

INDIVIDUAL AND RELATIONSHIP LEVELS													
		Group 1 villages (24)								Group 2 villages (23)			
No.	Activity	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
1	One-to-one contact (FSWs)												
2	Participatory group sessions (FSWs)												
3	Safety plans (FSWs)												
4	Counselling services (FSWs)												
5	Provision of services and commodities (FSWs)												
6	Provision of violence support services												
7	Special events												
8	Leadership training												
9	One-to-one contact (IPs)												
10	Group sessions (IPs)												
11	Provision of services and commodities (IPs)												
12	Champion identification and training												
13	Couple events												
14	Couple counselling												

4.2.2 Interventions at the CBO level: Board members, staff and crisis management teams

The Chaitanya AIDS Tadegatwa Mahila Sangha (CATMS) has been implementing targeted HIV prevention interventions in the Bagalkot region for over 10 years. They have mastered components of outreach, condom promotion, STI services, and referrals to Integrated Counselling and Testing Centres (ICTCs) and antiretroviral therapy (ART). They have also worked to reduce violence and harassment from clients, police, and street criminals. But risk reduction in the intimate relationships of FSWs is a new challenge for them. Although aware of the problem, they lack the means to address it.

a. **A key component of this project is to strengthen the capacity of the CBO to help sustain project outcomes. Activities with the CBOs will include the following:**

i. ***Building the capacity of the CBO board*** by conducting workshops on gender equity, norms and roles in intimate relationships, and raise awareness that violence need not be tolerated. They will also be informed about laws that protect women against violence, and to understand that these laws also apply to FSWs. The workshops will aim to empower them to challenge violence and support the intervention. Two two-day workshops will be organised for the CBO board members.

ii. ***Training the CBO's crisis management team,*** comprising supervisors, peer educators and a lawyer on retainer, on gender equity, the context and norms that influence IPV, and the law. It will also equip them with skills to address the issue. Two two-day workshops will be organised for the crisis management team.

iii. ***District level advocacy*** through a campaign by the CBO to protest against violence against FSWs, attract attention, and initiate public discourse.

iv. ***Networking and alliance building*** in the district and state to integrate violence against FSWs into the movement for violence against woman. Meetings will be organised with women's organisations to enable participation in their advocacy events. The project will also help the CBO to develop linkages with the Santawana Kendra counselling centres run by the state government's Department of Women and Child Development to support women who experience violence. Networking and advocacy with the free Legal Aid Board can result in legal aid and advice to sex workers in times of crisis.

b. **Intervention outcome indicators at the CBO level are described below (Table 4.5: Outcome indicators at the CBO level)**

TABLE 4.5: OUTCOME INDICATORS AT THE CBO LEVEL

Outcome level	Indicators
Long-term outcome	• Increased institutional response and alliance building at the CBO level to address violence and HIV risk in intimate relationships.
Medium-term outcomes	• Lower acceptance of IPV at the CBO level. • Improved capacity of the CBO to prevent and respond to IPV.

c. **Outputs, activities, indicators, means of verification, and targets at the CBO level are described below (Table 4.6: Output and activities at the CBO level)**

TABLE 4.6: OUTPUT AND ACTIVITIES AT THE CBO LEVEL

Outputs	• Regular training sessions conducted with CBOs and crisis management teams. • District level advocacy campaigns conducted. • Links with women's organisations established.

No.	Activity	Indicators	Means of verification	Target
1	Build the capacity of the CBO board on IPV issues.	• Number of training sessions conducted on IPV for CBO board and staff. • Number of participants trained. • Number of CBO meetings at which IPV is discussed.	• Training reports • Meeting minutes	• 2 sessions for CBOs. • 80 per cent of CBO board members and key staff participate. • The CBO discusses IPV at meetings once every two months.
2	Train the crisis management team.	• Number of training sessions on IPV for the CMT. • Number of participants trained. • Number of CMT meetings at which IPV is discussed.	• Training reports • Meeting minutes	• 2 training sessions for the CMT. • All CMT members participate in every training session. • IPV discussed at all CMT meetings.
3	Conduct district level advocacy events on IPV.	• Number of district level campaigns organised on IPV.	• Events report	• 2 district level campaigns organised on IPV.
4	Build alliances with other networks working on IPV.	• Number of meetings organised with other networks. • Number of meetings organised by other networks attended by CBO. • Number of joint campaigns planned and implemented.	• Meeting minutes • Event report	• 2 meetings on IPV organised annually with other networks. • 1 joint event organised with other networks.

d. **The timeline for the intervention at the CBO level are described below (Table 4.7: Timeline – CBOs)**

TABLE 4.7: TIMELINE – CBO LEVEL ACTIVITIES

CBO LEVEL												
		Group 1 villages (24)								Group 2 villages (23)			
No.	Activity	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
1	Train CBO members on IP issues.												
2	Train and strengthen crisis management teams.												
3	District level advocacy events.												
4	Links with women's organisations and other networks.												

4.2.3 Interventions at the community level: Village and community leaders, neighbours, Panchayati Raj institutions and SHGs

There is little understanding within the community in the intervention area of the rights of FSWs in the context of IPV and the laws that protect them.

a. **Interventions to raise awareness of IPV, domestic violence and the law, and to challenge social norms at the community level include the following:**

i. ***Folk shows and street plays*** identified or scripted with a gender lens. As breaking social norms is challenging, reinforcing gender awareness will help in facilitating reflection and thinking. This will be done in consultation with the CBOs concerned with IPV/ domestic violence, and performed twice in the intervention villages during the intervention period.

ii. ***Community events*** such as rallies and campaigns conducted with other CBO programmes to raise awareness and exhibit the strength and solidarity among FSWs against violence.

b. **Intervention outcome indicators at the community level are described below (Table 4.8: Outcome indicators at the community level)**

TABLE 4.8: OUTCOME INDICATORS AT THE COMMUNITY LEVEL

Outcome level	Indicators
Long-term outcome	• Increased dialogue and coordinated community action to change norms that enable violence against women.
Medium-term outcome	• Lower tolerance of IPV at the community level.

c. **Outputs, activities, indicators, means of verification and targets at the community level are described below (Table 4.9: Output and activities at the community level)**

TABLE 4.9: OUTPUT AND ACTIVITIES AT THE COMMUNITY LEVEL

Outputs	• Folk shows propagating against IPV. • Community campaigns against violence at the village level.

