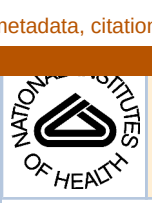

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Intimate Partner Violence Is As Important As Client violence in Increasing Street-based Female Sex Workers' Vulnerability to HIV in India

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Abstract

Objectives—There are no studies that examine street-based female sex workers' vulnerability to HIV from both clients and intimate partners. This study documents street-based female sex workers' experiences of client and intimate partners, examines the intersections of violence, alcohol use in condom use, and highlights survival strategies used to avert harm.

Methods—Ethnographic data were collected from 49 female sex workers though focus group discussions and in-depth interviews.

Results—Female sex workers experienced multifarious forms of severe client and intimate partner violence. Sexual coercion and forced group sex in the context of alcohol use posed formidable barriers for condom use negotiation. Further, traditional gender norms dictated women's inabilities to negotiate condom-use with intimate partners. However, there was evidence of adoption of successful survival strategies in the face of danger and women's positive evaluations of the benefits of sex work and their contributions to family well-being.

Conclusions—Harm reduction efforts with female sex workers need to account for their vulnerability to HIV from intimate partners in addition to clients. HIV prevention programmes need to include male clients in order to reduce harm among street-based female sex workers. There is an urgent need to build on sex workers' strengths and involve them in designing individual level, community, and structural interventions that could help in reducing women's vulnerability to intimate partner violence and HIV in India.

Keywords

Female Sex workers; violence; client-violence; intimate partner violence; HIV; alcohol; India

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Background

Globally, sex work been recognized as an important factor in the spread of HIV/AIDS (UNAIDS, 2006). Women around the world have resorted to sex work as an income generating activity for centuries (Mulia, 2006) in the face of scarce resources to cope with crises and provide for their families. Financial dependence on men, inequitable power relationships and often violent intimate relationships for women around the world heightens their vulnerability to infection due to constraints in condom negotiation, and norms and expectations of partner fidelity (Heise, 1993; Jewkes, et al., 2003; Rao Gupta, 2002; UNAIDS, 2007).

In India, there are an estimated 3 million adults infected with HIV and heterosexual transmission is the primary mode of HIV acquisition (Dandona, et al., 2006). HIV in India was first detected among female sex workers (FSWs) in South India (Simoes, et al., 1987). Since then, studies have shown high prevalence of infection among female sex workers and their clients (Gangakhedkar, et al., 1998). Indeed, future projections of HIV in India have suggested that working with sex workers and their clients to promote harm reduction will contribute to significant reductions in the burden of HIV (Venkataramana & Sarada, 2001).

Sex work in India is both complex and diverse. Definitions of and self-identification as sex workers vary as do number of clients, length of time spent in sex work and reasons for being in sex work (Dandona, et al., 2005; 2006). Further, there are inter and intra-regional differences. However, harms to women arising from sex work have similarities which can be categorised as those arising from contextual factors and those from individual factors. The context of sex work introduces harms such as client violence, exploitation, infection resulting from an inability to negotiate condom use, and criminalisation; while individual factors could include background factors that influence women's entry into sex work, substance use, and experiences of childhood and intimate partner abuse (Cusik, 2006). Primarily, harm is caused due to FSWs' inability to use condoms with sexual partners. This is fuelled by harassment, physical violence, rape, and forced unprotected sex at the hands of clients, passers-by, security personnel, hotel managers, gangs, pimps, and police (Asthana & Oostvogels, 1996; Izugbara, 2005; Jayasree, 2004; Wechsberg, et al., 2005). Research evidence highlights client resistance to condom use and lack of power in negotiating safe sex with clients as critical in placing FSWs at higher risk for sexually transmitted infections and HIV (Asthana & Oostvogels, 1996, Bhave, et al., 1995; Chattopadhyay & McKaig, 2004; Jayasree, 2004; Pauw & Brener, 2003; Wojciki & Malala, 2001).

