

**MOVING FROM PARADIGM TO PRACTICE: THE
ASHODAYA SEX WORKER EMPOWERMENT PROJECT
IN MYSORE INDIA AND ITS PROMISE
FOR HIV/AIDS PREVENTION**

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ABSTRACT

Empowerment has gained prominence in the field of public health as creating enabling environments is increasingly being conceptualized as fundamental to marginalized populations' ability to enact public health messages. Yet empowerment's application requires further investigation in order to comprehend how successful strategies can be applied in future contexts. Ashodaya Samithi, a sex worker collective in India produced positive health advances through empowerment processes. It has reported a reduction in sexually transmitted infections and increased condom use. As the HIV prevalence rate in India is 0.36 percent, and 11 percent to 90 percent amongst sex workers, their engagement in HIV prevention is instrumental. However, sex worker interventions have been widely criticized for their stigmatizing influence and ineffectiveness. Qualitative research with the Ashodaya collective demonstrates the promise empowerment-based projects hold for subverting vulnerabilities, transforming risk, and preventing the spread of HIV.

Keywords: Empowerment; Sex Work; HIV; Mobilization; India

Subject Terms: Community-Based; Participation; Condom Use; Prevention Strategy

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GLOSSARY

Ashodaya Samithi	Sex Worker Collective in Mysore, India (Ashodaya: Ray of Hope/Light, Samithi: Collective)
AVAHAN	India AIDS Initiative- Bill and Melinda Gates Foundations
Community Empowerment	“A social action process by which individuals, communities, and organizations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life” (Wallerstein, 1992).
Disha	Ashodaya’s support staff
Goondas	Kannada word which loosely translates to thug
Hijra	Of South Asian cultures, neither man nor women, a third gender. Conceptualized in Mysore as transgender.
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
Lodges	Short-term room rentals where sex work takes place
Mobilization	The process of recruiting members of a community into a collective and the subsequent formation of a cohesive group in order to problem solve common vulnerabilities
MSM	Men who have sex with men

“Humanity is the space where those who limp through time, far out in the shadows and beyond the margins of respectability, status, and power, are brought into the light of honour, rights, peace and dignity. Humanity is the space where those who are broken by their guilt, their losses, their disease, by their social rejection and abandonment, and eventually by their impending death, do not have to live and die lonely and alone”.

—Dr. David Roy author of *Injection Drug Use and HIV/AIDS*.

INTRODUCTION

In India, HIV spreads, as it does in much of the world, along the fault lines of poverty, gender inequality, and marginalized communities (Guzman, 2001; Farmer, 1999). As those who are marginalized often operate in a context of restricted choice, HIV prevention programs must move beyond individual behavioural change strategies (Wallerstein, 2006). Empowerment offers a useful framework for health interventions as they can enable communities to transform the very structures that shape their vulnerability and enact the public health messages delivered. Ashodaya Samithi, a sex worker collective in Mysore India, is a powerful example of the promise empowerment-based projects hold for subverting vulnerabilities, transforming risk, and preventing the spread of HIV.

Ashodaya Samithi's empowerment-based model has achieved great progress since its inception in 2004. The collective has reported a reduction in sexually transmitted infections (STI), an increase in condom use, and the mobilization of 1,500 sex workers from the Mysore area (Reza-Paul, 2008). These significant landmarks are a product of collectivization, emerging sex worker identities, and improved relations with key stakeholders. Ashodaya's ability to transform the very vulnerability that endangers their health, demonstrates community empowerment's effectiveness as a strategy for HIV prevention.

Empowerment Framework

In recent years, the promise of empowerment-based interventions has gained more prominence in the field of public health. The empowerment framework provides useful strategies for creating enabling environments, which is increasingly being conceptualized as fundamental to marginalized populations' ability to enact public health messages (Wallerstein, 2006).

The empowerment paradigm seeks to create supportive environments, transfer decision making power to participants, allow participants to gain greater control over resources and information, build healthy public policies, and promote collective action (Wallerstein, 2006). Empowerment is therefore conceptualized as a goal in itself, and as a means to health. The framework also engages with Paulo Freire's notion of "conscientization" as project participants are not viewed as passive vessels into which education can be deposited, and acted upon. Rather, education is assumed to initiate transformations if it is based on a collective reflection of participants' positions, values, and knowledge (Freire, 1970).

For the purposes of this paper, and as it relates to Ashodaya, empowerment is characterized in relation to social justice processes as follows:

Empowerment strategies mean challenging control and social injustice through political, social, and psychological processes that uncover the mechanism of control, the institutional or structural barriers, the cultural norms and social biases, and therefore enable people to challenge internalized oppression and to develop new representations of reality (Wallerstein, 2006, p.18).

The empowerment paradigm also strives to reduce marginalized populations' vulnerabilities. For the purposes of this paper vulnerability will be defined as the limited ability to control ones circumstance (UNAIDS, 2008). Vulnerability for Mysore's sex workers is dictated by the interrelated factors of gender, sexuality, societal status, powerful stigma, and economic constraints. These vulnerabilities may determine their ability to negotiate safe sex, to choose their partners, to be free of violence, and access health and legal institutions which would ensure their health and safety (Basu, 2004; O'Neil, 2004; Blanchard, 2005). Nonetheless, sex worker's vulnerability is not static. Rather it is best understood as a relationship between hazards and the coping strategies that may be employed to mitigate harmful circumstances (De Leon, 2006). For example, sex workers have devised protective mechanisms in response to their vulnerability to client violence. Mobilization transformed a previously competitive and isolating environment into one of camaraderie and protection. Sex workers described calling each other on their cell phones when doing business with a new or questionable client. If their colleague did not answer at the agreed time this indicated that they needed assistance. Thus, vulnerability will be utilized in this paper, not as fixed, but as a fluid representation of sex worker's changing landscape of risk, and the tandem coping strategies enabled by the mobilization of Mysore sex workers into the Ashodaya's empowerment-based project.

