Redefining Self and Community: Understanding the Empowerment Experiences of Female Sex Workers within the Context of HIV/AIDS Prevention Programs in Karnataka, India

By

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A thesis submitted to the Faculty of Graduate Studies
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Abstract

This thesis explores the empowerment experiences of female sex workers within the context of HIV/AIDS prevention programs in Karnataka, India. Multiple case studies were carried out to describe the context and empowerment strategies of three HIV/AIDS prevention programs for female sex workers in different districts in Karnataka. To understand the perspectives of various program stakeholders, semi-structured interviews and focus group discussions were conducted with female sex workers, peer educators, program staff, and government officials. The study identifies strengths and limitations of the programs based on the assessment of program stakeholders. Twelve key themes illustrate how the HIV/AIDS prevention programs have influenced meaningful transformations in the lives of sex workers and other program stakeholders. The main themes that encapsulate female sex workers' empowerment experiences include the following: HIV/AIDS and health; condom use and negotiation; self-esteem and capacity development; sense of control and options for the future; participation and ownership of programs; solidarity and collectivization; and legitimacy and disclosure of sex work. These themes reveal how female sex workers interpret and articulate the experience of empowerment. The stories largely involve sex workers redefining self and community, finding both renewed feelings of self-worth and a sense of belonging and usefulness to the community of sex workers. The empowerment experiences of women in this study are not uniform and likely reflect a small proportion of sex workers who are actively engaged in the HIV/AIDS prevention programs in Karnataka; however, these experiences represent the potential of effective programs to bring about positive changes, including improved health-protective behaviour, in the lives of sex workers.

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List of Abbreviations

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral (treatment/drug)
BMGF	Bill and Melinda Gates Foundation
CBO	Community based organization
CBPR	Community based participatory research
CIDA	Canadian International Development Agency
DMSC	Durbar Mahila Samanwaya Committee
FGD	Focus group discussion
FSW	Female sex worker
HIV	Human immunodeficiency virus
ICHAP	India-Canada Collaborative HIV/AIDS Project
IEC	Information, education and communication
KHPT	Karnataka Health Promotion Trust
KNP+	Karnataka Network for HIV+ People
MSW	Male sex worker
NACO	National AIDS Control Organization
NGO	Non-governmental organization
PE	Peer educator
PLC	Program-linked clinic
PLHA	Person living with HIV/AIDS
PPTCT	Prevention of parent-to-child transmission
SAG	Self help affinity group
SHG	Self help group
STI	Sexually transmitted infection
VCT(C)	Voluntary counseling and testing (centre)

Chapter 1: Introduction

1.1 HIV/AIDS Contexts: Global, India, and Karnataka

Since 2001, the HIV/AIDS epidemic has been the fourth highest cause of death globally and the leading cause of death in sub-Saharan Africa (UNAIDS, 2006; Vass, 2001). The UNAIDS *2006 Report on the Global AIDS Epidemic* makes the following estimates for 2005: 38.6 million people were living with HIV, 4.1 million people became newly infected, and 2.8 million people died of AIDS. The burden of disease is disproportionately experienced, with 95% of the people with HIV/AIDS living in developing countries (UNAIDS, 2006; United Nations Population Fund, 2007).

In 2005, India had a national HIV prevalence of 0.9% (for ages 15 to 49) and an estimated 5.7 million adults and children living with HIV, the largest population of people with HIV in the world (UNAIDS, 2006). There is much variation in the HIV prevalence across the country. At the end of 2004, HIV infections were largely concentrated in seven states considered "high prevalence" (defined as more than 1% prevalence in antenatal clinics): Karnataka and Andhra Pradesh in the south; Maharashtra and Goa in the west; and Mizorum, Manipur, and Nagaland in the northeast (National AIDS Control Organization or NACO, 2007b). India has a highly heterogeneous epidemic comprised of a large number of local concentrated epidemics and pockets of high-risk networks, such as female sex workers and men having sex with men (Moses et al., 2006).

The Karnataka State AIDS Prevention Society (KSAPS) estimated that in 2004, the state of Karnataka had 500,000 people living with HIV/AIDS, and both the HIV incidence and deaths due to AIDS were on the rise (KSAPS, 2004b). In 2004, the overall

HIV prevalence in Karnataka was 1.25% among women testing at antenatal clinics and 12% among women attending sexually transmitted infection (STI) clinics (NACO, 2007b). However, in the same year in some districts of Karnataka, the HIV prevalence among women attending STI clinics was over 20%; additionally, several districts in the northern region of Karnataka had HIV prevalences of more than 3% in the general population (Blanchard et al., 2005). Similar to HIV prevalence trends across India and Karnataka, there is heterogeneity within the districts of Karnataka. For example, a 2003 study revealed that three adjacent sub-divisions of one district in northern Karnataka had significant differences in HIV prevalence (ranging from 1.2% to 4.9%), and the differences were even more pronounced in rural areas (Moses et al., 2006).

1.2 HIV Prevention Programs: Core Group and Sex Workers

HIV/AIDS prevention interventions or programs to date have widely utilized the concept of the STI "core" group (e.g. Fogarty et al., 2001; Ford & Koetsawang, 1999; Kaul et al., 2002; Laga et al., 1994; Ngugi, Wilson, Sebstad, Plummer, & Moses, 1996; Robinson & Hanenberg, 1997). Although there is no single definition of the core or vulnerable group, the various perspectives that inform this debate have a common goal of controlling and preventing STIs, including HIV, through strategic or targeted intervention (Thomas & Tucker, 1996). The STI core theory holds that population rates of STIs "are driven by spread among highly vulnerable groups of individuals that are characterized by high rates of partner change (often with each other), longer duration of infection often related to poor access to acceptable health care, and highly efficient transmission of

infection per exposure, all contributing to high rates of [STIs]" (Aral, Holmes, Padian, & Cates, 1996, p.S131).

Mathematic models, by proponents such as Anderson and May, have also lent support to targeting HIV interventions to core groups (e.g. Anderson, Medley, May, & Johnson, 1986; Anderson, May, & McLean, 1988; Anderson & May, 1988). Therefore, many prevention programs have focused on female sex workers and high-risk men (such as long-distance truck drivers, fishermen, factory workers, and the military) because a decrease in STI prevalence within this group should theoretically lead to a decrease in the STI incidence in the general population (Ngugi et al., 1996). Furthermore, Moses and colleagues (1991) have shown that targeted prevention programs could be relatively inexpensive.

Although the rationale for focusing programs on the core group is sound, it is important to recognize the implications of targeting an already marginalized group of people. These groups are "epidemiologically more likely to become HIV-positive at the same time as they are significantly less likely to be reached or respond to appropriate health services and education precisely because they are marginalized" (Crane & Carswell, 1992, p. 175). O'Neil and colleagues (2004) note that a greater focus on sex work since the emergence of the HIV epidemic in India has often led to an intensification of stigmatization and marginalization of female sex workers. Yet, it has been claimed that prevention programs in India that target female sex work alone could end the HIV epidemic (Nagelkerke et al., 2002). Thus, it is imperative to employ effective HIV prevention programs for female sex workers that do not blame and further stigmatize

women; this strategy would also ensure that female sex workers do not resist preventive practices due to feelings of stigmatization (O'Neil et al., 2004).

There has been growing recognition of the need to consider broader socio-political and economic factors affecting the HIV/AIDS epidemic; the risk of HIV infection must be situated in context of other risks and vulnerabilities, like poverty, violence, and gender inequality (Farmer, Connors, & Simmons, 1996; Kielmann, 1997; Nath, 2000; O'Neil et al., 2004; Parker, 2001; United Nations, 2001). There has been increasing interest in alternative interventions that are more culturally sensitive, cost-effective, sustainable, and multi-dimensional compared to individual-level behavioural interventions (Beeker, Guenther-Grey, & Raj, 1998; Blanchard et al., 2005; Busza & Schunter, 2001; Jana, Basu, Rotheram-Borus, & Newman, 2004; UNAIDS, 2000). Many of these alternative programs extend rather than replace behaviour change models, and they focus on community participation and empowerment, linking HIV/AIDS prevention with broader goals of community development and social justice (Beeker et al., 1998). Kempadoo and Doezema observe that HIV/AIDS prevention efforts have contributed to the formation of sex worker organizations, "inadvertently empowering sex workers in other areas than just in health matters" (1998, p.19). They also note that AIDS conferences have provided a platform for the advancement of the international movement for sex workers' rights. There are numerous examples of sex workers' organizations that are actively involved in HIV/AIDS prevention programs: they include Synergy Women and Development (SYNFEV) in Senegal, Centro de Orientación Integral (COIN) in Dominican Republic, and the Mahila Samanwaya Committee (the Sonagachi Project) in Kolkata, India (Kempadoo & Doezema, 1998).

HIV/AIDS prevention programming in Karnataka has taken into consideration the epidemic's heterogeneity, as well as the evidence from research and interventions for HIV/AIDS and other STIs. Programs have both focused on the "core" group (mostly female sex workers) and adopted an empowerment approach.

1.3 HIV Prevention Programs in Karnataka: ICHAP and KHPT

Karnataka state in South India has a population of nearly 53 million and contains 28 districts (KSAPS, 2004a). Karnataka is a predominantly rural and agrarian state with a level of poverty slightly higher than the national average and a relatively low standard of living compared to its level of industrial development (Orchard, 2004). Characteristics of the state, including a high HIV prevalence, influenced the India-Canada Collaborative HIV/AIDS Project (ICHAP) to choose Karnataka as one of its focal points (ICHAP, 2003c). ICHAP was a five-year project established in 2001 in Karnataka and Rajasthan; it was implemented by the University of Manitoba (U of M) and partners, with funding from the Canadian International Development Agency (ICHAP, 2003b). ICHAP's mission is to mitigate the impact of the HIV/AIDS epidemic on vulnerable groups by: (1) providing technical assistance to national and state-level governmental and non-governmental organizations (NGOs) in order to strengthen the institutional capacity for the planning, design, implementation, and evaluation of HIV/AIDS programs; and (2) developing and piloting Demonstration Projects – HIV/AIDS prevention program models – which are rural and community-based (ICHAP, 2003c). One of these Demonstration Projects is implemented by a sex workers' collective and includes risk and vulnerability reduction strategies that are meant to intervene with the institution of sex work

(Macchiwalla, 2005). ICHAP's model is based on a foundation of activities – institutional/organizational capacity, enabling environment, and information – and on five pillars for programming: (1) communication (primarily through peer education outreach); (2) focused prevention; (3) voluntary counseling and testing; (4) STI management; and (5) care and support (ICHAP, 2003b).

Karnataka Health Promotion Trust (KHPT) is a partnership between U of M and KSAPS established in 2003 to implement the project *Sankalp* (Sanskrit term meaning "determination") or *Scaling up HIV prevention in Karnataka*, which is funded by the Bill and Melinda Gates Foundation (Blanchard, 2005). The overall goal of *Sankalp* is to reduce the transmission of HIV and STIs in the state of Karnataka; to achieve this, the project initially focused on female sex workers and male clients, but revised its objectives by the end of the second year to include "men who have sex with men" and transgender individuals (KHPT, 2006). KHPT is involved in these main activity areas: (1) evidence based participatory planning; (2) outreach and communication; (3) STI treatment and care including condom programming; (4) developing an enabling environment; (5) sustainability through community mobilization and ownership; (6) capacity building; and (7) monitoring and evaluation (KHPT, 2006). KHPT programs cover sixteen districts, consisting of a population exceeding 35 million and more than 40,000 sex workers; the programs are implemented primarily by partner NGOs at the district-level (Blanchard, 2005). All programs have the same overall goal and program activities, such as peer education outreach and condom and STI programming, but implementation of programs may vary depending on the geographic location, the predominant typology of sex work in the district, and the unique features of the NGO (Blanchard, 2005).

Both ICHAP and KHPT promote the empowerment of sex workers, broadly viewed as vulnerability reduction. They emphasize mobilizing the sex work community to participate towards the ultimate goal of community ownership of the HIV/AIDS prevention programs. However, there have been few qualitative studies to understand the perspectives of female sex workers and other program stakeholders regarding the HIV/AIDS prevention programs. Moreover, it is important to consider potential issues and implications of empowerment strategies.

1.4 Conceptualizing Empowerment

The empowerment strategy or method emerged in the 1960s with near universal appeal among diverse social movements, including feminist and anti-poverty movements (Cruikshank, 1999). Empowerment has been conceptualized in many ways, including as a set of processes – such as a social-action process that promotes community participation (Wallerstein, 1992) – and as specific outcomes, like increased political efficacy and opportunities for shared decision-making (Hawe, 1994). Community empowerment is often synonymous to community participation, which could be defined as *a means* to action or as *an end* in itself (Asthana & Oostvogels, 1996). Defying a single definition, empowerment strategies generally involve creating and transforming the subjectivities of certain citizens for social reform, and empowerment is conceptualized as consisting of three parts – "consciousness, knowledge, action – [to] connote the transition from powerlessness to full citizenship, from subjection to subjectivity" (Cruikshank, 1999, p.70).

It has been argued that the roots of empowerment in the health field date back to the origins of the public health discipline in the mid-1800s (Beeker et al., 1998). However, many researchers see the *Alma Ata Declaration* of 1978 as laying the groundwork for empowerment approaches to health interventions; an empowerment process was implicit in its promotion of comprehensive primary health care, whereby community participation would be the key method to addressing the underlying causes of poor health (Asthana et al., 1996; Rifkin, 1988; Werner, 1988). A meta-analysis of 40 exemplary health promotion programs showed that the following methods were frequently used to empower communities: enabling services; rights protection/promotion; public education; media use/advocacy; organizing associations/unions; empowerment education; and work training and micro-enterprise (Kar, Pascual, & Chickering, 1999).

Similarly in HIV/AIDS prevention programs, empowerment strategies "are variously operationalized as AIDS education, partner negotiation training, community organizing, case-management, outreach, self-help groups, consciousness raising, organizational networking, leadership training, and individual and group-based problem solving" (Beeker et al., 1998, p.831). Rekart provides a typical conceptualization of empowerment in programs for sex workers:

> [Harms associated with sex work - such as drug use, disease, violence, and discrimination -] can be mitigated by empowerment–ie, the provision of the means and opportunity for self-assertion. Personal empowerment is the awareness and strengthening of personal skills and options to control and improve sex workers' lives. Community empowerment strengthens the community's ability to participate in positive changes. Social empowerment enables sex workers to fight for their rights and acceptance in society. The aim of empowerment is to reduce vulnerability [such as poor self-esteem, lack of education and skills, and poverty]. (2005, p. 2126)

Cruikshank (1999) notes that an uncritical perspective on empowerment tends to dichotomize power and powerlessness, assumes that relations of empowerment are social

and not political power relationships, and treats empowerment as a quantitative increase in the amount of power possessed by a person. She argues to the contrary that the empowerment relationship is established by expertise, is initiated by one party seeking to empower another, relies on the knowledge of those to be empowered, and involves both voluntary and coercive exercises of power upon the subjectivity of the empowered. Finally, relations of empowerment "both constitute and fundamentally transform the subject's capacity to act; rather than merely increasing that capacity, empowerment alters and shapes it" (Cruikshank, 1999, p.71). It is important to carefully examine community empowerment and community participation because the rhetoric behind these popular concepts could serve many different agendas (Clements-Nolle & Bachrach, 2003; Cruikshank, 1999; Israel et al., 2003; Strawn, 1994; Sullivan et al., 2003).

There is growing literature on the implications of not having a clear consensus on the meaning of empowerment and on what constitutes an empowerment strategy, as well as on the epistemological debate over whether empowerment is a liberatory or repressive exercise. In recent years, research on empowerment of female sex workers in India has emerged, with a focus on the Sonagachi Project (Bandyopadhyay & Banerjee, 1999; Jana et al., 2004; Nath, 2000; UNAIDS, 2000). However, there is little documentation on how sex workers communicate their experience of the transformations brought about by empowerment strategies. Thus, the voices of sex workers are largely missing from empirical literature. In Karnataka, there has been no formal study of how female sex workers are affected by the empowerment approach to HIV/AIDS prevention programs.

1.5 Purpose, Research Questions, and Significance

Purpose of the study

The purpose of this study is to understand how various HIV/AIDS prevention program activities and empowerment strategies in Karnataka affect female sex workers (program users or beneficiaries), as well as other program stakeholders. The study aims to learn about the experiences and opinions of different program stakeholders – from beneficiaries to those involved in implementation – with respect to program goals, activities, and services. The study strives to show how female sex workers make sense of the programs' influence on their lives; it emphasizes the women's experience of empowerment, which involves their subjectivities, others, sex work, HIV/AIDS, and the broader environment.

Main research questions and objectives

1. *How do different organizations conceptualize and implement empowerment strategies within HIV/AIDS prevention programs for female sex workers?*
    - Describe the context and empowerment strategies of three HIV prevention programs for female sex workers in different districts in Karnataka.
2. *How are the programs perceived by various program stakeholders?*
    - Understand perceptions of different program stakeholders (female sex workers, peer educators, program staff, and government officials) with respect to program activities and strategies, including their assessment of program strengths and limitations.
3. *How do female sex workers articulate the experience of empowerment?*
    - Understand and present female sex workers' own interpretations and experiences of empowerment.

Significance of the study

It is recognized that the HIV/AIDS epidemic is both an emergency and a long-term development issue (UNAIDS, 2004). Thus, preventing and controlling the HIV/AIDS epidemic is one of the most important global priorities and is one of eight Millennium Development Goals or MDGs (Lewis, 2006; United Nations, 2007b). The *Declaration of Commitment on HIV/AIDS* made at the United Nations General Assembly in 2001 reinforced and reaffirmed commitments made in eleven previous declarations (United Nations, 2001). Yet, the *2007 Progress Chart* on MDGs reveals that the target of halting or reversing the spread of HIV/AIDS by 2015 will not be met in any region (United Nations, 2007a).

In India, as in other developing countries, the growing HIV/AIDS epidemic threatens to erode every aspect of society, from education to development (ICHAP, 2003b). Poor, marginalized, and disadvantaged groups are particularly vulnerable to HIV/AIDS (Garmaise, 2003; Sherr, 2004; UNAIDS, 2006), and female sex workers in India represent a vulnerable population that is linked to the HIV/AIDS epidemic (O'Neil et al., 2004). Therefore, it is crucial to implement effective strategic prevention programs for female sex workers. Researchers in recent years have asserted the importance of empowerment approaches to HIV/AIDS prevention, but there is no consensus on the meaning and measurement of empowerment, or on the strategies it implies (Beeker et al., 1998).

Beginning to understand the effects of various empowerment approaches to HIV/AIDS prevention among female sex workers in Karnataka may have important implications for future programming. Learning about the experiences of sex workers may

offer clues to optimizing empowerment strategies. Understanding and promoting empowerment may lead to increased community ownership and sustainability of the programs, as well as improved effectiveness of services delivery. Learning about the perceived strengths and weaknesses of the various programs may also contribute to improving the delivery and impact of HIV prevention services in Karnataka. It has been argued that the perceived effectiveness of HIV prevention measures influence health-related behaviour (Wilson, Dubley, Msimanga, & Lavelle, 1991). Trying to understand the perceptions of program stakeholders, especially female sex workers, may be part of an important process of mobilizing the community. Looking at multiple programs may also promote sharing of knowledge and best practices among implementing partners of ICHAP and KHPT.

Chapter 2: Methodology

2.1 Study Design

Multiple Case Study Strategy

A qualitative research paradigm is best suited for gaining a deeper understanding of participants' lived experiences of a phenomenon by allowing data collection to respond to increasingly refined research questions (Marshall & Rossman, 1995). The case study strategy is considered to be "in complete harmony with the three key words that characterize any qualitative method: describing, understanding, and explaining. Such a study is best able to describe and understand the case under investigation" (Hamel, Dufour, & Fortin, 1993, p.39). It is also appropriate for studies in which research questions are more diffuse and exploratory (Marshall et al., 1995). A case could take on various meanings, including the following definitions: a case is a specific, complex, and functioning thing (Stake, 1995), or an individual, event, or entity (Yin, 1994). A case study is an empirical inquiry that:

> investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident... [You] would use the case study method because you deliberately wanted to cover contextual conditions – believing that they might be highly pertinent to your phenomenon of study. (Yin, 1994, p.13)

I chose to conduct case studies to explore three different HIV prevention programs. This strategy offered many advantages to fulfilling my study objectives. Though the case study shares commonalities with other research strategies in social sciences, it is distinctively needed to understand complex social phenomena (Yin, 1994). Case studies facilitate exploration of complex phenomena by using a variety of evidence, such as documents and interviews in context; the ability to deal with a range and mixture of

information sources allows for superior description without having to rely on detailed observation (Hamel et al., 1993).

In addition to its holistic emphasis on context, a case study approach is preferable when *how* or *why* questions are being posed, and when the researcher has little control over events (Yin, 1994). Questions in my study included *how do organizations conceptualize and implement empowerment strategies within HIV/AIDS prevention programs* and *how do various stakeholders perceive the programs*? As the study progressed, more *why* questions developed.

Yin explains that the main criticism of this research strategy is the case study provides little basis for scientific generalization; however, he argues "case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes... [Thus] the goal is to do a 'generalizing' and not a 'particularizing' analysis" (2003, p.10-11). Although researchers argue that a single case study can be generalized when it reaches a "fundamental understanding of the structure, process and driving forces" (Normann, 1970 quoted in Gummesson, 1991), conducting multiple case studies is considered to increase generalizability (Gummesson, 1991; Herriott & Firestone, 1983; Stake, 1995; Yin, 1994). Herriot and Firestone explain how multiple case studies may optimize description and generalizability:

> [M]ultisite qualitative studies address the same research questions in a number of settings using similar data collection and analysis procedures in each setting. They consciously seek to permit cross-site comparison without necessarily sacrificing within-site understanding. (1983, p.14)

Therefore, the multiple case study strategy offered an effective and flexible means of exploring and understanding three HIV prevention programs in a way that would be more generally applicable in Karnataka.

Community Based Participatory Research

In qualitative research, it is important for the researcher to clearly indicate the values, assumptions, and perspectives that inform her/his research and influence analysis of data (Marshall et al., 1995; Kincheloe & McLaren, 1994). My approach to research is strongly influenced by the principles of community based participatory research (CBPR), known by other names including participatory action research, rapid assessment procedure, emancipatory inquiry, and collaborative action research (Wallerstein & Duran, 2003). CBPR is a collaborative approach to the research process between researchers and community members that aims to combine "knowledge and action for social change to improve community health and eliminate health disparities" (Minkler & Wallerstein, 2003, p.4). Characteristics of CBPR include the following: research is participatory and cooperative; it involves co-learning and local community capacity building; it emphasizes both research and action; it is an empowering process through which participants can have an influence on their lives (Minkler et al., 2003).

