

## **Empowering sex workers, men who have sex with men and people living with HIV: the role of social capital in preventing the spread of HIV in Andhra Pradesh, India.**

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### **Background**

Despite the fact that it is home to approximately 2.5 million people living with HIV (UNAIDS, 2007), India remains a low-prevalence country. To have the greatest impact on the epidemic in low-prevalence settings, it is important focus prevention efforts on people living with HIV and populations most likely to be infected, such as sex workers and men who have sex with men. These populations are key because they are particularly vulnerable to being infected and transmitting the virus. Without their mobilization and empowerment, the epidemic will continue to grow (Global HIV Prevention Working Group 2003; Campbell and Mzaidume 2001). Based on this evidence, the Frontiers Prevention Program (FPP) aims to contribute to HIV control in India. The Horizons supported study is nested within the FPP.

### **Overview of the Frontiers Prevention Program**

Managed by the International HIV/AIDS Alliance, with funding from the Bill and Melinda Gates Foundation, the FPP supports the delivery of a comprehensive package of interventions within 40 sites in Andhra Pradesh. The FPP aims to reduce HIV incidence in these sites by reducing risk behavior and STI prevalence among three key populations (KPs)—female sex workers, men who have sex with men, and people living with HIV.

The central hypothesis underpinning the FPP is that providing a comprehensive package of services and interventions to KPs will empower them to reduce risk behaviors. In order for empowerment for prevention to occur, it is necessary to improve KPs access to services, create an enabling environment free of stigma and discrimination, and build their social capital. Social capital is defined as: the ability to obtain support, to count-on or to trust peers, members of non-governmental organizations (NGOs), and/or family members; the ability to participate in and belong to groups; and individual confidence and self-esteem.

Five key set of interventions were implemented under this program:

- Individually focused health promotion;
- Provision of sexual health services and commodities, and AIDS care, especially through the establishing of Mythri clinics which provide STI syndromic management to KPs
- Community mobilization, through KP outreach workers and linking to referral structures
- Structural and environmental interventions to create an enabling environment through the setting up of drop-in-centres (DICs) or safe spaces (usually linked to Mythri clinics)
- Capacity strengthening of local NGOs.

A rigorous evaluation was implemented consisting of 1) an external evaluation measuring the impact of the interventions, collecting data on knowledge, attitudes, practices and behaviours (KAPB) at baseline and endline; this was augmented by the collection of bio-markers (STIs) as proxy indicators for HIV prevalence and 2) an internal evaluation focusing on how well the program is being implemented which consisted, among other things, of monitoring and tracking activities and assessing changes in the capacity of NGO/CBO implementers over time.

The focus of this research summary is a study nested within the wider FPP evaluation that focused on validating the hypothesis that increased empowerment and social capital will have an impact on behavior change. The study explored the following research questions:

- Does the FPP empowerment for prevention approach increase the level of social capital

- among key populations actively involved in interventions?
- Does increased social capital lead to increased empowerment for prevention, actual reduction in risk behaviors, and changes in knowledge, attitudes, and behavior?
- Does the FPP approach lead to an enabling environment in which stigma and discrimination are reduced?
- What is the relationship between an enabling environment and social capital?
- To what extent are NGOs/CBOs and the services they provide participatory, client-centered, and community based, and how does this change over time as a result of capacity building and other inputs?

## Methods

At baseline 8 sites out of the total of 40 sites were selected for the current study. These were 4 sites in which the FPP project was to be implemented and 4 sites where the Avahan project – the Andhra Pradesh State AIDS control Programm’s project - was carried out. At endline, the research team decreased the number of sites and increased the number of interviews in each site; a total of 5 sites at endline were selected: 3 FPP sites and 2 Avahan sites (see Table 1). Soon after the FPP started, Avahan started implementing FPP-like interventions in their sites. Therefore, instead of attempting to see whether there were differences between FPP and Avahan sites at endline, the study ultimately focused on looking at change over time in all the sites.

**Table 1: Sites and Sub-Sites selected for Baseline and Endline**

District	Baseline Study		2 <sup>nd</sup> Round Sites
	Sites	Sub-Sites	
<b>FPP Sites</b>			
Medak	Andole	Sangareddy, Jogipet	Sangareddy
Karimnagar	Karimnagar	Vemulwada	Vemulawada
Chittoor	Srikalahasti	Nagiri, Putturu	Not Selected
Khammam	Bhadrachalam	Kothagudem, Sarapaka, Manuguru	Bhadrachalam
<b>Avahan Sites</b>			
Kamareddy	Kamareddy		Not Selected
Chittoor	Madanapalle	Kalikiri, Vayalapadu	Not Selected
Ranga Reddy	Hayatnagar		Hayatnagar
Anantapur	Gooty	Guntakal	Guntakal