The empowerment paradigm, and its wide application to the field of public health necessitate concrete examples. Without these examples, "empowerment" may be overly applied, and consequently rendered meaningless due to

ambiguity. Additionally, empowerment programs should be documented in order to optimize the framework's lessons, and to warn against potential pitfalls and erroneous application. Therefore, its application from theory to practice requires further investigation in order to comprehend how successful strategies may be applied in future contexts (Ghose, 2008; Wallerstein, 2006). As such, the case study approach of the Ashodaya empowerment-based project provides a remarkable example of how empowerment processes can produce positive advances for the health of marginalized populations. Outlining the processes by which the collective achieved positive advances will contribute to public health's understanding of "empowerment", its framework, its challenges, strengths, as they unfolded in the context of a sex worker's HIV prevention project in India.

Project Objective

The following will outline how Ashodaya's empowerment-based project produced positive advances, and subverted vulnerabilities through the processes of mobilization, collectivization, group identity, and political action. This paper will explore how empowerment processes significantly subverted sex worker's social vulnerabilities, and by extension reduced their exposure to HIV. As such, this paper situates itself in conversation with public health HIV prevention projects. More specifically, it speaks to a complex body of work which engages, supports, and critiques empowerment as a theoretical framework aimed at improving the lives and health of marginalized populations.

BACKGROUND

HIV/AIDS in India

The Indian HIV prevalence, based on the National AIDS Control Organization of India sentinel surveillance data, is estimated to be 0.36 percent (NACO, 2009). Within India's populous country, this seemingly low prevalence translates into over 2.6 million people infected with the virus (NACO, 2009). Though India's prevalence may not seem alarming, India's large population means that it ranks third highest in the world, after South Africa and Nigeria, for the number of infected individuals (UNAIDS, 2009). Although India's epidemic has impacted all strata of society, its spread has disproportionately affected sex workers, their clients and partners, injection drug users, and men who have sex with men (AVAHAN, 2008). The epidemic is also concentrated in six states, including Karnataka, situated in Southern India, where prevalence's range from 1 to 3 percent, tipping the scales to a generalized epidemic (NACO, fact sheet, 2006). The Indian epidemic is driven by the complex factors of gender inequity, poverty, migrant work, cultural taboos, and stigma regarding sexuality and HIV (O'Neil et al., 2004; Romero et al., 2006).

Sex Work in India

Sex workers in India are instrumental to the reduction of HIV/AIDS. The nature of sex work creates a common route of transmission for the virus, and introduces an obvious hazard to their health. HIV prevalence varies amongst sex

workers of Bombay, Delhi and Chennai ranging from 50-90 percent, with a low of 11 percent in Kolkata (Basu, 2004). Mathematical models of various public health strategies have suggested that the Indian epidemic could be halted by focusing on female sex workers (Nagelkerke et al. 2002). The authors boldly state: “in India a sex worker intervention would drive the epidemic to extinction” (Nagelkerke et al. 2002, p.89). Consequently, sex worker’s engagement is imperative to the control of the epidemic.

However, educational prevention projects focused on commercial sex workers (among high risk groups such as MSM and injection drug users), though epidemiologically rational, have been widely criticized for their stigmatizing influence and ineffectiveness in curbing the AIDS pandemic (Treichler, 1999; Parker, 2001; Asthana, 1996; Romero et al, 2006). Rather than being viewed as allies in the fight against AIDS and individuals who have equal rights to health, sex workers have been negatively portrayed by public health interventions. Interventions have conceptualized sex workers as poor victims and fallen women, or as a public health threat perceived: as a “pool of infection” and as “vectors of disease” (Butcher, 2003, p.1983). These perspectives though focused on women, also extend to the wider sex worker population, which in India also consists of men who have sex with men (MSM) and Hijra (transgender) populations.

The binary of these perspectives (fallen women and vectors of disease) erases both personal agency and the socioeconomic context in which women, men, and Hijras come to sell sex. It also fails to acknowledge the varying

trajectories that lead male, female, and Hijras to sex work in Mysore.¹ Though it is clear that some individuals are directly coerced into sex work, others involved in the trade choose selling sex as their best option in constrained circumstances (Basu, 2004). Responses to the epidemic must acknowledge that, “selling sex is a pragmatic response to limited range of options” (Butcher, 2003, p.1983). The conceptualization of sex work must therefore include an acknowledgement that sex workers are not merely “victims with no agency” or “pools of infection.” Rather, interventions should focus on reducing sex workers’ vulnerability by addressing the structures that dictate risk, as well as creating coping strategies for sex workers to protect themselves (Halli, 2006).

Pressure to further criminalize sex work in India affects the successes of sex worker collectives like Ashodaya. The Immoral Trafficking Prevention Act (ITPA), an act already implemented into law, is currently under review within the Indian Parliament. The ITPA aims to halt the trafficking of women into the sex trade (Joffres, 2008). However, the successful passage of the stricter ITPA guidelines would likely mean an increased policing of sex workers who are not trafficked. Its impact is predicted to drive the sex trade further underground, thereby increasing the vulnerability of sex workers to violence and infection. Increase policing of sex workers also threatens to undo the work of successful sex worker collectives such as Ashodaya (Field Notes, June, 2008).

Furthermore, the ITPA’s presence in India’s parliament is a reminder of the

¹ Seventy sexual life histories of Mysore male sex workers challenge the dominant public health perspective that selling sex emerges solely out of poverty. Rather Lorway et al, argue that male trajectories of sex work are intertwined with self-discovery, sexual identity, and social norms (Lorway, 2009).

powerful divergent perspectives, of government and civil society, regarding sex work and the polarized strategies that either support a reformist, protectionist agenda (Joffes, 2008; Day, 2008), or argue that sex workers are best protected through empowerment-based projects that help to reduce vulnerabilities (Jana, 2004).