The driving force behind CBPR is addressing health disparities by focusing on the priorities and questions that are most relevant to the community. CBPR is a process that relies on the knowledge and strengths within the community and requires a long-term commitment by both researchers and community members (Israel et al., 2003). Promoting a partnership between researchers and community members involves an emphasis on building trust, negotiating roles, and recognizing that relationships are "subject to overall power relations in society" (Wallerstein et al., 2003, p. 38). CBPR is particularly suitable for research with oppressed or marginalized communities that have historically been left out of the research process (Clements-Nolle et al., 2003).

My study does not encompass all the characteristics of CBPR; however, many of the principles, motivations, and issues behind CBPR are relevant to my research. It was important for me to make the research process as participatory as possible, involving the community of sex workers, as well as others who are involved in HIV prevention programming for sex workers. The purpose of this was to make the inquiry as relevant as possible to the community. As described later in this chapter, members of this broad community had opportunities to contribute to the development of research questions and the process of data collection. Issues of trust and power were important to consider in working with the community, especially sex workers.

My main source of data came from speaking with the community members (program stakeholders). In addition to learning about stakeholders' experiences with the programs, encouraging participation in the study would affirm the value of their knowledge and opinions. This would allow participants to feel that they can affect positive changes to the programs and increase their sense of ownership over the programs (Thomas, 1993). Therefore, "involving people in gathering information, knowledge production itself may become a form of mobilization" (Gaventa & Cornwall, 2001, p. 76). In order to support this process, I strived to make my thesis speak *on behalf* of the participants, especially female sex workers – this is an important aim of CBPR and critical ethnography (Thomas, 1993).

I was motivated to conduct this research by the ultimate goal of addressing health disparities among female sex workers in Karnataka. I was influenced by CBPR's emphasis on the cyclical process between knowledge production and action (improvement or solution of practical problems) (Gaventa et al., 2001). The primary

objective of my research is to acquire knowledge and understanding that translates into program improvements. I also see the dissemination of my findings as an important component of the research process.

2.2 Study Procedures

Selection of and Access to Study Sites

Selection of the three study sites was initially determined by managers of the ICHAP/KHPT projects who are knowledgeable about the HIV prevention programs and organizations (NGO or CBO) in all the districts. The selection was meant to reflect the diversity across Karnataka, both in terms of regional variation and program characteristics. While the main goals and activities are the same for all the programs, the three study sites offered some contrasts to one another; the population of program users varied and each implementing organization has some unique features. The selected organizations were also considered to be relatively accessible, having demonstrated professional and cooperative working relations with ICHAP/KHPT staff.

When I arrived in Karnataka in early August 2005, one study site had been confirmed and the other two sites still had to be negotiated with staff of the organizations. The confirmed site was in District A in northern Karnataka, and Program A was an ICHAP project implemented by a CBO of sex workers, a sex workers' collective. This program was one of the first HIV prevention programs in Karnataka; the other programs were relatively young and were implemented by different NGOs. The two other study sites were finalized by early October 2005. As outlined in Table 1, the HIV prevention

programs under study vary by geographic location, implementing organization, and population using the services (defined by predominant typology of sex work).

Table 1. Characteristics of the three study sites.

District (Location in Karnataka)	**Program, Organization Type (Project)**	**Predominant Typology of Sex Work in District**
District A (Northern)	Program A, CBO Sex workers collective (ICHAP)	Traditional (Devadasi), Home-based sex work
District B (Central)	Program B, NGO (KHPT)	Street and Home-based sex work
District C (Central)	Program C, NGO (KHPT)	Street and Home-based sex work

I was initially introduced to the CBO and NGOs by ICHAP/KHPT managers. I also introduced myself to the directors of the NGOs through a formal letter in which I explained my motivations and intentions for conducting the research; as well, I provided a two-page synopsis of the study purpose and procedures. Since the CBO staff in District A are illiterate and/or require translation from English, I conveyed these ideas to them in person with the help of a translator. I clearly indicated that my affiliation with ICHAP/KHPT was for the academic purpose of conducting independent research for my master's degree. I also indicated my aim of making the research process as participatory as possible. I assured the program staff that the study would pose minimal intrusion to their regular activities.

Data Collection Methods and Instruments

I carried out different methods of data collection between August and December 2005. I began with reviewing secondary sources of information on the HIV prevention programs within ICHAP/KHPT. Most of the reviewed documents were produced by the implementing organizations or by ICHAP/KHPT; these included annual reports and

program proposals. Other documents, such as epidemiologic reports and sex work mapping studies, were produced by external organizations. This review facilitated an initial understanding of the organizations and programs. The emphasis of this phase of data collection was on gaining a description of the programs, their design and implementation methods. This data collection and review was complicated by the fact that there were several changes to the selected study sites before they were all finalized in early October.

Listening to different voices and versions of "reality" is a key strategy to uncover "truths" in participatory research (Gaventa et al., 2001). In order to understand the experiences and perceptions of various program stakeholders and to maximize the quality of information obtained, I chose to use different data collection instruments with different stakeholders. An in-depth interview is a way to obtain flexible and high quality information that strengthens the voice of the participant and allows the interviewer to be guided by participant's responses (Gaventa et al., 2001). This method also reinforces the importance of confidentiality, which may help participants to feel more comfortable and open. Focus group discussion (FGD) is useful because it permits checking of information with a larger number of participants and allows participants to be stimulated by other viewpoints (Marshall et al., 1995). On the other hand, participants may feel reluctant to share certain information in a group setting (Scrimshaw & Hurtado, 1987). FGDs were ideal for gathering the thoughts of many peer educators, while in-depth interviews were more appropriate for conversations with sex workers, program staff, and government officials.

Discussions with all stakeholders consisted of the same general topics, which are outlined in Table 2. Prevention indicators (PIs), developed by the World Health Organization's Global Programme on AIDS, were used to help derive some initial topics for discussion: the most relevant PIs included knowledge of prevention practices, condom availability, reported condom use with non-regular sexual partner, and sexually transmitted infection case management (Mertens et al., 1994). Particular emphasis was placed on understanding stakeholders' perceptions of the program strengths and limitations. I developed guides that would facilitate semi-structured interviews and FGDs, and the content of the guides varied somewhat for different stakeholders (see Appendix 1: Guides for Interviews and FGDs). A few program staff helped refine the guides by providing their input and suggesting additional questions.

Table 2. General topics for interviews and focus group discussions.

1. Description of the program and organization
2. Knowledge about the program and HIV/STI prevention practices
3. Experience before the program
4. Experience of delivering or using services offered by the program
5. Perceived strengths and limitations of the program
6. Contextual information about the district, HIV/AIDS, and participants

I used the interview/FGD guides flexibly, aiming to place emphasis on topics that participants found to be most important or interesting. Therefore, the questions evolved to best reflect the various perspectives of participants.

Participant Sampling

A purposive sampling strategy was used to select participants in all groups of program stakeholders. Program staff and certain government officials were considered key informants, as they are individuals who have a particular interest in and knowledge

about the HIV prevention programs in the districts. Program staff were self-selected based on their titles and responsibilities; the majority of interviews were conducted with staff of the CBO/NGOs and several interviews were held with staff of ICHAP/KHPT. In each district, the program staff were involved in determining which government officials would best serve as key informants. Introduction to government officials was facilitated directly through program staff in the districts. In addition, I sent a formal letter of introduction to the government officials before our meetings; a high-ranking government official, who works within ICHAP/KHPT, also sent these officials a letter of support for my study. The key informant interviews were conducted in locations convenient for the participants; they were typically held in participants' offices. I interviewed most key informants in English, but I worked with a translator to interview program staff from District A. The duration of interviews ranged from 20 minutes to roughly 2 hours.

Peer educators are sex workers, who are hired by the programs to carry out outreach work with fellow sex workers in their home towns. They undergo training, similar to other program staff, in various areas including HIV/AIDS, condom promotion, and communication skills; they also attend regular staff meetings. They are paid an honorarium for the outreach work, but sex work remains their main source of income. Thus, peer educators could represent the perspectives of both sex workers and program staff, and their responses may be triangulated with both groups of program stakeholders. The FGD method permitted a large number of peer educators to participate and hence allowed for a better representation of sex workers. In each district, program staff and I worked together to determine the groups; we aimed to include a variety of experiences and at the same time have fairly homogeneous groups to promote easy discussion. In each

district, 3 FGDs were conducted with groups of 3 to 6 peer educators from the same or neighbouring *taluks* (sub-districts); a total of 46 peer educators participated (including FGDs without transcripts, there were 59 participants, about 60% of all peer educators in each district). I facilitated the FGDs with a translator (similarly to interviews, translations were provided on the spot); discussions averaged 1.5 hours in duration and took place in quiet rooms within the program offices.

Peer educators were asked to help recruit sex workers for in-depth interviews. General criteria for participants included their age, home *taluk*, and typology of sex work (see Chapter 3 for descriptions of sex work population in each district); the main idea was to find women who would represent various experiences of sex workers across the district. Due to the unpredictability of many sex workers' schedules, interviewees were often recruited after my arrival in the field. Interviews took place in 4 or 5 different *taluks* across each district and the numerous interview locations included participant's home, program office, literacy centre, and my hotel room (locations were chosen to accommodate the preferences of participants). I had assumed that most sex workers would prefer to be interviewed in their homes and that the formality of being in the program office may increase social desirability bias. On the contrary, most participants were much more at ease in the program offices. In each district, a translator and I interviewed 6 to 8 women and our conversations lasted 30 minutes to 1 hour.

Program staff and peer educators were instrumental in facilitating good quality and relevant data collection. They helped develop questions and a participant sampling strategy. They also helped coordinate field visits. Their involvement may be viewed as presenting a potential bias to data collection and this legitimate concern is addressed in

the discussion on limitations of the study. The total number of participants is shown in Table 3, and Tables 4 to 9 provide detailed information about the sex workers, including peer educators, who participated in the study.

Table 3. Participants from the three districts.*

Stakeholder Group	Instrument (Language)	District A	District B	District C	Total
Female sex workers	Interview (Kannada)	8	6	6	**20**
Peer educators	FGD (Kannada)	16	17	13	**46**
Program staff (from CBO/ NGOs and ICHAP/KHPT)	Interview (Eng, Kann)	5	4	5	**14**
Government Officials	Interview (English)	3	4	4	**11**
Total		**32**	**31**	**28**	**91**

* This includes participants from audio-taped conversations only.

Female Sex Workers Who Participated in In-Depth Interviews

Table 4. Female Sex Workers from District A.*

Home *Taluk*	Age	Typology of Sex Work	Age Start Sex Work	Partner and Children	Literacy and Alternative Work
1	18	Home-based (Devadasi)	14		Illiterate, No alt.work
1	27	Home-based (Devadasi)	14	3 children	Illiterate, No alt.work
1	25	Home-based (Devadasi)	-	1 child	Illiterate, No alt.work
1	35	Home-based (Devadasi)	18	3 children	Basic literacy from Program A
2	36	Home and Lodge-based (Devadasi)	-	4 children	Illiterate Runs shop
3	30	Street-based (Devadasi)	-		Illiterate Does field work
2	30	Home and Lodge-based	19	Regular partner 2 children	5th standard education No alternative work
2	18	Home and Lodge-based (Devadasi)	14	No partner No child	Illiterate, No alt.work

* This excludes Program A staff, who are also sex workers.

Table 5. Female Sex Workers from District B.

Home *Taluk*	Age	Typology of Sex Work	Age Start Sex Work	Partner and Children	Literacy and Alternative Work
1	28	Home-based	27	Regular partner 3 children	Cleans houses
2	45	Home-based	25	Husband left 1 child	Works as tailor
2	36	Street-based	-	Husband left 2 children	9th standard education Used to work in mill
3	22	Street-based	16	Husband left 1 child	6th standard education No alt.work
4	60	Home-based	20	8 children	Used to work in office
4	28	Street-based	20	4 children	No alt.work

Table 6. Female Sex Workers from District C.

Home *Taluk*	Age	Typology of Sex Work	Age Start Sex Work	Partner and Children	Literacy and Alternative Work
1	30	Street-based	-	Husband left 2 children	Illiterate Various small jobs
2	20	Home-based	-		5th standard education No alternative work
2	35	Street and Lodge-based	32	Divorced 2 children	Illiterate, No alt.work
3	30	Street-based	21		Illiterate, No alt.work
1	32	Street-based	17	Reg. partner 2 children	Illiterate, No alt.work
4	25	Street-based	21	Widow	Illiterate, No alt.work

Peer Educators Who Participated in Focus Group Discussions

Table 7. Peer Educators from District A.

Home *Taluk*	Age	Typology of Sex Work	Age Start SW	Time as PE	Partner and Children	Literacy and Alternative Work
1	21	Home-based (Devadasi)	15	2 year	Lover 2 children	Basic reading No alt. work
1	24	Home-based (Devadasi)	12	5 month	Lover 2 children	Illiterate, No alt.work
1	35	Home-based (Devadasi)	13	4 year *	Lover 3 children	Illiterate, No alt.work
1	37	Home-based (Devadasi)	22	4 year *	Lover 1 child	6th standard education No alt.work
1	25	Home-based (Devadasi)	13	3 year	Lover 1 child	Illiterate, No alt.work
1	38	Home-based (Devadasi)	13	4 year *	Lover 3 children	Illiterate, No alt.work
3	21	Home-based (Devadasi)	9	1 year	Lover 2 children	Signs name No alt.work
3	20	Home-based (Devadasi)	19	1 year	Lover 1 child	8th standard education No alt.work
3	20	Home-based (Devadasi)	12	1.5 year	Lover 2 children	7th standard education No alt.work
3	22	Home-based (Devadasi)	14	1 year	Lover 2 children	7th standard education No alt.work
3	28	Home-based (Devadasi)	12	4 year *	No partner 2 children	Runs pan shop No alt.work
4	40	Home-based (*Devadasi*)	14	4 year *	Lover No child	Illiterate, No alt.work
4	30	Home-based (Devadasi)	18	2 year	Lover 3 children	5th standard education Runs shop
5	22	Home-based (Devadasi)	14	2 year	No partner No child	Illiterate, No alt.work
5	22	Home-based (Devadasi)	15	1 year	No partner 2 children	Illiterate, No alt.work
5	21	Home-based (Devadasi)	15	4 year *	Lover No child	5th standard education Works as tailor

* This includes time working as a peer educator for another NGO prior to the start of Program A.

Table 8. Peer Educators from District B.

Home *Taluk*	Age	Typology of Sex Work	Age Start SW	Time as PE	Partner and Children	Literacy and Alternative Work
1	35	Home-based	27	1.5 year	Widow 2 children	10th standard education No alt.work
5	30	Home-based	25	1.5 year	Husband 2 children	12th standard education No alt.work
5	23	Street-based	20	2 year	Husband No child	10th standard education Works in phone booth
1	28	Street-based	26	2 year	Husband 4 children	10th standard education Works as tailor
5	38	Home-based	33	8 month	Husband 3 children	10th standard education No alt.work
1	38	Home-based	32	8 month	Widow 2 children	10th standard education Does some childcare
2	18	Street-based (only MSW)	16	4 month	Partner No child	12th standard education Works as tutor
2	35	Street-based	32	6 month	Husband 3 children	Illiterate, No alt.work
2	36	Home-based	35	1 month	Husband 2 children	7th standard education Runs a shop
2	28	Brothel-based	23	2 year	Widow 2 children	Illiterate, No alt.work
2	38	Home-based	37	6 month	Husband 5 children	Illiterate, No alt.work
3	28	Street and home-based	20	1.5 year	Husband No child	Illiterate, No alt.work
4	30	Street and home-based	25	8 month	Partner 3 children	10th standard education Used to do housework
4	21	Home-based	19	1 year	Lover No child	9th standard education No alt.work
3	26	Home-based	20	5 month	Lover No child	3rd standard education No alt.work
3	26	Street and home-based	23	10 month	Husband 3 children	12th standard education No alt.work
4	23	Street and home-based	18	1 year	Partner 1 child	7th standard education Used to work as tailor

Table 9. Peer Educators from District C.

Home *Taluk*	Age	Typology of Sex Work	Age Start SW	Time as PE	Partner and Children	Literacy and Alternative Work
2	35	Street-based	20	1.5 year	Partner 2 children	Illiterate Used to sell peanuts
5	28	Street and home-based	22	4 month	Widow 4 children	4th standard education No alt.work
5	36	Street-based	21	1 year	Divorced No child	Illiterate, No alt.work
2	36	Street-based	28	2 month	Husband 4 children	2nd standard education No alt.work
1	45	Street-based (Devadasi)	20	1 year	No partner 3 children	2nd standard education No alt.work
1	34	Home-based	29	1.5 year	No partner 2 children	Illiterate, No alt.work
1	45	Street-based	20	1.5 year	Husband 3 children	Illiterate, No alt.work
1	40	Street-based	30	1.5 year	Husband 3 children	8th standard education No alt.work
1	34	Brothel-based	29	2 year	Partner 1 child	Illiterate, No alt.work
1	30	Street-based	28	1.5 year	Husband 2 children	Illiterate, No alt.work
6	35	Street and home-based	25	3 month	No partner 3 children	Illiterate, No alt.work
3	20	Street-based	16	5 month	No partner No child	9th standard education No alt.work
6	33	Street-based	27	3 month	Husband 2 children	2nd standard education No alt.work

2.3 Ethical Considerations

Before conducting the study, ethics approval was obtained from the University of Manitoba Health Research Ethics Board in Winnipeg, Canada, and the St. John's Medical College and Hospital Institutional Ethical Review Board in Bangalore, India. All participants were informed about the study's purpose and procedures, including the purpose of audio-taping the interviews and FGDs. They were ensured of their confidentiality and that their participation was voluntary. Informed consent was obtained from all participants as witnessed verbal consent. This consent process was chosen because: (1) most sex workers are illiterate and cannot sign their names and; (2) sex workers may feel uneasy about the potential misuse of the forms containing their names. With the prevalence of fear of police and of public disclosure of their occupation, obtaining audio-taped verbal consent from sex workers is a more sensitive method. Many researchers state that valid consent does not have to be written (Scrimshaw et al., 1987). Some researchers argue that using signed consent forms is often culturally inappropriate and more generally, that requirements of the formal ethics review commonly conflict with the processes and purposes of qualitative research (van den Hoonaard, 2007).

The consent forms and my notes from interviews/FGDs were stored in a secure place. Participants' names, and other identifying features, were not used to label audio-tapes or notes. I maintain sole access to the list of participants. To further protect participant anonymity, the names of the organizations and the districts are not identified in my study.

Due to the emphasis on making this research participatory, it was crucial for me to maintain a positive and transparent relationship with participants, especially program staff

and peer educators who most influenced the study's progress. I communicated to participants the importance of their participation and I was able to obtain steady input and assistance from them. This process had to be balanced with the aim of minimizing intrusion on the regular activities of program staff and peer educators.

2.4 Data Analysis

Constant comparison method was used during data collection. All audio-taped interviews and FGDs were translated and/or transcribed into verbatim transcripts. I completed transcriptions of the English interviews by February 2006. The translator who worked with me during data collection translated and transcribed some of the Kannada data. However, she could not continue the work and a few other people helped translate and transcribe the remaining data. I received the remaining transcripts between June 2006 and February 2007.

The verbatim transcripts were analyzed using *NVivo* software program. I organized the content into five broad categories, consistent with the topics in the interview/FGD guides: (1) context; (2) program description; (3) program implementation and adoption; (4) program outcome; and (5) program assessment. More specific categories or codes formed and evolved as analysis progressed; 40 codes were ultimately used and reports were generated for codes or clusters of codes for analysis of patterns and themes. The major themes which emerged from the data related to the broader concept of empowerment, and 12 key themes are discussed in Chapter 4. Thematic analysis involved various layers of examination: explorations within and across different stakeholder groups, as well as within and across different programs/districts. I also paid attention to patterns

across different typologies of sex work. I looked for discrepancies or negative instances of patterns.

Documents were reviewed for background information about the programs; they were largely used to provide the context to stakeholder experiences and perceptions.

2.5 Limitations of Study

There were various limitations in my study. I am not conversant in Kannada and relied on a translator for discussions with female sex workers, peer educators, and some program staff; this influenced how much control I had over the direction of the conversations. While translations were provided on the spot, the translator had to selectively present details and elaborations of participant responses because of practical time constraints. Thus, the direction of conversations was sometimes based on the translator's interpretations of what was important rather than my own. The translator and I frequently spoke about how to conduct interviews/FGDs efficiently, and at the same time, ensure that I was attuned to all interesting and important ideas. Though I could later obtain all details from the transcripts, it would have been ideal to have full control over the direction of interviews/FGDs.

The audio-tapes from 6 interviews (with 5 program staff and 1 sex worker) and 3 FGDs (representing 13 peer educators) from District A were lost in an unfortunate incident. My translator was carrying these tapes while traveling in Rajasthan, and her bag was stolen. Two major concerns arose: protecting participant anonymity and retrieving data. Considering that measures had been taken to secure anonymity (see Ethical Considerations) and that the audio-tapes went missing in a distant state, I felt confident

that participant anonymity would not be compromised. With respect to the second concern, the translator and I tried to retrieve data by going over the questions and making detailed notes of the responses as we recollected them. This information retrieval process took an entire work day. Photographs of the women taken at the time of the interviews/FGDs were instrumental in helping us accurately recall the responses and events. Although these responses could not be used in the formal analysis of transcripts, they were generally considered in my analysis. I re-interviewed three of the same program staff, while the other missing data were replaced by interviews and FGDs with new participants.

2.6 *Validation Strategies*

I used various strategies throughout both data collection and analysis to assure that my study is valid. As I was aware that opportunities for member checking of interpretations would be limited, extra precaution was taken during interviews/FGDs to obtain a clear understanding of participants' responses. When responses were unclear, the question was posed in a different way. Additionally, I often repeated or interpreted participants' responses during our conversations. It was also important for me to stay neutral while asking questions so that I would not influence or bias the responses (Scrimshaw et al., 1987). Furthermore, there was an effort to maintain a consistent method of data collection, such as interview wording and manner of questioning, which increases the reliability of the data (Beebe, 2001); this is particularly relevant for considering multiple study sites.

An important method for ensuring accuracy of the data was audio-taping the interviews/FGDs and using verbatim transcripts for analysis. I used triangulation on multiple levels to examine patterns and themes: (1) within participants of same stakeholder group; (2) across different stakeholder groups; (3) within one study site; and (4) across the three study sites. Triangulation was a key method for detecting socially desirable responses, as well as negative or discrepant information that runs counter to the identified themes. These negative instances are presented along with the major themes in Chapter 4.

Chapter 3: The Context of HIV/AIDS Prevention Programs in Three Districts

In this chapter, I present descriptions of the three HIV/AIDS prevention programs in the following areas: (1) Context, which includes information on the district, sex work population, and the implementing organization; (2) Program goals, implementation, and design, including empowerment strategies; and (3) Program strengths and limitations, based on the assessments of various program stakeholders. The information in this chapter provides a general context for the next chapter, in which I explore the experiences of stakeholders with the programs and emphasize the empowerment experiences of female sex workers.