At baseline (2004) a total of 118 IDIs were conducted across the 8 sites: 32 with female sex workers (FSWs), 32 with men who have sex with men (MSM), 16 with people living with HIV (PLHIV), 24 with gatekeepers who interact with key populations, and 14 with NGO staff working in the sites. In addition to the interviews, 32 focus group discussions (FGDs) were conducted across the 8 sites —16 FGDs with FSWs and 16 FGDs with MSM. At endline (2006) a total of 150 IDIs were conducted across the 5 sites: 50 with FSWs, 50 with MSM and 50 with PLHIV.

FSW and MSM respondents were recruited mainly from the Drop-In-Centres (DIC) and hot spots with the help of outreach workers (ORWs). PLHIV respondents were mainly identified through PLHIV networks and Voluntary Counseling and Testing Centers (VCTC) counselors. The interviews were recorded with consent of the respondents and later transcribed. Transcripts were then translated to English, coded, and entered into Atlasti.

This research summary presents findings from the endline data and compares these results with baseline findings (see also Samuels et. al. 2006 and Samuels, et. al 2008).

## Respondent Characteristics

### FSW

The majority (over 60 percent) of FSW at endline in the 21-30 years age group and illiterate,

and over 40 percent were married. While a majority (33/50) depended solely on sex work for their livelihood, 17 were engaged in other work in addition to sex-work, including being house maids, sweeping, helping in a toddy shop, quarrying, agriculture, and beedi (local cigarettes) making. More than half of the FSWs (28/50) were engaged in sex work for less than 5 years. While majority were street-based sex workers and usually solicited clients from local hot spots and/or depended on their network of clients, peers and brokers, a few worked temporarily from brothels and operated along highways.

### **MSM**

More than half of the MSM respondents at endline (26/50) were in the 21-25 age group. Fifteen were currently married to women and two reported to be married to their male partners. A majority was literate. More than half of the MSM respondents (27) had a regular job and only 3 respondents said they relied totally on sex work for their livelihood. Less than half (22) of the respondents reported demanding money for sex. Another 15 respondents said that they accepted gifts from their partners/clients. Thirteen respondents said that they solicited '*panthis*' ("masculine men") purely for sexual pleasure and accept neither money nor gifts from them.

The majority (48/50) of respondents were '*kothis*', usually described as "feminized males", with some adopting female dress and mannerisms. In sexual behaviors, Kothis are generally the receivers of anal sex, and are quite often engaged in sex work as an income generating activity. One respondent was a "panthi" –the men who are "clients" of the Kothis and one was a "double-decker" who reported being both a "receiver" and a "penetrator" in male-to-male sexual activities.

### **PLHIV**

About half of the PLHIV respondents at endline (23/50) were in the 21-30 year age group and 19 were in the 31-40 year age group. Twenty-five PLHIV respondents were married and 14 were widowed, their spouses having died of HIV; 2 respondents were divorced and another 6 were separated from their spouses. Fifteen PLHIV respondents were illiterate and 29 had studied between 1-10 years in schools. Of the 50 respondents, 36 had some form of employment; 14 were not employed and depended on their spouses or families for support. More than half the respondents (26) were diagnosed with HIV within the last two years. Another 20 were diagnosed 3-5 years ago.

### **Key Findings**

#### **There is an evidence of growing trust and involvement of key populations with the NGO sector**

The second round data suggests a much higher level of trust and involvement of KPs with NGOs than found in the first round. However there were site level differences. More FSW and MSM respondents reported trust and involvement in the NGO in Hayathnagar, Vemulawada and Guntakal sites compared to Sangareddy and Bhadrachalam. While many of the PLHIV respondents reported involvement with the site NGO in Sangareddy, Vemulawada and Hayathnagar, none of the PLHIV respondents in Bhadrachalam and Guntakal reported any involvement with the site NGO. Variation in the level of involvement can be partly explained on the basis of variation in program coverage and the variation in the duration of service delivery. While NGOs in Hayathnagar, Vemulawada and Guntakal have been working at the sites for about 3 years, those in Sangareddy and Bhadrachalam have operating there for less than a year. In Sangareddy the program focuses primarily on FSWs; MSM services were provided mainly through a new CBO. The only clinical services for MSMs were provided in the Mythri clinic under an arrangement between the CBO and the FFP program.