No.	Activity	Indicators	Means of verification	Target
1	Folk shows and street plays	• Number of folk shows/ street plays conducted. • Number of villages covered through folk shows/ street plays.	• Events register	• 2 shows in 24 villages in Years 1 and 2 and in 23 villages in Year 3.
2	Community events	• Number of community events conducted. • Number of villages in which the events are held.	• Events register	• 1 event in 24 villages in Years 1 and 2.

d. **Timelines for the intervention at the community level are described below (Table 5.0: Timeline – Community)**

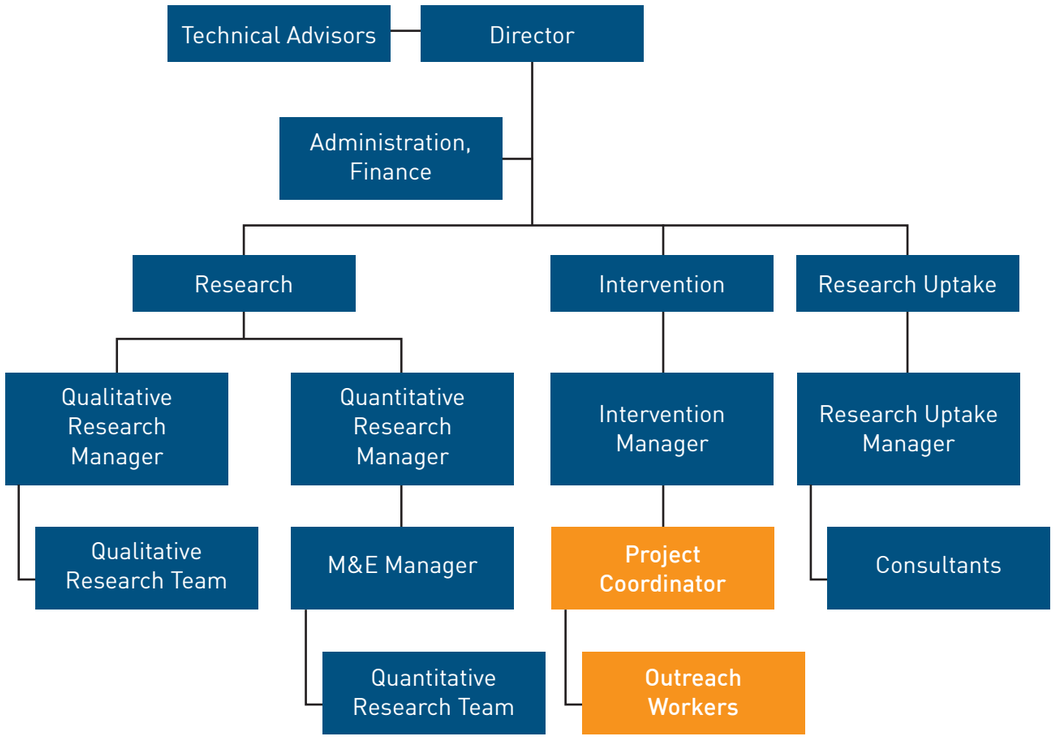
TABLE 5.0: TIMELINE – COMMUNITY LEVEL ACTIVITIES

COMMUNITY LEVEL													
		Group 1 villages (24)								Group 2 villages (23)			
No.	Activity	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
1	Conduct folk shows and street plays												
2	Community events												

5 MANAGEMENT STRUCTURE

The roles and responsibilities of each position are as follows (Figure 5.1: Management Structure):

FIGURE 5.1: MANAGEMENT STRUCTURE



a. **Director:**
The main contact point for the donor and programme team, responsible for the deliverables and compliance with donor policies and regulations. Director is responsible for submission of quarterly and annual programme and financial reports. The Director leads and motivates the project team to ensure smooth implementation, adequate resources, and timely troubleshooting with creative solutions. Part-time consultants support the Director as and when needed.

RESEARCH

b. **Manager, Qualitative Studies:**
Undertake exploratory research on the structural drivers of HIV, identify research areas, design studies, develop protocols, implement and analyse data, provide written and oral reports, and engage in primary data collection, if necessary.

Responsibilities and tasks

- Design qualitative and operations research, identify areas of research.
- Review literature and develop research protocols.
- Design guides, tools, and other methods to collect qualitative data.
- Collect and analyse qualitative data from interviews, non-participant observations, and focus groups.
- Assist and implement research projects by reporting on the status of various tasks and recommending ways to improve research design.
- Create and deliver professional presentations on research results.
- Analyse qualitative data, make critical observations of analyses or data, and identify patterns in the data.
- Prepare clearly written technical and analytical reports.
- Recruit, guide, and supervise field staff contracted to implement special studies to evaluate project effects and impacts.
- Guide staff in preparing progress reports.

c. **Manager- Quantitative Studies:**
The quantitative studies manager is responsible for undertaking baseline, midline and end line surveys in the project. The manager identifies research areas, design surveys, develop protocol, implement and analyze data, provide written and oral reports, and sometimes engage in primary data collection. The quantitative studies manager is also responsible for guiding the M&E overall strategy and implementation of related activities within the project, along with providing timely and relevant information to project management. This entails close communication with all involved in M&E design and coordination.