3.1 Program A

Context

District information

District A in the northern region of Karnataka is spread over approximately 6,600km^2 and is divided into six *taluks*, administrative sub-divisions (Directorate of Economics and Statistics, 2003). In the 2001 census, the district had a population of nearly 1.7 million, with about 70% of the population in rural areas and 30% in urban areas (ICHAP, 2003c). According to the district's official website (2007), the male literacy level is 69% and the female literacy level is 38%. In 2004, District A had a 2.6% HIV prevalence in the general population (represented by percent of pregnant women who tested positive for HIV at antenatal clinics in District Hospitals and First Referral Units), the fourth highest district prevalence in the State (Karnataka State AIDS

Prevention Society, 2004a). In addition to the high HIV prevalence, other reasons that made District A an appropriate place to launch HIV prevention activities in Karnataka included: (1) the district was newly created in 1997 and was recognized to have especially poor infrastructure and health facilities; (2) the primarily agrarian economy was linked to high levels of mobility and migration, patterns associated with higher HIV risk and vulnerability; (3) the predominantly home-based, Devadasi tradition of sex work presented a particular challenge for reaching sex workers; and (4) District A had a registered sex workers' collective and cooperation from community and government leaders (ICHAP, 2003c).

Sex work population

A base line survey of female sex workers conducted in 2002 reveals characteristics of the sex work population in District A (ICHAP, 2003a). It was initially estimated that there were 1,426 sex workers in District A; the estimate has since increased more than two-fold. The survey showed that there are more sex workers in rural areas: it was approximated that about 60% are in rural and 40% are in urban areas (ICHAP, 2003b).

Table 10 shows the number of female sex workers by typology of sex work. Nearly 80% of sex workers are home-based and more than 90% are traditional Devadasi sex workers (ICHAP, 2003b). In recent years, a number of researchers have produced literature on the history and characteristics of traditional sex work and Devadasi women in Karnataka (e.g. Blanchard et al., 2005; O'Neil et al., 2004; Orchard, 2004). The Devadasi system dates back many centuries and involves dedicating young women to a deity or temple, where the women have responsibilities, like dancing and providing

sexual services to priests and temple patrons (O'Neil et al., 2004). The traditional spiritual role of these women has eroded and the Devadasi system has become synonymous to commercial sex work, particularly in the northern districts of Karnataka (ICHAP, 2003a).

There are many young women involved in sex work in District A. Close to 60% of sex workers are under the age of 25, with over 25% under the age of 20 (ICHAP, 2003a). Other characteristics of female sex workers in this district include the following: over 78% of female sex workers are illiterate; about 13% have other sources of income (mostly in agriculture); and about 12% of women migrate for work (ICHAP, 2003b).

Table 10. Number of female sex workers by typology of sex work in District A.

Typology of sex work	Initial estimated number of sex workers, July 2002	Estimated number of sex workers, August 2005	Number of sex workers registered in Program A, August 2005
Home	1123	3045	3271
Street (Public)	14	270	150
Brothel	283	Not available	Not available
Lodge	6	Not available	Not available
Dhaba	0	10	6
Other	0	423	284
TOTAL	**1426**	**3748**	**3711**

Implementing organization

In District A, the implementing partner for the ICHAP project is a community-based organization (CBO), which is a sex workers' collective. Macchiwalla (2005) provides some background information on the CBO. It was formed as a *sangha* (collective or group) of Devadasi women in 2000. The purposes of this *sangha* are: (1) to protect women's life and their children's health; (2) to reduce women's dependence on *dhanda* (sex work); and (3) to promote women's engagement in other activities. The *sangha* urges women to send their children to school and to allow their daughters to marry and discontinue the tradition of *dhanda*. The activities of the *sangha* have focused

on training women for self-development, addressing issues of violence faced by women, and encouraging women to engage in a financial savings program. The *sangha* membership has an annual fee of 11 rupees (about 30 cents Canadian) and in early 2005, it had an official membership of 1,200 women across District A.

The sex workers' collective participates in meetings of *Sahabhagini*, the state-level federation of sex workers. Even before partnering with ICHAP to implement the HIV prevention program for sex workers, the collective worked with another NGO to increase HIV/AIDS awareness and distribute condoms in two *taluks* (ICHAP, 2003c).

Government institutions and other NGOs

According to the district's official website (2007), the public health care system in District A mainly consists of 9 government hospitals, 45 primary health centres, 232 family welfare sub-centres. There are six sites for voluntary counseling and testing (VCT) services (ICHAP, 2004) and at least one site for prevention of parent-to-child transmission (PPTCT) services (Karnataka State AIDS Prevention Society, 2004b); there is no antiretroviral (ARV) centre in District A, but there is an ARV centre in a neighbouring district (National AIDS Control Organization, 2007a).

There are a number of NGOs working in the area of rural and women's development in several *taluks* (Macchiwalla, 2005). Beginning in 2001, ICHAP developed connections with various stakeholders across the district, including the district administration, local leaders, and NGOs. ICHAP initiated the establishment of the District AIDS Steering Committee, which monitors HIV/AIDS-related issues and consists of representatives of major government departments, researchers, and members of civil service organizations (ICHAP, 2004). Until early 2006, ICHAP also implemented an HIV

prevention program for the general rural population in District A. The district also has an organization, which provides support and care for persons living with HIV/AIDS (PLHAs or positive people), and this is connected to a state-level network of positive people, KNP+ (Karnataka Network of HIV+ People) (Macchiwalla, 2005).

Goals, implementation, and empowerment strategies

Goals, objectives, and design

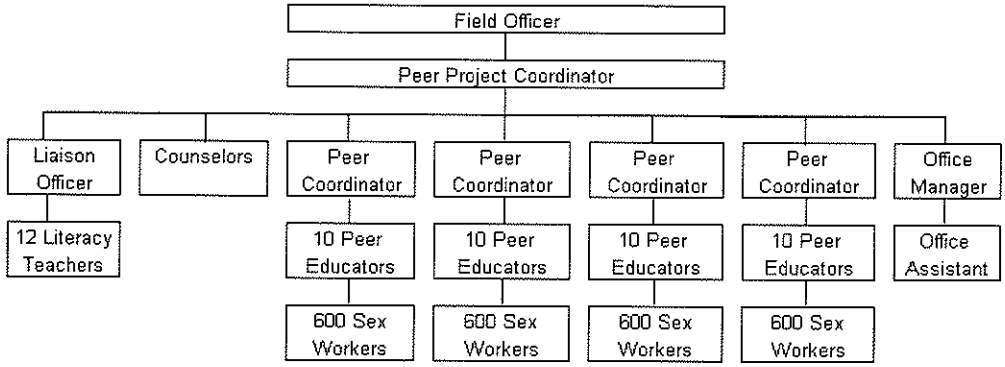
The sex workers' collective in District A partnered with ICHAP in March 2003 to implement Program A, which has the goal of reducing HIV infection among female sex workers in the district (ICHAP, 2003b). The objectives of the program are:

> To cover 1600 sex workers and their clients with high-quality prevention program through IEC (information, education, and communication) and outreach;
> To make quality STI case management, condoms, and counseling and testing facilities accessible to sex workers;
> To ensure availability of care services for HIV positive sex workers;
> To empower sex workers and reduce their vulnerability through literacy, capacity building, alternate income generation, and collectivization.

Program A strategies are framed as either risk reduction or vulnerability reduction (ICHAP, 2003b). Risk reduction strategies include increasing awareness about HIV/STIs and safe sex and providing access to condoms and STI treatment. Vulnerability reduction strategies include promoting the rights of sex workers and advocating against the harassment of sex workers, providing economic alternatives to sex workers, fostering participation and decision making of sex workers in the program, and providing support and care to HIV positive sex workers. Essentially, "risk reduction can be achieved [by making] the act of sex work less dangerous... [and] vulnerability can be reduced through interventions that lessen a woman's dependence on sex work" (ICHAP, 2004, p.19).

Program A activities are delivered through the peer education outreach model, which relies on peer educators to interact with sex workers and provide IEC, promote and distribute condoms, and make referrals to STI clinics and VCT centres (ICHAP, 2003b). The organizational structure of Program A is shown in Figure 3.1 – this also roughly represents the structure of Program B and Program C, as they use a similar peer education outreach model. As indicated in this figure, the program strives to maintain a 60:1 ratio of sex worker to peer educator.

Figure 1. Basic organizational structure of Program A (Macchiwalla, 2005).



Implementation and main activities

Program A began in four *taluks* in 2003 and expanded to include all six *taluks* by the second year (ICHAP, 2004). First year activities focused on recruiting and training staff, identifying and training doctors for STI clinics, and establishing the program's outreach and services. Selected quantitative indicators discussed in this section are presented in Table 13 (see page 62).

When sex workers consent to registering in the program, their information is collected and used to track and analyze service use. According to the *Monthly Report* (2005e) from Program A, over 2,500 female sex workers (about 90% of the estimated number of sex workers) were registered in the program by July 2004. By August 2005,

over 3,700 women were registered in the program, covering 99% of the estimated number of sex workers in the district. It is important to note that registration does not mean regular contact with the program staff and use of program services – this is also applicable to Program B and Program C. As mentioned, the ideal sex worker to peer educator ratio is 60:1, but the actual ratio has generally been higher: between January and August 2005, the ratio of registered sex workers to peer educators ranged from 67:1 to 86:1 (Monthly Report 2005e). Moreover, the program's outreach plan targets areas with higher volumes of sex workers, and little emphasis is placed on villages with less than 10 sex workers (Macchiwalla, 2005).

Peer educators use various skills and tools – like flip charts, flash cards, penis models, and songs – to educate women about HIV/STIs, demonstrate and promote condom use, and encourage women to use STI services. By the end of the first year, more than 1,000 condom outlets had been set up across the district and more than 550,000 condoms were distributed; condom outlet locations included areas of sex work activity and inside auto rickshaws (Macchiwalla, 2005). From January to August 2005, a monthly average 90,633 condoms were distributed to female sex workers (Monthly Report 2005e).

STI programming uses syndromic case management and involves a partnership between private and public health care systems; for example, the government provides some drugs and the program makes referrals to government services, like VCT centres (ICHAP, 2004). STI camps began in December 2003 and within two months, 3,043 male and female patients were treated in 20 STI camps across 4 *taluks* (Macchiwalla, 2005). By 2005, the program was conducting 12 STI clinics each month (with a fixed day, time, and venue) in all 6 *taluks*, as program-linked clinics (PLCs). From January to August

2005, an average of less than 2% of the registered sex workers were treated for STIs; not all attending the STI clinic are treated for STIs, but this overall number attending the clinic was not available (Monthly Report 2005e).

Empowerment strategies

As indicated, empowerment of female sex workers – through literacy, capacity building, alternate income generation, and collectivization – is a program objective. Twelve literacy schools were established beginning in October 2003, and there was a monthly average of 944 women (approximately a third of the estimated number of sex workers) attending literacy classes between April and September 2004 (Monthly Report 2005e). However, these numbers decreased and between January and August 2005, the average monthly attendance was 240 women. Many sex workers found the classes boring and their motivation to attend classes decreased (Macchiwalla, 2005). According to interviews with stakeholders, some literacy classes are run by daughters of sex workers and this is a point of pride for the women.

Program A has encouraged sex workers to form self help groups (SHGs) to start financial savings and it has linked women to banks, as well as to micro credit organizations that provide training and loans. By early 2005, 17 SHGs had been formed with 236 members; the SHG members save 10 rupees per week (Macchiwalla, 2005). By August 2005, there were nearly 300 women (about 8% of registered sex workers) participating in SHGs (Monthly Report 2005e).

Empowerment strategies also include activities aimed at the establishment of an enabling environment – an environment, which facilitates and supports the empowerment of sex workers, as well as the efforts of HIV prevention programs. A fundamental

enabling aspect of the program is that it is community based and emphasizes the participation and decision making of sex workers (ICHAP, 2004).

Program A has also aimed to collaborate with those outside of the sex work community. It has been involved in activities to raise general awareness about HIV/AIDS and to sensitize key stakeholders to the problems facing sex workers and Devadasi women (ICHAP, 2004). Program A staff participate in the District Steering Committee on HIV/AIDS and they voice issues of sex workers to various government officials and community leaders. The program has held educational and advocacy events with the police, family members, local leaders, clients and lovers, madams and brothel owners, and the general community. In 2003, Program A conducted 50 meetings in the general community (Macchiwalla, 2005).

Program A works closely with an ICHAP project aimed at the general population. The program also has strong ties to the district organization for HIV positive people, which is connected to KNP+ (Macchiwalla, 2005).

Strengths and Limitations

There was an overwhelming consensus among all stakeholders that condom programming is the main strength of Program A. The program has succeeded in promoting the importance of condoms, as well as in making condoms readily available and easily accessible to sex workers and others. Thus, the availability and accessibility of high-quality, free condoms is appreciated as a crucial HIV prevention strategy by sex workers, peer educators, program staff, and government officials. Furthermore, an examination of the numbers of condoms distributed and accounts from sex workers

suggest that condom programming has reached a large proportion of sex workers in the district.

Most of the participants also felt that STI service is a strength of the program. All interviewed sex workers had used and were pleased with STI services; they also believed that their peers valued the services. Sex workers also appreciated the education on health and HIV/AIDS, as well as the relationships they have formed with peer educators and program staff. Many sex workers expressed gratitude for the program holding lovers' meetings. Program staff also believed this to be an important activity that needed more attention in the future.

It was apparent that program staff and peer educators value the SHG initiative. Peer educators are all likely part of SHGs and this suggests that existing SHGs are useful and functioning well. Not all interviewed sex workers talked about SHGs, reflecting the relatively small proportion of sex workers participating in SHGs. Only a few sex workers mentioned the literacy class, but those who did felt that they gained great benefits; one woman enthusiastically reported that she is able to travel more easily because she can now read bus signs.

Program staff emphasized the strength of the program being community-based. They also believed that the strong linkages with external services (VCT centre, support centre for positive people, and ICHAP program for the rural population) allowed them to work more effectively. Although government officials have limited interactions with the program and sex work community, they have noted some strengths. They felt that the provision of effective counseling by peer educators and program staff at hospitals was helpful. Government officials also saw the program serving a social welfare function.

Program stakeholders also noted limitations and suggested improvements for Program A. Sex workers, including peer educators, would like the program to go beyond providing condoms and STI treatments to helping address other priorities of women. Most women wanted help getting loans for SHGs, so that they could find alternative work, and pensions. They asked that the program focus on helping their children. There was a strong attitude that sex work should be discontinued, at least for their children.

Program staff also believed that efforts should be made to meet the broader needs of sex workers. They felt that both SHGs and literacy schools should be strengthened so that more women could benefit from these initiatives. Program staff and government officials believed that making small changes could greatly improve the program. For example, holding separate meetings for HIV positive sex workers was seen as unnecessary and wrong. It was suggested that interesting modes of communication, such as films, dramas and folk dances, be used to educate more people. It was also felt that program staff could be more active in analyzing and investigating problems; this may necessitate more training.

3.2 Program B

Context

District information

District B is located in the central region of Karnataka and spans an approximate area of 8,400 km^2 which is divided into six *taluks* (Directorate of Economics and Statistics, 2003). It relies on agriculture as its main economic activity and in the 2001 census, District B had a population of over 1.5 million, of which 82% was rural and 18%

was urban (Swasti, 2004). According to the District Statistical Office, the male literacy level is around 63% and the female literacy level is around 37% (Swasti, 2004). In 2004, District B had a 0.8% HIV prevalence in the general population, placing District B among six other low prevalence districts in Karnataka; nevertheless, HIV prevalence in the district has been increasing (Karnataka State AIDS Prevention Society, 2004a). District B contains a number of tourist spots and travel to and across the district is readily facilitated by numerous highways (Swasti, 2004).

Sex work population

The *Annual Progress Report* (2005a) for Program B highlights results from the 2004 urban and rural situation needs assessments, which describe characteristics of sex workers in District B. The predominant typology of sex work is street-based (in public places). According to the initial sex work mapping and site-validation, it was estimated that 68-77% of sex work is street-based and 18-21% is home-based; however, based on the number of sex workers contacted, the proportion of home-based sex work is more likely 30-40% (see Table 11). By January 2005, over 54% of the estimated number of sex workers officially registered in the program. Among these registered sex workers 60% were above age 30, 38% were between ages 20-29, and only 2% were below age 20; 60% of the women started doing sex work over the age of 30. About 12% of these registered sex workers were migrating to other districts for sex work and 34 % were considered high volume sex workers (have more than 10 clients per week).

Table 11. Number of female sex workers by typology of sex work in District B.

Typology of sex work	Initial estimated number of sex workers, June 2004	Site-validated estimate number of sex workers, August 2004	Number of sex workers contacted at least once by March 2005
Street (Public)	628	1874	893
Home	194	431	707
Lodge	101	52	20
Brothel	0	47	36
Dhaba	0	29	82
Other	0	3	0
TOTAL	**923**	**2436**	**1738**

Implementing organization

Various sources provide background information on NGO B and its work prior to implementing the KHPT HIV prevention project; these include the *Annual Progress Report* (2005a), *Revised Project Proposal* (2005f), and the NGO website. NGO B has been working in all six *taluks* of District B since the early 1980s, implementing development projects that focus on livelihood improvement through watershed management and promotion of "self help affinity groups". NGO B is involved in similar work across the state of Karnataka and has some projects in the neighbouring states of Andhra Pradesh and Tamil Nadu. NGO B has been involved in some health projects, such as Reproductive Child Health, but it has no prior experience with HIV/AIDS programming. In any project, NGO B is guided by the following *Mission Statement*:

> To foster a process of ongoing change in favor of the rural poor… [that] can be sustained by them through building and managing appropriate and innovative local level institutions rooted in values of justice, equity and mutual support.
> To recreate a self-sustaining habitat based on a balanced perspective of relationship between natural resources and the legitimate needs of the people.
> To promote strategies through which the full potential of women and children are realized.
> To influence public policies in favor of the poor.
> To strengthen networks and linkages between and among formal and informal institutions that can foster and sustain the impact of the development initiatives. (2005f, p.6)

Government institutions and other NGOs

The public health care system in District B basically consists of 3 government hospitals, 64 primary health centres, and 314 family welfare sub-centres (Karnataka State AIDS Prevention Society, 2004b; Swasti, 2004). There are only two sites for both VCT and PPTCT services, and no ARV centre in District B (National AIDS Control Organization, 2007a; Karnataka State AIDS Prevention Society, 2004b).

Over the years, staff members from NGO B have built relationships with the district administration. Program B staff participate in the District Advisory Committee on HIV/AIDS, along with government officials and other members. NGO B also has connections to other NGOs working in the district; it has cooperated with various NGOs on the watershed project and is now part of a larger network of 18 NGOs that meets occasionally to discuss ongoing projects.

Goals, implementation, and empowerment strategies

Goals, objectives, and design

NGO B partnered with KHPT in February 2004 and field work in all *taluks* of District B began in March. In order to achieve the overall goal of KHPT to reduce HIV and STI transmission in the population, Program B has outlined objectives and strategies to meet the objectives (Annual Progress Report 2005a). The first objective is to reduce HIV/STI transmission in core populations (sex workers, their partners and clients) through increased and sustained condom use and reduction of STIs; the main strategies to achieve this include behaviour change through outreach, using the peer education model, and health care programming. The second objective is to increase leadership and improve the enabling environment for effective HIV/STI prevention and care; the strategies to

meet this objective involve institution building through the formation of self help affinity groups (SAGs or SHGs), strengthening support for networks of HIV positive people as well as the District Sex Workers Advisory Committee, and supporting the District Advisory Committee.

Sustainability is the underlying principle behind these strategies. SHGs tend to involve saving money and promote participatory planning, decision-making, and sustainability; the idea is that SHGs will ultimately plan and manage community interventions (Revised Project Proposal 2005f). Likewise, the preferred mode of STI programming is the referral clinic, where a doctor provides health services to sex workers in an existing clinic at fixed dates and times. NGO B has also partnered with another NGO to set up "key clinics", which provide STI syndromic case management to men at a cost (Revised Project Proposal 2005f).

Program B has designed the "ABC4D" Approach to HIV/AIDS prevention; ABC4D stands for Awareness, Behaviour change promotion, Continence, Condoms, Community, Continuity, and Drugs (Revised Project Proposal 2005f). Raising awareness, promoting behaviour change and condom use are typical elements of most HIV prevention programs. Continence refers to a focus on promoting self-restraint and permanent adoption of safe behaviours through continued education. Programs must involve community participation and ownership. Continuity is synonymous to sustainability. Lastly, the program should include STI drugs, as well as provide ARV and other treatments for people with HIV/AIDS. At the end of 2005, not all elements of this model had been implemented, such as ARV treatment provision.

Implementation and main activities

Program B has established an office in each *taluk* and in three *taluks*, the program office is located in *taluk* hospitals; the offices also contain drop-in-centres, where sex workers can rest and socialize and where SHGs can hold meetings (Annual Progress Report 2005a; Annual Progress Report 2006a). As is the case for all implementing partners of KHPT, conducting a situation needs assessment of the sex work population and capacity building of staff took up considerable time in the beginning of the program. KHPT provided various training sessions for managers, peer educators, doctors, and other program staff. In the first two years of programming, Program B focused on various activities. Selected quantitative indicators discussed in this section are presented in Table 13 (see page 62).

In District B, initial efforts to break into networks and identify sex workers were successful; the program reached over 70% of the highest estimated number of sex workers and registered over 80% of contacted women (Revised Project Proposal 2005f). In March 2005, the program had identified 1,651 female sex workers and by March 2006, all of the 1,843 identified female sex workers were registered in Program B; regular contact, defined as two or more interactions per month, has been maintained with over 70% of registered sex workers (Annual Progress Report 2006a).

Implementation of program activities, such as condom promotion and education about HIV/AIDS and STIs, largely relies on peer educators and outreach workers. A peer educator is the first point of contact for sex workers and serves as a bridge between sex workers and program staff. An outreach worker does similar work but is not from the sex work community; she/he may focus more on interactions with the general community,

like store owners who have set up condom outlets. In August 2005, Program B was relying on 29 peer educators and 10 outreach workers for its outreach activities (Cumulative Monthly Report 2005c). At this time, the sex work to peer educator ratio was about 60:1 for all identified sex workers. By March 2006, there were 1,843 registered sex workers for 38 peer educators, resulting in a 49:1 sex worker to peer educator ratio (Annual Progress Report 2006a).

Outreach work largely involves condom education, promotion, and distribution, including stocking condom outlets. At the end of the first year of programming, there were about 80 condom outlets in all major sex work locations across the district (Revised Project Proposal 2005f). Between January and August 2005, there was a monthly average of 13,640 condoms distributed to female sex workers (Cumulative Monthly Report 2005c). By March 2006, there were 116 condom outlets and an average of over 150,000 condoms distributed per month (Annual Progress Report 2006a).