In India, legal sentiments to further police sex work co-exist with successful sex worker collective models. The empowerment-based model, upon which Ashodaya is based, was first initiated by the Sonagachi sex worker project of Kolkata. The Sonagachi project is India's longest running, and arguably the most successful sex worker collective in India. Fifteen years since its inception, it now boasts a low sex worker HIV prevalence (11 percent) and high rates (90 percent) condom use (Basu, 2004; Ghose, 2008). Sonagachi's success is due, in part to reframing sex work as an occupation with occupational risks (Jana, 2004). Sonagachi altered the discourse of sex workers from "fallen women", and "vectors of disease", and reframed sex workers as women who support their families. As the original director of the project expressed during the research team's interview in Kolkata, the new conceptualization of sex work as a legitimate occupation led to a re-conceptualization of self for sex workers and a new image in the wider community (Jana, 2004; field notes July 2008). Sonagachi's focus on mobilizations, collectivization, and shifting community norms, became pillars of the project and the model reproduced by Ashodaya.

Ashodaya Collective

Established in 2004 by the India AIDS Initiative (Avahan), Ashodaya Samithi is funded through the Bill and Melinda Gates Foundation and implemented by Karnataka Health Promotion Trust (KHPT). Four years into its inception, the project already lays claim to significant successes. The community-based collective has mobilized 1,500 members from the Mysore city centre and neighbouring Taluka's (districts). Ashodaya now boasts its own health clinic, a reduction of STIs among its members, and increases in condom use (Reza-Paul, 2008). These advances have been drastic. Two Integrated Behavioural and Biological Surveys (IBBA) sponsored by KHPT in 2004, and 2006, show a more than 50 percent reduction in STI's (syphilis rates fell from 25 percent to 12 percent, Trichomonas fell from 33 percent to 14 percent, Chlamydial infection from 11 percent to 5 percent and gonorrhoea fell from 5 percent to 2 percent), and considerable rise in condom use (reported condom use at last sex with occasional clients rose from 65 percent to 90 percent, and from 7 percent to 30 percent with regular partners) (Reza-Paul, 2008). Additionally, the collective has established fruitful relationships with local police, health authorities, and lodge owners which have allowed the sex workers of Mysore to significantly alter their working environment, helping them to protect themselves.

Despite the project's measured successes, it must be clear that advances are never a "fait accompli". The process of mobilization, the building of group norms, and the creation of enabling environments need to be continually refreshed since both the environment and stakeholders with whom sex workers

interact do not remain static. For instance, the positive advances in building supportive relationships with Mysore police have been threatened by the appointment of a new police constable in 2009 (Robert Lorway, personal conversation, July 2009). Successes should therefore be interpreted as positive advancements, rather than problems that have been solved.

METHODOLOGY

Project Context

The research study was conducted within Ashodaya Samithi, Mysore's sex worker collective situated in the Southern Indian state of Karnataka. The project was conducted alongside three other research projects that focused on various aspects of the collective, these included: clinic utilization, monitoring and evaluation, and structural violence.² The topic of this paper, Ashodaya's Mobilization, was identified by the collective as an important area to explore in order to elucidate results from the Integrated Biological and Behavioural Assessments (IBBA). Additionally, each project fulfilled a practicum requirement for the student's Master of Public Health at Simon Fraser University.

Research Principles

The research process drew from Community Based Participatory Research Principles (CBPR), in order to ensure the relevance and community ownership of the research results (Wallerstein & Duran, 2006). CBPR necessitate the community's determination of the research goals and topic. The Ashodaya Board of Directors, comprised of sex workers, was also involved in this research process by reviewing the interviewee purposive sample list and the interview guide to ensure cultural acceptability. Lastly, research results were disseminated to the community, and feedback was included in the findings.

² Research team included: Elena Argento, Vanessa Dixon, Katie Brushett

Data Collection

Over a three-month period from May to July 2008, each researcher applied qualitative research methodologies to their respective projects. These included interviews, focus groups, and participant observation. The researchers spent five to six days a week conducting participant observation at the Disha project office, the Ashodaya office, and the collective's drop in centre (DIC). Participant observation involved the following; observing and participating in guide (peers educators) and research meetings, sharing daily lunches and hourly sweet chai, participating in protests, attending parties thrown in the honour of visiting sex workers, attending research presentations with Ashodaya members at the KHPT head offices (project implementing body), and visiting Mysore's sex work zones (areas where street based sex work takes place) and lodges where sex work takes place. Our daily presence within the office and the DIC was instrumental in building trust and rapport with the staff and the sex worker community. It also allowed for informal conversations with male and female sex workers, board members, visiting researchers from KHPT, and project staff. These informal conversations were recorded in field notes and supplement the data collected in interviews.

Interviews were also used to gather qualitative data for each specific topic. The mobilization project achieved nine semi-structured interviews and a focus group discussion. Recruitment was determined through a purposive sample in order to capture various perspectives of Ashodaya's Mobilization. Participants represented a variety of gender, staff and sex workers, as well as time spent with

the collective. The project staff and the researcher approached members of Ashodaya in the DIC in order to recruit participants. Participants also approached the researcher requesting that their contribution to be included.

Key informant interviews were conducted with two male sex workers (one who had been a technical advisors and guided the project's inception, and the other who had been involved with the collective for 18 months), two female board members, (whose long-term knowledge of the collective's mobilization process were essential to the project's goals), two staff members (one male and one female, whose history with the project differed), two female guides (who are also sex workers), and one new female sex worker. A focus group discussion on the topic of political mobilization was conducted with four female sex workers with differing history of involvement with the collective. Each of the sex workers interviewed asked that their names be used in reports and presentations. However, in order to satisfy SFU ethic requirements names were omitted.

As interviews were conducted in Kannada, the region's local language, Hindi and English, simultaneously translation was provided by a Disha staff member who was paired with the project. As the data was collected over a short time frame, another researcher typed transcripts as the simultaneous translation was provided. This process greatly reduced time spent on the subsequent transcription of the tape recorded interviews, doubled the number of interviews each researcher attended, and most importantly, allowed for the researchers to present their findings back to the community before their departure from India. The interviews took place either in the councillor's office, the lunchroom in the

Disha office, the meeting room in the Ashodaya Office, or in the Ashraya (male sex worker) drop in centre. These closed rooms provided a modicum of privacy, however sounds beyond the thin walls were often distracting and interruptions were frequent as the organized chaos of the drop in centre prevailed. Each interview varied in duration between 40 and 90 minutes.