#### ***Recruiting ORWs from within the KP populations and using a client-focused approach helped increase involvement of KPs***

The interviews suggest that ORWs and peer educators, appointed from the KPs, played a major

role in involving KPs in the activities of the NGO. FSW respondents spoke of the ORWs as having leadership qualities, as being people whom the KP community listened to and whom the FSWs trusted and respected; they were often referred to as a “sister”, “*amma*” (mother), or “friend”.

Most FSW and MSM respondents said that they came to know about the NGO through ORWs and many were brought to Mythri Clinic by them. The ORWs provided KPs with condoms at hot spots or at their homes; they were also a source of information about HIV and motivated KPs to access sexual health services.

ORWs also play a facilitating role for greater peer interaction and setting up of CBOs. In many instances ORWs were seen as a source of support in terms of providing money, food, arranging legal help, enrolling children of KPs in school, taking KPs to hospitals, and settling disputes between peers.

*....she gives condoms and told us about these diseases (jabbulu).. She is like an elder sister to me... She helps me in all aspects. Two three times she gave me money, gave food and took me to hospital. If some one has a quarrel with me, she intervenes and rescues me from that quarrel.*

*FSW, 27 years, Hayatnagar*

The ORWs seem to have a lesser role in bringing PLHIVs to the NGO. Among the 5 sites only Vemulawada had one PLHIV ORW and one PLHIV peer educator.

There were also a few instances, however, when members of KPs did not want to be associated with NGOs or with ORWs since it stigmatized them further:

*The Project Manager had asked me to work here as an ORW. They also offered me a salary but I declined. I, somehow, did not like that work. If any known person sees us while distributing condoms, he may think badly about us.*

*MSM, 20 years, Sangareddy*

### **Fully functional Mythri Clinic enhanced access and quality of services**

At baseline (2004), sexual health services were just being set up in some FPP sites and in others STI treatment was provided through a referral network of private doctors. Presently, all the sites have fully functional Mythri Clinics providing counseling, health check ups and STI treatment. The clinics are staffed by a full time Auxiliary Nurse Midwife (ANM), counselor, a clinical administrator (from the KP community), a clinical assistant and a part-time doctor. Services are provided for free, in a stigma-free environment; whereas before, difficulties were reported in accessing health services, and KPs were uncomfortable revealing their histories to doctors and felt they were looked down upon and discriminated. At the Mythri Clinics KPs are assured of confidentiality, warm and responsive behavior of staff, effective communication, availability of good quality medicines and services and regular follow-up.

*We feel happy about the medical services offered by the doctors here. We cannot express freely with the outside doctors because the activity we do should be kept as a secret. Here the doctors are familiar to us and they know well what we do. But we feel a bit embarrassed if we have to speak to the outside doctor on these issues.*

*MSM, 35 years, Bhadrachalam*

While most of the FSW and MSM respondents were appreciative of Mythri Services, a few had complaints about the perceived quality of medicines, behavior of the staff, and that were often referred to other services. A few respondents indicated that the NGO/clinic was situated far from their residences and that they spent a lot of time and money in accessing the services. The timing of the clinic functioning was also inconvenient to some KPs, who stated that the times when the doctor was available was when they needed to work.

### **Availability and easy access to Drop-in Centres (DICs) enhanced cohesion amongst peers**

All the sites had Drop-in-Centres (DICs) with recreational facilities for KPs. Many MSMs and FSWs said they visited the DIC: some of them came frequently, a few came daily, and one FSW practically lived there. For most respondents, the DICs are safe spaces for sharing, discussing, learning, and generally building solidarity among peers.

*Many people come here, people who are HIV-positive, AIDS patients, eunuchs, MSMs, all kinds of people. All of us watch TV in DIC, chat and spend some time together and share our problems. All of us feel jovial; there are no differences between us.*

*FSW, 25, Hayathnagar*

*I am having much happiness and satisfaction in my life because of this DIC. I am staying happy because of all of them (KPs at DIC) speaking to me with love and concern, sharing all my problems and difficulties with them, eating together, watching TV along with everybody and sharing all the things with everybody.*

*PLHIV, 38 years, Sangareddy*

On the other hand DIC was also seen as stigmatizing in the case of some FSWs, since through visiting them they feared that other people would come to know of their occupation.

*These kind of offices (DIC) are there in Uppal, Saroornagar. They told us to go to these offices also. But I did not go to these offices. Saroornagar office is near only, but if my neighbours see me going into this office it will not be good, so I am not going.*

*FSW, 35 years, Hayathnagar*

### **An increasing number of CBOs/networks were seen as a result of the interventions**

Many respondents said that their self-confidence and knowledge about many issues had increased as a result of their involvement with CBOs. Interactions with their peers also fostered a sense of belonging and a desire to work for their community and safeguard their rights and interests. Many respondents could recount instances where peers received support from the CBOs.

