A Community-based Qualitative Study to Explore the Experience and Understandings of Intimate Partner Violence among Female Sex Workers and their Intimate Partners in Karnataka, India

by

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Abstract

Objectives: To explore how women who sell sex, or female sex workers (FSWs), and their male intimate partners describe their experience and understandings of intimate partner violence (IPV) in northern Karnataka state, south India.

Background: The high prevalence of intimate partner violence (IPV) among FSWs has been increasingly recognized. There have been few studies on IPV involving FSWs and these have usually adopted quantitative methods to examine risk factors for violence from clients rather than intimate partners.

Methodology: A qualitative exploratory study informed by a community-based research model was conducted in partnership with two local organizations in India, Karnataka Health Promotion Trust and *Chaitanya Mahila Sangha*. 21 semi-structured, individual in-depth interviews were conducted by trained community research investigators between July and October 2014 with a purposive sample of FSWs and their male intimate partners in Bagalkot district, Karnataka. Thematic content analysis was conducted through multiple steps involving community collaboration.

Results: Intimate relationships were characterized by emotional and material support that were an important part of both partners lives. Participants stated how the contravention of gender norms was viewed as a "mistake" that provided one of the most important triggers of violence. Violence varied in each relationship, with some couples reporting no violence, most experiencing at least verbal or minor physical violence, and a few cases of severe physical violence. Broader structural constraints compounded the ability to fulfil

gender roles and thereby heightened vulnerability to IPV, including financial pressures, stigma and illegality of sex work. Variability in acceptance of violence existed between those who unconditionally, conditionally or never accepted violence. The methods to prevent or deal with violence depended on the level of acceptance of violence and types of violence. If violence was minor or they believed that the woman's "mistake" justified violence, they usually recommended that individuals adjust to avoid "mistakes"; otherwise they suggested the need for broader family, community, or legal support.

Discussion and Recommendations: The results show the interplay of multiple levels of issues contributing to the "structural vulnerability" to violence in intimate relationships of FSWs. The findings support the push for structural approaches to be taken by IPV programs. These would work not only on the individual and relationship levels to address immediate triggers of violence, but also the community and societal levels, with the integral involvement of community partners, to more effectively address vulnerability to IPV.

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Dedication

To the inspiring women in Karnataka who dedicated their time, shared their stories, danced, sang, and laughed with me. Naanu ninna preetisuttene.

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Chapter 1) Introduction

1.1) Intimate Partner Violence

There has been increasing public health evidence for the pervasiveness and health consequences of intimate partner violence experienced by women across the globe. The World Health Organization's (WHO) definition of intimate partner violence (IPV) is a, "behavior within an intimate partner relationship that causes physical, sexual or psychological harm, including physical acts of aggression, sexual coercion, psychological abuse or controlling behaviours" (1). In a recently published WHO study, the estimated average life-time prevalence of physical and/or sexual violence from an intimate partner among ever-partnered women was 30%, with the highest prevalence at 37.7% in the South-East Asian region (including India, Bangladesh, East Timor, Maldives, Sri Lanka and Thailand) (2). The report also cites numerous studies that link IPV with many other health consequences including reproductive health issues, alcohol use, depression and suicide, injuries, sexually transmitted infections (STIs) and human immuno-deficiency virus/acquired immune deficiency syndrome (HIV/AIDS), and death from homicide (2).

Increasingly research in India, among other regions, has shown that women who sell sex, also termed female sex workers (FSWs), experience particularly high rates of different types of violence from intimate partners, though some research has started to explore the benefits of intimate relationships for FSWs (3-6). Intimate partners of FSWs in India can include men who are regular or long-term clients who provide financial, non-monetary, or emotional support; men who are husbands, lovers or cohabiting or non-

cohabiting non-paying partners; and sometimes pimps who have control over their work and finances (3, 7-10). In a survey of FSWs in Bagalkot district, Karnataka state, intimate partners were understood to be lovers, a common term often used by younger women; husbands or those who are legally or informally seen as long-standing partners among women in the *Devadasi*[1] tradition who cannot legally marry; and *hiriya* or *malak*, which are terms in the local language *Kannada* for a long-standing emotional relationship with an intimate partner that is more often used by older FSWs in the region (6). In a study in five districts of Karnataka state, south India among a representative sample of 1750 FSWs, 23% and 29% of women respectively whose main partner were husbands or boyfriends reported experiencing physical violence in the last 6 months (11). In Panchanadeswaran and colleagues' study in Chennai among 100 FSWs, 77% and 87% of the women reported verbal threats and physical force respectively from intimate partners to have sex (9). However little research has been done to understand the more complex context of these intimate relationships in terms of various material and immaterial supports and constraints, and to understand where violence figures or why it exists in some relationships and not others.

Growing attention to various forms of violence experienced by women in sex work has been sparked by research showing how violence compounds the risk for HIV, which in turn has supported the design of structural interventions (12-16). The structural

[1] *Devadasis* are women who have been dedicated to a god or goddess as part of a regional socio-cultural tradition. They historically served gods or goddesses, performing various religious duties in the temple including sex work for priests and others. The sex work involved in *Devadasi* traditions has become increasingly commercialized and covert after it was officially banned by the Indian government in the 1980s (see more in Methods section 3.3) (11).

elements that have been found to relate to IPV experienced by FSWs include low socio-economic position in society, alcohol use by intimate partners, social exclusion, stigma and criminalization of sex work and unequal gender-based power in relationships with clients, lovers, husbands, pimps or others (3, 17). Researchers have found that HIV risk in intimate relationships continues to be difficult to address compared to violence from others, like clients and police, largely because of the added layers of socio-cultural and economic factors in intimate relationships that can limit safer sexual behaviours (1, 6).

Despite the global occurrence of violence towards women from intimate partners, and the efforts to define this, interpersonal violence is a variable and context-specific process. Thus it is important to understand the meanings associated with violence in a given cultural context (18). Not many studies have explored these meanings in the context of interventions to address IPV experienced by FSWs, nor have community-based research frameworks been applied for this purpose. Most studies on intimate partner or domestic violence have been focused on women in general rather than in the context of sex work (19-21). There have been an increasing number of studies, mostly quantitative, that describe the intersection of higher HIV risk associated with intimate partner violence among FSWs (12, 22, 23). Yet these have almost always focused on client or police violence (24). A few studies have used a community-based research model to look at violence, though never in the context of IPV facing sex workers (25, 26). Some studies have quantitatively examined macro-social factors affecting IPV among FSWs using multivariate analysis (17, 27). There are also a couple of studies that have undertaken a qualitative exploration of violence and condom use in intimate relationships among

female sex workers, but never among their intimate partners (3). Lack of knowledge on IPV facing FSWs represents a significant gap in the literature that hampers the design of interventions that seek to address the specific concerns that women in sex work have around IPV in a way that is contextually-relevant and potentially more effective.

Due to the complex issues underlying female sex workers' vulnerability to violence as well as HIV, community-mobilization through the creation of community-based organizations has become a central tenet of some HIV/AIDS programs working with FSWs (11, 28). In line with the increasing role of community-based organizations in HIV prevention and care efforts, as well as the increasing epistemological shift towards working with stakeholders as integral partners in the research process, community-based research (CBR) is seen as a valuable approach both as an end in itself as well as a means to help all partners better understand the issues and develop or enhance health programs (25, 26). This method draws on the strengths of both local and academic partners for the purposes of researching important issues that will aid in the development of culturally-appropriate and sustainable interventions, as well as increase the capacity of those involved to conduct research in the future (26, 29).

1.2) Context of the Present Research

The research presented in this thesis was conducted within the context of an evaluation of the intimate partner violence prevention program called *Samvedana Plus* that is being implemented in north Karnataka state, India by the non-governmental organization, Karnataka Health Promotion Trust (KHPT), and their long-time partner

community-based organization (CBO) *Chaitanya Mahila Sangha (CMS)* in Bagalkot district, Karnataka. KHPT is a non-governmental organization that was set up through a partnership between the Karnataka State AIDS Prevention Society and the University of Manitoba in 2005. KHPT and its predecessor the India-Canada Collaborative HIV/AIDS Program (ICHAP) have been working for over ten years in south India on HIV prevention and maternal, neonatal and child health. The community-based organization *Chaitanya* has also worked with KHPT for over ten years, and was formed as a collective of women in sex work that has increasingly led the programming around STIs, condoms, HIV testing and treatment in Bagalkot district. *CMS* also works to empower their members individually and collectively to address a range of issues including skills-training, counselling, service provision and micro-credit programming.

Between 2011 and 2017, KHPT is undertaking a project called "Tackling the Structural Drivers of the HIV/AIDS Epidemic" or STRIVE. STRIVE is funded by the UK's Department for International Development (DfID) within a multi-organization Research Programme Consortium led by the London School of Hygiene and Tropical Medicine (LSHTM). The aim of STRIVE is to use research in the design and evaluation of interventions to address the structural barriers to HIV prevention, including violence, gender norms, alcohol use, stigma and discrimination, and socio-economic circumstances (30). Within the STRIVE project, in the next three years KHPT is working with *Chaitanya* in Bagalkot district to implement and evaluate an intimate partner violence program with sex workers and their intimate partners called *Samvedana Plus*. Consistent with the literature, this intervention was developed in response to initial local evidence

suggesting intimate partner violence limits women's ability to use condoms with intimate partners, and thereby heightens their HIV risk.

The aim of the *Samvedana Plus* program is to reduce intimate partner violence and increase condom use in intimate relationships by addressing intermediate factors that have previously been found to relate to IPV, such as self-esteem, self-efficacy, safety, HIV risk perception, critical thinking on violence and gender norms, and knowledge of laws and supports among FSWs and their intimate partners. The intervention will be aimed at three levels: individual FSWs and their intimate partners; community-based organizations of female sex workers; and the larger community where the FSWs and the intimate partners live. At the individual level, the intervention will focus on the formation of reflection groups and on individual/couple counselling to enhance self-esteem, critical thinking, individual and collective efficacy and action to reduce intimate partner violence and STI/HIV risk. At the level of FSW collectives, the intervention will focus on strengthening supportive crisis management systems for FSWs experiencing intimate partner violence, improving distribution of male and female condoms, and improving referrals to clinical services for FSWs and their intimate partner. At the larger community level, the intervention will link the FSW groups to women's organizations, identify and train male champions and folk media troops to build a supportive environment and community against intimate partner violence.

In 2012 *CMS* expressed to KHPT and I that they would like to better understand IPV facing their community of women in order to inform their interventions. Subsequently and separately in 2013, a mixed-methods evaluation of the *Samvedana* Plus

program was planned by KHPT and LSHTM to understand the processes and causal pathways through which positive changes occur in the STRIVE medium-term outcomes, such as knowledge and attitudes on violence and condom use, and eventually the levels of violence and condom use in intimate relationships over the course of the three years of the *Samvedana Plus* intervention.

Included in the KHPT-LSHTM multi-method evaluation is a qualitative case-study component to follow individual women, as well as some women and their intimate partners as couples, to explore how the *Samvedana Plus* intervention has affected their experience of, and response to, intimate partner violence and consistent condom use. Thus, the CBO's interest in researching IPV was combined with the KHPT-LSHTM evaluation to undertake a longitudinal qualitative study that is informed by a CBR model. As a baseline for the KHPT-LSHTM evaluation, exploratory in-depth interviews were conducted with FSWs and intimate partners around topics chosen by the women from the CBOs and in light of the STRIVE evaluation outcomes to be assessed in later rounds of the study (see Appendix A for Figure 3 and Table 4, with outcomes and respective qualitative measures in the *Samvedana Plus* evaluation framework).

1.3) Purpose Statement

The purpose of this study was to use a qualitative, exploratory research design informed by a community-based research (CBR) approach to explore the experience and understandings of violence within intimate relationships among 21 purposively selected

participants, including 15 women, as well as six male intimate partners of six of the individual women in Bagalkot district of Karnataka state, India.

The study was conducted in collaboration with a Research Committee of women from the sex-work community in Bagalkot, selected by *CMS* for the purposes of the study; the Karnataka Health Promotion Trust, myself and others at the University of Manitoba; and with support from researchers at London School of Hygiene and Tropical Medicine. As part of the community-based research design, KHPT, University of Manitoba and London School researchers trained two local women, the community research investigators, to conduct interviews and collaborate on analysis. The results of this thesis will serve as a baseline for the larger qualitative case-study component of the STRIVE evaluation, in which the same participants will be followed over the three-year implementation period of the *Samvedana Plus* program.

1.4) Research Questions

The overarching research question of this study was: "How do women in sex work and their intimate partners in Bagalkot and Bijapur districts, Karnataka state, south India describe their experience and understandings of violence in their intimate relationships? Specific questions for exploration in this study included:

a) What is violence and how does it affect the participants' lives?
b) Why do participants think violence occurs in their intimate relationships?
c) When and why is violence acceptable or not?

d) What strategies do participants employ to prevent or cope with violence in intimate relationships?

1.5) Ethical Considerations

There are many ethical concerns that had to be considered throughout the process. It was important that the primary research question, methods and processes were of relevance and interest to the community research committee as well as for program purposes. We aimed to ensure that the interview guide was culturally appropriate, sensitive and clear to maximize disclosure and enhance the ability to use the information for positive purposes (31). We enacted a collaborative process with the research committee to achieve these goals. During the process of discussing tool development and study design, there was evidence of some benefits to the individual participants including a sense of relief from sharing issues, and potentially improved understandings by thinking critically on the issues, or having access to services from the program. Further, the consent process included a disclosure that the main benefit is meant to be for the community, through the use of the information to improve the community-based organization's programs and potentially address IPV in an effective way. On the other hand, we attempted to avert any possible harm for participants and the research investigators when conducting research around this sensitive issue. The potential harms included psychological distress for participants or research investigators, or potential backlash from partners.

Previous researchers have found that taking measures like “vague first contacts”, privacy, confidentiality, and referral support systems minimize the potential risks of violence research (32). Based on these recommendations, precautions were built into the study through iterative training by KHPT of community research investigators on ethical principles and safeguards during interactions with participants and in handling the interview recordings. To address the potential risks, the following steps were taken:

1. *First contact:* The community research investigators first met with the potential participants and their families through initial contact before the interviews. The participants were recruited using a vague “first contact” when others may be present in which the potential female participant was asked about her interest in a health study. If they agreed, they set up a time to ask for informed consent and thereafter to conduct the one-on-one interview.
2. *Informed consent:* An informed consent form was developed based on KHPT and University of Manitoba templates and with input from the community research committee. When the community research investigators could meet the potential participant in private and if informed consent was obtained using the informed consent form, the community research investigator asked the participant’s permission to conduct the interview based on full disclosure of information on the study and then asked consent to contact their intimate partner. If she consented to this, the intimate partner was contacted in a similar way to participate in the study by the male KHPT research investigators (FSW and male partner consent forms are included in Appendix D). Some participants were illiterate and unable to read

consent forms, which was addressed through KHPT's oral informed consent process. Potential for removal from the study based on any issues during data collection was indicated to potential participants in the informed consent process. Contact numbers and support from CBO peers or counsellors was offered during consent in case the participant felt they would like to discuss issues that emerged in the interviews further (33, 34).

3. *Interviews:* All the interviews were one-on-one and the locations for the interviews were determined based on the comfort of the interviewee to be either in the home, a neighbour's home or a public place (33). The CRI and participant agreed on a code that they would use to stop talking if anyone else interrupted the interview, and if this occurred, a plan to start the interview again at a new time or place was decided prior to the interview. Further, the participant was asked if they would like to continue the interview at multiple points to ensure continued voluntariness. For male participants, interviews were conducted by a trained local researcher hired by KHPT and experienced in interviewing intimate partners and other men from Bagalkot.
4. *Analysis:* Approaches to improving confidentiality and anonymity during the analysis of the interviews included dissociating names from responses at the point of analysis, providing access only to researchers involved, and determining by whom and where the data would be used and stored. The research committee felt that the analysis should be done in collaboration with KHPT to assess how the intervention has influenced the lives of participants in the topic areas described

above, which could inform improvements in the intervention where necessary. Analysis was first conducted between KHPT, research investigators, and I on individual interviews to develop descriptive findings, and then with the research committee to make meaning out of the descriptive findings using aggregate data to maintain confidentiality. Participants will be acknowledged and the research committee will be given authorship on publications. It will be necessary to convey all the results and not just the ones that suit a certain hypothesis or story preferred by certain partners. The methods of the study must also be conveyed in detail so that the audience can assess the rigour and comparability with other studies, as Auerbach et al. suggest (35). After this baseline round of interviews was completed, we conducted a debrief workshop with the research investigators as part of the analysis to understand the overall dynamics of the interview, as well as asking them about their experiences and challenges in conducting the interviews to help improve the experience in subsequent interviews.

To ensure these ethical considerations were taken into account, a safety protocol including the above elements was developed with the research committee and reiterated in the training of the community research investigators as others have suggested (33, 34). Extensive training and role-plays with the interview guide at the beginning, as well as frequent meetings, and ongoing debrief sessions, have been found to help facilitate and ensure a positive experience for those involved in community-based research and were therefore used in this study (25).

Chapter 2) Literature Review

2.1) Theory on Intimate Partner Violence

Intimate partner violence (IPV) and its root causes have come to be understood through different lenses from a growing body of research in numerous contexts. The WHO has outlined and drawn on various frameworks that inform research on IPV including traditional perspectives such as the human rights approach, family violence theories and the criminal justice approach; perspectives rooted in feminist and critical thought; and more recently those applied in public health such as integrative approaches that merge aspects of traditional and/or critical lenses on IPV (1, 36-38).

2.1.a) Mainstream Approaches

Mainstream approaches draw largely on human rights and criminal justice discourses as well as sociological family violence theories. The human rights approach is largely based on Western conceptions of individual rights that are to be protected by the state, seeing violence as a violation of many rights including the rights to life, liberty, autonomy and security of the person; the rights to equality and non-discrimination; the rights to be free from torture and cruel, inhuman and degrading treatment or punishment; the right to privacy and bodily integrity; and the right to the highest attainable standard of health. The criminal justice approach that is based on assumptions of the rule of law emphasizes enforcement of laws against violence after it has occurred (1). Western discourses of human rights and criminal justice have been found to be influential on public health programs and practice. This is discussed by researchers who hold that

domestic violence has come to be seen as a new realm of criminality; for example in their paper Shahidullah and Derby argue: "the fact that domestic violence is being increasingly defined and perceived as a domain of new criminality suggests the increasing modernisation and globalisation of issues of human rights, gender equality, and laws against interpersonal violence" (39). Venning and colleagues came to a similar conclusion in their study around the work of NGOs on domestic violence in Indonesia, which they argue are increasingly applying a criminal justice approach at a local level (40). Lawson also outlines traditional sociological thought on IPV such as family violence theories, which include variously systems theory, exchange theory, ecological theory, subculture-of-violence theory, and resource theory (41). These assume that domestic violence should be explained beyond individual pathology to understand family dynamics.

2.1.b) Critical Perspectives applied to IPV

Critical perspectives on violence have been rooted in neo-Marxist, feminist, and/or post-structural streams of thought. Among the most noteworthy to have been applied for understanding domestic and interpersonal violence is Connell's theory of gender and power, which emphasizes patriarchy, power relations and hierarchical constructions of masculinity and femininity as the predominant elements underlying gender inequalities (42). The theory posits three socially-reinforced and intertwined structures existing to characterize male-female relationships that act at both interpersonal and institutional levels. These include the sexual division of labour, sexual division of power, and the structure of *cathexis* (or affective attachments and social norms). These structures are theorized to produce gender inequities, and consequently often heightened

vulnerability to health problems for women. This approach has been applied in a few studies in different contexts to understand gender norms in relation to violence against women (36, 43, 44). Panchanadeswaran and colleagues conducted an ethnographic study and positioned the results using this theory to understand HIV risk among female sex workers in Chennai by examining vulnerability in cases of IPV from different sources, their lack of control in relationships and the role of traditional gender norms in the outcomes of sexual negotiation (36). They found that the theory was partially validated, with important applications of each structure in various aspects of their exploration of HIV vulnerability of FSWs (36).

A related concept within R. Connell's theoretical work that has been applied to IPV is "hegemonic masculinities" (42). Connell and Messerschmidt have defined this concept as a "pattern of practice (things done, not just a set of role expectations or an identity) that have allowed men's dominance over women to continue" (42). It was originally conceptualized in opposition to "emphasized femininity", and is rooted in the concept of hegemony from Antonio Gramsci in his work to understand the stabilisation of class relations across history. It also draws on gay liberation movements' concern with power and difference by emphasizing that some manners of being are more ideal than others in a given society and point in history. The ability to achieve the characteristics of a given "hegemonic masculinity" is constrained and shaped by embodiment, institutional histories and economic forces, personal and family relationships, and can be seen to be enacted and reinforced at the local level of daily practices, the level of culture and state, and on a transnational level through politics, media, macro-economic policies and so on

(42). George has applied this concept to exploring masculinity in a working class Indian community. She found that ideals around physical strength, being a provider and protector, duties in the public sphere, and having honor were all important aspects of "hegemonic masculinity". In contrast, "emphasized femininity" was characterized in terms of propriety, duties in the private sphere, and submission to men. She points to a link between gender in these terms and IPV by noting that when the boundaries of appropriate femininity are violated, the dominance characteristics of masculinity are enacted through violence from a male to a female partner as a way to penalize or censure the woman (43). This theory has been minimally applied in the context of FSW-client relationships and only in India. Torri has most directly applied this concept to examine the role of caste differences on the interactions between clients and female sex workers of *Devadasi* caste, concluding that, "the social control and hegemonic masculinity of upper caste men is asserted and maintained through defilement and appropriation of lower caste and 'dalit' women's sexuality" (45). More recently, Connell has continued to develop her theories on gender and health to become more integrative of both feminist and other streams of thought. She has advocated the relational theory on gender that outlines the need to understand social relations of power as gendered processes, which are embodied and enacted by men and women over the course of history, and that affect health on multiple levels (38).

2.1.c) Public Health Approaches for Understanding IPV

It is becoming increasingly common to integrate disciplinary theories on violence and specifically IPV. Lawson outlines the importance of integrative perspectives, such as

Anderson's merging of family violence resource theory and feminist perspectives, and Heise's integrated ecological framework (41). The spectrum of prevention approach is another that has been adapted by clinicians for addressing sexual violence and emphasizes going beyond individual to community, organizational and social norms approaches, and has been used to categorize interventions to address violence against women (46-48). According to Davis, studies must consider the important concept of norms around femininity, power, violence, masculinity, and privacy that underlie individual behaviour surrounding sexual violence. He therefore recommends a primary prevention approach that aims to replace current norms with healthier ones through a community-wide solution (46). The integrated ecological framework for IPV developed by Lori Heise has been more widely applied in public health (49, 50). Heise's application of an ecological framework for IPV outlines four levels of factors, including the individual level of biological and personal history factors, relationship characteristics such as communication, educational disparity or multiple partners, community contexts such as poverty levels, education, employment rates and sanctions against IPV, and the macro-social level factors such as socio-cultural norms or policies around violence (37). This approach has been used to structure studies of IPV by academic researchers and public health organizations alike (49, 51-53).

2.2) Epidemiological Evidence on IPV Prevalence

In the last few decades, researchers have been working to better understand the phenomenon of widespread violence against women, including IPV, in a range of

contexts. The majority of studies have been quantitative and have determined the prevalence of different forms of violence such as physical force or abuse; being beaten, sexually coerced or raped; psychological or verbal abuse, and so on. Most studies have been about violence against women generally, but some are specifically related to female sex workers. Global estimates for the prevalence of IPV has varied from an average of around 13% up to 60% of women aged between 15-49 years according to a WHO multi-country study (49). Research studies often examine the prevalence in a given population, and their findings reveal vast variations between samples, regions and countries. For example, Hosseini and colleague's study among 251 married women in Iran found that 78.1% reported minor or severe violence from their partner and 39.8% reported both (54). In three former Soviet Union countries, a study among a representative sample of ever-partnered women from National Health Surveys (NHS) found that the prevalence of ever experiencing physical violence alone was between 10-20%, and 5-6% reported ever experiencing sexual violence (55). Balogun et al. report that in their sample of 300 rural women in Oyo state, Nigeria, lifetime prevalence of IPV was 64% (21). A study analyzing WHO data with a representative sample of Brazilian women compared two regions, one that was more urban and another more rural, and found that the prevalence was 28.9% and 36.9% respectively (20). In India, an analysis of the National Family Health Survey's third round in 2005-6 among a population sample found that 31% reported ever experiencing any violence and 10% reported severe violence (56).

Rates of violence among FSWs were often particularly high according to a number of studies. Most of them focus on work-related violence from clients or pimps

more often than from intimate partners. Decker and colleagues have assessed the difference between those FSWs who have been trafficked versus those who have not in a sample of 815 women in Thailand. They found that 36.6% of the women experienced workplace-related violence in the last week, and women who had been trafficked were nearly twice as likely to report such experiences (15). Katsulis and colleagues' study in Mexico on client violence found that 27% of women in sex work had experienced violence from a customer (24). In Canada, Shannon et al. found that among FSWs in Vancouver, 57% reported experiencing any form of violence in the last 18 months of study follow-up (27). Though IPV facing FSWs has been less commonly quantified, a study in Mombasa, Kenya found that in a sample of over 600 FSWs, 78.7% reported having specifically experienced IPV in the last month (57). KHPT's report on the results of the most recent representative survey in five districts found that 68% reported experiencing client violence and 36.7% experiencing violence from non-paying intimate partners in the last 12 months, with little difference between districts (17, 58).

A number of studies have also specifically examined domestic or intimate partner violence in the context of pregnancy due to its negative impact on maternal and neonatal health outcomes (14, 19, 59-61). Makayota examined lifetime prevalence of violence among pregnant women in Kenya, which was 53% overall and 26% physical violence among 300 women, which was just slightly higher than the prevalence within the last twelve months before pregnancy (19). One study among FSWs examined adverse reproductive health outcomes as well, and found that women who had experienced any physical or sexual violence were more likely to become pregnant, have forced and

sometimes multiple termination of pregnancies, and to report lower condom use with intimate partners (14).

2.3) Quantitative Research on Factors contributing to IPV

Quantitative studies have often aimed to find associations between IPV and individual or community-level characteristics to determine who is most at-risk, primarily with respect to the women affected rather than intimate partners (3, 19, 24, 62). Numerous population-based studies have shown that IPV is most common generally among women who are not currently married, socio-economically disadvantaged, with lower income and education level, and rural rather than urban dwelling (56, 63). There are studies that have found that either older or younger women are more likely to experience violence, illustrating that there may be risk of violence across the lifespan and for women of various relationship statuses (21, 55, 56, 63). In a study using India's National Family Health Survey-3, Dalal and Lindqvist found that there were higher adjusted odds of experiencing sexual abuse among younger women, but higher adjusted odds of physical abuse among older women, possibly because of longer duration in the relationship. Others most-at-risk were those in rural areas, least educated, and among scheduled caste women (56). Though there are fewer studies on characteristics of men involved in IPV and particularly as study participants, studies have found that enacting IPV was more often among those of lower education and younger age in a study in Nigeria (21). Among a representative sample in Eastern European countries, characteristics of men who were

more likely to perpetrate IPV included those who were unemployed, had lower levels of education, were working class, or were older (55).