One of the important individual factors highlighted in past research is substance use by FSWs and clients. FSWs' use of alcohol (Gossop, et al., 1994; Izugbara, 2005) and/or psychotropic drugs to cope with the physical, emotional, and psychological distress of sex work contributes to their vulnerability significantly (Romero-Daza, et al., 2003; Vanwesenbeeck, 2001) and may also increase exposure to harm by decreasing the ability to engage in safe sex or increasing the possibility of violent/forced sex. In India, male alcohol use has been found to be a risk factor for unprotected sex with FSWs and acquisition of STI/HIV (Madhivanan, et al., 2005), and also with concurrent sexual partners (Schensul, et al., 2006).

Addressing partner violence is critical to reducing harm to women and may be a risk factor for HIV infection among women (Dunkle, et al., 2004; El-Bassel, et al., 1998a,b; Maman, et al., 2002). Studies from India not only demonstrate gender differences in risk of HIV/STIs (Panchanadeswaran, et al., 2006a), but also suggest that violent episodes between sexual partners are high and frequent (George, et al., 1998; Go, et al., 2003; Shrotri, et al., 2003; Panchanadeswaran, et al., 2006b). Intervening among sex workers and their clients therefore is a key national priority. Comprehensive structural interventions geared towards HIV

prevention and harm reduction for FSWs such as those in Sonagachi in Kolkata, India (Cohen, 2004; Jana, et al., 2004) and Thailand's 100% condom promotion campaign (Hanenberg, et al., 1994) have been effective when they addressed contextual and individual risk factors. However, these interventions were conducted in brothels. Although they are relevant to sex workers in a myriad of circumstances, they do not address some of the most important risk factors for the most marginalized FSWs-- those who are street-based.

In Chennai city, where this study is based, sex work practice is not organized into brothels and a significant proportion of FSWs are street-based. Other studies in India suggest that sex workers work part-time or on a seasonal basis (Dandona, 2005). Addressing HIV prevention effectively requires understanding the unique prevention needs of these non-brothel based FSWs. In this study, we proposed to contribute to this understanding by studying a sample of street based sex workers in Chennai. The specific aims of the current study were to: 1) Describe the various forms of intimate partner and client violence experienced by female sex workers; 2) Explore how experiences of violence, sexual coercion and alcohol use impacted sex workers' abilities to negotiate condom use; 3) Document specific survival and coping strategies used by women to avert harm.

Methods

Sample and data collection

This study was nested within a five-country NIMH Collaborative HIV/STD Prevention Trial study that seeks to test the efficacy of HIV prevention messages delivered through community popular opinion leaders (CPOLs). Briefly, CPOLs are individuals whose friends and close associates look to for advice, affirmation and counsel (Kelly, 2004). The considerable formative research that accompanied identifying and recruiting study participants in this trial found that male wine shop patrons and female sex workers who solicited clients at these venues were are highest risk for infection (Sivaram, et al., 2007; 2004; 2005). The current study was an attempt to gain a deeper understanding of the risks of FSWs in Chennai. The rapport built during the NIMH trial was evidenced in FSWs' continued involvement in prevention efforts and hence helped in the recruitment process for this study.

Recruitment of FSWs involved a multi-pronged approach. Initially, trained trial field staff conducted regular, bi-weekly field trips to various locations in Chennai city to talk to key contacts and CPOLs about the study. These FSWs provided word of mouth referrals to others in their social networks. Potential respondents were provided contact information of the project staff. Subsequently, identified FSWs were approached for participation in the study, in either focus group discussions or in-depth interviews. We did not record data about women who refused participation in the study. A sex worker was considered eligible to participate in the study if she: (1) had been a female sex worker for at least one year, (2) reported being in an intimate relationship with a non-paying male sexual partner currently/in the past year, and (3) reported experiencing at least one form of violence (verbal/physical/sexual) from either clients and/or intimate partner in the past year, (4) solicited clients on streets and public venues such as cinema halls, bus terminals, railway stations, hotels/lodges and/or independently/through brokers/through informal social networks and provided sexual services at a venue of the client's choice.

Between March and July 2004, 49 FSWs participated in eight focus group discussions and eleven face-to-face in-depth interviews. Four trained female ethnographers were responsible for data collection. The first author and the NGO's lead ethnographer (second author) provided on-site refresher training in conducting focus groups and in-depth interviewing. In-depth interview and focus group guides were pre-tested and subsequently finalized. Written, informed consent completed the recruitment process. The protocols and procedures were

approved by institutional review boards from both Johns Hopkins University and YRG Centre for AIDS Research and Education (YRG CARE) in Chennai.

