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A Family-Based Sexual Health Communication Intervention With Sex Worker Mothers in Kolkata, India

Abstract

Objective: Increased parent-child communication has been found to strengthen family relationships and reduce adolescent sexual risk behaviors. These processes, however, have not been studied in the sex worker population. Given the fact that the children of sex workers often do not leave the sexual risk environments inhabited by their mothers, the manner in which sex worker mothers shape their children's sexual risk behaviors is crucial to their health and well-being. Family-based sexual health communication interventions (FSHCI) have the potential to change adolescent sexual risk behaviors within the sex work community.

Methods: Utilizing a sequential mixed-methods design, this study 1) explored sex worker mothers' normative, behavioral, and control beliefs about sexual health communication with their adolescent children by conducting in-depth qualitative interviews with 34 sex worker mothers, 2) utilized the results of this analysis to design a FSHCI collaboratively with Durbar, a sex worker collective in Kolkata, India, and 3) tested the feasibility and preliminary efficacy of the FSHCI in improving the frequency of mother-children communication about sexual health with a small sample of sex worker mothers.

Results: Durbar's collectivizing processes were instrumental in shaping participants' orientation to sexual health communication with their children. FSHCI was successful in changing participants' attitudes and comfort about sexual health communication and the frequency of sexual risk reduction communication. Furthermore, participants' attitudes and perceived behavioral control were significantly correlated with the frequency and comfort of sexual health communication.

Conclusion: This is the first study to explore mother-child sexual health communication and test a FSHCI in the sex worker community. Findings support the importance of understanding both community and family level processes in developing and implementing interventions. Findings also support the feasibility of a FSHCI in the sex worker community.

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A FAMILY-BASED SEXUAL HEALTH COMMUNICATION INTERVENTION
WITH SEX WORKER MOTHERS IN KOLKATA, INDIA

Samira Ali

A DISSERTATION

In

Social Welfare

Presented to the Faculties of the University of Pennsylvania
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DEDICATION

I would like to dedicate this dissertation to Durbar, who welcomed me with open arms to and treated me like family.

I would also like to dedicate this dissertation to my parents, Bashir Ali and Saeeda Suleman, who have always been supportive and never discouraged me to fulfill my dreams.

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ABSTRACT

A FAMILY-BASED SEXUAL HEALTH COMMUNICATION INTERVENTION WITH SEX WORKER MOTHERS IN KOLKATA, INDIA

Samira Ali

Toorjo Ghose, Ph.D.

Objective: Increased parent-child communication has been found to strengthen family relationships and reduce adolescent sexual risk behaviors. These processes, however, have not been studied in the sex worker population. Given the fact that the children of sex workers often do not leave the sexual risk environments inhabited by their mothers, the manner in which sex worker mothers shape their children's sexual risk behaviors is crucial to their health and well-being. Family-based sexual health communication interventions (FSHCI) have the potential to change adolescent sexual risk behaviors within the sex work community.

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Chapter One

Introduction

Worldwide, about 2,400 youth ages 15-24 are infected with human immunodeficiency virus (HIV) everyday (UNAIDS, 2012). Youth account for almost half of new HIV infections (UNAIDS, 2012). While HIV infection rates have stabilized in recent years in India, adolescent infection rates have alarmingly increased. Youth comprise 25% of the country's population, but now account for 31% of all HIV cases (NACO, 2009). Sexual behavior is often initiated in adolescence and is associated with high risks of HIV, sexually transmitted Infections (STI), and unplanned pregnancies (Guo, Chung, Hill, Hawkins, Catalano, & Abbott, 2002). Children of sex workers face a number of issues, including early sexual debut, marginalization, separation from parents, and low education levels (Beard et al., 2010; Chege, Kabiru, Mbithi, & Bwayo, 2002; Pardeshi & Bhattacharya, 2006; Sloss & Harper, 2004). More specifically, they are particularly vulnerable to contracting HIV because they are raised in environments characterized by poverty, violence, gender inequality and limited resources that impact their ability to negotiate for safer sex (such as sex with a condom) (Beard et al., 2010; Sinha & Dasgupta, 2009).

It is estimated that 2.6 million female sex workers (FSW) live in India (Bureau of Democracy, Human Rights, and Labor, 2002) and over half have children (Sinha & Dasgupta, 2009). Social and structural issues, such as limited opportunity to attend school, lower quality of education, stigma, and financial responsibility at young ages, experienced by children of FSW are significantly associated with HIV infection (Underwood, Skinner, Osman, & Schwandt, 2011). HIV prevention interventions with

FSW in India have focused on individual sexual behavior, disregarding that FSW are mothers and that their children are at a high risk for early sexual debut, sexual risk behaviors, and HIV (Sinha & Dasgupta, 2009). Given the fact that the children of sex workers often do not leave the sexual risk environments inhabited by their mothers (Ghose, Swendeman, George, & Chowdhury, 2008), an exploration of how FSW mothers can impact their children's sexual risk behavior becomes a crucial public health issue.

With the primary goals of strengthening families and reducing adolescent sexual risk behaviors, family-based sexual health communication interventions (FSHCI) in the USA, South Africa, and the Caribbean have produced positive outcomes of families, reporting more frequent discussions about sexual health and other sensitive topics, greater comfort discussing these topics, more accurate knowledge about HIV, and child-reported increased condom self-efficacy (Baptiste et al., 2006; Baptiste et al., 2009; Forehand et al., 2007; Sperber et al., 2009). Advantages of FSHC interventions include parents' ability to individualize sexual health messages according to their child's developmental stage and family values, and to engage in continuous discussions with their child. However, there is a dearth of scholarship on how mothers communicate with their children around issues of sexual risk in India. Specifically, a review of the literature failed to identify any study on the manner in which Indian sex workers communicate about these issues with their children. Utilizing a sequential mixed-methods design, the aims of this study were to 1) explore mothers' attitudes, perceived norms, and perceived behavioral control about sexual health communication with their children and 2) construct, implement, and test the feasibility effectiveness of a community collaborative FSHC intervention in a sex worker community in India.

Chapter Two

Female Sex Work in India – Definition and Discourse

Sex work - definition

Sex work refers to activities where money or material goods are exchanged for sexual services (Outshoorn, 2005). The term “sex work” was coined in the context of the feminist rights movements in the 1970s to create a space for acceptance for women working in the sex industry (Kempadoo, 1998). As opposed to prostitution, the term sex work legitimizes the work as an income-generating profession. Kempadoo (1998) further elucidates the definition of sex work:

It (*sex work*) is a term that suggests we view prostitution not as an identity – a social or a psychological characteristic of a woman, often indicated by “whore” – but as an income-generating activity or form of labor for women and men. The definition stresses the social location of those engaged in the sex industries as working people” (p. 3)

Female Sex Workers - Background

It is estimated that 2.6 million female sex workers (FSW) live in India (Bureau of Democracy, Human Rights, and Labor, 2002). A demography of 6,648 sex workers in the southern state of Andhra Pradesh found that most were 20-34 years old, 74% were illiterate, mean age of first sexual intercourse was 15.1, mean age of starting sex work was 21.7 years, and most had children (Dandona et al., 2006). Women often enter the trade due to economic factors such as having to support their family and meeting the basic needs of housing and eating (Devine, Bowen, Dzuvichu, Rungsung, & Kermodé, 2010; Nag, 2006). While sex work has existed for many centuries, it has become a

prevalent topic in social science research over the past 30 years because of sex workers vulnerability to HIV/AIDS. Individual factors, such as having multiple partners or inconsistent condom use, as well as structural and environmental factors such as a stigmatizing environment put FSW at a high risk for contracting HIV (Beattie et al., 2010; Cornish, 2006; Jayasree, 2004). Stressful work conditions, such as difficult clients, police brutality, incarceration, and victimization leads sex workers to experience high rates of trauma, making them more susceptible to HIV and often compromising their children's safety (Church, Henderson, Barnard, & Hart, 2001; Dalla, 2000; Farley & Barkan, 1998; Jayasree, 2004; Suresh, Furr, & Srikrishnan, 2009; Panchanadeswaran et al., 2010). Involving sex workers in community mobilization interventions is one of the tactics that has proved successful in decreasing HIV transmission rates and enhancing the quality of life of sex workers and their families (Jana, Basu, Rotheram-borus, & Newman, 2004).

While there is a growing body of research on FSW pathways to sex work and their risk behaviors, little is known about their role as mothers and the relationship with their children (Chege et al., 2002; Pardeshi & Bharracharya, 2006; Sloss & Harper, 2004). In the remaining sections of this chapter, I will provide a brief background on the legal and feminist perspectives on sex work, discuss the status of sex workers in India, and lastly explore how the risk environment shapes the lives of FSW and their children.

Perspectives on Sex Work

Legal Perspective. The present legal arena in India is heavily influenced by British colonialism that existed prior to India's independence in 1947, in which sex workers were contained to specific areas of the city to be segmented from the general population. This ostracism allowed the government and health officials to regulate sex workers and their "disease-ridden" bodies. Red-light districts were formed in urban areas that were heavily populated by young men and still exist today, including the site of this study (Gangoli, 2006). Foucault's conception of governmentality, the techniques designed by the state to control human behavior, and biopower, the practices of modern states to regulate their subjects, are concepts that are relevant in the context of government enforcing social control on sex workers (Foucault, 1984). This governmentality and management of bodies is still rampant in present day with an emphasis on tracking sex workers who have HIV and imposing social control on their bodies that are rooted in morals.

This governmentality is exercised through laws like India's Immoral Trafficking Prevention Act (ITPA). According to the ITPA, sex work is legal; however soliciting clients, practicing sex work in the public, operating brothels, and sharing income earned from sex work with anyone over the age of 18 is illegal (Sahini, Shankar, & Apete, 2008; Westmarland & Gangoli, 2006). Many sex workers are criminalized for their work because they often fall under one of the aforementioned categories. Moreover, the ITPA is a "one shot" law that aims to abolish human trafficking as well as prostitution, in that sex work and trafficking are not differentiated in the law. This problematic homogenous category labels all sex workers as traffic victims, not taking their choice to work as a sex

worker into account. Furthermore, the terminology used in the ITPA is ambiguous, leading to different interpretations and misuse of the law by authorities. This criminalization of sex work has been found to increase police harassment, HIV/AIDS risk, violence, and increase stigma and discrimination associated (Ahmad, 2001; Blankenship & Koester, 2002; Open Society, 2010; Pauw & Brener, 2003; Shannon, Rusch, Shoveller, Alexson, Gibson, & Tyndall, 2008; Shannon & Csete, 2010; UNAIDS, 2002; WHO, 2001). In addition, the criminalization of sex work puts sex workers children at risk because mothers are in constant fear of being arrested and possibly even losing custody of their children (Open Society, 2010). Recent research examining the impact on decriminalization on the lives of sex workers has found that it leads to reduction in police brutality and violence, increases access to health care, promotes occupational safety, and reduces HIV risk (Abel, Fitzgerald, & Brunton, 2009; Open Society, 2010).

Feminist Perspective. Women's rights movements in India and around the world have played an important role in creating a space to discuss sex workers rights in India (Sahini et al., 2008). While the spread of HIV in the sex worker population has increased the surveillance levels, it has paved a path for sex workers rights to come into the limelight on national and global levels. Gangoli (2008) asserts that Indian feminists have addressed sex work in three different ways: 1) silence 2) hurt and violence 3) choice and liberation. These ideologies have informed the legal and political discourse on sex work in India and thus are important to understand. The silence and the hurt/violence ideologies address the "prostitute body" without addressing their experience (Gangoli,

2008). The hurt and violence ideology runs parallel to the Western radical feminism ideology, in which sex workers are conceptualized as victimized bodies that are objects of patriarchal oppression and need to be *saved* from their profession. According to this ideology, sex workers lack agency and are treated as a homogeneous group that have suffered the violated experiences. Thus, in this ideology, sex work can never be seen as a form of work.

The third ideology of choice and liberation holds that sex work is a women's choice, rather than an exchange that strips women of agency. India's sex workers rights groups illustrate how collective identity and mobilization has challenged the silenced and hurt/violence ideologies. Sex workers rights collectives, like the Durbar Mahila Samanwaya Committee (Durbar), have turned traditional views about sex workers on its head. Durbar originally formed as a HIV and STI intervention and collectivized to challenge the mainstream view about sex work. This ideology of choice and liberation is best described by the following passage in the Sex-Workers' Manifesto written by Durbar (DMSC, 1997).

Like many other occupations, sex work is also an occupation, and it is probably one of the 'oldest' profession' in the world because it meets an important social demand. But the term 'prostitute' is rarely used to refer to an occupational group who earn their livelihood through providing sexual services, rather it is deployed as a descriptive term denoting a homogenised category, usually of women, who poses threats to public health, sexual morality, social stability and civic order. Within this discursive boundary we systematically find ourselves to be targets of moralising impulses of dominant social groups, through missions of cleansing and sanitising, both materially and symbolically. If and when we figure in political or developmental agenda, we are enmeshed in discursive practices and practical projects which aim to rescue, rehabilitate, improve, discipline, control or police us. Charity organisations are prone to rescue us and put us in 'safe' homes, developmental organisations are likely to 'rehabilitate' us through meager income

generation activities, and the police seem bent upon to regularly raid our quarters in the name of controlling 'immoral' trafficking. Even when we are inscribed less negatively or even sympathetically within dominant discourses we are not exempt from stigmatisation or social exclusion. As powerless, abused victims with no resources, we are seen as objects of pity. Otherwise we appear as self-sacrificing and nurturing supporting cast of characters in popular literature and cinema, ceaselessly ready to give up our hard earned income, our clients, our 'sinful' ways and finally our lives to ensure the well-being of the hero or the society he represents. In either case we are refused enfranchisement as legitimate citizens or workers, and are banished to the margins of society and history (p. 2).

While there are differing ideologies about sex work in India, feminist and non-governmental organizations (NGO) have started to come to the consensus that the current legal framework of criminalization is causing more harm than good for sex workers. Furthermore, it is evident from the review presented above that sex workers' quality of life is impacted by these the ideologies and laws. This current environment, however, also impacts sex workers' children, a dynamic that has been poorly explored.

Sex workers and their Children – An Unexplored Dimension

While there has been a plethora of research on sex workers' sexual practices and moralistic debates about the profession, little efforts have been made in the social sciences to understand the role of sex workers as mothers and relationships with their children. The stigma of sex work often causes FSW and their children to be discriminated against from society, which often plays an important role in stripping them of their basic rights of health, safety, and education. Mainstream society and media have superficially depicted the role of sex worker mothers, further marginalizing and stigmatizing them (Basu & Dutta, 2011). This is evidenced by the documentary, *Born into Brothel: Calcutta's Red Light Kids*, filmed by two photojournalists, Zana Briski and Ross

Kauffman, about sex workers and children in Sonagachi, one of the largest red-light districts in Kolkata and the site of this study. Overall, the film depicts sex workers as incompetent and hopeless mothers who are incapable of taking care of their children. Briski, who Basu & Dutta (2010) conceptualized as a neocolonial savior, attempted to relocate the children of FSW to a prestigious boarding school because she felt as if the children were “doomed” in their current lives. This misrepresentation of sex workers and their children’s identities and communities has done harm in promoting sex worker rights. Thus, challenging this mainstream ideology as well as understanding mothers and children in the sex worker community are important realities to uncover.

In India, most FSW are single mothers and many have more than one child (Basu & Dutta, 2011; Dandona et al., 2006; Sinha & Dasgupta, 2009). Emerging research suggests that sex workers remain in the sex trade to financially support their children (Basu & Dutta, 2011; Sinha & DasGupta, 2009). The combination of structural and individual issues, often due to the stigmatizing and demoralizing conditions of being sex workers, cause mothers to report feeling worried and stressed for their children’s safety and well-being (Basu & Dutta, 2011; Dalla, 2004; Sloss & Harper, 2004). While only a few studies explore sex worker mothers outside of the context of their work, it has been found that FSW report different concerns for their sons and their daughters. FSW fear their sons will initiate drinking and using drugs at an early age and are concerned for their future educational and job opportunities (Bletzer, 2005; Ling, 2001; Sinha & Dasgupta, 2009). For their daughters, FSW fear that their daughters are at high risk for sexual abuse from their clients. In addition, some are concerned that their daughters will fall into the sex trade because they will be deemed unmarriageable; while others were not as

concerned and felt that the sex trade was a realistic option for their daughters (Sinha & Dasgupta, 2009). The financial demands faced by mothers, coupled with social marginalization, make their female children highly vulnerable to sex trade at a young age (Ling, 2001; Sarkar et al., 2006). Though child (under 18) prostitution is illegal, it is an issue that persists on a large scale with about 25% sex workers under 18 (Bureau of Democracy, Human Rights, & Labor, 2002). The following review will provide a better understanding of how the risk environment impacts sex workers and their children.

Risk environment – mothers and children. Rhodes (2009) described the risk environment as “comprising types of environment (physical, social, economic, policy) interacting with levels of environmental influence (micro, macro)” (p.193). These components shape the context in which risks are (re)produced. Harms like disease, violence, and mental health, are contingent upon the environment sex workers live in. In no way does the risk environment framework imply causality nor is it positivist in nature, rather it is a tool or framework that guides the contextual understanding of sex work (Rhodes, 2009). In the following sections, I will utilize an adapted version of the risk environment framework to describe the FSW and the macro and micro level factors that impact their lives and the lives of their family.

Table 2.1: Risk Environment (adapted from Rhodes, 2009)

	Risk Environment	Example
Macro	Social	Peer & social norms; community attitudes; community health services practices; Stigma, discrimination of marginalized groups
	Legal/Political	Legal stance on sex work; local policing
	Physical	Unsafe working conditions; unstable housing; differential practices of the law by legal enforcement
	Economic	Poverty; few opportunities for women
Micro	Individual	Mental health; drug use, HIV, victimization

Macro - Social Environment. The social environment is comprised of community and institutional attitudes, cultural norms and values, and gender and social inequalities. The stigma faced by FSW and their children leads to discrimination experienced on many levels. Specifically, researchers have found that discriminatory attitudes and practices by the community, police, service providers, and families lead to increased vulnerability to violence/harassment and homelessness and limited access to healthcare, and on an

individual level, differential treatment by their extended families (Basu & Dutta, 2010; Cornish, 2006; Sinha & Dasgupta, 2006).

Societal discrimination also leads to unfair practices by landlords, as many FSW report being evicted from their apartments by their landlords (Cornish, 2006). Many sex workers report being ostracized by their family members because of the profession and often report lying about being sex workers in the fear that their family will cut off ties (Sinha & DasGupta, 2009). Apart from societal level stigma, FSW also experience internalized stigma, in which they internalize the stigma that they have experienced. For example, FSW often identify as being “spoiled” and unable to have a family life because the society has labeled their profession as “bad” or “dirty”, thus they are not able to be a “good family person” (Cornish, 2006).

Children of sex workers are differentially treated because of the stigma associated with their mother’s profession. Specifically, scholars have found that children are discriminated against in schools outside of the sex worker community, limiting their opportunity to advance not only in education but also employment opportunities (Cornish, 2006; Sinha & Dasgupta, 2009).

Macro - Legal Environment. The legal environment can be conceptualized as policies governing the sex trade that influence women and their children on an individual level. Gangoli (2006) asserted that “at a general level, anti-prostitution laws in India are designed not so much to stop prostitution, but to regulate and control prostitutes and their bodies” (p.136). As stated earlier, the laws on sex work in India are ambiguous and compromise the health and safety of sex workers and their children. For example, the ITPA states that it is unlawful for sex workers to solicit in a public places. However, the

definition of solicitation is vague and is open to interpretation and can be misused on many levels (Wad & Jadhav, 2008). Under ITPA, police have a right to arrest women they believe are “soliciting” in a public place; however women are picked up even when they are not soliciting and just merely sitting in public spaces (Barde, 2008). In addition, the ITPA states that it is illegal for sex workers to share their income with anyone above the age of 18. This component of the law is extremely problematic because many children who are over the age of 18 live off their mothers’ income.

FSW are in constant fear of being arrested and abused by the police. They are often put in vulnerable positions because police demand sexual services in exchange for a clean police record. Thus, they are reluctant to report police harassment (Biradavolu, Burris, George, Jena, & Blankenship, 2009; Burris & Xia, 2009; Cornish, 2006). These legal implications impact the lives of FSW children as well. Sinha & Dasgupta (2009) found that police officials raiding red-light districts often wanted sexual services from FSW’s daughters. Additionally, children of sex workers may experience marginalizing treatment by local authorities by wrongfully being put into a homogeneous category of being deviant or being involved in the sex trade.

Macro - Physical Environment. The physical environment sex workers live in or work from has potential to put them at risk for increased violence and HIV transmission. Brothel-based sex workers often live in conditions characterized by close quarters, little privacy, and a dense population. Street sex workers may operate from secluded places, such as a car, hotel, or a customer’s home and experience higher rates of violence because of unsafe work conditions, compared to indoor sex workers, often providing services in a clients’ car (Church et al., 2001; Harcourt & Donovan, 2005; Roxburgh,

Degenhardt, & Copeland, 2006). Structural conditions, such as exposure to police brutality simply by being on the street, puts street sex workers more at risk for discrimination and disease.

However, brothels have potential to serve as protective spaces. Ghose, Swedenman, and George (2011), in their recent study of brothels in India, conceptualized brothels as protective spaces that ultimately decrease HIV risk. Brothel environments may be safer than operating from the streets because they are more regulated and not as secluded as working out of a car. Additionally, women might have access to more social services, as they might have more exposure to community-based organizations through mobile community and peer health workers. Additionally, childcare tends to be less of a concern for sex worker mothers with children living in the brothels because there are more people to look after the children in the brothel setting than in others. On the other hand, children living with their mothers in brothels might be exposed to high rates of violence, drugs, and sexual activity (Sinha & Dasgupta, 2009). Additionally, children might be discriminated against in school or from their friends that live in communities outside of the red light district because of the physical location of their residence (red-light district). Children who attend school in other communities are often stigmatized and discriminated against, thus reluctant to attend school (Chege et al., 2002).

Macro - Economic Environment. The economic environment is the income generating informal economy operating in the space. For many, joining the sex trade is an economic response to poverty. In a study with 57 FSW in Chennai, India, poverty and lack of education were cited as main reasons for entering sex work (Suresh et al., 2009). Women earn more as sex workers than they would in another job. For example, FSW in

Kolkata have been found to earn double the amount of money compared to other women in India (Rao, Gupta, Lokshin, & Jana, 2003). Many enter sex work to support their children (Castañeda, Ortíz, Allen, García, & Hernández-Avila, 1996; Basu & Dutta, 2011; Sinha and Dasgupta, 2009) and this is particularly salient after women become widowed, abandoned, or divorced.

Sex workers might face economic injustice by madams, pimps, local moneylenders, political leaders, and local criminals. They are often expected to pay unreasonable amounts of interest on money loans or expected to pay part of their pay for local criminals (Basu & Dutta, 2008). The economic insecurity faced by sex workers puts them at a high risk for HIV because clients often want their services with stipulations, such as sex without a condom (Basu & Dutta, 2011). Consequently, they are put in vulnerable situations because they have to provide such services to financially support their family.

The economic choices mothers make are closely related to their identity as mothers and the ability to provide financial and health security for their children. Many mothers report wanting to educate their children at respectable boarding schools outside of their community so that the children can have promising futures (Sinha & Dasgupta, 2009). In India, children have to pay for tuitions, books and additional items required for school. Often times FSW mothers report that they are not able to afford these school-related costs because of increasing rent costs, causing their children to drop out of school (Sinha & Dasgupta, 2009).

Micro – Individual.

Violence/trauma. FSW report experiencing high rates of child abuse, with more than half of 475 sex workers from a multisite worldwide study reporting physical or sexual abuse in their childhood (Choi, Klein, Shin, & Lee, 2009; Farley & Barkan, 1998; Roxburgh et al, 2006; van Brunschot & Brannigan, 2002). Difficult clients and police brutality lead sex workers to experience high rates of trauma (Church et al., 2001; Dalla, 2000; Farley & Barkan, 1998; Suresh et al., 2009). These incidents are seldom reported to the police (Sanders, 2001), causing FSW to be more at risk for future attacks. In several studies, police have been found to bribe FSW for sex and beat them in some instances (Cornish, 2006; Rhodes, Simic, Baros, Platt, & Zikic, 2008; Katsulis, Lopez, Durfee, & Robillard, 2010; Suresh et al., 2009). While experiencing violence can lead to mental health issues, it can also lead to higher risk for contracting HIV. Men who coerce FSW into having sex seldom use protection (Beattie et al., 2010). Additionally, men who are sexually violent are more likely to have multiple sex partner and thus more likely to have HIV. Moreover, violence is more likely to re-occur because the illegality of sex work deters women to seek help from officials (Beattie et al., 2010; Decker et al., 2009; Dunkle et al., 2006; Rhodes et al., 2008). Children who are exposed to domestic violence have a high risk of developing emotional issues, behavioral problems, and can suffer from developmental delays (Holt, Buckley, & Whelan, 2008; Osofsky, 1995).

Mental health. Many scholars have found that FSW experience high rates of mental illness and psychological distress (El Bassel, et al., 1997; Jackson, Bennett, & Sowinski, 2007; Ling, Wong, Holroyd, & Gray, 2007; Sanders, 2004; Wang et al., 2007). High rates of physical and sexual violence are associated with post-traumatic stress

disorder (PTSD) symptoms (Farley et al., 1998; Kaysen, Resick, & Wise, 2003; Ling et al., 2007; Roxburgh et al, 2006; Farley et al. (2003), in their cross-sectional study in nine countries, found that 68% of 854 sex workers met the criteria for PTSD. In another study with 57 FSW in Chennai, India, scholars found that most FSW experienced PTSD and charged violence as the prime reason for these feelings. Similarly, El Bassel et al. (1997), in their study with 346 women found that sex workers suffered significantly more psychological distress than the non-sex workers. In a qualitative study with 68 FSW in Canada, Jackson et al. (2007) found that many experienced high rates of emotional distress and contributed demanding and restricting work condition, difficulty balancing family and work life, and lack of money to their feelings. It is well documented that maternal mental health is associated with parenting practices and familial relationships (Tomlinson, 2010). Specifically, early in a child's life, maternal depression is associated with low child birth-weight (Patel, DeSouza, & Rodrigues, 2003) and impaired child cognitive development (Murray & Cooper, 2003).

HIV/AIDS. The National AIDS Control Organization of India (NACO) estimates that the human immunodeficiency virus (HIV) prevalence among FSW in major Indian cities is more than 50% (NACO, 2001). While the HIV rates have stabilized worldwide, FSW are still being disproportionately infected (UNAIDS, 2010). FSW account for .5% of the female population, however make up 7% of women who have HIV (NACO, 2009). With many social science researchers jumping on the HIV bandwagon, HIV has been a defining force in sex work research; in fact HIV has brought sex work rights issues to the forefront of human rights debates. Sex workers face a high risk of HIV not only because of individual risk factors of having multiple sexual partners and high rates of injection

drug use, but also because of structural factors consisting of stigma, reduced access to health care services, and harassment, as discussed above (Rekart, 2005). Cocaine use has also been found to be associated with unprotected sex and poor judgment (Pauw & Brener, 2003). Maternal HIV has been found to be associated with child depression, anxiety disorders, and disruptive disorders (Forehand et al., 2002; Lester et al., 2006; Pilowsky, Zybert, Hsieh, Vlahov, & Susser, 2003). Moreover the increased levels of depression in children can ultimately lead to heightened risk of unsafe sexual behavior (Donenberg & Pao, 2005).

Summary of the risk environment. The above discussion on the risk environment depicts how the combination of macro and micro factors shape the lives of FSW and their children. The risk environment framework serves as a useful framework to explain how the risks, both structural/environmental and individual, faced by sex worker mothers impact their children, family processes and ultimately family relationships.

Children of Sex Workers

It is evident from the research presented above that poverty, stigma, discrimination, and parent-level factors influence a child's educational attainment, physical and mental health issues, and behavioral problems (Brooks-Gunn & Duncan, 1997). As these children age and become sexually active, and thus more vulnerable to HIV, it is important to assess the factors surrounding these behaviors and how parent-child relationships can be strengthened to reduce harms associated with risk behaviors.

Adolescence. Adolescence (age 10-19) is a developmental period in which physical, psychological, and cognitive changes take place (Montemayor, 1983; Kirby, Lepore, & Ryan, 2005). Physical changes are marked by menarche and breast development for girls and for boys, facial hair and rapid growth in height. Cognitively, as children proceed through adolescence, they develop the ability to think on abstract levels, develop and hold opinions and have debates. Psychologically, adolescents attempt to form a personal identity, likely to be in constant negotiation with their parents and their own identity, and often experiment with substance and sexual behavior. Thus, adolescents have unique needs as they progress to adulthood, such psychosocial needs of family support, in-group importance amongst peers, to acquire life-skills, and to establish responsibility and respect for themselves. Adolescence is not a fixed phenomenon; rather it is embedded in a complex interplay of culture and society. A young person's life is shaped by a multitude of factors, including culture, parents, peers, and their community. While each factor influences adolescents' life differently, peers play a unique role during this stage. Youth often navigate towards their peers for support and acceptance, influencing them in both positive and negative ways. Specifically, peer pressure has been found to be associated with increased risk behaviors, such as exploring sexual relationships and drug use (Henrich, Brookmeyer, Shrier, & Shahar, 2006). These normative changes can be particularly challenging if adolescents do not have support from their parents or guardians.

Sexual exploration often initiates in adolescence and, if risky, can lead to a high risk of contracting HIV and Sexually Transmitted Infections (STI). Without the much-needed support during adolescence, youth are more likely to have unprotected sex and

have several sex partners, putting them at an elevated risk for contracting HIV (Kotchick, Shaffer, Miller, & Forehand, 2001; Lynch, Krantz, Russell, Hornberger, & Van Ness, 2000; Repetti, Taylor, & Seeman, 2002). Youth are engaging in sexual activity at younger ages than ever before (Meschke, Zweig, Barber, & Eccles, 2000) and scholars have found that adolescents who engage in sexual activity at younger ages are more likely to have STI and multiple sexual partners (CDC, 2000; Santelli, Brener, & Lowry, 1998). Many structural and individual factors impact the risk environment for contracting HIV or STI. Family instability and poor academic performance have both been found to be associated with higher risk sexual behavior in developing countries (Blum & Mmari, 2005). Compared to older girls, younger girls are more at risk for developing pregnancy related complications and more vulnerable to cervical problems (Awasthi, Mishra, & Shahi, 2006; CDC, 2008). Girls living in poverty-affected areas are more likely than boys to be forced to have sex, increasing their vulnerability for HIV (Campbell, 2003). When compared to adolescents living in non-slums, adolescents living in slums or in poverty are more likely to engage in sexual activity at a younger age and to have sex without a condom (Kabiru, Beguy, Undie, Zulu, & Ezeh, 2010).

Adolescence in the Indian context. There are an estimated 239 million adolescents in India, accounting for 22.8% of the population (UNFPA, 2003). This phase is marked by an increased need for peer in-group acceptance, a process that leads adolescents to gravitate away from their families and toward their peers. Family plays a crucial role in Indian adolescents' lives; as older adolescents rarely move out of their parents' house and females often move into their in-laws house upon marriage. Adolescents constantly attempt to strike a balance between their family and peers for

support or acceptance. Many scholars have highlighted the dearth of culture-specific research on adolescents, indicating the need for more exploratory studies (IIPS & Population Council, 2010; Jejeebhoy, 1998).

Gender disparities still persist in India, with girls facing discrimination on institutional, social, community, and family levels (IIPS, 2010; UNFPA, 2003). This gendered oppression not only impacts girls' economic status, but their ability to access healthcare and health outcomes. A recent sub-national youth needs assessment conducted by the Population Council found that, when compared to boys, girls reported more parental restrictions in regards to visiting their friends, attending community programs in the village or the neighborhood, and attending a health center unescorted (IIPS, 2010). An examination of gender role attitudes also revealed a stark difference between girls and boys. More boys than girls reported that educating boys is more important than educating girls and girls should not be allowed to make marriage-related decisions (IIPS & Population Council, 2010).

In regards to education, the gender gap is wide. A recent sub-national study, conducted in six states Indian states, found that educational attainment was low amongst girls, with 30% of girls completing high school, compared to 42% of boys (IIPS and Population Council, 2010). Additionally 25% of girls, compared to 8% of boys (ages 15-25), reported never attending school (IIPS and Population Council, 2010). Over half of boys and girls cited economic reasons for never attending school. The gender gap widens immensely when considering youths' marriage status, with 30% of married boys, compared to 46% of unmarried boys, completing high school and 18% of married girls, compared to 43% of unmarried, completing high school. Drop out rates are high for both

boys and girls, but the gender gap widens between the ages of 15 and 17. As evidenced by the data presented above, girls are less likely to attain an education and more likely to have never attended school, which is even more pronounced in married girls (IIPS and Population Council, 2010).

Early marriage is widespread because of the social mores and economic constraints faced by families. Early marriage disproportionately impacts adolescent girls' sexual and reproductive outcomes, educational attainment and economic status (Jain & Kurz, 2007; UNICEF, 2005). The National Health and Family Survey III (NHFS-III), a nationally representative survey implemented by the Indian government, found that almost half (47%) of women ages 20-24 were married before the age of 18 (IIPS, 2007). Early marriages are often arranged and girls are rarely asked their approval of the marriage and often feel anxious and scared about opposing the marriage (IIPS, 2010). After marriage, girls face high risks of sexual and physical violence, unwanted pregnancy, mental health issues, and social isolation (IIPS, 2010).

Adolescent Sexual Behavior. National reports indicate that 10 to 30 percent of adolescent boys and up to 10 percent of adolescent girls engage in premarital sex in India (International Institute for Population Sciences (IIPS) & Macro International, 2007; International Institute for Population Sciences (IIPS) and Population Council, 2010; Jejeebhoy, 2000). While adolescent sexual behavior in India remains a poorly explored topic, a handful of studies suggest that adolescents are at a heightened risk for HIV infection because they engage in sexual activity with limited information about HIV, both

how it is transmitted and the health implications of HIV (Gong et al., 2010; Jejeebhoy, 2000; Selvan, Ross, Kapadia, Mathai, & Hira, 2001).

Factors that impact sexual risk behavior. Extreme poverty, limited sexual knowledge, sexual risk behaviors, and cultural sensitivity to discuss sexual related topics have all contributed to the rise of HIV in the adolescent population. Discussions around sex, sexual health, and reproductive issues are often considered a taboo in India. These topics are rarely discussed within families because they are regarded as embarrassing and disrespectful (UNFPA, 2003). Additionally, many believe that if adolescents receive sexual education, they will be more prone to engage in sexual activity (Jejeebhoy & Santhya, 2010). Furthermore, based on these cultural norms and expectations, youth are reluctant to seek help and often guided by misconceptions learned by their peers or the media.

Early marriage. Firstly, early marriage is a risk factor. Despite efforts by policy makers and health advocates in India, early marriage (marriage before the age of 18) for young girls continues to occur. Early marriage directly impacts young girls' health and psychological well-being (Nour, 2009) because it exposes girls to sexually activity at younger ages, thus making them vulnerable to a host of reproductive health problems, such as STI, HIV, and pregnancy related complications (IIPS & Population Council, 2010). For example, Santhya and colleagues (2010) found, in their sample of 8,314 married women ages 20-24, when compared to women married before 18, women married after 18 were more likely to use contraceptives.

Poverty. Structural issues are also a salient factor that impact adolescent sexual risk behavior. It is well known that youth in poverty are more at risk for HIV than those

who are not. But given the studies presented above, little is known about those living in poverty in the Indian context. While higher income youth might have access to sex education through school and more access to healthcare, youth living in poverty might not even attend school and have little access to healthcare.

Sexual health and HIV/AIDS attitudes and knowledge. Young adults (15-24) comprise 25% of the country's population but account for 31% of the HIV cases (NACO, 2009). Though 15-24 captures a wide age range, it indicates that HIV is shifting from a disease highly prevalent in Injection Drug Users (IDU) and sex workers to adolescents and young adults. Many factors impact adolescent sexual behavior.