Responsibilities and tasks

- Design quantitative research surveys.
- Develop the overall framework for project M&E. For example, annual project review, process monitoring, and operations monitoring.
- Conduct literature review and develop survey protocol.
- Design questionnaires, tools, and other methods to collect data.
- Identify survey teams and train them
- Create and deliver professional presentations on survey results.
- Analyze quantitative data, including making critical observations of analyses or data and identifying patterns in the data.
- Prepare clearly written technical and analytical reports.
- Prepare quantitative data files, evaluate the quality of the data, and describe its structure.
- Guide the process for identifying and designing the key indicators for each component.
- Guide the process for identifying the key performance questions and parameters for monitoring project performance and comparing it to targets. Design the format for such performance reports.
- Develop a plan for project related capacity building on M&E and for any computer based support that may be required.
- Guide staff in preparing their progress reports.
- Review monitoring reports; analyze them for impact evaluation and to identify the causes of potential bottlenecks in project implementation.
- Organize (and provide) refresher training in M&E for project staff.
- Prepare reports on M&E findings, as required, working closely with technical staff and implementing partners.
- Undertake regular visits to the field to support implementation of M&E and to identify where adaptations might be needed.
- Guide the regular sharing of the outputs of M&E findings with project staff, and implementing partners.
- Develop the design and implement baseline, midterm, and end-line surveys, as required.

d. **Monitoring & Evaluation Officer:**
M&E officer is based in the site of intervention and is in charge of filed implementation of the survey and the project monitoring framework. The staff monitors the progress of various surveys conducted, supports in addressing field level challenges for the survey team. The staff also trains the data entry operators in the project to maintain quality in data entry and production of reports. The staff trains the project field level staff on monitoring and data collection tools and supports in using data generated from the projects in decision making. The staff also compiles project related monthly report and shares with the team.

e. **Qualitative and Quantitative Research Team:**
The responsibility of the team to collect data

for various research studies and surveys. The project has a separate qualitative and quantitative research team who undergo regular training to improve their skills.

INTERVENTION

f. Intervention Manager:

Located in northern Karnataka, the manager is incharge of the implementation of the intervention. The manager develops technical and implementation strategies for the project, address field level challenges that occur from time to time, monitors progress of the project as per the work plan and supervises the field implementation team consisting of the project coordinator and outreach workers. The manager is supported by the M&E Officers to undertake evidence based planning and ensuring quality of programmes. Manager is responsible for programme management, technical support and capacity building, advocacy and networking, and knowledge sharing.

The manager will coordinate with KHPT for grant release and submission of reports and funds, facilitate site visits of donors and government officials, assist in devising strategies and programmes for the FSWs and their IPs on the basis of data and field needs, coordinate with the field team to identify and document best practices in the programme area, coordinate and support the implementation of various qualitative and qualitative studies undertaken by the project.

g. Programme Coordinator:

Based in the district of implementation.
The coordinator is responsible for project implementation in the district. Coodinator oversees daily administration of the project and takes primary charge of providing management support, capacity building and documentation support to the CBO. The roles and responsibilities of the Programme Coordinator are detailed below.

Responsibilities and tasks

- Improve programming quality by providing management/ technical support in line with programming guidelines and strategies.
- Assist the outreach workers in analysing gaps and needs in the programmes in their sites and guide the process to address these gaps.
- Ensure that project outcomes are achieved in the intervention
- Periodically review project performance through monthly/ quarterly
- reports and field visits; identify gaps, and provide continual feedback to other
- team members; assist the Intervention Manager to develop plans to address the gaps.
- Submit monthly programming reports from the district in the prescribed format.
- Provide on-the-job mentoring support to help outreach staff analyse data progress with regard to the target.
- Assess the capacity needs of the field staff and formulate plans to address them.
- Network with government and non-government stakeholders for better services.
- Work in close conjunction with the field staff and help them develop follow-up plans to address gaps and achieve the desired change by overcoming bottlenecks in the programme.

h. Outreach Workers/ Facilitators:

Individuals with desired qualification and experience are recruited as outreach workers for the project. Peer counsellors with more than six years of interventions experience are also considered if they can read and write at least Kannada. There are 12 outreach workers, 8 women and 4 men. One male and one female outreach worker will be in charge of a cluster with about 80 FSWs and their IPs. The female outreach workers work with the FSWs, while the male outreach workers work with the IPs.

The key roles will be as follows:

- Line list and profile the FSWs and their IPs using the vulnerability indicators; understand their situation by frequently visiting them and their families through outreach activity.
- Prioritise the FSWs and IPs who experience violence in their relationship in the group sessions of the curriculum.
- Facilitate and monitor group sessions with FSWs and their IPs.
- Identify the leaders and allies for the FSWs.
- Conduct outreach/ family visits to investigate and solve problems and protect the women from crises.
- Organise special events for the FSWs and their IPs.
- Provide support at the time of crisis and violence
- Train the sex workers in condom negotiation skills
- Raise awareness about the legal protection measures available to FSWs and all other women.
- Maintain forms of government schemes, facilitate linkages and submit the forms to enable access to benefits.
- Mobilise FSWs and their IPs for clinics and ICTC.
- Identify male champions at the village and cluster levels and maintain a rapport with them.
- Identify leaders and mobilise them for leadership trainings.
- Assist the teams to conduct folk and community programmes
- Report progress to the coordinator and the CBO on a weekly basis.

RESEARCH UPTAKE

i. Manager – Research Uptake:

In addition to carrying out all documentation of best practices and translating the learning into action, the staff performs the following duties:

- Engage with end users and policy makers to ensure research findings are used for programming and policy
- Support the documentation of research and in writing the annual report
- Document activities, outputs and outcomes
- Document and publish success stories and lessons learnt
- Prepare briefs of research and assessments

6 MONITORING & EVALUATION

6.1 PROCESS MONITORING

A robust monitoring system will be established to monitor activities at the individual (FSW and IP), community, and CBO levels. Interventions with the FSWs and their IPs will be monitored using an individual tracking system to review inputs and outputs. The activities with groups of FSWs, IPs, CBOs, and communities, will be monitored using semi-structured tools that capture information on the type of activity, duration, and number of people reached. Regular review meetings, data analysis, and sharing and documentation of lessons will provide feedback to the stakeholders during and after implementation.

Implementation data will be recorded, analysed and conveyed to the managers and relevant stakeholders so that they can determine whether the project is being implemented as planned, and observe the interim results. The project will train staff to monitor IPV and service uptake to ensure that FSWs who face violence are identified, contacted and counselled.

