

**ENABLING ENVIRONMENTS PROMOTE ACCESS AND  
UPTAKE OF CLINICAL SERVICES AT AN HIV  
PREVENTION PROJECT FOR SEX WORKERS IN  
MYSORE, INDIA**

by

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# APPROVAL

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## **ABSTRACT**

Increasing sex workers' access and utilization of health care services is a key part of HIV prevention. An HIV prevention project in Mysore, India has been particularly successful in fostering a new norm of health care seeking among the local sex workers while facilitating community ownership of health care delivery. This paper describes how the use of occupational health ideologies, along with the creation of enabling environments facilitated uptake of project healthcare services, transformed power relations between sex workers and their healthcare providers and led Mysore's sex workers to initiate health enhancing actions that reached beyond project imperatives to serve self-identified community needs.

**Keywords:** Sex workers; health care services; HIV/AIDS; empowerment; India

**Subject Terms:** HIV Infections - Cross cultural studies; Prevention Strategy; Community-Based; Health Care Services

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## TABLE OF CONTENTS

<b>Approval</b> .....	<b>ii</b>
<b>Abstract</b> .....	<b>iii</b>
<b>Acknowledgements</b> .....	<b>iv</b>
<b>Table of Contents</b> .....	<b>v</b>
<b>Introduction</b> .....	<b>1</b>
<b>Purpose</b> .....	<b>4</b>
<b>Literature review</b> .....	<b>5</b>
<b>Methods</b> .....	<b>9</b>
<b>Findings</b> .....	<b>11</b>
Sexual Health as Occupational Health .....	11
Building Enabling Environments, Transforming Power Relationships.....	13
Beyond Project Imperatives .....	18
<b>Recommendations</b> .....	<b>21</b>
<b>Discussion</b> .....	<b>23</b>
<b>Reference List</b> .....	<b>28</b>

## INTRODUCTION

Currently, an estimated 2.5 million Indians are living with HIV/AIDS - the highest number of infections in any country outside of Africa (United Nations AIDS, 2007). As elsewhere, the Indian HIV/AIDS epidemic is concentrated amongst the most socially and economically vulnerable groups. This includes commercial sex workers (CSWs) who are rendered vulnerable to infection because of low rates of condom use, stigmatization, and limited access to quality health care. Consequently, unprotected paid sex is a major route of HIV transmission, particularly in Southern India (Halli, Satihal, and Moses, 2007).

In 2003 in Mysore, a city in the Southern Indian state of Karnataka, sex work was characterized by an HIV prevalence of 26%, high rates of other STIs, little awareness of sexual health issues, and low levels of condom use (Reza-Paul et al, 2008). Furthermore, sex workers seldom received appropriate medical care as fear of being identified as a sex worker, stigmatization, breaches of confidentiality, discrimination by healthcare providers, and the price of treatment prevented many of them from accessing services from qualified physicians.

In 2003 the University of Manitoba was awarded funding by the Avahan Initiative (the Bill and Melinda Gates Foundation) to establish an HIV prevention project to serve CSWs in Karnataka. In turn, the University of Manitoba works with the Karnataka Health Promotion Trust (KHPT) to implement these projects.

In Mysore, their work gave rise to Ashodaya Samithi - a sex worker collective and Disha – a learning site that works with the collective to achieve sex worker empowerment and HIV prevention, while sharing lessons with other projects throughout Asia-Pacific. Taking their cue from the Sonagachi Project, a 12-year Calcutta-based initiative, the staff at Disha and the members of Ashodaya employed an array of empowerment approaches to combat the marginalization of CSWs in order to enhance their access to HIV prevention. This included the creation of ‘enabling environments’, which facilitate the increased uptake and ownership of clinical health care services by sex workers.

In February of 2004, during the first year of the project, a clinic was established to treat STIs and facilitate health education among the population of sex workers in Mysore. Initially, the clinic was operated by the KHPT core team, and during the early months of operation the number of sex workers coming to the clinic for a health check up was low (Reza-Paul et al., 2008). As of 2008, Ashodaya Samithi runs Namma Clinic (Our Clinic) in Mysore along with a satellite evening clinic and 11 additional clinics in the surrounding area. Ashodaya’s clinics provide services to approximately 1000 to 1200 people every month. Moreover, the number of sex workers coming in for health checkups has dramatically increased.