Others have recognized the importance of broader, more distal factors leading to IPV. Most have conducted multivariate analyses and shed light on the associations between IPV and alcohol use, childhood abuse, unfaithfulness in the relationship, interaction with the justice system, or economic independence among both female sex workers and their partners (19, 21, 27, 50, 56, 64). For example, VanderEnde and colleagues recently published a review of the literature on community-level factors related to IPV globally and grouped these factors into five key categories: social disorganization, collective efficacy/social cohesion, socio-economic standing, community violence, and community gender norms (50). Most studies of IPV risk factors have used a sample of the general population in a given region or country, and though there is great variation, there are some common factors that have been found to be related to higher odds of experiencing IPV among the general population. In the analysis by Balogun et al. of a survey in Nigeria they found that women who had longer duration of relationships and had partners who consumed alcohol had two to four times greater odds of experiencing physical violence (21). In India, Dalal and Lindqvist found that those with a history of family violence compared to those without had an adjusted odds ratio was two to three times greater. Further, those using alcohol, in families where men were controlling, or when women were head of the household had greater odds of experiencing some form of violence (56). Hosseini and colleagues' study involving a population-based sample of Iranian women reports that the most significant socio-economic factors related

to IPV after adjustment were women's higher level of education compared to their male partners' and use of drugs by their partner (54). In a study in Brazil using WHO multi-country survey data, a history of violence between partners, sexual abuse in childhood, and use of alcohol were independently associated with IPV among women in both rural and urban areas. Financial autonomy of women in the rural area was also associated with IPV after adjusting for socio-economic factors (20).

In addition, many studies have also examined the strength of association for various factors associated with IPV among FSWs, some of which concur with studies on IPV among women generally while others were specific to their circumstances and work context. Alcohol abuse as well as economic insecurity have been reported as major factors contributing to violence facing FSWs in a range of contexts including India, where it often contributed to their entry into sex work in the first place (9, 65, 66). In Canada, Shannon and colleagues conducted a study among survival sex workers in Vancouver and found that after adjustment for individual and interpersonal risk practices, structural factors that were independently correlated with violence in the last 18 months included being homeless, soliciting in cars or public spaces rather than home, and lack of drug use treatment (27). Pack and colleagues conducted a recent multivariate analysis of data from a large sample of FSWs in Mombasa and reported that women supporting more than one other person, having experienced child abuse or mother's abuse, and greater alcohol consumption were related to higher odds of experiencing IPV in the last month (57).

In the context of Karnataka, Beattie et al.'s analysis of a population survey of FSWs in regions where KHPT works showed that those who were beaten or raped in the

last year were more likely to be younger, migrants, cohabiting or widowed/divorced/deserted, have regular partners, have early debut in sex work, or a higher weekly client volume than those who did not report violence (17). These risk factors often cluster so that women who were younger also had more clients, suggesting that some women are more likely to be faced with social- and health-related vulnerabilities and consequently also violence. In a more recent analysis of a KHPT cluster-randomized survey in other districts of Karnataka among FSWs, similar factors were found, including young age, early debut in sex work, current marriage, literate and non-local, to be slightly more likely to have experienced any violence in the past year. Those who solicited at home were least likely to experience violence compared to in brothels or on the phone, as well as those with lower client volumes compared to higher (58). Women were also asked why they thought they experienced violence from any source with close-ended categories for their responses. Approximately 90% of women reported it was "due to their engagement in sex work" in some way, while 60% said it was due to "financial constraints", and between 25-30% stated it was because of a "partner's alcohol abuse" and the "subordinate position of FSWs in society" (58). These studies examine broader factors underlying vulnerability and some focus greatly on work-related issues at a nominal level. However they do not offer a deep understanding of how contextual social factors surrounding and within intimate relationships of FSWs may influence or interact with the occurrence of violence on the individual level.

2.4) Qualitative Understandings of IPV

Existing quantitative studies provide substantial evidence to document the high prevalence of violence, determinants and factors, as well as the association with heightened HIV risk among women including those in the sex trade. Fewer studies have qualitatively explored the experience of violence and how these various factors may be leading to violence. Some qualitative studies have aimed to examine multiple levels of factors relating to the occurrence of IPV among women in a certain region (67, 68). Other studies have qualitatively examined the lived experiences of violence using grounded theory or phenomenological approaches, though never among FSWs (67-69). There have also been a few qualitative studies around violence and HIV risk among high-risk groups such as FSWs, especially in the context of HIV prevention efforts (13, 22, 24, 70).

2.4.a) Triggers and Acceptance of Violence

Qualitative contributions to understanding IPV among FSWs, at least from the perspective of women affected, are few but growing in number. These studies have started to broaden understandings of how individual life histories, relationship dynamics, community and societal norms and structures influence the experience of violence. For example, Decker et al.'s study in Baltimore found that though intimate partners were less often perpetrators of violence compared to clients, women expressed that IPV was usually severe and related to their involvement in sex work, often produced by sexual jealousy and issues of control (22). Studies by Panchanadeswaran et al. in Chennai, India among street-based FSWs show how power imbalances between women and their clients and

intimate partners can lead to violence and limited condom use, however women demonstrated some ability to resist or subvert violence (3, 36).

Informal participatory workshops in 2012 to inform KHPT's IPV interventions among women in sex work and intimate partners in Bagalkot, Karnataka revealed the importance of relationship issues and norms around violence and gender (52). The main causes that were expressed through problem-tree exercises were factors such as jealousy, insecurity, infidelity, unrealistic expectations of each other, and financial concerns. Women noted that when partners became disrespectful and insensitive to their needs or desires, such as the care of children, feeling as equally loved compared to partners' wives or suspicion and soliciting of clients secretly, were all triggers for conflict or violence. They also stated that partners showed their dominance and power over them through violence. From the perspective of intimate partners, conflict was triggered when they found shortcomings in their FSW partners, such as going out without permission or when they resisted sex, or if they had suspicion of their involvement in sex work. In addition, conflict was caused by the stress of having a dual role of lover as well as husband for another woman. Both parties viewed violence as acceptable in certain or even most cases. This suggests that intimate partners subscribe to certain social gender norms and the results of contravening them (52). This is relevant to consider in the context of studies that specifically use a gender lens to examine how norms on violence and gender relate to intimate partner violence (43, 44, 67, 71-74). Many norms around gender and violence that have been found within marital relations regarding violence are similar to those found

in the emerging qualitative evidence in the context of sex work, yet it has not been well-explored.

Further, there are also very few studies that have examined violence from the perspective of not only FSWs but also intimate partners in the context of sex work. The qualitative study in a Mumbai red light district by Karandikar is the only example of a peer-reviewed study that focussed on male partners, and in this case clients', views on violence and related triggers (70). However there is increasing recognition of the need to involve men in interventions against IPV (48, 71). KHPT recently conducted a qualitative study on masculinities, gender norms and IPV from the perspective of intimate partners, and reported on the ways that patriarchal conceptions of gender roles and male dominance influence violence (75). In that study, it was found that men equated masculinity with honour, hard labour and a good work ethic, whereas women's work was less valued and was seen as more domestic. Further, when women did not fulfil these roles, men felt the right to beat them to correct their behaviour. Though the concept of the ideal woman expected of the FSW was not substantively different from a wife, her line of work was not valued and instead stigmatized. Overall, the study asserted that underlying patriarchal and unequal gender attitudes must be changed to redefine notions of masculinity and thereby reduce the acceptability and perpetuation of violence (75).

2.5) Intersections between IPV and HIV risk

It has been found that the behavioural and social factors underlying the experience of violence and risk for STIs including HIV acquisition are very often parallel (2, 76).

The WHO's most recent analysis found that compared to women who have not experienced IPV, women who ever experienced IPV had 50% greater odds of incident HIV infection and 60% greater odds of incident sexually transmitted infections (STIs) (2). Dunker and Decker also review the many studies, including those assessing a causal relationship between gender-based violence and incident HIV infection, to affirm the link among the general population as well as FSWs specifically (77). They postulate theories to explain this association including direct biological effects, such as heightened transfer of HIV during violent sex, and greater likelihood for violent men to engage in risky sex; they also point to indirect social linkages such as limited ability for the women to advocate safe sexual practices, physical and/or psychological reasons, and the social norms around gender that underpin norms on violence (77). Dunkle and Decker also examine the way that many of these factors are magnified in the experience of FSWs, as well as additional unique factors like violence at initiation of sex work, or limited ability to use condoms with clients for economic reasons that put them at great risk of both HIV and IPV (77). Many of the same risk factors for violence also contribute to heightened HIV risk and as both health issues concentrate highly among FSWs, together they create what some call a "syndemic". This concept highlights the importance of interacting biological and social conditions in a population to heighten their risk of and impact from co-occurring health issues (78, 79).

Many studies conducted in India among FSWs have focussed on the interaction between violence and HIV risk (12, 14, 15, 17, 80, 81). Swain and colleagues found in their study of cross-sectional survey data with 5500 FSWs in four south Indian states that

women who experienced violence, and particularly sexual violence, in the past year had significantly higher rates of unwanted pregnancies and inconsistent condom use compared to those who did not, suggesting a higher risk of HIV (14). Similarly, Sarkar et al. reported that sexual violence was associated with lower ability for condom negotiation and higher HIV rates among trafficked sex workers in northern India (23). Panchanadeswaran and colleagues also found in India that among street-based FSWs in Chennai, IPV was as important as client violence in increasing women's risk of HIV leading to limited condom negotiation (3). Further, the only qualitative study around IPV and HIV among female sex workers was by Ghimire and colleagues, who conducted 15 in-depth interviews with FSWs in Nepal and found that violence from police, clients and intimate partners and low "self-efficacy" were the most noted factors that led to non-condom use with their clients and intimate partners (13).

In the other direction, it is also notable that women in sex work have been found to use condoms less with intimate partners generally, due to socio-cultural reasons around relationships and gender norms. Therefore the risk for HIV transmission is heightened. This is reflected in Ramesh et al.'s study in Karnataka where interventions have long been in place to work particularly on client condom use, where condom use rates were 32% among women and their intimate partners compared to over 70% and up to 90% among clients on average. In the report on their most recent Behavioural Tracking Survey analysis, KHPT found that:

> In both unadjusted and adjusted models, the odds of using condoms at last sex with all sexual partners for FSWs who have experienced any form of violence at the hand of the intimate partner/husband in the last 12 months was 63 percent lower than the odds for women who were not victimized to such violence. Experience of any form of violence

> being perpetuated by client or other individuals was not significantly associated with higher likelihood of condom use at last sex with all sexual partners (58).

Thus, there is a large body of evidence to affirm that vulnerability to HIV transmission and IPV are highly correlated and mutually reinforcing among women in sex work, and are mediated by related risk behaviours and social environments that must be well-understood in a given context.

2.6) Community-based Research on IPV

Community-based research (CBR) has emerged as an approach relevant for cross-cultural research with communities around IPV. White and colleagues used a CBR method to develop a culturally-relevant survey instrument to measure IPV among ethnic minorities in the United States (82). Magnussen et al. used a similar methodology to guide the topic selection and design of focus groups among Samoan women that aimed to better understand cultural perceptions, awareness, responses and actions around IPV (83). Community-based participatory research (CBPR) was applied in the context of a qualitative exploration of rural African American youth perceptions of the effect of dating violence on sexual health, including HIV risk (26).

Among FSWs, CBR has been rarely applied to explore IPV. Shannon and colleagues conducted a community-based participatory research mixed-methods study in British Columbia, Canada to examine the HIV-related vulnerabilities, barriers to accessing care, and impact of current prevention and harm reduction strategies among women in survival sex work (25). In the context of south India, CBR has been applied among FSWs and men who have sex with men (MSM) in Mysore, Karnataka to explore

relevant issues related to HIV and violence prevention, led by local peer-run organization *Ashodaya Samithi* with KHPT researchers (84, 85). In a multi-method study, Reza-Paul and colleagues report that violence has been addressed through community-mobilization in multiple stages whereby the community members countered violence from different sources through crisis response, increasing workplace security, creating an enabling environment for HIV risk reduction by working with police, then rapid response teams and safety, towards improving community protection (85). Though violence initially increased towards the community, they state that this was seen as a step towards changing power dynamics that will eventually lessen violence (85, 86). More detail on the use of CBR in this context is outlined by Lorway and colleagues, demonstrating how the methodology went beyond gathering information and was a key part in increasing community ownership, participation and ultimately achievement of the goals of the program (84).

2.7) Individual and Collective Methods of Violence Prevention and the Evaluation of Interventions

Few studies are currently focussed on evaluating interventions to address IPV, particularly among sex workers. The most well-established and multi-leveled intervention that has been evaluated is the Intervention with Microfinance for AIDS and Gender Equity (IMAGE) initiative in South Africa (81, 87). Most recently evaluations of the SASA! project in south Africa run by a related group have revealed positive results for improving gender norms and reducing violence (88-90) The WHO and others have also emphasized that while there has been much research undertaken to understand this issue,

there must be a push to use this research for the purposes of primary prevention of IPV (1). In this way, continued integration of research into the evaluation of programmes in a given context is a necessary way forward (1, 48).

2.8) Gaps in Understanding and Rationale for this Study

Though there is a large amount of quantitative evidence for the pervasiveness and underlying root causes of IPV among women generally and sometimes among FSWs, these studies necessarily use predetermined categories for factors that are explored and linearize the relationships between complex multi-leveled and interactive reasons for why it occurs. Further qualitative research is merited to gain a deeper understanding of the interplay between social issues and IPV from the perspective of individual female sex workers and their partners, and the relationship with low condom use in these relationships. Exploring IPV qualitatively and informing this from the start by local interests and considerations through the use of a community-based research model can provide insight into how violence is experienced and understood by both partners that can be used to optimize interventions.

Chapter 3) Research Design and Methods

3.1) Conceptual Framework

An empirically-based and widely used ecological framework developed by Lori Heise was adapted to inform the design of the current study, the research questions and tools, and specifically to understand the interplay of social factors and IPV in the context of intimate relationships of FSWs (see Figure 4 in Appendix B) (37, 91). The existing ecological framework was adapted to include factors identified in discussions at community workshops. The adapted ecological framework included potentially relevant factors affecting IPV at different levels; this was refined and used to develop the in-depth interview guide with KHPT, University of Manitoba, the community research committee and research investigators. Structural aspects in this model included gender norms, political and justice systems, norms on violence and alcohol use and distribution of resources. Relationship level factors included supports, family power dynamics, and relationship characteristics. Individual level factors included knowledge of IPV supports, self-worth and efficacy, problems and coping mechanisms, attitudes on violence and gender, and socio-demographic characteristics. The adapted framework was considered as a starting point during analysis, but did not prescribe or limit which concepts became relevant for exploration in the interviews.

3.2) Study Design

3.2.1) Exploratory Qualitative Methodology

This study used an exploratory qualitative design based on a community-based research (CBR) model. According to Miles and Huberman's well-cited approach to qualitative data analysis, this study's qualitative methodology can be characterized as a blend of collaborative (action) research and ethnographic content analysis, which aims to, "discover regularities, identify elements, and discern patterns as deficiencies or ideologies" (92). The analysis here can also be generically referred to as qualitative content analysis, which helps to build on or refine existing theory (93).

Data were obtained through individual in-depth face-to-face semi-structured interviews with a sample of 21 individuals (9 individual FSWs and 6 couples, including 6 FSWs and 6 of their male partners) in Bagalkot district, Karnataka to explore how women and their partners describe their experience and understandings of violence in their intimate relationships. Because of the exploratory nature of the study, we undertook an iterative planning process as well as inductive analytical methods. This helped to understand the importance of various themes to answer the research questions, which became apparent *a posteriori*. A timeline for the study is included in Appendix C.

3.2.2) Elements of the Community-based Research Model

This qualitative exploratory study was informed by a community-based research (CBR) model throughout. Each stage involved collaboration between the University of Manitoba and partners in Karnataka, India including the Karnataka Health Promotion

Trust in Bangalore, and a community research committee with seven members nominated by the peer-led community-based organization *Chaitanya Mahila Sangha* in Bagalkot. Montoya and colleagues have previously described community-based research as, "a collaborative approach to research that equitably involves all partners in the research process (from conception to dissemination) and recognizes the unique strengths that each brings" (26). Rhodes and colleagues also emphasize that key characteristics of CBR are co-learning, reciprocal transfer of expertise, and shared decision-making power and ownership of research products among community members, the NGO representatives, and academic researchers (94). The potential benefits of such an approach have been cited by Israel and colleagues to include enhanced usefulness, relevance and use of the data by all partners; combined strengths of partners with diverse skills, expertise, and sensitivities to particular issues; engaging local knowledge and ensuring a self-reflexive approach, strengthening research and program development capacity, better informed practice and more effectively addressing identified community needs (29). In line with these principles of community-based research, the community was a key decision-maker in the design, analysis, and knowledge translation phases of this research study. The results of this study also aim to comment on the successes and challenges of our approach for realizing the objectives of CBR, which drew on existing frameworks and were laid out by the various partners together at the beginning of the study.

Stages involved in the CBR approach taken by the study (see Tables 5 and 6 in Appendix B for an outline of related meetings in India):

Stage 1) Research Topic Selection

The first stage of the research was the topic selection in June 2012. In meetings between the community leaders from *Chaitanya Mahila Sangha* in Bagalkot district, KHPT program directors and I, it was recommended separately by both *CMS* and KHPT that violence and condom use in intimate relationships were key issues facing FSWs in these districts. These remain challenging to address through their programs.

Stage 2) Planning, Orientation and Training

Meetings in May 2013 with 15 leaders from *CMS* were conducted to determine the objectives, roles and responsibilities, phases, and tentative timeline for the baseline round of the case studies, as well as appropriate criteria for potential participant and research investigators. In June 2013, women were recruited to make up the community research committee that met throughout the study to make decisions on the design and contribute to the analysis and dissemination of the findings. Specifically, the leaders of *CMS* in collaboration with KHPT decided that the community research committee should be composed of 7-8 community members who may or may not be working with *Chaitanya*. Training of the research committee on research principles and processes occurred in July of 2013 by KHPT program directors and myself, and was followed by workshops to develop the objectives, questions, tools, and the ethical framework for the interviews. *Chaitanya* selected potential community research investigators from within the sex-worker community to conduct the interviews with the FSW participants. In

December 2013, all partners held workshops to train community research investigators on qualitative research, and finalize the tools in the local language. The final selection and hiring of two community research investigators was made to conduct the FSW interviews at this time. A trained male research investigator from the local district who had worked with KHPT on similar studies was involved throughout and interviewed the male intimate partners.

Stage 3) Ethical Approval

Ethical approval for the STRIVE Evaluation study that includes this qualitative component has been granted to KHPT by the St. John's Medical College and London School of Hygiene and Tropical Medicine's Research Ethics Board. KHPT and UM developed concept notes, protocols and tools for the qualitative study. Ethics approval from the University of Manitoba's Human Research Ethics Board (HREB; Ethics # H2014:108) was granted. Informed consent forms and the letters of ethics approval from UM's HREB are included in Appendix D.

Stage 4) Data Collection

After initial contact and informed consent with FSW participants, the research investigators carried out interviews in two stages using digital recorders. In the first stage, research investigators gained consent and started with the first question about relationships. In the next visit they completed the rest of the interview. After pilot testing with four women and one man, the remainder of the interviews were conducted, transcribed verbatim and translated by the translator with the assistance of the research

investigators. KHPT facilitated and helped community research investigators with data collection throughout the process.

Stage 5) Analysis

I conducted the first level of analysis to code the interviews in India with the help of KHPT researchers and research investigators in order to organize the findings in line with the in-depth interview guide sections, and determine the most important categories. These aggregate categories were then presented in workshops by the community research investigators to the research committee and KHPT intervention team. This helped to collectively determine how the important categories related to better understand IPV. This process informed the final level of analysis. Specifically, the community-based analysis provided information that aided in my derivation of themes to answer this study's research questions, which were then considered in light of broader theoretical literature.

Stage 5) Knowledge Translation

The community research investigators will be presenting the findings we developed to the *Chaitanya* Board of Directors as well as in community workshops for information and feedback. *Chaitanya* and KHPT will use the results to inform their programmes from 2015 to 2017. We are working on writing reports and research papers based on all partners' feedback on the results.

3.3) Description of the Study Setting

The state of Karnataka in South India had just below 53 million people in 2011 Census, with two-thirds living in rural areas (95). The study was conducted in Bagalkot, a

key district where the *Samvedana Plus* intervention is being implemented, and specifically in 2 *talukas* (sub-districts) including *Mudhol* and *Jamkhandi* in Bagalkot where KHPT has been working for over ten years with *Chaitanya* (see map in Figure 1 below). Bagalkot district has 1.65 million people, with 1.17 million in rural areas (95).

The *talukas* of *Mudhol* and *Jamkhandi* have been the site where much work on HIV prevention has been conducted, including in-depth community-based programs by NGOs (predominantly KHPT), to develop and strengthen peer-led community-based organizations such as *Chaitanya*. This was a response in part to the identified high prevalence of HIV in the late 20th century that was found to relate to a high degree of sex work in this area along a belt that extends from northern Karnataka into Maharashtra and up to Mumbai. This also corresponds with the historical *Devadasi* tradition that emerged centuries ago across this region.

Devadasi women were traditionally dedicated to a god or goddess in the temple, often the goddess *Yellamma*, to perform various religious duties including sex work with priests and others. They are most often from the *madar* caste today, which is a scheduled caste also recognized as a *dalit* or untouchable caste (96). In India, caste has been a long-standing system of social stratification that can be understood through the concepts of *varna* and *jati.* The former is said to originate in the Hindu Sanskrit text *Manusmriti* that outlines four *varnas*, from the head (Brahmins) of god to the feet (Shudras). In that text there was also a final fifth category made up of Untouchables that were separate from the original body of god and who have been traditionally restricted from performing ritual activities. Each of the *varnas* has been sub-divided into *jatis* or sub-castes along

occupational, ritual and other lines over time. However there is no universal, hierarchical set of *jatis*. More recently, since partition the castes have also become a political construct, so that those who are from the previously "untouchable" *jatis* are now constitutionally classified by the government of India as "Scheduled Caste" so as to provide some privileges in light of historical discrimination and disadvantage (96, 97). Historically women that had been dedicated to the *Devadasi* tradition were often of a higher position and likewise performed ritual duties; yet increasingly women have been drawn from lower castes such as the Dalit *madar* caste (96). Likewise, the sex work of *Devadasi* women has been increasingly commercialized and more covert after it was officially banned by the Indian government in the 1980s. This has been linked with increased stigma, socio-economic exclusion, and increased HIV and other health vulnerabilities (98).

Devadasi women's situation has been studied greatly in the context of HIV prevention programs in the region (7, 16, 98-100). This research, including a new study on the impact of intimate partner relationships in *Devadasi* women's lives on HIV risk (99), has shown that *Devadasi* women traditionally are not able to marry, and often occupy a unique gendered role, which includes the main financial provider for the family. Almost all participants in the current study were *Devadasis* (even women who sell sex who are not traditionally dedicated often still adopt the label '*Devadasi'* in this region). Characteristics of sex work and respective life circumstances have been found to vary depending on sex work typology, age, and so on (98).

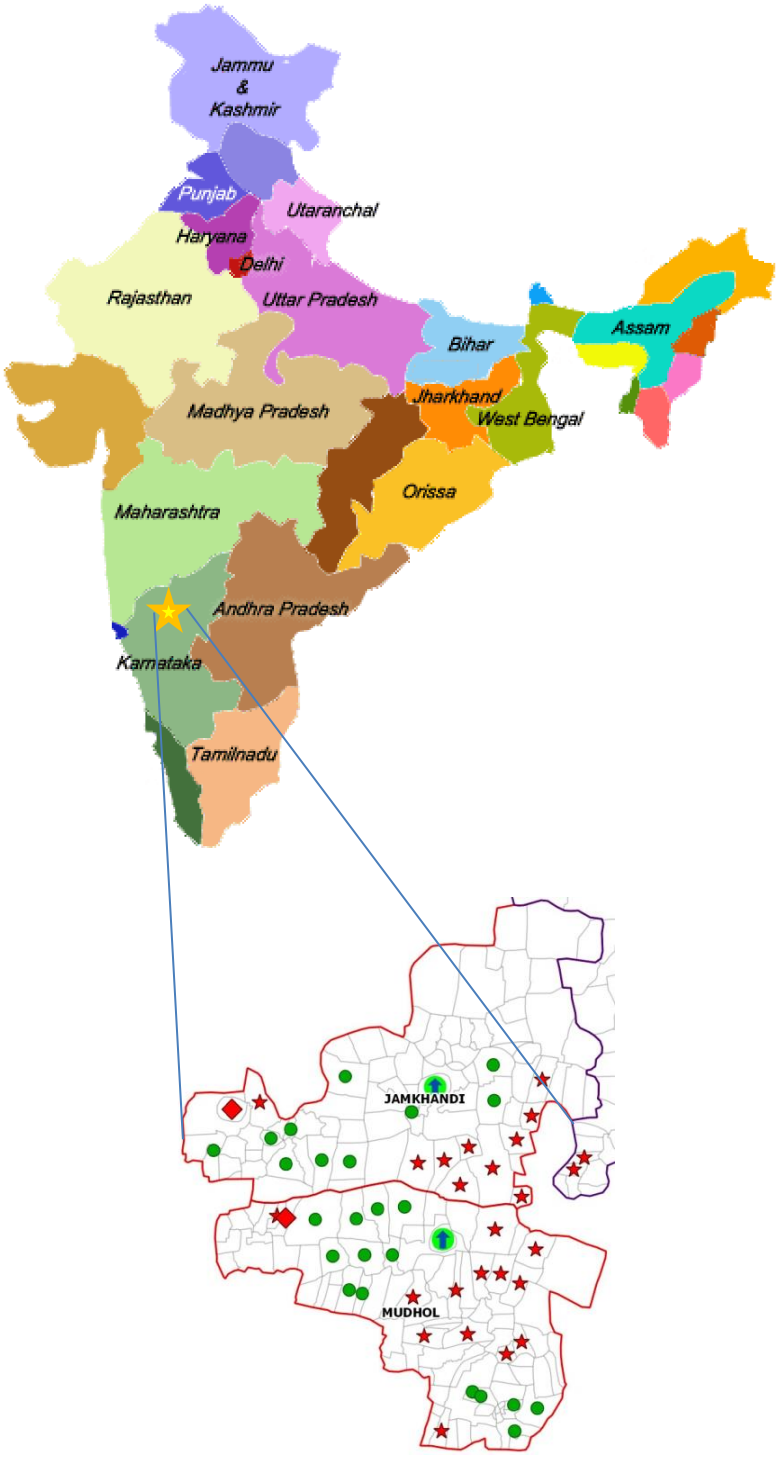


Figure 1: Study sites for the *Samvedana Plus* Intervention and Evaluation in villages of Mudhol and Jamkhandi sub-districts of Bagalkot district, Karnataka state, India

3.4) Participant Selection

FSW participants were selected from the "line listing"[2] of all the FSWs registered in the *Samvedana Plus* intervention. Individual in-depth interviews were conducted for this baseline study and will thereafter be done every six months for a total of seven interview rounds over the duration of the intervention (three years) to develop a complete set of cohort case studies (this thesis is based on the baseline round of interviews). Participants for this study were purposively selected from the intervention records (line listing) based on the presence of chronic intimate partner violence and poor condom use with intimate partners and within those categories, alcohol use and having children. Evidence from north Karnataka has shown that these factors have important associations with IPV.