At the CBO level, we will monitor the frequency of events, training sessions, linkages and community activities such as folk shows and male champion programmes. Inputs – including resources and personnel involved in the programme and in service delivery – as well as outputs – such as programme outreach and service delivery targets and indicators – will be measured monthly and quarterly. Field visits to troubleshoot monitoring snags will be conducted periodically as necessary.

The programme's computerised management information system will link data entry points and repositories at all levels for efficient and consistent data management and up-to-date information for assessment and planning. Data collected at the outreach level will be accessible to the CBO and KHPT. The flowchart below depicts data flow from outreach workers to supervisors and district programme coordinators (Figure 7.1: Flowchart of monitoring and data collection).

FIGURE 6.1: FLOWCHART OF MONITORING AND DATA COLLECTION

Outreach level	District Programme Coordinator level
• Reporting forms are filled in. • Data is edited for completeness and quality. • Records are used for planning and monitoring by counsellors. • Aggregation of data from counsellors.	• Reports received on monthly, quarterly, and annual basis from counsellors are consolidated. • Data is analysed and programme performance tracked. • Feedback is provided to the counsellors.

The programme's inputs and outputs are monitored by the proposed monitoring plan. The outputs expected and the indicators to measure them are listed below (Table 6.1: Programme outputs and indicators).

TABLE 6.1: PROGRAMME OUTPUTS AND INDICATORS

No.	Outputs	Output indicators	Data capturing tool	Frequency of data	Person responsible for compiling data
Interventions at the individual level (female sex workers)					
1	Contact/ outreach/ follow up	• No. of FSWs contacted/ outreached/ followed up for services	• Line list • Outreach reporting format	Monthly	Outreach worker
2	Group participatory reflection sessions	• No. of groups formed • No. of sessions conducted • No. of FSWs who attended at least 50 per cent of the sessions • No. of FSWs who attended all the sessions	• Session reports • Attendance register • Monthly progress report	Monthly	Outreach worker
3	Safety plan development	• No of FSWs with safety plans	• Line list	Monthly	Outreach worker
4	Counselling	• No. of FSWs offered individual counselling for IPV	• Counselling reports • Outreach reporting format • Line list	Monthly	Outreach worker
5	Services and commodities	• No. of male/ female condoms distributed • No. of FSWs who accessed services (STI, ICTC and ART)	• Outreach reporting format • Clinical records • Line list	Monthly	Outreach worker

6	Support after IPV	• No. of FSWs who experienced IPV • No. of FSWs given support after IPV	• Crisis reporting format • Outreach reporting format	Monthly	Outreach worker
7	Special events	• No. of special events conducted • No. of FSWs who participated	• Event register	Quarterly	Outreach worker, Programme Coordinator
8	Identification and training of leaders	• No. of leaders identified and trained • No. of leadership training sessions	• Workshop reports • Training reports	Thrice during the project	Outreach worker
Interventions at the individual level (intimate partners)					
1	One-to-one contact and sessions	• No. of IPs contacted/ outreached/ followed up for services	• Line list • Outreach reporting format	Monthly	Outreach worker
2	Group participatory reflection sessions	• No. of groups formed • No. of sessions conducted • No. of IPs who attended at least two-thirds the total number of sessions • No. of IPs who attended all the sessions	• Workshop reports • Attendance register • Monthly progress report	Monthly	Outreach worker
3	Identification and training of IP champions	• No. of champions identified and trained • No. of training sessions for champions	• Workshop reports • Training reports	Monthly	Outreach worker

4	Services and commodities	• No. of male condoms distributed • No. of IPs who accessed services (STI, ICTC and ART)	• Outreach reporting format • Clinical records • Line list	Monthly	Outreach worker
Interventions at the couple level					
1	Special events	• No. of special events • No. of couples who participated	• Event register	Monthly	Outreach worker
2	Relationship counselling	• No. of couples experiencing IPV who received couple counselling	• Counselling reports • Outreach reporting format • Line list	Monthly	Outreach worker
Interventions at the CBO level					
1	Build the capacity of the CBO board on IPV issues	• No. of training sessions conducted for the CBO board and staff • No. of participants trained • No. of CBO meetings where IPV was discussed	• Training reports • Meeting minutes	Thrice during a two-year period	Programme Coordinator
2	Training for the Crisis Management Team	• No. of training sessions • No. of participants trained • No. of CMT meetings where IPV was discussed	• Training reports • Meeting minutes	Annually	Programme Coordinator
3	District level IPV advocacy events	• No. of district level IPV campaigns	• Event report	Quarterly	Programme Coordinator

4	Alliances with networks fighting IPV	• No. of meetings with other networks • No. of meetings organised by other networks attended by the CBO • Number of joint campaigns	• Meeting minutes • Event report	Monthly	Programme Coordinator
Interventions at the community level					
1	Folk shows and street plays	• No. of folk shows/ street plays • No. of villages covered	• Event register	Every six months	Programme Coordinator
2	Community events	• No. of community events • No. of villages covered	• Event register	Every six months	Programme Coordinator

6.2 EVALUATION

Samvedana Plus was designed not only as a set of interventions to reduce FSWs' HIV/STI risk and vulnerability, but also to study the structural drivers of HIV transmission. Specifically, the programme will investigate the relationship between social norms and HIV risk in the context of FSWs' intimate partnerships and assess the efficacy of its interventions to alter such norms.

6.2.1 Purpose of evaluation

The purpose of the evaluation are to: (a) determine whether the interventions contribute to beneficial structural changes that increase condom use and reduce IPV in FSWs' intimate relationships; (b) assess the extent to which the intervention made a significant impact; and (c) understand why the interventions were effective.

6.2.2 Evaluation questions

The data collected will be analysed to answer the following questions:

a. What is the impact of the intervention on condom use and IPV in the intimate relationships of the target FSWs and their IPs?
b. In what ways has the intervention affected the response of the FSW community and general public to IPV?
c. Investigate the processes and causal pathways through which positive changes occur in the following areas: greater sense of self-worth; individual and collective efficacy; critical thinking on gender, violence, social norms and HIV risks among the FSWs and their IPs; greater sense of safety and well-being among the FSWs; increased awareness among FSWs and their IPs about HIV/STI risks in the context of intimate partnerships; increased awareness among FSWs, their IPs and other stakeholders about violence, rights and the law; and reduced acceptance of IPV among the FSWs.