Ashodaya was able to take on a large role in running their own clinics by creating a Clinic Management Committee (CMC) through which community members take part in clinic management and administration. The responsibilities of the CMC include monitoring the performance of the clinic doctor, monitoring

outreach services, running referral services, ordering and distributing medicines, and organizing village health camps. In addition to an increased role in administrating clinic services, community members have gone above and beyond project imperatives by initiating their own programs to support members living with HIV/AIDS.

In a span of four years, clinic usership has increased dramatically as a new norm of healthcare seeking has emerged within Mysore's sex worker community. Indeed, the Ashodaya community has gone from being passive beneficiaries of health care services to key agents in running their own clinic and in creating their own initiatives to serve the needs of their community.

This investigation into the successes and challenges of Disha and Ashodaya's efforts to increase sex workers' access and ownership of clinical services can be used to inform organizations with similar goals. Furthermore, it promotes a variety of strategies as tools for HIV prevention among marginalized groups. In sum, understanding the relationship between enabling environments and access to health care services is crucial because the adoption of successful prevention practices will be instrumental in reducing the morbidity and mortality due to HIV/AIDS among CSWs and throughout the Indian population.



## **PURPOSE**

The dramatic increase of Mysore sex workers' usership and ownership of clinical services is a result of strategies employed by Disha and Ashodaya to create enabling environments for this to occur. The objective of this paper is to identify and document the best practices involved in creating high service utilization and facilitating community ownership of health care services by the sex worker population in Mysore.

## **LITERATURE REVIEW**

Interventions focused on reducing the vulnerability of CSWs to HIV infection are of key strategic importance in curtailing the Indian AIDS epidemic as well as in protecting the health and human rights of sex workers (Blanchard et al., 2005). Although HIV infection arises as a result of specific individual behaviours, the notion of social vulnerability draws attention to the social factors that place certain groups at higher risk (Parker, 1996). Consequently, researchers have recognized that interventions that fail to address the social and structural factors that shape CSWs risk for disease are largely ineffective (Asthana and Oostvogels, 1996; Chattopadhy and McKaig, 2004).

Empowerment approaches have emerged as effective strategies for combating social exclusion and building the capacity of community organizations and individuals to make decisions and advocate for themselves and, thus, to reduce health disparities (Wallerstein, 2006). Accordingly, some prevention projects have broadened their focus by empowering vulnerable groups through community mobilization, skill building, knowledge sharing, and participation (Parker, 1996).

The Sonagachi Project, which has been successful in lowering HIV rates among sex workers in Calcutta, has become well known for its empowerment and participatory approach (Ghose, Swendeman, George, and Chowdhury, 2008; Jana, Basu, Rotheram-Borus, and Newman, 2004). Furthermore, Halli,

Ramesh, O'Neil, Moses, and Blanchard (2006) found an association between higher degrees of collectivization and higher knowledge of HIV/AIDS and reported condom use among female sex workers in Karnataka. However, structural approaches to HIV prevention remain challenging to implement (Asthana and Oostvogels, 1998; Gupta, Parkhurst, Ogden, Aggleton, and Mahal, 2008). Other authors have highlighted the difficult and complex nature of such strategies of empowerment and participation in regards to power relations within and outside of marginalized groups (Cornisha and Ghosh, 2008; Cornwall, 2004; Evans and Lambert, 2008).

While the successes of the Sonagachi Project have been widely published, Disha and Ashodaya Samithi remain relatively unexplored in the literature. The recent study of Reza-Paul et al. (2008) reports significant decreases in STI prevalence and increases in reported condom use following a targeted community-led structural intervention. However, while this large study demonstrates the successes of Disha and Ashodaya in quantitative terms, there is little understanding of the processes behind such accomplishments.

One of the significant accomplishments of the project has been to increase sex workers' access to and use of clinical health services as well as to increase their ownership and management of these services. Indeed, increasing access to health care services and treating concurrent STIs in at-risk populations has long been a key focus of global HIV prevention strategies (Steen and Dallabetta, 2003). For example, strategies that include regular screening and treatment of treatable STIs, along with a peer education and emphasis on

condom use have been proven effective in reducing STI prevalence among female sex workers and their clients (Steen and Dallabetta, 2003). Such efforts to prevent and cure STIs are key to HIV prevention efforts as STI presence increases biological vulnerability to HIV infection (Aral, Padian, and Holmes, 2005).