In preliminary workshops, more than one quarter of the FSWs reported having more than one intimate partner, and many of the intimate partners also had more than one FSW as an intimate partner (6). In these cases the relationships can be more complex and violence and condom use may vary in each partnership. Thus some of the interviews were conducted among established couples with both members of a partnership being interviewed (the couple cases) while others were conducted among unpaired individuals. The sample consisted of six couples and nine individual FSW, representing 15 cases, and

[2] The "line listing" is an Excel document containing KHPT's enumeration list of FSWs who were identified as potential participants for the *Samvedana Plus* intervention, and contains demographic information on each woman from 2012.

21 interviews. The selection criteria for the cases, which were determined with the RC, included:

- Villages that community research investigators are not from (Rabkavi in Bagalkot; and Bagalkot town, which is not in the intervention anyway)
- Chronic, repeated events of IPV (experienced in last 12 months, in 2011)
- Having a single intimate partner (for the couples)
- From both young and older age groups (those both below 25 and 25 or above)
- Representation of home-based FSWs as well as all other typologies
- Both women with and without children

In Bagalkot 1749 FSW were enumerated as potential participants in the intervention in 2011. Out of that number, 901 fell under the above criteria (those in villages except Rabkavi and Bagalkot town; have experienced IPV) and among these 431 FSW belonged to the 47 intervention villages. After removing 122 FSW who had migrated, had passed away, or did not had intimate partners, 309 FSW remained in the sampling frame. Of these KHPT selected 30 FSW to approach to anticipate inevitable refusals. Since a number of women initially selected from the list had migrated or passed away since the time of enumeration, it was necessary to select additional participants from the list, which lengthened the time taken for recruitment. This selection process is diagrammed below in Figure 2. The distribution of the final sample by Taluk and participant type is found in Table 1.

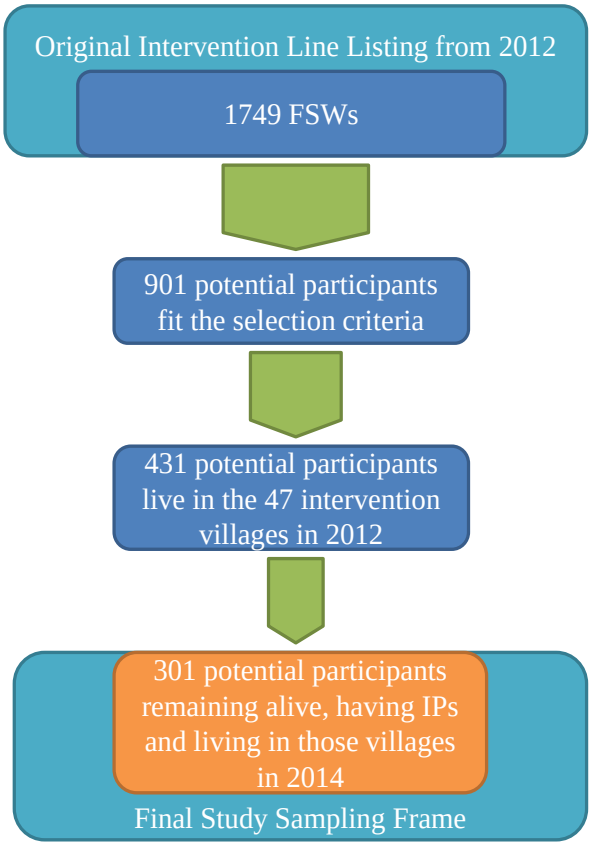


Figure 2: Development of Sampling Frame for Participants in Bagalkot district, Karnataka

Table 1: Participant Number Breakdown in Bagalkot

		***Mudhol* taluk**		***Jamakhandi* taluk**		**Total cases**
		Female	*Male*	*Female*	*Male*	
1	**FSW & IP**	3	3	3	3	**12**
2	**FSW**	5		4		**9**
		8	3	7	3	**21**

Recruitment and Informed Consent Process

The female community research investigators went to the villages and found a way to meet the FSW through contacts or finding her home based on the information in

the intervention “line listing”. If the potential participant had an intimate partner and she gave her consent to be interviewed, then consent was requested for meeting her intimate partner. At this time, the community research investigator then conducted the first question on relationship mapping and arranged for another time to conduct the rest of the interview that suited the participant. If the woman consented to having her male intimate partner interviewed, the partner was approached by the male research investigator in the same manner for consent and then the interview was conducted at a convenient time. If the woman did not consent for her partner to be interviewed, or her partner did not consent for the intimate partner interview, her interview was classified as an individual case. Otherwise, if she and he both consented for him to be interviewed, then their interviews were considered as a couple. No participants expressed that they feared losing services if they did not participate.

3.5) Strategies for Enhancing Rigour

Though there is now a range of criteria being applied to assess the rigour of qualitative inquiry, the strategies originated by Guba and Lincoln (1982) and since applied by others were used to enhance rigour in this study (101, 102). Credibility of the data to ensure that participants’ realities were optimally represented has likely been improved by the prolonged engagement we have maintained with the community. There was peer-debriefing with KHPT and UM researchers around the results of the study to uncover issues taken for granted by those more heavily engaged. Further, member-checking with the intervention team including counsellors, as well as the research

committee and community research investigators, was done to inform my interpretations. Triangulation with reports on the analysis of quantitative data of a representative sample of FSWs in the area and collaborative analysis with multiple researchers likely enhanced rigour. Transferability, or the ability to link the results to other contexts, should be enhanced by our use of purposive sampling that aimed to maximize variation based on participant characteristics in the quantitative line listing, and through description of the context gained through the interviewers' observations at the interviews. Approaches to enhance dependability or "stability" of the data as the process changed or emerged over time included an audit trail that I kept to delineate all methodological steps and decision points that affected how the study was conducted and the findings that emerged. To enhance confirmability of the data, I have tried to maintain reflexivity around the assumptions and potential biases toward the issues that could otherwise affect our methods of data collection and analysis. I also interviewed the community research investigators to understand their views on the interviews and the subject matter of IPV before we analyzed the results of the interviews together. The audit trail has also been used to trace my interpretations to the original data through the provision of quotes in the written results (101).

3.6) Positionality and Role of the Researcher

According to Stige and colleagues, qualitative research that pursues social critique and action through collaboration with local partners must inevitably be paired with self-critique in the form of reflexivity around the researcher's position within and towards the

research (103). In this way, there are implications of my position as a foreign researcher involved in the qualitative study informed by a community-based research model. Despite having lived for six years and subsequently worked for over five years in India, I do not share the same life experiences or cultural worldviews that surround the occurrence of violence against women in sex work in India, nor do I have first-hand knowledge of the complexities of women's relationships and the circumstances within which violence occurs. Stige and colleagues warn against "paternalism" by working "on behalf" of the participants for their own goals or values in the name of social critique; to avoid this the role of the research committee at each stage was invaluable (103). It was not possible to completely avoid power inequalities within decision-making due to the involvement of academic institutions in the process, and between the NGO and CBO. Directions of funding flows for the project created a particular dynamic and power structure as well as the involvement of an evaluation team with a somewhat separate agenda. Yet it has been emphasized throughout the process that each partner brings unique strengths that are necessary for the success of the research. To improve the equality between partners, I have tried to engage in extensive reading of the literature and adequate time with the community over a number of years to strengthen relationships and enhance my understanding of the context of the study at each stage. Involving the program coordinators from KHPT who already had a relationship with the community has also helped greatly to deal with issues and promote democratic decision-making. The language barriers that prevented me from conducting the interviews were addressed by employing local and community interviewers, which ideally improved the rapport and depth of the

interviews. Thus, my role has been primarily in the mechanics of the planning and implementation of the study, as well as being the primary person responsible for the first levels of analysis that can be brought back for the community members' interpretations, followed by my final interpretations and writing of the results.

For the analysis, it was important not to use a prescriptive framework, but some *a priori* codes that could guide the first levels of analysis while allowing important categories and themes to emerge inductively in subsequent levels so as to situate the results in relation to current understandings of and approaches to addressing intimate partner violence. One of the benefits of conducting qualitative inquiry for this project was that it allowed important issues to be raised through open-ended questions. I developed the codes and compared with the view of the community research investigators and research committee to develop subsequent categories and themes of interpretation. Thus I benefited from their feedback to clarify the value of my interpretations from their inside or emic perspective.

3.7) Interview Instruments, Questions and Measures

The in-depth interview tools were developed through workshops with the community research committee and researchers from KHPT, University of Manitoba and London School of Hygiene and Tropical Medicine. This process was informed by previous research and qualitative methodology that highlight an in-depth understanding of the social context of respondents' lives within which violence might occur, but which had not

yet been studied in such a way. The process of tool development during the workshops in July 2013 and December 2013 was as follows:

1) In July 2013, the theme areas of interest were developed in smaller groups and shared for the whole group's feedback.
2) Themes and sub-themes were summarized based on the research committee's question areas of interest by KHPT and University of Manitoba and made to be aligned somewhat with the STRIVE evaluation study outcomes from the conceptual framework (listed in the Development of Interview Guide below).
3) In the training/selection workshop of the community research investigators together with the research committee, guided by KHPT, University of Manitoba (Andrea) and LSHTM researchers (Martine Collumbien and Lori Heise), the tool was finalized in Kannada and then English (see below in Training of Interviewers). With the help of qualitative researcher Dr. Martine Collumbien, it was decided during the workshops based on discussions about the identified themes that the interviews would start with a new tool, the relationship map, in order to explore the social circumstances of each respondent in terms of the different supports from important relationships. The relationship map allowed a more natural way to start discussing the intimate partner relationship as well as providing a way to contextualize the relative importance of that relationship in her life. This process allowed the interview to then explore the positive and then negative aspects, and where violence may exist within that.

The English version of the interview guides that were developed based on the Kannada version during the training workshops and after field training are included below. During

the workshops in December the theme areas of the in-depth interview guide built off of the Samvedana Plus evaluation outcomes (self-esteem and self-efficacy, critical thinking on violence or gender, actual experiences/understandings of IPV, and methods to deal with IPV). These were considered and adapted in light of problem tree exercises with the research committee and community research investigators on the underlying causes or roots and the branches or resulting outcomes of IPV. These exercises led to the development of questions on issues they saw as important for understanding IPV, including supports, problems, hope and dreams, and expectations in the relationship. The sections of the interview tool that were finalized in the December meetings are included in Table 2 below.

Table 2: English Qualitative Interview Guide with Themes, Subthemes and Probes

Themes	**Subthemes**	**Possible probes**
Important relationships in our lives	Different people Support: give and get	• Who is in your daily life? Tell me all people you relate to on a regular basis ... Who else? (only if people are clearly missing probe: Intimate partner? Peers?) • *For each individual around the circle* what do you give and what do you get from them (in terms of support -practical, emotional/love, money)?
What about me?	Perceptions of self Perceptions by others	• What do you like about yourself? What are your good qualities? • What qualities do you see in others you would also like to have? Which one would you like most? Do you believe it is possible for you can change that? • *For each individual around the circle*: What do they like (/not like) about you? Why/why not? • Of all these people, who knows you earn money by selling sex?

Problems (*tonderek/ trasa*)	Most important problems	• What are the problems you are currently face in your life? Any others? What else? Any others? • Tell me more about your main current problem? What happened? What did you do?
Intimate relationships	Expectations vs reality in intimate partner / FSW relationships: Acceptance of/by intimate partner	• Tell me a bit more about your partner: what do you like most about him? • How do you express your love to him? How does he express his love to you? • What are your expectations from him – which ones does he not give/do? • What are his expectations from you? Which of those can you not fulfil? • How connected/accepted is he by other important people in your life?
Violence in the IP relationship (*himsa*)	Current/recent experience with violence Ability to deal with violence Norms about violence	• What are the most important disagreements in your relationship? • What type of abusive or violent behaviour do you experience? *Probe: emotional (threats/controlling behaviour)/physical violence/sexual violence)* • What are the triggers for violence (different causes setting it off)? • Tell me about your most recent experience of violence? What happened? (What set it off?) • What did you do? What else? *Probe* From whom did you seek support? from anyone else? • Are there ways you can avert violence from your partner (do you have any strategies)? What do you do? • How confident do you feel that you can avoid violence from your partner in future? • Do most FSWs in the community accept violence from intimate partners? What happens to those that do not accept violence? • Do important people in your life think you

		should accept violence from your partner? Who does not?
Condom use in intimate relationships	Condom use with intimate partner	• I would like to ask some question about condoms: do you think other FSW like you use condoms with their partner? Out of 10 how many do? • Do other FSW women think you should use condom with your partner? • When do you use condoms with your partner? • What happens if you insist on using condoms with your partner?
Intervention	Exposure to intervention Knowledge on Laws	• When experiencing violence who should women approach? • Has anyone approached you about violence? What did you get? *Probe: anything specific on violence with partners* • What was new? What was helpful? • Have you heard about laws to stop men using violence against women? Where did you hear about this? Tell me more… *... and to end:* • *What are the changes you want to make to feel happy and secure?*

The baseline FSW interview guides informed the adaptation of the semi-structured guide for interviews with the male partners. Intimate partner interviews were conducted by KHPT's male research investigator. All interviews were recorded using audio recorders and stored at KHPT Bagalkot office before and after transcription.

3.8) Training of Interviewers

Training of the community research investigators was done during the workshops in December 2013 with members of KHPT, LSHTM, four potential community research investigators, and me. The objectives were to explore issues of IPV and sensitization to gender and violence, to orient around community-based research objectives so far developed with the research committee, to impart interviewing skills and define roles and responsibilities of each party, and finalize the tool. All the themes were adapted, simplified and rearranged from previous drafts of the interview questions to bring to the workshops each day (as shown in the included tools). This was used for re-working during the training and also familiarization of the questions for the community research investigators as they were learning how to interview. Potential participatory tools were looked at and relationship-mapping was chosen to ask about social relationships, to smoothly transition to questions on the intimate partner relationship, and for reference in the rest of the interview. All the questions in the tool were translated in Kannada and adapted through mock interviews, checking for correct meaning in the local dialect and context with the workshop participants.

On May 20-23, 2014, Dr. Sapna Nair of KHPT led a refresher training workshop to practise one section of the tool at a time until it was strong, and then the whole interview guide together. At this time, a shortened tool was created using pictorial prompts with a short description that was clear for the community research investigators. Then the community research investigators took this sheet to the field because they expressed that it was difficult to interview smoothly while taking time to read long

questions. In this way, the community research investigators memorized the whole tool and were able to ask it more naturally. This Kannada version with visual probes used by the community research investigators in the field is included in Appendix E.

3.9) Tool pilot-testing

Pilot-testing of the in-depth interview tools was conducted in May and June 2014. The community research investigators completed two pilot in-depth interviews each with women that the CBO found for them (local FSWs in *Mudhol*), and one was transcribed and translated for the whole team including Dr. Sapna Nair and me to review. Dr. Nair and Vinitha listened to the other recordings in order to understand where to improve the subsequent in-depth interviews. The main issues in the in-depth interviews were that the community research investigators did not let participants speak in any gap at first, and there was little probing beyond repeating the questions. Thus a re-training day was held led by Dr. Nair with the community research investigators to discuss the challenges and ways to overcome them. After this, Vinitha translated one more pilot interview, and then there was one more training day to review everything, address any challenges the community research investigators faced, and more training on how to ask open-ended rather than closed-ended questions, how to get longer answers, as well as asking the difference between financial or material support and more intangible sources (love and affection and so on). At that time the field plan was developed with the community research investigators to determine which women each community research investigator should approach for consent from the sampling frame.

3.10) Data Collection

Data collection was completed between July and October 2014. The field plan was followed but there were many delays in getting consent due to some women from the line-listing having migrated or passed away. The community research investigators commented that rapport was very good with the women they approached, with much friendly dialogue occurring mostly before and after recording when they conducted interviews. Lack of consent was related to issues beyond rapport but was overcome in many cases because the community research investigator identified with the respondent as a fellow FSW from the same region. A major challenge for gaining consent that the community research investigators expressed was a common fear of recordings; one woman expressed a harmful previous experience of someone taping them to expose their involvement in sex work, while others were wary from lack of experience with recorders and their use. Another barrier was a desire not to be identified as a sex worker, often because of involvement in a government plan called *Devadasi* Rehabilitation Scheme, in which the government gives a pension to retired sex workers. In addition, the community research investigators told us that many women they approached had to ask consent from their family members or intimate partners. Thus their participation was not just their own decision in many cases and the community research investigators had to come back multiple times before getting consent. Some asked, "Why are you coming to talk to me and not asking other FSWs?" The community research investigator said that they reassured them by saying that the list of the CBO is like a lottery and anyway you have good experience and communication skills to share, so we came to ask you. Sometimes

women did not participate because they had already been interviewed for other studies. One of the community research investigators told me that a woman had consented to start the interview, but her mother told them to stop part way. However the interviewee asked the community research investigator to come back to the neighbour's house another time and they completed the interview there without the mother knowing. It was difficult to get the intimate partners to consent in many cases, reflecting the delicate nature of the study as well as the context of often undisclosed employment and relationship statuses. It was also not easy to find individual partner cases where the FSW did not consent and her partner did. For these reasons, recruitment, and therefore data collection, took a longer period of time than anticipated. As interviews were conducted, the recordings were brought by the community research investigators to KHPT's research investigators for transcription and Vinitha conducted the translation concurrently.

On September 26, 2014, we conducted a meeting between the community research committee and research investigators, KHPT staff, Dr. Nair, and me. I asked the community research investigators about their experiences in the field and then they also discussed this with the research committee for the purposes of sharing experiences, learning, and de-briefing. We then created an analysis plan, including a review meeting with community research investigators and male research investigator on each individual in-depth interview and subsequently, workshops with all partners to interpret the findings and to decide on next steps.

3.11) Data Analysis

All interview recordings were transcribed verbatim and translated from *Kannada* to English by the KHPT translators and research investigators in Word, which I imported for analysis into NVivo 10.0. The translated field notes of the community research investigators and the discussions with community research investigators and research committee informed my analysis of the interviews. The analysis for the current study has been done for the baseline of the case study period and will be built on biannually in an iterative manner by KHPT. The findings from the baseline analyses will be used to develop new questions for tool modification in the research committee monthly meetings with KHPT.

The analysis process involved multiple steps that have been iterative and overlapping. In the first phase, I conducted a descriptive analysis of the in-depth interviews completed by the end of October (12 in total). I then read the remainder of the in-depth interviews (21 in total) and started comparing them to themes in the in-depth interview guide and evaluation outcome measures. The codes I developed in the first phase were generally along the lines of the interview guide questions, being a semi-structured interview that the community research investigators had followed closely. See the in-depth interview coding scheme after going through FSW and intimate partner in-depth interviews in the table below:

Table 3: In-Depth Interview Coding Structure

NVivo Node		NVivo Node (cont'd)
Relationship structure		**Safety and well-being**
Neighbours		*Problems*
FSW Community		Financial problems

Intimate Partner		Social problems
Clients		Health problems
Friends		Occupational problems
Relatives		Coping mechanisms
Uncle or Aunt		*Description of support*
Children		Material support
Parents		Emotional support
Mother		Health-related support
Father		Domestic support
Sibling		Discordance
Niece and Nephew		*Satisfaction in life*
Spouse		**STI and HIV Risk Perception**
Intimate Partner Relationship		*Blood testing*
Interactions with Other Partner's Personal Life		*Condom use with Clients*
Expectations		*Condom use with IPs*
Ideal Image		*Norms*
Gender roles		*Behaviour*
Feelings and Emotions		**IPV**
Relationship Characteristics		*Feelings and attitudes*
Knowledge of Engagement in Sex Work		*Violence Norms*
Sense of Self-Worth		Self
Perceptions of self		Others
Perceptions by others		Behaviour
Social self-worth		Norm
Economic self-worth		*Experiences and Perpetration*
Occupational self-worth		Types of violence
Individual Efficacy		Emotional violence
Dreams, aspirations, goals		Physical Violence
Perceived ability to achieve dreams and goals		Triggers of violence
Control over CCU and IPV		Underlying causes
Useful Quotes		*Prevention and Coping*
Socio-demographic characteristics		Domestic Violence Act

For the first section on relationship mapping, I coded each relation in the respondent's life and then overlapped them with codes on the various supports, coping, problems and so on where relevant to see who and what was happening in each participants' life, and then particularly in the relationship with their intimate partner and

experience of violence. I then summarized the descriptive results for each section of the interview guide in Excel by participant, allowing a clearer understanding of each participant's interview and then also for comparison for the important categories based on the literature and the evaluation framework that was used to guide the interview tool.

In the second phase, on October 16, 2014 we interviewed the research investigators on each interview they conducted to gather additional information that they gleaned outside of the recording in the consent process or after the interview. We asked each of the interviewers to go into depth about the experience of interviewing each participant. They shared information on the consent process, additional points that came up when the recorder was off, and any information to fill in between the lines from the community research investigators' points of view. This process added a lot of background and insights and also indicated their point of view on what was discussed. Our discussions with the community research investigators helped with my interpretation of the results as well as assessing the benefits or drawbacks of the peer-interviewing approach. We also asked them to go section by section of the interview guide.

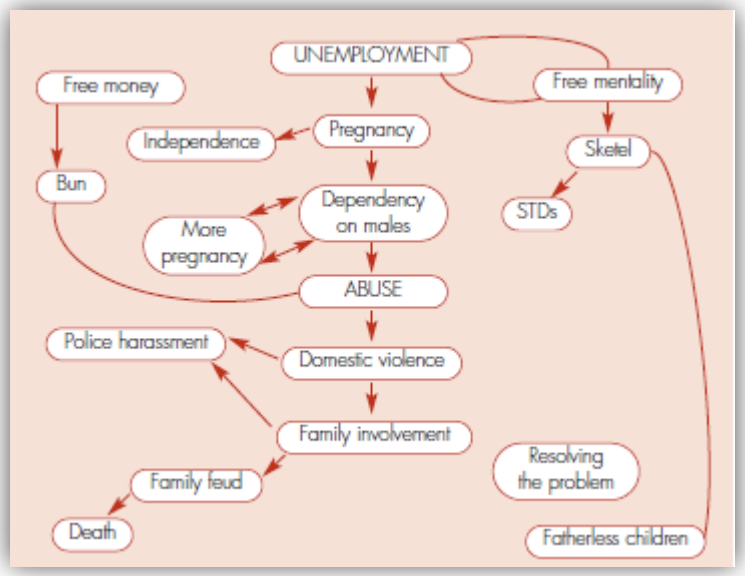
In our discussions with the community research investigators on each interview we developed lists of the main points from each interview. Keeping these in mind, the community research investigators helped to summarize the most important findings for each interview guide section across interviews, which were then presented to the research committee in our next analysis workshops. I put the main points into a PowerPoint presentation for Vinitha to translate to Kannada so that she could review it with the community research investigators. For the sake of confidentiality, the community

research investigators were part of the analysis of the individual in-depth interviews, while in the workshop analysis aggregate findings were used by keeping the individual in-depth interviews anonymous.

The third analysis step involved the interpretation in collaborative analysis workshops that we held on October 27-28, 2014 in Bagalkot. The community research investigators presented important findings in *Kannada* to the research committee, which were then interpreted as part of the next step of "meaning-making" in the analysis. The response from the research committee was that everything was "correct", a part of their daily experiences, and what they knew from routine work at the CBO. One concern was about what the immediate benefits to the respondents had been. The community research investigators responded that they could not guarantee to participants any direct benefits, except perhaps from sharing with a peer as reflected in some interviews, but that they told the respondents the benefit would be to inform the CBO's programs to help the community as a whole. The counsellors from the intervention team were also present and shared their experiences from counselling, which supported virtually all of the findings from the in-depth interviews that the community research investigators presented. Thus, our findings were confirmed or triangulated, and a degree of saturation was reached in this way.

For the community analysis, I had considered the best way to make meaning of the descriptive results by involving the research committee members. In the literature there is little previous work on collaborative analysis with communities, but only within academic teams. I drew on the WHO's document on researching violence against women

that uses the approach put forth by Miles and Huberman (1995), including data immersion (reading), data coding, data display, data reduction, and interpretation/conclusion (104). In line with the steps described above, I first undertook immersion, coding and displaying, which formed the basis to complete data reduction and interpretation collaboratively in the workshops. Then the group analysis approach that we used included an adaption of card-sorting and causal flow analyses as in the WHO diagram below (104).



Example of a Causal Flow Analysis Diagram from the WHO (104)

During the workshops, we formed two groups composed of one community research investigator each, the KHPT research investigators and counsellors. I wrote out each of the main findings from our descriptive analysis (as categories) by number on small sheets and Vinitha wrote them each on separate sheets of paper, making two copies of each in

Kannada, which we gave to two separate groups. We asked the groups to arrange the sheets to show which points related to one another, with violence and condom use in the middle. Initially the number of points was overwhelming. Also, not all the research committee could read the points. We changed the instructions so that the research investigators or counsellors put the condom use and IPV sheets in the middle, and read out all the rest to decide which points were most closely related to consistent condom use and intimate partner violence outcomes and therefore most important, and which were less important and placed further to the periphery. They grouped like points together as well. Thus it made more sense to them and the final diagrams were produced. This started more dialogue between all the members to prioritize and debate, and a lot of rearranging went on before the final placements. Then each group had a representative explain why the group arranged the diagram the way they did. The KHPT researchers and I participated in both groups and asked questions after presentations were made for clarification and delving deeper into the issues. Then we turned over the sheets to see the numbers and took a picture that I could decode to produce an English version. This helped to link categories and prioritize themes around the research questions as a mode of thematic analysis. The Causal Flow Diagrams from these community analysis workshops are provided in Appendix F, Figures 5 to 8.

Finally, I used the results of these collaborative stages of analysis to inform the descriptive analysis I had summarized in Excel. This allowed me to link categories as a basis to develop explore the importance of the intimate partner relationship within the

participant's relationship structure and where violence fit within this, to answer the research questions including:

a) What is violence and how does it affect the participants' lives?
b) Why do participants think violence occurs in their intimate relationships?
c) When and why is violence acceptable or not?
d) What do participants do to prevent or deal with violence in intimate relationships?

I then analyzed how our results could be interpreted in light of, and contribute to, other research and theory on the relationships between context and health behaviours and outcomes to answer the "why" and "how" questions.

Chapter 4) Results

4.1) Descriptive Results

Socio-demographic Characteristics

Participants' names were anonymized and pseudonyms are presented in the Results. Women in the study were between the ages of 24 and 47, with an average age of 34 years old. All of the interviewed women had never married, though a couple reported having a registered marriage with her lover, and all were *Devadasis*, though one in her interview said she did not start sex work in this way. Women had between one and five children except for two who had no children. All women except one identified with the "scheduled caste" status, with many being of the *madar dalit* scheduled caste.