STI programming began at the end of October 2004 with syndromic case management and presumptive/asymptomatic treatments through referral clinics (Annual Progress Report 2005a). Program B also provides general health services and encourages sex workers to come to the clinic once a month for general health checks. By August 2005, there were 9 referral clinics, no program-linked clinics, and a plan to establish at least 13 additional referral clinics (Revised Project Proposal 2005f). Between January and August 2005, monthly averages of 288 female sex workers used STI services and 80 women came for a general health check; the ratio of the number using STI services to the number of referrals for STI services ranged from 42% to 86% in these months (Cumulative Monthly Report 2005c). In the months from January to March 2006, an

average of 850 women were using STI services, even more than the number of STI referrals (Annual Progress Report 2006a).

Empowerment strategies

The strategies for achieving general vulnerability reduction and empowerment of sex workers involved institution building and development of an enabling environment that attempted to address broader issues facing sex workers and recognize the role of other members of society in sex workers' lives and in HIV prevention. In this district, institution building involves forming and strengthening SHGs of sex workers as well as networks of HIV positive people. In addition to generating common funds to meet sex workers' needs, the purposes of the SHGs were the following:

> To provide a forum for sex workers to talk to one another on a regular basis and support one another..., including peer support and encouragement for consistent safer behaviours; to create space for feedback and participation of the community in [the HIV prevention program]...; to be the point for linkage between sex workers and other organisations that can support them in their quest to access information, health services, financial services, other livelihood support services, etc.; [and to] create a community base for possible continuation of [the HIV] project-initiated activities beyond the funding period. (Annual Progress Report 2006a, p.12)

By March 2006, there were 67 SHGs with 901 members (about half of the registered sex workers), and 20 individuals were participating in the positive people's network (Annual Progress Report 2006a). The positive people's network in District B is linked to KNP+, the state-level network. Program B also formed the Sex Worker Advisory Committee with representatives from the SHGs, as well as sex workers who are

not members of SHGs (Annual Progress Report 2006a). The purpose of the committee is to discuss legal issues and problems of harassment, and it aims to secure services, like ration cards and other social benefits.

Program B has aimed to cooperate with others in creating an enabling environment to support HIV prevention work and to reduce the stigma and discrimination associated with sex work and HIV/AIDS. The District Advisory Committee (DAC) discusses HIV/AIDS issues and has representation from major government departments, as well as NGOs and community leaders. Through their participation in the DAC, Program B staff have negotiated with officials to procure government services (e.g. ration cards, housing, pensions) for sex workers. However, "in this, the progress has been rather limited" (Annual Progress Report 2006a, p. 14).

Awareness activities and sensitization programs were launched to increase awareness about HIV/AIDS and combat the harassment of sex workers. This included conducting street plays and placing wall writings/murals in major sex work locations. Police sensitization training has also been conducted. In the second year of programming, a total of 374 events targeted police officers, drivers, students, doctors, clients, and other members of the general community. In terms of dealing with the harassment of sex workers, Program B staff members have taken measures as individual incidents arise.

Strengths and Limitations

All stakeholders considered the availability and accessibility of condoms to be the main strength of Program B. The large numbers of condoms distributed attest to the wide reach of this program activity. Program staff and sex workers considered STI programming to be another strength. Most sex workers appreciated that condoms and STI

services are free, challenging the view of some program staff that charging small fees would increase the perceived quality and value of services. Sex workers also appreciated gaining information about health, HIV/AIDS and STIs. The women expressed an even deeper appreciation for program staff, including peer educators, treating them with respect and kindness. Many sex workers also believed that the program staff would help them acquire other benefits, such as housing.

Many peer educators felt that the program's focus on marginalized women, both sex workers and positive people, was one of the most important aspects of Program B. They believed that the program has been successful in strengthening peer educators. They also recognized the value of SHGs, as did other sex workers who felt that being part of the SAG made them feel safe.

Program staff believed that the major program strengths derived from the unique qualities of NGO B. For example, their initial entree into sex work networks was greatly helped by the fact that NGO B has been long-established in the district. The organization has also been part of a network of NGOs and has worked with the local government. They were able to negotiate with the district administration to set up some of the program offices in government hospitals.

The NGO's experience in forming SHGs from previous development work was also considered a major asset. In addition to this, Program B has been extensively guided by the NGO's philosophy of using existing systems. For example, it relied on referral clinics rather than program-linked clinics; this did not seem to impede STI programming. NGO B acknowledged KHPT for being flexible enough to allow Program B to remain connected to the NGO's philosophy. Yet, program staff felt that the impact of advocacy

efforts to date had been minimal and that KHPT needed to play a strong central role in advocacy and IEC activities.

Many sex workers expressed their hope that Program B would help them in other aspects of their life, such as providing loans and housing. Program staff, including peer educators, agreed that they should be addressing needs beyond HIV prevention. They also felt that the gap in providing care to HIV positive people needed to be filled. Furthermore, they strongly believed that focusing only on sex workers would not be sufficient and that much more emphasis should be placed on clients and partners. A KHPT staff member shared this perspective, suggesting that Program B reach out to clients and partners to "go deeper into the program rather than expand."

Government officials have little contact with the program, but they were generally supportive of program efforts. They respected the program's goals and were confident that the program was improving the status of sex workers and positive people. Most officials expressed the need for more IEC activities targeted at the general community.

3.3 Program C

Context

District information

District C is located in the central region of Karnataka and spans an approximate 6,000 km^2 area which is divided into six *taluks* (Directorate of Economics and Statistics, 2003). Agriculture is the main economic activity and in the 2001 census, District C had a population close to 1.8 million, of which 70% was rural and 30% was urban (Swasti, 2004). The District Statistical Office reveals that the male literacy level is around 63%

and the female literacy level is around 41% (Swasti, 2004). In 2004, District C had a high HIV prevalence of 2.1% in the general population (Karnataka State AIDS Prevention Society, 2004a).

Sex work population

As indicated in Table 12, initial mapping of sex work in June 2004 estimated that there were 1083 female sex workers in District C, with the following distribution of sex work typologies: over 70% street-based, 18% home-based, and 10% lodge-based (Swasti, 2004). A later site-validation by NGO C came up with a higher estimate of 1,330 female sex workers (Situation Needs Assessment or SNA 2004a). Though the estimated proportions of sex work typologies vary, the predominant typology is street-based sex work. By January 2005, there were 253 (20% of estimated) female sex workers registered in the program (SNA 2004a). The registered women had the following characteristics: 63% were above age 30, 34% were ages 20-29, and only 3% were below age 20; 62% were street-based and 27% were home-based; and about 40% were considered high volume sex workers (more than 10 clients per week).

Table 12. Number of female sex workers by typology of sex work in District C.

Typology of sex work	Initial estimated number of sex workers, June 2004	Site-validated estimate number of sex workers, January 2005	Number of registered sex workers by January 2005
Street (Public)	780	*958* *	157
Home	195	*239* *	68
Lodge	108	*133* *	5
Brothel	0	*0*	2
Other	0	*0*	21
TOTAL	**1083**	**1330**	**253**

* Numbers derived using the same proportions from June 2004 estimates.

Implementing organization

There are various sources that provide information about NGO C, including the NGO website and the publication, *Rights First: Working Together to End Poverty and Patriarchy* (2005g). NGO C is an international anti-poverty agency that has been working in India since the 1970s; its mission is to work with the most marginalized communities to eradicate poverty and injustice. In Karnataka, NGO C has been involved in various campaigns and thematic areas, including violence against girls and women, right to food, and HIV/AIDS. The organization also has a history of partnering with local NGOs, CBOs, and individuals towards achieving shared goals.

In all of its programs, NGO C is guided by five strategic objectives: (1) Build an alliance of the marginalized to bring about change through collective action; (2) Facilitate just and democratic governance through direct participation; (3) Enforce the rights of women and girls and change existing unequal gender relations by eliminating ideological and institutional barriers to their rights; (4) Address the immediate poverty needs so that people can overcome immediate crisis and move forward to demand their rights; and (5) Diversify the resource base to ensure long-term funding.

Government institutions and other NGOs

The public health care system in District C basically consists of 3 government hospitals, 62 primary health centres, and 320 family welfare sub-centres (Karnataka State AIDS Prevention Society, 2004b; Swasti, 2004). There are three sites for VCT services, four sites for PPTCT services, and no ARV centre in the district (Karnataka State AIDS Prevention Society, 2004b; National AIDS Control Organization, 2007a).

NGO C participates in the District AIDS Committee (DAC), which meets to discuss HIV/AIDS issues and consists of representatives from major government departments, NGOs, and other members. Through participation in the DAC, NGO C has aimed to collaborate with various government departments. It is also connected to several organizations for HIV positive people.

Goals, implementation, and empowerment strategies

Goals, objectives, and design

NGO C partnered with KHPT in February 2004 and in the first year of programming focused on urban areas and two of the six *taluks* of District C; it expanded coverage to all *taluks* after the first year (Annual Report 2005b; Annual Report 2006b). In addition to the overall goal of KHPT to reduce HIV/STI transmission in the districts, another goal of Program C is to form and strengthen institutions and groups of vulnerable people, including sex workers collectives and networks of positive people, to help these groups access their rights (Annual Report 2005b). The objectives for achieving these goals are: to increase knowledge and use of condoms by sex workers and improve their health seeking behaviours; to reduce the incidence of STI among sex workers and men at risk; to reduce stigma and discrimination against vulnerable women, sexual minorities, and HIV infected/affected people; to increase access to care and support for HIV positive people; and to facilitate community ownership for program sustainability (Annual Report 2006b).

In its publication, *Women, Girls, HIV & AIDS*, NGO C outlines its rights based approach to HIV/AIDS programming, which emphasizes the following:

> Right to dignity: Partnering with excluded groups such as HIV positive young widows, sex workers, and MSMs and mobilising the communities to fight stigma and discrimination.
> Right to self-determination: Building institutions of positive people for active participation and to facilitate access to rights and resources.
> Right to comprehensive care: HIV/AIDS related work should address issues of fear, stigma and discrimination, prevention and treatment, employment, education, nutrition, shelter, violence and atrocities, etc. (2004b, p.3)

Implementation and main activities

For most of the first year of programming, Program C operated out of one district office, containing a drop-in-centre and a program-linked clinic (PLC). By the end of the second year in March 2005, Program C had established an office in all six *taluks*, with PLCs in three *taluk* offices and a drop-in-centre in all six offices. As with all KHPT programs, much of the first year was devoted to conducting a situation needs assessment of the sex work population, to recruiting and training staff and peer educators, and to establishing strategies and outreach activities within the district. Selected quantitative indicators discussed in this section are presented in Table 13 (see page 62).

In March 2005, there were an estimated 1,330 female sex workers in District C (Annual Report 2005b). By this time, over 900 female sex workers across the district had been contacted at least once by the program; thus, 68% of the estimated number of sex workers were identified by the end of the first year. Of the contacted women, 36% (323 sex workers) were registered in the program and over 60% (550 sex workers) had regular contact (at least twice per month) with the program. By March 2006, 1,143 female sex workers were registered with the program, covering 86% of the estimated number of sex workers (Annual Report 2006b).

As in the other programs, peer educators and outreach workers serve as direct links to program users and are involved in the delivery of the major program activities. They have similar roles, but in Program C outreach workers may also act as supervisors to peer educators. In District C, outreach work began in two *taluks* and mostly in urban areas (Annual Report 2005b). In August 2005, there were 22 peer educators and 12 outreach workers; the ratio of estimated number of sex workers to peer educator was 60:1 and 32:1 for registered sex workers to peer educators (Cumulative Quantitative Report 2005d). By March 2006, there were 30 peer educators and 11 outreach workers, with a 44:1 ratio of estimated number of sex workers to peer educators (Annual Report 2006b).

Peer educators and outreach workers have been actively involved in condom programming. There have been dramatic increases in the number of condoms distributed to female sex workers. At the end of the first year, there were 68 condom outlets (Annual Report 2005b). In the months between January and August 2005, a monthly average of 4,226 condoms were distributed to sex workers (Cumulative Quantitative Report 2005d). By March 2006, there were 86 condom outlets and an average close to 90,000 condoms per month distributed to sex workers (Annual Report 2006b).

As already mentioned, STI programming in District C started with one PLC and five additional referral clinics by the end of the first year (Annual Report 2005b). By August 2005, there was a total of 3 PLCs and 5 referral clinics (Cumulative Quantitative Report 2005d). In the months from January to August 2005, a monthly average of less than 100 female sex workers used STI services; however, the numbers increased from as low as 30 women per month to 186 women per month (Cumulative Quantitative Report 2005d). In the same months, the number of women using STI services as a percentage of

the number of STI referrals ranged from 43-95% of referrals. Although Program C encouraged female sex workers to come to clinics for general health checks, very few women (average 4 women per month) were initially taking advantage of this (Cumulative Quantitative Report 2005d). By March 2006, there were 3 PLCs, 9 referral clinics, a monthly average of 220 female sex workers using STI services (34% of STI referrals), and a monthly average of 40 women attending clinics for regular health checks (Annual Report 2006b).

Empowerment strategies

The idea of empowering female sex workers and marginalized groups in general is congruent with the guiding mission and objectives of NGO C. Their rights based approach to HIV/AIDS explicitly endorses the rights of sex workers and others who are affected by HIV/AIDS. The program objectives towards forming and strengthening institutions and groups of vulnerable people – by reducing stigma and discrimination of sex workers; increasing access to care and support for positive people; and facilitating community ownership for program sustainability – are regarded as empowerment strategies. Program C has engaged in activities for developing an enabling environment, similar to Program B; but Program C has focused on rights, whereas Program B has articulated its goal as vulnerability reduction.

Program C has aimed to form SHGs among sex workers and also support groups for HIV positive people. The program staff from District C made a visit to Program B to learn from their experience in forming SHGs. By the end of the first year, only one SHG and one support group for positive people were formed (Annual Report 2005b). In order to encourage sex workers to come together, the program has emphasized community

mobilization activities, such as educational meetings and social events. By March 2006, there were 6 SHGs with 93 sex workers and 4 support groups for positive people with 39 members (Annual Report 2006b). In order to better understand the needs of positive people and to foster networks of positive people, Program C has maintained a formal connection to an organization for positive people in Bangalore (Annual Report 2006b).

Program C has cooperated with various government departments and other NGOs to acquire government housing, ration cards, and other immediate needs of the sex work community. Though the proportion of sex workers linked to these organizations has been extremely small, a number of women have been granted loans, secured pensions, and received assistance to put their children in shelters and school (Annual Report 2006b). Program C also maintains contact with relevant government officials and organizations through participation in the District AIDS Committee.

Awareness and sensitization programs on HIV/AIDS have also been conducted by Program C. Awareness campaigns have targeted vulnerable groups (slum dwellers, migrant workers, drivers, youths, etc.) as well as the general community. Program C has advocated for the rights of sex workers and positive people through sensitization meetings with the police, health care providers, and others. In the second year of programming, 32 advocacy events were held and 400 police personnel received sensitization training (Annual Report 2006b).

By the end of the second year, Program C began an adult literacy program, facilitated voluntarily by a peer educator; some peer educators have started taking advantage of this program (Annual Report 2006b). A resource centre has also been set up

in one of the *taluk* offices; it aims to make available books on health, HIV/AIDS, condoms, and other general reading material for use by the general public.

Strengths and Limitations

Condom programming was considered a main strength of Program C by all stakeholders. Though many sex workers viewed this as a major strength, they placed more emphasis on the good rapport they have with program staff, including peer educators. Sex workers expressed much gratitude for program people treating them with respect and care. Many sex workers appreciated learning about HIV/STIs and some mentioned the usefulness of STI services. Peer educators expressed much more confidence in STI services than other sex workers, but they agreed on the importance of rapport between the program and the sex work community.

Program staff and peer educators fully supported the program's focus on helping marginalized and vulnerable people. For example, Program C has provided nutrition and support to HIV positive people. It has also aimed to fulfill the immediate needs of sex workers, such as providing clothing. Program staff believed that they had created a platform for sex workers to demand their rights. They also thought it helpful to be connected to a network of NGOs in the district.

The program's particular emphasis on rights and on AIDS patients has been observed by government officials. Most government officials were impressed with the dedication and professionalism of program staff. They supported the program's advocacy efforts and believed that the police sensitization trainings were particularly effective. They all strongly felt that more IEC activities needed to be conducted and that the general population should be targeted.

Table 13. Cumulative figures for selected quantitative indicators for the three programs.

INDICATOR	Program A			Program B			Program C		
	July 2004	Jan.2005	Aug.2005	Jan.2005	Aug.2005	Mar.2006	Jan.2005	Aug.2005	Mar.2006
Program features									
Number of taluks covered	6	6	6	6	6	6	2	6	6
Number of drop-in centers in operation	6	6	6	2	6	6	4	5	6
Number of program-linked clinics in operation	3	12/month	n/a	0	0	0	1	3	3
Number of referral clinics	n/a	30	n/a	6	9	n/a	5	5	9
Number of condom outlets	>1,000	>1,000	>1,000	80	n/a	116	68 **	n/a	86
Outreach workers in place	0	0	0	12	10	10	9	12	11
Peer educators in place	29 †	45 †	47 †	20	29	45	18	22	30
Ratio of estimated sex workers to 1 peer educator	99	80	80	66	57	41	74	60	44
Program users (female sex workers)									
Esimated number of sex workers	2,875	3,600	3,750	1,323	1,651	1,843	1,330	1,330	1,330
Number of individuals registered in the project	2,583	2,900	3,711	1,393	1,634	1,843	373 **	697	1,143
Number of individuals with regular contact	n/a	n/a	n/a	1,304	1,322	1,645	231	262	1,028
Proportion of estimated sex workers who registered	0.9	0.81	0.99	1.05	0.99	1	0.28	0.52	0.86
Services used per month									
Number of condoms distributed to FSWs	96,420	90,400	90,633 ††	12,093	17,762	152,478 *	1,985	3,974	69,900 *
Total number of individuals availing STI services	n/a	n/a	n/a	312	417	542 *	60	186	220 *
Total number visiting for regular health check	n/a	n/a	n/a	45	56	401 *	0	12	40 *
Number of referrals to STI services	n/a	n/a	n/a	540	956	740 *	95	278	642 *

n/a Information not available
† Number includes peer coordinators
†† Monthly average for January - August 2005
* Monthly average for April 2005 - March 2006
** Number in March 2005

Chapter 4: Exploring Empowerment Experiences

In this chapter, I explore female sex workers' experience of empowerment within the context of the HIV prevention programs. First, I discuss how sex workers articulate the experience of empowerment and explain how the programs have contributed to transformations in sex workers' lives and work. Next, I show how program staff have been affected by their involvement in the programs. Finally, I examine the environment in which these personal transformations occur and whether the programs have influenced the development of an enabling environment, which supports the empowerment of sex workers.

I describe twelve key themes that have emerged from the data. Most of the themes illustrate sex workers' subjectivities on how the programs have influenced them: HIV/AIDS and health; condom use and negotiation; self-esteem and capacity development; sense of control and options for the future; participation and ownership of programs; solidarity and collectivization; and legitimacy and disclosure of sex work. Other themes reveal the experiences of program staff: reciprocal learning and vocation; and ethical dilemma. The final themes explore components of an enabling environment: accessibility, quality, and reach of services; faith in program and rapport with program staff; and stigma, discrimination, and rights.

4.1 Sex Workers' Experience of Empowerment

HIV/AIDS and Health

Participants indicated that prior to the implementation of the HIV prevention programs in the three districts, the majority of female sex workers had little or no knowledge about HIV/AIDS and other sexually transmitted infections (STIs). They

indicated that their knowledge was consistent with the awareness level of the general population. Those who may have heard about the disease held negative attitudes and misconceptions about HIV transmission and persons living with HIV/AIDS (PLHAs). The following account by peer educators from District C illustrates this early scenario experienced in all the Districts:

> [All] We did not know anything [about HIV/AIDS and STIs]!
> [P1] I came to know about this after I came to [Program C] office.
> [P2] Due to the information given to sex workers, they started protecting themselves from getting infected.
> [P3] We had a lot of myths and misconceptions. Our people thought that going near [persons living with HIV/AIDS], sitting with them, even their breath can infect us. Some people even secluded them and kept them away from the village. After coming to [Program C], we learned to treat them like any other human being, and we started mingling with them, having food with them and all.

In a separate conversation, another peer educator from District C shared her own experience of discrimination by members of society: "I am HIV positive. My husband and society secluded me. Now I have the hope that [Program C] can give me hope to live." She gratefully recalled being introduced to HIV/AIDS activists through Program C staff; she was inspired by meeting an HIV positive woman, who founded an organization for women and children living with HIV/AIDS, and a famous journalist, who highlighted the struggles of PLHAs and launched a campaign against "quacks" (unqualified health practitioners).

Most sex workers have learned about HIV/AIDS through the programs and are confident in their knowledge base. The following proclamation by a peer educator from District B demonstrates this confidence: "After the arrival of this program, we came to know everything about HIV/AIDS!" Though this may be an exaggeration, it is unmistakable that sex workers have gained confidence that their understanding about HIV

transmission and how to prevent infection has improved. Peer educators from District A share their knowledge:

> [P1] I cannot tell whether I have HIV. Only when we get our blood tested, only then can we say whether we have HIV or not.
> [P2] The women who deal with sex work are more at risk of getting HIV. We did not know what a condom was. Now we know what it is.
> [P3] The women hide themselves while doing sex work, they go out to the sugarcane fields, behind the rocks, or somewhere people cannot see them. They do not use condoms. These women who hide and do their work are more at risk of getting HIV.
> [P4] Those who have sex without condoms can get HIV.
> [P5] It may come to anybody. It is not because of sex alone. It may transmit through blood, injection syringes. If [HIV infection] occurs, people think that it has come through having sex only. That is the wrong thinking that people have in them.

It is suggested in the above excerpt that sex workers also recognize they may be at particular risk for HIV infection. Many sex workers believe that there are risks associated with their work, as indicated by a sex worker from District A:

> Women who are in a profession like mine are at high risk of HIV infection. This profession (sex work) is like a sword hanging over one's head. We would not know when a condom would tear off. We are always at risk... Many people come to us for sex... We would get infected in the process. Clients are never at high risk. Though at times, unknowingly we may pass on our infection to them. But most of the times, it is we who get infected from them.