The delivery and use of health care services, however, is shaped by the determinants of people's access and use of them as well as the health systems that are in place and the environments in which they operate (Gruskin, Ferguson, and O'Malley, 2007). Therefore, programs which focus on service provision alone have been criticized for not addressing the underlying social vulnerabilities that structure access to such services (Heise and Elias, 1995). For example, studies have demonstrated disparities in health care utilization related to gender, social and economic status, as well as perception of self worth (Bell, Mthembu, O'Sullivan, and Moody, 2007; Currie and Wiesenberg, 2003; Chamberlain et al., 2007).

Sex workers in particular experience numerous social, cultural and economic barriers that limit their access and use of sexual health services (Evans and Lambert, 1997). For instance, stigma around the practice of sex work and STIs is especially effective in creating barriers to sex workers access and utilization of health care (Chacham, Diniz, Maia, Galati, and Mirime, 2007). Such research points to the importance of advancing models of health care and STI treatment similar to those Ashodaya employs, which address the social and

economic marginalization of sex workers in conjunction with issues of health care service provision.

This paper advances the argument that the approaches to de-stigmatization and empowerment taken in the Ashodaya project have been effective in addressing social barriers and increasing health care service utilization while facilitating community ownership of service delivery. Although existing literature supports the importance of such strategies to HIV prevention, the processes behind the successful implementation of these practices remain relatively unexplored. This paper aims to address this gap by describing the processes behind the successful implementation of such strategies by Disha and Ashodaya in Mysore, India.

## **METHODS**

Ethics approval was obtained from the Simon Fraser University Research Ethics Board. Permission to conduct this research was also sought and received from the governing board of Ashodaya Samithi.

Qualitative data was gathered through semi-structured interviews with community members and project staff. Purposive sampling techniques were used to select interviewees from the Clinic Management Committee, clinical team, and community and non-community members who utilize the project's clinical services. Ten individual interviews and two focus groups were conducted during the month of June in 2008 with the help of Disha and Ashodaya staff. Thirty transcripts from interviews conducted by colleagues were also examined. Document review and participant observation supplemented the data gathered during interviews.

Data collection and coding was undertaken simultaneously in an iterative process. A priori codes were developed in advance of data collection and used in the coding of interview transcripts, document notes, and field notes. Emergent codes were added during the coding process. Coding with both a priori and emergent codes occurred in multiple stages – after each interview was transcribed, and then again as new information was collected and novel themes arose. In turn, analysis informed the process of editing and creating new interview guides as the research process unfolded. This grounded, inductive

approach was of particular use in generating ideas about the ways in which enabling environments relate to HIV prevention. Analysis was triangulated with the findings of collaborators and member checks were sought from Ashodaya insiders. Research findings were presented to the community and their feedback was integrated into this paper.

## **FINDINGS**

### **Sexual Health as Occupational Health**

Sex work is a dangerous occupation which carries the risk of numerous safety and health hazards (Alexander, 1998). Although STI's, HIV, and violence have long been considered "risks of the trade", these are rarely conceptualized as occupational health risks (Jana et al., 2004; Rekart, 2006). The reframing of the health risks of sex work as occupational hazards is a key component of the Sonagachi Project, where it has worked to empower sex workers by characterizing common health concerns as issues of a disenfranchised workforce rather than individualized problems (Jana et al., 2004).

The Mysore project has attempted to replicate this strategy and project staff framed STIs and HIV as occupational hazards of sex work in the hopes that this would empower sex workers to take control of their own wellness. This view, which was disseminated through peer educators and guides was taken up by community members and helped to combat the stigma surrounding STIs and HIV while working to reduce shame around the practice of sex work itself:

Earlier we thought that HIV was a big disease and dangerous, we were shocked by just hearing the word. But after we came here we started to learn, we got the message and we started to understand that for any profession there are diseases that will come...if you look too much at a computer screen, for example, you will get diseases in your eyes. Like that, we are sex workers and there is much opportunity to get STIs and HIV. Sex work is our profession, like any other profession and STIs and HIV are the occupational diseases of our profession.