We collected information on three domains – women's experiences of violence, role of violence, sexual coercion and alcohol in condom use, and specific survival and coping strategies. Focus group discussions lasted for around 2 hours, while in-depth interviews on an average lasted about 80 minutes and were conducted in the YRG CARE office at times that were convenient for the respondents.. Focus group discussions and in-depth interviews were conducted in the local language, Tamil, audio taped with the women's permission.

Data analysis

Interviews and discussions were translated and transcribed verbatim into English. All transcripts were checked by the first author (fluent in the local language Tamil and English) and the (second author) for translation accuracy and appropriate representation of the respondents' thoughts. All data were stripped of any identifying or personal information. Data were analyzed using Atlas.ti (Muhr, 2004). A broad coding plan based on existing literature was developed by the first and the ninth author based on the aims of the study. A line-by-line coding of the transcripts was undertaken. Responses to questions on violence, coercion, alcohol use and coping strategies were segregated and compared across interviews and focus groups. Sub-categories of data were clustered into broad themes. Prominent themes that emerged from analysis included: intimate partner violence, client violence, sexual coercion, alcohol use, and condom negotiation. Attention was paid to negative case analysis (Mays and Pope, 2000) to refine analysis and enable better understanding of the associations between phenomena under study. An additional theme that emerged was the circumstances that reinforced women's tenure in sex work and the perceived benefits of sex work. Results are organized according to the three domains of data collection: violent experiences, violence, coercion, and alcohol as factors influencing condom use, and survival and coping strategies. Finally, the specific circumstances that force women to persist in sex work and their perceptions of benefits are presented.

Results

Sample profile, marriage, and intimate relationship and entry into sex work

The mean age of women was 35.13 years (S.D. = 4.34, range: 25–42). Years of schooling ranged from none to ten years. All women, except one had been born and raised in Chennai city. All respondents identified themselves as 'currently married,' and in most cases, their families had arranged their marriage. Male partners of FSWs in our sample could be classified into 3 types: (1) 'paying sexual partners' (one-time clients) with whom women did not have an ongoing relationship, (2) 'paying regular partners' (regular clients) who saw sex workers periodically and who possibly had other partners; (3)'non-paying intimate partners' with whom women had an ongoing, often cohabiting relationship. These included husbands or ex-clients who women considered 'husbands'. Most of the women in the sample were separated from their husbands and were living with a 'non-paying' intimate sexual partner (an ex-client) who they considered 'husbands', including two widowed and one woman whose husband had deserted her. Women considered the intimate relationships with these 'non-paying' partners identical to a matrimonial relationship. Despite the dysfunctional nature of the relationships, FSWs perceived that their 'marriage-like' relationships accorded them respectability in their communities as is highlighted in the following quote by an in-depth interview participant:

> I used to think why I should live such a horrible life with him. But I know how difficult it is to survive with out any support. Generally it is very difficult to lead a life with out a male support. People wont give us a house for rent if we are single, so a life partner is must for survival. So I made up my mind to live with him and take care of

> my children, so that people will not talk behind me and I will have a male support to lead my life.

Women's narratives highlighted the meagre financial resources at their disposal and underscored poverty as the primary reason for women entering sex work. Necessity to provide for the family, especially children, and financial crisis overrode any resistance that women may have felt in entering the sex trade. In the context of unstable marriages, unreliable partners, lack of education and vocational skills, sex work seemed to be the only option available to many women. There was also evidence of women being forced into sex work by their husbands.

Experiences of various forms of intimate partner and client violence

FSWs in the current study reported experiencing a wide range of abusive behaviours from their regular, non-paying intimate partners, including emotional, verbal, physical and sexual violence. Data pointed to sexual jealousy and constant suspicions of infidelity as one of the main reasons that often led up to violent episodes. As one in-depth interview participant explained:

> I was deserted earlier by my first husband, probably because of that he (the current partner) constantly suspects me of having sexual relationships with other men. He hit me, caused injuries that I had to get stitches for, punched me, and burned me. He verbally abuses me constantly in vulgar terms…it is a horrible life.