A number of studies have found that adolescents hold little or inaccurate knowledge about HIV/AIDS and sexual health. In a study about female adolescents' (age 14-19) HIV and STI knowledge and attitudes towards sex in New Delhi, McManus and Dhar (2008) found that 30% (N=251) of the sample believed that HIV could be cured, and over half had never heard of genital herpes. While 9% of the sample reported ever engaging in sexual activity, 22% believed that there was nothing wrong with premarital sex. Additionally, almost half of the sample believed that condoms should not be available to adolescents because they feared that adolescents would engage in more sexual behavior. In a sample of 357 boys and 229 girls enrolled in grades 10-12 in Goa, India, scholars found that 53% of boys and 41.9% of girls believed that pregnancy could not happen during after having sexual intercourse one time (Shashikumar et al., 2012) Similarly, Solleti and colleagues (2009) found, in their exploratory study with Indian adolescents, that while adolescents had heard about HIV/AIDS, they did not fully understand its meaning and implications to health or had misconceptions about the

disease. In regards to sexual attitude, many girls felt that sex before marriage was immoral and that love should be a precursor for sex (Joshi, 2010). While condoms are available in health care facilities and pharmacies/medical shops, data from the IIPS youth needs assessment (2010) indicates that over 50% of girls and 40% of boys felt uncomfortable approaching health facilities and pharmacies for contraceptives.

Sources of information. Adolescents obtain sexual health knowledge from various sources. While schools are thought to be one of the main sexual health educators, they often provide scant information. Sessions are not culture specific and teachers often hesitate to discuss sexual topics in detail (Awasthi et al., 2006; Jejeebhoy, 1998). Teachers are often not equipped with the appropriate knowledge, have myths concerning sexual topics, and also believe that students might lose respect for them if such topics are discussed (Awasthi et al., 2006). For adolescents who are economically disadvantaged, school dropout rates are high, with boys dropping out to work to assist their families and girls getting married at young ages. For example, Hindin & Hindin (2007), in their study of 583 males and 475 females ages 15-19 from economically-disadvantaged areas in New Delhi, India, found that one third were in school at the time of the study. Thus, school might not be a viable option for sexual health education for a segment of the population that might be the most vulnerable.

With the rise in technology, an increasing amount of adolescents obtain sexual health information from movies and television (Hindin & Hindin, 2007). Adolescents also turn to peers for sexual health information (Jejeebhoy & Santhya, 2011; Joshi, 2010; Khalil, Ross, Rabis, & Hira, 2005; Mcmanus & Dhar, 2008; Saksena & Saldanha, 2003). Capoor and Mehta (1995) found that female adolescents reported learning information

about sexual intercourse, from their married friends or older sisters, and this information was often incorrect or unreliable, leading to many misconceptions of sexual behavior that can be detrimental to their health (Awasthi et al., 2000; McManus & Dhar, 2008; Joshi, 2010; Soletti et al., 2009). Joshi (2010), in a sample of 182 adolescents, found that older adolescents (ages 17-21) usually received sexual related information from their peers, books and magazines, and the television, while less than 10% received this information from their parents. In relation to peer norms, scholars have found that adolescents that had peers that were not sexually active were less likely to be sexual active themselves (Joshi, 2010). Given the likelihood of children receiving inaccurate information pertaining to HIV and low rates of open communication between parents and children, adolescents are at greater risk for engaging in risky sexual behavior (UNFP, 2003).

Parents are socializing agents that can educate children about sexual health related information, however parent-child communication about sexual health is rare (Guilamo-Ramos, Burnette, Sharma, & Bouris, 2009; Jejeebhoy & Santhya, 2011). While adolescents feel that sex education is important, many do not to receive the information from their parents (Joshi, 2010). Parents report refraining from discussing sex with their children because they often lack proper knowledge, believe that the media provides adolescents with information, and believe that females would develop knowledge “automatically” after marriage (Mahajan & Sharma, 2005; Saksena, & Saldanha, 2003). This lack of information or misinformation puts adolescents at a high risk for engaging in risky sexual behavior, such as sex without a condom. In addition, adolescents living in poverty are more likely to engage in sexual activity at a younger age and risky behavior (Kabiru et al., 2010).

As a whole, these studies indicate that while adolescents are not reporting high rates of sexual activity, they have little knowledge about sexual risk behaviors and most sexual-related information comes from peers and the media. The studies presented above are not without limitations, however. In the aforementioned studies, adolescents were recruited from schools or at random from cafes or bookstores. They were disproportionately from high-income families or from rural areas and thus. Thus, current research offers an incomplete picture of the adolescent sexual behavior and risk behavior in India.

Adolescent HIV prevention efforts. While there has been an increased effort to educate youth about sexual health related information, these efforts have only been made in schools (UNFPA, 2003). Most prevention interventions are one-time sessions at school in which adolescents learn about a plethora of sexual-related information, such as menstruation, reproductive health system, sexual activities, and contraceptives. These programs are often created under moralistic assumptions and stereotypes in society, such as negative attitudes toward homosexuality or that woman do not have sex before marriage (Khalil et al., 2005; UNFPA, 2003). Reaching out to students enrolled in schools severely limits the amount of students actually being reached, as many poor youth who are at most risk for HIV, are not enrolled in schools and less likely to be enrolled in schools that offer sexual education.

Saksena and Saldanha (2003), in their evaluation of a sexual health education class, found that only half of the students felt that sex education was necessary before the class was administered. After the class, almost 90% felt that it was necessary for their

healthy development into adulthood. While sex education in schools gives youth a glimpse into sexual health related topics, the sessions are often inadequate to achieve long lasting HIV prevention knowledge and the youth that are the most vulnerable to HIV are often not enrolled in such schools. Community based programs implemented by non-governmental organizations (NGO) are scant, but have promising results. Capoor and Mehta (1995) conducted a workshop to educate girls and boys ages 11-18 about sexual health at health fairs in Gujarat. They discussed emotional and physical changes that occur during adolescence, utilizing role-plays and case studies to convey their messages. The goal of the workshop was to explore adolescent's existing sexual health knowledge and also educate and correct any misconceptions. While the researchers did not evaluate the outcomes of the workshop, they did find that that youth who participated in the workshop were willing to openly discuss sexual health related issues. In addition, they recommend small group discussions and suggest that group-based interventions are an effective method to broach sexual health related topics.

Despite the central role families play in India, little is known about the impact of family communication on adolescents' sexual behavior. Recently, researchers have called for involving parents in sex education (Jejeebhoy & Santhya, 2011; Joshi, 2010; (Guilamo-Ramos et al., 2012). Parents play an essential role in socializing their adolescent and have potential to serve as sex educators for their children by creating long-term relationships in communicating about sexual health and sexual risks. The following sections will highlight the importance of parents as sex educators. While little is known about parents influence on adolescent sexual behavior in India, research from

other countries have found that parent's play a critical role in influencing adolescent sexual behavior.

Chapter Three

Parent-Child Sexual Health Communication

Adolescent HIV Interventions – A Paradigm Shift

The ideology informing HIV prevention interventions has shifted over the past three decades. Initially in the 1980s, HIV prevention programs aimed to intervene by increasing youth knowledge about HIV transmission in the hopes that it would impact behavior change. However, while these programs increased youths HIV knowledge, they failed to impact their sexual behavior (Coyle, Boruch, & Turner, 1991). The next decade of HIV prevention efforts turned to social cognitive theories, such as Theory of Reasoned Action (TRA) and Theory of Planned Behavior (TPB), to understand the sexual risk behaviors. Specifically these interventions addressed youth attitudes and intentions towards sexual behaviors, skills specific to condom use, and assertive communication based on “just say no” messages. While some of these interventions were effective in reducing adolescent sexual risk behavior, the outcomes were short-lived. In sum, these HIV prevention interventions failed to view the adolescent as part of a broader system of interactions and also intervene on multiple levels. Specifically, Campbell (2003), in her critique of individual level interventions, asserts “the forces shaping sexual behaviour and sexual health are far more complex than individual rational decisions based on simple factual knowledge about health risks, and the availability of medical services” (p. 7). Individual level HIV intervention informed by social cognitive models focus only on the proximal factors of behavior (such as attitudes towards the behavior), fail to link the proximal factors with larger, more contextual factors (such as parent and peer

relationships, community contexts), and rarely provide guidance on how to change sexual risk behaviors in the real world context (Campbell, 2003).

Thus, in recent years there has been increasing recognition that to understand, intervene, and analyze adolescent sexual risk behavior not only requires addressing the individual level, but the contextual, cultural, and structural levels that uniquely shape adolescent's values, attitudes, and intentions as well (Coates et al., 2008; DiClemente, Salazar, & Crosby, 2007; Dittus, Miller, Kotchick, & Forehand, 2004; Pequegnat, & Bell, 2012; Pequegnat, & Szapocznik, 2000). Rather than attempting to change individual behaviors, these recent set of HIV interventions intervene on family, peer, and community levels (Bhana, McKay, Mellins, Petersen, & Bell, 2010; Dittus et al., 2004). One such intervention is family-based HIV prevention interventions. With the primary goals of strengthening families and reducing adolescent sexual risk behaviors, these interventions have led to positive outcomes of increased parent-adolescent sexual risk communication and parental monitoring, increased parent comfort levels of discussing sexual topics, and reduction in adolescent sexual risk behaviors (Bell et al., 2008; Forehand et al., 2007; McKay et al., 2004; Stanton et al., 2004; Villarruel, Cherry, Cabriaes, Ronis, & Zhou, 2008). These interventions have implications for youth in India as well (Guilamo-Ramos et al., 2012; Soletti, Guilamo-Ramos, Burnette, Sharma, & Bouris, 2009).

Parental influence on children's behavior

Parenting practices have been found to influence children's sexual development and sexual risk behaviors (Buhi & Goodson 2007; Hutchinson, Jemmott, Sweet-Jemmott,

Braverman, & Fong, 2003; Pequegnat & Szapocznik, 2000). At a time when children are gravitating towards their peers for social acceptance, a child's relationship with their parents is often contested. However, they still seek guidance from their parents and parents can play a very important role in their adolescents' upbringing. Various parenting practices, such as parent-adolescent communication, parent monitoring, and parent-adolescent modeling, have been shown to influence adolescent sexual risk behaviors and substance use (Hutchinson et al., 2003).

Parent-adolescent sexual risk communication has been found to be associated with adolescent's sexual behavior. Scholars have found that parent-adolescent communication about sexual risk is correlated with adolescent's use of contraceptives (Aspy et al., 2007; Crosby et al., 2001; Miller, Levin, Whitaker, & Xu, 1998a), abstinence (Aspy et al., 2007), delay in sexual debut (Miller et al., 1998a), and increase in sexual knowledge (Somers & Paulson, 2000). Parent monitoring, defined as parents knowing where their child is, the activities they are engaged in, and knowing who their child's friends are, is a protective component of a parent-adolescent relationship. Specifically, infrequent parental monitoring is associated with higher likelihood of adolescents to be in risky sex situations (Aronowitz, Rennells, & Todd, 2005; DiClemente et al., 2001) increased reports of STI (Crosby et al., 2001), and increased risk of substance use (DiClemente et al., 2001; Stanton et al. 2002). Parents also serve as role models for their adolescents. Specifically, research has found that mothers' sexual risk behaviors are associated with higher rates of adolescents sexual risk behavior (Kotchick, Dorsey, Miller, & Forehand, 1999).

Parental influence – Indian context. Though research on parents' influence on adolescent sexual risk behavior is limited in India, recent research has started to explore parents' influence on adolescent sexual behavior (Guilamo-Ramos et al., 2012; IIPS, 2008; Jejeebhoy & Santhya, 2011; Soletti et al., 2009). Recent surveys of adolescents and their parents indicate that less than 10% of adolescents report discussions around romantic relationships, contraceptives, and sexuality with parents (Jejeebhoy & Santhya, 2011; Mahajan & Sharma, 2005; Saksena & Saldanha, 2003).

Soletti and colleagues (2009) conducted a study with families who lived in rural villages in Maharashtra to explore the feasibility of a family-based HIV intervention. They found that parents rarely communicated with their children about sexual-related topics, but were concerned about adolescent sexual behavior and HIV risk. Although most parents had heard of HIV, they were unsure as to how it was transmitted and the implications of the disease. Overall the researchers found that families were open to the idea of family-based HIV interventions. More specifically they found that an intervention would be feasible if it provided comprehensive sessions about HIV prevention and facts about the disease, culturally appropriate sessions, and hold it in conveniently locations.

Recent publications, such as a parent-child communication needs assessment in six Indian states of Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu, points to the growing concern around parent-child sexual health communication (Jejeebhoy & Santhya, 2011). The assessment found that mothers' communication with their children centered around menstruation (often when it had already initiated) and general messages about abstaining from sexual activity that were

often cryptic statements such as “stay away from boys/girls”. Parents in the survey reported a multitude of factors, such as embarrassment, shyness, and lack of knowledge, which inhibited them from communicating about sexual health with their children. Overall, the assessment found that parent-child sexual health communication is extremely limited and gendered. This report calls for more exploratory research on parent-child sexual health communication and the need for culturally grounded family-based sexual health interventions.

With young adults (15-24) comprising 25% of the country’s population and accounting for 31% of the HIV cases (NACO, 2009), it is essential to understand the role parents can play in their children’s sexual development, sexual education, and risk behaviors. Fortunately, there is a wealth of research from other parts of the world that points to the effectiveness of family-based interventions that aim to increase parent-adolescent communication about sexual health related information. The sections below provide a comprehensive review on the specific elements of parental influence on adolescent sexual behavior.

Components of parent-child relationships

According to Kotchick and colleagues (2001), family structure and family processes influence adolescent sexual behavior. While family structure and family process variables are interconnected, I have decided to discuss them separately to display their unique contribution to adolescents’ sexual behaviors. It is important to note that family structure and processes vary with each culture, however, the brief review below provides a glimpse into the most salient research findings about the relationships.

Family structure. Family structure can be conceptualized as parent's education, socioeconomic status (SES), or family composition (single parent, two parents). The absence of a father has been found to be a risk factor for adolescent sexual activity (Ellis et al., 2003; Kiernan & Hobcraft, 1997). The absence of a parent, namely the father, is of crucial importance because most children of sex workers have limited relations with their fathers. Ellis and colleagues (2003), in their longitudinal study with adolescent girls in the U.S. and New Zealand, found that adolescent girls whose fathers were absent from the home were more likely engage in early sexual activity compared to those who had a father present. Multiple theoretical perspectives have attempted to explain the relationship between an absent father and adolescent sexual behavior. One theoretical perspective asserts that the absence of a parent may lead to reduced parental control and monitoring (Hogan & Kitagawa, 1985; Newcomer & Udry, 1987). Specifically, two parents can simply monitor their children more closely than a single parent. Less parental monitoring has been linked to many adolescent sexual risk behaviors, including multiple sexual partners, early sexual debut (Borawski, Ievers-Landis, & Lovegreen, 2003; Browning, Leventhal, & Brooks-Gunn, 2005; Hogan & Kitagawa, 1985; Huebner & Howell, 2003; Mandara, Murray, & Bangi, 2003; Wight, Williamson, & Henderson, 2006). Another theoretical perspective holds that parents act as socializing agents. Parents socialize their children through modeling sexual behaviors and attitudes (Kotchick et al., 2001), thus their adolescents are more apt to learn these behaviors and attitudes from their parents. For example, since children are more likely to reside with their mother (McLanahan & Sandefur, 1994) a mother's attitude and sexual behavior, particularly if she has multiple partners, may influence a child to believe that their

mother's behavior is the norm. Specifically, Kotchick Dorsey, Miller, and Forehand (1999), in their study with 397 African American or Latino adolescents and their mothers, found that mothers' sexual risk behaviors (multiple sex partners, unprotected sex) were associated with their adolescents sexual risk behavior.

Parent-adolescent communication about sexual health. Mothers have been found to be primary communicators of sexual education and sexual risk behaviors. Adolescent girls are more likely to discuss sexual health related information with their mothers rather than their fathers and feel more comfortable discussing these topics with their mothers (Guzman et al., 2003; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998b). Feldman and Rosenthal (2000) asserted communication about sex is often geared toward more general, physical discussion, rather than more intimate discussions about contraceptive use and sexual decisions.

While it was once assumed that one time sexually-related communication between parents and adolescents was sufficient to delay sexual debut or decrease sexual risk behaviors, there is now an evidence-base that suggest there are many facets of communication that impact child sexual behavior (Jaccard, Dittus, & Gordon, 2000). The quality, frequency, and timing of communication and subjective orientation towards communication are all factors that contribute to an adolescent's sexual risk behavior. The following sub sections provide an overview of these facets.

Quality of communication. Perrino, Gonzalez-Soldevilla, Pantin, and Szapocznik (2000) asserted that the quality of discussion impacts adolescent sexual behavior. The quality of communication can be conceptualized as the tone, openness, skills, and scope. For example, parents might report discussing sexual intercourse with their adolescent, but

may not be open to discuss it in depth, may lack the skills to discuss it in detail or may convey an uncomfortable or unfavorable tone while discussing it. Specifically, researchers found that as communication between a mother and adolescent became more open and receptive as more sexual health related topics were discussed (Miller et al., 1998b). Another study with 397 African-American and Latina single mothers and their adolescents found that more open communication about sexual risk behaviors was related to less adolescent sexual risk-behaviors (Kothchik et al., 1999).

Parent's comfort level to discuss contraceptives impacts the quality of the communication. For example, Whitaker, Miller, May, and Levin (1999), found that parent-adolescent communication about condoms was associated with higher rates of actual condom use, but only when parents openly and skillfully discussed condoms. Additionally, Guzman and colleagues (2003), in their secondary analysis of sexual health communication and sexual behavior of 1,039 Latino youth, found that mother-adolescent discussions around sexual health were associated with adolescent abstinence.

Finally, scholars also emphasize that the communication must be bidirectional, involving speaking and listening from both the parent and adolescent, as opposed to parents taking on an authoritative role by simply ordering the child not to engage in sexual activity (Perrino et al., 2000). Taken as whole, these studies indicate that the quality and the way mothers approaches sexual health related topics are extremely important for communication to influence adolescent sexual behavior.

Frequency of communication. The amount of times parents discuss sex, HIV, or reproductive health information has been found to impact parent-child closeness and general perception about sexual health communication (Martino, Elliott, Corona,

Kanouse, & Schuster, 2008). Scholars have also found that not only frequency, but also repetition about topics through the course of their child's adolescence impacts parent-child relationships (Martino et al., 2008). Repetitive discussions about sexual health, as opposed to one-time discussions, have potential to provide adolescents with a space to better understand difficult concepts and overtime, establish their own value system. In addition, it also ensures that parents have the opportunity to relay the correct messages over time (Miller et al., 1998b). Martino et al. (2008), in their study with 312 adolescents and their parents, found that adolescents who reported more repetitious conversations about sexual health with their parents were more likely to feel closer to their parents, more likely perceive conversations about sexual health as open, and more likely to feel comfortable general and sexual health communication with their parents.

Timing of communication. The timing of the sexual health communication also uniquely impacts adolescents' sexual behaviors (Miller et al., 1998a). Developmentally appropriate discussions that complement the adolescent's psychosocial and cognitive stages have been found to impact adolescents' sexual debut. Miller et al. (1998a) in their study with African American and Latina mothers and daughters, found adolescents whose mothers discussed condoms before sexual debut were three times more likely to use condoms during their first sexual intercourse and more likely to engage in consistent condom use. Mothers can be effective in reducing risky behavior even after their adolescent has engaged in sexual activity, as they can tailor sexual health-related messages according to their adolescents' sexual experiences. For example, Hutchinson and Cooney (1998) found that amongst sexually active adolescents, increased parent-child communication about sex was linked to favorable sexual attitudes towards

behaviors, such as consistent condom use and communication with the male partner about sexual risk. As noted earlier, as children grow into adolescence they gravitate towards peers for acceptance and are often pressured into engaging in sexual behavior at young ages. Parents, however, can buffer this pressure by reinforcing sexual norms by continual communication in this phase (Tinsley, Lees, & Sumartojo, 2004). The timing of sexual health communication is extremely important because parents often underestimate their adolescents' sexual behavior and may not speak to them until after they are already engaged in sexual activity (Jaccard, Dittus, & Gordon, 1998).

Barriers to sexual health communication

It is evident from the research presented above that parent-adolescent sexual health communication impacts adolescent sexual behavior. However parents and adolescents are often reluctant to discuss sexual behaviors. Jaccard and colleagues (2000), in their cross sectional analysis with African American adolescents, explored the factors associated with the extent of parent-adolescent communication about sexual behavior and contraception. Mothers were reluctant to communicate about sexual health content because they were concerned about embarrassing the adolescent and afraid that they would not be able to answer their adolescent's questions. In the same study, the authors identified five main factors that prevented parents from discussing sexually-related topics: fear of encouraging sexual activity, uncertainty of the effectiveness of the communication, not having enough skills or knowledge to explain the topics, situational constraints, and difficulty engaging in mutual communication. Another barrier to

communication is that mothers often underestimate their adolescent's sexual activity, leading to limited discussion about the topics (Jaccard et al., 1998; Stanton et al., 2004).

Adolescents also have reservations about discussing sexually related topics. Jaccard et al. (2000) found that they were reluctant to communicate because they felt their mothers would pry into their personal life and they worried about feeling embarrassed. A study with 249 adolescent females found that in order to increase family communication about sexual health, adolescents said that they would like to be treated more as equal by their parents, parents should learn about adolescent lifestyles, and parents listening skills should improve (Pistella & Bonati, 1999). Other scholars have found that adolescents report their parents to be unsupportive, not able to be trusted, and disrespectful of their privacy (Neer & Warren, 1988; Warren, 1995). These barriers also hold in India as well and perhaps are even more pronounced given the taboo around discussing sexual related topics.

Barriers - Indian context. In a recent national parent-child sexual health communication report, over half of the parents surveyed felt that communication about reproductive health and sex were culturally unacceptable and were ashamed to discuss with their children (Jejeebhoy & Santhya, 2010). Parents reported that they often lacked knowledge to discuss sexually related information, believed that adolescents were already receiving the information from the media, and for females, believed that the knowledge would come “automatically” after marriage (IIPS, 2008; Saksena & Saldanha, 2003). In addition, parents were reluctant to discuss sexually related topics with their children, as they feared their children will be more likely to engage in sexual activities upon discussion of sexually related material (Mahajan & Sharma, 2005; UNFPA, 2003).

Family-based Sexual Health Communication Intervention (FSHCI)

Taken as a whole, it is evident that parents have a unique opportunity to strengthen their relationships with children and serve as sex educators that ultimately impacts adolescent sexual risk taking behaviors. FSHC interventions are created on the premise that parents should be aware of the importance of communicating with their children about sexual health. FSHC interventions seek to change the attitudes, subjective norms, and self-efficacy towards sexual health communication. In addition, FSHC interventions acknowledge that parents need a support system that assists them through the process of building relationships and discussing sensitive issues with their children. Parents need the skills, knowledge, and comfort to discuss sensitive issues in a meaningful and time-appropriate way with their children so they can correct myths or misconceptions their child might have about sex. In addition, parent-adolescent communication about sexual behavior and risk should be continuous, rather than a one-time event in which the child feels restricted to time (Dittus et al., 2004). Communication should be sequential in nature, meaning that the parent can build upon information discussed from previous conversations. Finally, parent-adolescent discussions are value-based so parents can ultimately tailor developmentally appropriate messages and skills for their children (Jaccard, Dodge, & Dittus, 2002).

Family-based sexual health intervention outcomes. FSHC interventions in the USA, Africa, and Trinidad have been shown to effectively increase sexual health communication and reduce HIV risk behaviors among adolescents (Baptiste et al., 2006; Baptiste et al., 2009; Hutchinson et al., 2003; Vandenhoudt et al., 2010). In particular, as

compared to control groups, families enrolled in family-based sexual health interventions reported more frequent discussions about sexual health and other sensitive topics, greater comfort discussing these topics, and more accurate knowledge about HIV (Baptiste et al., 2006; Baptiste et al., 2009; Sperber et al., 2009; Vandenhoudt et al., 2010). Adolescent outcomes of family-based sexual health interventions include increased condom self-efficacy, increased condom use, and increased report of sexual health communication with parents (Dilorio, McCarty, Resnicow, Lehr, & Denzmore, 2007). Below is a description of two community and family-based sexual health interventions that have elements that were used in this study.

Parents Matter Program. The Parents Matter Program (PMP) is Center for Disease Control (CDC) evidence-based community collaborative family-based HIV prevention intervention for African American families. African American youth were targeted because they are disproportionately impacted by unplanned teen pregnancy, HIV, and STI (Dittus et al., 2004; Kaiser Family Foundation, 2006). Created on the basis of being practical and brief, PMP is a five-session intervention for parents of children ages 9-12 years old that promotes and teaches effective parent-adolescent sex and sexual risk communication. With the ultimate goal of reducing risky adolescent sexual behavior, it was developed to address children in the pre-risk phase, before the debut of sexual activity and risk behaviors. Conceptually, PMP is based on four behavioral theories: social cognitive theory (Bandura, 1986), social learning theory (Bandura, 1976), problem behavior theory (Jessor & Jessor, 1977), and reasoned action theory (Fishbein and Ajzen, 1975).

The five sessions spanned over 5 weeks, were 2.5 hours in length and were facilitated by two African Americans. Researchers collaborated with community providers to create a curriculum. The three components covered in these sessions were: 1) Risk Awareness – raising awareness of the role of parents in impacting adolescent sexual risk behaviors. 2) Parenting Practices – skills building surrounding parent monitoring and supervision, communication, and negotiating peers. 3) Sexual Communication – boosting parents' self-efficacy on communicating sexually related topics (Long et al., 2004).

A randomized control trial (RCT) of PMP in the southern USA was conducted to test the efficacy of the intervention from baseline to one-year follow up (Forehand et al., 2007). 1115 parent-adolescent dyads were randomly assigned to one of the three interventions: 5 session enhanced session; brief 2.5 hours single communication session; and single general health session. Parents who attended all of the enhanced sessions, as compared to the control or the single session interventions, communicated more with their children about sexual risk behaviors and were more responsive to their children's question about sexual behavior. These results were consistent with children's report of communication as well (Forehand et al., 2007). As with all community based programs, program retention is often a barrier to effective intervention outcomes, however most parents in PMP attended at least 4 out of 5 intervention sessions and 90% thought that sessions were very important. Forehand et al. (2007) contended that longer follow up needs to be conducted to assess the sustained effects of the intervention. Regardless, the scholars concluded that PMP was an efficacious intervention that increased parent-child communication about sex and sexual risk behaviors.

With successful outcomes in the USA, PMP has also been disseminated in rural Kenya (Poulson et al., 2010). While the intervention was adapted to the cultural context of Kenya, the core elements of the intervention remained. An outcome evaluation revealed that 15 months post intervention, parents in the intervention increased their knowledge and skills on sexual health topics and felt more confident in discussing such issues. Additionally, parent-adolescent communication on sexual topics increased. Similar to the PMP USA program, retention rates were extremely high, as 98% of families attended at least four out of five sessions (Vandenhoudt et al., 2007). Outcome data is still being collected, but as of 2009 45,000 families had participated in PMP in Kenya. The most notable factors that contribute to success of PMP are: the establishment of collaborations and maintenance of communication between the community, agency, and academic partners at an early stage in the research process; theory-based intervention.

CHAMP. The Collaborative HIV prevention and adolescent mental health project (CHAMP) is a 12-session evidence-based community collaborative family-based sexual health intervention that was created on the premise that cultural and contextual factors and parental processes (such as communication and monitoring) influence adolescent development and thus are necessary components for an effective HIV prevention intervention (Sperber et al., 2009). Given the challenges faced by previous individual-level prevention programs of including cultural specific values in their interventions (Boyd-Franklin, 1993), McKay and colleagues set out to do just the opposite. They created partnerships with communities to design and implement CHAMP programs (McKay et

al., 2004). CHAMP researchers believed that adolescent risk behaviors should not be understood and changed just on the individual level, but family-level and community level processes also needed to be included as necessary ingredients for CHAMP to be effective in strengthening family relationships and decreasing youth sexual risk behaviors (Sperber et al., 2009). Overall, CHAMP intervention results indicated that parents in the intervention group reported better family decision making skills (ultimately impacting parental influence on their children), and an increase in parent-adolescent sexual communication, HIV/AIDS knowledge, condom use skills (Sperber et al., 2009). Additionally, adolescents who reported less sexual possible situations had parents who exerted more control on them (Sperber et al., 2009).

While there have been seven adaptations of the CHAMP program, they all focus on increasing parental involvement, reducing adolescent sexual risk behavior, and building strong community ties. Specifically, central to all of the adaptations are the contextual relevance and the strategic delivery of the program. Integrating cultural values, traditions, and beliefs have resulted in greater HIV/AIDS intervention program acceptance by the community and sustainability over time (UNFPA, 2004). Three elements have contributed to the effectiveness of CHAMP as an adaptable intervention (Bhana et al., 2010): 1) community collaborative framework in which community stakeholders participate in the development, implementation, and assessment of the intervention; 2) ecological theoretical framework that conceptualizes macro and micro levels of behavioral influence; 3) multiple family group designed to promote social support that ultimately influences parenting practices and peer support.

The Current Study – FSHC Intervention with sex worker mothers. Given the success of family-based programs with families who have been disproportionately impacted by HIV in USA, South Africa, Kenya and Trinidad, family-based interventions for families who live in high-risk context have potential to strengthen family relationships and ultimately decrease adolescent sexual risk behaviors. Both PMP and CHAMP have worked with populations that consist of single mothers that have been disproportionately impacted by HIV and poverty. Both programs have been adapted for communities in Africa and Trinidad where sexuality is often thought of a taboo and families feel ashamed to discuss it. These population characteristics are similar to those in India, particularly in the sex work community that is highly impacted by poverty and are mostly single mothers.

Fishbein (2000) asserted that the most effective interventions should have a theoretical foundation, but more importantly, it is necessary for community members and stakeholder to be involved in intervention development. The key elements of increasing parental communication by teaching families the skills to communicate about sexual topics through role plays, discussions, and supportive multifamily group environment will be essential components of the current intervention (FSHCI), but the cultural context of the intervention will be altered according to the experiences of the mothers and adolescents in the sex work community.

The Sonagachi Project (SP) is a community-based HIV intervention was established in the 1990's to initially tackle the spread of HIV, but now also aims to change the societal, institutional, and political level perception of sex work and increase access to healthcare (Jana et al., 2004). Many sex workers that have been a part of SP are

mothers. While sex workers who have been involved with Durbar and SP are exposed to many HIV messages, there are no interventions geared toward sex workers and their children. The setting of the ongoing Sonagachi Project is a good opportunity to introduce a family-based HIV prevention intervention model because of the community collaborative intervention model that is already established.

Chapter Four

Conceptual Framework

Overview

This dissertation will utilize the Theory of Planned Behavior (TPB) (Ajzen, 1985) to understand FSW mothers' attitudes, subjective norms, and perceived behavioral control around sexual health communication with their children. The purpose of using Theory of Planned Behavior is twofold: A) To utilize the constructs in the qualitative phase (Phase one and two) to better understand the depth and meaning of FSW mothers' attitudes, subjective norms, and perceived behavioral control around sexual health communication with their children; B) To test the preliminary efficacy of FSHCI on mothers' attitudes, subjective norms, and perceived behavioral control toward sexual health communication with their children (Phase three).

Theory of Planned Behavior

TPB is an extension of the Theory of Reasoned Action (TRA) (see Figure 4.1) (Fishbein & Ajzen, 1975; Ajzen, 1985). Both theories are based on social cognitive theory and have been widely used in health behavior research to understand individual behaviors (Albarracín, Johnson, Fishbein, & Muellerleile, 2001). TRA suggests that attitudes, belief and outcome expectancies about a behavior, and subjective norms, social pressures about the behavior, impact individuals' intention to perform a behavior. TRA, however, only explains behaviors that are in full volitional control, and limits understanding of behaviors in which individuals have limited control. For example, a person may not have full control of her sexual partner's condom use. Due to this

limitation, TPB was created to account for those beliefs in which individuals possess little control.

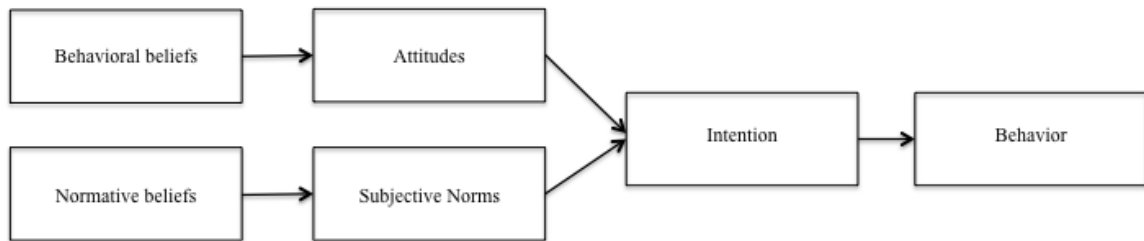


Figure 4.1: Theory of Reasoned Action (Fishbein & Ajzen, 1975)

According to the TPB (see Figure 4.2), behavior is guided by attitudes, subjective norms and perceived behavioral control or self-efficacy that are informed by beliefs (behavioral beliefs), normative beliefs that are informed by others expectations of that behavior (normative beliefs), and control beliefs are informed by the impact of external factors that may facilitate or impede the outcome behavior (control beliefs). In combination, these constructs form individuals' intention to engage in a specific behavior. A number of meta-analysis have found that the TPB effectively predicts behaviors (Albarracin, Johnson, Fishbein, & Muellerleile, 2001; Armitage & Conner, 2001) Albarracin and colleagues (2001), in their meta-analysis of 96 datasets from around the world tested the efficacy of TPB in predicting condom use, found that condom use was more likely if the participants intended to use a condom. Additionally, adolescent HIV prevention interventions based on TPB concepts have been found to be effective in reducing risky sexual behavior (Barker, Battle, Cumming, & Bankroft, 1998; Jemmott,

Jemmott, & Hacker, 1992; Rotheram-Borus, Gwadz, Fernandez, & Srinivasan, 1998) and delaying sexual debut (Jemmott, Jemmott, & Fong, 1998).

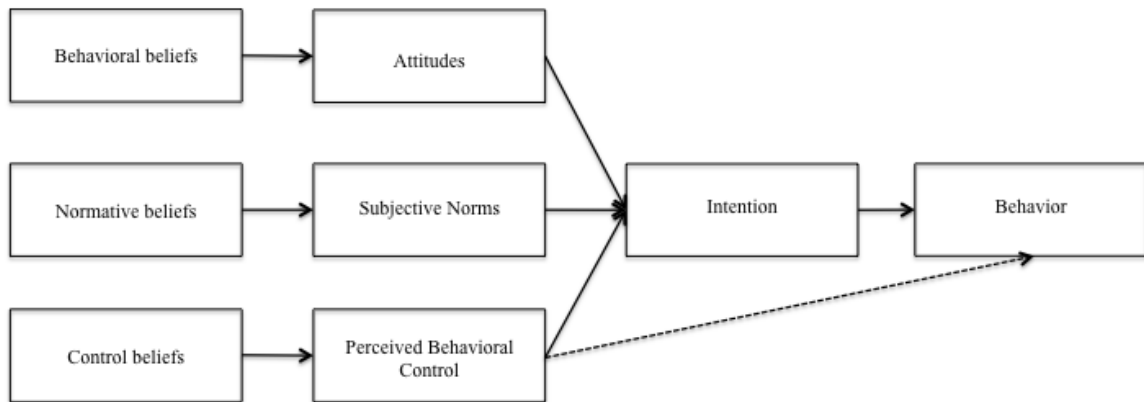


Figure 4.2: Theory of Planned Behavior (Ajzen, 1985)

Theory of Planned Behavior Constructs

Behavioral beliefs. Behavioral beliefs are favorable or unfavorable beliefs toward the outcomes of performing a behavior. Attitudes toward a behavior are informed by individuals' behavioral beliefs about the behavior. Ajzen (2000) suggested that the attitude construct is comprised of two subcomponents, emotional assessments of the behavior that evaluate the behavior as being enjoyable or unenjoyable and instrumental assessments of the behavior that evaluate the behavior as being beneficial or harmful. Attitudes have been conceptualized as having a direct impact on individuals' intention to perform the behavior. For example, for the purpose of this study, mothers' behavioral beliefs are unfavorable or favorable beliefs about sexual health communication with her child.

Normative beliefs. Normative beliefs are perceived social pressures to engage or abstain from a behavior. Individuals' subjective norms are informed by their normative beliefs about a behavior. As opposed to the attitude and perceived behavioral control constructs, the norms concept is more theoretically complicated. The subjective norms construct has been conceptualized to include an injunctive component and a descriptive component (Ajzen, 2000). The injunctive norms are social pressures to engage or abstain from a behavior and are based on whether one believes if those in their social network want one to perform the behavior. For example, for the purpose of this study, it is a mothers' perception if those in her social network want her to discuss sexual health with her children.