- Female sex worker and member of Ashodaya

By acknowledging sex work as a legitimate profession, project staff demonstrated their respect for the sex workers and built self-esteem among community members. Reducing stigma around sex work, STIs and HIV also led to increased service utilization as the shame around revealing STI symptoms was diminished.

In turn, sex workers came to see their health as integral to their livelihood.

Our body is the business for us. If our body is not clean and healthy we can't do our work... if a client is coming to have sex he will be satisfied if we are healthy. Clients will also spread the message to their friends that she is very clean and healthy, and that way we will get more clients.

- Female sex worker and member of Ashodaya

Participants indicated that since taking an interest in their health, they were now able to attract more clients and to charge more for their services. In other words, they came to understand that good health is good for business and to place an increased value on the work itself, reflected in their choice to charge more. Legitimizing sex work as an occupation also led to a sense of professionalism as community members began to take responsibility for the health of their peers.

Like other jobs, we have colleagues. Clients can go from one of us to the other, we don't want our ill health to spread to our other colleagues.

- Female sex worker and member of Ashodaya

Attaching sexual health to the idea of occupational health fits with a wellness approach to community health care. Sex workers were encouraged to attend the clinic for monthly health check ups in order to maintain their health so they would be able to do their work and earn money. This framing of sexual health and physical wellness as important to practicing successful sex work promoted positive health-seeking behaviour within the Mysore sex worker community:

It's not like [sex workers] go only when they are sick...Once a month they go for the health check up because we want to hear from the doctor that we are okay.

- Female sex worker and member of Ashodaya

Framing STIs and HIV as occupational hazards of sex work worked to create a new norm of health-seeking behaviour among community members as they realized the importance of good health to their profession and stigma around STIs and HIV was reduced.

## **Building Enabling Environments, Transforming Power Relationships**

Planning for the administration of clinical services was done with the community. Information was gathered on a list of preferred physicians, barriers to accessing STI services, and convenient hours of operation and location. It was decided that a clinic would be created in the same space as the drop in centre, near all three major sex work zones and that it would operate from 1-4 pm in the afternoon – the time when the least sex workers were in the field. Later, a second clinic was added near the city bus stand to cater to the needs of

community members who worked in the evenings and additional clinic days were added at clinics in outlying areas in response to requests from community members.

By prioritizing community needs from the initial stages, the core team worked to convince the community that the clinic was truly *their* clinic. As this male sex worker and Ashodaya member explains,

Our clinic is different from other clinics, because it is formed from the need of the community, and exists for the needs of the community... they [sex workers] expect good treatment from the doctor because it is our clinic.

- Male sex worker and member of Ashodaya

As project organizers had hoped, the sense among the community that the *Namma* clinic was “their clinic” created trust in the services offered there and distinguished it from other healthcare providers. However, it also worked to create a rights-based political consciousness among sex workers in which they formed their own understanding of their entitlements as sex workers and individuals. Connected to this was a notion of occupational health. “If we are not healthy,” one female sex worker and Ashodaya member explained, “we cannot fight for ourselves or our rights”.

Clinic staff were trained to make friendly small talk with community members who came to the clinic and because sex workers viewed the clinic as their own, they felt entitled to this treatment:

The community members will have a lot of problems, they will have many things in their mind when they come to the clinic...But when they come to the clinic we will make our doctor give them time and

make them feel comfortable and give treatment with a smiling face and then the sex workers can forget about their pain and their other problems.

- Male sex worker and member of Ashodaya

As Namma Clinic was established as a community based clinic, the comfort and satisfaction of sex workers was a priority. Further, as the language of this participant suggests, sex workers became more than passive recipients of services. They sought and demanded treatment that accorded with their new perceptions of sex work and their re-formed expectations of service providers.

The Clinic Management Committee (CMC) was created in 2006 to respond to community feedback regarding health care services in addition to looking after the clinic administration and staff. The CMC is made up of Ashodaya members who have established mechanisms to receive and respond to feedback from sex workers about the services they receive. Through the CMC the community is not only encouraged to provide feedback on the clinical services they receive but are also supported as they take action to initiate changes.