There were also instances when some of the respondents who had registered with the CBOs said that they were not aware of the CBO activities, and that they had not yet attended meetings. Lack of funds, lack of time, stigma attached to CBOs, lack of initiative by NGO staff, disunity among KPs, and high mobility of KPs were mentioned as reasons limiting involvement in CBOs.

### **Informal networks play a key role in enhancing social capital among KPs**

Informal networks among peers, partners and friends have been stimulated and sustained through the project activities. For FSWs, peers play an important role in their lives, providing security, protection, and sustenance. Most spoke about having one or two close friends who support them in their children's education, during sickness, and during price negotiations with brothel owners. For many FSWs such supportive behavior, however, coexists with mistrust: experiences of being cheated, backbiting, feelings of jealousy, and competition for customers were some of the reasons cited by the FSWs for their mistrust in peers. Most of the 50 FSW respondents, including those who were married, had a regular partner other than their husband; these partners were depended on for emotional and also for financial security reasons.

Some kothi MSM (11/50) were involved in *rithi* (rituals for getting accepted into groups of kothi) relationships with peers and spoke of small, informal, localized, "quasi-kinship" groups. The quasi-kin groups of the kothis have significant ritual aspects, as well as obligations of mutual support and aid. Others, though aware of such quasi-kin groups, did not want to enter into such relationships partly because they wanted to keep their identity secret and partly because of the obligations such relationships entailed.

About half of the MSM respondents, including most men who were married to women, had regular male partners who could be counted on for emotional and financial support. Respondents had

strong emotional attachment with their partners and many said that they felt insecure, lonely, and troubled in the absence of their partners.

*I have only one permanent partner. He is working in a bike repairing shop now. He is not yet married. Our relationship is such that we come to the rescue of each other in the times of need. We love each other and lead our lives as if we are husband and wife. Whatever I wish for, he used to bring that. Whenever I required any money, I used to ask him.*

*MSM 23 years, Vemulawada*

Among the 25 PLHIV who were currently married, their spouses were the primary source of care and support.

*My husband is now everything for me. I forgot totally about my HIV status because of my husband is taking care of me very well. Another thing is, I am HIV positive and my husband is negative. My husband is like God for me...*

*Female PLHIV 38 years, Sangareddy*

In a few cases respondents who were married reported that their spouses left them once they found about their HIV status.

The interviews also suggest that in addition to peers and partners, respondents have a range of other informal networks with family member, neighbors, friends, employers, gatekeepers, and clients. While these kinds of relationships were often characterized by lack of support, stigmatization and discrimination, and at times violence, interviews also pointed to occasions when support was obtained from within these networks.

*I have enough neighbors. One or two of them keep helping me every now and then. I borrow amounts either from my customers or from my friends. I repay their amounts later... For my children's education, the "Savaram" church pastor had helped me... They are now studying in that church school.*

*FSW, 29 years, Bhadrachalam*

### ***Interventions increased level of awareness of HIV/STI risks and risk reduction strategies among KPs***

At both baseline and endline, the majority of KPs from all the sites could correctly list the main symptoms of STIs and could indicate a number of correct routes of HIV transmission. There were, however, still misconceptions about modes of spreading HIV which included: touching or hugging an infected person; talking to and walking with an HIV-positive person; sharing food or drinks and using toilets used by HIV-positive persons; and through mosquito bites.

*I was told that this disease is contracted by doing sex work, through infected needles, by touching the AIDS patients, by staying with them, by walking through the streets though which AIDS patients had gone before. That is why I am planning to be cautious in future. But mosquitoes are more prevalent in our area. I am getting scared about it.*

*FSW, 24 years, Bhadrachalam*

At endline, most respondents reported use of condoms as the best method for preventing HIV transmission. Getting tested for HIV periodically was another measure commonly reported by the respondents. Other preventive measures like abstinence from sex, taking complete treatment from the doctor for STIs, avoiding sex with people having STIs, and using disposable syringes were indicated by all the categories of KPs. Applying turmeric, drinking water, lime or dettol in their genital areas and application of a gel on the client penis were also reported as good HIV preventive measures by a few FSWs.

All categories of KPs at endline ranked ORW and NGO staff as an important source of awareness on HIV. Mass media like TV, radio and newspapers has also played a significant role in creating awareness about HIV, especially among FSW respondents. Discussions with peers and clients

were also cited as important sources of information by FSWs and MSMs. Other sources of awareness mentioned by all the three categories of KPs were doctors from the government hospitals, clips shown in theaters, and posters displayed in government hospitals and roadsides. Counselors of VCCTC and staff at care and support NGOs were mentioned as an important source of awareness, especially by PLHIVs. A few mentioned community leaders and politicians as sources of HIV awareness.

