THE EVOLUTION OF FEMALE SEX WORK IN GUNTUR, ANDHRA PRADESH
A QUALITATIVE STUDY OF HIV-RELATED ISSUES

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THE EVOLUTION OF FEMALE SEXWORK IN GUNTUR, ANDHRA PRADESH: A QUALITATIVE STUDY OF HIV-RELATED ISSUES

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EXECUTIVE SUMMARY

Background

India has an estimated 2.3 million people infected with HIV, with unprotected paid sex a key factor in its continued spread, particularly in the southern states. Andhra Pradesh in southeast India has an adult HIV prevalence rate of 1.0% and is one of two states in India most severely affected by the HIV epidemic. Guntur district in Andhra Pradesh has over 19,000 female sex workers (FSW) and 21.2% are estimated to be HIV infected. Following recent police raids and brothel closures, the majority solicit sex at home or at their place of work.

The India AIDS Initiative, Avahan, of the Bill & Melinda Gates Foundation (BMGF) was established in 2003 with the aim of slowing down the HIV epidemic in India through targeted, integrated large-scale HIV prevention programmes with high-risk populations such as FSWs in six high prevalence states of India. As part of monitoring and evaluation of the Avahan programmes, qualitative ‘special behavioural surveys’ (SBS) were conducted with FSWs to examine in-depth, perceptions and behaviours pertaining to HIV / AIDS, condom use and sexual partners, relationships with the implementing NGO’s, and issues affecting the vulnerability of FSWs to HIV / AIDS to complement data captured earlier in cross sectional studies, termed ‘integrated biological and behavioural surveys’ (IBBA) and quantitative SBS.

Subjects and Methods

The study was conducted between February and March 2009 with FSWs in three mandals (Narasaraopeta, Piduguralla and Tenali) in Guntur district, Andhra Pradesh where one organization, the Hindustan Latex Family Planning Promotion Trust (HLFPPT) manages the HIV prevention programme through Gramasiri, a local non-governmental organization (NGO). Three focus group discussions (FGD) and 40 in-depth interviews (IDI) were conducted with 60 FSWs who were selected by stratified random sampling. These included younger and older age groups (<25 vs. >25 years), and women of different NGO risk categorisation (high, medium and low risk) to represent a spectrum of FSWs in this area. Interviews were conducted in the main language, Telugu, transcribed, translated and analysed for persistent themes and ideas.

Results

The study found evidence that sex work is changing in Guntur district, with clients now solicited by sex workers in their homes, often using mobile phones, or at their workplace rather than in brothels or public places, and clients most frequently requesting anal and oral sex, instead of vaginal sex. In addition, despite extensive education outreach by peer educators and frequent contact with clinical staff at the NGO and VCT services, few participants had accurate knowledge about HIV/AIDS, with the majority reporting unprotected anal intercourse with their clients. Most FSWs were unaware that unprotected anal intercourse put them at risk of HIV or other STIs. There was also confusion about the periodic presumptive STI treatment (PPT) or grey packs,¹ an STI control strategy, as well as about the efficacy of vaginal douching with Dettol and water, with many thinking these would protect against HIV infection.

¹ The “Grey Pack” consists of 1g of azithromycin and 400mg of cefixime and is a 3-6 monthly presumptive treatment for gonorrhoea and chlamydia infections
Older FSWs and FSWs who disclosed they were HIV infected reported living in extreme poverty, struggling to earn enough money from sex work to survive. Client numbers had fallen as these women had aged or become sick, and they frequently reported unprotected vaginal, anal and oral intercourse with all their clients as they feared loss of clients by the mention of condoms.

Many participants reported reductions in violence from pimps, madams, clients and the police compared with earlier in their lives. The majority had left early marriages to violent drunk husbands but domestic violence still reportedly existed for a significant minority. In addition, many FSWs reported daily alcohol use, often to escape from feelings of depression and hopelessness. Both domestic violence and alcohol misuse can present significant barriers to condom use, again contributing to the vulnerability of some FSWs to HIV and STIs.