Participants expressed that in the past sex workers had no options for recourse when dissatisfied with the healthcare they received. At Ashodaya sex workers' beliefs that they were capable of making changes in the way the clinic operated signified an increase in sense of ownership and a transformation in power relations:

We are in the capacity of calling the doctor to come for a meeting. We can tell the doctor if he is not treating us well. We are in a position that even though we are community members we can

criticize the doctor, we can give him suggestions about how to treat the patients.

- Female sex worker and member of Ashodaya

As this comment suggests, the community was active in monitoring the doctor and other clinic staff. That the sex workers took the initiative to give feedback about health services suggests they believed changes would result from it. This indicates that they knew their rights as patients and expected to be treated with respect. Furthermore, it represents a major alteration to the normal power relationship between physicians and patients in India and a successful challenge to biomedical authority (Van Hollen, 2003).

Capacity building has been essential to the process of facilitating the CMC's ability to receive and constructively handle feedback. Capacity building in this and other areas has been emphasized throughout the project as staff encouraged community members to build their skills through observation and participation. Experiential learning has been the primary mode of training community members to take over their own service delivery:

We didn't have classroom training... We are not qualified, we didn't go to college to learn how to manage a clinic, what we learned, we learned through life experiences.

- Male sex worker and member of Ashodaya

In effect, project staff brought specialized knowledge to the community by de-mystifying various technical, scientific, and bio-medically informed aspects of the intervention (R. Lorway, personal communication, February 25, 2009). In regards to health care delivery, capacity has been built in three areas:

responding to community feedback, clinic administration and management, and building rapport with other healthcare providers:

Before when the staff would go to the hospitals we would go with them and see how they interacted with the hospital administrators and staff and we observed them and we learned how to communicate effectively.

- Female sex worker and member of Ashodaya

Whereas before there was no dialogue between sex workers and health authorities, community members became confident when they declared, “We know how to communicate with management.” This kind of skill building prepared sex workers to take on increased tasks and responsibilities in accordance with the project’s mandate.

Sex workers also put their newly developed capacities to use in supporting each other in ways that fell outside and reach beyond project’s original goals. For example, because the scope of services offered through the project clinic was limited, sex workers were often referred to government hospitals and treatment centres for services such as HIV testing, emergency health care and Anti Retroviral Therapy (ART) treatment. The referral system, run by the CMC, ensured that another community member accompanies anyone who is referred outside of the project for services. The following story, related by a female sex worker, demonstrates how capacity building in communication with health care providers was used to support the health and well-being of community members:

A community member was pregnant and during that time, I took her to the government hospital. She was the first patient I took for a referral. In the waiting room the doctor kept saying to her that she is [HIV] positive in front of everybody and they were not treating

her... I understand what confidentiality is – I know that confidentiality should be maintained. So I went up to the doctor and I showed my identity card to him and I told him I am working for this organization and we are working for the [HIV] positives...“Doctor,” I said, “Why are you telling everyone that she is positive? Don’t you know that confidentiality should be maintained? I will make a case against you,” I told him. And he was shocked and he asked me, “Who trained you to talk like that?” I told him, “now that I work in this organization, I know the rules and regulations and you can’t talk to her like that.” So then he apologized to me and to the pregnant woman, and then he treated her very well.

- Female sex worker and member of Ashodaya

This case demonstrates the value of the referral system in providing advocacy to community members as they accessed services outside of the project. Furthermore it suggests that community members have developed a clear idea of their rights as patients and have come to expect fair treatment both in their own clinic and when accessing services elsewhere. Finally, it shows how both the project and individual community members are transforming power relations between sex workers and service providers.

## **Beyond Project Imperatives**

Project staff employed occupational health discourses and rights-based ideologies to accomplish their own goals of increasing health care service utilization and decreasing the prevalence of treatable STIs. Another result of the use of such strategies was the creation of an enabling environment in which sex workers began to view their occupation as a legitimate form of work and their personal and collective identity as sex workers as a legitimate identity. This enabling environment also provided the space for sex workers to realize that

there were multiple discriminatory forces inhibiting their work. Along with the deployment of occupational health discourses and rights-based ideologies there formed an atmosphere for sex workers to develop a political consciousness that led them to claim, take ownership, modify, and expand the services that were initially offered to them by project staff (R. Lorway, personal communication, February 25, 2009).