Data Analysis

Interview transcripts were coded using a priori, and emergent themes. Themes were informed through the extensive participant observation and informal conversations gathered over three months. In order to better understand Ashodaya's model of intervention a research trip was also coordinated with the Sonagachi project of Kolkata. This included the visit of three sex worker clinics, a guided tour through Kolkata's red light district, and interviews with the current project director, as well as Dr. Smarajit Jana, the project's original director.

Interview data, participant observation, informal conversations, extensive field notes, and the Sonagachi research trip all informed the data analysis and essay writing. Initial findings were subsequently presented to Ashodaya. An oral power point presentation was simultaneously translated for an audience of approximately 50 staff and sex workers. The feedback and questions from the community were incorporated into the results. The presentation also allowed the researchers to formally thank the community and ensure that participants and the wider collective had access to the research results. Lastly, a literature review of internal Ashodaya documents and peer reviewed articles on sex work and empowerment-based projects provided useful theoretical frameworks.

FINDINGS

The drop-in center (DIC) and the office for the Ashodaya collective are located five minutes from Mysore's famous palace and its bustling bus station. They are also strategically located in proximity to the three "party pick up" zones where sex work is conducted. Usual office activities involve a collection of guide meetings, board meetings, meal distribution, administrative tasks, protest organization, and community researcher's endeavors. The DIC, situated one floor above the project office, holds the clinic, the counseling office, and a shower (in order to prepare for clients) and make-up room. Straw mats cover the DIC's floor and are continuously occupied with women napping, chatting with their friends, rearranging their colorful saris, watching the news, playing social games, and braiding each other's hair.

The frequent use of the DIC laid the foundation for the mobilization of Mysore sex workers and the multiple of positive advances that will be detailed below. The Ashodaya collective improved stakeholder relationships with the police, health care professionals, and owners of lodges. Further, the mobilization of sex workers also resulted in a reduction in violence and lower rates of sexually transmitted infections (Reza-Paul, 2008). The collective's impact also included an increase in protective behaviors such as the reduction in the number of clients (enabled by higher fees), peer protection in the field, and an increase in condom use. These positive changes occurred through intricate processes of

mobilization, collectivization, peer education, the self-identification of men and women as sex workers, and political action. Building Ashodaya as a successful HIV intervention and a body of empowered individuals is a result of simultaneously addressing these various aspects of the project and the needs of the community as they emerged.

Mobilization

The Ashodaya collective began with the successful mobilization of over a thousand sex workers from the Mysore area. Mobilization, is described by AVAHAN, Ashodaya's funders, as the process of recruiting members of a community into a collective and the subsequent formation of a cohesive group in order to problem solve common vulnerabilities (AVAHAN, website). Ashodaya's mobilization techniques were grounded in sex workers' knowledge of their community and through the utilization of their social networks. Narratives of community mobilization emphasized the importance of sharing their own experience and building trust with new members.

In a context where "rehabilitation" efforts from NGOs threaten their livelihood, not interfering with sex workers while they work was seen as key to the process of mobilization. A member of the collective noted the importance of waiting until a sex worker was without clients:

I observe women in the field but I do not approach them immediately, I observe for a few days. See if they are soliciting and where they take the clients. When they are free I will approach them and tell her about my own experience as a sex worker.
—FSW

Features of the intervention also facilitated the mobilization process. The availability of services at the DIC such as affordable lunches, mats for rest, a television, games for entertainment, and access to health services drew in new members. Though not all of these features are typical of a HIV prevention project, they were essential in establishing a safe space where sex workers could attend with relatively little risk or commitment. The project was therefore not structured merely as an HIV prevention project, rather it established itself as a project concerned with the overall wellbeing of sex workers. As such, Ashodaya emerged as a personal space where sex workers could share their stories, struggles, and joys in a supportive and safe environment.

Collectivization

Ashodaya's collectivization produced profound changes for sex workers. Understood simply as the coming together of individuals from a community, the unifying process of collectivization increased sex workers' sense of belonging to a community, and in turn, increased their individual sense of respect. In discussing the collective, sex workers repeatedly described the project as a "community" or "family". One such example was captured in an interview with a female sex worker:

Ashodaya, this is not our office, it is like our Mother's house. Everyone feels like this. If we have any problem we can come here and share our problems, and we will get it solved. Many women are coming here and telling their own personal problems about their family, boyfriends, anything. —FSW

Ashodaya became a safe space where problem sharing and problem solving could take place. As sex workers face similar struggles with police, clients and goondas (which loosely translates to thug), exchanges amongst community members were highly valuable. Program staff and sex workers often reiterated that sex workers know their community best, and as such, solutions for sex worker problems must come from the sex worker community. Collectivization allows this process to occur both formally through meetings and informally at the DIC. As two female sex workers describe:

One thing that's important for me is to meet each other so we can exchange our thoughts, our feelings. Because we face problems with goondas, knives, acid and then we can come together and discuss all these problems and find solutions for ourselves. We are all sex workers together and this strengthens the group, this is protective. We can discuss about the clients too and get solutions.
—FSW

Before Ashodaya I was very helpless. Clients took us to lonely places, did something, and then would leave me. But after Ashodaya we are not facing such problems. Because of Ashodaya I am safe. —FSW

Over time, the DIC's personal space transformed into a critical space where sex workers could strategize new ways to mitigate their vulnerability. The unifying process established new safety strategies, protective networks, and ultimately, new community norms, all of which improved the wellbeing of sex workers and their ability to practice safer sex behaviours. One staff member described the protective impact of collectivization:

If they work in an isolated way they can be attacked easily, single sticks can break easily but sticks tied together are stronger...it was Ashodaya that made this change. —Project Staff Member

When vulnerability could not be subverted, the meaning of violent encounters was often transformed. During an interview, a new member of Ashodaya described being robbed at knifepoint by a client. Defenseless, she went to Ashodaya shaken and striped of her much-needed earnings. A group of twenty women consoled her, then rallied together and returned to the site of the robbery. Though they were unable to recover the money, confronting the client became a demonstration of unity and camaraderie. Without the collective, the event would have remained a tragic, violent robbery instead of a victorious story she proudly tells visitors.