Other program stakeholders, such as doctors and program staff, are impressed by sex workers' understanding of HIV/AIDS. In fact, some people feel that awareness about HIV/AIDS and prevention practices puts sex workers at lower risk than the general population. A referral doctor from District A states, "Most of [the sex workers] know about VCTC (voluntary counseling and testing centre)... Now the sex workers know about condoms, about HIV, they are more careful about that. But general population, they don't know about that, so they are more exposed; risk of HIV is more in general population." A government doctor from District C makes a similar observation:

> After going to [Program C], I have felt a very different situation. The [sex workers], they are very cautious. They tell their partners, "You should use condoms." Whatever amount of money they pay, it's of no use. There are two ways in this. One is the silent sufferers, housewives. Even though the husband knows his health status, he doesn't want his wife to be protected. But on other end, there are the women who are doing sex work itself; they don't want the partner to come without condoms. These are the two different ways of HIV/AIDS.

In addition to increased knowledge about HIV/AIDS, sex workers have learned about other STIs and how to maintain health in general. Moreover, they have begun to prioritize health. Before the HIV prevention programs started, most sex workers "did not bother about health." Now, they see good health as a necessity for taking care of themselves and their family:

> In the past, we were going to clients without using condoms. Then there were pimples, boils, and lumps all over the genital area... We used to spend a lot of money to get it cured in the hospital... Then these people from [Program B] came into the picture. They recommended us to use condoms, which they said are being supplied by the government. So isn't it better if we use condoms, so that we can protect ourselves and our family from getting infected with HIV/AIDS? We can also save the money that we would spend for a cure in the hospital. We can spend the same money to eat healthier food and feed our children properly. We sit for hours and advise the sex workers to follow these guidelines, so that they can protect themselves and others too.

This peer educator from District B demonstrates the shift in behaviour among many sex workers, from being uninformed about STIs to recognizing the importance of healthy practices. She also uses her personal experiences to teach and motivate other sex workers to prioritize their health. Other peer educators and program staff promote the same message. A program staff member from District A claims "there is no chance that the women get into any sort of trouble because we have trained them so that first, they take care of their health above all."

Many sex workers seem to have espoused this message and assert that health is an important priority in their lives. Since being in contact with the HIV prevention programs,

sex workers show more concern about their health and display improved health-seeking behaviours, such as attending STI clinics more regularly. A peer educator from District B observes this pattern among fellow sex workers:

> Whenever they have some health problem, they come for treatment without anyone's permission. They freely do so. Once or twice weekly they come to the clinic if they have any emergency problems. They do not just come to the clinic for treatment and leave. They enquire about the symptoms, the causes for infection, and the cure for that infection. They have become very intelligent nowadays.

Sex workers who obtain services from the programs report marked improvements in their health. More notably, being healthy is perceived to be associated with other outcomes. Many sex workers feel that by being healthy, they "can lead a happy and peaceful life." As discussed later in this chapter, improved health status is also linked to perceptions of self worth and value to family and society.

Condom Use and Negotiation

The strongest indication that female sex workers are better informed about HIV/AIDS/STIs is reflected in their increased awareness and use of condoms. In all three districts, most sex workers did not know about condoms before their participation in the HIV prevention programs. A sex worker from District A reveals, "First we had not seen a condom or learned how to use it... I came to know how to use it after [the program staff] came here and I came to know how some infections occur... If you do not use it, you may be infected." It should be noted that some sex workers had already learned about condoms before the start of Program A, due to the earlier presence of another NGO promoting condom use. However, these women firmly attribute their knowledge about condom use to Program A and state, "Only after we joined [Program A], we understood the

importance of condoms." Understanding *why* one should use condoms is an important lesson learned in the other districts as well. A sex worker from District B recalls, "Initially, we were never using condoms. Then these people from [Program B] made us understand the importance of condom usage, and we happily agreed to use condoms thereafter."

As suggested, many sex workers were introduced to condoms by the HIV prevention programs. Initially, they had doubts about the usefulness or importance of condoms and showed resistance to using condoms. Peer educators from District B recall their early experiences:

> [P1] We did not know that condoms could prevent STIs and also, we did not even know how to use condoms. When I was in village D, a nurse who was working in the government hospital had instructed me to use condoms, but I scolded her, "Why do you come here and spoil my clients?" And I had also beaten her one day. Then the nurse had explained to me that by using condoms you can avoid pregnancy and you will also look nice and glamorous. But as I did not know about this, I had beaten her… After joining [Program B] we came to know about everything…
> [P3] As I did not know anything about this condom, I used to refuse it. But we came to know everything after joining [Program B] and now we have experience in everything… Without condoms we will not go with any client.

Many peer educators recount stories about the initial challenge of teaching fellow sex workers about condoms. Some have had experiences of being chased out of homes and having doors slammed shut in front of them. A group of peer educators from District A amusingly recalled that some sex workers were even scared to touch condoms. These experiences largely reflect the general view that it is inappropriate or problematic to speak openly about sex and related topics. The following passage from a discussion with peer educators from Program C reveals another early barrier to condom promotion:

> [P1] In the earlier days, when we used to go to [sex workers] to give them condoms, they used to refuse taking the condoms, saying that they are not sex

> workers, why do they have to use condoms? Then we really did have a tough time convincing them why they should use condoms…
> [P2] People in our community were very much ignorant about genital infections. They shied away from talking about their hidden infections to others… But now things have changed, they have started using condoms regularly.

Peer educators from District B attest to the noticeable changes, particularly in the way sex workers have actively sought to incorporate regular condom use in their work, in a manner that neither compromises their own health nor makes them subject to public rebuke:

> [P1] Now that we conduct more and more programs, [sex workers] have stopped hesitating and are coming to us asking for condoms. Instead of asking for condoms directly, they use a code word, "chocolate"… Women have started using condoms regularly without any hesitation…
> [P2] They have started telling us that even if their client offers them 1000 rupees, they will not accept [clients] without condoms.

Refusing large sums of money from clients in order to ensure condom use is an idea repeated by many sex workers. A majority of sex workers who participated in the study reported increased and consistent condom use with clients, regular partners, lovers, and husbands. The reports on consistent condom use did not appear to vary by age or typology of sex work.

However, some street-based sex workers from District C reported inconsistent condom use with some regular partners or lovers/husbands. One woman claimed, "[My husband] doesn't go anywhere outside to have sex. He is at home... I need not use condom with him because he doesn't have sex with others besides me." Another woman stated, "Only with [my permanent partner] I do not use condom. He doesn't agree to use condom. But with outsiders, I use condoms." The most discouraging response came from a third woman, who seems to take a haphazard approach to condom use: "Whenever I feel like using [condom] I use it. When the clients are drunk I use it. I don't use every time…

When I have health problems I use condom." However, this woman also revealed that she had never used condoms before learning about them through Program C.

Peer educators and program staff, however, reported that sex workers' self-reports may reflect some social desirability bias; they speculate that some sex workers, desiring the approval of the program people, are underreporting inconsistent condom use. Thus, peer educators and program staff believe the trend of inconsistent condom use with regular partners/lovers/husbands is much more prevalent. A program staff person from District A suggests that the key issue as to why sex workers choose not to use condoms with this group of sexual partners is the importance of fidelity within the relationship. She posits, "For your soul, there is only one partner, your lover, and for your body, there are many [partners]." A peer educator from District A explains this idea in more detail using her own example:

> The lovers would have taken responsibility for that woman's family. So the very first thing I told that person (lover) is, "I will not continue my profession as a sex worker, I am completely dependent on you." But I continued my profession without his knowledge, as I wanted him to believe in me, as he was supporting my family. If I ask him to use condom, then he might doubt me that I am still continuing my profession as a sex worker… This is why most of the women hesitate to tell their lovers to use condoms.

However, the same peer educator notes, "But with the ones who are not frequent visitors, they compulsorily use condoms. That is why we conduct lovers' meeting, gharwali (brothel owner) meeting, [HIV] positive people's meeting in our office."

Another potential barrier to condom use is alcohol abuse, as posited by a program staff from District A: "It may be the situation where both the woman and the client may be drunk. In such cases, the woman might not use condom." This is related to the reality that clients typically reject condoms. However, there is good indication that women have

developed effective condom negotiation skills. Condom negotiation most commonly involves teaching clients about prevention of HIV/AIDS/STIs, as described by this sex worker from District A:

> Many [clients] agree when we convince them about their health and their family members. But there are some who, even after a lot of convincing, disagree to use condoms. We do not entertain such clients... Yesterday, one client had come to me. He was drunk, he wanted to have sex without condom. I convinced him about why he should use condom, I made him aware of STI. I told him that, "Money is not important for me but I want to always be healthy. In order to keep you in good health you should use condom."

Some sex workers and program staff believe that there have been improvements in clients' attitudes regarding condoms. A sex worker from District C reports, "Before I was finding it difficult to convince the clients to use condoms. But now the clients themselves get condoms when they come to me. If there are no condoms in my house, they get it from the medical shop... One or two clients used to refuse to use condoms. I don't allow them to come near my house!"

Despite the numerous barriers to condom promotion and the influence of socially desirable self-reporting of condom use, all stakeholders emphasize that condom use has increased. Some sex workers regard the condom as a "saviour of life" and several women even claimed to use multiple condoms at once as a safety measure. Peer educators from District B explain how they have dealt with some of the challenges to condom use:

> [P1] [Sex workers] were not using condoms with their permanent clients in the beginning. But now, after we have convinced them a lot, they have started using condoms with their permanent and regular partners. We had told them, "Look, you would have gone with so many clients, you will not know what kind of infections you have got from them... And you are at risk of spreading the same infections to your husband and children too. So it is better to use condoms to avoid such mistakes."
> [P2] Now we know how to convince the women to use condoms every time they have sexual intercourse. Moreover, we have taught them how to convince their stubborn clients who do not want to use condoms. We ask them to tell their

clients about the kinds of infections they will get and spread if they do not use condoms. We ask them to explain in detail about the risks the client would be taking if they do not use condoms. Then they will surely use condoms if they come to know about the risks behind not using condoms.

Self-Esteem and Capacity Development

The perspective that being healthy increases one's capacity to contribute to society is prominently held by sex workers in the three districts. The HIV prevention programs have educated sex workers to protect their health and nurtured them to become healthier. As a result, these developments have afforded sex workers an opportunity to validate themselves and be responsible and valued citizens. Improved self-esteem or sense of self-worth is the central change experienced by sex workers in the three districts. Many sex workers have discovered their own capacity through the development of specific skills. Peer educators from District C enthusiastically describe the various skills they have gained from being involved in the HIV prevention program:

> [P1] I have learned how to behave and talk to people... I was very impatient and rough. I used to hit people when I was angry. I know now how to mingle with people in a much more desirable way.
> [P2] I did not know to give respect to others. I did not get respect from others. I have a lot of confidence now.
> [P3] I did not know about HIV or condoms or medicines. Now I know enough to educate others about that. I also did not know how to deal with others. I also have a lot of confidence now.
> [P4] In my village, everyone used to tease me that I am like a nomad, unnecessarily laughing. Nowadays, their comments [about me] have changed... "S is changed. She is the one who guides others, advises others; [She] does social work in the area, hanging that bag on her shoulder." When I listen to such comments, I feel proud!
> [P5] I feel very happy to come to [Program C] office, attend the meetings and talk to others. Please come to H to see the changes we made there!

The above example is a typical one among peer educators, who undergo intensive training in different subjects, but not all sex workers receive this training. Nevertheless,

many sex workers feel they have gained useful skills. A sex worker expresses satisfaction at what she has learned from Program A: "I was not using condoms then... I learned about HIV... I also learned to read and write. Now I find it easy to read the bus numbers and boards when I want to move from one place to another... I feel that I too can live like any other woman in society. I feel very happy."

As expressed by peer educators from District C, many sex workers are confident in their learning abilities and are eager to expand their capacities:

> [P1] We have done all that we know. If you have something that you feel we should learn we are ready to take it.
> [P2] If you tell us what we should do, we will do it and prove our ability...
> [P3] We do want training in other fields too. If you provide us training, we are willing to learn more.
> [P4] You are learned people, you know how to read and write... But we are illiterate people. Even then, we can keep the knowledge in our brains and share with people like us. How many more trainings you give us, that much knowledge we will gain.

There are various other manifestations of sex workers' elevated confidence. As deemed by many sex workers, the ability to speak openly about different topics to many people epitomizes confidence and courage. A peer educator from District B boasts, "We never had courage to talk to the big people, men, leaders. Now we can even talk to a hundred of them!" The following two passages reveal decisive moments in the experience of peer educators from District C and District A, respectively:

> We were very scared when we used to see the police van. Once there was police training in [District C]. [Program C] office called ten peers, including me. When I went to the training, no peer was there except for me. I addressed the police personnel. They gave me listening ears. I felt that my life has meaning, I can even die now! I am so thankful to [Program C], which gave me this much confidence.
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> I didn't know what is STI. I didn't even know about HIV. We were like hard stones. [Program A staff] corrected us, taught us so much, just like hitting the hard stones. They filled so much confidence in us... We were scared of the police. We used to just run inside. Now if we see police, police come out to salute us, we talk

> to them boldly... We have gained more confidence than the educated women, just by putting this bag on our shoulders.

Public disclosure about being a sex worker is also linked to an increase in self-confidence, and this idea will be explored later in the chapter.

Many sex workers feel they have the capacity to help other women "to be good" by educating them about health and HIV/AIDS prevention. A sex worker from District B gives a powerful statement in this matter:

> From [Program B] we have learned so much that now we are in a position to teach others... Now I am capable of saving other's life. I have heard people talking proudly about those who give money and gold. But I am proud because life is more precious than [money and gold], and I am capable of saving such precious life!

Other program stakeholders readily confirm the changes and increases in capacity among sex workers. A program staff from District C makes the following observation:

> In the field, we face different problems and immediately we have to solve that problem... So every time we have to be very careful and creative. If they come to us with some problem, we should be in a position to give some suggestions. So we have to be very alert. It's different for every situation and every woman. Initially in the first year, we used to get so many calls everyday from the field... But [the peer educators] are so empowered. Now they don't really call. They learned to solve the problem themselves.

By demonstrating capability to implement the HIV prevention program, the sex workers who run Program A demonstrate increased personal efficacy. One woman shares her important learning experiences from Program A: "They say you sell gold only through the way you speak. I have learned what one can achieve through one's speaking abilities... And now I am confident that nobody will refuse to hear what I say, because I speak the truth!" Another woman reflects on the extent to which she has grown:

> I am not a qualified individual and initially I hesitated to mingle with other people... But now I have gained so much courage that I am capable of going to Delhi alone... My life has been possible because of [Program A]... It's like you

> sow a seed and water it so that it grows and gives fruits; it is the same with me. ICHAP people have helped me to grow to such an extent. They have helped me grow both professionally and with regards to my family.

As suggested above, these leaders emphasize that their personal growth took time, support, and necessitated overcoming many challenges. Another woman recalls her early experience:

> Initially, I did have problems as a [peer coordinator], because A and B were far away villages... I faced a lot of problems because I had to travel all alone. Then [an ICHAP program staff] gave me a lot of support and confidence... He said, "You search the village on your own, you will have a great experience." He used to say that we should never stand on land and try to measure the depth of the water. Instead, we should get into the water to know its depth.

With such role models, it is not surprising that some sex workers in District A have become politically active in the villages: "Now our peers have stood for election. Earlier they didn't have the courage to contest for the election. Now, our Devadasi women have become strong and courageous."

Sense of Control and Options for the Future

It is apparent that some sex workers have reflected on their circumstances and have resolved to lead happy and meaningful lives, regardless of the hardships facing them. A peer educator from District C simply states, "We have learned to live now." These women have gained a strong sense of mastery or control over their life and work, as revealed in this quote from a sex worker from District C:

> I didn't know anything before coming to this office. When I started doing sex work, I was ten years old. Sometimes I worried about being a sex worker. I thought if I get this kind of disease, who is there to look after me? When these kinds of thoughts came in my mind, I felt scared about my future. But now I don't have fear about HIV. I know how the HIV spreads from one to another. If I come to know that I am infected by HIV, I will eat good food and live another ten years without revealing this to my family members. There is no meaning in worrying about HIV.

This sex worker no longer fears HIV and is confident that she will be able to manage living with the disease; she is hopeful about her future.

Some women have undergone major personal transformations, as exemplified by numerous "before and after" scenarios. In a group discussion with her peers, one peer educator from District B recounted her story. She described her "old" self as an alcoholic, who drank to "forget [her] tiredness and pain." She did not have any knowledge about HIV/AIDS and felt a constant sense of fear that doing sex work made her susceptible to all kinds of diseases and struggles. She also remembers with embarrassment her initial interactions with the program staff. She used to yell and curse at them to leave her alone and would say accusingly, "You people inject us with something and make us die!" Another peer educator confirms this story: "I used to get so scared to even speak to her. If anyone tried to speak to her, if I held her hands, she would shoo me away saying, *Hey, how dare you hold me by my hands?*" As all the other peer educators in the room recall this with humour, it is clear that this peer educator is a different person now. The "new" person has "lost all such fears" about HIV/AIDS and other problems and is "leading a care-free life." She has also learned to respect her family members and as pointed out by one of her peers, "C has completely quit drinking. She has changed a lot now." She responds with pride, "Now I have the capacity of telling others not to drink!"

Sex workers are no longer apathetic individuals, who do not have control over their life circumstances. Some women have stopped drinking alcohol and engaging in other unhealthy habits, and they have begun to regulate the way they work. These trends are observed by a program staff from District A:

> Initially, [sex workers] never used to break our head over anything. They would say, "We don't care if we get infected with HIV, our luck will decide our destiny." Everyday they used to consume 10 packets of *gutkha* (a drug)... They have reduced their drinking and *gutkha* eating habits, as we gave them information about the bad effects of this habit early on... So we started brain-washing them, "When you can stay away from drinking and *gutkha* [during a training session], why can't you stay away from this for the rest of your life? This will improve your health." Instead of attending to 10, 12 clients per day, we asked them to reduce the number to 5 per day and ask for more money. Yes, they have changed their behaviour gradually.

In step with the noted behaviour changes, some sex workers have also begun to plan for the future. The women have started to place an importance on saving money, mostly through joining self help groups (SHGs). They have started considering alternative forms of income generation. They also typically focus on ways to improve their children's future. A program staff from District A reviews this development:

> Now [sex workers] send their children to school... They do not want their children to know about [the sex work] or follow in their footsteps. They have started educating their children about good habits, discipline, about environment, good behavior and manners... Initially, they used to spend most of their time with their lovers. Now they have controlled themselves from wasting time with lovers... Now they have started thinking about saving money for their future.

In discussing the same development from their own perspective, peer educators from District C imply that the nature of changes experienced by themselves and fellow sex workers is permanent or irreversible:

> [P2] [Sex workers] are planning to take loans from SHGs and start another enterprise, like papad making, incent stick, tailoring, candle making...
> [P3] We attended a lot of training programs. We changed in our thought processes. Now we want to do some enterprises. We are expecting loans to start some business.

A number of sex workers strive for the option of quitting sex work and there are reports that some women have succeeded in doing this. The following quote from a sex

worker in District B captures the main points about increased sense of control and future options among sex workers:

> If we look happy today, that itself is the change, isn't it? We are getting the confidence. I feel I should leave [sex work] and do something of my own and look after my family. I should also motivate others to be strong and get them to leave [sex work]... We don't have any status in society, we are getting old, we should do good and not bad. If we have our own occupation and own earning, we can keep [clients] away... If we have money in our hand, what can [clients] do for us? This is what I felt after I joined this program.

Participation and Ownership of Program

Beyond seeking services from the HIV prevention programs, some sex workers show an inclination to actively participate in program operations. They participate in varying degrees, from offering suggestions to improve programs to promoting condoms and bringing peers to the STI clinic. These women believe that the programs have "saved [their] lives" and they wish to share the benefits with other sex workers. A sex worker from District B reveals that she uses her improved knowledge and health status as an example to mobilize other women to attend the STI clinic:

> We became good by [the program staff] only... I didn't think much about anything, about health... Then F made me sit and she told me [about health] in detail... Then I came to know a little and I bloomed like a flower... We tell others and bring them here for the check up... Because when I say, "I am good, I am healthy," they come and say, "You are good, healthy, and there is charm on your face."

Related to their feelings of gratitude from being saved by program staff, some sex workers express a desire to give back to the programs. A sex worker conveys this sentiment: "I feel that I should do something of my own (a job other than sex work). Due to that, the name of [Program A] should be glorified."

Peer educators play a unique role in program delivery and they are paid a small honorarium for their work. One might argue that participation must be completely voluntary to be meaningful and that getting paid to participate poses a conflict of interests or may be perceived as coercive. However, this argument is quickly dismissed when taking into account sex workers' stories about how they were recruited as peer educators. Many sex workers had initial fears and hesitations about working for the HIV prevention programs, and they strongly doubted their capacity for enlightening fellow sex workers. A majority of the women state that the opportunity to "help" or "save" other sex workers was the main motivation for taking on the role of peer educator. A peer educator from District C shares her recruitment experience:

> When the staff offered us work, we did not want to work. We thought that they would traffic us somewhere, they would sell us to somebody. Gradually, we learned about the work. We do not work for the meager honorarium but work for the welfare of sex workers. [Sex workers] should be healthy, their children should be safe, their situation should improve. This is the objective of our joining the work in this office.

Peer educators from District B clearly reinforce this common motivation:

> [P1] Then [Program B] people explained to us about the nature of our work. They told us that we will have to identify women like us, gather them, and give them knowledge about HIV/AIDS. Then I thought, "Yes, I should come out of the house and join hands with these people to help them for a good cause." Then I decided not to look back once I stepped forward.
> [P2] Now I proudly talk to people and tell them I am in such and such a program, which is doing a lot of good work for the sake of sex workers. I say that [Program B] is empowering sex workers socially and health-wise too. Now I suggest them, I mean the "normal" citizens, to also join the program. After I joined [Program B] I have developed a capacity to teach other people what I have learned.

Some peer educators have faced problems from their participation in the programs, as indicated by this peer educator from District B: "This program is very nice and I am struggling very much to do this. And for the sake of this I have also faced beatings and

scolding." Nonetheless, these peer educators have learned to deal with the largely verbal assaults, as demonstrated by this woman from District C: "Let the people say anything, 'mouth of a pot can be closed, but not the mouth of people' (a proverb in Kannada). For example, a dog barks but it seldom bites. We should not be frightened by these barking dogs. We should go forward to help people." These types of confrontations are now rare in District A but were likely common occurrences at the beginning of the program. In spite of these challenges, peer educators, like this woman from District B, continue their field work with a great deal of pride: "I myself felt very happy because I was able to help some one... My soul would be satisfied if I was able to save some one's life."