Women's narratives in focus groups and interviews also pointed to episodes of severe physical violence with intimate partners, often with serious consequences as one woman pointed out, "Because of the severe violence, my eyes have been affected and now I have a problem with my eyesight." Another woman shared her experience, "He has even beaten me with an electric wire and subjected me to an electric shock."

There was also evidence of the violence from clients and potential clients on the streets, "When we are standing on the road, they (clients) will push us and beat us" and "They will also harass and verbally abuse using vulgar words, some others will say- 'I will pour acid on your face'."

Role of violence, sexual coercion and alcohol in condom use

Women faced a myriad set of risks from the inherently dangerous sex work environment including threats, violence and rampant sexual coercion, issues that were highlighted in focus group discussions: "We can't refuse when they ask us to have sex in different positions; they will pay only if we agree to do it….that is why our health is worsening." Another woman explained, "They will demand anal sex. When I had anal sex, I started bleeding, but we have to adjust to all those things." Forced group sex was also extremely common as the following quote reveals:

> One customer will come and pay the fee for himself, but then there will be ten men and they will not give more money. The others will be waiting by a bike or auto. The person will call other people, telling them to come with two or three people to have sex with her. They will threaten her to have sex with a lot of people for Rs.100–200.

Coercion, especially in the context of clients' alcohol use proved a formidable barrier in condom negotiation as women's narrations revealed:

> Clients have the tendency to shout when they are drunk and yell and also refuse to use condom during intercourse.

> Most of the time, they (clients) come fully drunk…and behave really badly. One of my friend's clients came in fully drunk, insisted on having sex, and started biting her breast and hurt her with burning cigarettes.

Negotiating condom use with regular non-paying intimate partners was a complex process for women. As women in in-depth interviews explained:

> Even if we tell them (intimate partners) about condom usage, they ask questions about trust and whether we are accusing them of going to a prostitute, this in turn creates lots of problems in the family. So we never ask our husband to use a condom.

> We cannot negotiate condom usage with our husband. But we can ask clients to wear condoms…we can tell them about the consequences, explain the reasons why he should use a condom. We can also walk out if they don't want to use a condom. But we cannot walk out on our husbands.

In focus group discussions, women shared their helplessness in the context of their own alcohol use:

> Some clients take us to parties, they ask us to drink so that we lose our consciousness and they come and have sex with us at that time. At those times, we will not be aware of how many men come and have sex with us. It does not stop there. Even the lodge owner comes and has sex with us.

Survival and Coping strategies adopted by sex workers

FSWs in our study used myriad strategies to remain safe and protect their health in the risky and dangerous sex work environment. These ranged from fixing rates and collecting the payment in advance, non-confrontation with problematic clients, encouraging potentially violent clients to get drunk, enlisting the help of peers and building strong supportive networks, coaxing, pleading, and reasoning, to aggressive retaliation in public places as illustrated by an in-depth interview participant:

> We also shout at them and tell them very clearly- 'Don't shout like that. We have come to this profession to survive so if the rate is ok you can continue with us, other wise you can leave this place.'

Some of the respondents also displayed personal power and strength in their abilities to successfully negotiate condom use with clients and also not accede to clients' demands. As one respondent highlighted, "Two clients asked me to come (have sex) without using Nirodh (the local brand of condom). But I refused them." Another woman's narration underscored the use of aggressive negotiation strategy:

> Generally, we don't remove our clothes completely, whereas our clients ask us to remove our clothes, they say that we pay you and so you have to do what ever we ask to do. But we will not do everything that they demand. We just tell them 'If you are willing, come, otherwise you can carry on with some one else'.

Circumstances that reinforced women's tenure in sex work and perceived benefits

Partner alcohol use, under/unemployment, and pervasive intimate partner violence, including severe physical and sexual violence contributed to the persistent instability of marital/regular intimate relationships that forced women to take the lead in providing for their families and reinforced their positions in sex work as the following quotes highlight:

> He won't go for job at all and all the time he will be fully drunk. I have waited for long … what to do? I have to take care of my children so I took this profession. Now he fights with me and hits me saying that I go out for sex.