The collectivization of sex workers may not always successfully protect sex workers, but where it fails, the meaning of the violence is often altered through the support that the collective provides. This change in meaning serves to empower sex workers by challenging internalized oppression. Consequently, these “new representations of reality” (Wallerstein, 2006, p.18) allow sex workers to enact the public health messages provided by their peers and protect themselves, and their clients from sexually transmitted infections.

Sex Worker Identity

The collectivization process, the support it awarded, and the emerging conceptualization of sex work as a legitimate occupation lay the foundation for the community to self-identify as sex workers. Though an uneasy process, especially when declaring their occupation to family members, identifying as a sex worker involved with Ashodaya helped to transform sex worker’s self

perceptions. Sex worker identities also helped to alter the perception of sex workers in the wider Mysore community. Identifying as sex workers resulted in subverting their vulnerability by creating new community norms regarding the legitimacy of their work. Employed in a legitimate occupation, sex workers demanded better treatment from the Mysore community, clients, and family members.

Before Ashodaya, people from the public would call us prostitutes. After the organization, people say Ashodaya is doing good work preventing HIV. Now people call it sex work. After coming to this project, people started realizing that it is like a profession and that they should respect it. —FSW

Before this project I used to be alone in the field, I never mingled with other SW. I didn't want to identify myself as a sex worker; I didn't have respect for my community or my work. Now I think I should respect my work. I am a part of this community. Now if there is an opportunity to go in front of the TV or the paper I will fight for that opportunity. —FSW

Identifying as a sex worker became a rallying point for the collective.

Narratives collected in interviews demonstrated that challenging internalized and social oppression became part of the empowerment process. It encouraged other members to join and provided a sense of legitimacy, as well as a negotiating tactic when navigating differing power relations with clients, police, and health care professionals.

Mobilizing in the Face of HIV

Sex workers have often been “shamed and blamed” in the context of the HIV pandemic (Scambler & Paoli, 2008; Butcher, 2003). It is therefore significant

that the members of the Ashodaya Collective were successful in renegotiating their identities and their role within the epidemic. Rather than be perceived as “disease harbourers”, members of Ashodaya reframed their identity as HIV prevention educators.

I was traveling by train when I met a banker, during the discussion he asked me what I do and I told him that I work in HIV prevention. He started asking me questions so I told him about how it is spread and so on, he was very impressed that I could give him so much information. —FSW

One official was observing me one day and asked what I was doing and what information I was telling people. So I told him about condoms and HIV and he congratulated me for doing a good job. —FSW

The positive redefinition of sex workers’ role within the pandemic translates into valuable cultural capital, especially for sex workers whose position within society often translates to abuse, and rarely the respect that working for a health project provides. These comments also suggest that choosing to self-identify as “sex workers” is not only adopted to fit the public health label, but for the pragmatic role it awards them. Sex workers’ role in HIV prevention efforts may therefore be a catalyst for involvement with the sex workers’ collective. During the dissemination of research results, a male sex worker and board member of the collective suggested that the high prevalence of HIV within the sex worker community also provides a powerful incentive for involvement. As such, the onset of HIV for the sex worker community is both an increased incentive for collectivization and HIV prevention a means by which their internalized and societal oppression can begin to shift.

Political Mobilization

The personal space provided by the drop in center and the collectivization that ensued became a catalyst for political mobilization. Challenging the various structures that maintain marginality and structure risk was recognized by the collective as essential to the protection of sex workers, and the prevention of HIV/AIDS. Community empowerment strategies therefore involved the creation of enabling environments where sex workers could apply the safe sex practices advocated by the project.

Ashodaya's political mobilization has taken many forms. Public rallies demonstrated the community's strength and unity to those who impact their work. Ashodaya's sex workers also used local and national media to demand their professions' right to health and safety. This visibility helped to negotiate more positive relationships with police, lodge owners, health care professionals, business owners, and local politicians. An increased visibility for this typically marginalized population has translated into much needed protection.

If we conduct rallies it is very important because the society should accept us. If they don't accept us we will go underground and this would be detrimental to HIV awareness. We are developing a space for ourselves in society. —MSW

The rallies give us visibility. If the client gives me problem I can talk back to him because of the organization. The clients are also afraid; now that there is a sex work organization clients can't get away with as much. —FSW

We are scattered at the beginning, no respect. Here we came together and showed our unity, strength and power. —FSW

Public rallies and protests, such as the June 2008 Immoral Trafficking Prevention Act (ITPA) rally to protest the amendments, demonstrated Ashodaya's unity and strength while providing opportunities to interact with the media and use it as a tool for spreading information. Ashodaya has participated in May Day Rallies for workers rights, World AIDS Day demonstrations, the Cauvery water dispute, a blood donation drive, and Indian Independence Day celebrations and Mysore's entertainment committee. These demonstrations have not always focused on sex worker rights or HIV awareness, but nonetheless Ashodaya deemed their involvement important in an effort to assert themselves as valuable members of the wider Mysore community. Political action and involvement in demonstrations also cultivates a sense of empowerment. One of the earliest members of Ashodaya described her involvement in India's Independence Day celebrations:

Before we couldn't participate in Independence Day because if we went to our kids' schools our children would get teased. So with Ashodaya we had our own independence day and raised the flag. Only then did we get our own Independence Day. —FSW

Yes I participate in all the rallies, if we don't participate how will Ashodaya grow? It is our duty to participate, to fight for our rights. In Delhi, everywhere they are fighting, if we do not participate in Mysore then what is the point of Ashodaya? It is our duty to fight for our rights because we are a family. We fight so that we can have a happy life, a smooth life, and a happy family. —FSW

Members of Ashodaya have also strengthened their ties to local politicians. During the 2008 municipal election, sex workers assisted in politicians' campaigns. They reasoned that if they worked for certain politicians,

the politicians and their parties would be more sympathetic to their cause and responsive to their needs once elected. Campaigning for politicians illustrates Ashodaya's capacity to create a more enabling environment for sex workers by cultivating allies with key stakeholders.