**Conclusions**

High rates of unprotected anal (and vaginal) intercourse with clients, husbands and other non-paying partners was an unexpected finding in this population exposed to an NGO intervention for several years. Furthermore, sharing of clients amongst home-based FSWs means substantial sexual mixing is likely occurring in this setting where many of the target population are already HIV infected or at high risk of HIV/STI infection. HIV/AIDS education outreach workshops are urgently needed to correct continuing misconceptions about HIV/AIDS and to educate FSWs about the high risk of unprotected anal intercourse for infection with HIV and other STIs. In addition, additional structural interventions which address the extreme vulnerability of older, HIV infected or alcoholic sex workers, as well as those experiencing domestic violence, are required if HIV prevention programming is to be effective. As the sex work environment evolves in response to the rapid development and modernisation currently taking place in India, monitoring the changing sex work environment and adapting programmes accordingly will be crucial to ensuring HIV prevention programmes are able to continue to reach these increasingly vulnerable target populations effectively.
BACKGROUND

The HIV epidemic in India

India is the second most populous country in the world and has an estimated 2.3 million people living with HIV / AIDS (1, 2). The epidemic is highly heterogeneous with HIV prevalence rates highest in the four southern states of Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu, and the two north-eastern states of Manipur and Nagaland (1, 3). Unprotected paid sex is thought to be a key factor in its continued spread, particularly in the southern states, where rates amongst female sex workers (FSW) have reached over 30% in some districts (1). Indeed, mathematical modelling suggests that HIV prevention interventions targeted at female sex workers alone could halt the HIV epidemic in this country, if applied at sufficient scale and quality (4).

The India AIDS Initiative, Avahan

The India AIDS Initiative, Avahan, of the Bill & Melinda Gates Foundation (BMGF) was established in 2003 with the aim of slowing down the HIV epidemic in India through targeted, integrated large-scale HIV prevention programmes with high-risk populations in 83 districts in the six high prevalence states of India and in 17 sites along the National Highways (5). The programmes target FSWs and their clients, men who have sex with men (MSM), Hijras (transgendered people) and injecting drug users (IDUs) and are tailored to the local situation and needs. Key programme components include: (i) focused HIV and STI prevention peer education outreach, with an emphasis on condom promotion and provision, (ii) behaviour change programs for HIV and STI risk reduction among regular partners of FSWs, (iii) improved quality and accessibility of high-quality STI management services for FSWs and their partners and (iv) key population (FSW / MSM / transgender) collectivisation and community mobilisation.

Sex work in Andhra Pradesh

Andhra Pradesh (AP) is situated in the south-east of India and has a population of 76 million people (2001 census). The capital of the state is Hyderabad and Telugu is the main language spoken. It is a predominantly Hindu state (84%), with Islam (9%) and Christianity (5%) also practiced (2001 census). AP has an estimated HIV prevalence of 0.97% amongst the adult population and, along with Maharashtra, is the state in India most severely affected by the HIV epidemic (1).

Guntur district in AP lies on the east coast of India, on the Bay of Bengal. The main agricultural products of this region are rice, tobacco, cotton and chillies. The district has a population of approximately 4.5 million people and is divided into 57 mandals. Baseline mapping of the sex worker population in 2004/2005 by the local implementing NGO’s estimated that over 19,000 females sell sex in Guntur district (6). The mean age of FSWs is 31 years and the majority (61%) are illiterate (7). FSWs in the district often have small children to support, are usually unskilled and are often divorced, widowed or separated from their husbands leaving few economic alternatives for survival. Following police raids and the closure of brothels by the police in recent years, sex work has been driven underground and few women now solicit sex in brothels. Thus, the majority of FSWs are home-based (45%) or street- based (35%), with a minority soliciting sex in brothels (14%) (7). Guntur district has

2 A mandal is an administrative area, like a sub-district.
high HIV prevalence rates among high risk groups, with 21.2% of FSWs and 13.1% MSM estimated to be HIV positive (7, 8).

**NGO interventions in Andhra Pradesh**

The Swagati project, meaning ‘self-propelled’, is an HIV targeted intervention project funded by the Bill & Melinda Gates Foundation through the Hindustan Latex Family Planning Promotion Trust (HLFPPT). Swagati was established in January 2004 and works with sex workers in nine coastal districts of Andhra Pradesh, including Guntur. In Guntur district, Swagati works in 47 of the 57 mandals, with the state government AIDS control organization, APSACS, working in the remaining areas. Approximately 5400 FSWs have registered with Swagati and 6000 FSWs have registered with APSACS. The main project objectives have been to (i) empower the key population to adopt safer sex practices and treatment seeking behaviour through behaviour change communication, (ii) reduce the incidence of STI’s through improved testing and treatment services, (iii) increase the correct and consistent use of condoms through appropriate social marketing interventions and (iv) increase correct and consistent use of condoms amongst high risk males (clients).