According to KHPT's quantitative baseline evaluation survey data for the qualitative participants, collected earlier from the participants by separate research investigators, all but two women carried out work outside of sex work. Respondents made half to all of their income from sex work, earning between 500 and 9000 rupees ($10-$170) per month, and the rest coming from work in non-agricultural or agricultural labour earning from 1500 to 4000 rupees ($30-75) per month. Most of the female participants started sex work at age 13 or 14, just after puberty, with the oldest being 18 at initiation. The majority solicited clients from their home, and otherwise there was one woman respectively who said she conducted sex work in public places, in a vehicle, or through contact by phone. The maximum client volume per week was five clients on average, with most women saying they had two to three clients per week.

All the women in the qualitative study said they had one intimate partner and that they refer to him as *hiriya* or *malak*, or less commonly, boyfriend or lover. About half of their intimate partners were literate and all were married. Most were agricultural or non-agricultural labourers or cultivators and about half were Scheduled tribe or caste rather than general caste. The length of their relationship ranged from 4 years to 25 years with an average of 13 years, and half of their partners started as clients. Only a few women said they saw him every day; most said that it was at least once a month or a few times a year. A quarter of women said they had children from others than their lover, and only a quarter of their partners reportedly knew they were in sex work. According to the quantitative survey results, all but one of the women said their partner helped financially support her family and accompanied her when she went out, provided protection, or helped make important decisions sometimes or always. Most women felt respected by their partner often or always. Two-thirds of the women also said that they were occasionally or frequently afraid of their lover but only a handful said there was some or a lot of tension in the relationship. A third of the women said they used a condom at last sex with their lover with another third saying they never used condoms.

Intimate partners who were interviewed as part of the current qualitative study were between ages of 21 and 48, with a mean age of around 36 years old. Their occupations were working on agricultural land, in construction as a contractor, working at a petrol bunk, and as a driver and shepherd. A couple of them who were from the region had large families that they cared for, one with multiple brothers and another with five children. Another intimate partner's family was from a northern state and he was not in

contact with them; he considered his lover's family and their four children as his own (though the woman revealed confidentially to the community research investigator that one of the children is not his). Similarly, one of the intimate partners was somewhat out of touch with his own family as he did not support them and they were less than pleased that he chose to marry his lover. One of the intimate partners had education up to 5th standard (grade), another studied up to the second year of Commerce College but dropped out, and the others did not have any formal education. One man commented that though he did not go to school, he had as much or more knowledge than those who are educated. Their wages varied from the driver who made on average 100 rupees ($2) per day, to the construction contractor who currently made 3-400 rupees (almost $10) per day, though it was much less before he moved up in his job. All the intimate partners were Hindu except one who was Muslim. Most of them were married, with one having a registered marriage to his lover, while one was never married. However his lover commented that she felt he may get married one day if he goes back to his home place; still he was adamant that he wanted to stay with her life-long. One of the intimate partners said specifically that he was of the *madar* caste, which is recognized as a scheduled caste by the Karnataka state government. This also indicates that he is of the same caste that most of the *Devadasi* women are from, including most of the respondents. Yet others were from higher castes than their female partner.

Relationships and Supports

Female and male respondents provided information on the important relationships that were in their lives at the time of the interview. Most mentioned their mothers and

their intimate partners were the closest to them. Also important in most of their lives were their fathers, if alive, siblings, and children. Some also had an aunt, uncle or grandmother who was particularly close or supporting them. Respondents mentioned friends, peers, and clients where relevant, near the end of the list of important relations, and not all were very close to them or relied on them as much as close family and lovers for support.

Supports that they gave or received from these relations fell into the categories of emotional, material, domestic (e.g. cooking, cleaning, or ironing clothes) or health-related supports (e.g. help in linking to hospital services or blood testing). Female respondents often stated that their mothers, if present, would support them emotionally or domestically. All women also cared for their mothers by bringing them to the hospital when ill or providing household needs. Most women greatly supported their brothers or other family members with money or domestic support, and many got some support when needed in return from family. For example, Nandhini stated that she cooked and cleaned for her brother and his wife. Sangita also said that she would do anything for her parents, brothers' or sister's families need; she said she even paid nearly 200 000 rupees (around $3770) on their hospital bills, as well as paying for her siblings' marriages, giving them land, and caring for her brother's and sister's children:

> *I take care of them more than I take care of myself… I don't care how much I need to spend, but I want them to be happy and healthy… My younger brother drinks alcohol heavily. He is living separately, but his sons live with me; I am taking care of them.*

In this case, she said that her sibling's situation was worse than her own; they relied on her greatly but could not give anything to her in return. However, her aunt and uncle were

able to financially support her, and so did her intimate partner. It is often the case that women who begin sex work become the bread-winners in the family, as expressed by Sharmistha who reiterated that,

> *I have shouldered the whole responsibility of the family like a man… I am leading the family by shouldering all the responsibilities even more than a male member.*

Further, Indu stated that her brother had lost all the money they earned earlier to alcohol and gambling, showing how the women's family members can become dependent on them financially:

> *When we were in Goa, we earned lots of money. However, as I did not understand anything then, I used to hand over all the money to my brother. But my brother bankrupted everything including his own earnings. Now we take care of ourselves and look after our own bread and butter.*

In this way, women often played a large role in supporting many family members.

Most respondents had younger children for whom they provided education, clothes, hospital costs and school supplies. For those with children, they usually provided love and affection in return, and women hoped that as their children's positions may be improved as adults they could support them in old age. A few of the respondents who were above 40 years old had children who were adults, or had daughters-in-law, who cooked and cleaned in the home or helped with expenses.

Peers from the sex-work community most often provided condoms or information on health, helped with CBO membership, helped to get loans from the CBO, provided resources to solve problems, or took them to the hospital for blood-tests. Some peers were also considered friends but in other cases the women reported that they did not really go out or socialize. Neighbours were not a significant part of anyone's social network but

Veena stated they discussed common things casually together. Clients also did not provide emotional support but were said to be important and sometimes essential because of the financial support they provided to the women. The women said they sometimes provided clients with emotional support. Some women also stated that they had now stopped sex work, which correlated widely with their partner's support as well as his expectations for her not to continue sex work.

There were few cases where respondents reported problems in their social relations. Parvati stated that she had fought with her sister; her family also scolded her lover not to come there and had problems with him as a result. Sangita related that her brother drank heavily and was estranged from the family but she cared for his sons. Indu expressed the greatest family conflict, due to her choice to stay with her intimate partner despite both their family members' disapproval, which resulted in reduced family supports to her. One intimate partner related that he experienced tension between himself and his step-mother, due to his relationship with his own mother and his lover, in which case his lover became an even more significant source of emotional support. He and another intimate partner also felt that his family would be angry that he did not spend enough time with his family and his wife but stayed with his lover.

Overall the main problems that both women and men faced were financial. For some women this occurred because of large hospital bills for their mothers, their own delivery at childbirth or other health issues, and especially when they needed to pay for children's school fees. However health and education were incredibly important to respondents and they relied in part and sometimes completely on intimate partners for

financial support for this. In terms of intimate partners' experiences of financial problems, Manjunath faced difficulty because he supported six family members including his own family and his lover's. Intimate partners also had stress related to the financial challenges of maintaining two families. For example, Manjunath expressed that he still had a good deal of difficulty providing for all those he supported. He felt it would be difficult to achieve his goal of starting his own business, which prevented him from living as happily and carefree with his lover as he would like. Ajay also experienced financial issues but relied on friends rather than family for a loan due to the tensions between himself and his step-mother. For Ravi, tension also arose from work. Another partner had been diagnosed with HIV, but felt that though he made some mistakes in his youth, his goal was to stay happy and healthy with his partner who also tested HIV-positive. They were both on anti-retroviral therapy, using condoms and working as counsellors to help other people.

Coping mechanisms for all who mentioned financial trouble included borrowing money from others, especially a family member, intimate partner, or close friend, taking a loan from the CBO, or finding more work, including sex work for some of the women. For other health or social problems they called a family member or a peer. Overall, being a member of the CBO was also a great source of self-worth and support, such as the ability to give and get loans from the micro-credit program to help each other, and to stand up in cases of violence as a group of women. Two of the participants had also been peer educators with the CBO and expressed feelings of self-esteem from this occupation. This was made possible in part by the fact that their lovers were not with them very often and allowed them a good deal of mobility. A couple of male partners mentioned that

drinking became a coping mechanism and some mentioned that they relied on their female intimate partners for emotional support. Thus respondents relied on many supports and safety mechanisms, some having more than others, in order to maintain well-being and happiness in the face of any problems or challenges that occurred in their lives.

Characteristics of Intimate Partner Relationships

Within the social relationships that women had, their intimate partners were important and often a crucial source of material and emotional support. Most of the intimate relationships in this study started when the woman met her partner in the village as a client or otherwise in the market, at a function, at a CBO event, or through mutual friends. As explained by one FSW, originally her grandmother encouraged her to take him as a client because she should provide the "bread and butter" for the family. However they developed a mutual attachment so that he became a permanent partner who was "like a husband", and thereafter he supported her financially so that she did not need to search for more clients:

> *Interviewer: You would have gone in search of clients?*
> *Respondent: Yes, but I liked him most and I never had a thought that I should go in search of clients. He was also taking care of me very well by giving more and more money whenever he was having it.*

In one extraordinary case, the intimate partner who was from a distant state related how he met her in a large city where she was doing sex work, and when she left for a death in the family he searched across Karnataka to find her, eventually ending up in this district and staying with her ever since "like a husband". The relationship lengths ran from just one year to over 30 years. Most of the married men had had an arranged marriage before

he met his partner, but a few men got married by their parents to another woman after their intimate relationship started. In either case, about half of the men had children in both their marital and intimate partner relationships, and the rest either had no children or only one with the study participant. Some were from the same village and this affected in part how often she saw him because he had to be home with his own family enough of the time. For a few of the couples, the man lived with her almost all of the time, but the rest came between every few days to once every month or two.

All of the women but one reported that their intimate partner came both for love and for intimacy, as Kaveri told the interviewer:

> *Interviewer: Okay, you said he comes to your home and shows love and affection to your family. How?*
> *Respondent: It is not about just giving and taking. It is beyond that. He does everything from the bottom of his heart. It is proven in his actions. No one supports either financially or in any other way without having love. He doesn't come here just to satisfy his lust. He comes here thinking that he has family over here. For that he offers everything.*

Like this woman, others greatly emphasized that their partner provided support, love and affection as a husband would. At the same time, some of the women did not feel they should count on him to always be there for support, and made an effort to ensure she had what she needed for the future in case the relationship ended.

Intimate partners also expressed in great detail how they met and the relationship that they shared. They all mentioned that they came to love their partners for their good qualities and wanted to be with them permanently and thereby take responsibility for their lives. Many of the intimate partners expected their partners to leave sex work after the start of their relationship and his support for her, but around half of the women told the

interviewer that they still did sex work without him knowing. One man said that he did not like that he started their relationship as a client of hers, revealing his attachment to her but also the dislike of her engagement in sex work in general:

> *I felt she could continue to take money or something from me because first, she came to me for the sake of money and later she fell in love with me. First, she saw my money and then my heart. I do not like that, anyone should see the heart first and then the money comes, yet I gave (money) to her. There is no use if they waste their life for money.*

All of the male partners interviewed were confident that their lover cared for them and that this was shown in their actions.

All women stated that intimate partners provided important to crucial material support, which was often termed as "taking responsibility of", "maintaining" or "running" her life. This included the expectations that he buy clothes or jewelry, provide regular sums of money to help with food or bills, sometimes for her children's birth or marriage, or to build a house or open a shop for her. Lakshmi stated that her IP also gave emotional support including love, and helped take them to the hospital or care for her family. Likewise, Veena stated that her partner showed love by caring for her family, but she asked him for more money and he did not provide it; this correlated with the fact that she did not feel much loved by him. Predominantly, men and women in the study likened their relationship to a marital relationship, as Manjunath expressed:

> *She was Devadasi so they will have that sex work, which she left... She promised me that she will not do such vulgar work and I have promised that I do not get addicted to bad habits. She followed her promise and I have followed my promise. I do not cross it if she marks a line. We were more than like a wife and husband…Yes, everyone knows about this.*

Similarly one man responded that he took her as a registered wife without his parent's permission:

> *I fell in love with her in a weak moment and it became a strong love between both of us. We became like a good pair as wife and husband; she is like my wife. She is as equal to my wife; we do not have any fight.*

His female partner also expressed that it is most important to her that he treat her as his wife. Padma stated that they share everything as husband and wife and he solves all her problems. Similarly, Bharati emphasized repeatedly that her partner of over 30 years became like a husband in her youth, and allowed her to stop sex work right away by providing everything for her:

> *I always recall how our living conditions were before I met him, compared to how we are now. He made a lot of difference. He gave three children; he cared for me very well whenever I fell sick. He took me to many temples, he took me on trips; he has done everything for me… Even in hard times, he hasn't been away from me, we faced everything together… I don't see such a scene in a dream also. I have complete faith in him. It's a really great thing to be proud that we are in a relationship from the last 34 long years. It is really amazing. I don't think you will see another example of such that being bound with one person honestly and having three children, and still loving each other with immense trust is not a joke.*

In this way, being like a married couple was held as an ideal and related to the aspiration for a socially and legally-sanctioned male-female relationship. Sharmistha said that her intimate partner of three years was currently unmarried and they would like to marry if his family would approve. She said that today there is a shift away from *Devadasis* working in sex work because the practice is now illegal and seen as the reason for the spread of HIV. Thus, for their relationship to continue and to be acceptable it should be distinct from an affair or a client relationship by becoming a marriage. Further, in one couple case in which he left his wife and they wanted to have a registered marriage,

Manjunath, referring to his partner Nandhini, stated that their relationship was *"more than a husband and wife*" relationship, inferring that it is closer or more intimate than the average marriage. One intimate partner's comment helps to explain that this was because theirs started as a love relationship unlike the usual arranged marriages in the region:

> *In cities, people love a person first and then marry another one. However, that does not happen in our villages. We marry the girls whom our parents select for us. So, we adjust with that girl and never leave her. In any case, we will have a lover; no one is disturbed because of this. We have a lot of pleasure in that relation even if we get to meet only once in a year. That feeling [he said heart] is different [with smile].*

Still other men responded that their families were not pleased to know that they had lovers, especially being *Devadasis* and therefore having been with many men, reflecting stigma that is attached to both her profession and having extra-marital relationships. This is expressed by Amisha, who said that her lover is known as a husband and she a wife within the community, calling it an 'open secret' because it is awkward to publicly use the terms lover or *hiriya*.

Female respondents all stated that they provided food and cared for their partners when they came. Sita and Shanta, and especially Parvati, stated that they gave money to their partners as well. In this way, support between intimate partners was mutual but not equivalent. Caring for him materially was also reflected within male respondents' accounts as a way that their partners showed their love for them. The intimate partners who were interviewed felt that they had already come to achieve their goal of happiness to some extent, with a large component being their life with their lover and their children. This shows that the couples in the study had fairly good quality relationships in their

view. However they had the hope that their relationship could be even more accepted and respected in society, and remain life-long, as one intimate partner responded,

> *As long as we live we want to eat together and share roti [bread]; I want to be happy with my children.*

Similar to their female partners, other men mentioned the importance of their children, as well as their education and ability to get a good job and status in society. Thus, their responsibility to their partner and their children was important to most of them.

4.2) Results on Intimate Partner Violence

Research Question 1: What is violence and how does it affect the participants' lives?

Intimate partner violence was rarely the central feature of the interviews in this study. However it became clear that there were differing types and levels of violence deemed note-worthy when participants were asked about fights and violence in the relationship. All but two women said that they had fights, with at least mutual scolding or controlling within the relationship and in almost all of these cases some physical violence was reported. In only a few cases did the woman say that physical violence occurred routinely, but there were a couple reported incidents in which the woman ended up with a bloody head or having pulled hair. In one case, the woman expressed that she had scratched him and bit him badly on a few occasions out of anger from him insulting and beating her. Evidence of emotional violence included reports of manipulation, blackmail or controlling behaviour, but this was never expressed when answering questions about violence. In this way, "violence," or *himsa* in *Kannada*, was for the most part equated with physical beating of various kinds.

There was a range of responses to questions on violence from male partners in the study. Some said there was no violence that occurred, even when the female partner reported controlling behaviour as well as beating in a couple cases. A few men said that they had beaten their partners earlier in the relationship, such as Krishna who said he had not been mature and did not control his anger. These men said that later they did not fight besides some arguments or scolding each other in "comedy". The research committee explained the concept of "comedy" meant that women and men may have slapped or scolded each other around common disagreements but it was not considered serious, as Manjunath related that,

> *I beat her when I am joking with her, it is in comedy… Comedy means while we are joking to each other I beat her and she beats me.*

This was confirmed as occurring by their female partners. In one of the more outspoken accounts about violence, an intimate partner reported beating his lover rarely, or as he stated, once per week, fortnight or month. His partner also discussed how incidents of violence occurred when he became angry and that he had beaten her recently. Thus, when asked about violence, women and men defined this as a physical beating that caused injury, and not generally including controlling, emotional or sexual violence as included in the WHO definition of IPV (1). Violence was generally seen as a topic to be discussed with care and in some cases, the interviewers felt that occurrences of violence may have been concealed or played down, particularly by intimate partner. Still, a number of partners were open about when and why violence occurred in their and other relationships.

Research Question 2: Why do participants think violence occurred in their intimate relationships?

Though relationships provided much support in respondents' lives, a web of issues within the intimate partner relationship also provided potential reasons for fights and violence to occur. The most important reasons for violence found through analysis of the interviews and in the collaborative analysis diagrams and discussion were: a) expectations held by each partner for the other; b) distrust related to infidelity and engagement in sex work; and c) acceptance of violence by women, their partners, their families, and the society as a whole. All of these issues were linked to each other and to additional layers of issues, including personal circumstances and relationships, intimate partner relationship characteristics, attitudes and social norms. Thus these links will be compared and explored where relevant, particularly in light of the interpretations made by the community Research Committee.

a) Expectations in Intimate Partner Relationships

Numerous female and male participants stated that unmet expectations, particularly in relation to money and gender roles, were triggers for disagreements, emotional violence, or mild to serious physical violence. The qualitative analysis revealed that "expectations" of their partners that were shared in the interviews were most commonly also the triggers of violence when unmet. In addition, when presented as a category that the community research investigators identified from the interviews as being important to the community analysis, the research committee placed this as one of the

most proximate issues to the experience of emotional and physical violence in intimate relationships.

The unmet expectations for intimate partners expressed by some women included theft, chewing *gutka* (a type of tobacco), or alcohol consumption. These activities sometimes triggered fights between them. However, the main issue that caused conflict was women's expectation that their partner be present and provide financial support or material goods. These demands were also seen to be an important trigger for violence according to the research committee and intimate partner counsellors in the community-based analysis. In this way, Sangita stated that most of their quarrels occurred because of mutual expectations:

> *Interviewer: You told that you quarrel with each other, what is the reason for that?*
> *Respondent: We quarrel while giving or taking a few things. I shout at him if he delays his arrival after fixing the time for going to the market or elsewhere. He starts giving reasons like he had some work on his land or this and that. He will take me to the market next time. We quarrel when there is any delay in giving or taking things, that's all.*

One reason this led to fighting or violence was that male partners often had financial difficulties supporting both families or had occupational challenges. For example, Manjunath stated that it is challenging to make enough money but he must support her:

> *We need money to give, isn't it? One man is earning and there are four people to sit and eat those earnings. Nowadays we do not get anything [like water, firewood] at a cheap rate…*

Pestering by female partners often caused much frustration for a number of intimate partners, leading to verbal or physical violence, as Ravi expressed:

> *For the sake of children, for the sake of money, and for household things etc. one or the other problem will be there. She fights with me if I do not go there for two weeks and if I do not give money when I did not get salary.*

Similarly, Krishna stated how this pressure had caused fights earlier in their relationship:

> *From the starting days I have responsibility of my family and here. I have to take care of my family and my brothers… I have to think about the future so we had some fights when she says to come to [her] home regularly.*

From the women's perspectives, these expectations for support related to their hopes for the future of their families and their well-being, including the understanding that they will stop earning money from sex work in many cases. This also related to their aspirations for a higher social status symbolically and materially by having a partner like a husband to support them, and thereby fulfilling male gender roles in the relationship by "taking responsibility" for their female partner's lives. There was evidence that these aligned with social norms by the fact that their families held the expectation that if he comes to her, he must support her. For example, Veena expressed how her partner did not meet these expectations:

> *Interviewer: Ok, how is the relation of your lover with your family members?*
> *Respondent: They are good. They do not say anything in front of him. They can say only to me when household things are not there.*
> *I: What do they say?*
> *R: They say that he is ready to sleep with me but does not get the needs of the house. They also lament that it was we who allowed him, thinking that he will take the responsibility, but he has spoilt my life.*

Unlike most of the couples, this woman said that she supports her partner more than he does her, and thus she does not care for him that much. In line with the gender role expectations for a marital relationship, she stated that it is her expectation that he provide for her as the basis for their relationship:

> *Interviewer: You feel that he should give money and that is enough.*
> *Respondent: That is enough for me, if he says that he will treat me as equal to his wife, do I need to go like I am madly after him?*

This negative case, in which she supported him more than the reverse and therefore felt less attachment to him, further illustrates the way that unmet expectations that seem to reflect social gender norms can lead to conflict. Exposing some of the deeper reasons that expectations led to conflict, Rani stated that it was very important to her that he treat his wife and her equally, gifting her things that he provided for his wife or that other women had, like a *mangala sutra* (gold marriage necklace), mobiles and a television:

> *Interviewer: Okay what are the other examples of fighting between you?*
> *Respondent: See recently I asked him to buy a mobile phone for me. He has bought a touch screen phone for his wife; I also demanded for the same phone. He shouted at me saying that I was asking him for everything that I had seen. I told him don't touch me if he couldn't buy it for me… He agreed then… I told him that all my friends are in high-level. They insult me if I carry old model phones. I had forced him in that manner.*

At the same time, her intimate partner acknowledged that he may beat her non-seriously or in a "joking" manner, like to call her to make food for him. However he stated how he felt that expectations should be fulfilled mutually to avoid continual conflict and violence:

> *If I give her trouble immediately after coming to home, how can she manage? So I have to listen to her and judge myself what is right and what is wrong so as to have a good life… We both should listen to each other and act accordingly. If I follow my own way, she will also do the same thing. The life shouldn't be like 'dosa [flat bread] at everyone's home has holes'.*

Hence he expressed a common notion that intimate relationships should not be seen by society as resoundingly conflictual, even though all homes face challenges.

The expectations women held for their lovers' support related in part to the financial and social exclusion that they faced as *Devadasis* who are or were in sex work.

This was both the motivation for them to desire a better future for their children and the greatest challenge for its achievement. For example, women said they had great financial strains as the main bread winners for their family members and were not able to marry to gain long-term assets, as Kaveri expressed:

> *Interviewer: What could be the reason for this [women being harassed]?*
> *Respondent: Why because, the women are economically poor. In case they don't get money from the men, there are chances that they become apart. That is the reason the men take advantage [harassing the woman]. The women don't allow them inside if the men don't take care of them, they only allow when they give money or something in the proper way. If the men don't give, women avoid them, and then such violent acts take place in their relationships.*

It was important to women that they see their children become educated, married, and thereby obtain higher status so as to support them in their old-age and ensure their children will not face the types of exclusion they did, as Amisha stated:

> *I spent for their education and I am ready to spend further whatever the amount will be, but they must learn well, study well. They should become intelligent… Yes, I want them [my daughters] to achieve something. Falling into this profession, I cannot change my fortune now. I am a devadasi, and I will be devadasi. This brand won't be perished.*

In addition, she stated that sometimes because her partner had a drinking habit, he did not listen to her and failed to meet her expectations for monetary support or care for her children as much as those with his other wife, which she found intolerable:

> *Respondent: I think he is taking care of them well more than my children. And here, I am the both dad and mom to my children. If I ask him to bring a notebook for my children, after 4 or 5 days then he brings. In the case of his own children he fulfils this immediately. That is why I am working a job. Few days, I am fed up with him…*
> *Interviewer: Have you fought each other recently?*
> *R: Yes, as I said I fought with him as I wanted him to deposit some amount in the name of my children. Once he said, "I didn't deposit, what will you do. I am not dead yet, still alive. I am planning what to do'. I said, "You are doing everything*

> *for your wife and children, you are not doing anything to my children, will you share the property? You are not depositing any money, and wasting all the money to drink only. What will you do for our future?" When I ask like this the fight starts.*

However, she said physical beating from his side also occurred sometimes when she went out without him knowing, though she said she fought back once by hitting him with her sandal because he insulted her in public. Many other women, especially those who had fairly frequent or long-standing interactions with their partner, also related their goals to the expectations they had for their intimate partners to support their families' futures. This was reflected in Shanta's account that her children should not enter the same life in sex work that she has and the lover can aid in this goal:

> *I have to give a good life to my children; I have to send them to a good family. I want them to get a good education and a good life. They should not become like me and they should not face the comments that they are daughters of such women. People should praise me that, even though she is a Devadasi she gave a good education to her children. I have that desire that they should not face the words as 'her mother is a Devadasi and they too became a Devadasi'. They have to praise me that, she had a lover and he is good with her so he gave a good life to her and her children.*

In this way, women relied sometimes completely on their partners to fulfil their desires to give better lives to their children. This led to fights mostly when she felt he did not provide enough while he faced economic strain or simply reacted out of anger in reaction to her chastisement.

Violence was also often said to occur when the female partner contravened the gender role expectations her male partner had for her. These types of expectations that surrounded appropriate female behaviours were common across interviews, suggesting ascription to norms for a male-female marital relationship. In one extreme case, one of the

women mentioned that her partner got angry whenever she did something that he disliked, particularly when he was drunk. Men's expectations for their female partners included that she should cook and clean for him, satisfy his sexual desires, not leave the home, and to be "good" with him. The contravention of such gender role expectations were universally classified as "mistakes". Such "mistakes" that led to violence were expressed by Ravi when he said that,

> *Any man will get angry if women do mistakes. He will not get angry if she cooks and serves properly and she obeys them.*

Though less commonly expressed, one woman shared how her partner expected to have intercourse more frequently than she liked:

> *I cannot do sex excessively… He wants to do sex on every alternative days. I cannot do it frequently. I say him to come, be with me, spend some time with and go. Then he argues with me.*

Similarly Rani expressed that many men will force their female intimate partners to have sex in any manner they desired, but if the woman rejected it they will beat them. Another expectation for women that Rani and other female participants expressed was that they should not leave the home nor get dressed up and go out:

> *They [partners] doubt the women, they question that why she gets ready beautifully, why she goes out. They force the women to stay back at home, they restrict the mobility of women, so violence takes place.*

This was an expectation particularly held when the male partner was supporting her, as Manjunath stated:

> *I do not send her outside, when I am earning she has to be in the home.*

In other cases, male partners helped their lover to find work other than sex work, but none of the partners accepted their engagement in sex work. Implying they held mutual expectations, Ravi stated that,

> *If I am good with her, she will be good with me. If I stop giving money today she starts working [in sex work]*.