Whereas descriptive norms are social pressures based on whether their social network performs the behavior or whether one observes their social network performing the behavior (Ajzen, 2000). For example, mothers' perception of whether those in her social network communicate with their children about sexual health. The norms construct is very intriguing because of the norms surrounding sex work and their families in India. In addition, the collective identity processes that have been documented in health behavior research have the potential to uniquely contribute to this study's conceptualization of subjective norms (Ghose et al., 2008). Norms around sex work are changing in India because of collective mobilization around issues of life insurance, banking, health and sex workers rights (Ghose et al., 2008; Jana et al., 2004). Multiple levels of social norms, such as sex worker community level, family level, general social norms around India, norms around mothering, have potential to impact parenting practices. Sex workers and their families are subjected to stigma and then

further internalize this stigma. These norms have a debilitating effect on parent-child relations and around open communication about sexual health because mothers may internalize the experienced stigma.

Control beliefs. The control belief construct was included in TRA, to make it the TPB, because the TRA lacked the ability to assess behaviors that individuals did not have complete volitional control. Control beliefs are individuals' belief that they have the appropriate skills, resources and power to perform the outcome behavior. Control beliefs can also be understood by two subcomponents of self-efficacy, a person's perception that they can complete the specific behavior with ease/ difficulty and confidence, and controllability, that a person has complete control over the behavior (Ajzen, 2002). Ajzen (1985) also suggested that control beliefs indirectly influence the behavior through intentions, but also directly impact the behavior. For example, behavioral control beliefs can be conceptualized as mothers' perception about having appropriate skills, powers, and resources to meaningfully communicate with their child about sexual health.

Behavioral Intention. Behavioral intention is the intention to engage in the behavior. Fishbein and Ajzen (1975) have found that intention to perform a behavior is precursor to actually perform the behavior. Simply put, how much effort someone would set forth to perform the outcome behavior. For example for the purposes of this study, the intention is to communicate about sexual health with their child about sexual health.

Parent-Expansion of the Theory of Planned Behavior

In recent years, TPB has been criticized because it fails to evaluate the impact of distal factors that influence an individual's behavior. Distal factors, such as parents' influence on adolescent's behaviors, are important to measure. As suggested by Bronfenbrenner's (1977), an individual is directly or indirectly influenced by various systems.

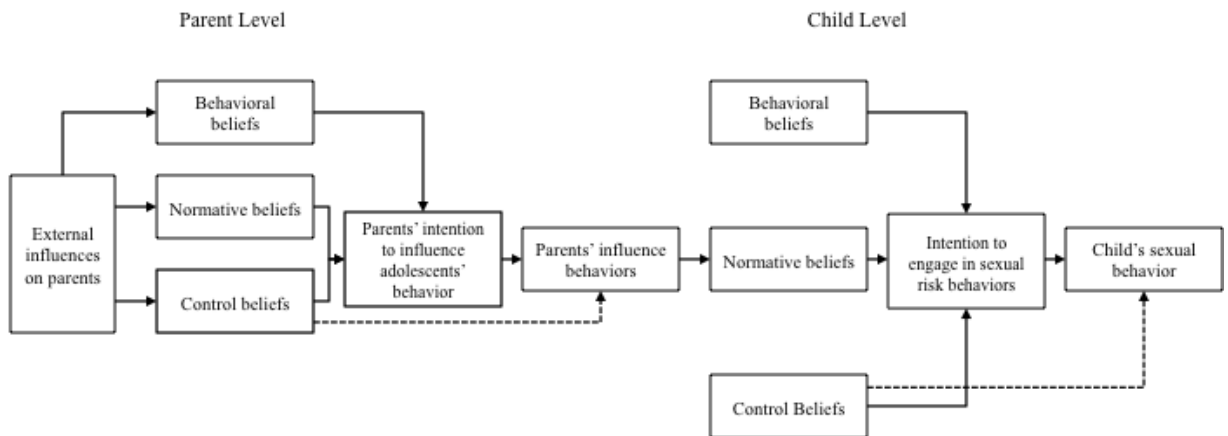


Figure 4.3: Theory of Planned Behavior Parent Extension (Hutchinson & Wood, 2007a)

Thus, one can never view individuals' behavior without taking account the environment and relationships. Parents play a critical role in protecting youth from risky sexual behavior. However, until recently, parents have rarely been included in the theoretical framework as having a direct or indirect impact on adolescent sexual behavior. A recent expansion of TPB (see Figure 4.3) highlights that parental behaviors (such as communication) influences attitudes, norms, and control beliefs an adolescent has, which directly informs their intention to engage or not to engage in a specific

behavior (Hutchinson, & Wood, 2007a). Hutchinson et al. (2003), in a study that informed the Parent Expansion TPB, found that increased parent-adolescent sexual risk communication was significantly associated with unprotected sexual encounters experienced by the adolescent daughters. In a study with Jamaican adolescents, Hutchinson and colleagues (2007b) qualitatively investigated the constructs of the TPB parent expansion among Jamaican parents and adolescents. They found that behavioral beliefs (attitudes toward a behavior) were associated with the intention to use a condom and to actually use a condom. The main aim of their study was to inform a family-based HIV intervention and the need for it was fully supported by the data collected, as most adolescents indicated wanting to learn more about sexual health and reported limited negotiating skills when in sexually charged situations.

Study Model

Figures 4.4 to 4.6 display components of the family-based sexual health communication intervention. In Figure 4.4, we hypothesize a direct effect from FSHCI to each of the mediating variables, subjective norms, attitudes, and perceived behavior control. In Figure 4.5, we hypothesize a direct effect from each of the mediating variables to the outcome of frequency of sexual health communication. In Figure 4.6, we hypothesize a direct effect from the family-based sexual health communication intervention to the outcome of frequency of sexual health communication. We are able to examine the different paths of potential associations by breaking the figure into components. Finally, Figure 4.7 displays the FSHCI study model as a whole.

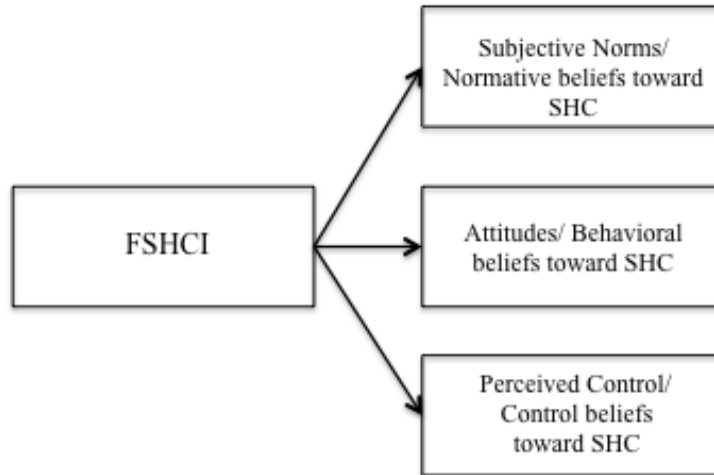


Figure 4.4: FSHCI effects on Mediators

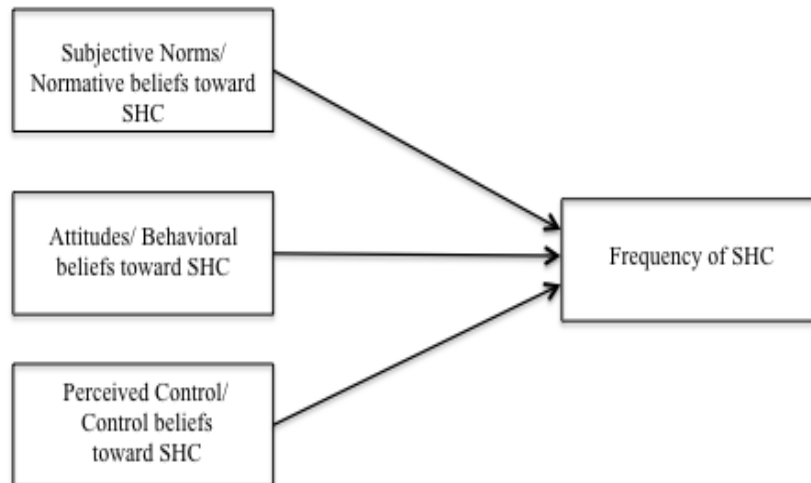


Figure 4.5: Mediator Effects on Frequency of Sexual Health Communication



Figure 4.6: FSHCI Effects on the Frequency of Sexual Health Communication

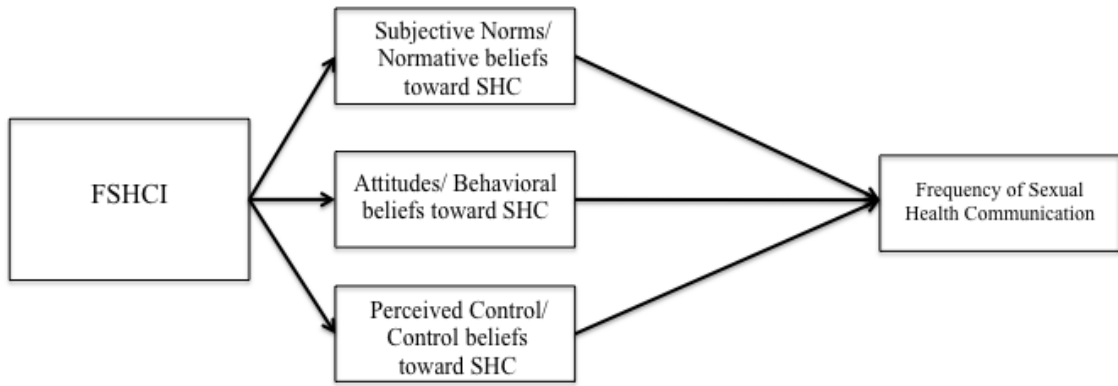


Figure 4.7: FSHCI Study Model

Chapter Five

Study Design and Methods

Study Research Hypotheses

I hypothesize that FSHCI will increase mothers' frequency of communication by improving the subjective norms, attitudes, perceived control and intentions toward sexual health communication.

Specifically, compared to the pre-test time point, at post-test participants will:

H₁: report higher levels of favorable subjective norms, attitudes perceived control, and intentions about communicating with their children about sexual health in the next one month.

H₂: report more frequent discussions about sexual health with their children.

H₃: report more comfort in communicating with their children about sexual health.

H₄: the frequency of communication outcome will be mediated by the subjective norms, attitudes, and perceived behavioral control.

Research Question

- a. What are the context specific factors that shape sex worker mothers' subjective norms, behavioral and perceived control beliefs about sexual health communication with their children?

Overall Approach

The study was conducted in three phases. In phase 1, we conducted formative research to better understand the Durbar Mahila Samanwaya Committee (hereafter Durbar) community context and establish the Durbar community collaborative board (DCCB). In phase 2, elicitation interviews and focus groups, as recommended by the Theory of Planned Behavior scholars, were conducted to better understand sex worker mothers' subjective norms, attitudes, and perceived behavioral control about sexual health communication with their children (Fishbein & Ajzen, 2010; Montano & Kasprzyk, 2008). The design of the family-based sexual health communication intervention (FSHCI) was finalized and the instruments were tailored. In phase 3, participants were recruited and the feasibility and preliminary efficacy of the FSHCI intervention were examined through a quasi-experimental one group pre-test, post-test design and qualitative process interviews. Community-based interventions, such as this study, are most effective when the community is involved in all aspects of the research project. As such, the DCCB were involved in all components of the research process.

Study Setting

This study took place in Kolkata, West Bengal, India. West Bengal is a state situated on the eastern side of India, along the Ganges River and bordering Bangladesh. Kolkata houses the largest red light district in Kolkata, named Sonagachi, with about 9,000 sex workers. Sonagachi, meaning golden tree, has been in existence since the mid-nineteenth century, when it was a bustling red light district serving mainly the British soldiers (Sinha & Dasgupta, 2009).

Durbar and the Sonagachi Project. The Sonagachi Project (SP)

(<http://www.durbar.org/index.asp>) was conceived in Sonagachi in 1992 as a community-based HIV prevention intervention to address the high rates of HIV that was spreading through community of sex workers. SP is now a sex worker led and peer-based HIV intervention that utilizes community empowerment and education to increase condom use and reduce the spread of HIV (Jana et al., 2004). Durbar, which means *Unstoppable* in Bengali, now coordinates all SP related programs, including a sex workers union and a child of sex worker union. Differing from individual-level behavior change interventions, SP is community-level structural intervention that aims to change the societal, institutional, and political level perception of sex work and increase access to healthcare (Blankenship, Friedman, Dworkin, & Mantell, 2006; Blankenship, West, Kershaw, & Biradavolu, 2008; Ghose et al., 2008). DMSC has partnered with the Indian Government to implement HIV interventions among sex workers and has been supported by funding from the National Institutes of Health, the World Health Organization, and the Bill & Melinda Gates Foundation.

SP has had substantial success in increasing sex worker's condom use, from 3% reporting condom use in 1992 to 90% in 1999 (NACO, 2001). The project now runs a medical clinic, banking co-operative, support groups, and school for children of sex workers. The project has been replicated throughout West Bengal and has been shown to increase condom use at replication sites (Chakrabarty, 2004). SP has recently been conceptualized as a structural intervention that has changed the risk environment sex workers are exposed to both on macro and micro levels. In addition, SP is now regarded as a model community-based HIV intervention by the World Health Organization

(WHO) and for sex worker communities around the world (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Wallerstein, 2006).

Through their multi-tiered mobilizations, Durbar has pioneered movements in couching sex work as a choice. Since its inception, Durbar has (re)framed sex work as legitimate work by organizing and mobilizing sex workers to engage in political and community advocacy, raising consciousness within the FSW community and various stakeholders, and infusing the rights-based ideology through the organizations various factions (Amra Padatik (children’s collective), USHA (micro-finance cooperative)) (Ghose et al., 2008; Swendeman et al., 2009). Furthermore, Durbar encourages political advocacy participation through sex work rights rallies, national and international sex work conferences, and leadership roles that provide opportunities to engage and negotiate with local and national politicians and institutions that have long history of being oppressive agents. Ghose et al. (2008) suggest that framing sex work as “legitimate work”, as Durbar has done, aligns sex work with other labor rights movements and de-stigmatizes sex work through identifying oppressive agents at community and structural levels.

Phase One: Formative

The formative phase was conducted to better understand Durbar and the sex worker community as well as establish a community collaborative board at Durbar (DCCB). This formative research helped to shape all aspects of the research study, including the research protocol, the interview protocols, and the intervention development and implementation. CCB have been viewed as essential in many

intervention studies (Sperber et al., 2009) and ensure that the research is by the community and for the community. Thus, one of the first steps was to establish a Durbar CCB (DCCB).

Durbar CCB. I initially conducted informational interviews with Durbar clinic and office staff and children of sex workers who were over the age of 21 and involved in Amra Paditik (the children of sex workers collective that is overseen by DMSC). The purpose of these informational interviews was to better understand the needs of Durbar and mothers who were sex workers, as well as assess the interest in the topic of mother-child sexual health communication. Discussing these topics with different stakeholders helped to obtain a varied perspective of the phenomena. The informational interviews also helped to recruit DCCB members. Two Durbar staff and three children of sex workers collective members established the CCB for this study. They were instrumental in every aspect of the study, including the development of the qualitative interview protocols, participant recruitment, and intervention development, implementation, and assessment. As a start, the DCCB shared their thoughts and experiences about mother-child relationships and sexual health communication in the sex worker context. They were immediately intrigued by the topic and thought it was very necessary to intervene on such issues because of the lack of family-based initiatives at Durbar. I shared my experiences and also provided examples of family-based sexual health communication interventions that have been conducted in other parts of the world. Then we held many meetings to discuss components of previous interventions, such as CHAMP and PMP that would be feasible and meaningful in this setting. We simultaneously conducted individual in-depth interviews and focus groups (see Phase 2 for details and Chapter 6 for

results) with mothers who were sex workers about their salient normative, behavioral, and control beliefs about SHC with their children. These interviews ultimately informed the FSHCI curriculum and measures. Two members of the DCCB facilitated the FSHCI, while the other three members oversaw the logistics of the study.

Phase Two: Qualitative

The Family-Based Sexual Health Communication Intervention (FSHCI) protocol and relevant measures were identified prior to elicitation interviews through the DCCB. In phase two, we conducted elicitation interviews and focus groups to elicit the relevant Theory of Planned Behavior constructs of salient behavioral, normative, and control beliefs. The elicitation interviews contributed to the further development of FSHCI curriculum and the measures. These processes helped to ensure the cultural fit of the FSHCI curriculum and the measures.

Sampling Procedures. Snowball sampling was used to recruit participants. As a first step, participants were recruited from Durbar's membership list of sex workers. In addition, Durbar staff members who were familiar with Durbar members and with the inclusion criteria for this study identified potential participants. Participants were also approached at the Durbar offices and clinics about participating in the study. Participants were asked to refer other potential participants for the study as well. Study investigators verified if participants met the inclusion criteria. If individuals met the inclusion criteria, study investigators provided a brief explanation of the research project. Sampling was stopped after theoretical saturation reached, i.e., new concepts stop emerging from interviews (Guest, Bunce, & Johnson, 2006). Unlike other sampling techniques,

theoretical sampling is driven by the data rather than a need to achieve a certain sample size (Charmez, 2006). Thus, the purpose was not to achieve generalizability, rather it was to contribute to theoretical and conceptual development of a phenomenon.

Inclusion criteria for mothers to participate in the study: a) Over the age of 18, b) live in Kolkata, India, c) have a child between the ages of 10-21, d) speak Bengali or Hindi.

Qualitative Data Collection.

Elicitation interviews. We conducted in-depth semi-structured qualitative interviews with 34 mothers who identified as sex workers. 40 individuals were approached for the interviews and six individuals refused to participate because of schedule conflicts. Interviews lasted from 20 to 60 minutes and most were audio-recorded with the participants' consent (See Appendix A for elicitation interview protocol). Five participants were not audio-recorded because of technical issues with the audio equipment. In these cases, I took notes during the interview, debriefed with the translator and then wrote a memo immediately after the interviews. With the participants' consent, a Durbar translator, who spoke Bengali, Hindi and English, was present at most of the interviews. Interviews were held at a location and a time of participants' convenience. Most interviews took place in a private space at the Durbar office, Durbar clinic, or at participants' residence. Most of the interviews were conducted in Hindi, while six of them were conducted both in Hindi and Bengali. Upon meeting face-to-face, verbal consent was sought.

A research assistant, who was trilingual in Bengali, Hindi and English, and I transcribed the interviews into English. This triangulation helped to ensure the linguistic and conceptual equivalence of the transcription, minimizing the threat of losing the meaning of the words and concepts. Transcript files were password protected and located on a password-protected computer.

The first six interviews were conducted with a brief protocol, in which we were interested in better understanding mother-child relationships and sexual health communication. We then coded the data and utilized the sensitizing concepts of attitudes, norms and control beliefs to better understand the cognitive processes in the remaining interviews. The interviews were geared toward eliciting mothers' salient behavioral beliefs, normative beliefs and behavioral control beliefs about sexual health communication with their children (see Appendix A). To uncover participants' salient behavioral beliefs about sexual health communication with their children, questions addressed the advantages and disadvantages of communicating about sexual health with their children and positive or negative outcomes of communicating about sexual health with the child. Salient normative beliefs about sexual health communication were assessed by asking participants questions about who would approve or disapprove sexual health communication with their child and beliefs regarding who communicates with their child about sexual health. The questions about salient control beliefs focused on the participants' perceptions of the environmental and situational facilitators and challenges of communicating with their children about sexual health. Conducting elicitation interviews helped to gather qualitative data about the Theory of Planned Behavior

constructs that ensured a good fit of the FSHCI curriculum and the measures to the context.

Participants' profile. Participants were women who identified as sex workers and had children between the ages of 10 and 20. Sex work was the primary source of income for all of the participants. Most of the women were brothel-based sex workers and a few were flying sex workers who travelled daily from the suburbs or village to the red-light district for work. About half of the women were originally from Kolkata and the other half had migrated from other parts of West Bengal to find employment. Their ages ranged from 25 years old to 50 years old, with most women between the ages of 30 and 40. Most of the women were involved in sex work for over ten years. A little more than half of the women had two or more children. Their children's ages ranged from 10 years old to 21 years old and about half were female. About half of the children lived with their mothers, while the other half lived with extended family in the village, in a hostel or boarding school, or lived separately with their spouse. Almost all of the women said that they entered sex work to provide for their children. Most of the women were the primary financial support for their families and many also noted financially supporting their extended families, such as siblings or parents. Most of the women were single parents and provided narratives of being abandoned by their husbands within a few years of their marriage. A little more than half of the women said they had discussed HIV/AIDS, puberty, condoms, or STI with their children. Most of the women had not disclosed that they were sex workers to their children.

About half of the participants were Durbar peer educators while the other the other half were community members who utilized Durbar's services. A little more than

half of those associated with Durbar, for over 10 years, through peer education work or service utilization. The differing level of participation in Durbar allowed for a nuanced understanding of the aspects of Durbar that shaped mothers' behavioral, normative, and control beliefs about sexual health communication with their children.

Focus groups. In addition to the elicitation interviews, we conducted five focus groups with 5-7 sex worker mothers in each group. Focus groups lasted about one hour. One focus group session was audio recorded, while I took notes in the other focus groups. Focus groups were conducted in collaboration with the DCCB. Similar to the elicitation interviews, the fit and appropriateness of the FSHCI curriculum and the measures was assessed. The focus groups questions elicited participants' salient beliefs about sexual health communication with their children (see Appendix B). Additionally, the questions explored if the concepts used in the FSHCI curriculum and the measures fit into the cultural context and how they can be further tweaked to better serve sex worker mothers and their children. Focus groups also revealed the different opinions held by participants and provided insight into collective beliefs about mother-child sexual health communication.

Qualitative data analysis. Dedoose qualitative data analysis software was used to code the individual interview and focus group data (Dedoose, 2013). Data collection and data analysis were conducted simultaneously throughout the study, in that we were in constant interaction with the procedures so that data could be coded and categorized accordingly, which assisted in subsequent interviews (Charmaz, 2006).

Elements of constructivist ground theory were used in the qualitative data collection and analysis. Charmaz's conceptualization of grounded theory emphasizes the role of interpretation and meaning. Additionally, the approach highlights that meaning is co-constructed by the researchers and the participant rather than being discovered. Thus, grounded theory is an interactive and interpretative process, in which the researcher is conceptualizing and constructing the participants (re)construction of reality (Charmaz, 2006). Unlike the initial conceptualization of Glaser and Strauss (1967), Charmaz specifically argued that "...neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We construct grounded theories through our past and present involvements and interactions with people, perspectives, and research practices" (Charmaz, 2006, p. 10). A constructivist grounded theory methodology was used in this study because we were interested in how mothers make meaning of communication, specifically sexual health communication, and relationships with their child.

The data was coded as it was collected and memos were used to further explore how the codes were connected, ultimately triggering new ideas to emerge. First, I read through all of the transcripts, without coding the data. Then I conducted open coding, which helped me to stay grounded in the data. These open codes were compared between interviews. I was then able to note new codes, allowing for themes and patterns to emerge (Charmaz, 2006; Oktay, 2012). Some of the open codes included stigma, spoiled, mothering, fighting for rights, being friends, talking freely, and not my duty. Specific attention was paid to the phrases or words participants used in the interviews. Charmaz delineates these phrases to be in vivo codes in that they are the "symbolic marker of the

participant's speech and meanings" (Charmaz, 2006, p.55). In vivo codes help the researcher to stay grounded in the actual data and away from preconceived concepts, by using the participants actual terminology to develop categories.

As open codes were compared between interviews and re-organized accordingly, they were grouped into concepts and categories. Additionally, we identified the most frequent and salient codes while engaging in focus coding for the remaining interviews. Diagrams and notes were used to form conceptual audit trails (Charmaz, 2006). Sensitizing concepts from the theory of planned behavior were to used as categories. These categories included behavioral beliefs about SHC, normative beliefs about SHC, and control beliefs about SHC. Theoretical coding was used to establish connections between the categories developed from the initial coding. Conceptual diagrams were created through this process and used to better understand the relationship between the codes and categories.

Strategies for Rigor. Establishing rigor is an important component of grounded theory that helps to ensure quality (Padgett, 2008). A number of strategies were employed to enhance research rigor. First of all, research decisions were methodologically transparent (Auerbach & Silberstein, 2003; Charmaz, 2006). All details regarding coding and category development were noted. I kept a researcher journal for the purpose of writing every step in the research problem and noted any concerns. Data triangulation was attained by data collection through in-depth interviews, focus groups and through interactions with different parts of the community (sex workers, Durbar staff) (Padgett, 2008). Member checking was used to provide participants and the DCCB with the opportunity to comment and contribute to the findings (Creswell, 2007).

Positionality and Reflexivity. By adopting a community-based participatory research framework, I aimed to be a collaborator in all aspects of the research study with sex worker community and Durbar. Thus, examining my own role and biases were necessary throughout the study (Maxwell, 2005).

I have worked with children and their families impacted by poverty and HIV both as a social work practitioner and as a researcher in the United States. Prior to my dissertation research, I had not worked in research capacity in India. However, I do have other associations with South Asia. My parents immigrated from Pakistan to the United States in the 1970's. Though I was born and raised in the United States, I have been rooted in the culture and the language of Pakistan.

Prior to starting this dissertation research in India, I was very self-reflexive about both my roots in the South Asian culture and the Western culture. I was not exactly sure how it would impact my work with the sex work community, as they had worked with many westerners but perhaps not with someone who identified as Pakistani but from the West. I found myself very aware of not only my cultural status, but also my economic status as someone from a middle socio-economic class.

My role and interactions with Durbar and the study participants depended on the phase of the project. In the qualitative components of the study, which lasted all three phases, I was extensively involved with Durbar and also the participants. Maxwell (2005) highlights that “in qualitative studies, the researcher is the instrument of the research, and the research relationships are the means by which the research gets done” (p. 83). While I developed strong relationships with the DCCB members, I was extremely aware of my presence as a person of Pakistani origin and a researcher from the West. All of these

identities were very delicate in the context of this work. I wanted to make sure that I wasn't using any of these identities to get the work done, which was often a process that one did not have to try to do, as it just happened because of the power dynamics at play. For example, because I was an outsider, there were many times project-related tasks were put at the forefront of DCCB's agenda, however I knew such prioritization was not something that would be sustainable over time or something that was feasible. Thus, I worked with DCCB to help them understand that durbar family project related tasks were not urgent and that they should not feel that they had to get to it immediately. As such, they also assumed ownership of the project and fit in Durbar family project related tasks when feasible as opposed to making it a priority over their work.

I was able to conduct most of the qualitative in-depth interviews and focus groups because I spoke Hindi. This not only helped to form relationships with study participants but also with the DCCB. While some of the members spoke English, the fact that I spoke Hindi helped to facilitate conversations better but also created a sense of trust and created a space for conversations outside of the research project. For example, there were many instances we engaged in conversations in the office but also during meals that would not have happened had I not known Hindi. While this was a benefit and strength of the study, it posed some challenges with research participants. Perhaps my outsider status allowed me to get more interviews with participants. Additionally, perhaps answers to the question were biased in that participants responded in to questions based on their perception about what I wanted to hear as the interviewer.

On the other hand, during Phase 3 of the project, which included the implementation of FSHCI, I played a role more in the development and logistics of the

intervention rather than the implementation of it. Trained facilitators who were DCCB members and longtime sex workers who were mothers implemented the intervention. This helped to promote the sustainability of the project because the DCCB had taken full ownership of the project by this stage.

My role as a social work researcher but also my South Asian identity impacted the ways in which I interviewed participants and made sense of the data. I was able to understand the underlying meaning of some cultural specific concepts, however at the same time because I was not Bengali or from the sex work community, I was not able to understand others. When study participants realized that I spoke Hindi, they assumed that I would be able to speak and understand Hindi, and that I would be able to understand all components of the language and the latent meanings. While it took me sometime to understand this piece of the process, I did make it a point during the consent procedure to acknowledge that there might be aspects of the conversation that I would not be able to understand and in such cases the translator would step in.

I utilized both identities of a researcher of South Asian identity during data coding and analysis. While at many times this was an advantage because I was able to understand the cultural context, it was a challenge because I did not want to pose any bias or overanalyze the data that would ultimately take me down a path of interpretation that was not consistent with the participants' construction of the phenomena. Thus, to eliminate these threats and also to ensure the rigor of the study, I engaged in member checking and also had a co-coder who coded a portion of the interviews and engaged in many discussions about the interpretation of the data.

Phase Three: Family-based Sexual Health Communication Intervention (FSHCI)

Overview. The third phase of this study examined the feasibility, implementation, and preliminary efficacy of FSHCI. The study examined the short-term impact of FSHCI for mothers on the following variables: a) frequency of mother-adolescent sexual health communication; b) comfort of mother-adolescent sexual health communication; c) attitudes, perceived norms and perceived control about mother-adolescent sexual health communication. To accomplish this, a quasi-experimental one group pre-test, post-test design was conducted.

Quasi-Experimental One group pre-test, post-test design. A one group-pre-test, post-test design was the most feasible design for this pilot study. Given that the concept of parent-child sexual health communication had never been studied with sex worker mothers, a family-based intervention had never been conducted with the community, and the limited amount of resources, we thought it was necessary to conduct the study without the control group for this pilot study. While it was the most feasible design for this pilot study, there were limitations to this design that ultimately threatened the internal validity of this study (Cook & Campbell, 1979; Shadish, Cook, and Campbell, 2002). History and testing were the main threats to internal validity, or a threat to relationship between independent and dependents variables. History is an event, other than the intervention itself, that occurs between pretest and posttest that produces effects on the individual. For example, additional exposure to family-based programming outside of the intervention has potential to impact mothers' outcomes. While Durbar did not hold any other family-based programs during the duration of the study, we are unsure if the

participants were exposed to such programs elsewhere. Finally, testing is when participants are influenced by the testing instrument (survey assessment) rather than the intervention itself. This was a threat in this study because most of the participants had not been exposed to the concepts of parent-child sexual health communication. As such, they were primed about it through the survey assessment before the intervention had even started. The survey assessment could have triggered participants to communicate with their children about sexual health rather than the intervention. Shadish et al. (2002) suggest that a control group reduces the threat to internal validity because one can isolate the effect of the intervention on participants. In future studies, we plan to include a control group in the design.

The FSHCI consisted of 4 sessions in the span of one day, focused on parenting skills, communication, sexual health, parent-child relationships, and empowerment. Participants were involved in the study for approximately 6 weeks between baseline interviews and 1 month post-intervention follow up. Each intervention group consisted of 8- 13 mothers. The intervention was delivered by specially trained Durbar staff who were familiar with community.

Participant Recruitment Procedures/Enrollment.

Recruitment. 41 sex worker mothers were recruited from Durbar offices and clinics throughout Kolkata, India. A community liaison from Durbar assisted with participant recruitment. Participants were recruited through referrals and community events. Participants were first screened to determine eligibility. Women who met the eligibility criteria were consented and completed the baseline assessment. Inclusion

criteria were: a) Over the age of 18, b) live in Kolkata, India, c) have a child between the ages of 10-21, d) speak Bengali or Hindi.

Enrollment in the intervention lasted about five weeks. There were four points of contact with the participants 1) initial recruitment to explain the study 2) baseline assessment and consent procedure 3) intervention 4) post-1 month assessment and qualitative process interviews. While FSHCI was a novel program for sex workers, we utilized similar strategies that Durbar has used for previous interventions. Given the proximity of the brothels to the Durbar clinics, study personnel recruited most participants by going to their homes about three to four days before the intervention. A few participants were also recruited from Durbar's clinics. We recruited study participants from four red-light districts. The intervention was implemented in each of four sites. At the time of the first interaction with potential participants, study personnel explained the study in detail, provided participant responsibilities, and noted the participants' names and contact information. If interested, participants were asked to sign up for a time slot within the next one to two days to complete the baseline assessments and consent form. Upon consent, participants were assigned unique identification numbers, which were entered into a computerized tracking form. The identification numbers were written on the surveys. Names of the participants do not appear on any study forms. Participants were given a handbag and provided with a meal and tea during the intervention.

A total of 50 people were approached and 9 people refused. 5 people refused to participate in the intervention because they had clients during the time of the intervention

and 4 refused because they were not interested in attending the intervention. The following table provides the breakdown by site.

Table 5.1: FSHCI Field Sites

Site Name	Assessed	Intervention Attendance	Post-assessment
Searphully	9	9	8
Rambagan	9	9	8
Bow Bazar	13	13	11
Kalighat	10	10	10
Total	41	41	37

Retention. Retention rates were high as the intervention was held for one day as opposed to multiple days. In one site, two participants had to leave during the last session because they had personal emergencies. In follow up interviews, they noted that they would have been interested in attending additional intervention sessions. In one of the four sites, the intervention had to be divided into two days. Participants had to leave 1.5 hours into the intervention because they had to get water from the wells and that was the only time the water was accessible that day. This schedule conflict was not made aware to the study personnel beforehand, but the issue was dealt with in the best way possible. We scheduled the last 1.5-hour of the intervention for another day. Six out of the ten participants returned for the second day of the intervention. Out of the four participants that did not return, two participants did not want to return, one participant had moved to

the rural area, and the other one was working. While holding the intervention over two days was unexpected, over half of the participants returned to the intervention. We learned that participants were interested in attending multiple sessions.

We followed up with study participants one month after the intervention to conduct post one-month assessments and qualitative process interviews.

FSHCI – the intervention. FSHCI was delivered to parents who have children ages 10 to 21. A total of four groups, with approximately 8 to 13 mothers in each, participated in FSHCI. Given the goals of strengthening family relations, increasing communication, promoting collective identity and enhancing social support and between families, the multiple-mother group provided mothers with the opportunities to receive support from each others, provided a space to discuss uncomfortable topics, and helped to break down conversational barriers through role play and other constructive techniques. The intervention consisted of 4 sessions spanning over 3 hours in one day. Given that this was a pilot study, it was important to first test the feasibility of creating and implementing this intervention on small scale. Recent interventions have found that one-session interventions, such as this one, have the ability to produce desired outcomes (Jemmott, Jemmott, Braverman, & Fong, 2005; Roye, Silverman, & Krauss, 2007).

Components of FSHCI. FSHCI is geared toward promoting collective identity within the group and healthy family processes and relationships. The FSHCI curriculum was based on components of the Parents Matter Program (PMP) and CHAMP, and previous scholarship of Durbar (see Chapters 3 and 8 for details on each). Both intervention curriculums have advantages. The aim was not to adapt these interventions,

but utilize the concepts and approaches that proved successful in both of the existing interventions (see detailed discussion in Chapter 8).

FSHCI curriculum. The FSHCI curriculum addressed: a) mother-child processes, such as communication about sexual health, b) HIV knowledge, c) puberty, d) disclosure about sex work. Overall the curriculum was centered on changing participants' attitudes, perceived norms, perceived behavioral control, intentions, and comfort about communicating with their children about sexual health. The curriculum was developed for sex work population and was co-created with the DCCB. Below is a brief description of each session. Refer to Appendix C for a more detailed description and Chapter 8 for intervention development processes.

Facilitator training. The two facilitators were involved in the intervention from the beginning of the project and throughout its implementation. Both of the facilitators expressed interest in facilitating intervention when I met with them in phase 1 of the study. Both of the facilitators were mothers, sex workers, and has facilitated numerous programs at Durbar. The facilitators were also members of the DCCB that was established to oversee the project. The community board also included three young adult children of sex workers who also assisted in the curriculum development. Facilitators were involved with the curriculum development. Additionally, the facilitators were trained in the curriculum during five meetings over the span of 3 weeks. The training was focused on the curriculum content, group-intervention processes, and any other issues of concern.