**Monitoring and evaluation of Avahan programmes**

To monitor and evaluate the impact of the Avahan funded programmes, Avahan supports a series of surveys that measure changes in behaviours, STIs and HIV in the target population. These observational data provide parameter estimates for mathematical modelling that can estimate the number of HIV cases averted in high risk groups and the general population. The surveys include (i) Cross sectional studies termed ‘Integrated Biological and Behavioural Assessments’ (IBBA) which involve STI/HIV testing and face-to-face questionnaires with members of high-risk groups and their clients, (ii) similar but more in-depth cross sectional behavioural studies termed ‘Special Behavioural Surveys’ (SBS) (which have quantitative and qualitative components) and general population surveys (GPS) and (iii) regular behavioural tracking surveys (5).

The baseline IBBA survey was conducted with 405 FSWs in Guntur in May 2006 (8). Exposure to the HIV prevention programme was high with 95% reporting contact by a peer educator in the previous month and 84% reporting visiting the NGO STI clinic in the past 3 months. Eighty-five percent reported consistent condom use with clients and 15% with their regular partner. Eleven percent were infected with syphilis, gonorrhoea and/or Chlamydia and 21.3% were HIV infected (8).

The SBS (quantitative) survey was conducted with 217 FSWs in Guntur in January 2008. This study revealed that there was much sexual mixing between FSWs and their different sexual partners (husband / cohabiting partner / clients / non-commercial partners). Condom use was far from ideal, with few FSWs reporting 100% condom use with all sexual partners (always use condom: regular partner 9.8%, non-paying client 29.8%, regular client 84.6% and occasional client 76.3%). In addition, one third (32.2%) of FSWs reported anal sex, which is far higher than rates reported by FSWs in other districts in Karnataka and Mumbai, for which we have SBS data. Although most (>98%) had had contact with a peer educator, only 14% reported correct knowledge of HIV/AIDS transmission routes.

**Purpose of this study**

Following quantitative surveys with FSWs in Guntur in May 2006 (IBBA) and January 2008 (SBS), the main aims of this qualitative study were to examine in-depth:
(i) If and how perceptions of HIV/AIDS had changed over time, and the impact of HIV/AIDS on FSW behaviour with clients and other sexual partners;
(ii) Relationships and condom use with various sexual partners, as well as barriers to condom use;
(iii) Perceptions of the HIV intervention programme, familiarity with the various clinical and non-clinical services available;
(iv) Issues not covered in the IBBA and quantitative SBS, including experiences of stigma, discrimination and violence, and relationships with the police and others.

It was anticipated the findings from this study would be used to contextualise and validate the quantitative survey data. The findings will also highlight ways in which programmes might work with FSWs more effectively to reduce their vulnerability to HIV/AIDS.
SUBJECTS AND METHODS

Setting

This study comprised a qualitative SBS, conducted with groups and individual FSWs in three mandals of Guntur where the quantitative SBS was done in January 2008: Narasaraopeta, Piduguralla and Tenali. Tenali is a rich region, with a high standard of living and a prominent wealthy class. An estimated 340 women sell sex in this mandal and FSWs are mostly home-based. Narasaraopeta is on the national highway between Chennai and Kolkata, and has an estimated 420 FSWs. This area was previously characterised by brothel and street-based sex work but this has generally been replaced by home-based sex work due to frequent police raids and a strict 10pm curfew enforced by the police. Narasaraopeta is known to have some traditional sex workers from a caste called Dommari. In Piduguralla, 355 women have been identified as sex workers. Sex work in Piduguralla is similar to sex work in Narasaraopeta, with women in these mandals typically earning less than in Tenali. Some FSWs are home-based, whilst others work in local factories or quarry mines, where they also solicit clients. Gramasiri is the NGO implementing the HLFPT Swagati project in these three mandals.