6.2.3 Evaluation components

The evaluation will have three main components:

a. ***Quantitative assessments,*** which will include quantitative baseline, midline and endline assessments with the FSWs, and baseline and endline assessments with their IPs.

b. ***Qualitative process documentation,*** which will include longitudinal case studies with the FSWs and their IPs, as well as in-depth interviews with the facilitators of the programme.

c. ***Detailed implementation monitoring*** by measuring the exposure of each target group to the various components of the intervention.

6.2.4 Impact and outcome indicators

The evaluation will collect quantitative and qualitative data on the impact and outcome indicators as described below (Table 6.2: Indicators for each target group).

TABLE 6.2: INDICATORS FOR EACH TARGET GROUP

Outcome Levels	FSWs	IPs	FSW CBO	General community
Impact-level outcomes	• Increase in consistent condom use in intimate relationships • Decrease in physical and/ or sexual violence from their IPs	• Increase in consistent condom use in intimate relationships • Decrease in use of physical and/ or sexual violence in intimate relationships		
Long-term outcomes	• Increase in individual processes and action to reduce IPV and HIV/STI risk • Enhanced HIV/STI risk perception and skills for self-protection		• Increase in collective processes and action to reduce IPV and HIV/STI risk	• Improved supportive environment for dialogue and action on IPV
Medium-term outcomes	• Enhanced sense of self-worth and individual efficacy • Improved sense of safety and well being • Reduced acceptance of IPV		• Increased appreciation of STI/HIV risks in the context of intimate partnerships • Increased awareness of violence, rights and laws with respect to IPV • Reduced acceptance of violence by IPs	• Increased awareness of violence, rights and laws with respect to IPV • Reduced acceptance of IPV
	• Enhanced critical thinking on gender, violence, social norms and HIV risk • Increased appreciation of HIV/STI risks in the context of intimate partnerships • Increased awareness of violence, rights and laws with respect to IPV			

6.3 STUDY DESIGN

The study will employ a cluster-randomised control trial design with waitlist control, using the village as the unit of randomisation. Fifty per cent of the village clusters (n=24) will receive the intervention for the first 24 months (Cohort 1); the remaining 50 per cent (n=23) from months 25 to 36 (Cohort 2). The evaluation design involves: (a) quantitative baseline, midline and endline assessments in both cohorts among FSWs, and baseline and endline assessments with their IPs. In both cohorts, the baseline will be conducted in month 1, midline in month 13, and endline in month 25; (b) qualitative, longitudinal case studies with FSWs and their IPs; (c) in-depth interviews with facilitators of the program; and (d) process/ implementation monitoring. Intervention will begin in Cohort 2 after the outcome from the initial intervention group has been evaluated (Table 7.3: Phased introduction of programme components).

The design of the study was based on an enumeration of the FSWs in the villages of Mudhol and Jamkhandi talukas of Bagalkot district in 2011-12 to identify those who fulfill the following criteria: (a) more than one IP; (b) frequently change IPs; and (c) whose IP has more than one sexual partner. These characteristics were associated with STI vulnerability in a previous study[2]. Forty-seven villages were identified for intervention, with intensive programme components introduced in the phased manner described above.

The villages were stratified on the basis of two criteria – population size and number of FSWs with IPs (<=12 FSWs and >12 FSWs. There are two sets of villages i.e. villages with <=12 FSWs and with >12 FSWs in the strata.) – to allocate cohorts. Two strata of FSWs with IPs and three strata of village population size were created, giving a total of six strata (three sub-groups based on size of population under each group based on number of FSWs with IPs). Randomisation of villages was then performed within each stratum using STATA. Half the villages were randomised into Cohort 1 and the other half into Cohort 2, acting as a control arm initially and receiving the intervention after 24 months. The manner of introducing the programme components (Table 6.3: Phased introduction of programme components) and the profile of the villages (Table 6.4: Demographic profile of villages by intervention cohort) are presented below:

TABLE 6.3: PHASED INTRODUCTION OF PROGRAMME COMPONENTS

Month 1	Month 2-12	Month 13	Month 14-24	Month 25	Month 25-36
Baseline questionnaire administered in Cohort 1 (24 intervention villages) and Cohort 2 (23 control villages)	Intervention in Cohort 1: 412 FSWs	Midline questionnaire administered in Cohort 1 (intervention) and Cohort 2 (control)	Intervention in Cohort 1 continues	Endline questionnaire administered in Cohort 1 (intervention) and Cohort 2 (control)	Intervention in Cohort 2 (remaining 23 control villages) if proven effective (388 FSWs)

2 Shaw S and Pillai P. Understanding Risk for HIV/STI Transmission and Acquisition within Non-Paying Partnerships of Female Sex Workers in Southern India. Karnataka Health Promotion Trust, India (2012). http://www.dfid.gov.uk/r4d/PDF/Outputs/Strive/Understanding_Risk_within_Non-Paying_Partnerships.pdf

TABLE 6.4: DEMOGRAPHIC PROFILE OF VILLAGES BY INTERVENTION COHORT

Demographic profile	Cohort	
	1	2
Number of villages	24	23
Mean household size	5.3	5.3
Sex ratio (F/M*1000)	983	985
SC population (%)	19.7	20.7
ST population (%)	4.5	2.3
SC/ ST population (%)	24.2	23.0
Literate total adults (%)	53.4	52.0
Literate males (%)	60.9	60.2
Literate females (%)	45.7	43.7

These 47 villages have 800 FSWs with IPs, an average of 17 such FSWs per village (Table 6.5: Profile of FSWs by intervention cohort).