Table 5.2: FSHCI Session Outline

Session	Goals	Content	Theoretical Construct
<p>Introduction – Talking and Listening (30 minutes)</p>	<ol style="list-style-type: none"> 1. To introduce the purpose and goals of the intervention 2. To provide the mothers with space to get to know each other and feel comfortable with each other 3. Mothers identify and share concerns 4. To increase parents awareness that they impact their child’s health and safety behaviors 5. Improve intention to communicate about sexual health 6. Improving mothers’ self-efficacy about sexual health communication 	<ul style="list-style-type: none"> • Parent-child relations • Positive reinforcement • Communication - importance of timely and comprehensive sexual health communication; • Gender egalitarian and open communication • Communication as the underlying theme of this “workshop” 	<ul style="list-style-type: none"> • Attitude • Norms
<p>1. Sex Work and mothering (30 minutes)</p>	<ol style="list-style-type: none"> 1. Mother feel comfortable about discussing sex work disclosure 2. Provide mothers with a space to discuss challenges in disclosing their profession with their children 	<ul style="list-style-type: none"> • Discuss mothers point of view about disclosing about their profession • Importance of disclosing sex work as work to children • How to disclose • Sex workers rights • What does it mean to be a sex worker and a mother? • How do mothers manage stigma around sex work? 	<ul style="list-style-type: none"> • Attitude • Self-efficacy • Norms
<p>2. Growing up and Puberty & Communication (45 minutes)</p>	<ol style="list-style-type: none"> 1. For mothers to discuss biological and emotional aspects of puberty 2. For mothers to 	<ul style="list-style-type: none"> • Developmental processes and issues pertaining to their children • What happens during 	<ul style="list-style-type: none"> • Attitude • Self-efficacy

	<p>discuss issues around communicating with each other about growing up issues and puberty.</p> <p>3. To breakdown any misconception about sexual health and about sexual health communication</p>	<p>this phase? What are some of the challenges?</p> <ul style="list-style-type: none"> • Gravitation toward peers. • <i>Game</i> - Families will play the puberty game that will help them to overcome barriers to discuss puberty and growing up. 	
3. Peer pressure (20 minutes)	<p>1. For mothers to discuss the peer pressure faced by their children in regards to sex and drugs</p>	<ul style="list-style-type: none"> • Discussion around peer pressure and how it plays out in their communities • Skill sharing about how to talk to children about peer pressure 	<ul style="list-style-type: none"> • Attitude • Norms
4. HIV/AIDS knowledge and Communication (45 minutes)	<p>1. To increase families awareness of HIV/AIDS and sexual behavior</p> <p>2. To make mother aware of the importance of them being sex educators</p>	<ul style="list-style-type: none"> • Activity - HIV game • Divide mothers into 2 teams • Ask true/false questions about HIV 	<ul style="list-style-type: none"> • Attitude • Self-efficacy

Measures. Instruments consisted of measures that had been utilized in similar interventions and with similar populations. As determined in phase one and two, the instruments were tested for cultural relevance, reliability, and validity through in-depth semi-structured interviews, focus groups and individual meetings with sex worker mothers and the DCCB. In addition, measures were pilot tested with a focus group and during the initial pilot study with eight mothers. The instruments were revised based on feedback. Basic demographics, along with the following constructs were assessed at baseline and post 1 month. Refer to Appendix D and E for the instruments.

Descriptive Variables. The following questions were asked: age, marriage status, highest level of education completed, Durbar affiliation, years of Durbar affiliation, age they started sex work. Children specific variables were: number of children, age of children, residence of children, child grade and biological or adopted.

Mediating variables. These questions were created using the theory of planned behavior constructs of attitudes, subjective norms, and perceived behavioral control, and intention to communication about sexual health in the next one month (Fishbein & Ajzen, 2010). These questions were created using the elicitation process in phase 2. The questions were measured on a 5-point Likert scale, with 5 being the most favorable.

Subjective norms toward sexual health communication. “Most people like me want me to talk with my child about sexual health issues”; “Most mothers like me want me to talk with my child about sexual health issues”; “Most people who I respect and admire want me to talk with my child about sexual health issues in the next 1 month”; “Most people in my family would approve if I talk about sexual health issues with my child”; “Most of my family members talk about sexual health issues with their

child regularly”; “As a durbar sex worker, it’s part of my durbar sex worker duty, advocacy and my activism duty to talk about sexual health issues with my children”.

There were six items measuring this construct. The items were summed, with a range of 0 to 24.

Attitudes toward sexual health communication. “Talking to my child about sexual health will be harmful/beneficial”; Talking to my child about sexual health will be useful/useless”; Talking to my child about sexual health will be interesting/boring”; “Talking with my child about sexual health will be stressful/relaxing”. There were four items measuring this construct. The items were summed, with a range of 0-16.

Perceived behavioral control. “How confident are you that you will be able to talk about sexual health issues with your child?”; “How confident are you over that you could overcome obstacles that prevent you from talking about sexual health issues with your child?”; “I believe I have the ability to talk about sexual health issues with my child”; “Whether or not I talk about sexual health issues with my child is entirely up to me”; “It’s under my control if I want to talk with my child about sexual health issues”. There were five items measuring this construct, with a range of 0 to 20.

Intention. “In the next 1 month, I plan to talk with my child about sexual health issues.”

Outcome variables.

Frequency of sexual health communication. The frequency of mother child sexual health communication was measured by the mothers’ report of how many times they talked to their child about sexual health topics. Six questions regarding sex education topics (SED) asked “Have you ever talked to your child about: a) what sex is,

b) how the body changes (puberty), c) when he/she is mature enough to have sex, d) sexual relations between a boy and girl, e) menstruation, f) how babies are made”. This scale has been used in numerous parent-child sexual health research and has shown an internal reliability of (alpha = .88) (Ball, Pelton, Forehand, Long, & Wallace, 2004; Miller, Forehand, & Kotchick, 2000; Vandenhoudt et al., 2010). Six questions regarding sexual risk reduction topics (SRR) asked “Have you ever talked to your child about a) peer pressure (when peers try to talk others into doing something that they might not want to do), b) condoms, c) postponing sex, d) sexually transmitted diseases, e) HIV/AIDS, and f) family planning. Internal reliability is (alpha= .83) (Ball et al., 2004; Forehand et al., 2007; Miller et al., 2000; Poulson et al., 2010; Vandenhoudt et al., 2010). In order to fit the cultural context and ensure proper translation, adjustments were made to two of the questions. Please refer to Table 5.3 for the questions.

Table 5.3: Adjustment to Frequency of Sexual Health Questions

Original question	Translated question
4. Have you ever talked to your child about visiting or friendships between boys and girls (sex education topic)	4. Have you ever talked to your child about relations (including sexual relations) between boys and girls
10. Have you ever talked to your child about diseases you can get when you have sex? (sexual risk reduction topic)	10. Have you ever talked to your child about Sexually Transmitted Infections?

Comfort of sexual health communication. The construct was measured by asking mothers' ten questions about how comfortable they felt discussing sexual health topics with their children. Topics included: a) HIV/AIDS, b) having sex, c) Sexually Transmitted Diseases, d) puberty, e) sexual relations between a boy and girl, f) getting menstrual cycle, g) how babies are made, h) peer pressure (when peers try to talk others into doing something that they might not want to do i) condoms, j) sex work. This item was measured using a 4-point likert scale ranging from very uncomfortable to very comfortable. The scale was adapted to be used with mothers, instead of with adolescents as it has been used in previous studies (Dilorio, Kelley, & Hockenberry-Eaton, 1999; Hutchinson & Cooney, 1998; Ogle, Glasier, & Riley, 2008).

Implementation of Measures. Baseline and post-assessments (at 1 month follow up) interviews took approximately 20 minutes. Trained interviewers administered interviews with the participants.

Training of Data Collectors. Two Durbar members and one research assistant were trained in conducting the baseline and post one-month assessments. They were trained during 4 meetings on the survey content and interviewing techniques.

Post-intervention Qualitative Interviews. In-depth semi-structured interviews were conducted with participants within four to six weeks after the intervention. Qualitative questions allowed for a better conceptual understanding as to the impact of the intervention on participants' intention, attitudes, subjective norms, perceived behavioral control, and comfort toward sexual health communication. Additionally, the

interviews helped to assess participants' satisfaction and additional comments about FSHCI. Refer to Appendix F for the post-intervention interview protocol.

Human Subjects Protection. See Appendix G

Data Analysis Plan. Descriptive analyses were conducted to summarize the sample and to obtain a better understanding of mothers' sexual health communication practices with their children. The items from each scale were summed. The scales were examined for internal consistency. Specifically:

Mediating Variables.

Subjective norms items. There were a total of six questions that measure perceived norms, four that measured the injunctive component and two that measured the descriptive component. Scores ranged from 0 to 24, with a higher score indicating more social pressure to communicate with their child about sexual health.

Attitude items. There were a total of four questions that measure attitude, two each for the two dimensions, evaluative (beneficial, harmful; useful, useless) and affective (interesting, boring; relaxing, stressful). Total attitude scores ranged from 0 to 16, with a higher score indicating a favorable attitude towards sexual health communication.

Perceived behavioral control items. There were a total of five questions that measured perceived behavioral control. Scores ranged from 0 to 20, with a higher score indicating greater perceived behavioral control.

Intervention effects. To examine intervention effects, paired sample t-tests were used to assess differences in pre-test and post-test scores of measures of outcomes

(Hypothesis 2 and 3) and mediating variables (Hypothesis 1). Given this is a pilot study with a sample size of less than 50, we have included results that meet significance at $p < .05$, as well as marginally significant results at $p < .10$.

Bivariate analyses. We conducted bivariate analyses because this was a preliminary analysis with a small sample size (Hypothesis 4). We used Baron and Kenny's technique to detect the mediation of the effect of FSHCI on outcomes (Baron & Kenny 1986). The presence of mediation (at this preliminary analysis stage) was assessed by running three bivariate models: 1) the mediators (subjective norms, attitudes, and perceived behavioral control) as the dependent variables with the intervention as the independent variable, 2) the outcomes (frequency of SHC and comfort of SHC) as the dependent variable with intervention as the independent variable, and 3) outcomes (frequency of SHC and comfort of SHC) as the dependent variable with the mediators (subjective norms, attitudes, and perceived behavioral control) as independent variables.

Missing data. Sample sizes for the analyses differ for each of the measures because of missing data. Complete case analysis/listwise deletion was used for the analysis if participants were missing data for the measure. Thus sample size for each analysis differed.

Chapter Six

Qualitative Results

Participation in Durbar

Results indicate that participation in Durbar's collectivizing processes is instrumental in shaping participants' normative, behavioral and control beliefs toward sexual health communication. As discussed in Chapter 5, Durbar's collectivizing processes include participating in Sonagachi Projects' peer education model through its training and engagement, creating consciousness through rights-based ideology that casts sex work as legitimate work, advocating for empowerment and ownership over one's body and sexual health (Ghose et al., 2008; Jana et al., 2004; Swendeman et al., 2009). These sensitizing processes are part of an overarching hegemonic process that interact with the mediating cognitive processes of normative, behavioral, and control belief formation. Using exemplar quotes from individual interviews and focus groups, I discuss the ways in which sex worker mothers' construct normative, behavioral, and control beliefs about SHC. Specifically, normative beliefs are constructed through Durbar norms and societal norms on sex work and sexual health communication. Behavioral beliefs are formulated by Durbar collectivizing processes and societal stigma about sex work and sexual health communication. Control beliefs are shaped by feasible resources made available by Durbar and conceptualizations of the context of space (See Figure 6.1).

Construction of Normative Beliefs about SHC

Normative beliefs about SHC were constructed by Durbar norms and societal norms on sex work and sexual health communication. In this chapter, I discuss Durbar

and societal norms about sex work and its role in shaping mothers' normative beliefs about SHC. I first provide the context of both Durbar norms and societal norms that shed light on the particular sensitizing processes that are at play in the normative belief formation about SHC.

Durbar formulates norms on sex work and sexual health. Durbars' collectivizing processes trigger sexual health communication between mothers and children. While the cognitive constructions about sex work were not an initial process of interest, it quickly became evident in the preliminary analysis that it was a crucial element to better understand the facilitators and barriers to SHC. Specifically, we found that Durbar's reformulations about sex work norms operate as sensitizing processes that shape the norms around sexual health communication. Exposure to Durbar's sex workers rights-based ideology shaped women's normative beliefs about sex work, ultimately constructing their normative beliefs about sexual health communication with their children.

Since its inception, Durbar has fought for the rights of sex workers. Through its collectivizing processes and advocacy, Durbar has framed norms around sex work as being a choice, rather than subscribing to the hegemonic normative belief that sex work is a coercive act in which women lack agency. Furthermore, Durbar has created an ideology that emphasizes choice and agency for sex work as a profession and for sex workers to have ownership over their bodies.

Participation in Durbar's collectivizing processes, such as protests, rallies, educational initiatives and Sonagachi Projects' peer education model has not only (re)framed sex work as a choice and but has created safer working environment resulting

better health outcomes (Ghose et al., 2008; Jana et al., 2004). Durbar's norming processes included establishing norms around sex work as work but also norms around practicing safe sex and advocating for one's sexual health. This was particularly shaped through casting sex work as work, demanding sexual health as a right through SP's peer education model, instilling ideologies of choice, and articulations of duty as a Durbar sex worker.

Casting sex work as work. Many participants reflected about Durbar's impact on their conceptualization of sex work even though the interview protocol did not address specifics of their involvement and thoughts about Durbar. Their relationship to Durbar, whether it was through being a peer educator, clinic worker, or service utilizer, helped them to frame sex work as legitimate work, shaping their normative beliefs around sex work. P18, a mother of three children and a Durbar member for six years, described how her perceptions of sex work changed over the years.

I don't have any pain in being a sex worker. Before Durbar I had difficulty. But ever since I joined Durbar I have not had any difficulty. I did not know much about sex work before. I didn't realize that it wasn't bad. Now I know the work. Before when I came to sex work, I heard a little about Durbar but when I came to work, I thought this is no type of work and it is different from other types of jobs. It's not good work. I met with other sex workers and started thinking that this is also a type of work. Just like people drive autos. This is work also! The sex work is also a type of work. I like it a lot. We always go together, as Durbar, to government officials to fight for our rights. We always get a lot of respect because we are from Durbar. (P18)

Ghose et al. (2008) suggest that in order to make meaning of the collective action, participants articulate narratives that keep them engaged in participating in Durbar. This articulation can be done by combatting stigma of sex work (Ghose et al., 2008). As P18 noted, the collective experiences with other Durbar sex workers helped her combat the stigma associated with sex work because the collective narrative legitimized the work as

any other type of labor work. Her engagement with government officials helped her to make meaning out of the profession. Additionally, her advocacy efforts with Durbar and public title as a Durbar worker helped her to manage the societal stigma against sex work.

This narrative of Durbar changing conceptualizations of sex work was not unique to women who had high levels of participation in Durbar. P29, who recently started to work as a flying sex worker and a mother of a 13-year-old daughter and a 19-year-old son, discussed the impact of Durbar on her conceptualizations of sex work. Her affiliation with Durbar legitimized sex work as work not only for herself, but also with her clients. She compared her current life as a sex worker to her life before.

I've noticed a little change in myself after being involved with Durbar. When I started sex work, I thought what type of work is sex work? Why did I choose this work? Back then I used to think how will I be able to educate my children and show them the right way. But then I joined Durbar and I think that the work I selected is a good time of work. Before, I was not very smart. I did not know much about Durbar and sex work back then. Durbar was not with me then. So I thought if someone sees me, especially someone in the village, I would get kicked out of my house. In the village they would say, that I messed up their community. This type of stuff happens. Seriously! So I was scared. That's why I didn't like the work that I did before. I was not free before. I always had tension. Now I am free. I am able to talk about everything. Now, after being with Durbar, I can tell my men that I work here at Durbar. Before I had to hide that I was a sex worker when coming to the red-light area. I don't have to hide when I come here now. I can openly come. Everyone knows what Durbar does and that it is a good place. (P29)

Though P29 had only started working at Durbar a few months ago, the Durbar collectivization processes, such as conceptualizing sex work as legitimate work through her association and support from Durbar, helped her to make meaning out of the sex work profession. Through these processes she was also able to combat the stigma against sex work. Since Durbar is known throughout Kolkata was able to use her title as a Durbar worker to legitimize her work to her clients as well.

Demanding sexual health as a right through peer education. Durbar has created norms around sexual health as a right, a core component of the Sonagachi Project's peer education model. One of the key features of the Sonagachi HIV intervention project, which Durbar oversees, is the peer education model (Jana et al., 2004). The Durbar collective trains sex workers to educate peers about safer sexual practices and sex workers rights and encourage healthcare checkups at the project's clinics. Beyond the educational role of peer educators, however, is one of building a cohesive community amongst sex workers. Specifically the peer education program can be best described by the following:

Our initial peer education programme was designed not only for outreach activities but also for attainment of self-reliance, confidence and dignity and to transfer that image to influence other members of the community which actually facilitated the creation of a base whereby the sex workers could network among themselves and function as a group for collective bargaining....initially they started as health educators but they gradually got transformed and they fit themselves into the bigger canvas of society to act as a community leader, community mobiliser and as an agent of social change (AIIHPH1997:9). A.I.I.H.P.H. (1997) Five Year's Stint at Sonagachi: A Dream, A Pledge, A (DMSC & TAAH)

Thus it is not surprising that the collective meaning make process around sex work was even more salient for women who were peer educators. When asked about her experiences as a peer educator, P15, a long time Durbar peer educator, exclaimed

I like everything about Durbar! That is why I am discussing it with you. Sex workers have problems, sexual problems. I try to help the women understand these sexual health problems. If you try to (as a non sex worker) help the sex workers understand about such issues, it won't be that good. But if a sex worker helps another sex worker understand, it is better. Community! That is what a community is. I like the peer education work. I can communicate with all sex workers about important matters. I have a network of people to people to talk to. I talk to the sex workers about sex work, condoms, gonorrhoea, other STI, and HIV. If other sex workers experience violence, we (Durbar) can get together and

protect the sex workers. We can fight for them. We can teach them too. We also have a lot to learn from others. (P15)

P15 discussed that it was more effective for sex workers to educate sex workers, rather than others who were not sex workers. Additionally, she points out that sex workers collectively help each other out in the time of need. The collective action against sex work violence was very prominent in many of the Kolkata red-light districts. Many of the women who had been involved in Durbar since its inception all discussed the standing together as one to fight against the physical violence as well as the structural violence they so often experienced in the mid 1990's.

Peer educators particularly target newer sex workers in their communities to relay the sexual health messages. As such, the impact of peer education model on establishing sexual health as a right is apparent just in a matter of a few interactions. One of the newer Durbar service recipients and mother of a 10-year-old boy noted that Durbar peer educators taught her how to protect herself with clients.

I did not know much about HIV or condoms before coming to Durbar. I only came to know the importance of using condoms with my clients after meeting with the peer educators. The peer educators came to talk to me many times and they said that sex workers around here use condoms. It is important to use condoms to protect from HIV. Now I know how to keep myself safe with the clients. I did not know this before. (P13)

Instilling ideologies of choice. In addition to the peer education model establishing Durbar norms about sexual health rights, peer educators also instilled ideologies of choice in their interactions with sex workers in the community. P26, a longtime Durbar peer educator and mother of two young adolescent children, learned of Durbar through a peer educator who knocked on her door about 10 years ago. She shared

her thoughts about the ways in which Durbar changed the discourse around sex work both for the sex work community and herself.

Sex work is good work. The government has not yet given us official recognition, so we cannot openly identify as sex workers. But in certain forums like government meeting or workshops we can come out as sex workers. We love and respect our work. We think it is honest work. I've only started to feel like this after joining Durbar and becoming a peer educator... through their trainings. Earlier (before Durbar) I was not sure about sex work and I did not know about these things (sex work, protection, HIV) much. We had to be secretive and were often forced into sex work. Now sex work is entirely up to us, whether or not we want to or not want to do it (sex work), it is entirely my personal matter. (P26)

She speaks about collectivizing processes that have impacted her freedom of speech.

Specifically she highlighted that Durbar brought upon such changes by empowering sex workers.

We have gained the courage to speak our minds, we have learned about this work and how ancient this profession is. If we do it openly with dignity then it is good for everyone. I have learned all this from Durbar. That is why we, as sex workers, can speak our minds now. (P26)

For P26, Durbar played an integral role in educating her about her rights as a sex worker and empowering her to regain control of her body.

As noted before, newer Durbar members also provided narratives of ideological shifts about sex work. P20, a newer Durbar member, discussed how her conceptualizations about sex work changed after living in the brothels with other sex workers and getting more exposure to Durbar through peer educators. She described the difference between durbar norms and societal norms.

My thoughts have definitely changed after living here and after going to Durbar. When I first came here to this district (red light district), I thought this was bad work. But after talking to peer educators and other people at Durbar and thinking, I thought I am making money now, so what if I do this work. Before I was not making money. I am able to make something of myself now and feed my children. I survive on my own! See, I am from the village. The village girls are

very different and they are different in front of men. They don't suck on their husbands' dick. I never used to suck my husbands. They think it's dirty, but I do it here to make money. After coming here, I realized I did not even know about sex! I learned about everything after talking to the girls here and the girls I live with. We always talk about what we do to make money. (P20)

Durbar peer educators helped P20 to make meaning out of sex work. She was able to obtain a sense of independence. She proudly discussed the ability to make money for sexual acts that she would have never done with her husband while living in the village.

Duty as a Durbar sex worker. The ways in which women make meaning of sex work, through the Durbar collectivizing processes described above, enables the establishment of norms around sexual health communication with their children. While Durbar did not have particular programs that addressed mother-child sexual health communication, the norms established around sex work and sexual health at Durbar shaped mothers' norms about SHC. The normative belief construction around sexual health communication included articulations of one's duty as a Durbar sex worker.

Many women, who had been involved with Durbar for years, vocalized that it was their duty as a Durbar sex worker to discuss sexual health with their children (see detailed discussion on attitude formation). Particularly, the exposure and continued involvement over decades, in some cases in, such Durbar collective norming processes informed mothers' normative beliefs about sexual health communication.

P3, long time Durbar peer educator, previous General Secretary, and mother of a 15-year-old girl exclaimed "I am a sex worker and peer educator. Why wouldn't I talk to kids about sex and HIV?" Later in our conversation P3 expressed that educating others about sex work and sexual health is part of her duty as a Durbar peer educator, thus it was

also important for her to discuss these topics with her children as she did not want them to catch sexually transmitted diseases.

Similarly, P2, a long time Durbar leader and mother of one adolescent boy, described her motivators behind communicating with her son about sex work and sexual health.

Since I've been involved with Durbar, I know more about sexual health. Before, I knew very little. I know more because of Durbar and can talk to my child about sex work and HIV. I feel more powerful than before. I have never hidden my work because when I stand at my gate, the public sees me. If I was never with this sangatan (Durbar), I would have never been informed about sex work. This sangatan is powerful. Because of the sangatan I was able to learn and teach my children. If I was not in Durbar, I would be like the rest of the mothers (not educating their children and hiding the profession). There is a difference between mothers who are in Durbar and those who are not. We have kept involved in sangatan and share our experiences with our children. My child respects me because of this. (P2)

While the collectivizing processes at Durbar informed her normative beliefs about SHC, Durbar's norms about sexual health rights and educations also contributed to these beliefs. She stresses the fact that she has never hidden anything from her children, therefore always feeling empowered to discuss anything with them. Additionally, she notes that had she not been a part of Durbar, she would be just like the rest of the mothers who don't communicate with children about sexual health. Due to her involvement in the Durbar collective processes, she has been able to take on the group identity, stay informed about sexual health through Durbar, and thus pass on the information to her child. P2 continued the conversation by enunciating the importance of SHC.

So we at Durbar think that when the child is at a certain age, you have to say something, you have to talk to him as a friend. If my son does something outside.. has sex outside, he should know that I am there as a friend and at least he will know to use a condom. Any other boy, won't know. At least my son will be safe... he will know what to do. He will tell me his problems. I won't even really have to

tell him to use a condom, wherever he will go, he will remember to use a condom because he will think "my mommy told me about HIV", so I have to use a condom. (P2)

Durbar's sex workers duties also included peer educator duties. The duties of peer educators extended beyond peers to also educate children in the community as well as their own children. P5, mother of a 17-year-old boy expressed that her role as a peer educator helped her to educate not only sex workers, but also children in the community. Her perceived norms around peer education duties and her descriptive normative beliefs (the behavior that is actually being practiced in ones reference group) were that other peer educators are communicating about sexual health with children in the community. Additionally, she noted that the normative belief around SHC was that other mothers in the community refrained from discussions about sexual health with their children. Thus Durbar peer educators have stepped in to help the sex worker mothers in the community.

I think that kids know about condoms and STDs at 12 or 13. I think they know that much. The kids who live here know because they see us they see us going around talking to people. We do a lot outreach activities and share information. These kids are also part of the community so they realize what's going on. They understand that maybe our mothers are feeling shy and are hesitant to have these conversations with us and we too can't directly talk to them about this stuff. But these Didi's (Durbar peer educators) who go from door to door they talk about these issues to them. (P5)

Given that Durbar created norms around sexual health education, a few mothers felt that sexual health awareness was widespread in the red light district. P15 felt that sex and HIV were discussed everywhere, that such discussions were the norm around the sex work community.

Nowadays HIV and condoms are discussed openly and everywhere. It is on the TV, in the new. In the sports show people wear a red ribbon about HIV. But I am not 100% sure if mothers talk about this. (P15)

Normative beliefs were also constructed based on mothers' perception transferring the knowledge. P3's, who was a longtime sex worker and mother of an adolescent daughter, involvement with Sonagachi Project's education and advocacy led her to believe, and also act on her beliefs, that educating her daughter about sex work and sexual health was her duty as a Durbar member. Her duty as a Durbar educator transferred to educating her daughter. Interestingly, P3 felt that it was important to discuss HIV with her daughter so her daughter could share her knowledge with her peers.

I like to share information about HIV and condoms with my daughter so she can educate other children at her school. It is important for children to learn this information. (P3)

Similarly, P31 felt that it was important to discuss sexual health with her daughter around the age of 13 or 14. When asked why she discussed and when she planned to discuss some topics at such an age, P31 responded

I have talked to my daughter about some things already. I think it's important to discuss such topics at a young age. These days the children are so precious. They interact with so many people and get to know stuff about sex. If I tell her then she knows and she can also tell some of her friends about it. (P31)

The impact of societal norms on SHC. Normative beliefs were also constructed through the formation of societal norms. As discussed in Chapter 2, sex work continues to be a taboo (see discussion on attitudes also). Society often constructs sex workers as deviant, not only because of the criminalization of sex work through the legal system but also because they defy the traditional norms of being in monogamous relationships characterized by having one sex partner. Additionally, sex workers are often thought of as promiscuous and vectors of HIV. These societal norms go beyond labels, rather such deleterious norms are entrenched in the structures and practices of the legal, economic,

and social systems that are a part of sex workers daily interactions. Similarly, given that societal norms are often driven by cultural norms, families are reluctant to discuss sexual health (please refer to Chapter 2 for detailed information). Discussions around sex, reproductive health, relationships, and HIV are rare and if they occur, they are often indirect (Lambert & Wood, 2005; Soletti et al., 2009). Parents are not socialized as being the primary communicators of sexual health information, thus they often feel uncomfortable and unprepared to discuss such information. For sex workers, the two worlds of societal norms about sex work and sexual health often collide. Some mothers in our study felt that discussions about sexual health with their children would instantly reveal their sex work identity, thus they refrained from such discussions with their children (see section on attitudes/behavioral beliefs).

Unlike mothers whose normative beliefs about sex work and sexual health were based on Durbar norms, many of the mothers' normative beliefs, most of whom had low levels of participation with Durbar (either were Durbar service utilizers or were new peer educators), were shaped by societal norms about sex work and SHC. Particularly, societal norms were articulated through perceptions of SHC as encouraging sexual activity, subscribing to societal norms about gender, and conflict between social roles.

Perceptions of SHC as encouraging sexual activity. Some participants felt that discussions about sex and HIV would encourage sexual activity. P16, who started sex work a few years ago, recently started to receive medical treatment from Durbar's clinic. Her 12-year-old son and 7-year-old daughter lived with her in the brothels. When asked if she ever discussed sexual health with her children, she responded

No, I have never shared this information with my children. If I share this information with my children they will get spoiled (engagement in sexual activity), no? The child will always remember that my mother is spoiled (get into sex work or go to sex worker) if I talk about it. Why would I do that? I have never shared about HIV before. If I talk to my 12-year-old child about HIV, they will always wonder why my mother is talking to me about such things. My child would be able to trace that I am in this work, sex work. I don't want my child to know that I am sex worker either. As a mother, how can I tell my children that I work as a sex worker? How can I? What if my child tells other people? This is the issue. If the people in the village that I am from find out, they will banish me. (P16)

P16 adhered to the societal norms that discussions about sexual health and sex work would spoil the child. She felt that such discussions would not only lead to disclosing the nature of her work, but also spoil her children. She internalized the societal norms around sex work and feared discussions around sexual health would reveal the nature of her work. Additionally, she felt that discussing HIV with her child would spoil her children in that they would become sexually active with the knowledge or become sex workers themselves in the future.

Some mothers who had been involved with Durbar for a long time expressed their frustration with sex worker mothers in their community. P2 held the normative belief that mothers outside of the Durbar network and mothers who were not sex workers did not discuss sex with their children, thus their children were not as safe as her son. When asked if mothers in the community discuss sexual health with their children, a long-time Durbar peer educator and previous General Secretary exclaimed

Mothers do not talk to their children! Listen, I have been in this Sangatan for so long, so I know what mothers do! There are many mothers who don't even share anything. They are shy and think their children will get spoiled if they talk. (P2)

P2 was very interested in discussing the concept of normative referents' beliefs regarding mother-child sexual health communication. She went on to say

This type of thing (mother-child awareness) does not happen here. It does happen with HIV, however. For instance, we go to the Didi's and talk to them about HIV and tell them to go to clinic and get check up. But it does not happen with other sexual topics and with children... like how a mother should be with a child. A mother should be with a child like a fiend. A mother should talk to their children about their work... they should get comfortable about such discussions. There should be an understanding. (P2)

Subscribing to societal norms about gender. Normative beliefs about SHC were also driven by societal norms based on gender. P20 had not discussed sex, HIV, and condoms with her children, however shared how her feelings differed for her son and daughter. Her normative beliefs about a girl's sexuality and marriage were shaped by societal expectations of girls' "purity".

I don't have much tension for my son because he is a boy. Nobody will do anything to a boy. But I have lots of tension with the girl. What if something happens to the girl? No one will marry her if something happens to the girl (talking about rape). Look, as a girl, if I dress up nicely and go out at night and some man will take me away and if the boys go out at night, nothing will happen to them. You know? Nothing will happen to the men. No one says anything to them. Such things only happen to girls. (P20)

Normative beliefs around menstruation specific communication were more salient than normative beliefs regarding any other sexual health topic. P17, a longtime sex worker but new to Durbar, held the normative belief that mothers in India communicated about menstruation with their daughters because they were deemed marriageable when their period started. Thus, due to this normative belief, she felt that it was necessary to communicate about sexual health with her daughter.

I think that mothers who live here talk to their children about periods. A girl gets her period once a month. Mothers should take care of it. Children don't know what happens. When it happens, in our India there is one duty what when a girls gets her period, they are able to get married. But if we don't get them married off then, then we will have to take care of them. In India, that happens. When that (period) happens, then we have to take care and explain to the child. We have to

keep them on straight path. It is a must to protect them. If we don't protect them, then we won't be able to take care of the child. If mummies don't talk to their children, then how are we supposed to protect our children. (P17)

One participant discussed societal norms about being a daughter-in-law, which ultimately impacted her conceptualization of sex work and SHC. While P31 had disclosed to her mother-in-law about sex work, her mother-in-law was concerned about other community members finding out about the nature of her work. Her mother-in-law wanted P31 to abide by the social norms of what is expected of the daughter-in-law

All she (mother-in-law) told me was that whatever you do , do it away from home, do not do anything in the locality. No one in the neighborhood should come to know, whatever you do away in the city is no concern, if someone tried to slander you here no one will believe them since your conduct is OK here in the locality. (P31)

Later in the conversation P31 expressed her feelings about raising a child. She highlighted that she wanted a stable family, which was deemed the expected life, but also toying with the idea of getting a lover. P31 felt that she had to live the expected normative life of and Indian women, that of living with the in laws. However, in sharp contrast was her life as a sex worker, in which having a babu (long term lover) was often a norm. Through this conversation, she voiced concern about the child's upbringing and felt that it was not appropriate for the child to be stripped away from home. The norms about sex work were in sharp contrast with the norms around the family life P31 discussed.

It is very, very important. See, I believe that in a woman or man's life having a child is very important. If they get married and cannot have a child that's unfortunate. No matter what troubles you have in marriage once you have a child you make it work. In the middle of a fight between a husband and wife when they hear the child calling out they will stop and think about the child. For example in my own case I am with this family (in-laws) only for this child. Say if I did not have this child then I would not have stayed back for my disabled husband and

mother in law alone. But my child is my reason to stick to this family. I am still young and I think I can get a lover to support me if I were to move out, but then I will not for the child. Well, I could move out with her, but then she will not get a stable family and when she grows up she will not get the respect of coming from a good family. Now I am with my in laws and once my daughter grows up , I will be able to find her a good match, they will understand that since the father cannot work, the mother has to work to support, my neighbors will have nice things to say about the family and my daughter will have a good chance in life. I am doing all this for her. (P31)

Conflict between social roles. Interestingly, independent of level of participation in Durbar, mothers who established boundaries between their roles as sex workers and their role as mothers held the normative beliefs that mothers should refrain from SHC with their children. Mainstream societal norms often facilitated this role division. While some of these mothers had been affiliated with Durbar for many years, they felt that anything sexually related should be left at work and never discussed at home. P5 (A6), a longtime Durbar sex worker and mother of a 13-year-old daughter, exclaimed that

There are such mothers who treat their kids as friend and discuss sexual stuff pretty openly... Yeah there are. I am not one of them, there are such mothers though. (P5)

She differentiated herself from the mothers that discussed sexual health with their children. While she had been a Durbar peer educator for many years, she believed that sexually related information should not be discussed with children.

Similarly, P4, also a longtime sex worker and peer educator, acknowledged that she gained confidence about discussing sexual health with sex workers, however has had difficulty in discussing sexual health with her sons.

It is important we talk to the girls around here (other sex workers). We have gained confidence by communicating about HIV and condoms with these girls. It has also helped us to gain courage to discuss some of the issues with our family.

However having said all this I still find it difficult to discuss this directly with my sons. (P4)

While both P4 and P5 were active and longtime Durbar members, they held the normative belief that sexual health communication should only be with their peers and not their children, as it was too difficult to discuss such matters with their children.

Similarly, P20 created a boundary between sex workers in her community and herself. In efforts to differentiate herself from the sex worker mothers she lived around, P20, who was a new Durbar service utilizer, described a recent frustrating event. P20's children resided with her mother in the village and felt that the red-light district was not an appropriate environment for children.

The girls over here (other sex workers) only know how to yell and scream. They even yell and scream at their children. Why would I keep my children here.. in this type of environment? NO!

There are children here and they watch their mothers bring in men. There is a girl that lives next to me. The mother brought in a customer and the little girl says to me "my mother brought a man here and she is about to close the door. She was such a little girl like 5 or 6. I got so mad!!!! I was thinking if it was my girl, I would slap her! A mother does not want their children to find out about this place and turn out bad. These women, here, they are living like that in front of their children. They are doing everything. What will happen is that when the child gets older, the next day, you will see that the girl will be working here. Ok? (P20)

The social norm that children should not be exposed to sex or be aware of their mothers profession is illustrated in P20's discussion. In hopes to keep sex work and also sexual related information far from her child, she sent her child to reside with her mother in the rural area. Her normative beliefs about sex work were informed by society, in that sex work was a bad profession and the red-light district was not suitable for children.

Additionally, normative beliefs that mother-child sexual health communication is taboo remain widespread. P8, who is a longtime sex worker and peer educator, recalls a scenario with a sex worker and her sister who weren't affiliated with Durbar.

Here in the red-light area, the children see their mothers doing sex work, so children come to know about their mothers. I don't think mothers discuss such things directly with their children. See, it is still very difficult to talk about these things with children. For example, the other day we were doing some awareness campaign and visited this house where a girl who is in sex work lives with her younger sister. The sex worker's sister does not do this work. The sex worker, who is the eldest, was very anxious and asked us to go away and not discuss sexual matters like disease or condoms in front of the younger sister. The younger sister is getting married and the elder one did not want to corrupt her. We told them that it is good to know about these things, but she was very reluctant for us to stay and explain things. People here still feel embarrassed to discuss such things, so they do not want to discuss it. (P8)

P8 uses this example to illustrate that most people in the sex work community are embarrassed to discuss sexual health. Despite the fact that the girl P8 visited was a sex worker, she did not want her sister to be exposed to sexual health information. The presence of Durbar peer educators made her uncomfortable.

Construction of Behavioral Beliefs about SHC

Behavioral beliefs about sex work and sexual health communication were constructed through positive attitudes due to Durbar participation and negative attitudes due to societal stigma. Similar to normative belief construction, one of the most salient factors was that the level of participation in Durbar's collectivizing processes impacted mothers' attitudes toward sexual health communication. Specifically positive attitudes toward SHC were shaped by familiarity with sexual health topics and negative attitudes were shaped by beliefs that mothers should not be a source of SHC, the belief that

children hold sexual health knowledge, and belief constructed based on stigmatized experiences.

This section illustrates the influence of level of participation in Durbar on sex worker mothers' behavioral beliefs about SHC with their children. I first provide the context of Durbar and motherhood as it relates to sex work and SHC attitude formation and then discuss both the positive and negative attitude formation. Finally, I close with an in-depth analysis about participant's conceptualizations of the convergence between sex work and sexual health communication, its association to stigmatized experiences and how such dynamics impact sex work disclosure to children.