Study population and sampling framework

Narasaraopeta, Piduguralla and Tenali were selected purposively for this study, as three of the four mandals where HLFPT funds the HIV intervention programme and where the quantitative SBS study was undertaken in 2008. In these areas, HLFPT estimates that 90% of FSWs are registered with the local NGO. The registers note basic sex worker characteristics, and also note whether the sex worker is considered high, medium or low risk for HIV, which is based on 1) number of clients per week; 2) number of non-paying partners; 3) last attended clinic; 4) whether she previously had an STI; 5) number of condoms taken from clinic in relation to number of clients per week. These registers were used to sample women for the survey.

First, one FGD was conducted in each of the 3 mandals. Each FGD consisted of a homogenous group of FSWs based on either age (<25 vs. >25) or risk (high-risk) category and comprised a maximum of eight participants each, the ideal number for an FGD. The decision about which mandal would have which type of group was random. Thus younger (25 years and younger) FSWs participated in the Tenali FGD, older (>25 years) FSWs participated in the Piduguralla FGD and ‘high-risk’ FSWs participated in the Narasaraopeta FGD. After identifying which women fit the selection criteria in each mandal, the participants for the FGDs were then selected randomly from the list and local staff helped to find the women and arrange for the FGDs.

After we had read the FGD transcripts and identified key issues, we proceeded to the next stage of the project, which was to select 40 FSWs for an IDI from the NGO lists. We chose to interview 12 women in Tenali and Piduguralla and 16 in Narsaroapet, numbers approximately proportional to the estimated number of FSWs in each mandal. From the same FSW registers, we first stratified by age and risk level and then selected the designated number of FSWs randomly. We planned to have equal numbers of high risk women, but there were not enough in the selected mandals and so we had mostly medium and low risk women (Table 1). For both FGDs and IDIs, the selected participant names were given to the NGO, and their community staff helped to recruit respondents.
In-depth interviews and Focus Group Discussion guides

In-depth interviews (IDI) and focus group discussion (FGD) guides were developed following preliminary fact-finding trips to Tenali, Piduguralla and Narasaraopeta in January 2009 that involved informal discussions with NGO key informants and FSWs in all three areas. The key themes for the FGD included (i) knowledge and awareness around HIV/AIDS, (ii) changes to sex work and FSW behaviour over time, (iii) experiences of stigma and discrimination, (iv) perceptions of risk to HIV infection, (v) condom use, sexual history and sexual practices, (vi) sex work migration, (vii) experiences of violence, and (viii) perceptions of the HIV intervention programme (Appendix 1). The key themes for the IDI included (i) sex work history (ii) relationships with others on the sex work circuit (iii) experiences of violence, stigma and discrimination (iv) sex work migration (v) condom use (vi) sexual partners and relationships (vii) perceptions and attitudes towards HIV / AIDS and (viii) perceptions of the HIV intervention programme (Appendix 2).

All interviews were conducted by two trained female researchers in the local language, Telugu between February and March 2009. The purpose of the study was explained to all participants and confidentiality was assured. All interviews were recorded on cassette tape and informed consent was provided by all participants. Interviews were transcribed and translated from Telugu into English and analysed for persistent themes or ideas.

Ethical approval

Ethical approval for this study was granted by the Research Ethics Review Board at the Centre Hospitalier affilié Universitaire de Québec, Canada, the Health Research Ethics Board of the University of Manitoba, Canada and the Institutional Review Board of St. John’s Medical College in Bangalore, India.
RESULTS

Study population

A total of 60 FSWs participated in the study; 20 FSWs in 3 FGDs and 40 FSWs in 40 individual IDIs. Participants were between 18 and 48 years old, with a mean age of 29.4 years. The majority were Hindu (68%) with the remainder Muslim (18%) or Christian (13%). Equal proportions of the respondents were either married or separated/divorced (38% each); 7% were single, and 17% were widowed. Participants had been selling sex for a mean of 10.0 years in the IDI and 6.1 years in the FGD (range 4 months to 27 years) (Table 1). Data are presented from both FGDs and IDIs, though some themes come from the FGDs when it is not always possible to identify the speaker.