Women in the study also expressed how their partners made them stay home, and if they did not it led to fights. Further, Sharmistha revealed that this expectation may be held because it is like marital relationships:

> *If I go somewhere [without permission], he argues with me; he doesn't like if I go somewhere, he doesn't allow me. We are like married couples. If I need to go somewhere, I will inform him and go, he also does same thing. He doesn't allow me to go anywhere at all.*

The importance of fulfilling expectations was also revealed when women stated how they used to have fights and experience violence, but now they had adjusted to ascribe to these ideal characteristics. For example, Padma stated that she used to go into town with her friends who her lover did not approve of, but this was no longer a source of fighting:

> *Nothing now, earlier we were fighting but now we are happy. Yes that was in my teenage years, I was quiet when he beat me. He was beating me when I went to roam outside [to the market or shopping]*.

She stated that this was related to the view held in society that if their relationship was good, there was no need for her to go around in public, making him question her. Additionally, Krishna related that this reduction in violence over the course of a relationship was related to his ability to control his anger more now as a 46 year old than when he was young and undeveloped:

> *Earlier my mind was not much developed… When we are young we get angrier… But it depends on our control to handle the situation and show our feelings properly. Our love is very important than everything and everything depends on it.*

b) Issues related to Distrust and Engagement in Sex Work

One of the most common and inflammatory issues underlying the occurrence of violence according to the participants was the distrust and fear around infidelity between partners. This was identified by the research committee in the community analysis and confirmed in the overlap between issues I coded as "trust, honesty & fidelity" and "triggers of violence" in NVivo. There were cases in which both women and men fought with their partners based on accusations of infidelity, which were always denied. In a few cases, it was clear that the women were wary that he should never show affection, in a couple cases to his own wife, but most certainly to other women. In one case of clear distrust from both partners' sides, Ajay related how his partner suspected him of infidelity when he was being friendly with another woman in public:

> *I was out of station for as many as 15 days; I had been to work… I hadn't called her over phone at all. She started shouting at me saying, 'you have left me for fifteen days, you are not caring for the family, and the child's health got upset'. I said, 'I will come and take the baby to the hospital, you don't worry'. She was not at all stopping, she kept on questioning me…There was a girl who is the friend to my friend, I was talking to her by holding her hands, then my wife [lover] saw that and misunderstood it and started crying and ran back to home. In that anger, I had beaten her. I said to her that that lady was like a sister to me, but she still did not believe me and kept questioning me. She said, 'you held her hands in front of me itself, what all can you do in my absence'.*

He went on to express how this made him angry enough to beat her on numerous occasions:

> *If my phone remains busy when she was calling, she doubts me saying that I am in another relationship, with someone. I become upset then. She blames me like this.*

> *I smack her then. She doesn't eat anything for couple of days, she keeps quiet herself. After couple of days, we again become normal.*

In this way her suspicion around his suspected infidelity, and related expectations for fidelity as in a marital relationship, was a major source of conflict. This was added to emotional attachments that led both partners to expect fidelity and otherwise react out of jealousy.

Distrust from the man's side related most greatly to the strong disapproval of her engagement in sex work. Men universally held the expectation that their partners should stop sex work and if they did not, this was expressed to be the greatest "mistake" that women could commit that led to violence. Though most of the women were currently doing sex work, at least occasionally, almost all the women stated that the only person who did not know this was their partner. At the same time, all the intimate partners commented that they made their partners stop doing sex work when their relationship started. For example, Ajay gave a detailed account of his expectation for her to leave sex work since they met; they had been one of the only couples who got a registered marriage despite him being previously married as a child:

> *She looked at me and walked away keeping her head down. Later I went and proposed her straightforwardly. I told her that I liked her calmness very much. She also proposed me and following that she revealed the dark side of her life. I said, she had to leave that (sex work) profession, if she was really liking me. I assured her that I would not make anything shortage for her. I also told her that she needed not to spoil her health; I was going to marry her at the cost of my parents so that I wanted her to eschew the sex work profession completely. Once I told her like that she agreed. Later we got married [registered]. She also asked me that whether she could join some other jobs. I said except sex work, she could choose any other jobs. I also warned her that she should not play double game- I meant having relationship with someone in my absence was unacceptable.*

Indeed, male partners almost all shared the attitude that if they were supporting their female partner, they did not need to go out or earn anything, or at least not from sex work, which relates to the expectations held in intimate partner relationships from both sides. If she secretly maintained sex work it would lead directly to violence. From Rani's perspective, she admitted that her partner caught her red-handed and yet he compromised first and they made up:

> *He shouted at me saying that I was not at all trustworthy to him despite the fact that he had done so much for me and I had looked for other client. He questioned me that, what he has not done for me? On that day, I had been caught by him red-handedly. I couldn't answer him and kept myself silent. After that I again started using the phone with the same SIM card. I rang him up. He didn't pick up my call. Later he started telling me that he was busy and he was out of station. He started giving reasons every time whenever I was asking him to come and meet me. He told me not to dial his number. I thought that he was in an angry mood, so I just made up myself and left it then. Then, he himself called me after 3 hours or four. He hadn't talked to me for as many as two days, on the 3rd day he called me. It has been happening always. He is catching me red-handedly every now and then. He scolds me, beats me, I cry. He makes up with me. He avoids me for couple of days and comes himself later. How can his love towards me allow him to avoid me completely?*

In this way, a number of women indicated that their partners were monitoring whether she was engaging in sex work, either through their social networks or by setting phones to record conversations so that they could listen to them. This type of suspicion, apart from providing emotional abuse, led to violence even if she was not engaging in sex work. This related to men's expectations for female partners to maintain modesty by staying in the home and especially not associating with other men or women in the sex work community. This occurred when Lakshmi said she went to participate in a CBO activity:

> *I went to another village to participate in a drama. When I went there I spoke with a person on the phone. He heard that recording and beat me.*

Another woman reported that her partners' friends had falsely reported to him that she did sex work though she did not, and this caused violence on a couple occasions. In other cases, disagreements resulted when the male partner found a client leaving her house or that he heard her speak directly to them on the phone, as Nandhini related to the interviewer:

> *Interviewer: Do the doubts on you bring disagreements between you?*
> *Respondent: Yes. It happens.*
> *I: How does it happen?*
> *R: He doubts on me and he checks my phone that with whom am speaking and who all calling me.*
> *I: You said that he does not put any conditions on you and now you are saying that he checks your phone.*
> *R: He caught me once I am talking with another person, from that time he started doubting me.*
> *I: What do you say in such times?*
> *R: I will tell one or the other lie.*
> *I: You lie, what do you say?*
> *R: I tell that any of our relatives called me or I will tell my brother had called me.*
> *I: Does he believe?*
> *R: If he believes he will be silent otherwise he calls back to the same number.*

Similarly for Sharmistha, though she said she had a strong relationship with her partner of three years, she linked their desire to be a married couple to the expectation he had held from the beginning that she stop sex work. Though she was adamant that she did not do any sex work despite being given offers, she said this was the cause of a hundred fights earlier in their relationship, often because someone told him this about her (sometimes erroneously) or because he saw her talking with a man humorously at her *pan* (local tobacco leaves) shop:

> *Interviewer: You said that you keep fighting every now and then, what are the reasons for fighting between you usually?*

> *Respondent: Sometimes he doubts about me.*
> *I: What sort of doubt?*
> *R: He suspects that someone has come to my home, that I am doing sex work with clients. I tell him that even if he came at midnight and checked what I was doing, I don't have any fear because I am not doing such things as he suspects. No one comes to my home. I don't behave like that. Though I explain to him clearly like this, he still argues with me in that matter. He hits me, he blames me; he says he will not come again and go, but he comes again after three days or four.*

At the same time, she said she trusted him because though they fight, he would always come back.

Even in the cases when her sex work was concealed successfully and violence did not result, women said that if he found that out he would kill her, which could be considered to be controlling behaviour and emotional violence. In this way, women also stated the importance of their friends or family in aiding the concealment of her sex work, sometimes by allowing her to do sex work in her friend's home or making excuses on the phone that she was speaking with her brothers. In a few cases, the women also said that they are not doing sex work anymore. This was clearly related by some women to the widespread expectation that because the partner was supporting her, she had to stop sex work, as Sharmistha expressed:

> *I am not doing sex work, I am with him permanently, and this is his condition… He looks after everything; he fulfills all my desires, why should I go in search of clients? I was into sex work before he came. That is why I am saying that I am not doing it with clients. That is his order.*

The interviewers felt that in most cases where they said they have stopped sex work this was likely to be true, but in a few others they suspected the women even feared to share this openly in the interview. One woman asked the community research investigator directly that she not let her partner find out that she is doing sex work.

The expectations of fidelity were accompanied by deeper social implications of her engagement in sex work. Specifically, there was noticeable stigma when intimate partners and women themselves discussed how they or the public view sex work; they often described this by using words like "dark side", "vulgar work", or "whore". A couple of men expressed how their partners did not want to bring their status in society lower by remaining associated with women doing sex work. According to Padma, her lover did not want her to associate with those who have a bad name in society, which the community research investigators explained were other women in the sex work community. Another woman said that if she roamed outside with her friends who he felt were "not good" due to their sex work profession, then he became angry and beat her. Further, respondents linked these expectations for fidelity in their intimate partner relationship, and therefore desistance of sex work, to the norms for a marital relationship, as Amisha states:

> *I forgot that [sex work] profession. We are living like married couples. He and I are like wife and husband and the whole village knows it… And at that village no one identifies me as his 'whore', rather they say I'm second wife of him [lover's name]*.

Nevertheless, she was quite aware that she will always remain a *Devadasi* and felt embarrassed for giving this name to her children; further she said a second marriage is never legally supported and she will never be legitimately married to her lover.

Though the social stigma that intimate partners associated with sex work led some women to share feelings of lower self-worth, women also felt that if they continued sex work, it was important being the most important bread winner for their families, and they were glad to be able to afford symbols of wealth such as gold or new clothing and

electronics. His expectation for her to stop sex work meant that she must derive material and social status mostly or even solely from him, as discussed earlier. However in some cases, especially when the woman felt that she did not trust him to stay with her, respondents continued secretly in sex work to maintain financial security or status. Others worked in other occupations. In contrast with others who held the view that doing sex work is a mistake or who stopped sex work and relied solely on her partner, Rani stated most unapologetically that,

> *See he may give some money today, but it may not remain with me for a long time. We may have to spend such money only for our hospital expenses or any other such expenses in future... To survive in future, we have to go according to our plans; we cannot depend on lovers always. We may not be fit to continue this profession as the days goes. So, from now itself we try to earn as much as possible for us. Therefore, we don't agree that it is our mistake. It is our profession. Whatever we do is defensible.*

Amisha shared a similar view that she did not support her lover materially, though he supported her, and she also continued other work because she was not certain he will remain with her, as even husbands sometimes proved unfaithful:

> *I don't bother because I don't know what happens in the future. I have seen many cases even in the marital relationships also there are issues between wives and husbands. There are culprits in those marital relationships too. I know all these things because I am also working in rural areas. So in case he goes away from us, what about me and what about my children and family, what about all of us? We may not even be able to use the stove in the kitchen if he left us all of a sudden, if we are completely depending on him. That is why I go and find some work always. I won't be backed by anyone including my lover… still I like to work and earn to be self-dependent. However, I didn't give him any sort of thing so far.*

However she also attributed her need for independence to his drinking habit that she said made him less dependable.

Another reason for heightened suspicion of infidelity by the male partner was when the woman suggested using condoms, which in turn led to disagreements and in a number of cases violence. Many women tried to use condoms with lovers at one point, which most related to their contact with peer health workers that informed them on its importance in both client and intimate relationships, but had given up due to his refusal. Though the partners often started as clients, the expectations were different for exclusive and marital relationships compared to sex work, as one woman reported her lover to believe:

> *He said, "Hey, don't you know to whom it [condom] is given [for sex work]? Throw that away, why you are giving that to me. I am not that kind of person". He was shouting like this. He was not using the condoms… Once he came to beat me when I asked him to use condoms; I think I tried couple of times. He never listened to me.*

Further, some women indicated that their partners get angry because they think if she asked him to use condoms, with her history of engagement in sex work, that she is seeing other clients or men. Sharmistha stated that this led to fights and sexual coercion by her partner:

> *Interviewer: In which circumstances [did you use condoms]?*
> *Respondent: All the times. I used to use it whenever he comes. He questions me that why I force him to use though he is the lone partner to me and I have no other relationships. I say him that I will allow if only you use this condom…*
> *I: You fight each other then.*
> *R: Yes. He fights with me and starts intercourse.*
> *I: If you are stubborn. What will happen then?*
> *R: He fought with me as many as four times till now because of condom use. If I force him, he says he doesn't come again, but I cannot live without him. So I agree.*

The same reasons were given by other women who said that most of their friends did not use condoms with lovers either. Indu expressed how condoms symbolize HIV prevention, and by extension non-exclusive or client sexual relationships, and thus her lover would leave her if she kept insisting:

> *Interviewer: So they are not using condoms?*
> *Respondent: They [lovers] question us that whether they have any diseases like AIDS and why should we want them to use the condoms. They show their anger if we force them and say that if we force them they would leave us…*
> *What can I do now, if I insist my lover to use condoms he threatens me like that. I can insist my clients to use condoms when I do sex work secretly, but if we force the lover he would leave me; how can I lead my life then?*

In this way, respondents referenced broader social norms as the basis for lack of condom use in committed marital, and by extension intimate, relationships in contradistinction to client relationships.

c) Research Question 3: When and why is violence acceptable or not?

The third research question to understand when and why violence was accepted was also an important aspect linked to the perpetuation of violence in this study. Social norms around the acceptance of violence have been identified as a structural factor underlying IPV and low condom use in IPV conceptual frameworks and in the theory of change for the *Samvedana Plus* intervention. Thus it is important to assess the existent views on acceptability of violence and variability within them.

Though the interview guide explicitly asked about respondents' own and other's opinions on when or why violence may be acceptable, interviewees identified both the acceptance and the non-acceptance of violence as being cause for violence. In addition, once this was presented as a category from the interviews to the research committee, they

also identified the issue of acceptance of violence as a main reason for violence to continue, which intersected with gender role expectations and norms as discussed earlier. There was evidence of the importance of norms on violence in both FSW and intimate partner interviews.

Social norms have been understood to manifest as both "normative" and "empirical" expectations (105). The former refers to when something is held to be right or wrong based on what people think they and others should do. The latter represents what people say they or others actually do, which can confirm the normative expectations (105). In this study, normative expectations around when violence is acceptable were said to be held by either the respondent or those they knew. As suggested earlier, one of the overarching instances when violence was seen to be acceptable was if the female partner made a "mistake". "Mistakes" fell into categories raised earlier in the results on expectations and issues around fear of infidelity or involvement in sex work. For example, Lakshmi explained how violence occurred when she was participating in a drama, and her partner recorded her conversation on the phone with another man that he listened to later. This was also reported by partners such as Ravi who said that he must correct her through violence, referring to it as a norm for husbands and wives that he thinks are shared by the interviewer:

> *She should not have any contact with other men, because I have taken the responsibility of her life. So I will beat her if she commits mistake. I will be like a husband with [lover's name] as how you are with your wife.*

Similarly, Manjunath expressed that if a female partner committed "vulgar acts", in other words engaging in sex work, then the male partner can beat her.

Further, it was common for women to express that they should accept any kind of violence if they made a "mistake" particularly when their IP was taking responsibility for their lives, which was an ideal for their relationship. For example, Veena expressed that in her view, men beat their lovers because they will give everything for the household, so they have a right to beat her if his partner makes a "mistake". This was also held by male partners, such as Shankar who stated that he does not beat her because he is not supporting her:

> *Interviewer: Didn't you have even one disagreement in your relation in the past 7-8 years?*
> *Respondent: I do not fight with her.*
> *I: Don't you ask her why she went to other places?*
> *R: Why should I bother about that? I am not maintaining her, she has her own life. I cannot maintain her life, then why should I create a problem?*

Women and men also stated how violence was acceptable because it was a sign of love in the relationship. One woman said that he was like a husband and she must accept violence if he supported her with love, which she said was a commonly shared view in society:

> *Interviewer: Do you mean that men beat the women when they did the mistake?*
> *Respondent: Yes, he beats her because he gives money to her, if someone goes to stop the fight he argues with them that he has that right because he gave money to her. That is why no one will interfere in such issues.*

Another woman stated that her partner was like a husband, providing everything materially and emotionally, therefore she and her peers felt that violence was acceptable in all circumstances:

> *Interviewer: Okay when you fight like this, do other women tell you that you should accept it?*
> *Respondent: Yes, they tell that I should accept though he beats me, hits me as he looks after everything for me. They told me to adjust with him.*

I: If you think that, why should you accept it though there was no mistake from your end?
R: No, I don't think like that.
I: If you think so?
R: No, no matter how much serious it was, we should accept it.
I: Though he hits you for no reasons, then?
R: No, I don't get angry on him even if he beats me, slaps me.
I: You are telling that you don't mind at all though he had beaten you for no reasons, if so what do you think in those situations?
R: I feel as if I was beaten by my husband, no one else.
I: You believe that he is like your husband though he had beaten you and you don't mind at all?
R: Yes, because when he becomes angry he hits me, blames me, but I lead my life believing that he is like my husband and no one else. I think as if he hits me because he loves me.

In this way, women felt that it was right to accept beating when he supported and loved her like a husband. Similarly, one intimate partner clearly expressed the normative roots of the view that violence was equal to love when the interviewer asked openly how he showed his love to his partner:

When we fight each other, I show more love towards her.

He went on to express that this was not only a personal view but also represented broader norms:

Yes sir, there is a saying, 'Where there is love, there is a fight'.

This was also something that the community research investigators expressed to me to be surprising to them that the participants shared in their interviews. This sheds light on the potential ways that gender norms in the community around male-female relationships can feed into the norms around violence, which may lead some women to accept it. Confirming that there are social norms around violence, some participants and the research committee explained that women may be accepting of violence because their

family or friends said they should accept it if he was supporting her. For example, this woman shared how the family may say that if she kept him in her life, then she must accept violence:

> *Interviewer: Do they think that they should not oppose it if their lovers beat them?*
> *Respondent: Yes, such people are there.*
> *I: Why they feel so?*
> *R: They feel that he is taking care of everything, so that we should accept it. They tell, 'you kept him with intent, so you have to bear with such violence. You never listen to us when we told you to kick him out, so you should accept it now whatever it is'. They tell like this.*

Sita also stated how if the mistake is from the woman's side, then no one addresses it, but if she has not made a mistake then her family will not stay quiet:

> *If the mistake is from the woman's side it will stop [she will adjust and the dispute will end]; if the mistake is from his side, her family member's will not become quiet.*

Acceptance of violence, as a sign of love or correction for "mistakes", such as contravened gender role expectations, can be seen as normative expectations that are characteristic of a social norm. This was supported by the fact that the view that women should conditionally accept violence were similar across a large number of participants in the study, and in their view, shared by other reference groups such as their partners, family members or friends as well (105).

In some of the women's views, empirical expectations supported the normative expectations on acceptance of violence when mistakes were made. In other cases, they did not follow the normative expectations to accept violence conditionally, as violence was not seen as right, but they accepted it for more pragmatic reasons. In one case, Rani did not feel that violence was right, yet she did not oppose it and made him feel guilty after

the fact. Her intimate partner Ajay shared the view that violence was equal to love, but also said he felt guilty after he beat her. Another reason to accept violence was when she relied on her partner and did not want him to leave. This shows how the dependence she had on her partner meant that the power balance in the relationship was in his favour if she wanted him to stay:

> *Interviewer: Why do the men beat women?*
> *Participant: When we accept the man whom we love we have to accept everything from him, he might send us out, we have to accept beating from him and we have to go to him when he calls us on the bed. For that sake they keep us.*

Similarly, Indu said that her partner threatened to leave to prevent her from fighting back, though she was not convinced he would:

> *Interviewer: What can be consequence if you protest during such family violence, you were telling that "if we are at fault, then it is okay for us to remain silent, but when we haven't done anything wrong, then why should we remain silent", what can be the consequence if you are not ready to get beaten?*
> *Respondent: When we protest, he says that he is going to leave us.*
> *I: Did he threaten you like that?*
> *R: He won't leave me, but he threatens me like that, so that I shouldn't say anything or abuse him in future.*

Likewise, Nandhini expressed that she did not accept violence if it was not because of her mistake (in one instance she was beaten when her partner found that she was doing sex work and she felt it was her fault). Yet even if she did not make a mistake, she said she had to accept violence because otherwise he will leave her. This was often rooted in the need that women have to maintain the relationship for the crucial material, social or emotional support that her partner provided. This was supported by the fact that some women felt that they should accept violence after maintaining a long-term relationship

with their partner. According to Amisha, she would rather forgive and forget than end the relationship because she only had one partner unlike her partner who has his wife:

> *Sometimes I feel as if I should leave him. And some other times I feel that anyhow I have adjusted with him till this day, how I can I leave him. So we fight and forget. We were not talking to each other for a week, when had been fighting. He was not coming to my home for a few days. I couldn't bear it; I was ringing his mobile myself. Since he has a wife and children at his home, what makes him call me? But I have him as only one partner, it is he and no one else.*

In a very similar account, Sharmistha shared how she was determined to stop fighting with him and accept violence to maintain their intimate relationship:

> *I calm down thinking that what we gain from such fighting. We have been maintaining our relationship from long back and we don't want to split between us like this. So I always wish to lead my life only with him till the end. So, it doesn't make me feel angry towards him even if he beat me. He behaves badly sometimes but comes back again or talks to me over the phone nicely. I take it in a positive note. People try to encourage me to question him, but I don't listen to them and forget what they said then and there, and continue with him only. No one comes to my home other than him.*

Acceptance of violence in relation to empirical expectations also emerged out of fear, as Parvati stated that violence is not right but women accept it because they have to lead a life and avoid shame:

> *I: Do any women think that they should not accept violence?*
> *P: Yes, such women also will be there. Those who do not accept violence, they become a victim and those who accept violence they will be happy after compromise.*
> *I: Does anybody say that one has to accept violence or do they themselves accept it?*
> *P: They themselves accept violence, they feel insult if it comes out.*

Evidence of both empirical and normative expectations were represented in her account, as she referred to both the broader norm around accepting violence among other women, and pointed out that acceptance of violence may occur out of fear of being a victim again.

Thus these various accounts all illustrate the important connection between the supports provided by the intimate partner, gender roles expectations in the relationship, and norms on the acceptance of violence.

However there was variation in the level of acceptance of violence, demonstrating that norms are not completely homogeneous. Some women conditionally accepted violence as described above, but others did not accept violence in any circumstance. Though less common, a few women felt that they should question their lover. Sharmistha felt that her partner did not need to unconditionally have his way, which was fuelled by the disrespect she felt when he stole money from her salary:

> *Interviewer: Does he take your salary?*
> *Respondent: Yes, he had taken. He pulled the salary amount from my hand, but I didn't keep quiet and I will not be. We loved each other but I didn't give him my money because I must take care of my children and family. It is not possible for me, I don't like this attitude. I don't accept that we should not go against our lovers.*

One more distinctive account was given by Kaveri, a long-time CBO peer educator who said that she did not accept violence because violence is fundamentally wrong, and that there should be equality in the relationship. This was also because she felt a sense of freedom to leave him if he treated her badly:

> *Interviewer: Why they should not accept it?*
> *Respondent: Because when we treat them very well bearing in mind that they are like a husband. They should also respect us and treat us in a dignified manner. Do you think we have kept them to behave like that? We don't. That is the reason.*

In another couple case, Rani's lack of acceptance for violence was fuelled by her belief that he may not always stay with her; thus she did not agree that her continuation in sex work was a "mistake" since she needed to remain independent. She stated that violence

was never acceptable and that she stood up to her lover after a fight because she could not be sure of how long he would stay, due to her position as a *Devadasi* and like a secondary wife:

> *Interviewer: Who will compromise first after fighting each other?*
> *Respondent: He himself compromises first, though he didn't commit any mistakes. I defeat him, I never been defeated. Why should I compromise? We have been offering them everything; they take care of us by arranging everything for our needs. That is it. Why should we bend? Whatever it may be, they cannot take care of us as same as they do for their wives. Though anything went wrong, we won't get the status of wife. Everyone including our lover treats us as 'whore' on one or the other day. In such conditions, why should we get scared about them? Now he has love and affection towards me, who knows, what would happen tomorrow? So I don't care much as he does.*

Lack of acceptance manifested a bit differently in another couple case, in which little violence was reported and the partner shared that he had a great deal of commitment and attachment to her as his sole partner. His FSW partner stated that she stood up to him in fights because she did not fear him leaving her; he would always return because of their children, if not for her. However, though she did not agree, the presence of norms around accepting violence was still evident as she stated that other women in her area told her to be good and "adjust with him" because he took responsibility for her and their children. Thus both women who felt prepared for him to leave or were completely certain that he would not leave were less likely to accept violence.

It was clear that variation in norms on violence also existed within the broader community. Usually community views on acceptance of violence were also conditional, just as in respondents' accounts that violence was acceptable when mistakes were committed. Veena explained that elders in the community differed in opinions; some said

that because he supported her he had a right to beat her if she made a mistake, while others asked why he should beat her even if he was supporting her:

> *Interviewer: Do the people say that women have to accept violence from their lover?*
> *Participant: Some of them say like that and some say that, why should she accept it from him? Each of them says differently.*
> *I: They say like that also.*
> *P: Yes, some say that why she should accept if he gives money. Some say that he has taken her responsibility so she has to accept. Each of them says differently.*

Kaveri, who was the peer educator with the CBO and felt violence is normatively wrong, stated that there are shifts in the views held by the public:

> *Interviewer: There may be some women who accept to be beaten up. What will happen then?*
> *Respondent: Its left to individuals, if you ask me, it is totally wrong if the men are allowed to hit them. In recent days, the thinking has changed among public. No one will be ready to be hit by anyone.*

Some of the intimate partners' views varied as well. In a unique couple Krishna echoed his partner Kaveri's views that violence was never correct, as he shared,

> *There is no use in beating women, there will be some disagreements in between couples but beating women is not correct, I do not do like that.*

Neither of them reported any violence in their relationship despite sometimes fighting over unmet expectations; they had been together happily for over 30 years. Indu also reported that her partner would feel sorry for beating her because she had sacrificed a lot to be with him:

> *Respondent: Even if we remain silent when they beat us it doesn't mean that the act is justified. Anyhow he knows that I have left home with my children, and if we remain silent then he will take it for granted, then he will start thinking that I am also like his wife and will do the same thing again and again, but he is not that type, he feels sad for his act and he hasn't beaten me like that.*

> *Interviewer: If you remain silent when he beats you, then what will he do next time?*
> *R: He feels sorry for his act because he realizes that I have left home along with my children and deserted other family members just because of him, and I have to spend my life with him. So he stops quarreling with me again and again, but if we start protesting and try to hit him then the situation can go out of control.*

Some intimate partners in the study explained that they did not think violence was practical or right in some cases. For Ajay, who had reported beating his partner when she made the mistake of talking to other men, explained in depth that violence was necessary for her to change her behaviour, but surely not ethically or practically right:

> *Interviewer: Do you think beating the women like this is appropriate?*
> *Respondent: I don't feel anything while beating, but after that I feel pain myself sir. I think like I would have not beaten her because it is nothing but harassment, I could have been set it right with verbal conversations. I think like that. However, she doesn't understand if I show softness, but I know beating like this is surely a misdeed. The differences may increase if I keep on beating her. Sometimes it may lead to untoward incidents like if I hit her on any sensitive parts, the [on the] spot death can be witnessed. Then it is like dilapidating our own beautiful life. But it is not solvable verbally. That is the problem. There is a limit for man. If she keeps on doubting me, questioning me what I should do then, I may lose my patience. If wives do like that the good husbands also incur bad habits like consuming alcohol and beating the wife in its influence. So far, I didn't drink it. Who knows what will happen next [laughing]*.