Impacts of Mobilization

The sense of safety, belonging, and power, which emerged from successfully mobilizing over a thousand female sex workers, male sex workers and Hijras, has had profound effects on their health and safety. These positive advances in subverting their vulnerabilities were enabled firstly by the drop in center, which provided a safe space where sex workers could meet and share their common joys and struggles. Their shared identity and their sense of legitimacy regarding their profession transformed the DIC's safe space into a critical space. The collective subsequently grew beyond its original public health objective to include public protests and social engagement. The empowerment of sex workers and the individual and collective transformations which occurred led to sex workers challenging the unequal power relations in which they operate to create safer, more healthy lives for themselves and their community.

The following section briefly outlines how empowerment processes actually translates to healthy lives for sex workers. Firstly, without empowerment safer sex education would not have translated into safer sex behaviors, as sex workers' marginalized status constrains individual "choice". The collective's empowerment allowed sex workers to gain a new perspective of themselves and their work through the social cohesion the organization provides, the

legitimization of their profession, and the new skills and information provided by their peers. Secondly, creating more enabling environments through increased visibility, increased protection, and improved rapport with key stakeholders provided the landscape upon which “choice” could be enacted, and vulnerability to HIV subverted.

Subverting sex workers’ vulnerabilities was partly achieved through bettering relationships with the police (Biradavolu, 2009). This resulted in a decrease of harassment by the police, and in the occurrence of police raids in lodges and in the field. The decreased fear of raids allowed for sex workers to meet in the field, and made it possible for sex workers to carry condoms without fearing that they be used as “evidence” of their profession. A pragmatic result of decreased police pressure means more time for sex work interactions. This includes more time for condom negotiation and more time for sex itself, which the use of condoms often requires. Building rapport with lodge owners also allowed for more protective behaviors. Through their involvement with Ashodaya lodges began to carry condoms, and began providing informal protection for sex workers. Using lodges (short-term room rentals usually located in city centers) instead of conducting sex work in open spaces, impacted sex work by also providing more time for each sex work interaction.

Increased protection and support from other community members also enabled sex workers to more confidently negotiate condom use, due to a decreased fear of clients’ violent reactions. The collectivization of sex workers also led to fewer clients. Through sharing their experiences and altering their

perceptions of their work, sex workers who may have charged lower rates began to raise their fee. Sex workers would also refer clients to another sex worker if they knew that she was in greater financial need. Increased financial security enabled women to have fewer clients and to be more selective regarding their client choice.

The changing landscape of sex work in Mysore allows education regarding HIV and STI's delivered by their peers to be acted upon. Formal meetings and informal discussions in the DIC also allow for condom negotiation strategies to be shared amongst sex worker. One female sex worker tells her clients, "Why buy a disease from me that you will spread to your wife for a few minutes of pleasure"?

The changes in condom negotiation, police and lodge owner interactions, and protection amongst sex workers are by no means an exhaustive list of the changes mobilization has created. These changes do indicate, however, how empowerment processes subverted sex worker vulnerabilities and in turn reduce their exposure to HIV. These transformations cannot be viewed in isolation as each is integrally related to the other. The ability of Ashodaya to tackle these multiple enabling factors demonstrates the strength of the empowerment intervention and the roots of its success.

DISCUSSION

The processes of mobilization, collectivization, identity formation, and political action, required to impact change amongst Mysore sex workers, demonstrates how complex transforming vulnerabilities to HIV remains. Ashodaya's positive advances in subverting sex worker vulnerability deepen our understanding of how empowerment paradigms can be applied to HIV prevention. Empowerment-based projects, however, have also been met with challenges (Evans, 2008). Exploring the limitations of empowerment is essential to our understanding of these programs and valuable for future applications.

Empowerment Challenges

The literature on empowerment-based models outlines important challenges faced during project implementation and how well-meaning programs can have unintended consequences. These include concerns regarding the role of sex worker identity (Cornwall, 2003; Ghose, 2008), inequality within collectives (Cornwall, 2003; Wallerstein, 2006), and violent backlashes (Kim et al. 2007). Ashodaya's example provides further insight on how limitations of empowerment paradigms unfold during a project's implementation. Specifically, the testimonies collected of the Ashodaya project dispute some of the literature's challenges, offer new interpretations of limitations, and provides further cautionary notes.

Sex Worker Identity

As involvement in projects is often negotiated through identity politics, (Ghose, 2008) a common challenge faced by empowerment projects involves the inclusion and exclusion of those within the collective (Cornwall, 2003). Identity politics and its impact on empowerment projects prompt interesting questions, such as; when does an individual engaging in sex for pay come to identify as a sex worker? Does identifying as a sex worker lead to more condom use? Does identifying as a sex worker motivate involvement in health interventions? Can one exchange sex for money without identifying as a sex worker? And ultimately what impact does identity politics have on sex worker empowerment-based organizations?

Identity may also mitigate condom use, as individual decisions are often influenced by larger social norms and expectations. Campbell and Macphail's project in South Africa suggests that condom use is "structured by social identities rather than individual decisions" (Campbell & Macphail, 2002, p.332). Furthermore, Ghose et al. outline how identifying as sex workers for the members of Sonagachi was integral to condom negotiation (Ghose et al. 2008). Thus, the role of identity in empowerment projects may lead to safer sex behaviours.