Starting sex work

The reasons participants gave for starting sex work were usually linked closely with poverty, lack of education, spousal alcohol abuse, and violence perpetrated by their husband and other family members, which had led to separation or abandonment. As a result, many of the women we interviewed had been impoverished and abandoned or were widowed women supporting young families, with few alternative options open to them to earn money. Most participants reported starting sex work to support themselves and their children following marriages to violent, drunk husbands at a very young age (age 11 or 12 years):

“The little children would cry out in hunger. There was nothing in the house. If I asked my husband he would say that he could not do anything as he had no money... One day when my children were crying out in hunger, I couldn’t bear it any longer. I went to the man and invited him for sex.” She was 13 yrs old. IDI 4 Piduguralla

Although most started selling sex out of desperation, with no other means by which to survive, many had since left these violent relationships. Having survived the violent and harsh experiences of their early teens, many said they were happy to be free of their husband:

“He [husband] got to know the truth [about sex work] from the neighbors and left me. He did nothing when he was there; I just thought it as ‘good riddance’”. IDI 3 Tenali

For those participants who were still with their husbands, many reported started selling sex to bolster the meager monthly salary provided by their husbands:

“My husband works as a waste collector for Municipality Lorry. Our income is less but we are living happily...I get Rs.500 per customer. If I go 8 times in a month I will get Rs.4000 per month. My husband gets Rs.3800 as salary. I feel this is enough.” IDI 12 Narasaraopeta

Some participants reported being sold to brothels in their early teens by a variety of agents including their families, field overseers and rickshaw drivers. This sometimes occurred following rape, as the loss of their virginity destroyed the possibility of marriage for them:

“When I was 17... some fellow who was hiding behind a tree saw me and raped me after forcibly closing my mouth. As I returned crying, everyone tried to console me. A friend of mine told me, you have been raped, no one will marry you now, moreover your family is very poor, come with me to Hyderabad... In that way I started sex work.” IDI 7 Narasaraopeta
While working at the brothels, these women would often send their monthly wage home to support their families and siblings. Once the brothels were closed down, they continued to sell sex as this was the only profession that they knew.

For those participants who disclosed their HIV status during the interviews, all reported that they started sex work after their own or their husband’s HIV diagnosis. All were now alone, having been abandoned or widowed by their husband and disowned by their families (see section below on heightened vulnerability of HIV positive FSWs).

Finally, a few participants reported starting sex work because of the pleasure they derived from sex. These women either did not have a husband (often because he had died) or they had a husband who did not satisfy them sexually:

“People do sex work for money and are always after it [money]. I do it for satisfaction and I do not bother much about money. Earlier, I didn’t have a husband and I wanted sex. What should I do? That is why I did sex work. They gave something for it. My present husband is old and I want a lot of sex. That is why I do it without his knowledge.” IDI6, Narasaraopeta

There was evidence that the reasons for entering sex work may be starting to change, as some of the younger participants reported entering sex work to be able to fund the material luxuries afforded by their richer peers:

“Look at me. I am pretty, but was not born into a rich family. Look at the way society is developing. There is a lot of modernity around. There is a change in the life-style. But there is no change in the mind-set or the life-style of the lower and middle class people. It won’t come quickly either. But when we look at our friends and their way of dressing up, we cannot buy similar things if we want to...” FGD Tenali

Husbands, permanent partners and lovers

Just over one third of participants were still married at the time of the SBS, and 55% had been married at some time and were now either separated, divorced, widowed or deserted by their husbands. Feelings towards husbands varied with some expressing ambivalence or animosity and others affection towards them:

“He [husband] is dumb but a very good human being. I cannot do injustice to him. Already I am doing unethical work. He likes me very much. If he is at home, he helps me in domestic work also.” IDI 12 Narasaraopeta

Many married women reported doing sex work secretly, either soliciting sex at home when their husband was out at work, or going to work in the fields or factories and soliciting sex whilst at their workplace:

“My husband does not know that I am doing sex work. He doesn’t even suspect when I am the last to leave. He just thinks, poor girl, may be some work is left over in the field; she will finish it and come. My husband is very nice.” IDI 5 Narasaraopeta

Some described using a burkha to conceal themselves when out with clients or lovers:

“I wear the complete headscarf (burkha)... I saw my husband two times outside. That is why I wear burkha so that nobody can identify me. Even women of other religion too are wearing burkha and moving fearlessly. My acquaintances borrow burkha from me and later return it.” IDI 10 Piduguralla
FSWs were reluctant to disclose their sex work to their husbands either because they did not want to hurt their feelings or because they were afraid their husband would leave them. A few were also anxious their already violent spouse would beat them if they discovered they were selling sex.