***Many respondents expressed hope or desire to avoid HIV/STI infection and/or to avoid infecting others with HIV/STIs***

The second round interviews indicate that maintaining their health was a key priority for both MSMs and FSWs. Many of the respondents indicated that they were disturbed and scared by pictures showing people affected by STIs and HIV and by the plight of some HIV-positive people they knew. Apprehensions about their and their children's future, the knowledge that HIV does not have a cure and that STIs and HIV can be easily prevented, along with easy accessibility of condoms and sexual health services also appeared to have brought about changes in attitudes regarding STI/HIV prevention among many respondents. A sense of empowerment of respondents especially FSWs, to avoid HIV/STI infections, was apparent in many interviews. Many married MSMs and those with regular partners also expressed their desire to avoid infecting their spouses/partners.

*"I use condom with him (partner) also. Earlier I was not using with him but since 5-6 years, I am using the condoms. Why because they are saying about the transmission of these types of diseases (AIDS). I use condoms even with my wife at home. She doesn't know that I go out here and there (sex work). Why should we spoil her? So I use condom with my wife- MSM, 38, Guntakal*

The knowledge that they could lead near normal lives if they take precautions, the fact that ARV drugs are now available, the availability of support services for PLHIVs, and interaction with peers in PLHIV networks, has similarly empowered many PLHIV respondents to take care of their health. Many said that they have voluntarily abstained from sex, even though they have sexual desires, because they did not want to infect others. Those who reported that they had sex either within marriage or outside, expressed strong desire to avoid infecting others with HIV.

*.....Ever since I was tested positive for HIV, we both have been living separately. Thus, I have been away from sex for more than a year now. Though I do get the sexual desire time and again, I do not get tempted, consoling myself that I should [not] get the lives of other men spoiled by this.*

*Female PLHIV, 21, Bhadrachalam*

*When I am going out to have sex with other women and also my wife I am using condoms from the time I knew that I am HIV-positive.*

*Male, PLHIV, 24, Sangareddy*

***Many respondents developed skills to reduce risk of HIV/STI transmission***

Compared to baseline, more FSW and MSM respondents said that they were able to negotiate condom use with partners/clients. In fact, most respondents said that they will not engage in sex with a client without a condom. Many said that they themselves bring condoms. If the client did not know how to use the condom, they demonstrated how it is used. If client still refused to use a condom, many said that they returned his money and asked him to leave. Most respondents indicated that they learnt how to use condoms and negotiate condom use from ORWs and NGO staff.

*Initially when any customer says he does not like using condoms I used to accept. But now after knowing everything about HIV particularly after knowing that there is no medicine for this disease I have been using condoms at any cost. I am educating each and every customer who comes to me on this issue.*

*FSW, 24, Bhadrachalam*

Some respondents reported skills in negotiating violence from clients, police, and rowdies or thugs. Other preventive behavior included: avoidance of certain type of clients like drunkards, poor or shabbily dressed persons; avoidance of certain areas known for clients who do not use condoms; and decreasing the number of clients. Some MSMs said that they use alternate safe sex methods including non-penetrative sex. Some KPs were actively involved in distributing condoms and mobilizing peers for HIV prevention. A few respondents said that they would encourage clients infected with STIs to seek treatment.

**KPs are motivated to use sexual health services and commodities**

The interviews suggest that most MSM and FSW respondents are motivated to use condoms and other sexual health services like counseling, STI treatment, and HIV testing. While concern for their health and fear of contracting HIV is a key factor, accessibility of inexpensive good quality services contribute significantly to utilization of services. The ORW, peer educators, counselors, and NGO doctors as well as interactions with peers have played a key role in motivating MSM and FSW respondents. Many respondents indicated that they try to motivate their peers to use services and access services from Mythri Clinic.

In all the sites MSM and FSW respondents are mainly accessing condoms from the FPP/ Avahan program. Many said they received condoms from ORWs and peer educators in the field. Others said that they collected condoms from the DIC. Some said that they are taking condoms from condom boxes kept by the NGO. A few obtain condoms from government hospitals or ask the client to bring them, and a few purchase condoms from medical shops and pan shops. Many reported that they were too shy to buy condoms or get them directly from organizations; for these reasons provision of condoms by ORWs directly to the respondent at their homes or at convenient public places was seen as very helpful.