Durbar shapes attitude about sex work. Participants' attitudes toward sex work were often associated with their attitude toward SHC with their children. There was a constant tension between identifying sex work as a dichotomy of good or bad. Many mothers expressed that sex work was a good profession because they were able to provide their children with shelter, food, and an education. However, at the same time felt that it was not a good profession because they feared their children would be upset once they learned about their profession. In some instances, women discussed that their children did not like that their mothers were sex workers, thus mothers felt very guilty about their work. Negative attitudes toward sex work, often held by mothers who were not involved in Durbar or who were new to Durbar, were related to negative attitudes toward sexual health communication. Positive attitudes toward sex work, often held by mothers who were closely involved with Durbar, were often related to positive attitudes toward SHC. As with norms formation about sex work and SHC, participants' level of participation in Durbar played an integral role in constructing positive attitudes toward

SHC. The attitudes mothers' held about sex work and SHC stemmed from deeper ideological norms, as such the norms were often related to attitudes.

Conceptualizations of motherhood shape attitude toward sex work. In addition to Durbar's impact on attitude formation, women's conceptualization on motherhood shaped their attitudes about sex work and sexual health communication. Behavioral beliefs about sex work and SHC with children were also informed by mothers' conceptualizations of their duty as mothers. The social constructions of motherhood and sex work conflict in many ways (Dodsworth, 2012). As such, sex workers often navigated multiple barriers on social, political, and family levels to make decisions for themselves and their children. As discussed earlier, Durbar challenges the hegemonic discourse about sex work, which ultimately informed mothers' conceptualizations about themselves, their profession as sex workers, and their role as mothers. Some mothers felt that it was their duty as mothers to educate their children about sexual health, while others did not (see unfavorable attitudes toward SHC section).

Motherhood played a central role in the choice to work in the sex work industry. Many women in this sample entered sex work and continued to work as sex workers to financially support their children. When discussing their children, all of the mothers smiled and spoke with enthusiasm about their experiences as mother. In many of the interviews, mothers noted that they had never discussed motherhood with other interviewers. It was a topic that they did not speak about very often, yet their children were the motivation behind the work that they did. P18, who had a 14-year-old daughter and 2 adult children, was longtime sex worker but newer member of Durbar. She voiced her opinion about being a mother and a sex worker.

I was a child before too. I have a mother too, so I felt that I wanted to be a mother. I am very lucky that I am a mother and then after that I am a sex worker. Before being a mother, I thought that it is very important for all women to be mothers. If I was not a mother, then I would be alone all my life. So, after having my children, my pain and difficulty all went away. I know they would always be with me. That's what I wanted. That is such a big thing! (P18)

P18 discussed that it was difficult to engage in sex work because she did not consider it a good type of work, however her pain regarding the work subdued when she had children. Many mothers expressed that their pain about sex work went away when they had children. In many instances, children were the only support system mothers had because their husbands had died or abandoned them within a few years or marriage.

In a focus group, even the participants who were silent for the majority group spoke enthusiastically about motherhood. A mother of an 11-year-old girl discussed that she liked to be called a mom, just like she called her mother by “mummy”. During this discussion, a few others in the focus group chimed in as well.

F17a - If someone becomes a mom, they become will become very happy. If I have a child, that child will call me mummy. My mother has done so much for me. I want to do the same for my daughter, so I can feel all the pain and joy in my heart just like my mother did with me. That's why every woman should become a mom. It is her responsibility to become a mother.

F17b - What she (F17a) is trying to say is that if I call someone a mother, there should be someone else that calls us mom too...understand?

F17c - Every woman wants to be a mother. It is special to be called “mummy”.

The identity of motherhood was integral to being a woman in Bengali culture. The cultural norm of getting married, having children, and living “respectable lives” as a wife and a mother in society was an expectation and discussed by mothers. Some mothers recalled living this “expected life”. For one mother, however, living this “expected life” caused pain and thus she wished a different life for her daughter. P20, A mother with a 12-year-old daughter discussed that she would not want her daughter to go through the

same pain that she went through. When asked to clarify, she stated that she got married when she was a teenager and had the misfortune of having a bad marriage. Her husband was physically and emotionally abusive and abandoned them when the daughter was a baby. She said that she would never marry her daughter as a teenager because of the circumstances she faced in her own marriage. Though this mother engaged in this normative and expected life similar to those of the ones in the village she was raised in, she was divorced and started sex work at a young age because it was one of the only means to support her daughters' education. She experienced the social stigma of divorce while living in the village but did not internalize it and was able to relocate to Kolkata for better opportunities.

I will not get her married. It is important for my daughter to become someone and get educated. I don't want this married life for her because look at what happened to me. I regret getting married. Look at me. (P20)

Some women felt that their motherhood had been stripped away from them because they were single parents. P30, who started sex work six months ago and was not a Durbar member, had two young adolescent girls. P30's husband left her two years ago for another woman. She was still grieving this loss because she had to start sex work in order to support her children.

It felt good to be a mother when my husband was there with me. I was able to be a mother then. Then it was good. But now I feel like why am I even a mother? Why? How am I supposed to look after my children? What am I supposed to feed them? What am I supposed to do? It is necessary that the father is there too. (P30)

P30 struggled with being a single mother and also a sex worker. She was ashamed about the work that she had to do in order to support her children but also verbalized that there was no other work for her. She was in the process of negotiating her identity as a newly

single mother and sex worker, as well as working through the internalized stigma that was constructed because of the stigma set forth by society at large. She later discussed that she would never be able to disclose about sex work to her children because it was not a job fit for a mother.

Some of the other mothers' opinions on single motherhood differed, however. P32, a mother of 16-year-old girl and 18-year-old boy and whose husband is disabled, discussed that mothers have more responsibilities toward their children than fathers. She has been able to support her husband along with her children because of sex work. When asked about her meaning of motherhood, she exclaimed that it is a tremendous amount of responsibility.

Motherhood is about a responsible attitude towards your child. Their father cannot work. I have come to do sex work so my children do not suffer any hardship. I have never thought of keeping the money to myself or taking on a lover. All I have wanted to do is to bring up my children. Motherhood is a lot of responsibility. I feel it is better to remain single. Mothers have to take more responsibility. Fathers do not always take up as much as mothers do. I feel that my life has gone into being a mother and assuming all this responsibilities. I have suffered so much for the children. I wanted to kill myself in the beginning but could not. I had to be there for my children. (P32)

Some mothers were able to manage the stigma against sex work by maintaining separate identities, being a mother or a sex worker. This way of managing the stigma resulted in the choice to refrain from disclosing to their children and extended family. However, some women maintained their mother identity by disclosing about their profession to their children. They often did not live two separate lives, as opposed to the mothers who separated their identities; rather they often said that they were mothers and sex workers (See section on negative attitude due to stigma). Conceptualizations of

mothers' duty informed participants' attitudes about sexual health communication with their children

Positive attitudes toward SHC due to Durbar collectivizing processes.

Women's level of participation in Durbar played an instrumental role in shaping their attitudes toward sex work and SHC with their children. While the behavior of interest in this study was mothers' sexual health communication with their children, it quickly became apparent that mothers' attitudes toward sex work, which Durbar has played a key role in, shaped their behavioral beliefs toward SHC. Mothers' increased level of participation in Durbar, such as mothers' peer education training, leadership involvement and participation in rallies and other rights-based rallies, often led to favorable attitudes toward SHC with children. The overall attitudes toward SHC were interconnected with participation in Durbar and attitudes toward sex work as work. Thus for many of the mothers, attitudes toward SHC arose out of the normative beliefs surrounding sex work and SHC. Specifically behavioral beliefs were constructed by familiarity of sexual health due to Durbar's collectivizing processes.

Familiarity of sexual health due to Durbar collectivizing processes. Overall, most mothers who had high levels of participation in Durbar, felt that it was favorable to communicate about SHC. Specifically, they felt more comfortable discussing HIV rather than sexual activity and reproductive health because it was easier for them to discuss the aspects of a disease as opposed to sexual activity. P24, who has been a Durbar member for 12 years, is a mother of six adolescent and young adult children. In a discussion about her attitudes toward sex work and sexual health communication she expressed that

initially she held an unfavorable attitude toward sex work, but participation in Durbar related activities led her to change her attitude about sex work.

My husband passed away when I was 25. What was I supposed to do with six children? I became a painter to support my children. Men would ask me for sex when I was a painter, but I would just run away from them. I had seen Durbar in the area, so I went to their office to ask what they do. I started sex work to make money at that point. When I first started sex work, I thought what happened to me? Why did I start this work? I thought this work was bad. Then Durbar taught me what sex work was. So, I thought to myself, I have six children and I need the money. I started to work as a community mobilizer for Durbar. I like the work because of Durbar. Now I think that this work (sex work and Durbar work) gave me my house, my children's education. I am able to do everything on my own. Stand up on my own! (P24)

Later on in the conversation, she noted that discussion about HIV with her children was important to keep them safe.

I taught them because there are so many diseases out there, like HIV. If one has HIV you never get cured, so I think it's necessary to talk to children. The children get pregnant or when they get older they might do irresponsible stuff. Who know who has what disease and they can pass it on. That's why it's important to teach your children and make they understand. (P24)

P24's favorable attitude toward sexual health communication with her children was triggered and formulated by the way in which Durbar conceptualized favorable attitudes toward sex work and sexual health. She felt that Durbar helped her to make meaning of sex work through educating her about sex work, HIV, and also giving her the opportunity to serve as a community mobilizer. The combination of these participatory activities shaped her attitude about sexual health communication. It is evident that Durbar's collective norms also impact attitudes about sex work and sexual health communication between mothers and their children.

One participant described that she was able to utilize her work as a way to introduce the topic of HIV. P3 discussed condoms and HIV with her daughter by highlighting the

importance of protecting oneself with clients. She first discusses how she disclosed to her daughter about sex work.

When I do sex work, my daughter sees me working. She sees me going into the room with the man. I thought that if I don't tell her about my work, she will always wonder what I am doing and will think bad things about me. I tell her to go upstairs when the customer is in the room and she comes back down when the customer leaves. She knows what to do. So, I made a decision to tell her about my work when she was 15. I don't want her to think anything bad about me. I tell my daughter "I've been doing this pesha (work) for many years now. In this line, there is a big chance to get HIV, AIDS, STI disease. Syphilis, gonorrhoea, all of these can happen. So I tell her, when I bring men home, I make money. If the men don't come, how are we going to eat? How am I going to feed you? I can make money and save money too. I also tell her that I work condoms and explain to her what a condom does. It stops the disease from spreading. (P3)

P3 couched her discussion about HIV and condoms when disclosing to her daughter sex work. Her duty as a longtime Durbar member and peer educator shaped her beliefs about disclosing sex work as well as discussing sexual health with her daughter. Later in the discussion, she highlighted that Durbar has educated her about sex work and sexual health.

Now I work with Durbar, so I know about HIV. When I did not work with Durbar, I did not know anything about HIV or condoms. The place we work, dictates what we know. If I did not work here, I would not know sexual health information. (P3)

Similarly P23 discussed her participation in Durbar as being the motivation behind talking to her daughter about HIV. P23, who is a longtime peer educator and mother of a 15-year-old girl who lived in a hostel, reflected about her first discussion about HIV with her daughter. She felt that it was necessary to discuss HIV with her daughter because of what she learned from Durbar.

When I joined Durbar, and started working as a peer educator, I learned about HIV. I also learned about sexual health information. So once I learned about this information, I thought it was necessary to educate my child about this too. Before

I even got a chance to discuss the information with her, she came to me to talk about it. So why would I not talk about it? I am very open with my daughter. Durbar definitely helped me. If I had not joined Durbar, I would not have known that much about HIV and I would not be able to talk to my child with such a free mind. (P23)

Her duty as a peer educator as well as the information she learned at Durbar about HIV and condom use served as an impetus to discuss sexual health with other sex workers but also her daughter. Furthermore, P23 noted that it was important for her as well as other mothers to discuss HIV with children to stop the disease from spreading.

It doesn't matter if it's a girl or boy. When, a child approaches adulthood, they will be sexual. A mother should make their children understand that if they have sex with anyone, they should think about it first and use condom. I think it's important for mothers to teach their children about this. It's good if they know about condoms and HIV otherwise the disease will spread. So it is important. (P23)

Similarly, P32 discussed how her feelings about sexual health communication with her children changed after she got exposure to Durbar. P32, mother of a 16-year-old girl and 18-year-old boy, is a longtime sex worker who commutes from a rural area in West Bengal to the red-light district and is newer to Durbar. While she felt embarrassed about SHC, she felt that it was important to discuss such matters after learning about the information from Durbar.

No, I have not talked to my daughter about sexual health before she got married. When she first started bleeding (menstruation) she came to me and said that I may have cut myself and am bleeding. I understood what was really going on then I told her what it is and how to remain clean. I felt embarrassed to talk to her. However, I now think it is important to have discussions about periods, sex, and HIV. After being here, I now feel that it is important. I am exposed to the information now here at Durbar and have also gained experience talking about such matters since that time, so I think having discussions about these issues is very good. (P32)

P31 noted that Durbar gave her exposure to the issues that were taken place in the community.

I tell these to my daughter because I think she should not run into any trouble. If I start early then as she grows older she will not have any problems and we will maintain our friendly relationship.

I am very fond of my daughter and of course working at Durbar has exposed me to lots of things. We get to see so many young girls who have been fooled by their lovers and brought here, all this we know from Durbar. Even before I became a sex worker, I always knew that I have to have a good friend like relationship with my daughter, so that she can open up to me, if she ever does anything wrong she should feel that it is OK to share with mother. If she is in any trouble and she comes to me then I can solve her problems. (P31)

Negative Attitudes toward SHC due to societal stigma. About half of the participants held unfavorable attitudes toward SHC with their children. Many of these mothers were newer to Durbar in that they had been involved with Durbar for less than 5 years. Many of the women who held unfavorable attitude toward SHC felt uncomfortable discussing the concept during the interviews and focus groups. They felt that sexual health, more particularly discussions around sex, were dirty and something that should not be talked about with children. Negative attitudes toward SHC were shaped by the belief that mothers should not be the source of SH education, belief that children already have SH knowledge, and the conceptualizations of the convergence of SH and sex work that was shaped through stigmatized experiences.

Mothers should not be the source of SH information. Some mothers felt that it was unfavorable to discuss sexual health with their children because it was not their duty, either as a sex worker or as a mother. In a focus group, K01, a mother of a 13-year-old

daughter, longtime sex worker, and Durbar service user, felt that it was unfavorable to talk to their children about sexual health because it was not her role as a parent. Rather it was their children's friends' duty, as they thought the information should be conveyed from a peer who is of similar age, as mothers were not supposed to discuss such information with their children.

Children should learn about HIV from their friends. It's better they do so that they can learn from someone their own age. When I feel like my daughter is old enough, I am going to tell her friend to talk to her about sex and HIV. Mother's don't talk about such embarrassing stuff with their children (sex, condoms). (K01)

During the focus group, many participants agreed that mothers should not discuss sexual health with their children. One of the participants agreed and recalled that her daughter learned about menstruation from her friends. She felt that was the expectation and that it was not the mothers' role to discuss sexual health with their children.

Interestingly the belief that sexually related information should not be discussed with children was not isolated to those with less levels of participation in Durbar. While most peer educators held favorable attitudes toward SHC, one Durbar peer educator felt that SHC was not favorable with her children. P8, mother of two adolescent girls, felt that it was a topic that should only be discussed with sex workers.

Well I could not discuss sexual things with my daughters. As a peer worker, such discussions are only for the job. We can freely discuss this with only sex worker, as friends. But it is difficult with your own daughters. (P08)

Later on in the conversation she further delved into the reasons behind not communicating. P8 felt that she did not have the opportunity to communicate with her daughters when they were younger.

When they were very young I was not in sex work. I did not know much about HIV or condoms. I did not discuss anything with them. Things were different 10

years back., Now a days they have some of this (puberty, sex HIV) being discussed in schools and in the movies, but ten years back there was such no discussion. These days in schools they teach girls how to use napkins (Tampons), all of this was not there ten years ago. I could not initiate a discussion on my own. (P08)

Belief that children already know SH information. Many mothers felt that it was not necessary to discuss sexual health with their children because children already knew about sex, HIV, condoms, and puberty. One reason for this is because they felt that children learned about sex, HIV, and condoms from technological sources, such as computers and television. Thus mothers' felt that it was better to eliminate such difficult discussions with their children about sexual health topics. P29, a mother 2 adolescent boys and a new Durbar peer educator, felt that it was not necessary to discuss sex work or sex with her children. While she briefly discussed relationships with girls with her older son (18 years old), she thought that it was not necessary.

One should NOT talk about sexual stuff with children. Nowadays, the children know more than us because it's everywhere. They watch it on the TV. Sex work and sex is everywhere these days. These things are so open now that so many people discuss it. It's in the community, in the paper and it's on the TV. Someone is always talking about it. That's why I don't think it's necessary to educate the children. How to even explain it to the children? Wherever you go, sex is there. (P29)

Feelings that children already possess sexual health knowledge were driven by participants' feelings of embarrassment, as such topics were deemed as societal taboo to discuss with children. P04, born in the Sonagachi red-light district, is a longtime sex worker, Durbar employee, and mother of three older adolescents (1 girl and 2 boys).

I think my sons know about these topics but they have never talked to me about this. They ask me not to worry. I just mention that I hope you know that there is this disease called HIV/AIDS, to this they reassure me and tell me that it is OK and that they know what is what and how to go about it.

Honestly I do not know exactly what they know. If I could sit them down and tell them the details and give them all information that would indeed be good, but I am not able to do that. I feel so awkward and shy about such discussions. (P04)

Conceptualizations of the convergence of SHC and sex work. Participants discussed the convergence of sexual health communication and sex work, which was associated with stigmatized experiences and the management of such stigma. It is evident from the results presented in this section that the constructions of attitude and norms formation overlap.

Context of stigma against sex work. Attitude formation about sex work and sexual health was impacted by women's stigma management capabilities, such as the ability to combat the stigma or opting to conceal the stigma. As such, the different types of stigma participants experienced often shaped the negative or unfavorable attitudes about sexual health and sex work. The ways in which women managed the stigma, either through combating, concealing or in some instances a combination of both influenced their attitude toward sex work and also toward sexual health communication with their children.

Despite the increase of sex workers rights movements that aim to eliminate the stigma and discrimination against sex work, it remains a critical issue that not only impacts the quality of life of sex workers, but their children as well. I will briefly discuss three types of stigma to provide a better landscape into how stigma unfolds in the context of mothers who are sex workers. The stigmatized experiences, and the management of, effects women's relationships with their children and thus impacts their beliefs about engaging in sexual health communication with their children. While the questions in the

protocol did not directly ask women about the different levels of this stigma associated with sex work, women often told narratives that incorporated these types of stigma. It quickly became evident that stigma management played an important role in how women chose to live their lives and also their relationships with their children. Their understanding of stigma associated with sex work was couched in a complex nexus of cultural, social, and structural factors. This section aims to uncover the impact of enacted, internalized, and anticipated stigma on women's attitude toward sex work and sexual health communication with their children.

Uncovering the ways in which women manage stigma and its impact on the cognitive processes, which ultimately impact mothers' decision to communicate with their children about sexual health are, essential to understand. While most women discussed the role of stigma in their lives, there was variation in the way it was processed, experienced, and handled. Women managed the stigma through a wide spectrum between combatting the stigma to concealing the stigma against sex work.

Enacted stigma. Experienced or enacted stigma manifests in the form of discriminatory practices, such as violence, institutional and interpersonal discrimination or social exclusion. This might include unequal access to healthcare, differential treatment by police, or discriminatory practices by banks and schools. Many of the women discussed encounters of discrimination that were present before Durbar started various community mobilization movements. As P2, mother of 6 year old and 13 year old boys, reflected about her life in her prior residence of Khidderpour red-light district, she recounted experiencing both emotional and physical violence many times from the local goons, local shopkeepers and the police.

So when I was in Khidderpour for about 11 years, there a don mafia.. like a mob. There was lots of violence at that time!!! I got abused many times also over there. They robbed my house and messed up many things around the community. (P2)

Enacted stigma was not only experienced by the person who is stigmatized, but also by those that are associated with that person. For example children of sex workers were often denied admission to schools or if accepted, they were often given unequal treatment. P2 decided to move out of Khidderpour red-light district because her son was abused by the local mafia and was often made fun of by the students at the local school. This enacted stigma against sex work in the forms of physical violence and discriminatory actions toward her child set forth by the school informed her decision to move to another red-light district.

S33, a longtime durbar project coordinator, described a recent incident of enacted stigma with a child of a sex worker.

Recently I was contacted by a mother of a child who was given some problems at a non-community area (area outside of the red-light district). The child's school teacher told him "you are from the red-light district.. how much will you even be able to learn in school?" We all helped them to protest. This type of discrimination and stigma still happens, especially in the non-community areas. (S33)

Internalized stigma. Enacted stigma often leads to internalized stigma (or self stigma). Internalized stigma (Goffman, 1963) is the belief that the negative qualities constructed by society about sex work actually apply to the self. Sex work is often socially constructed to be "dirty work" and a job not suited for mothers.

P16, a newer Durbar member, felt that mothers should not talk about sex work with their children because it not a good profession.

I don't ever want to talk to my children about sex work or sex. They will think I am bad because I am a sex worker. I am spoiled. I don't want them to know that. (P16)

This stigma is compounded because sex workers are often conceptualized as vectors of sexually transmitted diseases (Kempadoo, 1998; Kempadoo, 2001). Women learned of these social constructions from their experiences interacting with service providers, social control agents, non-sex worker communities, media, and friends and family. P27, mother of a 13-year-old son, recounts her thoughts about being a sex worker, and consequent actions of washing her clothes before she entered the house. She discusses that when she first started sex work clients made her feel

Before I used to be very scared of sex work and I did not like doing it. This was way before. When I used to go with a client in Sonagachi to work, I would then go home and take my clothes off before going inside the home and wash them before I entered the home. I would take a shower and then go inside my house. I would say that I work in a hospital so I cannot go inside the house without showering. That's how dirty I thought it was. (P27)

Due to sex workers' vulnerability to HIV and STI, the majority of the research exploring sex workers' lives attempts to understand their sexual practices and labels them as vectors of diseases. Link & Phelan (2001) state that such labeling entails distinguishing differences between people to create groups is one of the components of the stigma process. Many of the women in this study were aware of this status that most researchers often held. In some instances, women assumed that I wanted to inquire about their sexual practices and often provided a narrative of their safe sex practices and strategies used to lure customers into using condoms. When I said that was not the topic of the interview, although they were welcome to share their experiences, they often looked perplexed. This internalized stigma, that of taking on the identity of being HIV

positive or one that is at high risk of contracting the disease, illustrates the hegemony of the medical model. In addition it reveals the exploitative powers that are often invisible in the individualized, HIV risk reduction approach (Patton, 2002).

Concealable stigma is a type of internalized stigma that cannot be seen. Women might choose to conceal the stigma because of the enacted stigma that they anticipate. For instance, some mothers concealed their identity of sex work from their children, friends, and families so they didn't have to suffer from the enacted stigma. This concealing process included sending their children to boarding school or a hostel, physically changing ones appearance in different social settings, and withholding their trade from their families. Women often told their families, who often resided in the village, that they worked as domestic workers. P31, a new Durbar sex worker, noted that she did not want to reveal her profession to her family in the village.

It is very good that I can come to an office to work for Durbar. My family back at home, does not know that I am engaging in sex work in this area. They know that I work for Durbar. This is very convenient for me. (P31)

Anticipated stigma. The combination of enacted and internalized stigma can lead to anticipated stigma, in which a person expects negative treatment from others once their identity is revealed. Anticipated stigma can be understood by examining the process of mothers' choosing whether or not to disclose about sex work to their children. Women's choice to disclose was often related to the reaction they anticipated others to have once they had disclosed about their profession. In some instances women chose to conceal their profession from their children because they did not want their children to lash out. Some mothers described that they had seen other sex workers children become

emotionally and physically violent upon learning of their mothers' profession. In a focus group, when discussing disclosure about sex work to children, P35 exclaimed

I am afraid to tell my children about the work that I do. It's not suitable for them. I have seen many mothers whose children have yelled and screamed at them because of this work. I just saw an incident like that happen just last week. Why would I put myself through that? I don't want to put myself in a situation like that. Why would I hurt my children in that way? (P35(FG))

Another focus group participant immediately responded

You are hurting your child more by not telling them. You have to be honest to your children, make them understand. That is the way we can get rid of stigma. Our children learn from others and that is why they violence their mothers. We have to explain to them. Make them understand that we are doing this work for them. To feed them, to give them an education. (P40(FG))

P24, a long time sex worker and mother of six children ages varying from older adolescents to adults, discussed working at Durbar with her children, but never disclosed about sex work. When asked if she ever disclosed to her children about sex worker, she explained

No but they know that I work at Durbar... I will never be able to tell my children because if I tell them.. they are just too old now. They will hate me. My work is not recognized either, so I cannot tell them about it. If I tell them that I am a sex worker, everyone will find out and they will get tortured from everyone. (P24)

For half of the mothers who had not disclosed to their families and children about sex work, motherhood identity provided them with the ability to conceal or disconnect with their sex work identity. P16 often visited her 12-year-old girl and 7-year-old boy in the village, where they resided with their grandmother. She had not disclosed to her children or extended family about her profession, thus she was extremely careful about her presentation when visiting the village.

When I go home to the village, I look simple. I wear a saree when I go back home. I never wear a churidaar or a nighty. I just wear that here. If I wear churidaar in the village and dress up, the village people will automatically think that I am a sex worker. Even if I dress up a little and look nice, they will think that I am a sex worker. I am away from home and because of that too, they will be 100% sure that I am a sex worker. (P16)

P16 managed her identities by changing her appearance so people would not assume that she was a sex worker. While she believed sex work was a good profession for her, she anticipated the stigma that she would receive from her village if they found out about her work, thus chose to present herself in a normative way.

Impact of stigmatized experiences on sex work disclosure to children. Enacted, internalized and anticipated stigma played into women's decision about disclosing sex work to their children, ultimately impacting their decision to discuss sexual health with their children as well. The ways in which women managed stigma was closely associated with their choice to disclose to their children about sex work. This section will provide a better understanding about the beliefs about sex work disclosure. An illustration of the cognitions behind the disclosure process will help to better understand mothers' attitudes about sexual health communication.

Mothers who disclosed. Mothers disclosed about sex work for various reasons. During a focus group discussion, a mother who had disclosed to her child about her profession at a young age, exclaimed that her child was very understanding of sex work being a form of work. She said that her child held a favorable attitude toward sex work, and thus she did not face harassment from her child, and attributed the child's reaction to the fact that she had disclosed about sex work when the child was young. Providing

advice to her fellow mothers in the group, K1 exclaimed “If your own child doesn’t understand and respect you, then no one else will”.

For some mothers, sex work was a way of being, an identity that made them who they are as a woman, as a mother, and as a social justice advocate. The sex work rights – based ideology was infused in FSW mothers’ identity. P2, who introduced herself as a sex worker and previously was the Durbar General Secretary, noted that she had never concealed her profession from his child. She exclaimed

My older child was always involved with this work in some way, He saw my clients. I never hide anything from my son. The didis (other sex workers) around here hide their children. They put their children far away or lie and they hide their profession. But this will cause lots pain for the child in the future because when the child grows and when the child finds out that their mom is a sex worker, then that child will have mental problems. (P2)

P2’s 15-year-old son had been involved in sex workers rights campaigns. She described a recent event where her son was interviewed about his experiences as a child of sex worker. P3 proudly discussed that her son was able to articulate that she was a sex worker and that he supported his mother work. She said that her son said (P2) “My mother is my house. She did this work (sex work) and was able to feed us, educate us, so why wouldn't I support my mother? Why wouldn't I say that the job my mother does is like any other job. Like any other job.”

P2’s attitude toward sex work, which was based on her experiences through Durbar-related rights-based activities and leadership positions, informed her parenting decisions about disclosing to her child about sex work. Additionally, because she was forthcoming with her children about sex work, she was able to shape her children’s attitude about sex work. Toward the end of the interview she described a recent situation

in which she observed an adolescent child hitting their mothers when he found out about his mother's profession. P2 said that she did not ever want her children to find out about her profession from someone else. Additionally, she said that she wanted her sons to be able to protect themselves when they engaged in sexual activity. She said that she has seen college aged boys visit the sex workers in her area and that younger boys should know how to protect themselves from the disease.

Some mothers had not disclosed to their children about sex work, but felt that it was important to do so. While P31 had not disclosed to her daughter about sex work, she held a favorable attitude about sex work disclosure.

I do not directly talk to her about sex work, but I tell her that once you grow up, I will tell you everything. I will talk to her about sex work in the future. No one else will be able to talk to her like I do. My daughter sees that I am working hard to support her. So if I share the details of my work with her, she will be able to understand that it is OK and my mother engages in this kind of work for our sake. If I keep quiet and she comes to know about my work from others then she may conclude that mother is in the wrong. She will misunderstand me and the great friendship that we now share will be lost. She will lose her respect for me and also her love towards me. If I tell her now, she will reason that my mother herself shares everything with me and does this work for my sake. If people try to slander me, she will defend me against them. She will know that my mother shares everything with me, that is a good thing. She is my only daughter I have to depend on her she is my source of support in the future. (P31)

Mothers who refrained from disclosing. In many instances, women concealed sex work from their husbands and families. This was often due to the different levels of stigma they had experienced or anticipated. While some of mothers who refrained from disclosing held favorable attitudes toward sex work, they preferred to conceal sex work from their husbands or families because they did not want to face the stigma or disappoint their families. P32, a newer Durbar member, discussed that while she held a

favorable attitude toward sex work, she did could not tell her family about sex work. She juxtaposes her family life with her life as a sex worker.

Our parents arranged our marriage and we agreed to whatever they decided, but I was never happy in this marriage. I have not had a moment of happiness with this man. He used to beat me up before. I have suffered so much, yet I have not left that family. This work that I do now is good; I think I will live the rest of my life here. Now I think that this is a good job, earlier. When I came here first I thought of it as dirty work, I was terrified of what it will people think if they come to know that I work here, but now I do not care. No one helped me in my time of need. I think this is good work. The earnings support my family. I still cannot tell them though. (P32)

Enacted stigma also played an important role in influencing mothers' choice to refrain from disclosing to their children about sex work. In many instances, mothers had witnessed children of other sex workers yelling and hitting their mothers when they found out about their mothers profession. A focus group participant recalls a recent incident when a son found out his mother was a sex worker.

I don't know about telling my son about sex work or even sexual matters. Just a few days ago saw a son beating up his mother. He had found out from his friends that his mother was sex worker. It was so bad. I felt so bad for the mother because it is a difficult situation. I don't want me children to react like that. (KF50)

Some mothers, however, held unfavorable attitudes toward sex work because they believed the work was bad. A majority of the women who held such attitudes had not been affiliated with Durbar for a long time and were not as active in Durbar's activities compared to the mothers who held favorable attitudes about sex work.

P30, a flying sex worker mother of 2 children, utilized Durbar's clinic services for the past six months. She recently joined sex work because of the lack of income after being abandoned by her husband. In describing her thoughts about sex work, she voiced concern and grief about her decision to do sex work.

First, I was a housewife and now look at me. I sleep with all the men. I don't like this work at all. But what am I supposed to do? No one will support me. I don't like this work but what am I supposed to do? There is no other work. I am not educated. Someone brought me to this work. I did not understand what this work was when I first came but now I understand the work. I feel a little bad doing the work but what am I supposed to do? There is no other work. (P30)

Later in the conversation she noted that she did not feel comfortable disclosing to her children about sex work because of the society's stigma against the work. While she had not communicated with her children about sexual health, she felt that it was important to discuss HIV with her children because it was something that could potentially cause harm.

Before the children get older, I am going to quit my job. When my children get older, I am going to discuss about HIV. It is necessary to discuss such things because who knows what will happen to the child if they are not aware of HIV. I think the appropriate age is 15. At that age they start doing stuff (referring to relationships, sexual activity). Before I did not know all of this sexual information but when I came here to this work I have been thinking more about it and also about talking to my children about it. (P30)

P30 started to think about sexual health topics after being exposed to Durbar, which was just a few months ago. Later in the conversation, she discusses aspirations for her children.

Ever since I have started this work, I think I will try to educate my children and get them raised in a good day. I want my children do know that I have done for them. I will try to buy a land and build a house. I will not depend on anyone. I like this work but the community will not accept this work and me. If they find out what work I do, the community will say that I am doing bad work. It is a village thing. (P30)

Such behavioral beliefs about sexual health communication and motherhood are couched societal expectations of good mothers. For instance, good mothers should have aspirations for their children and that they should work hard to raise their children, but only in ways in which that are accepted by the community. Though she says that she likes

the work, which has triggered her to think about discussing sexual health with her children, she is caught between societal constructions of a good mother and being a good mother and a sex worker.

Similarly, P17, mother of an 11-year-old daughter and longtime sex worker, felt that it was not necessary to discuss sex work with her children because her child would automatically learn of the work from the surroundings. However felt that, as a mother, it was necessary to discuss love and relationships with her daughter in the future even though at the time of the interview she felt that her daughter was too young.

I haven't talked to my daughter about HIV or condoms because she is just a child. I have thought about talking to her though. As a mother, I tell my daughter and other children in this neighborhood that love is not wrong. Loving someone is not wrong and it is not a bad thing. During a time when one is thinking about having sex, one should think about it wisely and then have sex. Children need to think about sex carefully. If they don't think about it carefully, they should not have it. I will probably talk to my daughter about HIV when she is 14 or 15. I will never hide anything from her. I will try to, as a mother, keep all the pain away from her. (P17)

P20, a mother of 2 young adolescents, joined sex work recently. She discussed her thoughts about disclosing to her children. While she felt that it was important to tell her children when they were older, she believed she had to provide them with shade until it was time to disclose.

Yes, I have thought about telling my children. I will tell them when they get older because I want them to know how I raised them. That when my children get older. Look, we have to make effort to raise the children. Its like a flower, you give them water to grow up. We have to give them the proper shade too. Right? If we don't do anything, the children will grow up by themselves, alone. We need to tell the girls that you need to do it like this...the right way. I don't want them to think bad about me. (P20)

P6, also a newer Durbar member, told her children that she was a domestic worker because she felt that it was not necessary to disclose about her profession. She felt that the societal stigma about sex work would taint the relationship with her children.

No they don't about my work. I have never brought them here in this locality. When they ask me where I go to for work, I say I go in the city everyday to work as a domestic help and a cook in a certain household. That is all they know about it. They may have heard from someone about my real work, they may have. I don't know. But I have never revealed anything to them. I have told them that I work at a office now, but they do not know it is the DURBAR office or the kind of work I do here

We don't discuss such stuff at home. Anyway I return home early every day. I leave this locality by five. I don't wait for customers in the evening. I leave by dusk. (P6)

P24, who had been with Durbar for over 10 years and mother of 6 children ranging from 16 to 30, felt that she had missed her opportunity to disclose about sex work to her children. She was able to shield her work by telling her children that she work at Durbar.

My children don't know about sex work, but they know that I work at Durbar. I will never be able be to tell my children. They are just too old now. They will hate me. My work is not recognized either, so I cannot tell them about it. If I tell them that I am a sex worker, everyone will find out and they will get tortured from everyone. (P24)

Construction of Control Beliefs about SHC

Control beliefs were constructed by mothers' use of feasible tools and resources made available by Durbar and mothers' conceptualizations of the context of space.

Control beliefs are the perception that one has the knowledge, skills and the capability to perform a certain behavior. Perceived behavioral control has been conceptualized to include both the self-efficacy, perception that one has the capability to perform SHC with their children (form of internal control), and perceived control, belief that one has the capability to overcome barriers, such as other people or events that have the potential to

interfere with the ability to communicate about sexual health (form of external control). Unlike the attitude and norms constructs, perceived behavioral control independently impacts a person capability to perform the behavior.