“If my husband knows, he will kill me.” IDI 9 Tenali

“… If my family persons come to know then they may burn me alive. I never allowed to know to anybody. All think I am going to snacks factory and earning some money. Even my permanent fellow may kill me if he comes to know my work.” IDI 8 Tenali

Some participants also reported a permanent partner or lover. ‘Permanent partners’ were described by FSWs as men with whom they had an ongoing relationship, who may or may not pay for sex. These partners were largely viewed as undesirable, as they demanded sex whenever they wanted it but provided little or nothing in return. They often forbade the women to continue sex work yet provided no financial support themselves. Thus many described why they refused to have a permanent partner:

“The people who keep us permanently come home drunk and create a big ruckus at home. He will insist on me not to go for sex work to anyone else and stay with him. Not only will he give me no money, he would feed off me and go home to his wife... It is also uncomfortable for the children if there is a stranger in the house. That is why we never let anyone stay permanently in the house...” IDI 3 Tenali

Many respondents reported feeling trapped or controlled by men in these relationships. Some permanent partners were extremely violent too:

“The person whom I kept permanently tortures me more. He tortures me after sex with me, he enquires that whether I am meeting anybody while going to home. He beats me like anything...” IDI 8 Tenali

In contrast, the couple of FSWs who had ‘lovers’ expressed feelings of love and affection towards them:

“He is very handsome. I just imagined how good it would be if we both were a couple. I never consider it as sex work. This is our relation...” IDI 10 Piduguralla

Solicitation of clients

Although the implementing NGOs described all registered FSWs as home-based, participants themselves described soliciting sex at home, but also on the streets or whilst at their place of work in the fields or factories. However, there was evidence that the modes of client solicitation had changed quite dramatically over the past decade with many women reporting that they used to work in brothels where sex work was controlled by madams. Women reported that they sometimes had to entertain up to 50 clients per day and had no choice about the numbers of clients or the types of sex they would have to practice:

“We [in brothel] had to do what ever type of sex that the boys ask for. There is nothing like, we will do only this and not that... If anyone comes [to brothel], he gets to have sex with the girl of his choice. If 20 people want me in a day, I must have sex with all 20 of them... I have sex is not less than 15 [per day]. This is the least number. Some days the number can also be 50.” IDI 7 Narasaraopeta
Women were paid monthly by the madam, and conditions were reported to be harsh. FSWs were beaten if they refused to do sex work, if the client complained about them, or if they accepted tips secretly from clients:

“...Some times I used to feel very tired. My customers included lorry drivers and farmers. If they complained that a particular girl was not cooperating, we were beaten up. I would sometimes hide the money given to me in the attic. But she used to find out and would put burn marks on the hand and take away the money.... You won’t believe me, but there used to be as many as 25 customers in a day. On such days, I would feel as if my private parts were torn apart.” IDI 1 Narasaraopeta

FSWs who had worked in brothels reported that they would be moved to a different brothel approximately every year to keep the supply of girls in each brothel ‘fresh’ for clients. Although women were paid far less per sex act than if they had been working outside the brothels and although they were not able to control the numbers of clients they entertained, there were advantages. As well as providing a regular income, madams could act as protectors from violence perpetrated by police and clients:

“... I was in the same brothel for a long time because she would abuse anyone who ill-treated us. She looked after us well. She would never ask us to do something which we didn’t like. She would take care of the police and brokers.” IDI 2 Narasaraopeta

However, condom use in the brothels was reportedly non-existent:

“While I was in Hyderabad [brothel], I knew nothing about condoms. We never used anything... Even in Vijayawada [brothel], I didn’t use condoms.” IDI 7 Narasaraopeta

Home based and street based women also used to often use middle men to control their business, but this was also not very satisfactory as they would often take half the sex worker’s earnings.