**Interventions led to behavior change, including consistent condom use and STI**

While baseline findings indicated that slightly less than half of the MSM and FSW respondents consistently used condoms with their clients, during the second round of data collection 40/50 FSW respondents and 43/50 MSM respondents reported consistent condom usage with clients (see Table 2). Very few baseline respondents reported usage of condoms with specific partners like lovers, husbands, boyfriends, and permanent panthis; at endline 24/40 FSW respondents who had a spouse or partner and 15/25 MSM respondents who had a partner reported consistent condom usage. Non-usage of condoms with regular partners by many FSW (16/40) and MSM (10/25) respondents is still a matter of concern. However unlike the baseline survey, what was evident, especially from MSM interviews, was their increased awareness that their regular partners may also have sexual relations with multiple persons and that it was therefore not safe to have sex with them without condoms.

Some MSM and FSW respondents revealed that on some occasions they did not negotiate condom use: that they disliked or could not get condoms, trusted in other precautions taken. Other reasons mentioned for not using condoms included the insistence of clients/partners not to use them, trust in their clients and, not using them “out of love.”

The baseline data found that NGOs were not a major source of STI treatment for FSWs and that they relied more on self treatment measures like buying medicines directly from medical shop, consumption of so called ‘cold foods’ like butter and milk, or using dettol in vaginal areas. The second round data indicate that the majority of FSW and MSM respondents were accessing treatment for STIs from Mythri Clinics.

**Table 2: Pattern of Condom Usage with Partner/Spouse and Clients Among MSM and FSWs in the Study Sites**

Condom use	Sangareddy		Hayat nagar		Vemulawada		Bhadrachalam		Guntakal		Total	
	With Spouse/	With Clients	With Spou	With h	With Spou	With Client	With Spou	With Client	With Spou	With Clients	With Spouse/	With client

	Partner		se/Partner	Clients	se/Partner	s	se/Partner	s	se/Partner		Partner	s
<b>MSM</b>	3	8	3	8	5	10	0	9	4	8	15	43
Consistent	0	1	0	2	0	0	0	1	0	2	0	6
Selective	2	1	1	0	1	0	1	0	5	0	10	1
Do not use	5		6		4		9		1		25	
No partner/spouse	10	10	10	10	10	10	10	10	10	10	50	50
Total												
<b>FSW</b>	4	7	6	9	6	10	3	5	5	9	24	40
Consistent	0	1	0	1	0	0	0	4	0	1	0	7
Selective	2	2	2	0	1	0	6	1	5	0	16	3
Do not use	4		2		3		1		0		10	
No partner/spouse	10	10	10	10	10	10	10	10	10	10	50	50
Total	3	8	3	8	5	10	0	9	4	8	15	43

### Stigma, discrimination and violence are major concerns of KPs

The baseline study highlighted the stigmatized and violent context in which KP groups exist in the sites (see also Samuels, et. al 2006a). No significant change in the context was evident in the second round of data collection. However it appears that KPs have been better empowered to handle stigma, discrimination, and violence which is reflected in various coping mechanisms and significantly increased seeking of support from peers, networks, and NGOs.

Most of the FSW and MSM respondents have been subjected to various forms of stigmatizing comments or gestures in their every day life. Much of the stigma against MSMs is directed to the more "feminized" kothis; feminized behavior in a male is particularly stigmatized as it is a direct contradiction to the general expectation that males should be "manly." It has been observed that there is relatively much less stigmatization of panthi MSM behavior, since penetrating is a male act. In addition, most panthis are married and otherwise play "normal" male roles in daily life.

Perpetuators of stigma include the 'general community,' neighbors, family members, spouse/partner, friends, peers, clients, health care personnel, staff at business establishments, government officials, house owners, colleagues, auto drivers, police, and rowdies. The more overt forms of discriminatory behaviour experienced by KP groups include avoidance and isolation, expulsion from rented homes, denial of services, opportunities and support. The majority of MSM and FSW respondents reported that they have experienced violence from various sources. Forms of violent behavior include; beating, verbal abuse and threats, robbing money and valuables, rape, 'unnatural sex' by force, coercive sex with multiple persons and coercive sex without condoms. The following quotes highlighting hiding when facing health care providers, fear when facing clients and partners and violence and jealousy among peers.