TABLE 6.5: PROFILE OF FSWs WITH IPs BY INTERVENTION COHORT

(Percentage of FSWs by selected socio-demographic characteristics, Cohorts 1 and 2)

Profile	Cohort	
	1	2
Current age		
< 25 years	9.9	10.6
25-29 years	24.2	24.0
30-34 years	21.8	22.8
35+ years	44.0	42.6
Mean age	**33.7**	**33.5**
Marital status		
Never married	0.0	1.4
Currently married	0.0	1.0
Divorced/ separated/ deserted	3.2	8.3
Widowed	1.4	1.8
Devadasi	95.0	87.4
Currently cohabiting (%)	73.7	68.6
Illiterate (%)	86.7	90.4
Mean client volume	**11.6**	**12.3**
Mean duration	**15.3**	**14.6**
Typology		
Home	89.5	87.4
Public place	5.2	7.1
Brothel/ lodge/ dhaba/ other	5.4	5.5
Age at start of sex work		
< 20	63.8	63.7
20-24	20.8	21.8
25-29	8.7	8.6
30+	6.8	6.0
Mean age at start of sex work	**19.0**	**19.2**
Local (%)	92.5	91.6
Member of any site group (%)	68.7	66.3
Mean number of children	**2.1**	**2.2**
Number of IPs		
1	81.8	77.9
2	16.4	19.9
3	1.8	2.2
Mean number of IPs	**1.2**	**1.2**
FSWs who have had another IP (%)	63.7	58.2

A summary of the different data collection methods for assessment, as applicable to the various target groups appears below (Table 6.6: Data collection methods by target group), followed by a more detailed description.

TABLE 6.6: DATA COLLECTION METHODS BY TARGET GROUP

Data collection method	Target groups		
	FSWs	IPs	Counsellors
Quantitative survey	✓	✓	×
Qualitative assessments: Longitudinal case studies using in-depth interviews	✓	✓	×
Qualitative assessments: In-depth interviews	×	×	✓

6.3.1 Quantitative assessments

Cross-sectional surveys will be conducted through face-to-face interviews using an interviewer-administered questionnaire for the FSWs and their IPs at baseline and endline in both cohorts. These surveys will measure the project's impact on the FSWs and IPs that report consistent condom use, and those that have experienced or inflict IPV in the previous six months. An initial assessment showed consistent condom use prevalence at 38 per cent and IPV prevalence at 47 per cent. To detect the difference between arms, we worked out the power considering the total number of FSWs with IPs in the selected 47 villages (24 villages in Cohort 1 and 23 in Cohort 2), assuming a 10 per cent refusal rate. The following table (Table 6.7: Power to detect a difference between arms – one year) shows the power calculation based on a risk of 47 per cent of the FSWs experiencing IPV, varying effect size and risk ration and at different 'k' values (intra cluster correlation).

TABLE 6.7: POWER TO DETECT A DIFFERENCE BETWEEN ARMS

Risk (%)	K	RR	Reduction (%)	Power (%)
47	0.15	0.75	25	88
47	0.15	0.77	23	84
47	0.15	0.80	20	73
47	0.20	0.75	25	86
47	0.20	0.77	23	82
47	0.20	0.80	20	70
47	0.25	0.75	25	89
47	0.25	0.77	23	85
47	0.25	0.80	20	70

These surveys will also measure the long- and medium-term outcome indicators (Table 6.2: Indicators for each target group) for the FSWs and their IPs. For each indicator measured, broad indicator domains are delineated and questions developed for each subject domain. A summary of the major and sub-domains for each indicator appears below (Table 6.8: Indicator domains and sub-domains). The survey questionnaires will be developed in English, translated into the local language Kannada, pretested, piloted, revised, and translated back into English.

a. ***FSW sampling:*** A regularly updated line list of FSWs and their IP status maintained by the CBO will be used to identify the FSWs for baseline and endline surveys. All women who engage in commercial sex work, are over 18, have an IP or did, in the preceding six months from these 47 villages, will be surveyed face-to-face about primary and secondary outcomes, and programme exposure variables.

b. ***IP sampling:*** Pretesting revealed that reaching a sample large enough to measure statistically significant change among the IPs was unfeasible due to concerns with recruiting. To increase the response rate among the IPs, therefore, men will be recruited from a line list of IPs and contacted initially by peer educators from the CBOs rather than the research team. Hence, while changes in condom use and IPV reported by the IPs will not be considered primary outcomes, pre-post intervention design will provide useful information about the nature of change that can and cannot be affected by the intervention.

TABLE 6.8: INDICATOR DOMAINS AND SUB-DOMAINS

Domain	Sub-domain
PROFILE (FSWs)	
Demographics	Location, age, caste, educational status, marital status, number of children, income from sex work and other work.
Sex work characteristics	Age at first sex, age at first commercial sex, place of solicitation, number of clients, number of occasional and regular clients, condom use during last encounter with clients, monthly income from sex work and from other work, violence from clients.
Details of intimate partnerships	Number of current IPs, IPs broken up with in the preceding six months. For two (main) current IPs: age, marital status, number of children, occupation, education, duration of relationship, living arrangements, frequency of visits and sexual encounters, whether he knows that she is a sex worker, type of support from him, consumption of alcohol.
Consistent condom use with IPs (FSWs)	
Condom use with IPs	For two (main) current IPs: male/ female condom use during last sex, frequency of male/female condom use with the IP, whether there an occasion in the previous month when condom was not used with the IP; use for anal sex; use when under influence of alcohol.