Another respondent highlighted women's helplessness in the face of inequitable gender norms that condone risky male behaviour: "Men have affairs; some times they don't come home. If the wife asks him for the reason he will start hitting her and break her head." However, there

was ample evidence of women's perceptions of the benefits of sex work. As one respondent said, "Whatever profession I might be in but I have given my children a good education." Many women also acknowledged their contributions in providing for their families and retained a sense of self-worth as the following quote shows:

> In most cases men they don't take up their responsibilities, they beat their wife, torture her, they drink alcohol, don't give money to run the family, don't take care of the children. Here the woman takes up the role of taking care of her family, goes for this trade and starts earning for the family. A woman faces poverty, violence, torture, and lots of hardships. So I feel a woman who undergoes all these problems is an ideal woman.

Many women shared comfortable friendships with some clients, who even served as their protectors under some circumstances, a quality that they did not often experience with their intimate partners. As one interview participant highlighted:

> Some (clients) who are very happy with my services will pay for the auto ride or give provisions for my family in addition to the regular fees. Some men just come for pleasure for five minutes. If there are problems with rowdies some clients will protect me by saying, 'She's my wife.'

Discussion

This is one of the first studies in India to document street-based female sex workers' multi-faceted vulnerability to HIV that stems from not only their work environment, but also from their intimate relationships. Co-occurring phenomena of violence, sexual coercion and alcohol use posed serious challenges for sex workers to remain safe with clients as well as intimate partners. Findings related to women's entry into sex work precipitated as a result of financial crises and being forced by partners was similar to earlier studies (Majumdar, 2004). Our study found ample evidence of the harms stemming from the sex work environment similar to earlier research, specifically, client violence (Asthana & Oostvogels, 1996; Izugbara, 2005; Jayasree, 2004); sexual coercion, and alcohol use (Gossop, et al., 1995). Findings relating to forced group sex that heightened FSWs' risk for HIV acquisition suggest that working with male clients is essential to reduce harm among street based sex workers in Chennai. Studies that seek to understand motivations for group sex and male norms about sex with sex workers can inform the development of gender norm transformative approaches that have worked earlier (Jewkes et al., 2007).

Our findings highlighted the multiple identities of female sex workers in Chennai as in earlier research (Wolffers, et al., 1999) as wives/intimate partners, sex workers, mothers, and as key providers for the family. Significantly, despite knowledge of their intimate partners' risky behaviours, women seemed to adhere to culture specific gender norms where condom use negotiation was concerned in intimate relationships, but displayed higher efficacy in their abilities to insist on condom use with clients as in earlier studies (Pyett & Warr, 1997). Experiences of partner violence and women's perceived helplessness appeared to cement and prolong their tenure in sex work. Interventions that focus on eliminating barriers to male condom use will need to be essential components of harm reduction efforts. Indeed, prospective studies in south India have shown that slight reductions in HIV incidence in the last five years can be attributed to increased condom use among men (Kumar et al, 2006).

Harms resulting from sex work can be grouped into those that are instrumental in women's entry into sex work, those that occur in the sex work context and factors/behaviours that contribute to sex workers' vulnerability (Cusik, 2006). Client violence in the sex work environment and exposure to intimate partner violence reinforced harms for sex workers in our study. Significantly, women's personal evaluations of the benefits of sex work and their

agency in adopting survival and coping strategies to stay safe and healthy provided evidence of the potential for introduction of harm reduction strategies among in this group. Harm reduction programmes for female sex workers in this group would need to adopt a multi-pronged strategy, including addressing structural and individual factors. Structural programmes should be based on existing models that address education, training and skills that enable women to pursue viable, alternate income generating options in addition to social campaigns that direct societal attitudes and discrimination against and decriminalization of sex workers, and social, educational and family policies that address needs of vulnerable populations (Cusik, 2006). The second set of harm reduction programmes would need to acknowledge and build women's personal survival strategies to assess and deal with risks, enhance personal empowerment that aid self-determination, and facilitate peer education on HIV knowledge, safe sex practices, and condom negotiation techniques (Rekart, 2006). Finally, the success of programmes for sex workers depends on facilitating the participation of sex workers themselves in the planning and outreach activities in order to mitigate harm and save lives.

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