Additionally, as sex worker identity was a key feature of Ashodaya's empowerment project, its lessons may not be applicable in contexts where men and women are involved in transactional sex and may not identify as sex workers. As Bruyn found (1992), "some women who only occasionally engage in

sex for pay will avoid condom use so they do not become identified as prostitute” (Bruyn, 1992, p.251). The role of identity in mitigating involvement in empowerment projects must therefore be considered in order to ensure that the benefits of prevention projects are far reaching (Halli, 2006; Cornwall, 2003).

Intersectionality of Oppression

The benefits of empowerment projects are also moderated by the unequal social position of those who participate (Unnithan & Srivastana, 1997). Here, the inequalities of gender, class, and race may be reproduced within collectives (Cornwall, 2003; Wallerstein, 2006) as “existing power relations are reflected in participatory projects” (Cornish & Ghosh, 2007, p.498). Since the ‘intersectionality’ (Van der Hoogte & Kingma, 2004) of vulnerability, is not always addressed in a singular project, certain individuals may become more empowered than others. Community empowerment projects must therefore be aware of the hierarchies inherent within groups and the multitude of inequalities that dictate which voices are heard in a collective, and who ultimately benefits from such endeavors (Cornwall, 2003).

In the context of Ashodaya the collective’s composition of male sex workers, female sex workers, and Hijras introduced an interesting gendered aspect to the project. Firstly, though far fewer in numbers, the MSM contingency of Ashodaya branched off into a subgroup called Adarsha in order to have their particular issues voiced within the collective. Participant observation conducted also suggested that Indian gender norms imbued the collective. Male sex workers often protected female sex workers in the field, prevented men from

entering the DIC, were more willing to talk to researchers, spoke with more frequency at meetings, and took on leadership positions more readily. A further exploration of gender within the collective is needed to more fully understand this gendered dynamic and reflection of patriarchal structures. Regardless, it indicates that all individuals within a collective do not experience the same opportunities and equality is rarely achieved (Evans & Lambert, 2008; Cornish & Ghosh, 2002; Cornwall 2007a; Cornwall 2007b).

Interestingly, one of Ashodaya's strengths is its focus on the collective, not on individual empowerment and individual change. As project benefits and opportunities are not equally distributed, focusing on changing the landscape of risk, improving stakeholder relationships, providing access to care, and protection though collectivization benefits all sex workers irrespective of their level of empowerment or involvement. Furthermore, one of the most powerful mobilizing strategies was allowing sex workers to participate in the collective within differing levels of commitment. This honours various sex workers' positions, even personalities, as some may only be comfortable accessing cheaper meals and a counselor, while another may vie for a position on the board and a spotlight during media events. What remains essential is that community empowerment translates to a subversion of vulnerabilities, and therefore a reduction in exposure to HIV.

Violence as a Backlash

Empowerment projects also face an important challenge in mitigating the potentially negative consequences of interventions. The engagement of

empowerment projects in relational power dynamics, can introduce a potential backlash from those who are threatened by marginalized groups (in most cases women) upsetting the existing distribution of power. Violent backlashes, often from intimate partners, have been reported as empowerment threatens ingrained gender dynamics and power divisions. “Attempting to empower women can potentially exacerbate this risk by challenging established gender norms and provoking conflict within the household” (Kim et al. 2007, p.1795). Informally, members of Ashodaya did indicate a rise in incidents of violence from boyfriends. Formally, however, sex workers only made reference to violent incidences and mentioned that sex workers no longer relied on boyfriends for safety and support since the inception of Ashodaya. As one female sex worker explained:

Now we have Ashodaya, so I know if I am sick or need help I know Ashodaya is there for me so we do not need the boyfriends with their violence and all. —FSW

This area of study requires further investigation within the Ashodaya collective in order to understand if reports of intimate partner violence indicate a rise, and therefore a backlash, or the increase in reporting due to the support the collective provides. Thus, violent backlashes remains a critical issue to consider in order to ensure that members of empowerment projects do not endanger themselves in the process of attempting to shift their vulnerability.

Value of Empowerment

Empowerment, despite its existing challenges, remains a viable goal for the achievement of marginalized populations’ health. The crux of empowerment’s

strength rests on the fact that it becomes a short hand for all its prerequisites: transforming internalized oppression, self-confidence, conflict resolution skills, culturally relevant knowledge, decision-making power, and strong social networks (Wallerstein, 2006). Empowerment-based models also support key features of effective public health interventions including the reframing of risk, a focus on wellbeing, the creation of enabling environments, and community project ownership.

Framing Risk Beyond the Individual

Community empowerment projects offer valuable tools for framing our understanding of risk, vulnerability, and agency. As Peterson and Lupton argue, public health discourses can often conceptualize the subject of disease as a deviant victim (Peterson & Lupton, 1996; Lupton, 1995). This framing of risk, in this case for sex workers, simultaneously assigns victims powerlessness and places the blame on the individual. The field of health promotion, Lupton argues, also assumes that individuals have a “choice” in preserving their bodies from disease (Lupton, 1995). Ashodaya demonstrate how choice can be constrained by a myriad of social oppression such as gender inequality and poverty. A new conceptualization of “risk” is therefore needed to address marginalized community’s health.

Risks experienced by sex workers in the state of Karnataka are well expressed through Blanchard’s use of Bourcier’s concept of “risk causation”. Bourcier identifies that risk is structured in four spheres: societal, community, institutional, and individual (Blanchard, 2005). Ashodaya’s focus on community

empowerment engages with these four spheres of risk through its focus on enabling environment, community protection, improved stakeholder relationships, and individual peer education. The concept of risk causation, as exemplified by Ashodaya, encourages prevention strategies that move beyond the individual to include a more holistically minded notion of risk. Empowerment discourses, therefore reinvigorate our understanding of power distributions and argue that structural transformations are essential to the subversion of vulnerabilities.