Govind expressed that in general women were both a wife at night but a mother in the daytime because she took care of the household needs, and thus hitting her would be like hitting his mother. However, the interviewer felt that he may have tried to give a socially desirable response; most others felt violence was conditionally acceptable as many women did. This was expressed conditionally by Ravi who said that,

> *It is correct to beat when they commit the mistake. If we beat them without any reason or without they done any wrong my hands will cut-off, I will get wounds on my hand.*

This referred perhaps to local conceptions of *karma* that if you committed an unjustified act it would end up resulting badly for you, suggesting it was held as a personal moral norm (105).

Hence, strong connections existed between acceptance of violence and gender role expectations for correct behaviour in the relationship. Further, it is clear that there were variations in the levels and contexts of acceptance around violence. There was evidence of normative expectations, and sometimes consistent with empirical expectations, among participants and those they knew that supported the existence of a social norm on the conditional acceptance of violence. For those who felt violence was correct or that it had to be tolerated, the solution was acceptance of violence and related adjustments in behaviour to prevent violence. However, only when violence was not seen as conditionally acceptable did it imply that changes must occur in the norms around mistakes justifying violence between partners and within the society at large. This leads to the final research question to explore what means for prevention of and coping with violence were most common or appropriate according to participants.

Research Question 4: What do participants do to prevent or deal with violence in intimate relationships?

According to the interviews and community-based analyses, the methods that participants viewed as appropriate to prevent or cope with violence were said to depend on the type and extent of violence, as well as whether violence was seen as acceptable or not in a given context. To prevent or deal with violence, a majority of the female respondents felt that they should adjust their behaviour, and many had successfully done

so in long-term intimate relationships so that violence had reduced. This was confirmed in the community analysis by the research committee, who felt that women would adjust by caring for her partner appropriately so that they can avoid small fights and prevent them from escalating. A few women stated that they should adjust and be good with him, which was supported by their peers, such as Shanta who said:

> Interviewer: *When you had fight with your lover, do the women in your area say that you have to accept his scolding or violence?*
> *Participant: No, they say to me that why I fight him when he is earning and taken the responsibility of me. They say to me to be good with him and to adjust with him.*

The need to adjust was also held by women who felt that if they did not accept violence, it would be worse for them and so they should keep quiet, as Sita shared:

> *Interviewer: What happens if you won't accept violence from your lover?*
> *Participant: That will be basic cause for fight, when a fight starts my children might ask him why he should beat me and what he has given to me.*
> *I: What else happens?*
> *P: It will not stop, if both sides keep quiet it might stop otherwise it leads to a fight.*

Whether or not the female partner should adjust her behaviour according to expectations and gender norms to avoid violence often depended on who committed the "mistake". If she did something wrong, many women felt she must bear the violence herself. However in a few cases the women would react by making their partners feel guilty even while accepting violence at the time, as Rani expressed:

> *Interviewer: In case if you don't accept such violent acts against you, how the situation would be then?*
> *Respondent: I will convince him. He tries to point out my mistakes to defend his violent behavior. And sometimes he beats me. However, after some time, he comes inside and sits silently telling that he wants to compromise with me. When he beats*

me, I don't oppose it, but I make him guilty for the whole thing. Later he himself feels bad about beating me and makes me up…
I: Does he agree for it?
R: Yes. I ask him whether he can throw away his wife whenever she does mistakes. I ask him whether he can get away from his wife like he does with me. He doesn't have any words to speak out then. I never defend myself by reminding his perception towards me rather I always compare his wife with me to shut his mouth. Then he himself falls in trouble. I tell him that he should treat me equally when he cannot get away from her, though she also commits same mistakes. When I talk like this, he forgets everything and continues his relationship with me.

The response to deal with violence also depended on the type or extent of violence. It was clear that issues considered minor were dealt with individually or within the couple, as Bharati shared how they mediated between them:

Interviewer: Earlier we were talking about fighting between you. You said that you were scolding him and questioning him, if he hadn't accepted when you scold him, what could have happened then? It may lead to something unpleasant.
Respondent: Nothing could have happened, because neither of us stretches if for long, we forgive and forget.

But in cases when there were repeated fights or injuries were incurred, families or neighbours would get involved. A number of women as well as the research committee in the community analysis expressed that the woman's own family members, often a brother, uncle, or parents, may provide support in persistent or serious cases of violence. This was the case for Parvati, who shared that he had injured her head a year ago:

Interviewer: Injury on head, what did you do then?
Respondent: I did not do anything. My mother and all family members warned him about that and he said that he would not beat again.

Kaveri also explained the different responses depending on the extent of violence:

No serious issues took place till now; we ourselves address the issues before seeking the help of laws. If it is really severe, then our higher officers come and solve them. If the issues are minor, we get them solved here itself.

However the male partner's family members were never said to be involved and sometimes even caused rifts in the intimate partner relationship, though in most cases the male partner's family acquiesced to the relationship if the male partner insisted on it. It was also expressed that violence in public was a social taboo and instead should only occur in private, as one male partner stated:

> *It is not our place to interfere with others if they have violence in their relationship; that is seen as their mistake.*

The research committee confirmed that this makes it difficult to expose the issue even within the family unless the violence, usually only when it was physical, had been very serious. Specifically, they said people do not want neighbours to know there is violence, especially when it is not a marital relationship. They stated that if violence occurred openly, the public would generally say that this was happening because of her so let us send her away to avoid the disturbance in the community. This reveals the implications of stigma and social exclusion towards sex workers as well as the disapproval around intimate partner relationships for keeping the resolution of violence a largely private matter.

In terms of more formal measures for violence, crisis management was mentioned and has been offered for a decade by the CBO in cases where women were beaten by someone. In addition, women and men in the study also had a range of knowledge on the Domestic Violence Act. A number of women had heard about the Domestic Violence Act from the CBO peer workers, a police man or a lawyer who had come to give the information in the village. Intimate partners had generally less knowledge about the

Domestic Violence Act, though some men who had more exposure or involvement in the community-based organizations seemed to be more open to methods to deal with violence like counselling. Some had heard about the Domestic Violence Act at community meetings and another man had heard from a television channel. Male respondents also expressed some fear and distrust of the laws, especially if they felt violence was justified. One man shared that he heard about the law from lawyers and policemen that he knew in the village. He shared insights into his notion of retributive justice for both men and women:

> *There is law to protect women and there is law to punish the women when they commit the mistake.*

No women said they had filed a complaint, but one said that she had threatened to call the police to scare her lover and prevent violence. The research committee members explained that because people did not want violence to be publicly exposed, they would not usually draw on formal measures.

A few women expressed the benefits for preventing and dealing with violence that came from the CBO helpline, help through information and advocacy by peer workers, or the collective strength between women as members of the CBO. In one extraordinary case, Rani detailed how she and ten other women were able to bring a severe violence case of one of their friends to the police and gain compensation for their friend:

> *"As [my friend] had asked for her ID card back in the presence of his [her ex-partner's] wife, he had become annoyed and hit her. We all came to know this and assembled together. We were planning what should be done. [My friend] decided to give a complaint… She had got injured severely since the blood was coming out from her head. We had directly taken her to the government hospital. After completing the admission procedures, we had met police and given a complaint…*

By that time a peer [from the CBO] had come there. She was accompanied by an ex-peer educator also. They helped us. They guided us well by staying with her for as many as three days… Later police came and told that they would summon him. He, his wife and neighbors came… We were 10 women and all went there together. We showed our strength by going together. We blamed him saying that such an incident might repeat again in later days with others. We asked what was wrong with her, was there any mistake if she asked for her ID card back.
"We shouted, 'You both lived together for more than six years. Didn't you remember your wife until then? Have you remembered your wife today?' He was pointing out that she had asked for ID cards when his wife was with him. We questioned, 'Did you forget your wife while sleeping with her? Did your wife come to your mind only today? What was wrong with this woman? If you don't want her, why do you have her ID card with you? Settle with her the amount that she deserves. How dare you to hit like this?'
"When we all had questioned him, he got stunned and begged us to forgive him. We told him not to say sorry to us because we wanted to settle the matter at the police station. We forced him to take care of her life and to do justice for her as she had belief only in him and she hadn't had any relationships with anyone until then. We asked him to do something for her future and what was the reason for avoiding her. We questioned him whether he had thought that she had no one to support her. We all shouted together at him in single voice. He was telling that he would reimburse all the expenses of her treatment for three days. We made him to settle as much as Rs.50000/- for her better future. She has two kids, one is boy and another one is girl…
"All such incidents made me become aware about legal procedures and facilities available for the women."

This detailed account demonstrates how women were able to use collective strength with aid from the CBO peer workers to support their friend to draw on the Domestic Violence Act. However the intimate relationship was finished before this happened. Only a couple women said they had left a previous intimate partner because he was violent. For those with current partners where the relationship was not going to end, it was less common for women to draw on the Domestic Violence Act. Instead, prevention methods were recommended by the CBO peer members, which ranged from telling her to adjust with him and not to do mistakes, to calling on the intimate partner counsellors that the program

provides or asking a friend or peer to mediate and determine how each partner can change so as to prevent further violence. The research committee members held various views when discussing the results, with most holding that interpersonal methods and counselling were best and a couple feeling that norms on the acceptance of violence must change more fundamentally. Likewise only Kaveri, who worked at the CBO and felt that violence is never acceptable, mentioned that they must continue advocacy against violence, through their community effort as no one else would stand up for them:

> *Interviewer: Why don't you accept it [violence]?*
> *Respondent: We have all combined together. The life of our women is like that only, everyone sees us contemptibly. So we are strong enough as a group. Don't allow any violence to take place because it hurts everyone if any of us is attacked. So we don't get adjusted with everything. We don't like violence of anyone on us.*

In this account, she expressed that the power to deal with violence could come through collective strength within their *Devadasi* community, as they should not rely on the broader society that stigmatizes women in their profession. This reveals the challenges that women in sex work face for being supported in the face of violence. Along this vein, one intimate partner shared a revealing account of the particular challenges that *Devadasis* face in the experience of violence, as unofficial and socially unsanctioned partners:

> *Interviewer: Do you believe that we can change such behavior of violence on women?*
> *Respondent: If there is violence or a fight between a wife and a husband, we can go to them and counsel them not to do that. It is our duty as an elder, and it is correct to say so in such a relationship. However, no one says anything to lovers.*

This relates back to the fact that when violence occurred, her family would be more likely to support her, given they felt violence is unwarranted, than his family who was neither

usually present nor highly supportive of their relationship. Similarly, Indu told the interviewer that her relationship with her own family was tense because of her choice to stay with her partner, and the neighbours did not lend support because it was considered an illegitimate relationship:

> *Interviewer: Have you both [she and IP] quarreled recently for some reasons?*
> *Respondent: When we quarrel like that, we don't let anyone of the neighbors come to know this because they start undervaluing us, saying that we are not wife and husband and we are quarreling like this as we are in an extra-marital affair.*

Thus, even though both male and female intimate partners usually aspired to the expectations for a marital relationship, the conditions of a marriage did not generally hold for the occurrence of violence or the measures taken to deal with violence. As reflected in some of the accounts above, this was because respondents felt people in society at large do not attribute the same social and legal legitimacy to intimate partner relationships as marital relationships, particularly with *Devadasis* who have relatively low social status.

Chapter 5) Discussion

A novel community-based approach was taken to research intimate partner violence facing women in sex work in this study. Through this we aimed to optimize the contribution of those positioned within and outside the study community and pursue the potential for social change towards collective purposes. There are three major aspects that will be discussed to reflect on the process and outcomes of this study. The first will be a consideration of the benefits and challenges of using a CBR approach as both a means and end in itself. The second aspect will be to demonstrate that our results support approaches that frame IPV in terms of "structural vulnerability" on multiple levels. The final element will be a discussion of how these multiple levels are mutually-reinforcing, using the example of the relationship between "gender" as a social structure and IPV as a social practice, as a way to further inform current IPV frameworks and interventions.

The CBR approach that informed this study was characterized by a number of distinctive elements, with both benefits and challenges for achieving the purposes of this study. There has been no previous study on a topic like IPV that has involved such an extent of community involvement; with the input of women in sex work from a community-based organization on the design and methods, with interviews being conducted by women from the community and among both female sex workers and their intimate partners, and with an analysis process that involved the direct input of the community research committee. Importantly, the approach taken in our study achieved a good degree of consistency with the principles of CBR in Israel and colleague's well-accepted conceptualization that informed the study design, including the building on the

strengths of all partners, collaboration and integrated knowledge and action at all phases, and arguably the co-learning and empowerment of those involved. Further, it will be followed up as a cyclical process of learning as knowledge will be shared with all partners and inform further iterations of the research (29).

The integration of program, research and community representatives within our research team benefited the results that were attained in many ways. The interview tool development was clearly appropriate and in local vernacular that never seemed to be misunderstood. This was evident in the degree of receptivity by the respondents to the questions that were asked. The interviews provided in-depth responses that could delve under the surface of IPV and explore broader individual and social circumstances faced by the participants. Having community research investigators interview the women in the study had challenges, including increased time and effort for training processes and initially less in-depth interview responses. It was evident that interviews became longer and more in-depth after each of their first few, owing to their increasing ability to listen and probe for longer answers and their ease with asking the interview prompts that they soon had memorized. The interviewers started to ask questions that were not directly in the guide, exploring relevant aspects that only they would think to ask by sharing similar life circumstances. For example one of the interviewees said that her partner was not married and that she wished to get married to him. The community research investigators responded by asking whether the woman thought he would get married, to which the woman answered yes and explained why. The community research investigators never

forgot to ask any of the questions, and all interviews provided important information for the analysis to answer the research questions.

Employing community researcher investigators also enhanced the rapport and appeared to heighten the relevance of the interviews, as well as providing some evident benefit to individual respondents. A number of women expressed that they were disclosing something sensitive to the community research investigator, especially if they were doing sex work. Others commented sincerely at the end that they were able to express freely due to the friendly manner of the community research investigator and benefitted from being able to share their thoughts, as this woman stated:

> *Interviewer: You have spoken to me so far very well.*
> *Respondent: I am also feeling happy.*
> *I: You are also feeling happy, okay fine.*
> *R: I have kept everything in my mind whatever we discussed till now. I don't forget anything because you came to help us. You say everything for our benefit…*
> *I: Okay sister, you have spoken very well so far, thanks for spending your time.*
> *R: I liked very much the way you have discussed.*
> *I: I am happy talking to you really.*
> *R: I know that you come to help me, you guide us well, and you create awareness among us. You explain the consequences of unhealthy practices. Human beings will learn as the age progresses. We will come to know how we should be, what we should do for having a healthy life. If we get knowledge from people like you, we can improve our quality of life.*

This woman's expression of appreciation demonstrates the extent of rapport that *Chaitanya* peers have with their community. It could have been a liability if the CRIs could not shift their roles and approach from peer educators to interviewers, even though they did not know the participants before. Though the women based their trust on the community research investigators being peers, the interview transcripts showed that community research investigators did not give any information or education as they

would as peer educators previously, which was an aspect of the training to be community research investigators. For example, if the women asked questions the interviewer would defer it until after the recording was finished. Another woman's final comments showed how the CBR method of using peer interviewers was part and parcel with the work and mission of the CBO to support their ability to improve their lives:

> *Interviewer: Thank you very much, see you.*
> *Respondent: It is okay. You also share some good things with us if we meet like this. Moreover, you are here to help the people like us. So we have to respect you. We usually keep everything inside, now you made me to feel quite relaxed as I expressed everything openly. That is also a kind of help from your side. There are so many things which I can adopt in our life; we must have to know such things. You didn't ask anything which is not supposed to.*
> *I: Thank you very much. Have you felt uncomfortable in any stage of the interview?*
> *R: No, nothing like that. What is there to feel like that? You have asked about me, about my lover. That is it.*
> *I: I am happy.*
> *R: I am also happy.*
> *I: Thanks, see you.*
> *R: Okay, Namaskara, visit again.*

Further, in a couple cases when the intimate partner or other family members came, they stopped the interview and recording as trained. Overall, the community research investigators were able to implement the ethical protocol with discretion.

The results that were shared by the community research investigators with the research committee were also authenticated as the members expressed that it was all "correct" according to their experiences working with the CBO and interacting with their community women. The prioritization and interpretation of the results of the study were highly consistent in the views of the community research investigators and research committee, providing a good deal of triangulation through member-checking, and their

interpretations were integral parts of my analysis presented here. This level of community involvement in analysis has rarely been undertaken in the field of IPV research, and even in public health. The collaborative multi-step approach to garner inside and outside views has proven to substantiate the answers to our research questions (84, 106).

While the authenticity and relevance of the results were enhanced in many ways by the use of a CBR model, arguably the most valuable aspect of this approach was less instrumental. This is in line with the critical and participatory action roots of a CBR approach, which emphasizes the inherent value for increasing the voice, power, and ownership in the knowledge produced by those involved in studies that examine vulnerability to health and social issues (29). The philosophy of CBR as an end in itself was therefore seen as relevant for a study on understanding vulnerability to IPV among a marginalized group (29, 84). Towards this goal, the research committee that is now formed plans to continue meeting each month with one member of KHPT present at their request to discuss all research projects that they undertake. Another intrinsic benefit was in strengthening the capabilities of women who had been senior peer educators in the community to be the community research investigators. We noted the community research investigator's increased confidence for speaking in groups, taking the lead during our community analysis, and improved reading and writing skills. They will ideally continue to interview in the next few rounds and potentially other studies. They will also be the representatives to share the results at the board meetings with the CBO and potentially in other platforms in the future. Lorway and colleagues provided another unique example of the challenges as well as benefits of CBR for developing important

social scientific knowledge that can inform health programs. Their approach was to minimize power inequalities as much as possible through commitment to a democratic and collaborative process throughout the research cycle (84). It will be beneficial to assess the long-term benefits from approaching CBR in this context over time through ongoing collaboration.

Long-term engagement with *Chaitanya Mahila Sangha*, a CBO established and strengthened initially by KHPT through grants for HIV/AIDS prevention, is now made possible over ten years later by the self-sufficiency that this CBO now has, to the extent that they apply for funding directly to the state government for a range of projects relevant to the community. Thus the application of the results will be supported by the larger infrastructure based on the long-term partnerships that have developed between *CMS*, KHPT, and others such as academic partners. This was arguably an important precondition for completing a CBR study such as this. However, maintaining equality in the partnership was not without challenges in this study, particularly with respect to time, money and decision-making power. Using a CBR approach lengthened the research process at different stages, which could have presented problems for the CBO and KHPT for timely application of the findings, and specifically for informing an ongoing intervention. As the first study of its kind in the region it likely took longer to proceed due to external institutional hurdles beyond the organizations' controls. However it also seemed that extended and close engagement increased commitment to the process all around. Because of the CBO's strong relationship with KHPT, the leaders of the research committee were able to ask for more control over the finances and increased salary for the

community research investigators over the course of meeting for this study. A couple of research committee members also questioned KHPT when they were told by external partners that the study required changes regarding sample size and interview locations without consulting them. However, the power held by the research committee was maintained through their ability to inform decisions, express opinions, and choose to continue supporting the research or not.

Israel and colleagues have outlined the critical and constructivist roots of CBR approaches, which aim to address the criticisms of positivist science for trying to remain distant and value-free (29). Likewise the CBR approach we took was based on the assumption that research methods and results are necessarily influenced by the social and historical positions of those involved. CBR aims to acknowledge subjectivity while maintaining the search for patterns and the development of theory, by involving multiple research partners who may view phenomena from different angles, as House contends: "[the] choice does not have to be between a mechanistic science and an intentionalist humanism, but rather one of conceiving science as the social activity that it is, an activity that involves considerable judgment" (29). Owing to the social and interpretive nature of CBR approaches, as in other methodologies, inputs in our analysis from inside and outside the study community reflected fundamental debates in literature on why IPV occurs and how it should be addressed. Specifically, there was disagreement around the implications of the central concept of "mistakes" in the interviews for addressing the perpetuation and acceptance of violence, which relates to the next aspect for discussion.

The second aspect to be discussed is how varying views on why violence occurs and how it must be addressed, particularly around the concept of "mistakes", among participants and research partners in this study shed light on broader debates between more individualized versus structural approaches to address intimate partner violence. As discussed earlier, a CBR approach allowed partners to voice differences in their acceptance of and methods to deal with IPV. This reflects long-standing disagreement still evident in the theoretical and practical literature on IPV. Many approaches to deal with violence have been most heavily focussed on individual behaviour and couple interactions, while others widen the focus to include the family as the primary unit of analysis. Examples include the criminal justice and family violence theories that assume the locus of change rests at the level of individuals (41). These approaches still hold much weight globally in domestic violence programs, particularly through educational approaches based on behaviour change models, and with violence being cast discursively as a new realm of criminality (39). In the *Samvedana Plus* program, increasing knowledge and access to support around the Domestic Violence Act has been a key focus thus far. This is also reflected in the types of studies being conducted, as many past and current studies on IPV have not moved beyond determining individual characteristics that are associated with experiencing IPV (55, 63). An individual-level focus was also implicitly reflected in some of the interviews and some of the research committee members' views that unmet expectations were "mistakes" that justified violence. For them, the recommended approach was to "adjust" and change behaviour to avoid "mistakes" worthy of violence. Yet other researchers have argued that behaviour change

and criminalization of domestic, and in this case intimate partner, violence may be one part of effective interventions, but on their own do not adequately address the context within which women in sex work are more vulnerable in the first place, including gender and violence norms, stigma, and socio-economic exclusion, as suggested by our results (39, 40).

Conversely, there were also a handful of women in this study and members of the research committee who felt that violence was never acceptable, and that the justification of IPV based on "mistakes" should be addressed among men and more broadly in the community. Increasingly researchers using quantitative methods are reporting significant associations between IPV and multi-level factors, including community acceptance and norms around violence and gender (50, 53, 56, 67, 107, 108). For instance, studies in India and Africa have found that socially-accepted gender norms associated with masculinity and femininity justify dominance of men over women, and lead people to conditionally accept IPV when gender norms were not met (36, 42, 67, 73). Others have used multi-level analyses to show the independent effects of village tolerance of abuse in the home as well as associations between state gender inequality and socio-economic status and increased prevalence of IPV in that area (107, 108). There have also been a few interventions that have been evaluated to address these factors, including those increasingly stressing the involvement of men (48, 88-90, 109). These studies are often based on and reinforce ecological approaches to IPV, and resonate with critical and integrative theories on IPV that highlight the need to address IPV structurally on multiple levels from the individual and relationship to the societal level (37, 110).

The empirical evidence from this study's interviews can help to clarify in these debates where the emphasis of interventions should lie. Specifically, this study sheds light on the role of not only individual or relationship characteristics, but on how these are influenced by structural elements, making women more likely to experience or unable to avoid violence (9, 66). In particular, the results suggest that women who are in sex work had more difficulty fulfilling the expectations for women generally and thus were more likely to make "mistakes" by contravening gender role expectations held for a wife, particularly by engaging in sex work. The concept of mistakes was found to be very similarly defined in another study as the explanation for much of the domestic violence toward a sample of young married women in India (111). This supports the conclusion that the gender role expectations held in intimate partner relationships are reflective of broader social norms for marital relationships. These challenges for avoiding mistakes facing FSWs were compounded by the low social status and associated social stigma placed on them, the cultural and legal structures making them unable to marry and criminalizing them as *Devadasis*, and economic challenges they often faced that kept them in sex work. All of these factors made it more likely for them to comply with the intimate partner and stay with them in the face of violence. On top of that, there was lack of support to prevent violence towards FSWs and even greater internalized acceptance of violence for some. This resonates with Flood and Pease's argument on the need to focus more on the interaction between attitudes around gender and violence and how these attitudes are affected by institutionalized power relations and material conditions that shape an individual's socio-demographic characteristics, such as socio-economic,

employment, or other measure of social stratification (110). In our study the concept of "attitudes" was reflected more in terms of "expectations" held for each partner, which were important in relation to their understandings of why violence occurs, whether it is accepted, and what is done to deal with violence.

The findings of this study shed light on why the most common issues said to be underlying vulnerability to IPV in KHPT's survey of FSWs were "engagement in sex work", "financial constraint", followed by their "subordinate position in society" (58). Likewise, KHPT's study on masculinity, gender norms and IPV among male intimate partners in 2012 found that FSWs were economically dependent on their intimate partner because men were able to earn more and their work was more valued (75). Violence was found to be a source of control and a means to reassert power over their partner if men felt their power was diminished either publically or in the relationship, echoing other research on domestic violence in Indian martial relationships (43, 44, 71, 75, 112). IPV was also justified by the social norms that permitted men to correct women's mistakes when they provided materially for them as in the current study. Our results add another layer of complexity in that intimate relationships do not appear to be normative or publically-sanctioned in India, as George also found, and thus require extra effort by the partners to justify by ascribing to norms in a marriage as the only socially or legally sanctioned male-female relationship in this context (43). In this way, our findings further shed light on how mutual expectations held by intimate partners and the broader societal acceptance of violence against women, within the context of broader socio-economic conditions and as a member of the sex work community, significantly increased the

likelihood for FSWs to experience violence. Hence, relying on behaviour change models to advocate that women "adjust" to avoid "mistakes", and even reducing individual women's acceptance of violence, would be insufficient to address violence structurally. In fact those efforts may even exacerbate violence by placing the responsibility on "vulnerable" individuals without changing the broader social structures on multiple levels, including social norms around violence and expectations in intimate partner relationships (110).

Framing health issues in terms of "vulnerability" has been part of an effort to contest individual-level frameworks, in favour of the appreciation of broader constraints that must be addressed (113-115). The concept of "vulnerability" has been offered as an alternative to deeming people as part of a high "risk" group in public health discourse (113). The purpose is to be more cognizant of the more distal factors underlying individuals' abilities to avoid certain health problems and in this case IPV (113). Fairly recent in applications to public health, researchers have gone further to adopt the term "structural vulnerability" from medical anthropology to challenge the sole reliance on, "behaviour change by imparting knowledge, skills and "empowerment" based on a cognitive model of rational choice theory in medical decision-making"(113). This framework also appreciates that though there may be common sources of "vulnerability" that make a population group more prone to experiencing health issues than another, there is also intra-group variability due to various social circumstances that individuals experience, as Delor and Hubert explain:

> By focusing on differences in vulnerability, the research must take stock of and understand the differences better, regardless of whether they are inter-group or inter-

> individual differences. The existence of differences on different levels makes it possible to oppose any monolithic vision of the group... At the same time, the individuals' identification with their reference groups or `in groups' is not left out of the work of understanding. Rather, one tries to determine how these ties are likely to increase or decrease the differences in vulnerability to a risk (115).