Increased ownership over community health care services is illustrated in the area of care and support for people living with HIV/AIDS. Such services were initiated by the community in response to the community's needs. For example, if an Ashodaya member is in the final stages of AIDS and is alone in the hospital, the community will arrange for someone to sit with them to keep them company until they pass away. This kind of service was not envisioned by the staff of the project, but is an example of sex workers taking ownership over the care of their community, and taking the initiative to establish services to support each other.

This role was formalized when Ashraya was created by community members in 2008. As a support group for people living with HIV/AIDS, Ashraya welcomes both sex workers and non-workers and after only two months, boasted over 400 members. In addition to serving as a safe space for HIV positive people to share their stories and discuss their issues, Ashraya works to fight discrimination and stigma around HIV/AIDS, plan income-generating activities for members who become too weak to practice sex work, build rapport with hospitals and government officials, and fight for the rights of positive people. As this



female sex worker and member of Ashraya and Ashodaya stated: “Yes, we are ready to be political.”

The creation of Ashraya was sex worker-initiated to fulfill a significant need in the community.

In the past positives didn't want to disclose their identity. Ashraya is a safe place where they can do that...in Ashraya, positives can tell their own problems, they can talk about their suffering.

- Female sex worker and member of Ashodaya

In the past, the participation of community members was utilized to help the project accomplish the project's goals; however, in the imagining and creation of Ashraya the community extended itself beyond the imperatives of the project. For example, the goals of the project did not include providing emotional support to people living with HIV/AIDS, but the community members who created Ashraya recognized a need in their community and took the initiative to fulfill that need. In this sense, Ashraya signifies a new level of ownership over community health care. Here, sex workers have gone above and beyond the goals of the project to define their own agenda, which includes providing services to the community as well as political action. In turn, the project staff's support of such community initiatives has been essential to their success.

## **RECOMMENDATIONS**

The community has come a long way in taking ownership over their own health care service delivery. They have taken on the responsibility for managing clinic administration and for monitoring service delivery. Furthermore, community members are looking to the future with an eye for growth and sustainability. This research suggests that the community is capable of managing their own clinic and creating new services to address their emerging needs. It is crucial for project staff and community leaders to continue to encourage and support community initiatives that extend beyond project imperatives.

In addition, it will be important during this process to continue to build capacity among a wide range of community members. At this point, capacity to run a clinic is concentrated among a small number of community members. While there is continual passing of skills and knowledge between community members, the process of training new people in the skills of clinic management should be emphasized.

Finally, despite awareness of the challenges of sustaining a clinic, every participant expressed a desire to see clinical services expanded. They see the current situation as only the beginning. Presently working to link government ART providers through their clinic, community members expressed a hope to create their own ART centre as well as to open a care home for adults and children with HIV/AIDS. Participants explained that they felt safe and

comfortable receiving health care from Ashodaya and that they hoped to bring all services “under one roof” and eliminate the need to go elsewhere for health care.

While such sentiments demonstrate how successful the project has been in creating services that satisfy the community, they also signify that a lot more work needs to be done to improve government health care services so that they may also be satisfactory to the community. Consequently, community members need to think about the implications of bringing all services under the umbrella of Ashodaya. For example, eliminating sex worker’s contact with outside service providers might work to further isolate and marginalize the community. Furthermore, expanding the scope of services that Ashodaya provides might threaten the organization’s financial sustainability.

Thus, while initiatives that work to fill a community need such as the development of a care home for people with HIV/AIDS should be supported and encouraged, this needs to be done with an eye for sustainability and integration. With regards to services already provided by the government health care system, the community might think about focusing their energy on continuing to transform their relationships with service providers, rather than creating alternatives. In addition to being more financially sustainable, fighting stigma and discrimination within the public health care system would produce an effect that reaches beyond the community of sex workers to other marginalized groups by shifting the norms of provider-patient interactions.

## **DISCUSSION**

Through the use of ethnographic research methods, this study was able to provide a qualitative compliment to existing quantitative data on clinic use and STI prevalence rates among sex workers in Mysore, India. This study was conducted alongside three other qualitative research projects, and data was enriched through the sharing of observations and interview transcripts between investigators. This also provided an opportunity for triangulation of data and inter-rater reliability for coding of interview transcripts.