*I faced problem when I went to the hospital. That is the reason I do not wear a sari and wear pants and shirt. I cover my plait with a towel, so that people don't see it and go to the hospital. Some people who recognize us in the hospital tease us.*

*MSM, 22 years, Sangareddy*

*My partner knows all this (involvement with another man). He used to threaten me that he would inform to my parents about this. He wanted me to have sex only with him.*

*MSM 20 years, Guntakal.*

*..... There are 3-4 drivers in one lorry. They harass me and prefer to have anal sex. I do not like it and get into tears. They threaten me by using knives. I do not agree to whatever they want. They go to extend by causing injures like even cutting my fingers (Here the respondent showed wounds on her hand)*

*FSW, 35 years, Sangareddy*

*Once, one sex worker had a quarrel with me. She started the quarrel saying that her client came to me. Then I told her that clients go to sex worker based on their interest, it is their wish, not our wish. She did not listen and hit me holding my hair. I also hit her. This incident happened two months back.*

*FSW, 35 years, Hayatnagar*

### **Members of KPs coped with stigma, discrimination and violence in various ways**

Despite members of KPs continuing to demonstrate feelings of guilt, self blame, inferiority, despair, that what they were doing was wrong or immoral (especially in the case of MSM), a range of coping strategies were adopted. These included keeping identities secret, disclosing only in order to seek support; avoiding and withdrawing from families and the general community. Many respondents also spoke about coming to terms with their profession, seeing sex work as essential for their and their family's survival, and as such self acceptance was seen to be growing. Similarly, some of the FSW and MSM narratives reveal efforts to deal with their stigmatized identities and take control of their lives; they were seen to exert control through, for instance, deciding with whom and where they go for sex work:

*"I do not go to other villages, as in any situations I do not do danda (sexwork) during the night time. I do only in day time and I come back as early as possible in the evenings".-FSW, 35 years, Guntakal*

Another form of taking control was seen by PLHIV respondents, speaking out.

*In my native place I told the village people that I am an HIV-positive person and told them about HIV and how to prevent it. I went to 30 villages in Dubbaka mandal. I was on the stage in all the villages*

*PLHIV, 28 years, Sangareddy*

Respondents from all KP groups, who were more aware of STI/HIV prevention and had access to health services, were seen to be more in control of their lives. Being cautious about their health has also helped MSM and FSW respondents become firmer in dealing with clients and in being able better negotiate condom use (see above). PLHIV respondents especially those who had experienced HIV-related symptoms felt much more in control of their lives when they were healthy. Ill health meant loss of control as their earning potential is decreased and they had to be dependent on others for care. The need to appear healthy was also to prevent others from knowing about their affliction and to counter stigma attached to visibly ill HIV patients.

### **At endline more KPs reporting receiving support for coping with stigma, discrimination and violence from family.**

The baseline study revealed that very few respondents received active support from others in dealing with abuse they experienced. Interviews at endline however indicated several sources of support for the KPs in coping with stigma, discrimination and violence including from family members.

*If I get hurt when somebody says something, I share with my mother. My mother then pacifies me. I will be normal forgetting everything when my friends come.*

*FSW, 23 years, Bhadrachalam*

*My husband supports me without letting me face any difficulty. He asks me to do work if possible otherwise, he asks me to stay at home. My husband even cooks food and feeds me when I feel difficulty in cooking. He husband stands by me and sees that I don't face any problem or difficulty.*

*PLHIV, 38 years, Sangareddy*

### **Over time, members of KPs have come to rely more on informal peer networks to cope and respond to stigmatizing or violent situations**

A clear change from the baseline is the involvement of KPs in peer networks within the sites and outside. The small, informal peer groupings of the KPs contribute significantly in providing social support to deal with stigma, discrimination, and violence. FSW respondents said that they confide and share problems of harassment with peers and help each other to escape from police and to deal with violent clients. Other examples of peers providing support include: paying fines and getting a peer out from prison, teaching peers how to handle trouble makers and negotiating a higher percentage from brothel owners.

*If they (peers) face any problem, or if a client harasses anyone, or if he doesn't give money one or the other will be there to help them and to solve the problem. If they are good we will be good to them or otherwise if they are harsh to us we will be the same way with them. We take care of the people who come into this business newly. We try to know why, what are those situations and help them.*

*FSW, 36 years, Vemulawada*

Many MSM respondents said that they could share their problems only with their peers; similarly, there is a realization among them that if they are united they could better prevent stigma, discrimination, and violence. They find much comfort and strength in confiding in their peers. Examples of peers providing support include: emotional support, preventing abuse from clients, educating community members on preventing abuse, publicly cursing perpetrators of discrimination and violence.

*The rowdies do come and threaten us sir. This bheela (a goon) some times troubles us. We tell him to go away. He offers us ten or twenty rupees and asks us to have sex with him, we abuse him and tell him that we don't need his money and tell him to go away. Or we clap, and other Kojjas who are having sex in nearby areas come running and scold the fellow.*

*MSM, 22 years, Sangareddy.*

### **Compared to baseline, members of KPs report greater reliance on CBOs and NGOs to cope and respond to stigmatizing or violent situations**

Compared to baseline findings, there has been significant scaling up of NGO activities in providing an enabling environment for KPs. One approach has involved advocacy work with community leaders, the police, and medical personnel to raise awareness about stigma, discrimination and violence. In all sites (except Sangareddy) a Core Advocacy Group comprised of KPs has been formed to deal with advocacy issues including, for instance, meeting police officials and sensitizing them about KPs. They are alerted to any incidents of violence or legal problems faced by the KP, immediately passing on this information to the CBO/NGO in the site.