Established through use of feasible resources and tools made available by Durbar. As with both the normative and behavioral beliefs, Durbar played an integral role in shaping mothers' perceptions about sexual health communication. One of the aspects of Durbar that played a salient role in constructing the control beliefs was its educational component. The Sonagachi HIV Intervention Project uses empowerment strategies, including leadership development, peer education, public education, organizing unions, work training, and rights-based advocacy and education (Jana et al., 2004; Swendeman, Basu, Das, Jana, & Rotheram-Borus, 2009b). These empowerment tactics have played an important part in changing sex workers' and their families risk environment, ultimately leading to better physical and mental health outcomes. The peer education model is of particular interest in shaping mothers' beliefs about their control over SHC with their children. Through intensive workshops, Durbar has trained over 400 peer educators on educating sex workers about HIV and STI, condom use negotiation tactics with clients, as well as other sexual health related information (Jana et al., 2004; personal communication with Dr. Smarajit Jana). They are assigned to particular areas in the red light district and educate sex workers in the field about the importance of condom use, HIV/STIs, negotiation tactics, etc. and they also provide referrals to health clinics run by Durbar. Not only do they educate sex workers, they often serve as social support that ultimately builds cohesion amongst the community (Jana et al., 2004). As such,

control beliefs were constructed through capitalizing on skills and knowledge learned through Durbars collectivization processes and through acknowledging the gap in SH knowledge.

Capitalizing on skills and knowledge learned through Durbar's collectivization processes. Control beliefs were constructed based on mothers' perception of the skills and knowledge that they gained through their education and role as peer educators. Peer educators also received materials, such as HIV education pamphlets and condoms. Many of the mothers who were peer educators felt that their role at Durbar had helped them gain more knowledge about HIV/AIDS and that they could ultimately pass on to their children. A11 a Durbar peer educator and mother of a 14-year-old girl

I didn't know much about HIV/AIDS before I started working as a sex worker and working with Durbar but since I have, I have started thinking about educating my children about this stuff HIV. I know this because of Durbar and will know more as I work with them." (A11, mother of a 14 year-old girl)

Another mother noted that while she felt that it was awkward to discuss puberty and sexual activity with her son, she was able to discuss HIV testing with both her son and daughter when her daughter got married. PA04, a longtime peer educator and mother of 2 adult sons and a 20-year-old daughter, used her daughters' marriage as a teaching moment to educate both of her children. She specifically noted that she was able to suggest an HIV test because she knew where to get them and how they were done because of her training as a Durbar peer educator. PA04 primary role as a peer educator was to educate sex workers about HIV test and accompany them to get tested.

When I was marrying off my daughter I told her to get a HIV test done. Since I work as a peer educator I know about these things. I told both my daughter and son in law to get the tests done. I felt like I wanted to have a detailed discussion about all sexual issues but I did not get the opportunity, so I could not. But I did

get the word through on HIV, however much they may be in love one cannot be absolutely certain about one's partner so I cautioned my daughter about HIV. That's what I told my daughter. (PA04)

PA04 later attributed her ability to converse about HIV and HIV testing with her children to her training and duty as a peer educator. She had gained specialized skills in discussing HIV testing with her clients, thus she was able to use the same skills with her daughter.

I have learnt specifics on HIV testing and HIV on the job as a Durbar peer educator counselor. I would not have any clue about it otherwise. What's helped me to talk with my family about HIV is that we see these patients; we take them to the hospital and clinic and see what state they are in. This has made me conscious about the disease and issues people are faced with. (PA04)

Similarly, P23 discussed that she learned about HIV and sex-related information from Durbar and only after her long tenure with Durbar was able to discuss such matters with her children. P23 has been a sex worker for 19 years and has been a Durbar peer educator for the past 12 years. While P23 did not initiate the discussion with her daughter, she had acquired the skills from her peer educator role to respond in the appropriate matter when her daughter approached her.

I started to think it was necessary to communicate about HIV, condoms, and sex when I joined Durbar and started working for them. I learned about HIV then. I also learned about sex stuff. So once I learned about this, I thought it was necessary to educate my child about this too. Before I even got a chance to discuss the information with her, however, she came to me to talk about it. So why would I not talk about it? I am very open with my daughter. I can talk even better and freely with my daughter because she started the discussion with me. Durbar definitely helped me to communicate about such things. If I had not joined Durbar, I would not have known that much about HIV and I would not be able to talk to my child with such a free mind. I was able to discuss this all. Durbar definitely helped me. (P23)

Many mothers did not know how to read or write and had some primary school education. Durbar, however, provided them with an opportunity to learn, teach others, and make a living independent of sex work. In many of the interviews, mothers often discussed that they were proud that they held knowledge about HIV, condoms, STIs, and sex to communicate with their children. In some interviews, mothers highlighted that they were not able to read or write, but were able to discuss such topics with their children. P15, a mother of a 17-year-old boy, a long time peer educator and sex worker, recalled her thoughts about a conversation with her son when he was younger. When asked if she had ever discussed sexual health with her son, she responded

My son knows how to read and write. He learns about HIV and condoms on TV. I also have materials (pamphlets and handouts) on HIV from Durbar because I am a peer educator. He reads those materials, so he knows about HIV. When my son was 14 or 15, he asked me “how do you get HIV and how does it spread to others?” He said he saw it on TV. I told him that it happens like this and like that... I explained everything to him about it. I also talked to him about condoms, because he sees that on TV also. (P15)

I felt very good when he asked me about it. I don't know how to read or write, but my children do. Because they know how to read and write, they want to know more information. Even though I don't know how to read and write, I still know about HIV because of Durbar. It was so good to discuss this with him. (P15)

As discussed earlier, many of the mothers who had discussed HIV/AIDS and STI with their children used Durbar materials to initiate the conversations. P2, a longtime sex worker and a part of Durbar's leadership, recalled one of her first discussions about HIV with her adolescent son

We do peer education around the brothel areas. We use a pamphlet to educate the sex workers. This pamphlet always stays in my purse. One day, my son asked me, mom what is this? So I said, read it. I told him a little and then also told him what happens between a girl and boy and sex. So, I said the place where a girl and boy

have sex, that place can have gonorrhoea. It was easier to have the conversation with him because I had the pamphlet. (P2)

P24, mother of six children, also used Durbar materials to facilitate her first conversation about HIV with her son.

Yes, I have talked to my children about HIV and condoms. When I joined Durbar, I always had Durbar books and condoms. I thought that if the children happen to see the book and condoms, they will think something bad about it. So, I decided to talk to them about it. I told them that I work in the HIV intervention program. I work with sexual diseases and sex workers. That's how I told them. I gave the children a leaflet too, so they could read it. I wanted to educate them about the disease. (P24)

Acknowledging the gap in SH specific knowledge. Inhibiting factors to SHC included little knowledge and skills to communicate about sexual health. While participation in Durbar led to sexual health specific knowledge, skills and general preparedness for mothers to discuss sexual health with their children, mothers who had low levels of participation in Durbar lacked skills and knowledge to discuss such topics with their children. P30, a newer sex worker, who was also new to Durbar felt that she did not have enough skills to communicate with her children about sexual health. However, she felt that she would be able to learn about HIV from Durbar and then discuss it with her children.

I don't know much about HIV and condoms but I will slowly learn and then I will be able to talk to my children about it.
I can learn more from here and I will try to meet the durbar people more to learn more about these topics. (P30)

P32, a newer Durbar member and longtime sex worker, felt embarrassed to discuss HIV, sex, and condom use with her children. She had never communicated with her children about sexual health. Not only did she feel like she did not possess enough knowledge

about HIV and condom use, she felt that she did not have enough skill to communicate with her adolescent son and daughter.

I feel embarrassed about discussing such topics. My children have lived so far away from me and I have not had the chance to interact with them as a friend. So, I do not know what they are going to think if I suddenly start talking about these issues. (P32)

In addition to her feelings about not having enough knowledge and skill about sexual health to communicate with her children, she felt that the physical separation between her children and her was a barrier as well to the communication. She emphasized that not having the opportunity to establish a friendly relationship with her children.

P3, a longtime Durbar leader, discussed in frustration that many mothers in the area did not have enough knowledge to communicate about sexual health and do not disclose about their profession with their children.

Most mothers around here do not talk to their children. There are many mothers who don't know anything, they know a little about HIV and that they should use condom, and that they should get a health checkups, but that's all. There is no sharing between mother and child. The general mothers (sex workers not affiliated with Durbar) definitely do not discuss such things. If you ask the child of a general sex worker what their mother does, they will not know. They won't say anything to their child because they are so shy. (P3)

There was a stark difference between mothers who had high levels of participation with durbar and those who did not. The skills and knowledge learned as Durbar peer educators helped mothers to facilitate discussions with their children. However, it was evident that mothers who were newer to Durbar or did not participate in Durbar did not possess the skills and often times the knowledge to discuss sexual health with their children

Established through context of space. Control beliefs regarding SHC were also established through mothers' perception about the children's residence and aspects of that space. This space included the red-light district, village, and boarding schools. Thus, space served as a both facilitating and inhibiting factor to SHC. Most of the children whose mothers had high levels of Durbar participation lived with their mothers, while only a few of the children whose mothers had low levels of participation lived with their mothers. Some women separated public life often associated with sex work and the brothels, from their private lives of those with their children and families, while others meshed their public and private lives. Mothers who sent their children to boarding school or to the village were able to manage their concealable stigma and anticipated stigma by separating their sex work life from their children. They did not want their children to find out about their profession, nor did they want their children to fall prey of the structural violence. Mothers who chose to keep their children in the red light district combatted the stigma by being forthcoming about sex work as work and their rationale behind the choice of this work. This section discusses participants' perception about (spoiled) space, its role on sending their children away, and how ultimately such choices influence mothers' control beliefs about sexual health communication.

Some mothers chose to send their children to boarding school while others felt that it was important to raise their children themselves. P2, a longtime Durbar leader, felt that it was important for her son to attend boarding school. She felt that they would not be able to take care of their children if the children lived with them. They felt that between working at Durbar and doing sex work at night, they would not have enough time to spend time with their children.

I put them in boarding because... See, I am not home all day because I am at work. For my older son, I put him in boarding because he needed some guidance guidelines (by guidelines she means.. he needed something.. more.. more than just going to school, he would be ready for the other school otherwise it would not have been good. He needed something extra to do well so he would be prepared for education. So I thought, since my older child did so well, I should do the same thing for my younger child. So, I thought if I put the younger one also, he would also be successful. So I enrolled him.. in the hostel. There are guidelines, like their eating time, playing time, studying time, there is a time for everything there.. I am not here all day, so it's better for them to be in boarding. (P2)

However, for some mothers the decision to send children away or keep them at home was very difficult. P15, also a longtime Durbar member, felt that it was important to keep her daughter at home.

Being a mother is a good thing but there are lots of troubles/worries related to being a mother. Many customers even used to tell me, why don't you send your children to boarding school. But I could never let my children go. I always wanted to keep my children by me. (P15)

The red-light district served as a protective space for some families. P17, a newer member of Durbar, recalled her life before Durbar in the interview. P17 was no longer worried about leaving her teenage daughter in her new residence of XYZ red-light district. Prior to moving to XYZ red-light district, P17 lived in a community outside of the red-light district and recounts that she was afraid of leaving her children with the neighbors because she was a sex worker. She was worried that the neighbors would harass her daughter, so often times she declined customers in order to stay with her child.

Before, I had to suffer a lot. I had lots of pain before I came to Durbar. I suffered a lot in some instances, but see the people here (XYZ red-light district), If I tell them to take care of my daughter, they will. I like the mummies here. They have daughters the same age as my daughter. That helps too. We help each other. Otherwise life would be very difficult. There would be a lot of difficulty if we did not have each other. (P17)

Durbar's clinic acted as a safe space for her daughter when there were no other options for childcare. She was able to ensure her daughters safety because she did not have to conceal her identity in the red-light district. Additionally, she was able to take more customers without worrying about childcare.

Red-light district space enables SHC. Mothers with high levels of participation with Durbar, felt that it was favorable to discuss sexual health because they lived in the red-light district and preferred their children to learn about sexual health from them rather than others. Thus, for these mothers, space, the red-light district, served as a facilitating factor for SHC and one that helped them to overcome barriers to sexual health communication. P10, a long time Durbar peer educator and mother of an 18-year-old son, who had already communicated about HIV discussed that one of the advantages to such communication was to keep her son safe. She acknowledged that he lived in the red light district and that he might engage in sexual behavior at some point, so it was important for her to discuss sexually related information.

I want to talk about HIV because he has grown up here and now 18 years old. He lives in these red light areas, I cannot control where he goes what he does, so I thought it wise to tell him about this (HIV). He should use condoms or else it would be dangerous. (P10)

Living in the red-light district was a driver for her to communicate with her son about HIV and condom use. She later shared that she had seen many boys her son's age loitering around the red-light district in hopes to receive sexual services. P10 also discussed the importance of SHC.

I will say that parents want the best for their children. They have to try to protect them and do not want them to go astray. They will always want the very best for them and will not want them to be in any danger. So these conversations are important. (P10)

The brothel space also played an important role in mothers' decisions to disclose about sex work to their children. The families' residence doubled as the space for sex work as well. Women lived in one room with their children in a brothel, a house with many rooms that are located in the red-light district. Rooms usually had one bed, a portable stove, and sometimes a television. This space was also used for sex work as well as family activities, such as eating dinner and doing schoolwork. Some mothers expressed that they often negotiated their work and motherhood in this space. Working while their children were present was a challenge and some mothers discovered methods to parent and see customers. They often sent their children to the neighbor's house or outside to play. P3, a longtime Durbar peer educator and mother of a 15-year-old daughter, discussed a recent conversation with her daughter.

I made her understand that in this place, I raised you, I feed you, I educated you. This is how I make her understand. My daughter asks, "why don't you let me come down to the room". I make her understand, look you are older now, some customer might grab your hand and you will go and he will ask "are you a sex worker". So, she knows the work that I do but I don't want her to do sex work now. (P3)

Similarly, P09, mother of an adolescent boy, recalled her experience of disclosing to her son about sex work. Living in the brothels and being exposed to customers, P09 thought it was important for her son to hear from her about her profession.

My son lived with me until he was 10. At that point he was old enough to understand what went on with me. I would be in the room with the customers, while he was sent outside to play, so he surely would have guessed. He knew that if we do not have customers we can't buy food. I brought him up like that. I have

been around in this area for so long, many people know me, if he were to hear it from one other than me, he would have felt hurt. So I took the initiative and tested waters. I brought it up with him (sex work), he was open to conversation. He understood what I was saying. I was afraid and anxious when I first discussed it with him. I thought to myself “What would he think, how will the conversation go?” I was worried that he may get angry and not talk to me. (P09)

Later in the conversation she disclosed to the interviewer that she contracted HIV many years ago and did not disclose to her son about the infection. However, she said that she thought it was important for him to know about the disease so he could protect himself.

He is a teenager and on his way to adulthood. I have told him have you seen the television advertisements (campaign adverts) and you live in this area? You are an intelligent boy I hope you get what I am trying to say. Please be safe. Whatever you do, wherever you go, it is Ok to like someone. If you do not have a condom, I will provide you with it. You know about this disease, it is infectious, but not if you sit beside a person or share meals with them. This disease can enter your body if you receive diseased blood or use syringes or if you have unsafe intercourse. I have laid it out clearly like this for him. (P09)

P09 felt that her son knew about her profession because of the close quarters they resided in. Thus, she felt that it was important to disclose to him about sex work before he found out from someone else in the community. Additionally, because of the space they resided in and things that the son observed in the red-light district, P09 felt that it was favorable to communicate about HIV and condoms with her son.

Mothers’ conceptualization of how space influenced and transmitted information about sexual health and sex work to children was also evident in discussions about the FSHCI. P06, mother of three adolescents and newer Durbar member, felt that it was only appropriate to hold the intervention with children who lived in the red-light district.

A workshop about sexual health would be good, but only for kids who stay here and have an idea of what’s going on. The kids who have no clue about their mothers’ profession and the things that come along with it will not be happy to know all this suddenly. (P06)

The red-light space inhibits SHC. Some mothers discussed that while SHC was favorable with their children, they believed that children already knew about sex and HIV because of the red-light space they resided in. Specifically, they felt that since children saw their mothers with clients and saw condoms at home, it was not important for them to communicate about such topics with their children.

My children know how to study. They know how to read, so they read it in the newspaper and watch it on the TV. I cannot say that they discuss such things with their friends, but they probably do.” (A14, mother of 3 adolescent girls and a son) (A14)

P17, mother of an adolescent girl and longtime Durbar service user, discussed her thoughts about sex work disclosure. She felt that it was unnecessary to disclose about sex work to her daughter because her daughter “saw everything” in the red-light district.

When asked if her daughter is aware of the work she does, P17 responded

She watches what’s going on around here. She is slowly growing up. I have never talked to her about sex work. She is young. When she turns 15 or 16 years old, she will just come to know by herself that mummy is doing is doing sex work. Right now, she usually goes into another room when there is a customer. She understands, no? I know that when she gets older that she will understand (about the work) by herself and that she herself will ask me.. "mummy, what is this". She has been watching ever since she was young. She will not even have to ask. Her brain will work - - she will understand. (P17)

P1, mother of an adolescent girl, felt that it was not necessary to discuss HIV and sex with her daughter because she felt that her daughter learned such things from the Durbar office space.

I don’t think it’s necessary to discuss HIV or condoms. When my daughter was young, she used to come over here to the office. So she has seen everything that she needs to. Yes. The children of sex workers, they are able to understand everything faster than other children. (P1)

Mothers' ability to control children's exposure to the red-light district was also a salient theme that ultimately impacted mothers' ability to communicate about SHC. Some mothers sent their children to a boarding school in hopes of limiting their exposure to life in the red-light district, while other children lived with their extended family in the rural areas. The physical space characterized as a red-light district and at times, by participants, as "Karaab" (bad or spoiled) played a critical role in mothers' decision to keep their children away from their life as a sex worker but also the physical space. The physical space of the red-light district that of narrow streets, close living quarters, and small local bars was often regarded as a bad place to raise a child. Sending their children to a boarding school, hostel, or to the village was a hope to keep their children away from the spoiled space and to provide them with a better life. Additionally, some mothers hoped that that keeping children away from the red-light district would conceal their sex worker identity. As P30, a newer sex worker, describes, the space itself was a reflection on the type of work.

I could never keep my children here. Where would I keep my child here? I do this bad work. IF the children find out the work that I do, it will be a big problem. That's why I keep my children with my mother and father. I work here and send money home. I don't like this work but what am I supposed to do? There is no other work. I am not educated.. I feel a little bad doing the work but what am I supposed to do? There is no other work. (P30)

P30 managed her identity as a mother and was able to protect her sex worker identity by sending her children away to live with her parents in the village. Her construction of sex work as bad work led her to also construct the space as bad. Later in the conversation P30 said that she felt that it was important to discuss HIV with her children.

15...I think its necessary to talk to them. Then they start doing that stuff.. Before Durbar I did not know all of this (HIV related knowledge) but when i came here to this work, since then I have been thinking this (to talk to my children) (P30)

Even though P30 was ashamed about her profession, she credited Durbar with educating her about HIV so that she could eventually discuss it with her children.

P12, a new Durbar member and mother of 18-year-old boy and 20-year-old daughter, said that she had never discussed sexual health with her children because she thought it was bad to talk about such topics. While P12 did think it was necessary to discuss sexual health with her son, she did not think it was necessary to communicate with her daughter. She then further explained that her opinion is shaped by her daughters' residence.

My daughter lives in the village. There is nothing bad there. There are no issues like sex or HIV over there. She looks after the farmland there, cooks and eats that's all. The village is not a bad place like here, so this type of stuff does not happen there. So that's why I have not talked to her about it. (P12)

Physical distance between mothers and their children ultimately created a barrier to sexual health communication. Mothers, especially those who had lower levels of participation with Durbar, felt that children were safer at boarding schools and thus protected from being exposed sex or sexually related information. P20, whose children lived in the village with extended family, initially preferred for her children to live with her extended family in the rural area, but realized that they were not safe there. She recalled a recent rape incident that triggered her aspiration of sending her daughter to a boarding school. In discussing this recent rape incident, P20 discusses worries about her daughter

I have a lot of stress for my daughter. She is getting older. My daughter goes out to play and she does not know anything. What if someone takes snatches her from outside. In the village, a little girl was recently raped. That's why I am scared. They raped and injured her. Then they threw her somewhere. I heard this and I got lots of tension. I want her to get into a boarding school soon so she will not be exposed to that. (P20)

While she thought she was protecting her child from the red-light district by sending them to reside with the extended family, she realized that her daughter was not safe there. Thus, she aspired to send them to boarding school. Later in the conversation she discussed her thoughts about sexual health communication with her daughter. She felt that her daughter would join the sex work profession if she discussed sex with her. However, she felt that it was appropriate to discuss sex, HIV, and sex work with her daughter once she was older.

I think it's important to talk to children about such things (HIV, condoms, sex). See, if I talk to my daughter about this stuff now, my daughter will continue to ask me about this stuff? So what is the point? She will never come here, so she will not need to know about the life here. I will never let her come here. So, why say this type of stuff? If I do say something to her about this, then she will quit her education and come to do this work (sex work) My daughter is young. That is why I am saying this. When she gets older and understands everything, she will ask me "what is going on over there" and then I can tell her don't do this type of work. It works like this and this is what happens. I haven't had the opportunity so what I will say. You need the opportunity. (P20)

P20 conflated sex work with discussion about sexual health with her children. She felt that if she communicated about sex or HIV with her children, they would know about her profession. Particularly for her daughter, she was concerned that she would just sex work, so it was better to refrain from such discussions. Additionally, she thought that since her children never visit her in the red-light district, they would not come to know about her profession. Thus there was no point to discuss such topics with her children.

Such cognitive processes about space and sex work informed her beliefs and ultimate decision to deter from discussing sexual health with her children.

The distance also eliminated opportunities for mothers to discuss sexual health with their children. P5's son now lives in a boarding school. She felt that she never had time to discuss sexual health with her son.

We hardly had time to talk about such things. I always had a stream of customers coming in and hence there was no time for me to sit down with him and spend time talking etc. (P5)

Chapter 6 Summary

Sex worker mothers were asked about their involvement in Durbar, general relationship with their child, and sexual health communication with their child. The level of participation in Durbar played a key role in shaping mothers' normative, behavioral and control beliefs about sexual health communication with their children. Thus, the Theory of Planned Behavior was modified to better understand the impact of the mothers' level of participation on mothers' cognitions about sexual health communication.

Results revealed that the sensitizing processes of Durbar's collectivizing strategies aimed to change normative, behavioral and control beliefs about sex work trigger the mediating cognitive processes of sexual health communication beliefs. Mothers affiliated with Durbar either as peer educators or as Durbar services recipients, mostly felt that sexual health communication with their children was favorable and important. Additionally, they were more likely to feel comfortable toward communicating with their children about sexual health and also more likely to have

communicated with them. In fact, some mothers expressed that they had used Durbar materials, such as HIV/AIDS fact pamphlets. However, on the other hand, mothers who had just started to receive services or were newer peer educators (less than 2-3 years) from Durbar felt that communicating with their children about sexual health was not favorable, not important and would ultimately lead their child to engage in sexual activity. Moreover, these mothers also felt that they were not equipped with the knowledge to communicate with their children about sexual health. Examining the interaction between sensitizing and mediating processes unravels the role of collectivity on individual decision-making. Scholars have found collective processes impact individual behavior, such as condom use (Ghose et al., 2008).

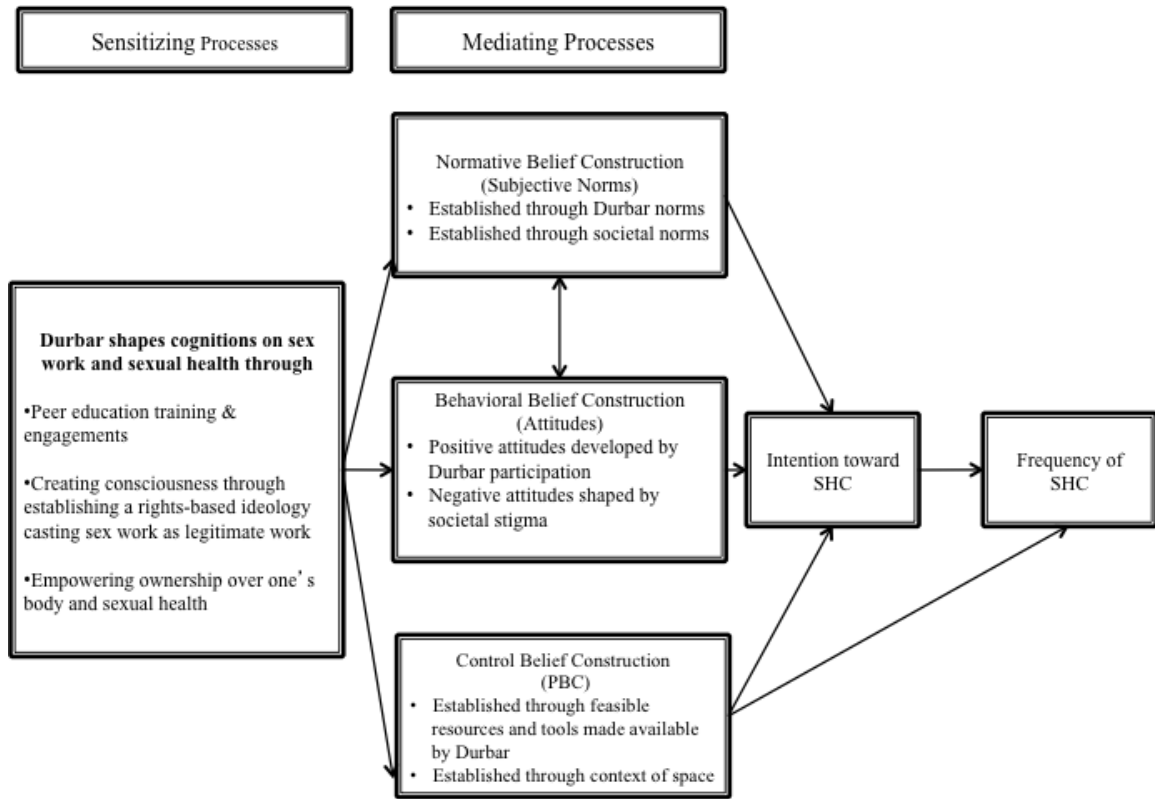


Figure 6.1: Context of Sexual Health Communication

Chapter Seven

Quantitative Results

This chapter presents results from phase 3 of this mixed methods study. Descriptive and frequency statistics were run for the variables. Next, paired sample t-tests were conducted for the variables to assess the difference within participants from pretest to posttest. Finally, bivariate associations were conducted to better understand the relationship between FSHCI, mediating variables, and outcome variables.

Sample Characteristics

Demographic Characteristics. Demographic characteristics are presented in Table 7.1. The sample consisted of 41 women. The average age of the participants was 36 years old. The average age of starting sex work was 20. Participants had been connected to Durbar (either through services or employment) for an average of 11 years, with a range of 1 year to 20 years. About a quarter of the women were peer educators with Durbar. About one-third (36.59%) of the women were unmarried and living with a babu (long-term lover) or a boyfriend, about a quarter (24.39%) were separated or deserted, and about 14% were currently married. 17% of the women lived alone and about half lived with a babu or a husband. A little more than half of the women never went to school and about 30% received an education up to eighth grade. Most women had two or more children, with a little less than half with two children and about 30% with three children. Children's characteristics are presented in Table 7.2. Women had a total of 88 children, with an average age of 13. Most of the children were biological. More than half of the children were girls. Most children resided at home with their mothers. Most children

were enrolled in school, with about one-third in primary school and about half in secondary school. While 41 women participated in the intervention, 37 were followed up at the one-month post-assessment. Thus, due to inability to reassess participants and missing data, sample sizes vary for the analysis.

Table 7.1: Parent Demographics

Variable	N	Mean or %
Current Age	41	36.90
Age of start of sex work	40	20.28
Years at Durbar	41	11.90
Marital status		
Unmarried (living alone)	1	2.44
Unmarried (living with babu/boyfriend)	15	36.59
Currently married	6	14.63
Separated/deserted	10	24.39
Divorced	3	7.32
Widowed	6	14.63
Education		
Never been to school	21	51.22
Up to 8 th	12	29.28
9 th to 12 th grade	3	7.32
Some college	5	12.20
Who else lives with you?		
Live alone	7	17.50
Babu	13	32.50
Husband	9	22.50
Other sex workers	3	7.50
Other sex workers children	1	2.50
Madam	3	7.50
Other	2	5.00
Big Sister	2	5.00
Peer Educator		
No	31	75.61
Yes	10	24.39
Number of children		
One	10	24.39
Two	17	41.46
Three	12	29.27
Four	2	4.88

Table 7.2: Child Demographic Characteristics

Variable	N	Mean/%
Age	88	13.82
Biological child		20.28
No	4	4.55
Yes	84	95.45
Gender		
Girl	50	56.82
Boy	38	43.18
Child residence (N=84)		
Home	56	66.67
Hostel/boarding		
School	5	5.95
Village	5	5.95
Other	18	21.43
Child Grade (N=68)		
0	7	10.29
1-5	23	33.82
6-8	19	27.94
9-12	14	20.59
Some college	5	7.35

Study Aim – Test of Main Hypotheses

This study tested the following hypotheses:

H₁: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report higher levels of favorable subjective norms, attitude, perceived control and intentions about communicating with their children about sexual health.

H₂: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report more frequent discussions about sexual health with their children.

H₃: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report more comfort in communicating with their children about sexual health.

H₄: The outcome of frequency of sexual health communication will be mediated by the subjective norms, attitudes, and perceived behavioral control.

Intervention Effects on Mediating Variables

H₁: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report higher levels of favorable subjective norms, attitudes perceived behavioral control and intentions about communicating with their children about sexual health.

The Theory of Planned Behavior scale was created in order to assess participants' attitudes, subjective norms, perceived behavioral control, and intentions regarding sexual health communication with their child. Tables 7.3 and 7.4 present descriptive statistics and results for the paired sample t-test. We found partial support for Hypothesis 1.

Subjective Norms. The subjective norms scale consisted of six items. The items were summed, with a range of 0-24. The Cronbach's alpha coefficient was .79 for the pre-test and .67 for the post-test (N=31). Although mean score difference was approaching the hypothesized direction, results indicate that there was not a significant difference in participants' subjective norms toward sexual health communication from pre-test mean score of 8.29 to a post-test score of 9.75 ($p = .80$) (see Table 7.3).

Table 7.3: FSHCI Effects on Mediating Variables

Scale/# of items	Internal Reliability	Pre-test Mean Score	Post-test Mean Score	p Value
Subjective Norms (6)	.79	12.04	12.56	.80
Attitudes (4)	.77	8.29	9.75	.07
Perceived Behavioral Control (5)	.74	13.03	13.97	.52
Intentions (1)		2.55	2.81	.35

Attitudes. The attitude scale consisted of four items. The items were summed, with a range of 0-16. The Cronbach's alpha coefficient was .77 for the pre-test. Results indicate that there was a significant difference in participants' attitude toward sexual

health communication from pre-test mean score of 8.29 to a post-test score of 9.75 ($p = .07$)

Perceived Behavioral Control. Perceived behavioral control scale consisted of five items. The Cronbach's alpha coefficient was .74 for the pre-test and .80 for the post-test. Although the change in mean score was approaching the hypothesized direction, results indicate that there was not a significant difference in participants' perceived behavioral control toward sexual health communication from pre-test mean score of 13.03 and post-test mean score of 13.97 ($p = .52$).

Intentions. Intention was measured with one item. Although the change in mean score was approaching the hypothesized direction, the mean for the pre-test was 2.55 and 2.81 at post-test. Results indicate that there was not a significant difference in participants' intention toward sexual health communication from pre-test mean score of 2.55 and post-test mean score of 2.81 ($p = .35$).

Frequency of sexual health communication

H₂: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report more frequent discussions about sexual health with their children.

Frequency of mother child communication was measured by mothers' report of how many times they had talked to their child about sex education topics (SED) and sexual risk reduction topics (SRR). At post assessment (post 1 month), parents were asked how many times they had talked to their child about the 12 topics in the past one month. The responses were then recoded into 0, *never talked to the child*; 1, *talked to child one or*

more times. The two subscales (SED and SRR) were created by summing six items for SED and six items for SRR, respectively. Thus each subscale has a range of 0-6. Tables 7.4 and 7.5 present descriptive statistics on the frequency of sexual health communication for SED and SRR. The alpha coefficient for the sex education topics was .84 for the pre-test and for the sexual risk reduction topics it was .85 for the pre-test, which was similar to previous studies (Forehand et al., 2007) (see Table 7.6).

Table 7.4: Frequency of Sex Education Communication

Item	Pre-test %	Post-test %
1. What sex is		
Never	76.92	67.57
Once or more	23.08	32.43
2. Mature enough to have sex		
Never	79.49	62.16
Once or more	20.51	37.84
3. How body changes		
Never	61.54	51.35
Once or more	38.46	48.65
4. Sexual relations between boy and girl		
Never	74.36	62.16
Once or more	25.64	37.84
5. Menstruation		
Never	53.85	45.95
Once or more	46.15	54.05
6. How babies are made		
Never	89.74	72.97
Once or more	10.26	27.03

Table 7.5: Frequency of Sexual Risk Reduction Communication

Item	Pre-test %	Post-test %
7. Peer pressure		
Never	61.54	59.46
Once or more	38.46	40.54
8. Condoms		
Never	76.92	54.05
Once or more	23.08	45.95
9. Postponing sex		
Never	82.05	67.57
Once or more	17.95	32.43
10. STI		
Never	71.79	45.95
Once or more	28.21	54.05
11. HIV/AIDS		
Never	69.23	51.35
Once or more	30.77	48.65
12. Family Planning		
Never	71.79	59.46
Once or more	28.21	40.54

Table 7.6 presents the paired sample t-test analysis for the SED and SRR subscales. We found partial support for Hypothesis 2. Our results indicate that there was a statistically significant difference from pre-test the mean score of 1.67 the post-test mean score of 2.62 ($p = .08$) for sexual risk reduction topics, however no statistically significant difference from pre-test to post-test for sex education topics ($N=37$).

Table 7.6: FSHCI Effects on Frequency of Sexual Health Communication

Scale	Internal Reliability	Pre-test Mean Score	Post-test Mean Score	p Value
Sex Education	.84	1.64	2.38	.17
Sexual Risk Reduction	.85	1.67	2.62	.08

A deeper analysis into the items on each scale revealed significant difference of mean scores over time for some items (see Table 7.7). The mean for the sexual education item “how to make babies” significantly changed from .10 at pre-test to .27 at post-test ($p = .08$). The mean for the sexual risk reduction item “condoms” significantly changed from .23 at pre-test to .45 at post-test ($p = .04$). The mean score for the sexual risk reduction item “STI” significantly changed from .28 at pre-test to .54 at post-test. ($p = .05$) All three of these significant results indicate that participants reported significantly more conversations about how to make babies, condoms, and STI from over time.

Table 7.7: FSHCI Effects on Frequency of Sexual Health Communication Items

Scale	Pre-test Mean Score	Post-test Mean Score	p Value
How to make babies	.10	.27	.08
Condoms	.23	.45	.04
STI	.28	.54	.05

Scores range from 0 – 1; Only significant values reported

Comfort of Sexual Health Communication

H₃: Compared to the pre-test time point, at post-test participants enrolled in FSHCI will report more comfort in communicating with their children about sexual health.

Each item (or question) of comfort of sexual health communication was measured on a 0-3 scale, with 0 being the most uncomfortable and 3 being the most comfortable. We found support for our Hypothesis 3. Table 7.8 presents the paired sample t-test for comfort of sexual health communication scale. Results reveal a significant difference in pre-test mean score of 10.59 to post-test mean score 15.4 ($p = .03$).

Table 7.8: FSHCI Effects on Comfort of Sexual Health Communication

Scale	Internal Reliability	Pre-test Mean Score	Post-test Mean Score	p Value
Comfort	.93	10.59	15.42	.03

Scores range from 0 – 30; Higher mean score means comfort

While mean scores improved for all of the items, only half were statistically significant from pre-test to post-test (see Table 7.9). The mean score for comfort about communicating about HIV/AIDS significantly changed from 1.33 at pre-test to 2.00 at post-test ($p = .02$) ($N=37$).

Table 7.9: FSHCI Effects on Comfort of Sexual Health Items

Items	Pre-test Mean Score	Post-test Mean Score	p Value
HIV/AIDS	1.33	2.00	.02
Having Sex	.718	1.32	.02
STI	1.03	1.81	.01
How babies are made	.795	1.35	.06
Condoms	0.82	1.43	.03
Sex Work	0.71	1.34	.04

Scores range from 0-3; Only significant items reported

The mean score for comfort about communicating about having sex significantly changed from .718 at pre-test to 1.32 at post-test ($p = .02$). The mean score for comfort on communicating about STI significantly changed from 1.03 to 1.81 ($p = .01$). The mean score for comfort on communicating about how babies are made significantly changed

from .795 at pre-test to 1.53 at post-test ($p = .06$). The mean score for comfort on communicating about condoms significantly changed from .82 at pre-test to 1.43 at post-test ($p = .03$). The mean score for comfort on communicating about sex work significantly changed from .71 at pre-test to 1.34 to post-test ($p = .04$).