As stated earlier, our results suggest that "vulnerability" to IPV was influenced by a woman's status as *Devadasi*. The tension between ascribing to norms for marital relationships and being *Devadasi*, leading to social stigma towards her and the inability to marry, was particularly illustrative of the structural nature of women's vulnerability to violence. Yet as Delor and Hubert assert, this was also mediated by other factors that made experience and understandings of IPV variable in our sample and likely among women in the broader community. These variations seemed to relate to the level of support from other relationships that women had with their family, friends or peers, which shaped their level of emotional and economic reliance on her IP. Further, the level of trust in their relationship and his marital and economic status, by referencing norms around violence and related expectations in marital relationships, also affected the level of IPV. The acceptance of IPV based on "mistakes" in this study echoes the results from a previous study in India by Kapadia-Kundu on domestic violence among young married women, their husbands and mothers-in-law (111). They also found that "mistakes" around gender role expectations, particularly around modesty and sex, held by all family members was the most notable reason for violence. However, households varied in terms of whether they took a more stringent or flexible approach on the issue of gender role expectations: "although violence and non-violent homes had largely similar gender role expectations, their reactions to perceived failures to fulfil these expectations differed"

(111). This suggests that it is important to consider the interplay of broader factors with individual views, actions and social conditions in order to better appreciate the variability in "vulnerability" to IPV and therefore tailor interventions in response. Thus our results should strengthen the push for multi-level approaches that aim to consider the balance between addressing individual behaviour change and relevant cultural, social and political factors contributing to "structural vulnerability" to health issues like IPV that disproportionately affect some individuals and communities (110, 113, 115).

The final aspect to discuss is how this study's results can deepen understandings on the mechanisms by which multiple levels shaping "structural vulnerability" to IPV may interact, and the implications this has for interventions, using the important concept of "gender" as it pertains to IPV. Gender is one of the social issues that is starting to figure prominently in research on structural approaches to IPV and other health issues (36, 48, 72, 75, 89, 91, 109, 110). This study's gender-related findings resonate well with Heise's integrated ecological framework on IPV that is widely-accepted in the context of public health. This framework integrates empirical findings on IPV among women globally, aims to integrate feminist critiques to include gender among other factors without being reductionist, and recognizes the need to move beyond the realm of the family as in previous IPV approaches (37, 41, 91). In this framework, gender-related factors are seen to operate at all levels: at the individual level of attitudes; the level of the relationship as "patriarchal triggers", like the inability to meet gender role expectations; cultural norms at the community level around acceptance of violence against women and gender roles; and on the macro-social level as "gender order", linking to rights,

entitlements and laws that contribute to the degree of gender equality in a society (37). Though the integrated ecological model suggests the interplay of different levels, such as the multi-leveled interaction of gender-related factors, some have argued that ecological models offer no clear explanation as to how this may occur (116). Likewise, few studies explicitly link different levels of factors that are implicated (91, 110, 116). This is important given that ecological models guide much of recent research on structural approaches to health issues. Gender provides an illuminating example that is relevant in our results of how different levels in an ecological conceptual model for IPV interact, and the implications for addressing violence.

To assess how gender as a social structure influences social practices, it is relevant to consider explicit social theories of gender, which some have argued has been too limited in health sciences to date (38). Influential social theorist Raewyn Connell has argued that the relational theory of gender is most favourable compared to those that are categorical (male and female as binary and ahistorical), or poststructuralist (focussing on discursive forms of power to the exclusion of material or institutional aspects) (38). Relational theory may provide insight into how gender may be conceptualized as a social structure that interacts with social practices between different levels in light of this study's results (38). In this conceptualization, gender is a historically-produced social structure that is constituted through patterned relations between men and women, as in an intimate relationship:

> Gender structures are not only cultural points of reference for daily life, as emphasised by poststructuralist theory. They also operate as emotional and material constraints, embedded in person-to-person relationships…, and in laws, economics, violence… Given

> a multidimensional structure of relations, the likelihood of complex gender effects on health is obvious (38).

In this way, gender is enacted to the extent that individuals accept and reproduce power relations along the lines of gender, such as those around gender roles in an intimate partner relationship. In relational theory, gender influences individuals but is also reproduced with differences over time due to the sum of individuals' agency, as Connell states:

> The conceptual task, which has made gendered embodiment so difficult to theorize, is to give full weight both to the social processes that shape bodies, and to the way bodies themselves are active in social processes. To put this more technically, gender theory must recognize both social dynamics and the agency of bodies, and think of both of them together (38).

Violence has been viewed by theorists as a fluid social practice that is influenced by social structures, relations, and other practices such as masculinities and femininities, on multiple levels (38, 117). To understand how "gender" as a structure can imbue social practices in the relations between men and women with power, Connell and Messerschmidt delineated the concept of "hegemonic masculinities", which they subsequently revised in light of ongoing research, to mean:

> The pattern of practice (i.e., things done, not just a set of role expectations or an identity) that allowed men's dominance over women to continue… Hegemonic masculinity was not assumed to be normal in the statistical sense; only a minority of men might enact it. But it was certainly normative. It embodied the currently most honored way of being a man, it required all other men to position themselves in relation to it, and it ideologically legitimated the global subordination of women to men (42).

In their view, discourses on gendered social practices can become institutionalized as well as necessarily interacting with issues such as race, class, and culture (42). Connell cites that these intersections are historical, emerging in a given context. For example, she cites

Chakravarti's exploration of the way that one's caste and religion are centrally related to gender relations in Indian marriage customs (38). In this context, as discussed, intimate partner relational dynamics were affected by the fact that women belonged to certain castes as *Devadasis*. However, Connell and Messerschmidt assert that acknowledging hegemonic masculinities as socially and historically produced allows the possibility that gendered power relations can change to become more equal in a given context (42).

Here it is relevant to consider elements of the long-standing structure-agency debate in social theory to further elucidate the relationship between violence as a social practice and gender as a social structure (118). The definitions of social structure and agency continue to be illusive and variable. In early structural-functionalist theories, social structures are conceptualized to deterministically shape social practices, while other theorists developed interpretive social theory in which the subjective meanings of social actions constituted the social world, without giving much consideration to notions of structure or constraint (118). Moreover, too little appreciation for the structural constraints on individual agency can support the tendency in public health to put the responsibility on individuals to adjust their behaviour rather than address the structural issues that are beyond their control.

Relevant contributions to this debate have been provided by sociologist Anthony Giddens who, like Connell, suggested in his theory of structuration that individuals act within the constraints, opportunities and resources in the social structure, but also reformulate such structures through their actions (119). In this way, people are seen as productive agents and variability in practices in one direction may cause change in the

social structure (116). These theories have started to be applied to understand how social context influences the distribution of population health in theory (114, 116, 120). The structure-agency debate has led some to clarify understandings of social structure, as Sewell explains:

> The notion of structure does denominate, however problematically, something very important about social relations: the tendency of patterns of relations to be reproduced, even when actors engaging in the relations are unaware of the patterns or do not desire their reproduction (118).

According to Giddens, agency is not individuals' actual practices or actions per se, but their capability to act in such ways, which implies the involvement of power at the nexus of social structure and practices (119).

To envision the interaction between structure and agency, Giddens and subsequently Sewell and others, posit that social structure constitutes rules and resources that shape this capability by enabling or constraining individual agency. These rules are seen as, "techniques or generalizable procedures applied in the enactment/reproduction of social practices," and may include collectively agreed-upon conventions and mores (118, 119). These would include gender role expectations for behaviour of men and women that constitute gender norms, and the related "mistakes" that were implicated for triggering violence in this study. While Giddens conceived of resources as primarily material, resources are more helpfully defined by Frohlich and colleagues in their use of social practice theory. They explain how social practices, which indeed involve negotiations of power, are mutually-reinforcing with social conditions (or relationships with other people) to produce collective lifestyles (120). Further, they draw on Amartya Sen's theories that viewed "capabilities" as both material and immaterial resources, including

one's social conditions, as shaping agency (120). Hence intimate relationships are rightfully considered in the context of all the relationships, or social conditions, that women and men in this study experienced as shaping their agency. In this context, violence as a social practice can be seen to relate not only to social rules but also the material and immaterial (like social conditions) resources that individuals have to draw on that together make up the social structure.

Applying these theoretical concepts to the results of the study can help demystify how structural elements of gender impact behaviours including IPV in intimate relationships and vice versa. On the macro-social level of the integrated ecological model, FSWs were found to have fewer resources to draw on due to structural constraints from their gender, occupation and wider socio-economic stigma and criminalization of sex work. Gender also manifested on the community level as the rules that shaped gender role expectations, such as appropriate behaviour in a relationship distinct from yet in reference to those for marriage, that were held by both respondents and other reference groups in the community (105). This in turn influenced their individual capabilities, which involved the possession of power, to enact social practices around gender role expectations in line with social norms, and ultimately to choose to act in or reject violence. In the present study, the gender role expectations, which were said to ascribe to those in a marriage, were particularly important but difficult to fulfil for FSWs in intimate partner relationships, leading to "mistakes". Further, violence seemed to be a social norm for any male-female relation as an acceptable means to correct women's "mistakes", therefore

heightening the likelihood of violence occurring in the intimate relationships of *Devadasi* women.

Though men and women in the relationship largely held similar expectations and associated "mistakes" that justified the practice of violence, there was also variation in views as to whether this really held true. As others have suggested, such variability in social practices can produce change in the social structure of gender over time (38, 120). This would hold true if individuals were able to act contrarily to commonly-held gender expectations, such as the rejection of the norm that "mistakes" justified violence, which would in turn start to change the social rules that constituted the social structure of gender in the first place. However in our study, the interviews suggested that change was most likely achieved through collective means as individuals largely remained resigned or with little agency to reduce violence, whether or not they accepted it. This was due in part to silence around violence, and especially in intimate partner relationships that were said to not be socially sanctioned. This supports Leatherman's argument that when structural vulnerability to a health issue is quite high, it is crucial to pursue structural approaches that change the system rather than individuals adjusting to preserve the status quo:

> A space of vulnerability then configures a specific set of conditions in which people live, and sets constraints on how these conditions are perceived, how goals are prioritized, what sorts of actions or responses might seem appropriate, and which ones are possible. The goal is to examine how people operate within this space—at times in unpredictable ways and with remarkable creativity, improvisation, and resilience—and the consequences of their actions in (re)producing the contexts of vulnerability… In cases of high vulnerability—where risk to exposure is high and coping capacities are limited—it is likely that any response will carry negative costs and might further increase vulnerability. In such cases, it might be quite rational to seek to change the system, not adjust to it... (114).

For many women in this study, "structural vulnerability" as conceptualized here can be seen to be quite high due to distal factors like gender inequality within legal, economic and social institutions and the norms held by herself, her partner and the wider society around when "mistakes" justify violence. Hence, interventions to address structural vulnerability should be accompanied by a more central recognition of the unity of structure-agency in the study of health to determine who may be more vulnerable and why, as Leatherman states: "The idea, then, is to take…the unity of structure and agency that have been central to political-economy and political-ecology, and make these central to the way we study human biology, health, and lived experience" (114).

In line with the shift towards integrative theories for understanding IPV that are supported by this study, further considerations for understanding gender in terms of the structure-agency duality are supplied by feminist thinking including Connell's and others'. These theorists warn against overlooking the interaction of gender with power and agency, and also seek to destabilize binaries such as those between victim and victimizer, peace and violence (42, 117). Some of these elements have become better appreciated in integrative public health theories while other elements have not been as of yet (37). In particular, the view of women as naturally victims and men as victimizers can be problematized by our results, for example women also fought with their partners and still asserted their agency to the extent that they had the resources available to them, either materially or immaterially. Further, in this study it was evident that violence was not discussed by participants as the most prominent feature of their relationships, as intimate partners were important for fulfilling many goals and aspirations in each other's

lives. This resonates with Confortini's proposition that rather than viewing a relationship as violent or not, researchers must look at, "how islands of violence can exist within seas of peace and vice versa" (117). Hence, both the constraints and opportunities shaping social practices, such as those presented by gender and the related power relations between intimate partners, must be considered without overlooking the potential for individuals to act with resilience and produce change (38, 119). This is starting to become better appreciated in other studies to some extent, but deserves further exploration (121). These elements of feminist thinking should be better integrated into theories on IPV moving forward.

In light of these theories on "structural vulnerability", gender and IPV, our findings confirm that social structure and agency should be seen as united in a duality, rather than separate. As a result, efforts to address social structure, like gender, as well as "agency" should be tackled simultaneously and on multiple, interacting levels. Theories on the structure-agency duality as socio-historically produced suggest that points of intervention on these multiple levels can be identified by determining where variability may already exist and using positive aspects as catalysts for change. This has implications for how IPV facing FSWs should be addressed. One relevant example of a multi-leveled approach to IPV facing a "vulnerable" group that may lead to transformations in both structure and agency is Oetzel and Duran's study with American Indian and/or Alaska Native communities (51). Their approach draws on a social ecological model to assert a multi-leveled approach to IPV interventions that address vulnerability from individual to macro-social determinants including gender, as well as age, historical trauma from

colonialism, and infrastructure (51). In their paper, they advocate an approach that blends conventional and culturally-informed interventions at each level. Of particular relevance to KHPT's programs, their recommendations for community-level interventions draw on Paulo Freire's theories on critical reflection and action to increase awareness of the effects of colonization and to spur on collective action among men and women, supported by external partners, to best achieve change not only in the immediate environment but at a community level (51, 122). A somewhat similar approach has been taken in KHPT's community mobilization approaches for HIV/AIDS prevention. Through this they have aimed to develop and strengthen CBOs that may empower individual women by increasing "power within" themselves, collective "power with" others in their community, and through structural change surrounding the criminal justice system, stigma and discrimination, and access to social entitlements to create an "enabling environment" to reduce vulnerability to HIV (86, 123).

Further on the implications of this study, women's individual views and their identification with their community as sex workers both shaped the degree that they felt they must accept violence and the appropriate responses to violence. Some women tried to distance themselves from the identity of a "sex worker" to legitimize their intimate partner relationships. Yet for many, the presence of collective support, fuelled by the CBO's peer workers, seemed to be sparking a change in their ability to mediate conflict in their relationship, question male dominance, and even to act upon this belief through increased power within themselves as well as peer supports to reduce their dependency on their intimate partner on the individual level. In addition, counselling with the male

partners is being undertaken not only around conflict and anger management, but also around common gender role expectations and norms around violence to which they may ascribe. In light of the present analysis, these individual-level approaches must be accompanied by broader structural changes on the community and macro-social levels. For example, KHPT's intimate partner counsellors and some research committee members felt that an analogous approach to those working in communities on HIV/AIDS awareness and stigma reduction could be taken to reduce IPV at the community and societal levels (16, 98). These include community campaigns and sensitization to change social norms among men and families in general on the community level where necessary, and further work to improve access to entitlements, advocacy against stigma and discrimination, improved economic assistance, and change in laws that heighten the structural vulnerability of women in sex work at the macro-social level (16).

In support of these approaches to reduce "structural vulnerability", community-based research that involves meaningful partnerships with community-based organizations should aim to enhance the agency of all partners. This should be done by learning from community members' proximate position relative to the study subject, rather than viewing them simply as objects of study, as Confortini asserts, "the subject/object distinction relies on the assumption that the object is passive, thus rejecting the possibility of her agency and empowerment" (117). Though other research methods may be as or more appropriate for other contexts and subjects, this study has aimed to show how a CBR approach to IPV was apt for garnering valuable knowledge as well as being a part of the process towards relevant transformation. The results of this study

support the use of CBR to strengthen the results based on the different perspectives of those within and outside the community. The CBR process in itself may also contribute to increasing the community members' capability to reduce IPV and improve broader goals for well-being not only individually but structurally.

Chapter 6) Conclusions

6.1) Areas for Further Research

This study's findings point to the need for greater efforts to research the structural nature of "vulnerability" to IPV by examining aspects like those important here, such as variation in gender and violence norms, socio-economic exclusion or stigma, power relations, or other relevant social issues in a given context that underlie IPV (89, 124). Further, studies on IPV should continue to adapt the concept of agency and capabilities for understanding the degree of "structural vulnerability", while integrating contributions of critical theorists on the involvement of power and "empowerment" for addressing IPV. This should be done not only in relation to gender as a social structure, but through examining the intersections with race, caste, or other structural characteristics that play a role (90, 121, 125). Alongside the implementation of programs to address gender-related issues, particularly with an increased effort to involve men, ongoing evaluation research should be undertaken to assess the effectiveness of different approaches for achieving change in the relationships and social conditions that are experienced by those who are most likely to experience IPV (48, 88, 125). Finally, researchers should consider the benefits of community-based approaches that would integrate their research with health programs through long-term partnerships with local NGOs and CBOs. This may provide momentum towards greater application of CBR methodologies that enhance collaborative knowledge development and application to address important social and health goals (84, 106).

6.2) Strengths and Limitations

The present study involved both strengths and limitations. Taking a CBR approach necessarily lengthened the timeline and therefore delayed the application of results. As an ongoing evaluation, the results will nevertheless feed back into the *Samvedana Plus* program by providing the baseline findings. The selection of participants was constrained by difficulties in finding people who fit the criteria, and it was a convenience sample that did not aim to be representative. Thus the results cannot be generalized to other contexts without considering the degree of similarity in broader social conditions. Those who consented may have been those who were more open or less afraid to discuss violence, causing selection bias through the inclusion of less extreme cases. However the original line-listing included only those couples known to the intervention to have reported violence. The creation of the tools through collaboration with the research committee aimed to reduce the discomfort of asking questions of a sensitive nature, however there may have still been some social desirability bias or non-disclosure present in the findings, particularly around the extent of conflict and violence in the relationship. However, being able to interview the community research investigators on their perceptions of the respondents' levels of comfort and openness helped a great deal to gain a trustworthy account. Further, by interpreting the results with the research committee members, we could assess to some extent how representative the interviewees' experiences were in relation to their various understandings and experiences of intimate relationships. The results were also shaped by the ability of the newly-trained community research investigators to probe and on the respondents' abilities

to articulate their views. As in all studies this varied, but it was clear that after the first few interviews they became more in-depth with sufficient information to answer the research questions. Further, this may not have been possible without involving peers in the interviewing process due to the rapport that they were able to achieve. Hence, the drawbacks of using this approach were anticipated and addressed as much as possible, and seemed to be counterbalanced by the numerous benefits that it provided.

6.3) Concluding Remarks

Our study on women's and men's experience and understandings of IPV allowed an appreciation of the wide set of social circumstances contributing to "structural vulnerability" underlying IPV. In light of debates in broader theory and literature, these findings may provide an impetus to truly commit to appreciating and addressing the complex multi-leveled factors rather than falling back on individualized approaches. This implies that the *Samvedana Plus* intermediate outcomes that predominantly lie at the individual-level, such as self-esteem and critical thinking on gender and violence, would be optimally addressed by considering these within a wider structural context in the theory of change. This would ensure that the shifts in theory towards "structural" approaches, supported by the understandings of IPV in this study, will be put into practice by IPV interventions. Facilitated by a CBR approach, this study demonstrated that the structural vulnerability to IPV among women in sex work was reinforced by a range of other health and social issues that were part of their experience and understandings of IPV, such as their socio-cultural and economic position and their efforts to fulfil the hopes

for children's future and general well-being. It stands to reason that all of these could be addressed in concert by focussing on more distal factors rather than the current reliance on vertical programs addressing health issues separately, as Parkhurst argues in support of structural approaches to HIV/AIDS:

> Health is also included within the capability approach, with a ''healthy life'' seen as a key capability for people to function. This points to the flaw in promoting policies guided by health impacts alone. A healthy life may be important, but health is only one of multiple capabilities needed to enable individuals to achieve their full functioning potential (126).

This is relevant given the evidence on the overlapping nature of vulnerability to HIV/AIDS and IPV, and potentially other health and social issues. This implies a more complicated yet necessary step towards thorough and effective public health strategies that integrally involve stakeholders and work on multiple planes.

Further, adapting social theory on the structure-agency duality deepens an understanding of the role of the social context in shaping the degree of IPV vulnerability, specifically by elucidating how levels in the increasingly-applied ecological model interact through the mutual reinforcement of prevailing rules and resources in the social structure and individual social practices (116). In this view, there is hope for social change by virtue of this interaction between individual agency and social structures. Thus, efforts to reduce vulnerability to violence must aim to cause shifts in social structure as well as to expand capabilities and therefore agency. The need to address IPV on multiple levels supports the move towards more integrative theories rather than being limited to the assumptions of a single field of thought (41). Such integrative approaches would indeed permit a better appreciation of the intersections between individual practices and capabilities, social conditions and relations of power, and structural constraints and

opportunities afforded by social rules and resources. This study has aimed to show that critical thinking, debate and decision-making between research partners in local contexts can provide a means to assess relevant interactions between features of the current social structure and social practices, and expose variation that may provide wedges for interventions to address "structural vulnerability" to IPV and ultimately enhance broader health and well-being.

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Appendices

Appendix A: *Samvedana Plus* Evaluation Outcomes and Measures

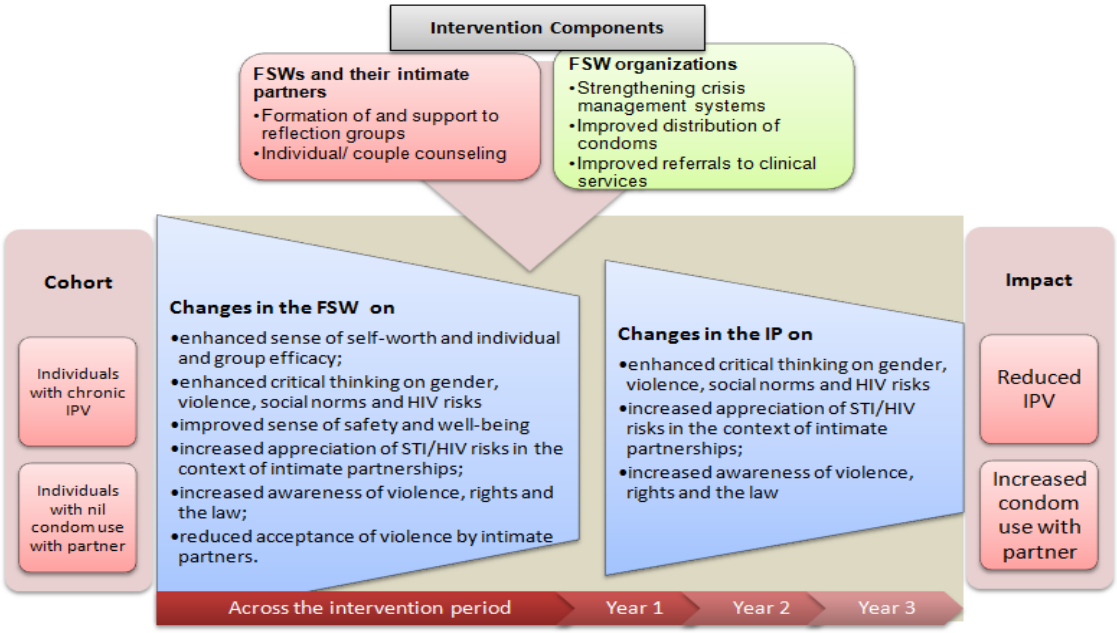


Figure 3: STRIVE Evaluation Case Study Component Conceptual Framework

Table 4: *Samvedana Plus* Intervention Outcomes and Respective Evaluation Qualitative Measures

Intervention outcomes	**Qualitative Measures in the Longitudinal Case Study**	
	Female Sex Worker	***Intimate Partner***
Increased individual processes and action to reduce intimate partner violence and STI/HIV risk	Narratives of how the women and their intimate partners are progressing towards increasing condom use and decreasing IPV.	
Enhanced sense of self-worth	Feelings about her value as a woman, mother, partner, earning member of family, decision-maker, community member, regarding her occupation, and perceived changes in these	N/A

	feelings brought about by participating in the intervention that influence levels of CCU and IPV.	
Individual efficacy	Perceived ability to deal with daily situations and problems, achieve her dreams and goals in life, have more control over condom use and sex in intimate relationships, and ability to find solutions for IPV.	N/A
Improved sense of safety and well being	Perceptions of feeling safe within the intimate partner relationship in relation to the partner, the family and community; her feelings of satisfaction about her relationships and life in general, and what aspects of the intervention have possibly influenced this.	N/A
Enhanced STI/HIV risk perception	Opinions on the perceived personal risk of contracting STI/HIV in intimate partnerships and perceived change in understanding the risk brought about by the intervention.	N/A
Skills for self-protection	Narratives from the women on their experiences in protecting themselves from IPV and negotiating condom use, and perceived changes the intervention has made.	N/A
Reduced acceptance of violence/ critical thinking on violence	Feelings and thoughts on the acceptability of different kinds of violence and their triggers within the relationship, the acceptability of different types of violence, any action taken to prevent or address violence in her life and in lives of other women (sex work or no sex work), in her community, and local FSW collectives' and/or interventions' role in preventing	Feelings and thoughts on different kinds of violence and their triggers within the intimate relationship, the acceptability of different types of violence, and the role of the intervention in addressing these underlying issues to

	and mitigating violence.	prevent/mitigate IPV.
Knowledge of violence, laws, and rights	Level of knowledge on available services or supports that relate to different types of violence in intimate relationships, including the Domestic Violence Act, and in relation to messages received while participating in the intervention and how that may have affected the use of violence or condoms in the intimate relationship.	