Through engaging in various aspects of programs, sex workers show that they want to play a larger role than that of passive beneficiary. The commitment of sex workers in their job as peer educators is undeniable. All sex workers emphasize that their participation stems from a desire to help fellow sex workers. Yet, different program stakeholders, including some sex workers, believe there is a weighty distinction between community participation and community ownership. Community ownership of the HIV prevention programs is an ideal goal promoted within all three programs. In Districts B and C, program staff feel more time is needed to successfully "transfer" the responsibility of the programs to sex workers. A program staff person from District C notes, "We were talking about ownership of the project to the community. But it takes its own time. See, after one year, peer educators... are not so empowered to take even a small responsibility. Most of them are illiterates, so it's difficult for them to manage immediately. But in the long run, it may work out." Similar thoughts are expressed by a program staff person from District B when asked how community ownership can be promoted:

> One, listen to what the people want. Second, when you say community participation, their mere presence is no use. The other thing people assume about community taking over and managing is that it can happen overnight. It cannot. You have to increase the capacities of these communities to be able to do something like that. The willingness and interest may be there, but they have to have the capacity. Otherwise they'll never do a good job. You'll still be holding their hand. It's a process that takes time. You have to plan for all that.

Program A is relatively advanced in the ascent towards community ownership. Aside from the technical and logistic support from ICHAP/KHPT that all program implementing partners received, daily operations of the program are run by sex workers. However, the pinnacle of successful community ownership is self-sustainability and Program A has yet to achieve this. An ICHAP staff person appraises the current situation:

> Self-sustainability is required for [Program A]. Now, the [HIV prevention] project people take initiative on all things. But the body of the [sex workers' collective], they are not actually working with [Program A]... [The sex workers' collective] president, the members, the secretary, those women are not working [in HIV prevention]... If [the HIV prevention program] takes control of this total collective, it will be a great thing in [District A]... Community involvement is there, but community ownership is required. But it may take a little time... If you make the [sex workers' collective] very strengthened, definitely this project will run for a longer time. HIV may not be there in two, three years, but this sex work community, the problems, it's a never-ending process.

Solidarity and Collectivization

All female sex workers in the three districts have undoubtedly faced hardships stemming from poverty. A majority of sex workers interviewed indicated that they have had to confront life's difficulties alone, without the support of family, friends, or institutions; many women were abandoned by their husbands and families. Most sex workers have grown accustomed to being ignored or treated negatively by everyone they encounter. Therefore, it is striking to learn that sex workers have come to view their peers as family members, as strongly expressed by peer educators from District A:

[P1] We are like our own sisters.
[P2] We are like the children of one mother.
[P3] We feel like we all are from one family.
[P4] We are more than our own family.
[P5] We all love each other, treat each other well.

The solidarity among sex workers apparent in all three districts has been stimulated by the HIV prevention programs, which have aimed to bring sex workers together. Sex workers easily relate to one another due to similar past experiences, but they are more strongly united by a shared future objective. As mentioned earlier in the chapter, sex workers are committed to helping others improve their lives. A peer educator illustrates this idea:

> I am from village J and she is from village R. Now all of us have come to [Program A] like the children of one mother, sharing each of us our experiences, may be our sorrows, happiness. This is the greatest thing that I felt [about Program A]. Moving around the villages, educating [fellow sex workers]... The women should be helped by providing education to their children. Through [self help groups] some kind of help should be provided.

Sex workers reinforce the view of an earnest connection to their peers in other ways. Some women, especially peer educators, feel they must to serve as representatives and examples for fellow sex workers. This is apparent in a discussion about responsibilities among peer educators from District B:

> [P1] Firstly, I should represent my community. I should make my community people so strong that they leave aside all their fears and come forward to support other people... My responsibility is also to spread maximum awareness about HIV infection. We should be the responsible citizens of this society. If people like us start creating awareness, only then will the community awaken to these kinds of dangers...
> [P4] We have also come from their position... We are representing them and more than sixty women, who do sex work like us, will be working under us. For that purpose we do not want to lose them. And when they get the complete information and awareness about the clinics, we must also instruct them about the use of condoms. So that they can have a healthy life and can take care of their children. And they can also lead a happy life...

> [P5] I thought that anyhow I have spoiled my life… I wanted to help other women who do sex work like me and they may be my sister or daughter. And I am doing this work for their sake…

The HIV prevention programs have encouraged sex workers to be part of a *sangha*, which means group, collective, or community. Program A is run by members of a large *sangha*, a district level sex workers' collective, which existed before the start of the HIV prevention program. Yet *sangha* is also synonymous to the small self help group (SHG), typically formed as a group money savings scheme. Program A promotes SHGs within the larger *sangha*. Program B and Program C help sex workers form SHGs and also encourage the women to join district level sex workers' collectives, which are independent of the HIV prevention programs. Since collectivization would precede community ownership of the programs, it is an important focus for program staff. A program staff person from District C notes, "We formed the small groups. When people think 'self help group', they think that it's only money savings part… [Rather, the SHGs are] rights based… In the group, they can achieve so many things and so many issues will be discussed, [such as] strengthening the groups and providing knowledge about the law and rights of women." Prior to the implementation of Program B, the NGO had years of experience with formation of SHGs. According to this program staff, Program B regards the development of SHGs as a crucial component of future planning:

> [This NGO] has almost become synonymous with the self help group movement… Our aim is that today what a peer [educator] is doing the group will take over… They would be responsible to make sure that their group members go for regular check-ups, … the group takes over the condom distribution… So we have started forming the groups. Now we have to train them; there's a lot of capacity building on how to be a good group, what are the requirements and responsibilities… We also have another structure... called the "community managed resource centre" [CMRC]… And that's our withdrawal strategy;… a resource centre, that's managed by the community, which can largely deliver or link to services depending on what they need… The CMRC can then take over the

> responsibility of providing STI services… That's our final aim. So we have to move from delivery mode, where we are doing everything, to promoting the groups and then linking them to the CMRCs.

Sex workers themselves have started to recognize the value of collectivization. Some women, like the program staff, view this as a matter of program sustainability. Most women see very practical advantages to being part of a collective; they feel more capable of facing and solving problems as a group. A peer educator from District C argues, "If there is unity among us, then we can face anything that comes. If I am alone, then I cannot fight against anything… If you fill us with courage to face everything with unity, then we can face any problems." Another peer educator from District B shows an insightful perspective on collectivization:

> We [sex workers] will also make our own association because we do not guarantee that this [HIV] project may continue further. And we are saving money in this association so that the savings may help us in the future, if we fall sick… They used to call us prostitutes. Now the people fear to talk to us. We have all come together and started an association and we have struggled for it… If anybody tries to beat any one of us, then we will all come together. In the beginning, we were scared to walk alone in the circle and we used to run if we saw any men… But now we can go alone. It's nice, only after the arrival of [Program B].

Program A staff and peer educators feel they are ahead of the other programs in terms of recognizing the benefits of sex workers' collectivization. The following passage describes some specific examples of accomplishments of the women working together:

> If there is any problem all of [the sex workers] get united. The road in their area was bad. There were big stones where people could not walk. All the women gathered in front of the *Panchayat* [local government] office and demanded the road repair, and they were successful in doing that. They have also worked together to get the civic services, like drinking water, bore wells, street lights, etc.

Legitimacy and Disclosure of Sex Work

Like the general population, many sex workers believe that sex work is bad and immoral. These sex workers feel ashamed about doing this work, yet this sentiment is overshadowed by their recognition that brutal circumstances often meant that sex work was their sole option for survival. A peer educator from District B states, "We do this job for the sake of our stomach... If someone is ready to give a job, then I assure you that I will quit this profession and lead a peaceful life. If I sit at home without doing any work, who will take care of us? So I thought it is better to commit this mistake than starve to death." Based on this type of justification, a few women make no apologies for doing sex work.

However, due to the inevitable negative attention from the community at large, a majority of sex workers would prefer not to be known or labeled as a "sex worker". With the exception of peer educators, most of the sex workers interviewed from Districts B and C engaged in sex work without the knowledge of family and neighbours. In contrast, almost all of the participants from District A were open about engaging in sex work. The open sex work disclosure in District A is explained by the presence of the traditional Devadasi system, which has socially sanctioned sex work for many generations. According to one sex worker, people even wrongly assume all Devadasi women are sex workers. However, as noted in the discussion on condom use, it is likely that some Devadasi sex workers are not candid with their lovers about continuing sex work. Though a majority of sex workers in District A are Devadasi, there are also non-Devadasi sex workers who may wish to carry out their work covertly.

In view of the importance of keeping their involvement in sex work hidden, sex workers show some courage by merely being connected to the HIV prevention programs. One of the messages that the HIV prevention programs tries to convey is that sex work is a respectable profession. There are sex workers and peer educators in all three districts, who have adopted this message. A peer educator from District B advocates for this message to fellow sex workers:

> Initially we have to change ourselves and then we have to motivate others. We tell [fellow sex workers], "First of all, you should have courage so that you can to talk to anybody who comes. And then you have to give awareness to them. It's true that we are doing sex work, but we should not take into consideration when they say that we are prostitutes, and you should not get scared of these things. Ours is a profession, we should respect our profession, and nobody should insult our profession. So for this to happen we have to change ourselves first."

This woman shows great insight by recognizing that self perception of sex workers must change before other people can accept sex work as an acceptable form of labour.

Within the HIV prevention programs, being open about doing sex work is equated to self-acceptance and is seen as an indication of improved self-confidence. The self-acceptance and self-confidence of the sex workers who implement Program A is undeniable. One woman casually argues, "There is no one who is spared of sexual desires. Even the gods were not left alone. We are just human beings, we also have a lot of sexual desires. So it is not bad to go to [sex workers] for sex." These women were not always so "bold" and they credit the HIV prevention program for their positive transformation. Similarly in the other districts, and as already observed in their motivations for participation, peer educators expose themselves to potential harms from disclosing their sex work status:

> Initially, I was finding it difficult to face the harsh words of people. Then, no one knew that we were sex workers. But now everyone knows that we are sex workers

but we have to come forward for a good cause. So why should we worry about what people speak about us?

Many peer educators use their own experience doing sex work to build relationships with other sex workers. With the support of peer educators and the activities of the HIV prevention programs, some sex workers have started to understand their rights and to feel comfortable revealing their sex work status. This is indicated by a group of peer educators from District C:

> [P1] Sex workers were not revealing their sex work before. But now they have got the confidence to reveal to others.
> [P2] They say, "What is wrong in doing it? Our work is just like any other work. We are earning through this way."
> [P3] After [Program C] started in our district, [it] has given us moral support in many ways, like harassment from police. [Program C] helped us by convincing the police and the way [police] used to mistreat us has been changed. So [sex workers] openly say that they are sex workers and they engage in sex work without any fear.
> [P4] They are so confident about our office. They know that [Program C] is always there to help them and support them.

4.2 Impact on Program Staff

Reciprocal Learning and Vocation

Not only the sex work community that has been influenced by the HIV prevention programs. Other stakeholders, mostly program staff, have obtained meaningful benefits from their participation in the programs. Indeed, the program staff often experience similar changes and personal growth as the program beneficiaries. Only program staff (and those outside of the sex work community) will be considered in this part of the discussion. The programs seem to have had minimal influence on a few government officials, like referral doctors who participate in program activities.

Program staff did exhibit improved self-esteem from acquiring special knowledge and skills. They credit sex workers directly for some key learning, suggesting capacity development is not unidirectional. An ICHAP program staff person states,

> I can say I learned a lot of things from [the sex workers]. Implementing the project, how to reach the women, how to convince the women,... all these critical issues. They know everything [about their peers]; they know the plus points and the minus points of the women. If any problems arise, they can handle these things in a very easy way...

Program staff have appreciated gaining an understanding about the poverty, violence, and injustice that strongly shape sex workers' lives. They have gained insight into a world they never knew existed prior to their involvement in the HIV prevention programs. A staff person from District C recalls one surprising discovery:

> Only after coming to the project, after interacting with the peer educators and the sex workers, that [I learned there are]... some pressures for them to come to sex work... Another thing I learned was that teachers would say, "My children, I would like them to become teachers", doctors would say, "My children should become doctors", but these sex workers never say, "My children, I would like to see as sex workers"... Nobody wants their children to continue [sex work].

These new insights have forced program staff to reflect on their own perspectives on various issues, challenging and influencing some of their opinions and decisions. It has also strongly informed the way program staff carry out their work and interact with sex workers. A staff person from Program C describes the process of learning about sex workers and persons living with HIV/AIDS:

> At first it was a challenge... I didn't have much idea about sex workers. Like any Indian family, even I have got certain [prejudices]. So I had to come out of that thing... [But] I was brought up... to help the people at risk... When we understand their background, we feel that we have to work for them...
> But now I can see a different world. We used to talk about women, in general, who are poor and vulnerable. But I never thought of sex workers and... how they're struggling, all those things...
> Second thing [I learned is] PLHAs, they need so much of emotional support. HIV is not death... Everyone is having that [misconception] in mind, and we need

> them to come out from that... We empower so much, we do counseling, we do emotional support and give nutritional food. But if somebody dies in one group, the whole group will get depression. Once again, it takes so much time to make them come out from that.

One KHPT program staff person shares an incident that made an enduring impression on her. A peer educator, who was working very diligently and recruiting many sex workers to the program, suddenly fell ill and died of AIDS. The program staff could only take her to the government hospital and regularly visited her at home with food, which they bought with the office budget. The staff felt distressed that they could not do more to help her or her parents, who bitterly observed, "She's dying of the same HIV which she was trying to prevent." The KHPT staff person tells the sobering story and the idea for programming it inspired:

> She couldn't talk when I visited her last. But she greeted me with folded hands and she was so happy to see me there. But I was feeling so bad because I couldn't offer her anything. That was the most painful thing I felt. Maybe KHPT should look into having some sort of insurance, at least for peers. I don't know if it's insurance as such, some monetary benefits ... They put their hearts and their souls, and they say I'm really working for this... The neighbours would look from far off, they wouldn't go near the house. But once they saw these NGO people going there and when I also visited, I heard that many of the neighbours started going to see how she was... And her mother was in tears. She said, "I don't have anybody to take her out. Okay, let her die but let her die on my lap. She is my daughter. She worked for you. Now I don't have anybody..." That was really painful. I can never forget that!

There are some unique challenges to working in an HIV prevention program for sex workers. Program staff talk in detail about the many personal and professional obstacles they have encountered. Despite these challenges, program staff perform their work with an indomitable sense of pride and duty. They believe HIV prevention is imperative, and that the program merits complete dedication and requires making sacrifices. A program staff person from District B summarizes her experience:

> It's been a learning experience... If you really believe in something, you can do whatever you want. You can always learn a skill through experience. Another learning is that we have to do a lot more for HIV/AIDS. I think we're just pretending that there's only 5.1 million; there's so much uncovered and it's going to hit us in the face. And when we have so many lessons already from Africa... We have to work much more urgently... That's why I'm supposed to be a part-time consultant, [but] I'm here every day of the week!

It is evident that program staff do not see the HIV prevention work as a mere job; they regard it as a vocation, a line of work to which they have a strong inclination and commitment. A program staff person from District C reinforces this idea and also outlines some specific obstacles she has faced:

> A major challenge was time. Actually, I was never compulsed to work for more than seven hours, but in order to give the services to the people, we have to work for more than seven hours... There is no time bound for us... Sometimes even on Sundays we come in. We are enjoying the work but our families feel neglected... As a woman, working in a sex workers' project is very difficult. She has to struggle with many things, like families, societies... because with sex workers project, more stigma is there. If I want to get my sister married, somebody might say, "Oh, her sister is working in sex workers project. Why do you want to get married to that girl?" So many problems will come. Or sometimes I may be going with a sex worker and my husband's friend may see and he may say, "Hey, your wife was going with a sex worker. What is she doing in that lodge?"... But even facing those challenges is a very nice experience, but we should have support from the family.

The program staff's tremendous efforts have not been without benefits. They report improved self-esteem from contributing to work that they deem as valuable. Many program staff reveal they have increased self-confidence from developing new capacities and overcoming hurdles. The following two passages, from an ICHAP staff and a Program C staff person respectively, exemplify the enhancements in self-perception among program staff:

> It was a great challenge at the start of my career. I thought if I can gain success in this project, definitely, I can achieve anything in my life!... My confidence level is increased... Now I can easily adjust with any people. Also my communication

> is improved... I can do [anything] because I see this… as a challenging job and I'm very satisfied with this job.
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> Actually, I am very grateful to [Program C] for giving me this opportunity… Being a woman, I had not thought that I could work so well. I was not knowing my capabilities, my talents. Coming to [Program C], I was given an opportunity to express my talents... Even now I am [expanding] my capacities… It's strengthening me, that is the lesson I have learned. I have found my capacities.

Ethical Dilemma

One person from District C used the term, *ethical dilemma*, but it represents a common struggle encountered by numerous program staff. The dilemma centres on the questions of morality and legitimacy of sex work, and the following passage clearly illustrates this predicament:

> [Program staff] will always have some ethical dilemma that we are suffering… In the project we are saying that sex work is not bad, sex work is not a crime. But as a person, can we accept these sex workers or telling them again and again that sex work is not bad?... [Sex workers] may ask, "If it is not bad, why are you not doing sex work?"… [As long as] the project goes on, that ethical dilemma will be there. Are we promoting sex work by providing STI services and condoms? Sometimes many people will ask us, like in police sensitization programs… Even [a district level politician] asked me like that, "Why are you keeping condoms in the lodges? It means that sex work is going on. I don't agree that sex work is right." He said that frankly. At that time, I was not able to answer him.

This program staff person and her colleagues face a paradox every day; they are respectable citizens who endorse sex workers' rights and who help sex workers conduct work that is deemed to be immoral in the wider community, in a safer manner. She believes she must accept this as reality and she elaborates on these ideas and attempts to resolve any hypocrisy she may experience:

> There is no answer [to the ethical dilemma], means the right answer… Because professionally we say that we are working for sex workers…, but personally, are we ready to accept sex workers? Can I give a job to sex worker in my house? It is very difficult. It is necessary that not only I should change, the whole family, the whole setup should change. Then only these sex workers can be accepted by

> society... Most of the work has to been done on clients also. Whenever there is demand, sex work is there. If the demand is not there, sex work will terminate surely.

This program staff person makes a crucial point: acceptance of sex workers as members of society will require more than behaviour change among certain individuals; it will necessitate widespread changes in the "whole setup" – the sociopolitical environment.

4.3 Enabling Environment

Accessibility, Quality, and Reach of Services

Notwithstanding sex workers' personal inclinations to use condoms, there are various environmental factors that can promote or inhibit condom use. Accessibility of condoms has an obvious influence on condom use. In all three districts, reliable and easy access to condoms is considered to be a strength of the HIV prevention programs. Sex workers can obtain free condoms from various locations (home, program office, brothel, outlet boxes in public places), and they have regular contact (at least once a week) with peer educators whose main mission is to promote and distribute condoms. A sex worker from District C says she takes advantage of all these condom sources, and also buys condoms from the medical shop; she explains, "I get the condoms from those places where I feel comfortable to go." It is rare that women do not find at least one location where they can comfortably access condoms. However, several women revealed that they are nervous to access condoms from a pulic source because they fear that people will discover their occupation as sex workers. For the same reason, these women avoid public communications with peer educators.

Access to STI services is a little more variable. Most notably, women who live in villages far from the urban centres where STI clinics are located have trouble attending clinics regularly. As explained by a peer educator from District A, this is linked to having to spend time and money to get to the clinic: "Those who are in villages, they do labour work for daily wages. Such women find it difficult to come to the clinic; they cannot afford to pay for the travel. For such women we pay for their travel and get them here for the treatment." This is a common enough occurrence in all the districts, but certainly not a sustainable program practice. A referral doctor from District A has also observed this and suggests a solution to the limitation:

> Nearby villages, they can hire a vehicle and the [STI clinic] should be conducted there only… Not whole day camp because only few patients will be there… for 20 people, we should not waste whole day. Only for 3 or 4 hours… Fixed day, fixed time. It will work, I think.

In addition to accessibility, the perceived quality of services has an influence on whether or not sex workers avail the program services. Most sex workers believe that the quality of condoms and STI services provided by the programs is very good. A woman from District C exclaims, "If [the quality] was not good, I would have run as soon as I saw you!" When conversing with a sex worker about the quality of the STI services, a peer educator from District B received the following indirect feedback: "It is because of your medicines we have become very fat. Thank you!" Complaints about the services may have been common at the beginning of the programs, but most sex workers now feel assured in the quality of services. Still, program staff argue that there should be some improvements to increase sex workers' attendance at STI clinics. A program staff person from District B suggests various ways to make STI services more amenable to sex workers:

> We don't want our community to get frightened by medical treatment... The STI protocols for drugs, a lot of them cause gastritis as a side effect... That's why we pushed for antacids to be part of the protocol. We in our clinics insist that our staff give them something to eat before or with their medicine. And we make sure we try and explain to them that they may have acidity... The green pack for vaginitis has 9 tablets... Now, they can't understand why they need to take all... Another thing is... that Indians are injection-crazy. So our doctors find it difficult and say, "Let us at least give a B complex injection!" (She laughs) So we have to work with the system and not frighten our community away...
> The cost-effectiveness issue, why are we discouraging them from taking responsibility? The willingness to pay is there... They may not be able to pay the same fee that we pay in urban setting, but here we're telling them it's free. Free in India means low quality... They'll pay if they know there's some value to it.

There are other suggested enhancements to the services that may increase service use and allow the programs to reach more sex workers. Many program staff and sex workers contend that the medical service focuses too narrowly on STIs and that it should include common general health problems. They also feel that offering medical services to sex workers' children and husbands/lovers may help bring more women to be checked for STIs. In fact, Program C saw increased clinic attendance from sex workers during a brief campaign that offered services to both women and their families. A staff person describes some additional services offered by Program B and explains why this is valuable:

> A lot of these women have non STI health problems,... which we unfortunately don't address. We say we'll give general treatment... That's how we are trying to mobilize women to come for check-up. We say we want to check your weight and see if you're okay... We are now developing a high-protein mix, which we aim to distribute. Because a lot of our women are underweight and plenty of them are anemic... But no one is checking for these things. We feel if you're going to do something, you might as well do it looking at the person as a whole.

There are also many who feel that the HIV prevention programs should be involved in helping sex workers obtain "immediate needs", such as food and housing. Many sex workers have prioritized health and appreciate condom distribution and STI treatments as valuable services, but they often implore the program staff to help in other

ways to improve sex workers' circumstances. Program staff have worked to connect sex workers to other services, such as ration cards, through the government and other NGOs. However, progress in obtaining these other services has generally been very slow. Peer educators from District C relay some common feedback from sex workers:

> [P1] No complaints at all, they say whatever [services] they get here is good.
> [P2] Most of them do not have their own house, so they ask for the house. Some ask for loans.
> [P3] They say, "You give us all kinds of services, you give us food, you give us treatment, you give education facility to our children, you have meeting with us... But if you give us a house to stay in, God will bless you. Most of us stay in footpath with our children."