Bivariate Associations

H₄: The outcome of frequency of sexual health communication will be mediated by the subjective norms, attitudes, and perceived behavioral control.

We conducted a series of bivariate regressions to better understand the paths between mediating variables, comfort of sexual health communication, and frequency of sexual health communication. We found partial support for Hypothesis 4.

Relationship between mediating variables on frequency of sexual health communication. Results indicate that while the correlation between subjective norms and frequency of sex education communication was in the hypothesized direction, the relationship was not statistically significant (see Table 7.10). However, the correlation between attitude and frequency of sex education (SED) was statistically significant. Whereas the correlation between attitude and frequency of sexual risk reduction communication (SRR) was not statistically significant, however the association was in the hypothesized direction.

Table 7.10: Bivariate Association between Frequency of Sexual Health Communication and Mediating Variables

Mediating Variables	SED Post-test		SRR Post-test	
	<i>r</i>	p Value	<i>r</i>	p Value
Subjective Norms	.03	.62	-.001	.98
Attitudes	.17	.05	.15	.12
Perceived Behavioral Control	.13	.09	.16	.09

The correlation between perceived behavioral control and the frequency of sex education communication as well as the frequency of sexual risk reduction communication were statistically significant.

Relationship between mediating variables and comfort of sexual health

communication. Results indicate that all of the mediating variables, subjective norms, attitudes, and perceived behavioral control, were all correlated with comfort of sexual health communication (see Table 7.11)

Table 7.11: Bivariate Associations between Mediating Variables and Comfort of Sexual Health Communication

Mediating Variables	Post-test	
	<i>r</i>	p Value
Norms	.69	.01
Attitudes	1.1	.0005
Perceived Behavioral Control	1.26	.0001

Relationship between Comfort of Communication and Frequency of Sexual Health Communication. Results indicate that the comfort of sexual health communication is correlated both with the frequency of sexual education communication and the frequency of sexual risk reduction communication (See Table 7.12).

Table 7.12: Bivariate Association between Comfort of Sexual Health Communication and Frequency of Sex Health Communication

Variable	SED Post-test		SRR Post-test	
	<i>r</i>	p Value	<i>r</i>	p Value
Comfort of sexual health communication	.23	<.0001	.17	.0004

Summary of Results

Figure 7.1 provides a detailed depiction of the intervention effects as well as the mediating relationships. We found partial support for our hypotheses. With regard to Hypothesis 1, results indicate that FSHCI was successful in changing participants' attitudes about sexual health from pre-test to post-test, however failed to produce significant changes in scores from pre-test to post-test on participants' subjective norms, perceived behavioral control, and intention to communicate about sexual health. With regard to Hypothesis 2, we found a significant difference in mean scores from pre-test to post-test only for the frequency of sexual risk reduction and not for the frequency of sex education. A further analysis revealed that participants reported more discussion about how to make babies (SED), condoms (SRR), and STI (SRR) from pre-test to post-test. With regard to Hypothesis 3, we found that participants' comfort of sexual health communication levels significantly changed from pre-test to post-test. A deeper analysis

indicates that participants reported feeling more comfort in discussing HIV/AIDS, sex, STI, babies, condoms, and sex work from pre-test to post test.

To further investigate the relationships between mediating variables, comfort of sexual health communication, and frequency of sexual health communication, we conducted a series of bivariate analyses. We found partial support of Hypothesis 4. The bivariate associations between mediating variables and frequency of sexual health communicate indicate that attitudes and the frequency of sex education is significantly correlated. In addition to attitudes, perceived behavioral control and the frequency of sex education as well as the frequency of sexual risk reduction were significantly correlated. All of the mediating variables were significantly associated with the comfort of sexual health communication. Finally, the comfort of sexual health communication was significantly associated with the frequency of both sex education and sexual risk reduction.

Chapter Eight

FSHCI: Development, Implementation and Feasibility

Summary

This chapter discusses the development, implementation, and feasibility of FSHCI. We conducted in depth qualitative interviews and focus groups with sex worker mothers and Durbar community stakeholders. Using data from the qualitative phase, we created and implemented a theory-based family-based sexual health communication intervention. Interviews and focus groups were also held with the intervention facilitators and the Durbar Community Collaborative Board (DCCB) to better understand their perceptions of implementing FSHCI. This data triangulation led to a better understanding sex worker mothers' needs and also helped to garner the interest levels of the community stakeholders and Durbar staff. We also conducted post-intervention qualitative process interviews with participants.

Development of FSHCI procedures and curriculum

Interest. Sex worker mothers and community stakeholders both expressed the need for more family centered care. While Durbar has been the pioneer for sex workers on individual and community levels, the community felt that parent-child relationship needs were not addressed. Many mothers voiced concern for their children's education, their health, and general well-being. Specifically for boys, mothers worried about their educational attainment, dropping out of school and substance use. Mothers from two out of the four red light districts we worked with felt that adolescent substance use was a major issue that was not being addressed. For girls, mothers worried about the prospects

of their marriage, saving enough money for their marriage, promiscuity before marriage, and sexual violence. One mother discussed the need for such an intervention

This type of workshop would be very helpful to me. It would apply to someone like me because my daughter is a teenager and she does not live with me. She lives in a rural place. I feel like she should know about sexual things these things. She is scared to go out at night. These days you never know what can happen. There is so much stuff going on and girls need to be aware. They need to know about how diseases are transmitted through sex. But I am never sure how to bring it up, so I think this workshop is needed. (VN810045)

Almost all mothers thought the FSHCI would be extremely helpful in supporting them through such challenges and intended to participate if it was offered.

Pilot FSHCI. Given the need assessed through in-depth interviews and focus groups with FSW mothers, DCCB, and community stakeholders, we conducted a small pilot test of the FSHCI with 8 mothers and their children through a multifamily group intervention. Following the CHAMP intervention model, mothers and children participated in the intervention together and then separately participated in a series of breakout sessions (Bhana et al., 2010). The intervention spanned one day for 5 hours, with a 30-minute break for lunch and was held at the Durbar children's residential home in Bariupour. This pilot contained similar sessions to the actual FSHCI (described in Chapter 5), with the exception of the sex work disclosure session. The aim of this initial pilot was to better assess the needs of the families and understand their interest in the FSHCI. Additionally, we wanted to examine how the multifamily group would hold out in this context.

While the intervention was successful in engaging mothers and children, we felt that it was necessary to take a step back for the larger pilot study. Process interviews with mothers revealed that they felt overwhelmed with the amount of information being

conveyed and felt that they needed a separate intervention focusing more on the mother-child relationship and communication aspect. Thus while we found families were interested in the content and the process, mothers wanted to participate in an intervention solely geared for them.

Intervention logistics. We wanted to make the intervention as accessible as possible for the participants. Thus we put careful consideration into the time, intervention delivery format and location when creating the intervention. We utilized existing community-based organization networks and resources to promote the intervention. Durbar has partnered with a number of academic partners to develop and implement interventions, thus they were familiar with the process.

Time. FSHCI was scheduled in the late afternoon after critically thinking about participants' schedules. Most sex worker mothers worked from 8pm to midnight and in some instances all night. In addition to these night hours, some mothers also worked from 10am to 1pm at Durbar. Initially it was decided that FSHCI would be held once a week for one hour for four weeks, however after conducting qualitative interventions and focus groups, it was decided that as a pilot study it was important to make it accessible for as many sex worker mothers as possible. The pilot feedback also revealed that mothers would not be available for 5 hours at a time. Additionally, holding novel intervention over the span of one month would deter sex worker mothers from attending. Thus the study personnel decided that the intervention would be held from 2:30 to 5:30 (see Chapter 5 for time breakdown).

Intervention Delivery Form. Given the collective nature of Durbar, it was decided from early on that a group format would be the best way to deliver the intervention. Initially The DCCB decided that the intervention would be delivered through a multifamily group format to mothers and their children, with group and breakout sections for each group. We conducted a small pilot study with eight mothers and their children to assess the feasibility of a FSHCI in this context (see discussion about interest). While the multifamily group model was successful in opening communication lines between mothers and their children, there were a number of feasibility issues that concerned the DCCB. The feedback from mothers and DCCB highlighted that it would be difficult for mothers and their children to attend the intervention at the same time, as some mothers did not live with their children but wanted to participate in the intervention. Additionally, mothers wanted to participate in the intervention before their children were exposed to the information. Similarly, the DCCB felt that mothers needed to be mentally prepared to understand the concept of mother-child communication before their children were exposed to the intervention. Thus it was decided that for the larger pilot study (this study) that only mothers would participate in the intervention.

Location of the intervention. The small pilot study helped us to better understand the best location for the intervention. The initial pilot study was held at the Durbar children's residential hostel in Baruipur, which is about one hour outside of Kolkata. We thought that since mothers visit their children at the residential center every Sunday that it would be feasible and sustainable to hold the intervention there. All eight mothers who were recruited for the pilot intervention attended, despite the monsoon. While mothers

and study personnel felt that the residential home was a good space to hold FSHCI, it was not feasible and sustainable for mothers to attend every week. Participants noted that they wanted to attend the intervention that was closer to their residence, rather than commuting a far distance. The distance would ultimately be a barrier to their attendance.

Intervention Curriculum Development. The interviews and focus groups with sex worker mothers, CCB and community stakeholders helped us to get a better understanding of necessary ingredients for the intervention curriculum. While parts of the intervention were based on PMP and CHAMP interventions, much of the intervention was created to fit the context of the sex worker community.

Particularly from PMP (Dittus, Miller, Kotchick, & Forehand, 2004; Forehand et al., 2007; Long et al., 2004), we borrowed the following elements: a) theoretically grounded intervention based on social learning theory (Bandura, 1975) and the theory of reasoned action (Fishbein & Ajzen, 1975) that aimed to change or add to parents beliefs about sexual health communication and provide parents with the appropriate knowledge about sexual health to increase their self-efficacy to communicate with their children; b) brief intervention format.

The theoretical base of PMP and the constructs of the theory of planned behavior, made an important contribution to the development of FSHCI. In the elicitation interviews and focus groups, mothers, particularly those that were minimally involved with Durbar, voiced that it was difficult to communicate about sexual health because they did not have enough skills (i.e. they did not know how to initiate the discussion) to effectively communicate about sexual health. Additionally, some mothers felt that

another barrier was the physical distance between their children, thus they never communicated about the SH. On the other hand, mothers whose children lived with them in the red-light district were also reluctant to communicate because they felt that their children already had enough information about sexual health. Thus to change control beliefs, we utilized didactic presentations that helped parents to learn techniques and skills to overcome the barriers of SHC with their children. Such activities also helped mothers to build confidence in their ability to communicate. Additionally, mothers who had communicated with their children about SH were given the opportunity to discuss “what worked for them”. A few of the mothers that had communicated about sexual health prior to the intervention utilized Durbar materials to initiate conversations. Such information exchange about the availability and utility of Durbar materials also had potential to impact participants’ self-efficacy.

Mothers voiced that the disadvantages of SHC with their children were that children would find out about their profession and that such communication would promote sexual activity. The advantages of SHC included that it would help promote their children’s sexual health safety and help to create and maintain a friendly relationship with their children. We wanted to change the mothers’ beliefs about the importance of discussing sexual health but also sex work with their children. Thus to address these behavioral beliefs, we held a series of discussions around the outcomes of communicating with their children about sexual health. Particularly, to brainstorm, we listed the positive outcomes and negative outcomes of SHC. We also discussed mothers’ adolescents. Mothers had an opportunity to discuss how their own mothers discussed (or did not discuss) menstruation and sex. The puberty game provided mothers with an

opportunity to discuss sexual health in a more biological way, highlighting the importance of health-based discussions that would ultimately keep children safe. Additionally, based on mothers' concern about sex work disclosure and its impact on SHC, we created a session to discuss attitudes toward sex work. We focused on the importance of sex work disclosure and techniques to discuss it in an effective way.

Mothers voiced that important referents in their lives were other sex workers in their community, Durbar, and their family. To address normative beliefs, facilitators addressed Durbar and societal norms about sexual health and sex workers rights. These were then tied into the establishing norms about sexual health communication. Facilitators highlighted that it was Durbar's norms to keep sex workers and their families safe. Thus as a Durbar member, it was their duty to promote children's sexual health.

Particularly from CHAMP, we adapted the following components: a) community collaborative design that was based on the premise "by and for the community" b) games. The community collaborative and empowerment components that are integral to CHAMP have also been critical components of the Sonagachi Project. We established a community board as the first step. The DCCB was involved in every aspect of FSHCI conceptualization, development, implementation, and assessment. Games were a key component FSHCI, as they helped to break up the conversations, were instrumental in providing examples and helped mothers to think in different ways that were often outside of their comfort zone.

FSHCI specific components. While there were many components that made FSHCI unique, below are the most salient components that make it unique. We integrated Durbar's norms about sex work and sexual health in the intervention. Specifically there

were discussions about sex workers rights, the right to sexual health, and the importance of sexual health education.

We created a session on sex work disclosure that ended up stirring many in-depth discussions amongst the participants. The sex work disclosure session went over time in all of the fields, as participants felt that the topic was essential and under-discussed.

While both PMP and CHAMP spanned multiple days, we decided that it was first important to gather the interest and acceptability from the participants without taking too much of their time. Thus, it was decided that the intervention would span one session for four hours in one day. Due to sex workers' limited literacy levels, games, role-plays, and other activities were decided as the best mechanisms to get the information across. In a focus group about curriculum development, one of the facilitators noted:

The general sex workers don't have much education. See, I don't have much education either, but after coming here I have learned a little more. Many sex workers don't know how to read and write. They don't have enough education to educate their children. Many don't know how and many just don't have time to learn. That's why it's important to engage the mothers on this topic. They need to know how important mother child relations are. There should be games and activities that should be fun but also informative. (FF1)

Another unique aspect of FSHCI was that the DCCB decided that it was not essential to focus on HIV. In many of our focus groups, one of the most salient themes was the intervention should not just be about HIV. The phrase "it's just not about HIV" quickly became a trend in our meetings. Further discussions around such sentiments revealed that most of the interventions at Durbar for the community were saturated by the topic of HIV. The DCCB believed the mothers would not engage if the messages in the intervention were solely HIV focused. Thus it was important for the DCCB to keep the intervention communication focused, rather than HIV-communication focused. While we

had a HIV session that focused on educating mothers about HIV transmission through the HIV game, it was not successful in half of the fields, as the sex work disclosure session often went over the allotted time and participants did not show much interests for HIV-knowledge related discussions.

The intervention was also made to fit a wide age range of children and both genders. The DCCB felt that it was important to get the word out about the intervention, thus mothers with children ages 10-21 were eligible to participate in FSHCI. Both PMP and CHAMP were geared toward younger adolescents; however we felt that it was not feasible to only recruit mothers who had younger adolescents. We felt that recruiting mothers who had children from a wide age range would help the group dynamics and also increase the level of knowledge transferred.

Additionally, DCCB decided early on that the intervention would only be geared toward the mothers, rather than the fathers. Most of the sex workers in the community were single mothers. In some instances Babu's (long term partners) of sex workers lived with the families. It was apparent in the individual interviews and focus groups that the mothers did not want Babu's to attend the intervention. The DCCB also felt that it was important for mothers to have a safe space to discuss their children. Thus, it was decided that the intervention would only be geared toward the mothers.

Intervention Feasibility

Based on Bowen and colleagues recommendations on evaluating feasibility studies (Bowen et al., 2010), we decided to evaluate feasibility on a) intervention implementation; b) intervention acceptability c) intervention integration.

Intervention Implementation. FSHCI was mostly implemented as planned with ease and efficiency. The facilitators felt comfortable implementing the intervention, in that they felt like experts in the curriculum, were able to answer participants' questions, and were able to handle issues related to participant dynamics. There were a few challenges that we encountered in the implementation.

Execution and implementation ease, quality, and efficiency. The first field site of implementation faced a few challenges. Firstly, there were some logistically difficulties that inhibited the assessments to be implemented 2-3 days beforehand. Thus, the interviewers had administered the pre-test assessments the morning of the intervention. This was a lengthy process that delayed the start of the intervention for a few hours. Mothers were asked to go home if they were waiting and were told that they would be called when the intervention started. While this was the most efficient way to deal with the time constraints, we quickly learned that in order for the intervention to start on time in other sites we would have to conduct the pre-test assessments 2-3 days before the intervention. Secondly, a few mothers who had to leave during session 3 to get back to work. Again, this was due to the intervention starting late.

As discussed earlier, the HIV session was not implemented in the last two fields because of time restrictions. While the advantage was that mothers were able to discuss the issues related to sex work disclosure to their children that were extremely challenging and under discussed, it prevented the standardization of the intervention across all sites. Thus, we decided to drop the analysis on the HIV knowledge variables. Along with this observation about the HIV sessions, facilitators and some participants felt that the HIV

section was not necessary because of the HIV knowledge they already held. Thus they felt that the session was redundant.

The third site of implementation also faced some scheduling challenges. The intervention was scheduled at the same time participants' were schedule to take water from the well. Mothers were able to participate in the intervention for two hours. We thought it would be best to schedule the additional 1.5 hours of the intervention the next day. Six out of the eight mothers returned the next day for the remaining sessions.

Resources needed for implementation. The intervention was developed with the limited resources in mind. We scheduled facilitator meetings during the work hours so that they did not have to spend non-working hours preparing or implementing the intervention. While facilitators voiced that the preparation and implementation was at time consuming, especially during the months of the International AIDS Conference Hub preparation, they felt that the intervention was extremely important and relevant for their current Durbar work. DCCB voiced, however, that the larger roll out of FSHCI should hire a part-time paid project coordinator.

Intervention Acceptability. Intervention acceptability was assessed through facilitators and participants' satisfaction, perceived appropriateness and expressed intention of continued use.

Satisfaction. Satisfaction was assessed through post-intervention process interviews with both the participants and the facilitators. Participants were very satisfied with both the FSHCI content and the facilitators. Particularly, they noted that they

enjoyed three key FHSCI concepts a) games; b) safe space to discuss their needs as mothers; c) discussion about topics that are rarely discussed.

Most participants were very satisfied with the games and many suggested that more games be incorporated into future interventions. They noted that they liked the integration of games and discussions. The game of most interest was the puberty drawing game. One participant said “I liked the discussions that we had after the puberty drawing game. It was very helpful”. Another participant, R1, noted “I liked the body map a lot. I never realized that so much development happened. It helped me to learn all of the changes that happen during that time (adolescence). I think I will use the body map with my child”.

Some mothers noted the difference between their attitude and comfort levels of sexual health communication before and after the intervention. Particularly one mother expressed

I have been thinking about such communication more since the workshop. I want to talk to my children about it. My son did ask me some question about sexual stuff but I did not feel comfortable discussing condoms because I feel that he is too young. But I did try to answer his questions about advertisements he sees on TV about sexual health. The workshop has helped and we need more! (R3)

The group format also helped to create a collective environment to discuss issues mothers encountered with their children as well as thoughts and experienced with SHC. Particularly, R2 noted that, “I did not realize all mothers go through these issues. The group format was very helpful. I used to be embarrassed to discuss sexual stuff, but this forum helped me to be open”

Interestingly, some participants expressed their satisfaction with the pre-assessment survey as well. The assessments were often viewed as part of the intervention.

One participant noted that it helped her to become more aware of sexual health communication.

Also, the survey was very helpful because once I answered the questions I realized that there were so many things that I was afraid to talk to my children about. But the thing is that its good to be friends with your kids and speak to them freely about these issues. It helped me to think about these issues. I feel like it introduced some topics to my brain. If you do the workshop every month, I will be learning more and I will keep remembering the topics. We should make our children aware – this is good. (VN81044)

Some interviewers felt that the pre-test assessments were as effective in getting the point across on sexual health communication as the intervention. Particularly, one interviewer expressed

I could not even complete the assessment and my participant was talking to me about how important it is to have these conversations. She expressed that she wanted to talk to her children about these issues and also expressed that these issues are never discussed within the community. (Int1)

FSHCI facilitators were also satisfied, but felt that the intervention should be longer. One noted IF1, “While I feel like we did a good job and got mothers to start thinking about these issues, I think the workshop (intervention) should be longer over at least 4 or 5 days. That is how we will be able to make a difference”. Additionally, they felt that children should also attend the intervention in future trials. Specifically IF2 noted “we need to make sure we include children next time. I don’t know if mothers will just talk instantly after our intervention. I think it’s better if children come with their mothers and that way they can practice what they learn. They can role play too”.

Perceived appropriateness. Participants felt that FSHCI addressed and filled gaps in their knowledge about sexual health and also healthy parent-child relationships.

Particularly, participants felt that the content was appropriate given the challenges they

faced with their adolescent children and felt that they learned specific knowledge and skills about initiating or increasing SHC with their children. VN810050, mother of a 15-year-old girl, felt that the intervention was important.

I had never thought about having frank discussions with the daughter about condoms. The workshop has definitely helped me to think through things and shaped my thought. One has to convey messages as friends – we should be friend with our children so that they understand how to keep themselves safe. I learned all of this from the workshop. (VN810050)

Participants identified ways in which FSHCI could be adapted to be more applicable. They felt that future interventions should cover issues related to adolescent substance use, have more sessions for a longer span of time and that children should also attend the intervention. While adolescent substance use was covered in the intervention, some mothers from two fields felt that it should be given more time. VN810052, who had 2 young adolescent daughters, noted

We have to talk about addiction, smoking drinking and the bad company it invites, we have to have these conversations as a friend and as a parent with our children, especially with the boys since they have their friends from the red light areas, and hence we must try to be careful, for girls there are special concerns whether or not she is being safe. We may have to indirectly say things like you know that there are these things these days. We should learn this from the workshop. (VN810052)

Unfortunately, field specific issues were not taken into account when we developed the intervention. Two out of the four fields faced adolescent substance use issues, thus wanted to learn of particular tactics to intervene with their children.

Many mothers felt that the one-day intervention was too short. They wanted more sessions that lasted longer, such as over one to two months. Specifically, one participant noted “we should have this workshop monthly. It was nice to get the mothers together

and it should happen more often. This is the only way that we will learn the information and also the workshop will help us to remember it over time”.

Finally, many mothers also felt that it would be appropriate for children to attend future interventions. They felt that children should also be exposed to the concept of sexual health communication and that they should also learn skills to discuss such issues with their mothers. Some mothers felt that such processes would be helpful for both the mothers and children, and the intervention would be an appropriate space for families to practice skills and techniques learned in the intervention. VN00810051 spoke to both the acceptability and the integration into Durbar. When asked about changes that should be made to the intervention, she noted

I think children should be able to come to the workshop. My children are already benefiting from the school run by Durbar, if I have to spare an hour a week for my children for their welfare, I will definitely do that. They can come with me. That will be better for both of us. They will learn a lot as well, just as I did. (VN00810051)

Intention of continued use. As discussed above, most mothers felt that intervention was too short. They expressed interested in continued use if the intervention was offered again. Facilitators also felt that too much information was covered during the intervention and that offering it over the span of a month would help to distribute the content.

Intervention Integration. When we developed the intervention, we wanted the intervention to be integrated into Durbar’s service delivery system. Thus, we conducted the intervention at the Durbar offices or clinics during hours other programs are usually

held, ensured facilitators were familiar Durbar faces that would be accessible after the intervention was over, and promoted Durbar's attitudes and norms about sex work. An example of the DCCB and the facilitators interest to integrate FSHCI into Durbar and to its promote sustainability occurred before the third field implementation. One of the facilitators approached me about training a third facilitator. She felt that it was appropriate to train another facilitator who was interested in the intervention to sustain it over time.

Chapter Nine

Discussion and Conclusion

Summary of Results

There have been recent calls to develop and test FSHCI in the Indian context (Guilamo-Ramos et al., 2012; Jejeebhoy & Santhya, 2011; Soletti et al., 2009). This is the first study to our knowledge that conducted an in depth analysis about the context of SHC between sex worker mothers and their children and utilized findings to develop, implement and test the preliminary efficacy of a FSHCI for mothers who are sex workers.

Qualitative results revealed that participation in Durbar's collectivizing strategies act as sensitizing processes that trigger mothers' normative, behavioral, and control beliefs about sexual health communication. Hypotheses testing revealed that while participants' frequency of communication about sexual risk reduction topics significantly changed from baseline to post-test, the frequency about sexual health topics did not. Additionally, participants reported feeling more comfortable about discussing HIV/AIDS, STI, sex, condoms, and sex work from baseline to post-test. Participants' attitudes about sexual health communication significantly changed over time. These results are particularly exciting given that this was a pilot study with a small sample size in which the intervention was implemented in one day. Moreover, together these data provide evidence that a FSHCI was feasible in the sex worker community.

The Landscape of Sexual Health Communication

Durbar's collectivizing processes stimulates mothers' cognitions about sexual health communication with their children. These collectivizing processes include mothers' engagement in peer education training and sustained role as a peer educator,

establishment of consciousness for a rights-based ideology casting sex work as legitimate work, and utilization of empowerment strategies to advocate for ownership over one's body and sexual health. Such collectivizing processes were pervasive throughout participants' narratives about their normative, behavioral, and control beliefs about sexual health communication with their children.

While some of the elements of sexual health communication were similar to the findings in recent studies in India (Guilamo-Ramos et al., 2012; Jejeebhoy & Santhya, 2010; Soletti et al., 2009), others were specific to the sex worker community in Kolkata. The attitudes toward sexual health communication and the actual communication itself depended on the sexual health topic (e.g. sex, condoms, HIV/STI etc.). Similar to previous studies, we found that some mothers were reluctant to discuss sexual health, most notably sex. Salient beliefs about sexual health communication included that children already held the knowledge and felt that children would be more likely to engage in sexual activity upon such discussions. Unique to this population, however were the high comfort levels towards discussions about HIV/AIDS and had communicated about it already, particularly amongst participants who had been involved with Durbar for a long time. Given the exposure to Durbar's HIV/AIDS prevention programs, participants valued the importance of such discussions. As such, we also found that most mothers, independent of level of participation with Durbar, held basic HIV transmission knowledge, while other studies have found low levels of HIV knowledge with other Indian populations (Guilamo-Ramos et al., 2012; Jejeebhoy & Santhya, 2010; Soletti et al., 2009).

Gender also played an important role in either facilitating or inhibiting sexual health communication. As opposed to other studies with Indian parents (Guilamo-Ramos et al., 2012) that found mothers preferred to discuss sexual health after marriage, we found that participants, particularly those who had high levels of Durbar participation, used a daughter's marriage as motivation to discuss HIV/AIDS and condoms prior to the marriage. They wanted daughters to protect themselves from the disease by using condoms with their husband in the event their husband was having sex outside of the marriage.

Communication also depended on whether or not participants' disclosed about sex work to their children. In this context, sex work and sexual health were conceptualized as being related. Irrespective of Durbar participation levels, mothers who had not disclosed about sex work were reluctant to discuss sexual health in fear of disclosure of their work. Thus while sex work acted as a facilitator to communication for some participants, it acted as a barrier to communication for others.

FSHCI in the Sex Work Context

Study results indicate partial support of our hypotheses. Partial support of the hypotheses is intriguing given the sample size and one-day intervention.

Figure 8.1 depicts the study model, displaying the paths of interest that were tested. We found intervention effects on the outcome of frequency of sexual risk reduction (SRR) as well as the attitude of sexual health communication. Additionally, we found that FSHCI was successful in changing comfort of sexual health communication levels. We were able to parse out the working parts of FSHCI and obtain an estimate of

the individual paths by examining the relationships between the mediating variables, comfort of sexual health communication and frequency of sexual health communication. Results indicate that both attitudes and perceived behavioral control were significantly associated with the frequency of sex education communication. Additionally, we found that all mediating variables were significantly associated with the comfort of sexual health communication. Finally, we found that comfort was significantly associated with both frequency of sex education and sexual risk reduction.

Intervention effects on the mediating variables. Attitude toward sexual health communication was the only theory of planned behavior construct that significantly increased from pre-test to post-test. This supports previous research in that attitudes have been found to salient predictors of behavioral intention and performance and often one of the only constructs targeted for behavior change interventions (Fishbein & Ajzen, 2010). We did not find a significant increase in intention to communicate about SHC, unlike other family-based interventions that have found that intentions to communicate about sexual health significantly increased from pre-test to post-test (Dilorio et al., 2006). Additionally, unlike other multi-session studies we did not find a significant increase in self-efficacy from pre-test to post-test (Forehand et al., 2007; Schuseter et al., 2008). One of the most salient themes in the qualitative post-intervention process interviews was the need for more FSHCI sessions. Thus, it is quite possible that the one-day intervention was not enough to change self-efficacy and intention, however with more exposure to the content participants self-efficacy and intentions would increase.

While FSHCI was geared toward changing all four constructs of the theory of planned behavior constructs, perhaps many of the discussions and activities were oriented towards getting a better understanding of ones beliefs and evaluate outcome expectancies that eventually shaped the attitudes. Additionally, it is also possible that the subjective norms measure failed to capture the norms.

Intervention effects on outcome variable - frequency of communication.

Similar to other studies, we found an increase in frequency of communication about sexual health from pre-test to post-test (Forehand et al., 2007; McKay et al., 2004). However, we only found significant intervention effects for the frequency of sexual risk reduction communication (e.g. condoms, HIV/AIDS, etc.) and not frequency of communication about sex education, while it was approaching significance. There are a few reasons for this. First of all participants might not have had enough time to discuss sexual health with their children in the month between the baseline and the post one month assessment. Secondly, a little less than half of the sample reported that their children did not live with them. This posed a challenge in actually communicating with children because of limited interaction. Future adaptations of this intervention should take children's' residence into account. Thirdly, intervention content focused more on the quality and content of the communication rather than the number of times participants' should communicate. Fourthly, participants might have felt more comfortable and thus have more frequent conversations about sexual risk reduction communication than sexual education because some of the participants might be primed through Durbar to discuss HIV and condoms.

Other interventions have also found that quality, such as levels of comfort, are more salient than the frequency in impacting children's risk behaviors (Otten, Harakeh, Vermulst, Van den Eijnden, & Engels, 2007). Frequency of communication only captures one aspect of the communication that is taking place.

Intervention effects on comfort of communication. Comfort of sexual health communication emerged as a salient theme in our qualitative elicitation interviews from Phase 1 of our study. Previous studies have also found that parents' comfort of sexual health communication impacts their ability to actually communicate with their child about sexual health (Guzman et al., 2003; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998b). Comfortable communication about sexual health has been found to predict children's delayed sexual intercourse as well as less probability of being sexual activity (Guzman et al., 2003). Furthermore, previous family-based interventions have found a significant increase of comfort of sexual health communication over time (Dilorio et al., 2006; McKay et al., 2004).

While the initial study model (see Figure 4.7) did not include comfort, rather it included intention to communicate about sexual health communication. However, given the salience of feeling comfort about sexual health communication in our qualitative interviews and its salience in the intervention itself, we thought it was necessary to include it in the study model in lieu of intention to communicate about sexual health. Given that intention to communicate about sexual health did not significantly change from pre-test to post-test, while comfort of sexual health communication did, we thought it was a justifiable addition. Intentions might operate differently in the context of the sex

worker community, given the nature of the work and the structural violence they experience, in which they often may not have the luxury to think on a month-to-month basis, rather on a day-to-day basis.

Thus, we thought it was essential to examine the intervention effects on comfort as well as the effects of the mediator variables on comfort of sexual health communication. We found partial support of our hypothesis that mothers will report more comfort of communication from pre-test to post-test. Participants reported a significant increase comfort from pre-test to post test. Particularly, to better understand if comfort of sexual health communication varied by item, we conducted paired sample t-test for each item. Comfort of communication about HIV/AIDS, having sex, STI, condoms, and sex work yielded significant results from pre-test to post-test. This might be due to the fact that most of the sessions focused on increasing mothers' comfort levels about sexual health communication. Most notably given the session on sex work was novel, it is intriguing that mothers' level of comfort about sex work communication changed over time. All four of the field sites spent more than the allocated amount of time on the sex work disclosure module. Participants were very interested with the content and wanted to develop skills around sex work disclosure to their children. Additionally, the curriculum covered Durbar norms about sex work and sexual health, which ultimately sparked discussion about the meaning of being a sex worker and a durbar sex worker. For similar reasons we saw an increase of comfort levels about condoms from pre-test to post-test.

Many mothers in FSHCI were exposed to the Sonagachi HIV Intervention project, thus in some ways they were primed for the HIV and STI specific information. As such, their comfort about HIV and STI communication significantly increased over time. The

activities and discussions around the keeping children safe from disease resonated with the participants and thus increased their comfort levels about such discussions.

Comfort levels about discussing “how babies are made” also significantly increased over time. The puberty diagram may have helped to increase comfort levels about discussing how babies are made. The puberty diagram sparked discussions about the reproductive organs. Even participants, who were resistant to such discussions, eventually joined the discussions about how to have a baby after participating in the puberty game. Some mothers voiced that they wanted to use the puberty diagram to initiate discussions about babies.

Relationship between mediators, comfort, and frequency of sexual health communication. We found that subjective norms, attitudes, and perceived behavioral control were all significantly correlated with comfort of sexual health communication as well as the frequency of sex education and sexual risk reduction communication. It is reasonable to assume that FSHCI produced significant increase in comfort of sexual health communication levels by targeting the specific constructs of the Theory of Planned Behavior (mediating variables). As such, the comfort levels were also significantly associated with the desired behavior change.

While we were not able to test a full mediation model using a structural equation model, the bivariate analyses provide as with the opportunity to explore the paths of association between FSHCI, the mediating variables, comfort of sexual health communication, and frequency of sexual health communication. This has led us to better understand the paths and also closely examine which FSHCI components, which were

based on the theory of planned behavior constructs, were significantly associated. In future studies, we aim to test FSHCI in a study that is powered by significance and conduct a path analysis of this model.

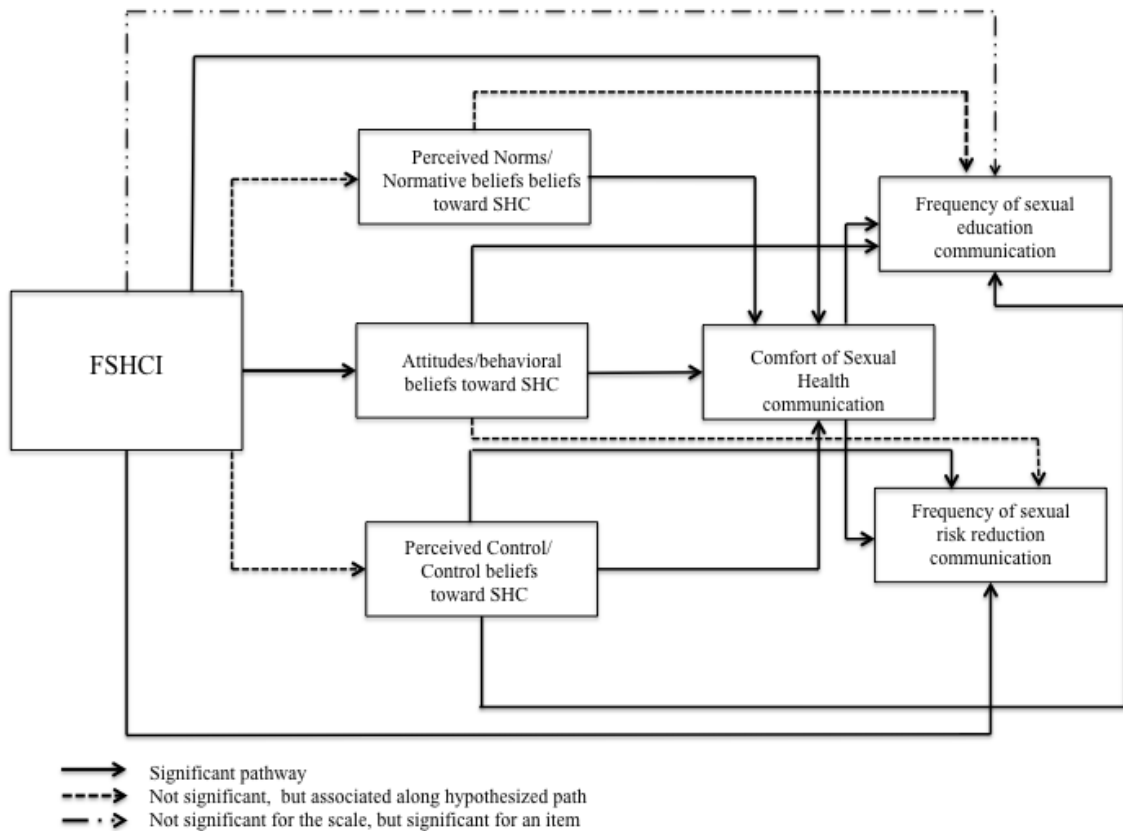


Figure 8.1: FSHCI Study Model

Theoretical Implications

The Theory of Planned Behavior serves as a useful framework to better understand the cognitive processes that precede mothers' intention to communicate with their children about sexual health. However it fails to capture the overarching processes that are at play between the community, family and individual levels. Thus, our model

adds a novel element of the relationships between sensitizing processes and mediating cognitive processes. These sensitizing processes, activated by Durbar's collectivizing strategies, interact with the mediating processes of the cognitions, ultimately triggering engagement in the behavior (see Figure 8.2). As noted in Chapter 6, The Theory of Planned Behavior constructs in the context of the sex worker community could not be understood without taking the sensitizing processes into account. This conceptualization of collectivizing processes builds on the work of previous scholars that have conceptually linked collective identity to behavior (Ghose et al., 2008).