Appendix B: Conceptual Framework to Guide the Research

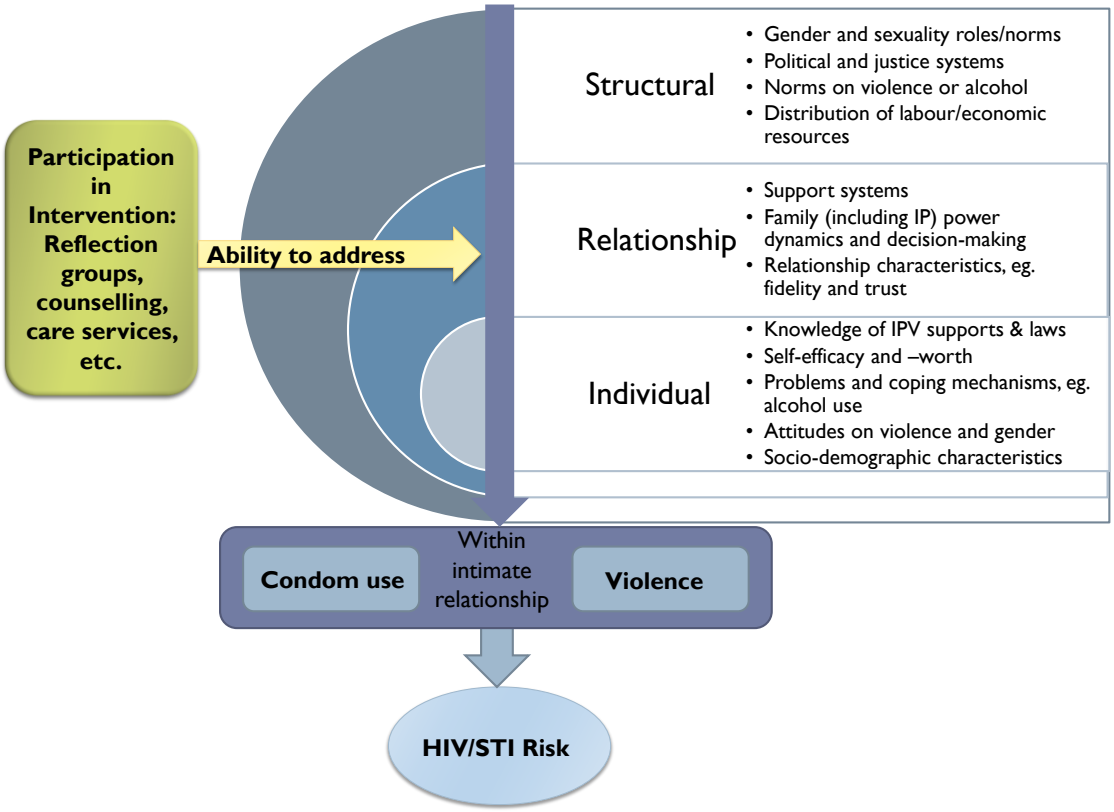


Figure 4: Adapted Ecological Framework for Addressing Underlying Factors related to IPV and HIV risk

Appendix C: Thesis Timeline

Table 5: Timeline of the Presented Thesis Research

Dates	Participants/Location	Activity
June 2012	-CBO leaders, KHPT, UM	-Research topic selection meetings in Bagalkot
May 2013	-“”	-Workshops on roles and responsibilities, research design, phases/timelines, participant and research committee selection criteria
June 2013	-KHPT, CBOs All in Belgaum	-Selected RC members -Planned orientation and tool development workshops for July 2013 in Bagalkot
July 2013	-CBO leaders, KHPT, UM in Belgaum	-Trained RC on research (qualitative and evaluation), ethics, and CBR -Developed research questions and started tool development in Belgaum
Aug 2013	-KHPT, LSHTM -KHPT -UM	-Approval of the protocol by KHPT, LSHTM -Ethical approval for the study protocol granted at St. John’s medical college, Bangalore -Wrote UM thesis proposal
Sept 2013	-All -UM	-Finalized the English and Kannada tools with LSHTM -Wrote UM thesis proposal and fill out ethics forms
Oct 2013	-UM -KHPT and RC	-Shared UM proposal with committee -Started selection of potential CRIs
Nov 2013	-UM	-Proposal defense
Dec-Jan 2013	-UM, KHPT, RC	-Select participants -Hire and train CRIs -Tailor the tool for CRIs use in local language
Jan-Apr 2014	-LSHTM -UM	-Ethical Approval at LSHTM -Ethical approval by UM HREB -Wrote literature review and methods in Thesis
May-Sept 2014	-KHPT	-Training, pilot testing and data collection with CRIs and male RI -Transcription and translation of interviews
October 2014	-UM -UM, KHPT and RC	-Coding of transcripts -Share results with CRIs, then RC for collaborative analysis and interpretation in Bagalkot
Oct 2014-	-UM	-Finished Methods in thesis

Jan 2015		-Wrote Results, Discussion and Conclusions in thesis
Feb 2015	-UM -KHPT	-Shared thesis draft with committee -Worked on manuscripts and reports with KHPT
March-April 2015	-UM	-Defended thesis and submitted to FGS

Table 6: Overview of CBR Meetings in North Karnataka, India

Meeting Dates	Location	Participants	Topics Discussed	Next steps
June 2012	CMS office, Mudhol, Bagalkot	Andrea, Raghavendra, around 7 *Chaitanya* reps	Research topic, CBR	Develop potential research committee
December 2012	CMS office, Mudhol, Bagalkot	Raghavendra, Parinita, Bagalkot CMS members	Orientation on CBR, potential members of Advisory committee	Form research committee, MOU details
May 28-30, 2013	CMS office, Mudhol, Bagalkot	Sapna, Andrea, Raghavendra, Mahesh, 11 CMS members	CBR, evaluation, methods, roles and responsibilities	Selection of research committee
June 2013	CMS and JMS in Bagalkot/Bijapur	Raghavendra, Mahesh, CMS	Selection of RC	Orientation and planning of research
July 9-11, 2013	Gyan Niketan, Belgaum	Andrea, Mahesh, Srikantamurthy, Chidambar, field RIs, 7 members of CMS RC	Orientation on CBR and research, tool development	Develop tool questions, protocol, hire and train RIs and select participants
August 21, 2013	CMS office, Mudhol, Bagalkot	Sapna, Gautam, 7 from CMS RC	Orientation on outcomes and tools, redevelop tool, RI selection criteria, reflections about	Plan training of RIs, recruiting participants and timeline revision

			CBR process	
September 23-25, 2013	CMS office, Bagalkot office	Sapna, Gautam (KHPT), Vinitha (translator), 5 from CMS Bagalkot, 6 potential RI candidates	Selection of CRI candidates and initial orientation, editing of tool based on LSHTM comments	Recruitment of RIs, plan for field training, recruit participants and reassess timeline
November 12, 2013	Belgaum	2 RCs from CMS, Sapna, Mahesh, Srikantamurthy, Chidambar, RIs (4), Vinitha	Discuss new changes and suggestions by LSHTM on selection of candidates and training of RIs, pertinent issues RCs wanted to raise	Decide how to select RIs, plan training workshops for December
December 10-13, 2013	Krishi Vigyan Kendra, Bagalkot Government Agricultural College	Sapna Nair, Mahesh Doddamane (Day 1-2), Srikantamurthy (Day 3), Chidambar Kabbur (Day 3-4), Vinitha V.K., 4 KHPT RIs, Martine Collumbien, Andrea Blanchard, 6 RC members, 8 potential CRIs	Orientation and Training on IPV, interviewing and research, and selection of CRIs; finalization of tool with CRIs	Field training, pilot testing of tool, of CRIs and data collection
May 20-23, 2014	KHPT Office, Belgaum	3 potential candidates for CRI, 1 selected CRI from Bagalkot. KHPT: Sapna, 2 RIS, Vinitha	Refresher training for the CRIs as part of the CBR; Training on tools, consent and ethics, and planning for	Field training and pilot-testing the tool

			field training and piloting.	
June 26, 2014	CMS office, Mudhol	2 selected CRI from CMS, KHPT: Sapna, 2 RIs, Vinitha	Review of piloting data and training for the CRI: review and training for CRI, field work planning	Data collection
September 26, 2014	CMS Office, Mudhol	2 selected CRI and 5 RC members from CMS and 2 CMS representatives. KHPT: Sapna, 3 RIs, Vinitha, Andrea	Experience-sharing from the field by CRIs, data collection process in the field, planned the analysis workshop with RCs in October	Analysis workshops with CRIs and RCs
October 16, 2014	CMS Office, Mudhol	2 selected CRIs from CMS. KHPT: Sapna, 3 CRIs, Vinitha, Andrea	Review and discussion on individual cases (IDIs) and summarize descriptive results for feedback from RCs	Analysis workshop with RCs
October 27-28, 2014	CMS training hall, Mudhol	2 selected CRIs and 5 RC members from CMS, representatives from CMS. KHPT: Sapna, 3 RIs, Vinitha, Chidambar, Andrea; Counsellors from Samvedana Plus	Overview of the CBR study, presentation of descriptive analysis by CRIs/KHPT, and interpretation and conclusion-drawing by RCs, CMS, and intervention team in groups	Incorporation of feedback to complete the analysis. Knowledge-sharing

Appendix D: Ethical Consent and Approval Forms

Informed Consent form for FSW Participants:

Karnataka Health Promotion Trust, Bangalore

Exploratory research with sex workers and intimate partner to understand how the intervention has affected the FSWs and IPs in addressing consistent condom use and violence in intimate partnerships

Information sheet

Explanation on purpose of this study:

Namaskar. As you know we work for Karnataka Health Promotion Trust (KHPT) Bangalore and KHPT is working since long time towards reduction of HIV. Female sex workers (FSW) are a distinct group of marginalized women that are more vulnerable to violence due to multiple factors. She may be in multiple intimate relationships that increases her vulnerability to both violence and health risks such as transmission of sexually transmitted infections and HIV. Programmatic interventions need to address the combined risk of gender-based violence and HIV.

Karnataka Health Promotion Trust (KHPT) plans to address this need under the STRIVE program by conducting a systemic intervention to address structural drivers of HIV among FSW in the northern Karnataka region. In this context a research is being undertaken to assess how the intervention has affected the FSWs and IPs in addressing consistent condom use and violence in intimate partnerships.

The information that you give will help for effective designing of further programs and the information provided by you will be kept secret and will not be shared with anyone. Your participation in this study is voluntary. Even if you agree to take part in the interview you have the freedom to not answer any question that you are not comfortable with and you can discontinue participating in the interview at any stage. For further clarifications carefully read this consent form and feel free to clarify any doubts that you may have regarding this study.

Methodology of the study

Longitudinal case study method will be used and the FSWs and IPs will be recruited at the beginning of intervention for a longitudinal case study through the intervention period of 3 years. Case studies will be constructed through interactions with the respondent every one year or sooner

Study Site

The study will be based in Jamkhandi and Mudhol taluks of Bagalkot district, North Karnataka. The study will be undertaken in collaboration with community based organization Chaitanya AIDS Tadegattuva Mahila Sangha in Bagalkot district.

Risks and dissatisfaction

By taking part in this study you may be exposed to the certain risks. There may be a lack of privacy while discussing sensitive issues; you might feel embarrassed while answering questions about your relationship with the partner and you might be scared when questions are of a personal nature.

To overcome these issues you are free to desist from answering questions that make you uncomfortable. As mentioned below secrecy will be maintained about information given and shared by you during the course of this study. I will be audio recording the conversation to aid the transcription processes.

Advantages:

Even if you and your community may not profit from this study in the short term, there are chances that it will surely be beneficial in the long run.

Duration:

The duration of study is 3 years and case studies will be constructed every year or sooner. Each interview will take about one hour each.

Confidentiality

We will not share your responses with any one; your name will not be mentioned in any communications related to this study; all information gathered will be kept confidential. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and that information will be stored in Bangalore under lock and key. It will not be shared with or given to anyone except researchers based in KHPT Bangalore, and in the UK and in Canada. Similarly, all the audio recordings will be coded and will be destroyed within 5 years from the beginning of the study.

Right to rejection: You can voluntarily participate in this study or you may not participate in the study. If you do participate you can reject it at any time. You decision not to participate will not affect any of the services that you may be availing and entitled to.

For any further clarifications or to clarify any doubts you may contact:
If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact: Dr. Shajy Isac, Karnataka Health Promotion Trust, 080-40400200 or Dr. Reynold Washington, St. John's Research Institute, 080-40400200

This proposal has been reviewed and approved by the Ethics Board of the St. John's Medical College, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find out more about study please contact the Ethics Board, contact : Member Secretary, Institutional Ethics Committee, St John's Medical College, Koramangala, Bangalore – 34 Bangalore Ph: 080 22065791/2

Karnataka Health Promotion Trust, Bangalore

Exploratory research with sex workers to understand the forms and manifestation of stigma and discrimination against HIV positive sex workers

Participant's consent

I have perused this form to the best of my ability and I have understood the purpose of my participation and have agreed to participate in the study. I also understand that the conversation maybe recorded and that I am free to stop my participation at any stage of this study.

Date: **Thumb Impression or signature of the participant**

Interviewer's undertaking:

I have understood the purpose and method of this study and I have read out and explained this to the interviewee in a simple manner and language.

Date: **Signature**

For participants who cannot read, or have difficulty in reading the consent form:
I, the undersigned, have witnessed the consent process for the participant named above and believe that the participant has understood and has knowingly given his consent.

Witness' Name Witness's Signature and Date

OR

Witnessed oral consent

I have perused this form to the best of my ability and I have agreed to participate and answer the questions and I have understood the purpose and my participation in this study. Herewith I am also giving my consent to record my interactions with the investigator and take photographs if it is required for the purpose of the study. I also understand that I am free to stop my participation at any stage of this study.

By allowing the witness to sign this consent form, I am not waiving any of my legal rights as a participant in this study, nor releasing the investigators or the sponsor from their legal and professional responsibilities.

Participant agrees to participate in this research study, and to answer the questions asked.

YES .....1 NO.....2

I, the undersigned, have witnessed the consent process for the participants, and believe that the participant has understood and has knowingly given consent as indicated above.

Signature of the witness:_____

Name of the witness:_____

I, the undersigned have fully explained the relevant details of this research study to the participant, and believe that the participant has understood and has knowingly given consent.

Name of interviewer:_____ Date:_____

Signature of interviewer:_____

Informed Consent Forms for Intimate Partner Participants:

Karnataka Health Promotion Trust, Bangalore

Exploratory research with sex workers and intimate partner to understand how the intervention has affected the FSWs and IPs in addressing consistent condom use and violence in intimate partnerships

Information sheet

Explanation on purpose of this study:

Namaskar. As you know we work for Karnataka Health Promotion Trust (KHPT) Bangalore and KHPT is working since long time towards reduction of HIV. I would like to talk to you about your thoughts on vulnerabilities among women in intimate relationships. Specifically, as a person related to the intervention we would also like you to share with us some experiences of yours. Some of this information may give us important lessons that can be used in an intervention that KHPT is implementing in this taluka.

The information that you give will help for effective designing of further programs and the information provided by you will be kept secret and will not be shared with anyone. Your participation in this study is voluntary. Even if you agree to take part in the interview you have the freedom to not answer any question that you are not comfortable with and you can discontinue participating in the interview at any stage. For further clarifications carefully read this consent form and feel free to clarify any doubts that you may have regarding this study.

Methodology of the study
Longitudinal case study method will be used and the FSWs and IPs will be recruited at the beginning of intervention for a longitudinal case study through the intervention period of 3 years. Case studies will be constructed through interactions with the respondent every one year or sooner

Study Site
The study will be based in Jamkhandi and Mudhol taluks of Bagalkot district, North Karnataka. The study will be undertaken in collaboration with community based organization Chaitanya AIDS Tadegattuva Mahila Sangha in Bagalkot district.

Risks and dissatisfaction
By taking part in this study you may be exposed to the certain risks. There may be a lack of privacy while discussing sensitive issues; you might feel embarrassed while answering questions about your relationship with the partner and you might be scared when questions are of a personal nature.

To overcome these issues you are free to desist from answering questions that make you uncomfortable. As mentioned below secrecy will be maintained about information given and shared by you during the course of this study. I will be audio recording the conversation to aid the transcription processes.

Advantages:
Even if you and your community may not profit from this study in the short term, there are chances that it will surely be beneficial in the long run.

Duration:
The duration of study is 3 years and case studies will be constructed every year or sooner. Each interview will take about one hour each.

Confidentiality
We will not share your responses with any one; your name will not be mentioned in any communications related to this study; all information gathered will be kept confidential. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and that information will be stored in Bangalore under lock and key. It will not be shared with or given to anyone except researchers based in KHPT Bangalore, and in the UK and in Canada. Similarly, all the audio recordings will be coded and will be destroyed within 5 years from the beginning of the study.

Right to rejection: You can voluntarily participate in this study or you may not participate in the study. If you do participate you can reject it at any time. You decision not to participate will not affect any of the services that you may be availing and entitled to.

For any further clarifications or to clarify any doubts you may contact:
If you have any questions you may ask those now or later. If you wish to ask questions later, you may contact: Dr. Shajy Isac, Karnataka Health Promotion Trust, 080-40400200 or Dr. Reynold Washington, St. John's Research Institute, 080-40400200

This proposal has been reviewed and approved by the Ethics Board of the St. John's Medical College, which is a committee whose task it is to make sure that research participants are protected from harm. If you wish to find out more about study please contact the Ethics Board, contact : Member Secretary, Institutional Ethics Committee, St John's Medical College, Koramangala, Bangalore – 34 Bangalore Ph: 080 22065791/2

Karnataka Health Promotion Trust, Bangalore

Exploratory research with sex workers to understand the forms and manifestation of stigma and discrimination against HIV positive sex workers

Participant's consent

I have perused this form to the best of my ability and I have understood the purpose of my participation and have agreed to participate in the study. I also understand that the conversation maybe recorded and that I am free to stop my participation at any stage of this study.

Date: **Thumb Impression or signature of the participant**

Interviewer's undertaking:

I have understood the purpose and method of this study and I have read out and explained this to the interviewee in a simple manner and language.

Date: **Signature**

For participants who cannot read, or have difficulty in reading the consent form:
I, the undersigned, have witnessed the consent process for the participant named above and believe that the participant has understood and has knowingly given his consent.

Witness' Name Witness's Signature and Date

OR

Witnessed oral consent

I have perused this form to the best of my ability and I have agreed to participate and answer the questions and I have understood the purpose and my participation in this study. Herewith I am also giving my consent to record my interactions with the investigator and take photographs if it is required for the purpose of the study. I also understand that I am free to stop my participation at any stage of this study.

By allowing the witness to sign this consent form, I am not waiving any of my legal rights as a participant in this study, nor releasing the investigators or the sponsor from their legal and professional responsibilities.

Participant agrees to participate in this research study, and to answer the questions asked.

YES .....1 NO.....2

I, the undersigned, have witnessed the consent process for the participants, and believe that the participant has understood and has knowingly given consent as indicated above.

Signature of the witness:_____

Name of the witness:_____

I, the undersigned have fully explained the relevant details of this research study to the participant, and believe that the participant has understood and has knowingly given consent.

Name of interviewer:_____ Date:_____

Signature of interviewer:_____

University of Manitoba Human Research Ethics Board Approval:

UNIVERSITY OF MANITOBA | BANNATYNE CAMPUS Research Ethics Board

P126 - 770 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Telephone 204-789-3255
Fax 204-789-3414

HEALTH RESEARCH ETHICS BOARD (HREB)
CERTIFICATE OF FINAL APPROVAL FOR NEW STUDIES
Delegated Review

PRINCIPAL INVESTIGATOR:	INSTITUTION/DEPARTMENT:	ETHICS #:
Ms. A. Blanchard	UofM / Community Health Sciences	H2014:108
APPROVAL DATE: April 16, 2014	**EXPIRY DATE:** April 16, 2015	
STUDENT PRINCIPAL INVESTIGATOR SUPERVISOR (If applicable): Dr. S. Bruce		

PROTOCOL NUMBER:	PROJECT OR PROTOCOL TITLE;
NA	A Community-Based Qualitative Study to Explore the Experience and Understandings of Intimate Partner Violence among Female Sex Workers and their Intimate Partners in Karnataka, India
SPONSORING AGENCIES AND/OR COORDINATING GROUPS: Department of International Development	

Submission Date of Investigator Documents:	HREB Receipt Date of Documents:
March 11 and April 10, 2014	March 12 and April 10, 2014

THE FOLLOWING ARE APPROVED FOR USE:

Document Name	Version(if applicable)	Date
Protocol: Protocol		April 8, 2014
Consent and Assent Form(s): Witnessed Oral Consent for Female Sex Workers received April 10, 2014 Witnessed Oral Consent for Intimate Partner Participants received April 10, 2014		
Other: Interview Guides received March 12, 2014		

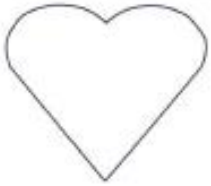
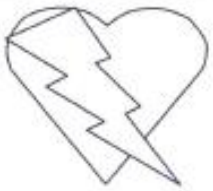
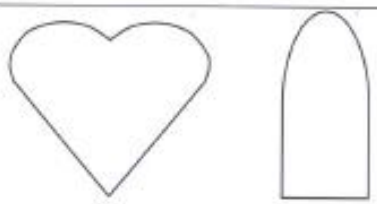
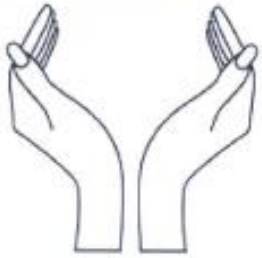
CERTIFICATION
The above named research study/project has been reviewed in a ***delegated manner*** by the University of Manitoba (UM) Health Research Board (HREB) and was found to be acceptable on ethical grounds for research involving human participants. The study/project and documents listed above was granted final approval by the Chair or Acting Chair, UM HREB.

HREB ATTESTATION
The University of Manitoba (UM) Research Board (HREB) is organized and operates according to Health Canada/ICH Good Clinical Practices, Tri-Council Policy Statement 2, and the applicable laws and regulations of Manitoba. In respect to clinical trials, the HREB complies with the membership requirements for Research Ethics Boards defined in Division 5

Appendix E: Kannada FSW In-Depth Interview Guide Pictorial Prompter

ಸೂಚನೆ ಪಟ್ಟಿ

 ಸಂಬಂಧಗಳು	ಸಂಬಂಧಗಳು(ಚಿತ್ರ) ಕೊಡುವದು ಪಡೆಯುವುದು
 ನನ್ನ ಬಗ್ಗೆ	ಧಂಧಾ ಯಾರಿಗೆ ಗೊತ್ತು? ನಿಮ್ಮಲ್ಲಿ ಇಷ್ಟಪಡುವದು/ಇಲ್ಲ ನಿನ್ನಲ್ಲಿಇಷ್ಟ/ಇಷ್ಟ ಇಲ್ಲ. ಬೇರೆಯವರಲ್ಲಿ ಒಳ್ಳೆಯ ಗುಣ ಬದಲಾವಣೆ
 ತೊಂದರೆ/ ತ್ರಾಸು	ಎಲ್ಲಾ ತೊಂದರೆ/ತ್ರಾಸು ಮುಖ್ಯ ತೊಂದರೆ ಏನಾಯಿತು ನೀವು ಏನು ಮಾಡೀರಿ

 ಲವರ್	ಇಷ್ಟ ಪ್ರೀತಿ ತೋರಿಸುವುದು ಆಸೆ/ಆಕಾಂ ಕುಟುಂಬ ಸಂಬಂಧ
 ಹಿಂಸೆ	ಭಿನ್ನಾಭಿಪ್ರಾಯ ಹಿಂಸೆ &ಕಾರಣಗಳು ಇತ್ತೀಚಿನ ಅನುಭವ. ನೀವೇನು ಮಾಡಿರಿ? ಎಷ್ಟು ನಂಬಿಕೆ? ಹಿಂಸೆ ಒಪ್ಪಿಕೊಳ್ಳುವ ಮಹಿಳೆ. ಇಲ್ಲದಿದ್ದರೆ ಏನಾಗುತ್ತದೆ? ನಾವು ಹಿಂಸೆ ಒಪ್ಪಬೇಕಾ? ಯಾರು ಹೇಳುತ್ತಾರೆ?
 ಕಾಂಡೋಮ್ ಬಳಕೆ	ಮಹಿಳೆಯ ಲವರ್ನ ಕಾಂಡೋಮ್ ಬಳಕೆ. 10ರಲ್ಲಿ ಎಷ್ಟು? ನೀವು ಬಳಸುತ್ತೀರೆಂದುಇತರೆ ಮಹಿಳೆಯರು ಅಂದುಕೋತಾರಾ? ನೀವು ಬಳಸ್ತೀರಾ? ಹೇಳದರೆ ಏನಾಗುತ್ತದೆ?
 ಯೋಜನೆ	ಯಾರು ಸಹಾಯ? ಅದು ಎಷ್ಟು ಸಹಾಯಕಾರಿ? ಕಾನೂನು, ಯಾರು ಹೇಳಾರ? ಹೆಂಗ ಸಂತೋಷ & ಸುರಕ್ಷತೆ?

Appendix F: Collaborative Analysis Results

Figure 5: Group 1 Collaborative Analysis Diagram (Kannada)

Figure 6: Group 1 Collaborative Analysis Diagram (English)

Figure 7: Group 2 Collaborative Analysis Diagram (Kannada)

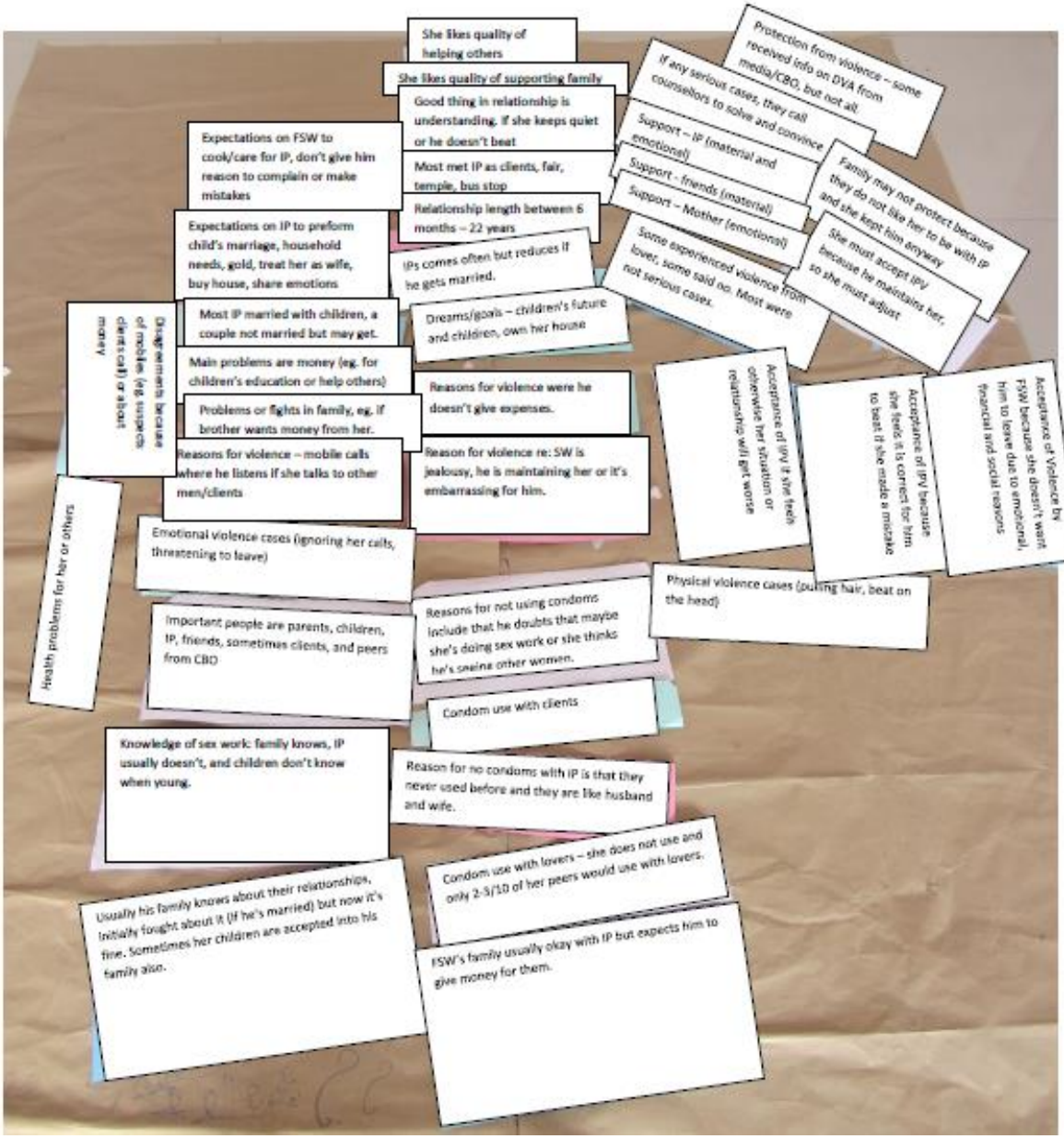


Figure 8: Group 2 Collaborative Analysis Diagram (English)