According to some program staff, another practical method to enhancing one program is learning from the experiences of other programs. Program staff are interested in learning about the activities and services of the programs in the other districts. Though they are considered "implementing partners" under ICHAP/KHPT, the various CBO/NGOs have few opportunities to communicate and share experiences. A program staff from District C recalls an example of learning from an implementing partner:

> Sometimes what happens, [other NGOs] may have some good programs, which we don't know about. We may have some good programs, which they don't have. If we have contact, we can share that. For example, for self help groups, we didn't have much... [Program B] is working very well with self help groups, so to learn that we visited [Program B for] two days, to three *Taluks*.

Faith in Program and Rapport with Program Staff

Almost all sex workers remember having initial fear and suspicion about the HIV prevention programs and anyone associated with the programs. Gaining trust and building strong ties with sex workers is regarded by staff as the major accomplishment of the programs, implying the challenges involved in this development. Now, the rapport between sex workers and program staff, including peer educators, is considered a strength

of all three programs. Many sex workers feel they are being treated with respect and kindness for the first time in their lives. They express appreciation for small gestures, like being asked whether they ate lunch. They simply feel good to be around program staff. There are a myriad of examples like the following two accounts from sex workers in District C and District B, respectively:

> I was thinking that nobody wants to talk to us and nobody respects us. But the people who work in [Program C] talk to us nicely, respect us, they care for the poor people like us and help us. We feel really happy… They advise us to take treatments from the clinic. They boost us with confidence.
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> Our peer educator N is a good lady and behaves very well with us. She speaks to us in a pleasant manner. Even if we refuse a condom, she convinces us to take it… We feel rejuvenated even if we speak with [program staff] for a short time… Even if we are not in a good mood,… in no time they change our mood with their pleasant voice and words. We forget our pain whenever we speak to them.

Some people argue that the rapport between sex workers and program staff in District A is particularly consequential, since program staff are also sex workers. An ICHAP staff articulates this opinion:

> The rapport with the women, that's the great thing… [Program staff] can motivate the women, modifying the women; they have good motivation skills… If you go to reach a woman and if you do not go with a sex worker, that is not possible. The advantage is [Program A staff can say], "I'm a sex worker, before being the program coordinator or peer educator, I'm also like you… I learned all the information, so now I'm working like a resource person."… That's the very important part of [Program A] people, they can easily motivate and convince any woman.

It is apparent that their relationship with program staff may be the primary draw for sex workers to make contact with and embrace the messages of the programs. Many sex workers believe the program plays an important role in their lives. They "put faith" and "have a lot of hopes" that the programs will help them. By engaging in program activities and supporting its objectives, the women feel they can legitimate themselves

and, in the words of a sex worker from District C, "get a good name from this office." The mutualism between sex workers and the programs is further illustrated by this woman from District A:

> Everything has become good because of [Program A]. Nobody else can do this kind of services for us. Nobody will treat us so well as [Program A] looks after us. All of us give our whole hearted support to [Program A]. They too support us so much. We use condoms with each and every client and say no to the clients who disagree to use condoms.

Many sex workers feel that the programs offer safety and protection for their current troubles, as well as a sense of security for their future. A sex worker from District B states, "[Program staff] are taking 100% care of us, like protecting us when we face any problems in our profession. They have even assured us to provide shelters for us in future." A sex worker from District A maintains, "Now I come to this office because I know there is nothing here to hesitate or fear. When the police see us roaming around for soliciting, we come and sit here. This is a safe place for us." The sense of protection has allowed sex workers to feel more liberated to carry out their work. Additionally, some women believe their future is dependent on the programs, as clearly demonstrated by a peer educator from District B:

> I listened to whoever talked in the meeting very patiently… Then I went back home and thought about it. I thought, "My future is hidden within [Program B]! Why should I not join this program and become an intelligent individual?"

For some sex workers, faith in the HIV prevention programs and the staff is so strong that they actually evoke ideas about God, or other prominent figures, like parents. A peer educator from District B passionately expresses this faith:

> Now I repent why I wasted my time at home for so many days… Why did someone not tell me about [Program B] before? When I start working in the field, I forget all the pain which I experienced in the past. I feel so happy to be in this program. People here are so caring and supportive. We feel like we have found

> God. I felt like I was in jail, and the [program staff] have given me bail and have released me from the prison.

A peer educator from District C explains one of the reasons she works so diligently for the HIV prevention program: "This [Program C] office is like our parental home. The way we have to take care of our parents, we have to take care of [Program C]. We accompany women to the clinic, we counsel them, we ask about their health..." This woman displays a strong sense of duty to the program and staff. Many of her peers possess this devotion for program staff, conveying the wish to make them proud or the commitment to not abandon them. A peer educator from District B further demonstrates this idea: "I will stick around with [Program B] until the end. I have decided that even if I have intolerable problems in life, I will not leave [Program B]." Even more than the sense of duty to a parent-figure, sex workers feel gratitude towards program staff. A sex worker from District B thanks program staff for helping her gain respect in the community:

> You (program staff) give condoms, which prevent diseases. You help us. It may be little or more, you give us. You give us the confidence that you are there with us... Parents themselves don't give that. In the community, when we don't have any health problems, when we have money, people will treat us well, right?

Program staff have certainly felt the impact of sex workers' high regard for them. They, in turn, are grateful for these responses from the women. The strong rapport between sex workers and program staff has facilitated these stakeholders to work together towards the common goal of helping sex workers. A program staff from District C shares her experience with some delight:

> [Sex workers] respect us [program staff] very much... Whenever in the field, we keep on thinking something wrong will happen... Then [the sex workers] will say, "No madam, 'til we are here you need not think, 'til we are here nothing will happen to you. We are here to protect you. You come to our field, we will take you to our house, we will take you to our spot." They will give that much respect to us.

Stigma, Discrimination, and Rights

Social stigma associated with HIV/AIDS and sex work is prominent and pervasive in the three districts. The prevalence of stigma clashes with the goals of the HIV prevention programs. This social stigma generates the belief that the two groups of sex workers and persons living with HIV/AIDS are interchangeable. Hence, the general community regards these two groups with contempt and aversion. This stigma is fostered by the public's misconceptions about HIV/AIDS, which has led to severe discrimination against members of both groups. A referral doctor from District A exposes, with much dismay, the fact that some of her colleagues mistreat HIV/AIDS patients and even disregard confidentiality rules. She admonishes, "Doctors, we should know how [HIV/AIDS] will spread... We should not differentiate between HIV positive people and other people... Why should we discriminate?"

Another doctor from District C broods over the reality that many people who test positive for HIV are too scared and ashamed to disclose their HIV status to anyone. She believes that this makes women particularly vulnerable and reports many of her HIV/AIDS patients are women, who became infected by their husbands:

> They don't even reveal [their HIV/AIDS status] to us doctors... But okay, we can take universal precautions, but I feel the women are the sufferers... Now I'm getting middle-aged women,... widows. They cry afterwards, "Madam, I didn't know my husband was like this..." Even after he knows that he is HIV positive and after the advice of the doctor, he never uses condoms, thinking that there is a social stigma. Like, if he tells his wife, his wife will reveal to others.

Many in the general community assume that sex workers are responsible for the HIV/AIDS epidemic. A program staff person from District A describes this situation and its impact on the sex work community:

> Before the spread of AIDS awareness, people had a misconception that AIDS spreads because of sex workers only. They used to torture us, put us out of the village, and make us quit our profession. They harassed us sexually. The situation does not vary from village to town, it is the same everywhere... Now people have started realizing that the sex workers compulsorily use condoms… It is the clients who do not agree to use condoms since they are drunk most of the times.

There are even some signs that the sex work community and the HIV/AIDS-affected community stigmatize one another. A program staff person from District C observes:

> We're having programs specifically for sex workers. So some PLHAs don't feel like coming here [because] they'll be branded. And sometimes sex workers will be branded as HIV infected… Even PLHAs, they don't know what is going on and why [HIV] is spreading. They feel it's because of sex workers… Then we have to enlighten them to create awareness in the general population.

However, as asserted earlier in the chapter, many sex workers associated with the programs have become well-informed about HIV/AIDS and have learned it is wrong to fear or mistreat those living with the disease. A peer educator from District C explains how she combats the stigma she encounters with her knowledge about HIV/AIDS:

> Whenever we went to sex workers to give them information, [other] people used to ask, "How do we know that you don't have HIV? Whether you will kill her, or what?" We used to tell them that when you become HIV positive, you do not die, you can get treatment at free cost in H.

There are many illustrations of how the HIV prevention program staff, including peer educators, have tried to work against the stigmatizing actions of the general community. Yet, program staff feel encouraged that the direct obstacles to their work have greatly diminished since the start of the programs. Peer educators from District C share their experience:

> [P1] When we went to put condoms in the outlet, some people teased us.
> [P2] People teased us when we take the condoms.
> [P3] …When people tease us, we should put the condoms in the box and go without looking here and there. Don't bother about those who tease you. We

should also tell him, "Look, if you want condoms take from this and use [condoms] and maintain your health!"
[P4] Sometimes we tell them, "You mind your own business! Don't interfere in our work!"
[P1] Now the people do not tease or talk ill about us. If sometimes somebody does that, we know how to tackle them.

It is apparent that many program staff and peer educators have learned to deal with the stigma related to their work. They and other program stakeholders believe that social stigma associated with HIV/AIDS and sex work has decreased, albeit to a small degree. A program staff person from District B reflects on this societal change and notes that program staff themselves had to overcome preconceived notions about sex workers:

> We haven't done any formal assessment, but from opinions and feedback, stigma is slowly coming down... Because first, people just heard about HIV but now they know a little more about it. So fear and stigma is coming down… [The program staff's] open involvement with sex workers has also allowed others to be more open to this whole idea that sex workers are not just a bad group of people… It took a lot of time for our [program] people to learn, because it's something different, but we just took to it and through our network helped spread non-discriminatory practices.

The most notable change, and arguably the most pertinent to sex workers, has been observed among police officers. Prior to the start of the HIV prevention programs, sex workers were extremely fearful of the police. The majority of sex workers can recall hiding in fright or running from the police, even when they were not being chased. Many of the women can also recount their experiences of abuse at the hands of police. These narratives illustrate episodes of police publicly humiliating, physically assaulting, and bribing/robbing the women. The program stakeholders unanimously agree that police harassment of the women has decreased. A sex worker involved in the implementation of Program A observes:

> Before the police people used to beat us up, scold us and assault us whenever they saw us. But now the situation has drastically changed, like they greet us when they

> see us, they offer us coffee and have a sense of respect now. The police even attend our programs and tell us they are happy with the kind of programs we are arranging and they are ready to support us.

As indicated, many sex workers feel that the police have started to respect them. A peer educator from District C adds, "Earlier [police] used to abuse us, ill treat us, but now they are not like that. They behave properly, respect us. At present, we go to the police station, they offer us a chair, they give us tea, they talk to us."

The improvements among police are mainly credited to the advocacy work done by the HIV prevention programs. With cooperation of the police in all three districts, program staff have provided special "sensitization training" to police officers; the training aims to increase awareness about sex workers' circumstances and rights. A program staff person from District C reports:

> I can say that police sensitization is doing really good in changing lots of policemen... The sex workers are telling, "Today I told the police, *Look sir, I don't have money to travel to my hometown. Just give me 10 rupees to go home.*" And this guy, out of pity, he'll just pull out 10 rupees and give it to her. But initially that was not the case. He used to stand there and say [to the sex worker], "Give me 50 rupees! Go and find clients and get 50 rupees for me!"... So I feel there is a major transformation of their attitude towards sex work and all.

Sex workers have also been the targets of insults and violence from members of the general community. Similar to their accounts of police abuse, many women convey countless ways they have been injured by neighbours, rowdies, auto-rickshaw drivers, etc. Most frequently, the women have received verbal threats and been called "prostitutes", but physical assaults have also been common. Some program staff and sex workers observe small improvements in the public's attitudes and behaviours towards sex workers. A peer educator from District C states, "When we were standing near the hotel, soliciting, people used to chase us away threatening they would complain to the police. Now the

same people respect us and greet us." As the following discussion among peer educators from District B suggests, many believe this modification is due to the public's increased awareness of a legitimate program that advocates for the rights of sex workers:

> [P1] But they respect us now after the arrival of this [HIV prevention] project. They are scared because if they say anything to the [sex workers] and if they give complaints [about sex workers] to the police, then the [program staff] will take revenge on them.
> [P2] ... The other people in the community will be afraid to talk with us due to the fact that we are working in this [program].
> [P3] Now they are not troubling our sex workers, but they have troubled a lot in the beginning. In the beginning, when sex workers used to stand in the foot path or near the shop, they used to tell us, "You are prostitutes and don't stand here because our reputations will get destroyed..." But now they will ask us to sit in the shelter if it is raining and also if it is sunny. Whereas in the beginning, they used to scold us in vulgar languages and they also used to say, "Throw stones at her!"... Now it is nice they are respecting us...
> [P4] See, this society has made [sex workers] step into this profession... But the society must not insult [sex workers] about their work. And if we explain to them why [someone] is doing sex work, then they will not talk ill about [the sex worker] and they will not insult [the sex worker].

The changed dynamics between sex workers' and the police or the public may also be explained by sex workers' increased understanding of their rights. The HIV prevention programs, with the help of lawyers, have informed women about their legal rights. Moreover, and as already discussed, sex workers believe they have the full support of program staff in defending their rights. A peer educator from District C recounted an incident, in which a group of young men bullied her and accused her of being a sex worker. She boldly responded, "I am a sex worker by profession." They shouted at her, drawing the attention of thirty onlookers and ultimately the police:

> The police arrived and he was about to beat me. I told him that the police do not have any right to beat me, this is my profession, this is my body, I sell it and earn my living. If you want to file a case, I will fight it... I told him that if he beats me, I shall also call my lawyer and I can drag him to the court.

This woman's story exemplifies sex workers' recognition of their rights, as well as their courage in standing up for their rights.

A peer educator from District B observes these developments among fellow sex workers, and articulates the importance of actively supporting one another in defending the rights of sex workers:

> A woman is beaten up by a man next door. She used to sit quietly. But she has to go to the police station and book a complaint. We know how to help women to do that, from the training. We can't achieve anything sitting inside our four walls. We have to go outside and learn... Now we have to become bold together.

A program staff person from District C offers a shining example of one peer educator's struggle and triumph for the right to distribute condoms. The woman had been conducting her work as a peer educator in an urban centre, some kilometers away from her home village, but she was spotted distributing condoms by some men from her village. Later that evening, the men prohibited her from entering the village, and she tried to defend herself by explaining the purpose of her work:

> So this lady said, "I am doing a very good, genuine thing and I am proud of what I'm doing." Then she showed her ID card and told them she's working for [Program C]. And in spite of this they said, "No, you did a wrong thing by distributing condoms, which men don't even hold in their hands!" She felt very bad and almost burst into tears, and she ran to the village head... She told him her story... So this man called a meeting of the whole village... He said, "Distributing condom today is not a crime. And what she is doing is helping many people and she is working for [Program C]. So I feel proud to have such a lady in this village." So she was really welcomed to that village and now she proudly says, "I distribute condoms!" Until then, it was a hide-and-seek business for her. And after that, I asked her about her experience. She said, "Men come to my house asking for condoms. I'm sort of a mini condom outlet in my village!"

The above example illustrates the recognition of sex workers' rights from the perspectives of both the sex worker and the general community. Nevertheless, this was chiefly facilitated by the influence of a powerful authority figure. The sex worker also had

the backing of an organization, which legitimated her work as a peer educator. Lastly, despite all these developments most sex workers continue to confront many injustices.

Chapter 5: Discussion

In this chapter, I discuss the significance and implications of the major findings of my study. I also discuss my findings in reference to the literature on sex worker empowerment, and in particular the developments and lessons of the Sonagachi Project, the most well-known and documented sex worker organization project in India. Lastly, I focus on aspects of the three HIV/AIDS prevention programs that could benefit from the findings of this study; I make recommendations on the development of an enabling environment based on the experiences of sex workers and the literature on sex workers' rights.

It is important to point out that the empowerment experiences conveyed in this study reflect the stories of a sample of female sex workers, rather than represent all sex workers in the three districts. Many of these sex workers have regular contact with the programs. Much of the information is also based on peer educators, who have some advantages over sex workers not engaged in outreach work for the HIV/AIDS prevention programs: they receive training and have more exposure to program messages (information on STI/HIV/AIDS prevention, sex workers' rights, etc.); they have ID cards and bags that acknowledge their connection to a legitimate program; and they have responsibilities and opportunities to overcome challenges in delivering program services. Nevertheless, peer educators still share important characteristics with other sex workers, such as relying on sex work as a main source of income. It may also be that peer educators are inherently different from other sex workers in that they are highly motivated individuals at the outset. This may be true for some individuals, but for the majority of peer educators their early experiences of fear/mistrust, hesitation/self-doubt, and

resistance to the programs mirror experiences of most sex workers. Peer educators must "represent" fellow sex workers because this is precisely what determines a successful peer outreach strategy: peer educators use their shared background and goals to reach other women.

At the same time, experiences of the sex workers covered in this study are not uniform. However, the heterogeneity of experiences is not easily disaggregated by district, typology of sex work, or socio-demographic characteristics. Where possible, I have noted any obvious distinctions. In general, the duration of involvement and the frequency of contact with the programs seem to strongly influence empowerment experiences: sex workers seem to benefit more from longer involvement in the programs and more regular contact with the program staff. In addition, a larger support network (size of the sex work community, including number of peer educators) seems to have a positive influence on women's experiences. The combination of these factors may provide and optimize opportunities for sex workers to internalize the program messages, and therefore, facilitate more empowering experiences. For instance, outreach strategies tend to emphasize areas with a higher number of sex workers, and the development of a strong network of peers over time may encourage the adoption of health-protecting practices.

Considering these interacting factors, it is not surprising that peer educators generally display more notable positive changes. It also helps explain the exemplary stories of empowered sex workers in some *taluks* of District A, where a sex worker collective already existed and the program has been in place longer than other areas. It suggests why some peer educators – who are new to the program, or who work alone (or with a limited number of peer educators) in areas of low sex worker volume – do not

display the impressive gains in knowledge and confidence as other peer educators in the same district. This information may have implications for outreach strategies; a simple sex worker to peer educator ratio may not be the only consideration for planning an effective strategy in all areas.

The importance of the above factors supports an earlier study, which showed that participation in collective activities and peer education had a positive impact on increasing knowledge and use of condoms among female sex workers in Karnataka, independent of receiving outreach education (Halli, Ramesh, O'Neil, Moses, & Blanchard, 2006). These are undoubtedly a few among many factors contributing to empowerment experiences of female sex workers in Karnataka.

In spite of the variability of experiences, it is clear that many of the sex workers who participated in the study have experienced meaningful transformations in their lives due to their engagement with the HIV/AIDS prevention programs. The effectiveness of the major program components – education and outreach, condom promotion, STI management, community mobilization – is apparent in the knowledge gains and behaviour changes among sex workers.

Sex workers' understanding of HIV/AIDS/STIs and prevention practices has increased. They have begun to prioritize good health, seeing it as a necessity for taking care of themselves and their family. Despite initial resistance and obstacles to condom promotion, sex workers' awareness and use of condoms have greatly increased. Many sex workers maintain that they negotiate condom use by teaching clients about STIs and they reject clients (and large sums of money) who refuse to use condoms. Though it is encouraging that some sex workers use code words, like "chocolate", to more easily

access condoms, this also implies that the social stigma attached to condoms is still very strong and may restrict access to condoms for some sex workers. Additionally, sex workers are not using condoms with all sexual partners: condom use with lovers, regular partners, and husbands is inconsistent due to issues of perceived fidelity between these partners and the women, as well as gender-power inequalities. This is an issue in all sites, even in District A where general condom use seems higher than the other districts. The fact that knowledgeable and health-conscious sex workers are compelled to forego condom use is a serious problem. Finding effective strategies to address this problem, through discussions with sex workers, must be a program priority. Most program stakeholders argue strongly that condom promotion needs to reach clients, lovers, regular partners, and husbands of sex workers.

Improved self-esteem is a central change experienced by sex workers, especially peer educators. This has resulted from sex workers developing their capacities and skills, including communication skills and improved health; in District A, some women have gained literacy through the program's schools. Sex workers believe being healthy increases one's capacity to contribute to society and therefore, allows one to be a good, responsible, and valued citizen. Indeed, some women feel they have become good and that their souls are satisfied with the ability to save someone's life. Peer educators have learned a great deal from their training and they are eager to learn more and prove their abilities. Peer educators have occasions to speak in public and sex workers regard the ability to talk to a large audience or to important people as epitomizing self-confidence. Ensuring that peer educators are knowledgeable, competent, and confident may be seen as a prerequisite for the empowerment of other sex workers: not only are peer educators the

first point of contact for sex workers to the programs, but they are role models to their peers. In fact, most peer educators share their own experiences of improved health and other positive changes to mobilize other sex workers. Therefore, continued efforts must be made to strengthen peer educators' role as outreach workers.

Sex workers assert that the transformations in their behaviours are permanent or irreversible, echoing Cruikshank's (1999) idea of empowerment as both constituting and fundamentally transforming the subject's capacity to act, and not merely increasing that capacity. An indication of this is that many sex workers have gained a sense of mastery or control over their lives. They have transformed – from apathetic individuals, who relied on luck to prevent diseases, like HIV/AIDS – into responsible citizens, who have controlled unhealthy habits (i.e. alcohol and drug abuse) and have started planning for the future, like participating in SHGs to save money.

Changes in sex workers at the collective level are demonstrated in improved solidarity, participation, and recognition of the value of collectivization. Sex workers share a strong solidarity through common past experiences, as well as future goals. Some sex workers, who are not peer educators, show an inclination to participate in the programs as more than passive beneficiaries (e.g. recruiting women to attend STI clinics). Many sex workers feel a sense of safety and better equipped to face problems in a group; there are inspiring examples of achievements by groups of sex workers in District A. Peer educators feel they must ably represent the sex work community. Peer educators also firmly assert that their motivation to participate in program delivery is to help or save fellow sex workers. They have faced harassment for their work, but these problems have decreased with the public's recognition of the legitimate programs backing the women. In

District A, peer educators do not face such public scrutiny now, but these problems were common at the beginning of the program. Program A may also be closer than the other programs to achieving community ownership of the program, as it is implemented by members of a sex workers' collective. However, it is argued that complete community ownership entails self-sustainability, which will require more time to develop. Lessons from the Sonagachi Project discussed later in this chapter may suggest ways of obtaining this ultimate goal.

Many sex workers share the public's view that sex work is immoral, and they prefer not to disclose their occupation as sex workers. In District A, Devadasi sex workers are publicly known as sex workers, but they may develop reasons to hide doing sex work (i.e. from their lovers). The programs promote the idea that sex work is a respectable occupation and consider the open disclosure of sex work as an indication of self-acceptance and confidence. Peer educators in all districts clearly support this idea. It is argued that for sex workers to be productive agents of change, the following notions must first be developed among sex workers: "Their human dignity has to be recognized, their occupation has to be accepted as a valid option, and the sex workers have to value their own lives and look forward to a meaningful future as legitimate citizens in a healthy society" (Bandyopadhyay et al., 1999, p.6). This study shows that many sex workers in the three districts are well on their way to being agents of change; however, it must be recognized that changing self-perceptions of sex workers may take time and that the women's view of themselves is also dependent on the broader community's perception of sex workers.