Experience of IPV (FSWs)	
Nature and frequency of violence	A list of the different types of violence will be used by the interviewer to capture whether the respondent has ever experienced each type by violence by any of her IPs, and whether she experienced it in the preceding six months.
Increased individual processes and action to reduce IPV and HIV/STI risk (FSWs)	
Individual initiatives to reduce IPV	For each incident of IPV experienced during the previous six months: plans adopted by the respondent to prevent IPV, cope with IPV, redressal mechanisms post-IPV, and her experience of these measures.
Individual initiatives to reduce HIV/STI risk	For each IP: measures adopted by the respondent to prevent and deal with HIV/STI, and her experience of these measures.
HIV/STI risk perception and skills for self-protection (FSWs)	
Perceived risk of HIV/STI from IP	For each IP: Perceived risk of HIV/STI, perceived risk of condom negotiation, perceived benefits/ barriers to consistent condom use.
Enhanced skills for self-protection	Understanding risks associated with IPs and how to protect against them, confidence and experience in changing partner attitude to condom use, ensuring that male and female condoms are available, HIV/STI treatment testing and treatment.
Self-worth and individual efficacy (FSWs)	
General sense of self-worth	Poor self-worth ("I deserve to be beaten", etc.), guilt and shame related to sex work, pride in ability to earn independently, perception of self in terms of others' opinions.
Self-efficacy	Measures of general self-efficacy, self-efficacy for consistent condom use and preventing IPV using scales.
Improved sense of safety and mental health (FSWs)	
Safety	Safety experienced in each intimate partnership, with regard to: (a) his alcohol use; (b) his friends; (c) his family; (d) disclosure of paternity; (e) disclosure of her occupation; (f) discussions about finances. Availability and accessibility of support structures/ systems, redressal mechanisms, sense of solidarity, etc., within the FSW community.
Mental Health	Suicidal thoughts; whether such thoughts had occurred in the previous 30 days; whether she has ever attempted suicide.
Level of critical thinking on gender, violence, social norms and HIV risk (FSWs)	
Critical understanding of violence	Degrees of tolerance/ acceptance/ reaction to violence by different perpetrators and to different types of violence.
Understanding of gender roles and norms	Series of statements on intimate partnerships, including normative and empirical expectations.
Awareness of IPV-related rights and laws (FSWs)	
Awareness of IPV-related rights and laws	Knowledge questions on the provisions of the Domestic Violence Act and redressal mechanisms.
Exposure to intervention (FSWs)	
Level of exposure to IPV prevention strategies	Attendance of reflection groups, counselling; couple counselling; perceived effect of counselling.
PROFILE (IPs)	
Demographics	Location, age, caste, educational status, marital status, number of children.
Details of intimate partnerships	Number of current IPs, IPs broken up with in preceding six months; For two (main) current partners: age, marital status, number of children, occupation, education, duration of relationship, living arrangements, frequency of visits and sexual encounters, whether he knows if any of his IPs has other partners, type of support given, frequency of consuming alcohol.
Consistent condom use (IPs)	
Condom use with partners	For each IP (for a maximum of two) and wife: male/female condom use during last sex, frequency of male/ female condom use (always/ most of the time/ sometimes/ never), occasion during the preceding month when condom was not used (if any); use for anal sex; use when under influence of alcohol.
Violence in intimate relationships (IPs)	
Perpetration of violence	For each IP (for a maximum of two) and wife: instances of violence in the preceding six months (13 statements for different forms); main trigger of last incident of violence; intention to stop using violence.

Individual processes and action to reduce IPV and HIV/STI risk (IPs)	
Individual initiatives to reduce IPV	For each incident of IPV during the previous six months: plans adopted to prevent IPV, cope with IPV, and redressal mechanisms post-IPV; his experience of these measures.
Individual initiatives to reduce HIV/STI risk	For each IP: plans adopted to prevent/ treat HIV/STI; his experience of these measures.
HIV/STI risk perception and skills for self-protection (IPs)	
Perceived risk of HIV/STI from partners	For each IP: perceived risk of HIV/STI, perceived benefits of/ barriers to consistent condom use with their partners.
Enhanced skills for self-protection	Awareness of risks associated with sexual encounters with their partners and protection against these risks, confidence/ experience with changing partner response to condom use, ensuring availability of male and female condoms, HIV/STI testing and treatment.
Critical thinking on gender, violence, social norms and HIV risk (IPs)	
Understanding of gender roles and norms	Series of statements on intimate partnerships, including normative and empirical expectations on violence and condom use.
Awareness about IPV-related rights and laws (IPs)	
Awareness of IPV-related rights and laws	A series of questions related to the Domestic Violence Act, its provisions, and redressal mechanisms.
Exposure to intervention	
Level of exposure to IPV prevention strategies	Attendance at reflection groups, counselling; couple counselling; perceived effect of counselling.

6.3.2 Qualitative assessments

Qualitative methods will be used to describe: (a) how the intervention has influenced the FSWs and their IPs to address issues of consistent condom use and IPV by conducting longitudinal case studies; and (b) changes in critical thinking on gender and IPV, and programme successes and challenges as assessed through process evaluation of the counselling and reflection groups. Following is a brief discussion of the target groups, number, frequency, and general content of each of these methods.

a. ***Longitudinal case studies:***
The longitudinal case studies will be guided by a qualitative community-based research methodology, involving research committees from a sex workers CBO called Chaitanya Mahila Sangha in Mudhol, Bagalkot. The studies will track a cohort of 10 FSWs and their IPs, 13 unpaired FSWs and five unpaired IPs of registered sex workers through the project period. These individuals will be interviewed at one-year intervals. The aim of this component of the evaluation is to investigate the factors and situations that assist or hinder positive change in intimate partnerships, negotiating safer sex, and IPV.

The study will explore these hypothesised pathways in the theory of action and document movement in the indicators of change identified in consultation with the sex worker-led CBOs implementing the intervention:

i. **For the FSWs:**
- Enhanced sense of self-worth and individual and collective efficacy
- Enhanced critical thinking on gender, violence, social norms and HIV risks
- Greater safety and well-being
- Better understanding of IP-related HIV/ STI risks
- Greater awareness of violence, rights and the law
- Less acceptance of violence by IPs

ii. **For the IPs:**
- Enhanced critical thinking on gender, violence, social norms and HIV/STI risk
- Better understanding of HIV/STI risk in the context of intimate partnerships
- Greater awareness of violence, rights and the law

Community researchers will use a community-based research methodology to interview the selected participants and explore the changes they perceive in relationship dynamics and personal empowerment.

b. ***In-depth interviews with facilitators:***
These will be conducted annually to explore the facilitators' experiences with their reflection groups, individual participants, and couples. The interviews are expected to capture changes in their own critical thinking about gender, violence and sex work, as well as attitudinal changes in the FSWs and their IPs due to counselling or reflection. Their understanding of the change in relationship dynamics, response to IPV, safer sex practices, and other factors or situations that assist or prevent FSWs from using their new skills will be explored.