In addition, the sex worker community was involved throughout every step of the research project including planning, data collection, confirming findings and providing feedback. The participatory nature of the research process was a key strength of this investigation as it provided the opportunity for community members to build qualitative research skills while enhancing the validity of the data being collected and ensuring that the research would serve community needs.

One weakness of the study resulted from the researcher's outsider status and reliance on translators, which made it difficult to gather rich information from interviews. Because of the success and visibility of Disha and Ashodaya, many of the community members interviewed for this research have had a lot of experience interacting with media through participating in interviews for local and national newspapers and television. In addition to being quite media savvy, they

were aware of funding processes and had a clear idea of how they wanted their project to be portrayed. While this suggests a certain level of empowerment, as these sex workers have taken charge of the way their community is represented, it sometimes felt as if interviewees were giving “the party line” and using this research project to project a specific image of the intervention. Three months of participant observation helped to give a fuller picture of the intervention as well as the environment created around it.

As Gruskin et al. (2007) argue, the delivery and use of health care services is influenced by the determinants of access to them, the health systems that are in place, and the social, political, and economic environments that these systems operate in. The process of increasing sex workers’ uptake, and usership of clinical services in Mysore involved altering all of these factors.

Through framing sexual health as occupational health, sex work was legitimized as a profession and the stigma around the practice of sex work was decreased. This opened up the space for community members to claim an individual and group identity as sex workers and empowered them to take control over their sexual health. At the same time, by prioritizing sex workers’ needs, planning with the community and facilitating transfer of management to the community, the clinical services created by the project were characterized by shifting power relations between health care providers and sex workers and were structurally different than those offered by the existing system. Capacity building amongst community members contributed to this shift in power relations and

worked to change the structure of sex workers' interaction with providers in the larger health system.

Empowerment projects that work with at-risk populations are often characterized as either a triumph of a marginalized community that has been given the tools to gain strength, power, and political will or as vaguely exploitative projects in which public health professionals employ empowerment and participatory discourses to influence vulnerable populations to accomplish their own predetermined imperatives (Li, 2008; Lupton, 1995). These findings, however, present a more nuanced version of empowerment in which both parties – the privileged professionals organizing the intervention and the vulnerable population of sex workers – exert their own will, accomplish their own goals, and serve their respective interests.

While core staff employed specific discourse in order to accomplish their predetermined imperatives, an enabling environment was created wherein the marginalized population were able to find and exert their own will and direct it towards their own aims. Thus, in this case, empowerment emerges as neither a manipulative tactic nor a simple exchange of power from the powerful to the oppressed. Instead, empowerment is borne out the interaction between the two groups, and the growing equity of their relationships. Health disparities were decreased through such processes as sex workers acted to fulfil the aims of the public health professionals who ran the project, but also to set their own priorities and initiatives to improve the health of their community.

There are numerous implications of this research for public health practice. Specifically, these findings present a useful exploration of the processes behind a successful empowerment-based HIV/AIDS prevention project for sex workers. While quantitative data clearly showed that the intervention had been successful in decreasing the prevalence of treatable STIs and increasing clinic use, investigation into how this was accomplished will be particularly useful to HIV/AIDS prevention projects hoping to achieve similar goals. In addition to serving as a learning tool, this research may work to promote the applicability of this model of intervention in other settings.

For example, Basu et al. (2004) have argued that the Sonagachi model, in which the notion of occupational health is central to reducing health disparities between sex workers and the general population, is replicable in other environments. However, Asthana and Oostvogel's (1996) discussion of a similar but unsuccessful HIV project for sex workers in Chennai blamed its failure on the street based nature of sex work in the city, arguing that the structure of sex work in Chennai stymied efforts to mobilize and collectivize the community. Whereas sex work in Calcutta is brothel-based, in Mysore it is mainly street-based. The findings of this paper suggest that an empowerment-based HIV/AIDS prevention project which utilizes an occupational health perspective can be successfully implemented in a street-based setting.

Finally, this research contributes to an understanding of the relationship between enabling environments and access to health care. Because HIV/AIDS is most concentrated in vulnerable and marginalized populations and because

increasing access and usership of sexual health services is a key part of HIV/AIDS prevention strategies, understanding how to promote access and usership among underserved populations is an essential part of alleviating the suffering of individuals and their families affected by HIV/AIDS and decreasing the global burden of the disease.



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