Sensitizing Processes. Tapping into Durbar's collectivizing processes lends to a better understanding of the elements that act as a catalyst for sexual health communication between mothers and children. Participants who had high levels of participation in Durbar's collectivizing processes often held more positive attitudes and felt that they had more control of sexual health communication than those who had low levels of Durbar participation. However this was not always the case. A few participants who had held leadership positions in Durbar or had been long-term peer educators resisted the idea of sexual health communication with their children. The dichotomy of work and private life was apparent in their lives.

There was a clear dichotomy between Durbar norms and societal norms. Participants' narratives about Durbar were couched in choice, freedom, and rights, while their narratives about society were couched in societal expectations, anticipated stigma, and experienced stigma. The conflict between the two social realities triggered participants' to formulate their cognitive beliefs about sexual health communication through one or both. On the other hand, the narratives of feelings of connectedness and

empowerment with Durbar were present for some of the women who had just been involved in Durbar shortly. Thus such collectivizing practices foster collective identity even amongst the newer participants.

Mediating Processes - Normative beliefs. Mothers' narratives indicated that normative beliefs about sexual health communication were constructed by Durbar norms on sex work and sexual health and through societal norms on sex work and SHC. Most of the participants that had high levels of Durbar participation provided narratives of how Durbar changed their conceptualizations of sex work over time, ultimately informing their labor practices as well as shaping the importance of keep their children through conversations about sexual safety. Many participants recalled entering sex trade feeling embarrassed, dirty and ill-informed about safe sex practices, however through the peer educator trainings and other Durbar events they were able to create meaning out of sex work. Such meaning included narratives of feeling free, gaining financial and physical independence from extended family or husbands that resulted in more ability to care for their children, practicing sex work safely. However these processes were not isolated to long-term Durbar members, service recipients and peer educators. A few women who had just started receiving services from the Durbar clinics or who had some interactions with the peer educators also voiced similar narratives.

On the other hand societal norms also shaped mothers' normative beliefs about SHC. Mothers who adhered to societal norms were often mothers who had little Durbar involvement. Such societal norms included that discussions about sex would lead to early sexual initiation. A few mothers discussed that it was only acceptable to discuss menstruation because of the implications it had on a girls' marriage potential. An

interesting component was that mothers, despite participation levels with Durbar, felt that by having discussions about sexual health would automatically disclose their engagement in sex work. Many mothers feared this, although some noted that they yearned to be honest with their children but feared the implications. Such norms were included as a topic of discussion in the intervention. Mothers managed societal norms and Durbar norms by establishing boundaries between their life as sex workers and their life as mothers.

Both norming processes, either through Durbar or societal, had implications for mothers' normative beliefs about sexual health communication with their children. Durbar's emphasis on the importance of sexual health education, keeping bodies safe, and having ownership over one's bodies all informed mothers' normative beliefs about SHC.

Mediating Processes - Behavioral beliefs. Behavioral beliefs were closely linked to normative beliefs. As such, there were some overlapping themes. Behavioral beliefs about SHC were constructed through positive attitudes due to Durbar's collectivizing processes and negative attitudes due to societal stigma. Additionally, the ways in which sex workers navigated their motherhood and being a sex worker often dictated whether they thought it was favorable or unfavorable to communication about sexual health and sex work. Durbar played an important role in legitimizing the work for some mothers, especially those who had been involved with Durbar for a long time, which ultimately helped participants to accept their profession and also disclose to their children about their sex work. Sex work disclosure processes often acted as catalysts to sexual health

communication. Some participants expressed using conversations about sex work as an opportunity to discuss HIV and condoms.

As with normative beliefs construction, level of participation in Durbar was a salient factor that influenced mothers' attitude about SHC. Participants who believed that sex work was a good profession (often those who had high levels of Durbar participation) provided narratives of ownership over their bodies and health. Such conceptualizations of sex work ultimately informed their favorable attitude toward SHC with their children. Participants expressed that that one of the most salient factors of SHC was to keep their children safe from HIV. Given that many mothers were exposed to the Sonagachi Project and knew people who had HIV, they understood the severity of HIV. Participants also discussed that SHC would help them to "be friends with their children", strengthening their relationship and serving as an impetus for children to be honest with their mothers. Advantages of SHC also depended on the content of the conversation. Mothers felt that it was more advantageous to discuss HIV and menstruation rather than other sexual health topics, such as sex and relationships between boys and girls.

On the other hand, about half of the participants felt that sexual health communication was unfavorable. Many of these participants had low levels of participation with Durbar, while some were mothers who had been involved with Durbar for years. Two of the most salient unfavorable behavioral beliefs were that mothers felt sexual health communication would serve as an impetus for children to engage in sexual activity and that children would find out about the mothers profession upon SHC. Additional reasons for such unfavorable behavioral beliefs included mothers feeling that they should not be the source of sexual health information because such matters because

children should learn from their friends, sexual health should only be discussed with sex workers, and belief that children already knew about sexual health through media and friends.

Stigma. The in-depth analysis around behavioral belief formation further revealed that stigma against sex work played a critical role mothers attitude formation about sex work and SHC. Since Goffman's influential book on stigma, many conceptualizations of stigma have surfaced that aim to understand the experiences of the stigmatized person. Goffman (1963) defines stigma as "an attitude that is significantly discrediting", that "others" the person in which a person takes on a "spoiled identity" (p. 3). Goffman's (1963) definition of stigma has been critiqued to be individualistic, in that stigma is conceptualized to be an attribute within the person rather than a product of multiple external factors. More recent scholarship has conceptualized stigma as a complex relationship between structural conditions, such as both symbolic and physical violence, and discrimination often produced by economic, social, and political powers (Link & Phelan, 2001; Parker & Aggleton, 2003). Stigma and the management of the stigma also impacted mother-child relationships. Experienced and internalized and anticipated stigma often led mothers to refrain from disclosing about sex work to their children, ultimately shaping their unfavorable attitude toward SHC. Some participants provided narratives of stigma management through disconnecting from their sex worker life once at home with their children. In such cases, mothers refrained from discussing sexual health with their children.

Mediating Processes - Control Beliefs. Control beliefs were constructed by mothers' use of feasible tools and resources made available by Durbar and mothers'

conceptualizations of context of the space. As with both normative and behavioral beliefs, mothers control beliefs were often shaped by their engagement with Durbar. The skills, knowledge, and resources learned and provided through the Durbar peer education trainings and experiences from continued involvement as peer educators increased mothers' self-efficacy and sense of control to communicate with their children about sexual health. Interestingly, some participants noted that while they did not know how to read or write, they felt empowered because Durbar had educated them about sexual health and thus felt proud to discuss such topics with their children. On the other hand, some mothers, particularly those who were not peer educators and newer to Durbar, however, felt that they did not possess the skills or knowledge to communicate with their children about sexual health.

Conceptualizations of space also shaped mothers' control beliefs about sexual health communication. The space participants and their children resided in informed their beliefs about their capability communicate about sexual health and sex work. As such, many mothers felt that they had the ability to control their children's exposure to the information related to sexual health and sex work. Some mothers established this control by sending their children to boarding school away from the red light district. Such decisions were driven by the notion that the red-light district was not a place to raise children and that children would have more opportunities away from the red-light district. Many of these mothers had not disclosed to their children about sex work or discussed sexual health because they were able to achieve the work and private life division through the space. On the other hand, mothers whose children resided with them in the red-light district felt that the context of the space, clients and the exposure to health clinics,

provided them with the capability to discuss both sex work and sexual health with their children. However, on a different note, some mother felt that they did not have to discuss sex work and sexual health because the red-light space exposed their children to sexual health and sex work. Thus, while they felt that they were capable to communicate with their children about such topics, they did not think it was necessary.

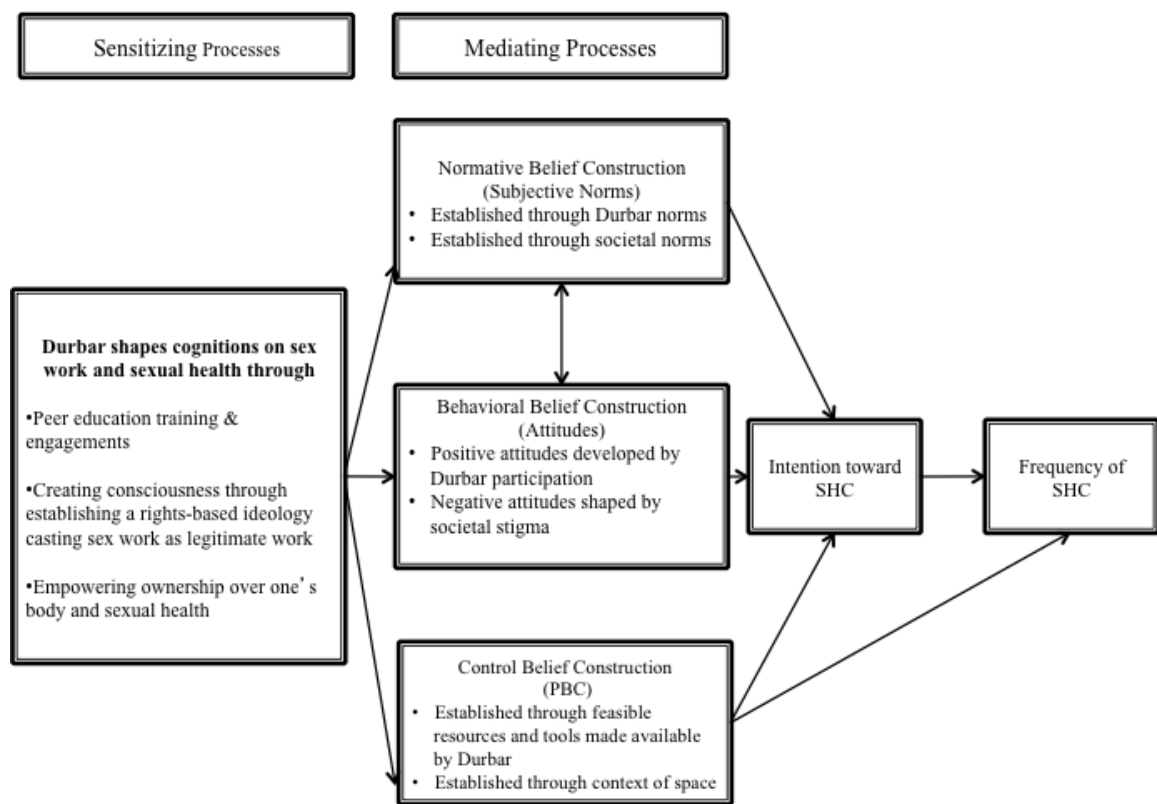


Figure 8.2: Context of Sexual Health Communication

Practice Implications

There are two distinct implications from this study: a) The importance of looking beyond the individual; b) the importance of interventions to be tailored to community based organizations as well as the individuals.

The need to look beyond the individual – families and communities matter.

The sex worker population has only been understood in the context of HIV. The labeling of sex workers as “vectors of the disease” has brought upon a surge of interest and interventions by both ant-trafficking organizations and sex worker run community based organizations that aim to contain the sexually transmitted diseases. As such, research on female sex workers in India has primarily focused on testing the effectiveness of HIV prevention interventions that seek to contain the disease by changing individual sexual practices (Jana et al., 2004). However, these interventions disregard the important role motherhood plays in FSW decision-making processes regarding their health and their children’s overall well-being (Reed et al., 2012). Thus, it is essential to look beyond the individual. Community and family interactions shape individual behavior and are crucial to understand to better meet the population needs (Campbell, 2003; Jana et al., 2004; Pequegnat, & Bell, 2012). For instance a recent study found that mothers who reported having three or more children influenced sex worker mothers’ likelihood of being in a risky situation, such as inconsistently using a condom (Reed et al., 2013).

This study looked beyond the work life of sex workers in order to better understand the family and community processes that shape their life, relationships and interactions with their children. We found that sensitizing processes that involve community level factors often trigger mothers’ cognitions about parenting practices.

Taking family and community contexts into account, just as this study did, not only provides one with a better understanding of the landscape individuals live in but also helps to better serve populations who are vulnerable.

Understanding the impact of community-based organizations on individuals is also essential. We found that Durbar's collectivizing processes not only shaped mothers' behavior but also their relationships with their children. As such, it is important to understand how community based organizations values, missions, and services impact their clients. As we found in this study, unintended processes and outcomes, such as the impact of Durbar norms about sex work and sexual health on sexual health communication, have the possibility to reach beyond the individual.

Interventions should be integrated within the community-based organization. While family-based interventions should be tailored to the individual, they should also be tailored to the community-based organization. The integration of FSHCI into Durbar was essential. We created a community board from the beginning of the project so that FSHCI could be immersed in Durbar's ideologies, values, and missions. As such, we were able to integrate Durbar's norms and empowerment strategies on sex work and sexual into the FSHCI curriculum. Such processes became essential in the acceptability of the intervention by both Durbar and the participants. Additionally, such processes also determine the sustainability of the intervention over time. We gave careful consideration to a variety of logistic and conceptual components of FSHCI to make it a sustainable program over time. We were also able to look beyond an HIV intervention because we established such a strong partnership from the beginning. FSHCI integration

into Durbar also meant that we had to better understand unmet needs of mothers who were sex workers.

One of the major critiques of community-based interventions that use a community-based participatory research approach is the lack of sustainability of the intervention (Campbell, 2003). Interventions often end when the grant ends, however it is essential to understand community-based organizations' missions, values, and resources to ensure sustainability of the intervention or adaptation of the intervention over time to fit the community context. We took multiple steps to ensure that we understood community strengths and the ways in which we could capitalize on them for the development and implementation of the FSHCI. FSHCI included Durbar's missions and values about sex work and sexual health.

Limitations and Opportunities for Future Research

Given that this was a pilot feasibility trial, we did not think it was possible to recruit a control group without piloting the intervention first. However, we have now laid the groundwork for a large randomized controlled trial and aim to test FSHCI in a bigger trial with post-assessments over one year. There have been recent calls to rigorously test family-based intervention (Akers, Holland, & Bost, 2011). As such, the next steps are to roll out FSHCI in a bigger study with more standardized procedures to ensure a rigorous implementation and test. While the intervention was feasible for many reasons (see Chapter 8), we failed to implement the HIV session of the module successfully across all sites. In process interviews participants voiced that they wanted to develop communication specific skills as they felt that they already held enough HIV knowledge

to communicate with their children. However, given that in some sites we were not able to implement the HIV session, it provided more time to discuss sex work disclosure issues. Another limitation is that the intervention was not tailored to a specific adolescent stage. While this did not manifest as a challenge on the ground, we acknowledge that future FSHCI trials should be catered to specific age ranges.

We also faced some challenges with the theory of planned behavior subjective norms questions on the assessment. Interviewers noted that these questions were the most difficult for participants to understand. More thought should be given to creating theory of planned behavior measures in future studies. As such, the theory of planned behavior constructs had more missing data than the other constructs. Future training of the interviewers will have to be more rigorous.

We conducted FSHCI in four different sites, two urban and two suburban sites. Facilitators noted that the mothers in the suburban areas were more reluctant to participate in the intervention. Additionally, session 1 often took more than the allocated time in the suburban areas because facilitators had to engage the mothers more than the other sites. The mothers in the suburban sites were a little more resistant to the concept of sexual health communication. For these reasons, it would be essential for future FSHCI trials to take site level differences into account.

Another limitation of the study is that FSHCI was held in the span of one day. While in some ways this was a strength of the study, in that retention was not an issue, it was a limitation as well. A one-day intervention does not allow for mothers to process and practice the skills learned. In multi-day interventions, such as CHAMP and PMP, participants had the opportunity to practice the skills learned and then share the outcomes

with their peers. Additionally, one of the main feedback from both participants and the DCCB was the need for a multi-day intervention. Future FSHCI trials should be implemented on more than one day.

As noted in previous chapters, we did not have an in depth understanding of the larger family context. We restricted our recruitment to mothers who were sex workers, however this limited our sample because fathers or babu's (long-term lovers) are also involved in the child's life. However, we felt that it was necessary to obtain a better context of the mother-child relationships in the sex worker community before inviting fathers or mothers' babus to attend the intervention. A better understanding of father-child or babu-child relationships is needed before we adapt an intervention.

Another limitation is that this study was only able to explore mothers' perspectives of sexual health communication with their children. It is also necessary to explore sexual health communication from the children's perspective. Future studies should conduct qualitative interviews with children of sex workers to better understand their needs and relationships with their parents. The data from the qualitative interviews will be used to tailor FSHCI to be implemented through a multi-family group format, in which both mothers and children will participate.

Summary

This is one of the few studies to explore mother-child relationships sexual health communication in the sex worker community. Furthermore, this is the first study known to the authors that developed, implemented, and tested a community-based and family-based sexual health communication intervention tailored to the sex worker community.

The findings here are threefold. Durbar collectivizing strategies establish collective identity that ultimately promotes agency and empowerment over one's body. These processes not only shape sex workers cognitions about their sexual health, but uniquely shaped their cognitions about structuring and conveying sexual health messages to their children. Secondly, having an in depth understanding of the community and family level factors allowed us to develop FSHCI that was tailored to sex worker mothers and to Durbar's missions and values about sex work and sexual health. As such, the intervention was believed to be feasible from both Durbar and participants perspectives. Lastly, we found that FSHCI was successful in changing mothers' attitudes about sexual health communication, comfort levels about sexual health communication, and the frequency of sexual risk reduction communication. A further investigation into the mediating variables revealed a significant positive correlation between attitudes and perceived behavior control and the desired outcome of the frequency of sexual education. Participants' comfort levels were also positively correlated with subjective norms, attitudes, and perceived behavioral control and also with the frequency of sex education and sexual risk reduction communication. These results indicate that a brief, one session long, FSHCI was successful in changing participants' attitudes and comfort levels toward sexual health communication. Furthermore, results provide evidence that as participants' attitudes and perceived behavioral control increased, so did the frequency of their conversations about sex education with their children. Looking beyond the individual, we found that both community and family level factors were salient in shaping sex worker mothers' cognitions about sexual health communication with their children. Research with

populations who are vulnerable should also look beyond the individual to intervene on community, family and individual levels.

Appendix A

Elicitation Interview Protocol

Warm up questions

- 1) **I would first like to get to know you better by asking you to tell me a little bit about yourself**
 - a. How long have you lived here?
 - b. What do you do in a typical day?
 - c. What are your working hours? How many days a week?

Relationship

- 2) **Relationship with your child**
 - a. How many children do you have? How old are they?
 - b. Do your children live with you?
 - c. How is your relationship with your child?
 - d. What do you like to do together?
 - e. How much time do you spend with your child?
 - f. Who takes care of your children when you are at work?
 - g. Does anyone help you take care of your children?

Communication

- 3) **General Communication**
 - a. What types of things do you talk about with your child?
 - b. What are the barriers to communication?
 - c. What helps you to communicate with your child?
 - d. Tell me about a time you and your child talked about something that was difficult
 - i. How was this experience?
 - e. Do you think parents can make a difference when communicating with their children
- 4) **Sexual Health Communication**
 - a. Have you ever talked about sexual health, sex, HIV with your child?
 - b. Who started this conversation?
 - c. How was the conversation started?
 - d. What was said in the conversation?
 - e. What made the conversation easier or more difficult?
 - f. What does your culture say about communicating about sexuality with your child?

- g. What influenced you to communicate or not communicate with your child about sexual health or HIV?
- h. How do you feel about communicating with your child about sexual health and sex?
- i. Do you think other mothers in your community are discussing sexual health or sex with their children?
- j. Do you believe that you know enough or have the appropriate skills to communicate with your child about sexual health or sex?
- k. Do you think your child is having sex?

5) Sexual Health Communication – Theory of Planned Behavior Elicitation

Experiential Attitude

1. How do you feel about the idea of sexual health communication with your child?
2. What do you like or dislike about sexual health communication with your child?
3. What do you enjoy/hate about sexual health communication with your child?

Instrumental Attitude

1. What are the plusses of you communicating about sexual health with your child? (What are some advantages of communicating about sexual health with your child? What are the benefits that might result from communicating about sexual health with your child?)
2. What are the minuses of communicating about sexual health with your child? (What are some disadvantages of communicating about sexual health with your child? What are the negative effects that might result from communicating about sexual health with your child?)

Normative Influence

1. Who would support you about communicating about sexual health with your child?
2. Who would be against you communicating with your child about sexual health?

Perceived Control

1. What things make it easy for you to communicate about sexual health with your child?

2. What things make it hard for you to communicate about sexual health with your child?

Self-efficacy

1. if you want to communicate about SH with your child, how certain are you that u can?
2. What kinds of things would help you overcome any barriers to communicate with your child about SH?

6) Intervention

- a. What are your thoughts about a family based HIV intervention?
- b. What would you like to learn from it?
- c. What topics would be helpful?

Appendix B

Focus Group Protocol

“Talking about Sexual Health with your Children”

A. Introductions (20 minutes)

- Participants and moderators will introduce themselves
- Participants will say the age of their children and share something special about their children
- Moderators will explain the purpose of the group. In addition, they will explain confidentiality and other group rules.

B. Theory of Planned Behavior Constructs (30 minutes)

- What are the advantages and disadvantages of communicating with your child about sexual health?
 - What are the positive or negative outcomes of communicating with your child about sexual health?
- Who would approve and who would disapprove when you communicate with your child about sexual health. Who communicates about sexual health and who doesn't?
- What are the factors that would make it easier or more difficult to communicate about sexual health with your child?

C. Family-based Sexual Health Communication Intervention. Moderator will review the FSHCI curriculum with the group (40 minutes)

- What are your thoughts about FSHCHI?
- What are the important topics that should be discussed
- What are the topics that should not be discussed
- What are the ways the topics should be approached?

D. Measures. Moderators will review the survey with the group. (30 minutes)

- Do these questions make sense?
- Should more questions be added/deleted?
- What improvements do you suggest?

Appendix C

Family-Based Sexual Health Communication Intervention Outline

“Durbar Family Program” Summary

- Durbar Family program is a parent-based sexual health communication intervention that aims to increase communication between mothers and children about various aspects of adolescents, such as puberty, sexual relationships, HIV, and sex work disclosure
- The pilot project was implemented at various Durbar field sites. Mothers who have children (ages 10 to 21) were be eligible to attend the workshop.
- Due to feasibility, the workshop will be conducted within 1 day and should take approximately 3-4 hours.
- 2 facilitators
- Survey should be administered before the workshop and 1 month after the workshop.
- See attached for the curriculum

Introduction – 20 minutes

- Overall theme = communication
- Introductions – facilitators and mothers
- Mothers should discuss the challenges of raising children
- This group should become a safe place for mother to discuss their needs and desires for themselves but also their children.

Session 1 – Sex work and mothering – 30 minutes

- Mothers point of view about disclosing about their profession
- Importance of disclosing sex work as work to children
- How to disclose
- Sex workers rights
- What does it mean to be a sex worker and a mother?
- How do mothers manage stigma around sex work?

Session 2 – Growing up and Puberty – 45 minutes

- Focus on the changes that happen to children in the teen years
- As kids grow up, they have to deal with the emotional and physical changes they are going through (remember mothers?!.. think back to when you were teens..

what changes were you going through).

- This is also a stressful period for mothers and it is important for them to understand how to translate their children's behavior.
- Mothers can help kids understand and deal with this better by preparing them and giving them correct information.
- **Activity – Mothers will draw the body and the changes that happen to children during adolescents**

Session 3 – Peer Pressure – 30 minutes

- Importance of bonding with children and becoming friends with children
- Sexual pressure, skipping school, drug use, and alcohol use are problems.
- How to talk to children about this?

Session 4 – HIV – 45 minutes

- Discuss the importance of discussing HIV and other STIs with children
- HIV facts
- Activity - HIV game
 - Divide mothers into 2 teams
 - Ask true/false questions about HIV

Conclusion

- Sum up the main topics
- Ask mothers to exchange contact information if they feel comfortable with doing that.

Appendix D

FSCHI Pre-test Assessment

The questions in this survey are related to your background and your relationship with your child. Some questions will ask about what you know, while others will ask about your opinion on something. Please answer the questions to the best of your ability. If a question bothers you, you can skip it.

Your answers will be kept confidential. Your name will not be attached to this survey.

Please think about your younger child (between the ages of 10 and 21) when answering these questions

Date: ____/____/____

ID #: _____

As you answer the rest of the questions, please keep in mind that sexual health issues mean

HIV/AIDS

Sexually Transmitted Disease

Sexual experimentation and relationships

Puberty – changes that happen to children when they grow up

A. Background Questions

We would like to ask you general information about your age, you children, and where you live.

1. How old are you now? _____ years

2. Where do you currently live?
 - a. Sonagachi
 - b. Kalighat
 - c. Seaphully
 - d. Bow Bazar
 - e. Other _____

3. How many children do you have and how old are they? Where do they live?
Grade?

	Age	Gender	Residence	Grade	Biological
Child 1					
Child 2					
Child 3					
Child 4					

4. In addition to your children, who else lives in the house with you?
 - a. Babu
 - b. Husband
 - c. Boyfriend
 - d. Other sex workers
 - e. Other sex workers children
 - f. Madam
 - g. Pimp
 - h. Other _____

5. What is the last class in school that you completed?
- Never been to school
 - Grade _____
 - Don't know
6. What is your current marital status?
- Unmarried (living alone)
 - Unmarried (living with Babu/boyfriend)
 - Currently married
 - Separated/deserted
 - Divorced
 - Widowed
7. How old were you when you started sex work? _____ Years
8. How long have you been part of Durbar? _____ Years
9. Have you ever gotten information to help you understand or teach your child about sexual health?
- Yes No
10. Have you ever used Durbar materials to discuss sexual health issues with your child?
- Yes No
11. Do you think your child is thinking about becoming sexually active?
- Yes No
12. Is it easier to talk to your son or daughter about sexual health issues?
- Son Daughter
Doesn't matter

B. Frequency of Sexual Health Communication between Mother and Child

The following questions ask about talking with your child. Tell us how often you discuss this topic with your child.

	Have you ever talked to your child about the following? If so, how many times?						
	0	1	2	3	4	5	6 or more
1. What sex is							
2. Mature enough to have sex							
3. How the body changes							
4. Sexual relations between a boy/girl							
5. Menstruation							
6. How babies are made							
7. Peer pressure (when peers try to talk others into doing something that they might not want to do)							
8. Condom							
9. Postponing sex							

10. STI							
11. HIV/AIDS							
12. Family Planning							

C. Comfort of Sexual Health Communication between Mother and Adolescent

The following questions ask about talking with your child. Tell us how comfortable you feel talking about these things with your child

	How comfortable are you talking about this with your child?			
	Very comfortable	Somewhat comfortable	Somewhat uncomfortable	Very uncomfortable
1. HIV/AIDS				
2. Having Sex				
3. STI				
4. Puberty				
5. Sexual relations between a boy/girl				
6. Getting menstrual cycle				
7. How babies are made				
8. Peer pressure				
9. Condoms				
10. Sex Work				

D. Sexual Health Communication Feelings

1. For me, talking to my child about sexual health issues over the next 1 month would be beneficial or harmful

Very harmful	Somewhat harmful	In the Middle	Somewhat beneficial	Very beneficial
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2. For me, talking to my child about sexual health issues over the next 1 month would be useless or useful

Very useless	Somewhat useless	In the Middle	Somewhat useful	Very useful
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3. For me, talking to my child about sexual health issues over the next 1 month would be interesting or boring

Very boring	Somewhat boring	In the Middle	Somewhat interesting	Very interesting
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4. For me, talking to my child about sexual health issues over the next 1 month would be relaxing or stressful

Very stressful	Somewhat stressful	In the Middle	Somewhat relaxing	Very relaxing
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5. Most people like me want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree	Somewhat disagree	In the middle	Somewhat agree	Strongly agree
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6. Most mothers likes me want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

7. Most people who I respect and admire want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

8. Most people in my family would approve if I talk about sexual health issues with my child in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

9. Most of my family members talk about sexual health issues with their child regularly

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

10. As a durbar sex worker, its part of my durbar sex worker duty, advocacy and my activism duty to talk about sexual health issues with my children

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

11. How confident are you that you will be able to talk about sexual health issues with your child in the next 1 month?

Very unconfident Somewhat unconfident In the middle Somewhat confident Very confident

12. How confident are you over the next 1 month that you could overcome obstacles that prevent you from talking about sexual health issues with your child?

Very unconfident Somewhat unconfident In the middle Somewhat confident Very confident

13. I believe I have the ability to talk about sexual health issues with my child in the next 1 month.

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

14. Whether or not I talk about sexual health issues with my child in the next 1 month is entirely up to me

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

15. It's under my control if I want to talk with my child about sexual health issues in the next 1 month

Strongly disagree

Somewhat disagree

In the middle

Somewhat agree

Strongly agree

16. In the next 1 month, I plan to talk with my child about sexual health issues

Strongly disagree

Somewhat disagree

In the middle

Somewhat agree

Strongly agree

Appendix E

FSHCI Post-test Assessment

The questions in this survey are related to your background and your relationship with your child. Some questions will ask about what you know, while others will ask about your opinion on something. Please answer the questions to the best of your ability. If a question bothers you, you can skip it.

Your answers will be kept confidential. Your name will not be attached to this survey.

Please think about your younger child (between the ages of 10 and 21) when answering these questions

Date: ____/____/____

ID #: _____

As you answer the rest of the questions, please keep in mind that sexual health issues mean

HIV/AIDS

Sexually Transmitted Disease

Sexual experimentation and relationships

Puberty – changes that happen to children when they grow up

A. Background Questions

We would like to ask you general information about your age, you children, and where you live.

1. How old are you now? _____ years

2. Where do you currently live?
 - a. Sonagachi
 - b. Kalighat
 - c. Seaphully
 - d. Bow Bazar
 - e. Other _____

3. How many children do you have and how old are they? Where do they live? Grade?

	Age	Gender	Residence	Grade	Biological
Child 1					
Child 2					
Child 3					
Child 4					

4. In addition to your children, who else lives in the house with you?
 - a. Babu
 - b. Husband
 - c. Boyfriend
 - d. Other sex workers
 - e. Other sex workers children
 - f. Madam
 - g. Pimp
 - h. Other _____

5. What is the last class in school that you completed?
- Never been to school
 - Grade _____
 - Don't know
6. What is your current marital status?
- Unmarried (living alone)
 - Unmarried (living with Babu/boyfriend)
 - Currently married
 - Separated/deserted
 - Divorced
 - Widowed
7. How old were you when you started sex work? _____ Years
8. How long have you been part of Durbar? _____ Years
9. Have you ever gotten information to help you understand or teach your child about sexual health?
- Yes No
10. Have you ever used Durbar materials to discuss sexual health issues with your child?
- Yes No
11. Do you think your child is thinking about becoming sexually active?
- Yes No
12. Is it easier to talk to your son or daughter about sexual health issues?
- Son Daughter
Doesn't matter
13. What are your thoughts about the intervention

B. Frequency of Sexual Health Communication between Mother and Child

The following questions ask about talking with your child. Tell us how often you discuss this topic with your child.

	Have you ever talked to your child about the following? If so, how many times?						
	0	1	2	3	4	5	6 or more
1.What sex is							
2.Mature enough to have sex							
3. How the body changes							
4. Sexual relations between a boy/girl							
5.Menstruation							
6. How babies are made							
7.Peer pressure (when peers try to talk others into doing something that they might not want to do)							
8.Condoms							
9.Postponing sex							
10.STI							

11.HIV/AIDS							
12.Family Planning							

C. Comfort of Sexual Health Communication between Mother and Adolescent

The following questions ask about talking with your child. Tell us how comfortable you feel talking about these things with your child

	How comfortable are you talking about this with your child?			
	Very comfortable	Somewhat comfortable	Somewhat uncomfortable	Very uncomfortable
1.HIV/AIDS				
2.Having Sex				
3.Sexually Transmitted Diseases				
4.Puberty				
5. Sexual relations between a boy/girl				
6.Getting menstrual cycle				
7.How babies are made				
8.Peer pressure (when peers try to talk others into doing something that they might not want to do)				
9.Condoms				
10.Sex Work				

D. Sexual Health Communication Feelings

1. For me, talking to my child about sexual health issues over the next 1 month would be beneficial or harmful

Very harmful	Somewhat harmful	In the Middle	Somewhat beneficial	Very beneficial
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2. For me, talking to my child about sexual health issues over the next 1 month would be useless or useful

Very useless	Somewhat useless	In the Middle	Somewhat useful	Very useful
--------------	------------------	---------------	-----------------	-------------

3. For me, talking to my child about sexual health issues over the next 1 month would be interesting or boring

Very boring	Somewhat boring	In the Middle	Somewhat interesting	Very interesting
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4. For me, talking to my child about sexual health issues over the next 1 month would be relaxing or stressful

Very stressful	Somewhat stressful	In the Middle	Somewhat relaxing	Very relaxing
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5. Most people like me want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree	Somewhat disagree	In the middle	Somewhat agree	Strongly agree
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6. Most mothers likes me want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

7. Most people who I respect and admire want me to talk with my child about sexual health issues in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

8. Most people in my family would approve if I talk about sexual health issues with my child in the next 1 month

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

9. Most of my family members talk about sexual health issues with their child regularly

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

10. As a durbar sex worker, its part of my durbar sex worker duty, advocacy and my activism duty to talk about sexual health issues with my children

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

11. How confident are you that you will be able to talk about sexual health issues with your child in the next 1 month?

Very unconfident Somewhat unconfident In the middle Somewhat confident Very confident

12. How confident are you over the next 1 month that you could overcome obstacles that prevent you from talking about sexual health issues with your child?

Very unconfident Somewhat unconfident In the middle Somewhat confident Very confident

13. I believe I have the ability to talk about sexual health issues with my child in the next 1 month.

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

14. Whether or not I talk about sexual health issues with my child in the next 1 month is entirely up to me

Strongly disagree Somewhat disagree In the middle Somewhat agree Strongly agree

15. It's under my control if I want to talk with my child about sexual health issues in the next 1 month

Strongly disagree

Somewhat disagree

In the middle

Somewhat agree

Strongly agree

16. In the next 1 month, I plan to talk with my child about sexual health issues

Strongly disagree

Somewhat disagree

In the middle

Somewhat agree

Strongly agree

Appendix F

Post-intervention Qualitative Protocol

1. What are your thoughts about the workshop?
2. Do you think it should be longer or shorter?
3. Do you think it should be offered on more than one day?
4. What does sexual health communication with your child mean to you now?
5. After participating in the workshop, what are the advantages or disadvantages of communicating with your child about sexual health?
6. After participating in the workshop, do you think people would approve or disapprove of you communicating with your child about sexual health? Why?
7. After participating in the workshop, do you feel like it is easier or more difficult to communicate with your child about sexual health?
8. After participating in the workshop, do you feel more confident about communicating with your child about sexual health? Why?
9. How can the workshop be improved?
10. Have you talked to anyone about the workshop that you attended?

Appendix G

Human Subjects

All participants were consented, informed of their rights in the study and were provided with the relevant project information in Hindi or Bengali. This study was approved by the IRB. The potential risks to the participants were very minimal. Participants might experience some discomfort when discussing communicating with their children about sexual health. Participants were informed that they could withdraw from the study at any time. They were also provided with research study personnel's contact information.

The study participants were protected from any risks, if any, associated with the participating in the study. Participants were assured that the information was solely being collected for research purposes and all information discussed will be confidential. Participants were made aware that participation in the study is voluntary. Unique identifiers were assigned to each name and transcripts of the interviews will not include any identifying information.

The study participants were made aware of potential benefits as well. Benefits included contributing to the creation of an intervention. In addition, they might benefit from the interviews and focus groups or intervention. The study will improve understanding of the sexual health communication patterns between mothers and their children and also will get a better insight into the mother's perception about methods to improve it, if necessary. Additionally, this study will test an intervention that will help to inform future more rigorous interventions.

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