Two major factors appeared to have changed the way the women of Guntur solicit clients in recent years: the recent police closure of brothels and the concurrent advent of mobile phones:

“There is a lot of difference [between then and now] - as much as there is between heaven and earth. In those days we used to do it in brothels. They were in full control. We had to satisfy each and every customer they sent to us... Now, there are cell phones. One gets the customers home and they do it at home. This is the usual practice now. They (sex workers) get to keep what they earn...” IDI 1 Narasaraopeta

Now, the FSWs largely solicit their clients either directly from their homes, through friends who pass clients onto them when they are not free, through client word of mouth, through the NGO field workers, through their own petty business (such as selling balloons or beads) or at their place of work (such as in the fields or factories):

“Here many people work on the fields. The boys come and ask when no one is around. Then when everyone leaves, we stay back as if we had some work to do.” IDI 5 Narasaraopeta

“I hang some balloons on a stick and roam on the road by selling them... they [clients] they come near me and ask for sex.” IDI 9 Narasaraopeta

- 13 -
“I dress up nicely and sit in front of the house and people ask me.” IDI 7 Narasaraopeta

The arrival of mobile phones has brought about key changes to sex work solicitation, as clients are now able to contact FSWs directly, and FSWs are able to call their past clients to remind them to visit again or to refer them to their friends. Several participants described how they sometimes share clients by passing on information when they themselves are busy:

“Boys themselves call us. Otherwise they give us their phone numbers. We call them and ask them to come. If someone else is in need of anybody they will send them. If somebody calls some friend, and if the friend is preoccupied, other friends will be informed. I am also like that. We have many friends. We have sex in whichever friend’s house is available” IDI 9 Tenali

Thus whereas women used to rely heavily on pimps and madams for their business, or to solicit strangers on the street, the closure of the brothels and police crackdowns has forced sex work to be more secreted. However, to mitigate the effects of this on client solicitation, the introduction of mobile phones has meant that the women have more autonomy over their lives and livelihoods by being able to pick and choose their clients, and to keep all the proceeds without the interference of middlemen.

Client characteristics

Sex worker clients span all sectors of society, with men of different ages, different occupations and different social status soliciting sex. The sex workers in this survey reported that clients were usually between 18-60 years old, and had occupations ranging from street cleaners, rubbish collectors, field and factory workers and petty businessmen, to wealthy businessmen, doctors, lawyers and politicians:

“Mostly, rubbish collecting people, labour from railway station, people who polish shoe in trains and people who live on daily wages come to me.” IDI 1 Tenali

“People of all ages come. But rich people don’t come to me. Workers, hawkers on the street, hotel boys, lorry drivers, people like that come to me.” IDI 3 Narasaraopeta

“People with high stature in the society like doctors, lawyers, medical shop owners, medical representatives, bank employees and college guys... All the ages but I won’t go with the people of 50 and more.” IDI 10 Narasaraopeta

Several women also told us that college students were frequent clients. When college students solicited sex, it was often to be taught about sex:

“People who are 18 years of age are usually college students. They do whatever we girls tell them. They tell us they have come to learn from us.” IDI 5 Tenali

Respondents told us that they sold sex to men of a particular social ‘class’ and the amounts women charged per sex act ranged from 40 up to 3,000 rupees, reflecting their own age and beauty as well as the diversity in the wealth of clients. However, sex work is an unreliable source of income, with many respondents reporting huge fluctuations in the number of clients they solicited each day. To cope with this, most reported altering the amount they charged clients depending on their needs at that time and the number of clients they had entertained recently:

“When people visit, it is around 200-300 per day... A different rate to touch different parts of the body... Depends on my needs also. If many come on that day, in order to
Venues for sex work

Women reported that they entertain their clients in a range of venues, both outdoors and inside. Venue choice depends on ease and availability as well as the ability of clients to pay for a room, for example. Women who solicited clients in the fields, factories, on the streets or in other public places reported that they usually have sex outside, for example in the fields, open spaces and along the railway tracks:

“We look for some convenient place. We do sex in empty bogies of train or near the railway track.” IDI 1 Tenali

Women who solicited clients at home by phone, or through friends, NGO field workers or ‘middlemen’ said that they usually have sex indoors, either in their homes, their friends homes, in homes of brokers or in a lodge:

“I do sex mostly at my home. If they accept to come to my home, I will bring them my home or else outside empty places. If they are well off we will go to lodges.” IDI 8 Narasaraopeta

“We do sex at middleman’s house. If rooms are not vacant at middleman’s house, then we go to empty places” IDI 15 Narasaraopeta

For FSWs who had wealthy clients, sex work usually took place in hotels, either in their home town, in towns elsewhere in Guntur District, or in other states in India.