The study will use semi-structured interviews collected at the end of each intervention year. The key outcomes of the approach will be: (a) to explore how well the facilitators have internalised the messages about the unacceptability of IPV and the importance of condom use in intimate relationships; (b) to explore how the facilitators perceive changes in relationship dynamics among the FSWs and their IPs, how they respond to issues of gender and violence in group sessions, and the challenges they face.

The facilitators trained during the intervention will be interviewed for baseline and periodic follow up. Four participants – two men and two women – will be randomly chosen from a list of project counsellors for that year and interviewed at the end of every year.

6.4 DATA ENTRY AND ANALYSIS

The quantitative survey data will be entered and cleaned using CSPro. Upon completion of the project, we will assess whether there are significant differences between baseline and endline in the key indicators of consistent condom use and IPV at follow up. The final analysis will also assess whether the two sequential arms of the cohorts differ significantly in outcomes.

The qualitative data from the case studies, in-depth interviews, and focus group discussions will be transcribed and translated into English. Qualitative analysis packages such as NVivo10 and ATLAS.ti will be used to identify the key issues and themes emerging over time. These findings will be used along with the quantitative findings to understand the impact of the intervention.

6.5 ANALYSIS OF PRIMARY OUTCOMES

At project completion, we will assess whether, at follow up, there are significant differences between the intervention and control FSWs in the key indicators of condom use and IPV. We will perform appropriate analysis for stratified trials on the cluster mean-summaries using the t-statistic to assess the significance of the arms and and differences observed between them. Stata 11 will be used for all analyses.

Adjustment for baseline measures of the outcomes and variables that appear to be imbalanced at baseline will be conducted using the two step method recommended in Hayes and Moulton Cluster Randomised Trials. While this analysis will give a valid estimate of effect, and is robust, it may not be statistically optimal given the variation in the size of the clusters. Therefore, we will also perform an individual analysis with random effects to account for clustering. Both of these analyses will be reported, and any discrepancies will be explored. Similar methods will be used to compare key indicators, short- and medium-term outcomes.

6.6 ETHICAL ISSUES

Appropriate procedures will be followed to obtain the respondents' informed consent. A key source of potential distress for the FSWs would be to disclose acts of violence or coercion by their IPs. The study will take great care to minimise potential for such distress or harm – questions will be carefully worded to ensure that they are non-judgmental, the interviews will be conducted in private, interviewers trained to respond sensitively to disclosures of violence or requests for assistance, and the respondents directed to sources of support, if required.

The study will obtain the requisite ethical clearances from institutional review boards in India and the collaborating institutions. A broad-based Community Advisory Board (CAB) will be established, and will meet quarterly.

6.6.1 Informed consent

Interviews will be conducted in private settings in a sensitive and non-judgmental manner. The purpose of the study will be introduced and the respondent's written or witnessed consent will be administered using an informed consent form prior to the interview. The Kannada/ English version of the consent/ assent form will be given to the participants to read; it will also be read out and explained prior to the interviews. Written informed consent will be sought prior to conducting the interviews. With those who cannot read or write, we will seek oral consent witnessed by a friend or family member of the respondent's choosing. As part of the consenting procedure, participants will be assured that their participation is voluntary, and that their decision to participate will not affect any benefits they receive from the intervention.

6.6.2 Strategies to maintain confidentiality

In the context of IPV research, confidentiality is both a foundation for participant privacy and a strategy for limiting harmful fallouts that may occur if others deduce the nature of the research. Therefore training and strict guidelines will be imparted to the field team to emphasise the importance of confidentiality as a cornerstone of the research.

Anonymity will be maintained by using proxy names to distinguish individual participants. The identity of the participants and the information shared by them will not be revealed to anyone who does not work in the research study. At no time will any of the information given by individual participants be shared with anyone outside the research team.

All questionnaires will be stored in locked filing cabinets in the KHPT offices in Bangalore after the data has been computerised. The computer data will be password protected and only the statisticians working on the teams will be authorised to open and/ or use the data. Unique identifying numbers will be used to identify the questionnaires; no identifying names will be entered with the computer data. All data used at LSHTM will be kept on the secure server.

6.6.3 Ensuring participant and researcher safety

Training of interviewers will include content on gender, violence and HIV, role-play, and value clarification exercises to limit the possibility that they will consciously or unconsciously come across as judgmental toward the respondents. They will be extensively trained on the survey instrument and how to handle potential breaches of privacy.

To limit stigma and possible retaliation from abusive partners, the study will be referred to in the community and with other family members as a study on women and men's relationships. Respondents will be informed of the true nature of the study as part of the informed consent process. We will assume that women know best how to limit their own risk.

The FSWs and their IPs will be interviewed separately. Discussions with CBO members running the project reveal that the FSWs live independently and have their own source of income, making them less vulnerable to threats of retaliation than other women might be. In addition, many of the IPs do not belong to the same village as their FSW partners.

During consent, access numbers to crisis response teams will be given to the women that they can call in case of a crisis. The interviews will be one-on-one and there will be a code to stop talking if anyone interrupts and a plan to start the interview over at a new time or place will be decided prior to the interview if this occurs. Interview locations will be determined according to the respondent's convenience.

6.7 TIME PERIOD

The total study period will be three years: three months of start-up activities, 24 months of intervention, and another six months of final assessments and analyses (Table 6.9: Study timelines).

The last six months of the project will be devoted to endline data collection (three months), analysis and reporting (three months), and dissemination of the findings to local communities, Indian policymakers, and the international community. Interim analyses will be conducted on a semi-annual basis, and a final report submitted upon completion of the project.

TABLE 6.9: STUDY TIMELINES

Activities/tasks	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
Cross-sectional survey among the FSWs												
Cross-sectional survey among the FSWs												
Longitudinal case study with FSW												
Longitudinal case study with IPs												
In-depth interviews with facilitators												
Intervention – cohort-1												
Intervention – cohort-2												

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