Community Ownership

Community-based empowerment initiatives also allows for emergent community needs to be addressed, and initiatives beyond the prerogative of public health to materialize. For Ashodaya, allowing the community to dictate the project's direction translated into an effective program, and created endeavors beyond the initial project's vision. Ashodaya formed a teaching site for other sex worker projects, street protest to gain a respected place within Mysore's community, and a restaurant to generate income. These initiatives emerged out of the community ownership of the project and serves to positively alter the environment in which members work.

Focusing on Wellbeing

Empowerment models of intervention are also valuable as they support the improvement of overall health, not simply the prevention of a certain disease. To impoverished and marginalized populations, HIV may be experienced, and conceptualized, as just another health issue. As acknowledged by Martha Ward:

“AIDS is just another problem they are blamed for and have to take responsibility for” (Farmer, 1999, p.79). This is not meant to belittle the significance of AIDS, but rather to underline the fact that victims of HIV/AIDS have often also been victims of violence, poverty, and gender inequality. HIV is therefore just another burden, another tragedy to be survived (Farmer, 1999). Centering public health interventions merely on HIV, versus the overall wellbeing of a community may be both ineffective and arguably unethical. The singular focus on HIV prevention would leave intact the structures that dictate vulnerability, and therefore, continue to subject marginalized populations to numerous assaults on their health, their dignity, and their humanity. Those involved in public health programs must ask themselves not only if this is an effective approach but what is accomplished by dissecting problems into small, isolated issues, and who benefits from this analysis (Farmer, 1999). Within this context, empowerment, and its focus on subverting vulnerability, reducing risk, and creating enabling environments, emerges as a viable framework for effective and ethical public health projects.

RESEARCH LIMITATIONS

Community based participatory research principles (CBPR) applied in this study produced both validity in the research findings, and limitations. CBPR principles included Ashodaya's Board of Director's determination of the research topic, as well as the boards' approval of the interview guide and the purposive participant list. Working collaboratively led to a long process of consultation with Disha staff and board members before the interviews were initiated. Furthermore, both the interview translation and the recruitment of participants were conducted in collaboration with Disha staff members. As such, the author acknowledges that the positive processes of community-based participatory research in terms of "community consent", "culturally bound knowledge", and "community ownership" (Wallerstein & Duran, 2006), also introduce an additional filter of information in the research.

The research project also experienced limitations in regards to translation. Language barriers meant that subtleties of participant's responses might have been lost. The necessity of translators, as noted by Orchard (2007), meant that the intimacy and rapport built throughout an interview was compromised. Simultaneous translation may also misrepresent the eloquence of participants' responses as sentence structures shift and are not edited for fear of changing the intended meaning. The logistical barriers of utilizing Disha staff members as translators for this project also introduced significant time constraints to the

research process (Viswanathanin, 2004). Despite the research project being community led, Disha staff members had numerous competing priorities that did not allow them to translate whenever participants were available.

In order to compensate for this limitation the four project researchers interviewed approximately ten individuals each, assisting in 10 other interviews by typing verbatim the participants' responses, and drew their results from the 40 cumulative interview transcripts that the research team produced. Though time constraints ultimately limited the number of interviews conducted the trust building process which occurred in the interim meant that the interview results were rich in detail as community members were enthusiastic about participating and found value in the research being conducted.

IMPLICATIONS FOR PUBLIC HEALTH PRACTICE

Ashodaya Samithi offers valuable lessons for public health practice. It supports the creation of empowerment-based, peer led, and structural interventions. Ashodaya's lessons are already being shared within India's sex worker populations through the collective's teaching site. These two-week training workshops impart Ashodaya's positive advancements, and allow sex workers from various parts of the country to share their work experiences and their shared struggle.

Nevertheless, Ashodaya's successful strategies should not be assumed to be uniformly applicable. As Wallerstein states: "successful empowering interventions can not be fully shared or 'standardized' across multiple populations, but must be created within or adapted to local contexts" (Wallerstein, 2006, #). To assume that Ashodaya's model would work everywhere ignores the peer-led, bottom-up approach that awarded its success. In short, its lessons can be transferred but its process is entirely unique.

The context of its success also warrants further attention. One may suggest that India's history of social movements could help garner support for collective action. Ghose et al. also suggest that Marxist ideologies of the worker were important in the creation of a successful Sonagachi Project in Kolkata (Ghose et al, 2008). Furthermore, the role of Hinduism may also be interesting in explicating the perceptions of self, which serve to support beliefs in the collective

struggle. As Lauren Leve's study of Nepalese women engaged in empowerment project indicates, the belief that "ones life is not your own" was culturally salient (Leve, 2007). Furthermore, Lorway (2009) also suggests that South Asian notion of the self may be far more permeable (Lorway, 2009). A more historical and cultural perspective of the project's context would provide valuable insights and inform the transferability of the project's lessons to interventions within India and beyond its borders.

As the discourse of "empowerment" has become highly prevalent in the field of public health one must be cautious of its application. Ashodaya's example, therefore, serves as a reminder of how paradigms of empowerment must be applied in order for their strategies to remain viable options for improving the health of marginalized populations.

CONCLUSION

The Ashodaya project is a powerful example of how a community-based empowerment projects can indeed be successful in preventing HIV transmission. As HIV is rarely a randomly allocated disease, nearly three decades of HIV has demonstrated that the disease spreads along the fault lines of society, it preys on those with little power, little status, little voice, those whose positions within society have been demeaned and marginalized. Ashodaya strengths and “success” therefore stems from altering this positionality in order to subvert their vulnerability. Its existence stands as an example of the positive impact of community-based work, of peer-led projects, and the importance of targeting entire communities. In addition, it provides evidence for strategies that steer away from public health interventions focused on the individual or solely on education as means of prevention. Ashodaya’s success depends on its ability to set new community norms, to create a safer environment in which sex workers earn their living, in providing a supportive network, and in challenging their vulnerability in multiple arenas of their lives.

In the words of Dr. David Roy, whose quote precludes this project, the Ashodaya collective has allowed the sex workers of Mysore to regain their humanity, and in the process lessened their exposure to HIV.

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