As already discussed above, outreach workers form the link between KPs and the NGO and are seen to be critical in empowering KPs to deal with abuse. In many instances the ORW directly deals with perpetrators of abuse to prevent future occurrences. In a few instances the ORW arranged for respondents to get released from jail.

### **Conclusions**

As a result of the various site-level interventions, findings show that KPs are motivated to adopt safer sex practices, are empowered to take care of their health, and are more confident. Members of KPs have been empowered through, among other things: increased awareness and advocacy programs; appointing outreach workers and peer educators from the KPs; providing DICs which create safe and supportive environments; providing sexual health services in a stigma-free environment; and encouraging the creation of informal and formal networks (including CBOs and NGOs) which have facilitated community mobilization.

Advocacy with community leaders and key public officials, e.g. police, have also encouraged the creation of an enabling environment in order to combat and prevent stigma, discrimination, and violence suffered by KPs. Despite these activities, stigma, discrimination, and violence continue to affect the lives of most respondents. What the second round data collection shows, however, is that as a result of empowerment, KPs are better able to deal with this stigma, discrimination and violence.

Overall, when comparing endline with baseline data, findings show that social capital amongst respondents has grown over the period of the intervention. Findings also show that uptake of health services and condom use have increased over the time period of the project. These positive findings, as well as findings of reduced STI prevalence rates in AP (see McPherson et al, 2008 and McPherson et. al forthcoming) are associated with increased social capital and empowerment of KPs, although causal pathways are difficult to demonstrate.

In order to prevent the spread of HIV amongst FSWs and MSM, interventions need to be holistic; they need to encourage the provision of good quality, affordable health services and commodities; they need to encourage a stigma-free enabling environment; and they need to empower KPs through building social capital and fostering solidarity amongst peers and others, thus increasing confidence and building self-esteem in order to ultimately effect real behavior change. The following recommendations emerged from the study:

***Family-level interventions are needed to foster support of KPs.***

While family members, including spouses, can be a source of stigma and violence, they can also provide individuals with needed support and assistance. Individuals who reported a supportive family environment were more likely to show signs of self-esteem and self-worth, and to be better equipped to cope with stigma. This underscores the need to examine the extent to which trust and support can be fostered among families of KPs.

***Strategies to involve clients of sex workers must be part of the overall program.***

Clients of sex workers represent one key, relatively neglected group of people. Not only can they be perpetrators of stigma and violence, but as the majority of them are married and are likely to have multiple sexual partners, they are also a bridge into the general population. Therefore, HIV awareness raising activities are needed to engage them in building an enabling stigma-free environment.

***Awareness raising and sensitization programs with doctors and other health staff are essential.***

The Mythri clinics in the sites have gone a long way in providing high quality health services in a friend, safe and stigma-free environment. Nevertheless, further awareness raising and sensitization programs are needed targeting doctors and other health staff since KPs report still suffering stigma and discrimination at the hands of some health care providers. This highlights the need to educate and sensitive health care providers to the need for confidential and de-stigmatizing service delivery.

***Peer support groups need to be carefully structured to take into account the challenges and sensitivities of different KPs.***

Training in group management and dynamics needs to be made available to established and newly-formed peer support groups. These groups can then, with the assistance of NGOs and other advocates, be in a stronger position to push for legal rights, safe spaces, and better access to public services. Efforts are also needed to help groups maintain confidentiality and communicate this group norm to prospective members.

***Efforts to engage people in powerful positions in the fight against stigma are needed.***

To mitigate stigma and create an enabling and empowering environment to practice HIV protective behaviors, programs need to focus on people in powerful positions, including government officials, health professionals, the media, legal professionals, and the police. Raising awareness among

these groups will not only assist in ending the vicious cycle of stigma, discrimination, and violence, but by these people speaking out, the silence and fear which often surround HIV with devastating consequences is likely to decrease.

***Life skills training and livelihood development need to be addressed.***

In order to empower individuals and assist them to climb out of the poverty trap, which is often a central push factor into sex work, NGOs need to examine what role they can play in providing or facilitating the provision of like skills training. In a possible next phase, consideration should be given of ways of linking key population groups with wider development programs and the government to encourage the building of partnerships with institutions responsible for delivering life skills and livelihood development training.

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