The potential for changing the public's perception of sex workers may be reflected in changes among the professional program staff, who had to overcome their own prejudices about sex workers. Program staff have benefited in various ways from their involvement in the programs. There has been reciprocal learning, where the learning and capacity development of program staff have been facilitated by sex workers. Learning about sex workers' circumstances has reinforced the attitude of program staff that they are following a vocation, which requires dedication and necessitates making sacrifices. Conquering the personal and professional challenges and the stigma associated with working with sex workers, especially for female staff, has helped improve the self-confidence of program staff. However, many program staff feel they face an ethical dilemma: are they promoting sex work by distributing condoms and treating STIs? Later in the chapter, I make a suggestion for addressing this specific dilemma. However, the problem may point to the general need for a mechanism to identify and address issues and conflicts facing program staff.

Examining an enabling environment involves looking at the interactions of sex workers with individuals and forces outside of the programs and considering the programs' impact in the larger context. Effective HIV/AIDS prevention cannot be implemented if access to (and the willingness to access) the means of adopting health-protecting behaviours is not present (Jana et al., 2004). Sex workers are confident in the quality of condoms and STI treatments provided by the programs. The majority of sex workers have excellent access to condoms, while sex workers who live far from clinics find difficulty in accessing STI services. Suggestions to improve STI service accessibility/use include conducting mobile clinics, providing treatments for common

general ailments, offering injections, and providing health services for sex workers' children and partners. All stakeholders believe that the programs should be involved in meeting sex workers' other needs, such as obtaining housing, food, loans, and services for children. Again, lessons from the Sonagachi Project may inform future steps on this front.

My study shows that nurturing a good rapport between program staff and sex workers is essential for reaching and maintaining contact with sex workers. Misra and colleagues (2000) have argued that a nonjudgmental approach is the best way to gain access to sex workers. Without a doubt, the kind and respectful approach of the program staff has allowed sex workers to develop faith in the programs; sex workers feel happy, safe, and believe the security of their future is tied to the program. This has fostered a sense of mutualism: the program allows sex workers "to get a good name" and gives them hope of a better future, and in turn, sex workers embrace the program's objectives and activities (in some cases, as if out of duty to a parent). This is a strength of the programs that needs to be maintained.

In all districts, there is strong discrimination and stigma against HIV positive people and sex workers. The programs' sensitization trainings have brought about positive changes among police personnel, and police harassment of sex workers has decreased. The programs' influence on the general community has been observed to a lesser extent. Sex workers, especially in District A, report improved attitudes in the general community. Additionally, peer educators and groups of sex workers seem to be able to command respect from others. Yet, many women still express fear over the possibility of being attacked by certain people (like auto-rickshaw drivers) when they are alone. Sex workers have begun to learn about and demand their rights, with recognition

that this is more easily done through collective action. In the following discussion, I try to identify relevant lessons from one of the most successful sex workers' collectives.

The Sexually Transmitted Disease (STD)/HIV Intervention Project (SHIP), known as the Sonagachi Project, began in Kolkata in 1992 as a government initiative (Bandyopadhyay et al., 1999). The Sonagachi Project is internationally recognized as an effective community-based HIV prevention project and is associated with lower HIV prevalence among sex workers compared to other urban centres (Jana et al., 2004). The project started with a focus on HIV prevention as an occupational health and safety issue and evolved over time; "Economic, political, and occupational power [for sex workers] were by-products of the program's effectiveness" (Jana et al., 2004, p.412). Sonagachi sex workers organized to form the Durbar Mahila Samanwaya Committee (DMSC) in 1995 to advance the goal of sex workers' rights, with the philosophy of fighting patriarchal power structures and not individual men and of transforming power relations between women and men (Nath, 2000). In 1999, the government handed over the SHIP program to a registered society of sex workers' collective and representatives of NGOs and government; this was the official transfer of program ownership to the community (Bandyopadhyay et al., 1999).

Jana and colleagues indicate that the success of the Sonagachi Project is based on five basic components of sustainable interventions that fit the acronym *CURES*:

> (a) *cost effective*: economic vehicles must be identified to initiate and maintain support for the interventions over time; (b) *useful*: programs must be useful to the target population, the stakeholders, and practitioners who must implement the program; (c) *realistic*: programs must be feasible to implement with the existing skills of the practitioners; (d) *evolving*: programs must evolve over time; and (e) *sustainable*: programs must have an ongoing funding stream and constituency within the community to achieve long-term results. (2004, p.411)

The authors also argue that the project is replicable across settings in India and internationally and that components of a successful program include: redefining the problem in a way that does not stigmatize individuals; helping the community assume responsibility with short and long term benefits; reducing environmental barriers; and providing resources. Some achievements of the program include the sale of condoms, formation of a local lending institution, and securing funding sources through networking with donors, media, and NGOs.

It is apparent that many developments of the three HIV/AIDS prevention programs in Karnataka parallel those of the Sonagachi Project: the programs have defined HIV prevention as a community priority and have fostered strong solidarity among sex workers; powerful allies and spokespersons have helped sex workers gain credibility and linked them with "more enfranchised groups"; and programs have increased the skills and competencies of sex workers, with peer educators serving as role models for other sex workers (Jana et al., 2004). These common features indicate encouraging outcomes for the programs in Karnataka and also suggest that lessons from the Sonagachi Project could be used in Karnataka. The evolution of the Sonagachi Project emphasizes the significance of time and timing. The goals of empowering sex workers and reducing stigma were achieved in different ways at different times and program features evolved with changing needs and priorities; for example, it was critical to fully establish the value of condoms before selling them (Jana et al., 2004).

It is important to recognize that any achievements cannot be taken for granted: most program developments will require constant attention and strengthening. For example, trouble within and ultimate dissolution of one SHG in District B had

reverberations across the district; program staff noted that it was a challenge to form the group in the first place, but an even greater challenge to regain the trust of sex workers after any conflicts. Even the Sonagachi Project has not evaded setbacks. In 2003, the project area was targeted by major police raids that were made under an anti-trafficking pretext; in a public statement, the DMSC emphasized the need for vigilance in maintaining program achievements (Kempadoo, 2005). This also points to the importance of establishing an enabling environment and the need to challenge laws, policies, and perceptions that endanger sex workers.

The HIV/AIDS prevention programs in the three districts of Karnataka have only begun the work needed in the area of developing an enabling environment. Further progress will require resolute and well-informed efforts to bring about changes in two broad areas: legal status and public opinion of sex workers. These goals connect the sex workers in Karnataka to the struggle of sex workers around the world. Thus, it is important to be aware of the global movement for sex workers' rights; the history, challenges, and achievements of this movement may help sex workers and their supporters in Karnataka to take action towards establishing meaningful changes in the socio-political context. The recognition that they are part of a global movement may be particularly helpful in addressing the "ethical dilemma" faced by program staff.

The concept of sex work, which views prostitution not as a socio-psychological identity but as a form of labour or income-generating activity, emerged in the 1970s through the prostitutes' rights movement in the United States and Western Europe (Kempadoo et al., 1998). The movement focuses on issues of identity, rights, stigma, working conditions, decriminalization, and legitimacy of sex work, and many view this

movement as linked to the struggles for the recognition of women's work and for basic human rights (Alexander, 1997; Kempadoo et al., 1998; McClintock, 1993; Truong, 1990). This global movement has involved the organization of sex workers and is led by the International Committee for Prostitutes' Rights (formed in 1985), the Network for Sex Work Projects in Asia (formed in 1991), and the national organizations of sex workers in the following countries: U.S., England, Australia, Italy, Canada, Germany, Ecuador, Uruguay, Brazil, Venezuela, Chile, Mexico, Colombia, Suriname, India, Peru, South Africa, Japan, Dominican Republic, Nicaragua, Indonesia, Tasmania, Taiwan, Turkey, and likely others (Kempadoo et al., 1998). These organizations have been successful in bringing about political changes, including the acceptance of the first sex workers' union in Australia in 1996 (Kempadoo et al., 1998).

In the *World Charter for Prostitutes' Rights,* 1985, an international community of sex workers and activists outlined the areas in which changes need to be made to guarantee the rights of sex workers: (1) Laws – "Decriminalize all aspects of adult prostitution resulting from individual decision... special clauses must be included to prevent the abuse and stigmatization of prostitutes"; (2) Human rights – "Guarantee prostitutes all human rights and civil liberties"; (3) Working conditions – "Prostitutes should have the freedom to choose their place of work and residence... There should be no law discriminating against prostitutes associating and working collectively in order to acquire a high degree of personal security"; (4) Health – "Since health checks have historically been used to control and stigmatize prostitutes... mandatory checks for prostitutes are unacceptable unless they are mandatory for all sexually active people"; (5) Services – "Shelters and services for working prostitutes and retraining programs for

prostitutes wishing to leave the life should be funded"; (6) Taxes – "Prostitutes should pay regular taxes on the same basis as other independent contractors and employees, and should receive the same benefits"; (7) Public opinion – "Support educational programs to change social attitudes which stigmatize and discriminate against prostitutes and ex-prostitutes of any race, gender, or nationality"; and (8) Organization – "Organizations of all prostitutes and ex-prostitutes should be supported to further implementation of the above charter" (International Committee for Prostitutes' Rights, in Social Text, 1993, p.183-5).

As indicated in the above *Charter*, the global sex workers' rights movement, framed within broader human rights and womens' rights, calls for decriminalization of sex work. This is because in many countries, laws around sex work involve abolitionist and anti-trafficking laws, which do not protect sex workers and instead deepen dangers for them (Alexander, 1997; Jasmin, 1993; Kempadoo et al., 1998; Kempadoo, 2005; Kotiswaran, 2001; McClintock, 1993; Misra, Mahal, & Shah, 2000; Nagle, 1997; Truong, 1990). These laws are particularly oppressive for women in developing countries (Kempadoo et al., 1998; Kempadoo, 2005; Kotiswaran, 2001; Misra et al., 2000).

These researchers would assert that the application and enforcement of the following laws involving sex work in India have endangered sex workers:

> Prostitution, as such, is not a crime in India but brothel keeping, living off the earnings of a prostitute, soliciting or seducing for the purposes of prostitution are all punishable offences. There are severe punishment for child prostitution and trafficking of women, according to the Immoral Trafficking (Prevention) Act… [The Devadasi tradition of dedicating young girls for sex work] is a crime. (Bastia, 2006, p.209)

It has also been argued that government policies in India involving the "rescue" and "rehabilitation" of sex workers have failed due to a lack of understanding of the sex

work context (Misra et al., 2000). The experiences of sex workers in my study confirm that the current laws and policies in India have been used mostly to harass sex workers. The women in my study also support ideas of the global sex workers' movement that sex workers do not want abolition of their work, but the right to work under safe and healthy conditions, as well as the right to make choices and enjoy the same benefits as others in the work force. Many perspectives inform the debate on prostitution law reforms, but many agree that simply legalizing the trade will not protect sex workers' rights (Jasmin, 1993; Kempadoo et al., 1998; Kotiswaran, 2001; McClintock, 1993; Misra et al., 2000). In a thorough analysis of the sex work legislation in India, Kostiswaran argues "legalization alone, without any legislative support to address the systemic discrimination that prostitute women face, is counterproductive to the feminist agenda of enhancing their life choices." (2001, p.241). The author suggests the best alternative is to adopt the previously proposed *Sex Worker (Legalization for Empowerment) Bill*, 1993, with some modifications; this Bill decriminalizes prostitution as well as provides anti-discrimination provisions under civil rights legislation.

There are many other issues that sex workers and program staff in Karnataka need to consider when engaging in political action. There is no doubt that sex workers in Karnataka, like sex workers around the world, have faced marginalization, discrimination, exploitation, and basic human rights violations (Busza et al., 2001; Farmer et al., 1996; Halli et al., 2006; Kempadoo et al., 1998; McClintock, 1993; Misra et al., 2000). However, it is important not to view sex workers as helpless victims, as this only reinforces stereotypes and intensifies the discrimination and violence in their lives (Alexander, 1997; Kempadoo et al., 1998; McClintock, 1993; Misra et al., 2000).

According to Judith Kegan Gardiner, "any theory that denies women 'agency' retards the changes in patriarchal social structure for which feminism strives, because it denies the existence of an entity to attack those structures" (quoted in Kempadoo et al., 1998, p.9). Instead, sex workers' shared experience of exploitation could be "a basis for mobilization in struggles for working conditions, rights and benefits and for broader resistances against the oppression of working peoples, paralleling situations in other informal and unregulated sectors" (Kempadoo et al., 1998, p.8).

Therefore, there are many potential allies for sex workers in their fight for radical transformations in sexual labour and for the recognition of human rights (Kempadoo et al., 1998; McClintock, 1993; Nath, 2000). In addition to improving legislation in India, popular images of sex workers (as innocent or evil, victim or aggressor, oppressed or immoral) need to be changed to reduce the stigma associated with sex workers (Misra et al., 2000). In Karnataka, the HIV/AIDS prevention programs will play a crucial role in influencing public opinion of sex workers. Program staff and government officials strongly felt that more powerful public advocacy and awareness campaigns for HIV/AIDS and sex workers are needed. Program staff also felt that a central effort for advocacy work with the government, public, and media would be most effective. ICHAP/KHPT may have the opportunities and resources to take on this central role: it has a high profile and strong ties to the state government, as well as local and international connections to NGOs and academia. Lessons from other sex work programs point to the essential role of NGOs and other members who bridge sex workers to mainstream society in initiating and supporting sex worker collectives (Misra et al., 2000).

In reflecting on the successes of the Sonagachi Project, Nath (2000) highlights the importance of stories and histories in rallying the community towards common objectives. As already suggested, the stories and histories of other organizations and global sex workers' movements could help educate and inspire sex workers and program staff in Karnataka. However, this strategy may also be used to rally public support. Sex workers in Karnataka believe that if the general community learned about their circumstances, they would no longer face discrimination and abuse. This certainly seems possible in Karnataka. Police sensitization programs have been successful in decreasing police arrests and abuse of sex workers. Furthermore, the program staff themselves overcame their own prejudices against sex workers; learning about sex workers' experiences has motivated program staff to dedicate themselves to the cause of supporting and helping sex workers.

In conclusion, sex workers actively involved in the HIV/AIDS prevention programs in three districts in Karnataka have experienced considerable learning, personal growth, and positive changes in their lives. Through implementation of the program and interactions with sex workers, program staff have experienced similar benefits. The dramatic improvements among numerous sex workers and other program stakeholders are encouraging examples of the potential for broader changes among citizens in the state of Karnataka. Some positive progress has been made in developing an enabling environment, but much of the work in this area is still ahead and will require well-informed and committed activism led by ICHAP/KHPT and their implementing partners. The most important lessons from this study may be captured by words of sex workers themselves. The following quotes from sex workers may inform strategies for strengthening and improving the programs for the empowerment of sex workers: "Sow a seed and water it

so that it grows and gives fruits" and "We should never stand on land and try to measure the depth of the water. Instead, we should get into the water to know its depth."

Appendix 1: Guides for Interviews and Focus Group Discussions

Guide for Interview with Female Sex Workers

1. Introduction
- Thanks for participating, assurances of confidentiality
- Introduction of interviewer and translator

2. Knowledge about program and prevention practices
- Which services do you use? Do you know of other services offered by the program?
- After gauging the women's awareness of the program, interviewer could mention specific services, like STI clinic

3. Experience before program
- What was your experience like before the program?
- Did you have contact with other NGOs/programs/government officials? What was your experience like with these programs and people?
- What was your experience in being contacted by an outreach worker from this program?

4. Experience with program
- Can you access services easily? What are some barriers to accessing services?
- Have you been satisfied with the services offered? What do you think about the quality of services offered?
- Do you use condoms with clients/regular partners/lovers/husbands? Where do you get condoms? What are reasons for not using or accessing condoms?
- What is your relationship like with peer educators/other NGO staff?
- Have you made new contacts through the program? With sex workers' collective?
- Has the program influenced changes in your work? In other areas of life?

5. Strengths and limitations of program
- Can you think of a specific time when the program helped you? Can you think of a time when you had a negative experience with the program?
- What are the most/least useful services offered by the program?
- What other types of services would you like to see?
- What are some changes that could improve the program?

6. Everyday experience and context
- Age, education, location of work, length of time using program services, etc.?
- Do you have other sources of income besides sex work? Are you considering finding other sources of income?
- Relationship with: Family? Other sex workers? Neighbours? Police?
- Has sex work changed in the community since the program started? Have the relationships between sex workers and community members changed?

Guide for Focus Group Discussion with Peer Educators

1. Introduction
- Thanks for participating, assurances of confidentiality
- Introduction of interviewer and translator

2. Information about district and HIV/AIDS context
- What are the needs and challenges created by HIV/AIDS in this district?
- What do governmental organizations and NGOs do to meet the needs and challenges?
- How does this organization work with other organizations?

3. Program description
- What services are offered by the program? What are the program goals and objectives?
- How many beneficiaries use the services offered by the program?
- What kinds of reviews or evaluations have been conducted?
- In what kinds of capacity building activities do staff participate?

4. Experience before program
- What was the situation like in the district before this program was in place?
- Did you have contact with other NGOs, programs, or government officials? What was your experience like with other programs and people?
- Was there any community participation involved in planning this program?

5. Becoming peer educators
- How was your experience in being recruited as a peer educator?
- Why did you choose to get involved as a peer educator?
- What kind of training did you receive?
- Can you share your experiences at the start of the program? What were the challenges you faced as a peer educator?

6. Experience of delivering services
- How do beneficiaries access various services? What are the issues and barriers to accessing services for female sex workers, the beneficiaries?
- How are beneficiaries responding to the services? What are some complaints you have heard from them? How often do you have contact with sex workers?
- How many condoms do you distribute in a week/month? Where do the beneficiaries access condoms? How consistently and when do sex workers use condoms?
- Do you help sex workers make new contacts, for example, with a sex workers' collective? What services and efforts aim to reduce sex workers' vulnerability? What are the major challenges in addressing issues of vulnerability?
- How are female sex workers viewed by the rest of the community, police etc.? What kinds of advocacy efforts have been undertaken in the community? Have the perceptions of sex workers changed since the program has been in place? Have there been any changes in sex work in the community since the program started?
- Have you spoken to sex workers and others to gain their perceptions of the program? Are sex workers involved in any planning of services and activities?

7. Strengths and limitations of program
- Which services are the most/least used or popular?
- What do you think is the most important service or aspect of this program?
- What are the difficulties or challenges facing the program?
- What are some changes that could improve the program?
- What are the most valuable lessons learned from implementing this program?

8. General information about organization
- Besides HIV prevention work, what other activities are you involved with?
- What is the organization's general approach or philosophy to service provision?
- What is the organization's philosophy on community participation?

9. Background questions
- Age, education, location of work, length of time as peer educator, etc.?
- Do you have other sources of income besides sex work? Are you considering finding other sources of income?

Guide for Interview with Program Staff

1. Introduction
- Thanks for participating, assurances of confidentiality
- Introduction of interviewer and translator

2. Information about district and HIV/AIDS context
- What are the needs and challenges created by HIV/AIDS in this district?
- What do governmental organizations and NGOs do to meet the needs and challenges?
- How does this organization work with other organizations?

3. Program description
- What services are offered by the program? What are the program goals and objectives?
- How many beneficiaries use the services offered by the program?
- What kinds of reviews or evaluations have been conducted?
- In what kinds of capacity building activities do staff participate?

4. Experience before program
- What was the situation like in the district before this program was in place?
- Can you share your experiences at the start of this program? What were the major successes and challenges in launching the program?Was there any community participation involved in planning this program?

5. Experience of delivering services
- How do beneficiaries access various services? What are the issues and barriers to accessing services for female sex workers, the beneficiaries?
- How are beneficiaries responding to the services? What are some complaints you have heard from them? How often do you have contact with sex workers?
- How many condoms are distributed in a week/month? Where do the beneficiaries access condoms? What is the rate of condom use among female sex workers?
- Do you help sex workers make new contacts, for example, with a sex workers' collective? What services and efforts aim to reduce sex workers' vulnerability? What are the major challenges in addressing issues of vulnerability?
- How are female sex workers viewed by the rest of the community, police etc.? What kinds of advocacy efforts have been undertaken in the community? Have the perceptions of sex workers changed since the program has been in place? Have there been any changes in sex work in the community since the program started?
- Have you spoken to sex workers and others to gain their perceptions of the program? Are sex workers involved in any planning of services and activities?
- What is the organization's relationship with government officials, KHPT/ICHAP staff and partner organizations, and other NGOs?

7. Strengths and limitations of program
- Which services are the most/least used or popular?
- What do you think is the most important service or aspect of this program?
- What are the difficulties or challenges facing the program?
- What are some changes that could improve the program?
- What are the most valuable lessons learned from implementing this program?

8. General information about organization
- Besides HIV prevention work, what other activities are you involved with?
- What is the organization's general approach or philosophy to service provision?
- What is the organization's philosophy on community participation?

9. Background questions
- Age, title, length of experience in current position, etc.?

Guide for Interview with Government Officials

1. Introduction
- Thanks for participating, assurances of confidentiality
- Introduction of interviewer

2. Information about district and HIV/AIDS context
- What are the needs and challenges created by HIV/AIDS in this district?
- What do governmental organizations do to meet these needs and challenges?
- What are some of the successes/setbacks you have encountered in these activities?

3. Knowledge about program
- What kind of role does this program play in relation to government activities?
- Do the program implementers keep you well informed about the program's activities and progress?
- Are you aware of the program meeting its objectives? Are you aware of any difficulties or challenges facing the program?
- Do you know how many beneficiaries use the services offered by the program?

4. Experience before program
- What was the situation like in the district before this program was in place?
- How does this program compare to other or previous NGO activities?

5. Experience with program
- What is your view of the services offered by the program? How is the quality of services? Are you aware of how beneficiaries are responding to the services?
- Are you aware of beneficiaries accessing services easily? What are barriers to access?
- Where do the beneficiaries access condoms? Are you aware of the rate of condom use among female sex workers?
- Have you visited the program site? Have you met with the program beneficiaries? How often do you interact with the program staff?
- How are female sex workers viewed by the rest of the community, police etc.? Have these perceptions changed since the program has been in place? Are you aware of there being any changes in sex work in the community since the program started?
- What kinds of lessons have been learned from the initiatives of this program?

6. Strengths and limitations of program
- What are the most/least useful services offered by the program?
- What other types of services would you like to see?
- What are some changes that could improve the program?

7. Background questions
- Age, title, length of experience in current position, etc.?

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