“I go wherever clients take me. If they take me to a hotel, they bear all expenses. Sometimes I go to hotels, or friends’ houses, or mostly have sex in my house. I never go to agricultural lands or behind the trees.” IDI 7 Piduguralla

In addition, some women with wealthy long-term partners reported that they sometimes provide a house for her to live in, and that they would have sex either there or at one of his homes:

“...He always needs to visit a place for his works. There he will buy an apartment for me. He bought a mobile. I go there he comes afterwards. He informs me when he comes. His staffs informs me when he is coming and asks me to stay there.” IDI 11 Narasaraopeta

Sex work migration

Although sex workers are thought to migrate from Guntur district to other areas in India for sex work, few participants in our study reported doing so. For the majority, the fear of new places, the fear of being sold or being caught by the police, the fear that their husband or families would discover they sell sex, and difficulties arranging childcare were key barriers preventing them from selling sex outside of their home town:

“I don’t go other villages or lodges. I am afraid of facing problems in other villages. Some people may cheat us leave us in unknown places. If we go to other states, we should be in complete control of brokers. I don’t like that and I don’t go anywhere.” IDI 4 Tenali

reduce the burden, I increase the rates... I am getting older so I am unable to do it with many people.” IDI 2 Narasaraopeta
Some did report travelling locally to neighbouring towns with clients, but most of these preferred to be home by nightfall. The only participants who travelled far for sex work were taken to these places by their rich clients:

“I go up to Hyderabad city. Most of my clients like to take me to outside towns. In each trip, I spend five to 10 days. Nobody suspects us in those places. Sometimes, I wear complete head cover (burkha) and people think we are a good couple. When taking the hotel room, the client says we arrived on some work and leave after the work is completed. Clients look after me very well and buy me whatever if I ask for...”
IDI 7 Piduguralla

Types of sex with clients

Contrary to previous studies in India where vaginal sex was reported to be the most common type of sex sold to clients, participants in this study reported that clients frequently asked for anal sex, and sometimes also oral sex:

“Since the beginning, people want sex from behind. They also like oral sex. I mostly do sex from behind (anal sex).” IDI 3 Tenali

Women who had been working as sex workers for a number of years explained that requests for anal sex were new:

“It is only now that they are behaving like animals. In those days they were humane... Now they do all sorts of repulsive things... They talk of sex from behind [anal sex] and oral sex. I had never heard of such things. Each body part must be used for the purpose it was meant for. Even educated people are supporting such behaviour...”
IDI 1 Narasaraopeta

The respondents mentioned that they think such requests emanate from recent exposure of clients to pornography via the internet and other media:

“At present, not only a lot of youngsters, even a lot of middle-aged people are watching such movies [pornography]. They show them even to us. Most of them are youngsters. There was a time, when I watched such movies the whole day with a man and had sex at least 10 times.” FGD Tenali

“The younger ones. They listen to us. They bring movies. They do as the white men do” FGD Piduguralla

Feelings about anal sex varied amongst participants. Some respondents said that they refused requests for anal sex because they found anal sex too painful or thought it was disgusting. A few women were happy to have anal sex with their clients as they found it pleasurable too, but most merely endured it because they felt that if they wanted payment, they had no choice but to do what the client demanded:

“They want it from behind [anal sex] or from the mouth [oral sex]. I don’t like doing it in that way. I feel like vomiting if it is done in the mouth. I just don’t like it from behind... I never did it even on repeated asking.” IDI 5 Piduguralla

“They are all field workers, usually are tall and very strong. While doing sex from back it will be very painful. But they give money so I have to do it and tolerate.” IDI 8 Tenali
Some FSWs reported that their clients preferred anal sex to vaginal sex because they could not ask their wives to perform non-vaginal intercourse and because the anus is ‘tighter’ than the vagina:

“They prefer it from behind or oral sex. They say it is too loose when it is done from the front.” IDI 6 Narasaraopeta

FSWs reported that clients were also asking, more frequently than before, to have intercourse in different positions, such as with the FSWs legs raised over her head, with the FSW sitting astride the client and vaginal sex from behind. They occasionally asked to be masturbated, or to see the sex workers naked. Again these were all things clients felt they could not normally ask their wives to do; however, FSWs also said they felt uncomfortable with these requests, particularly with being asked to sit naked:

“... If old men come, they make us take off our clothes and look at us. We used to feel odd to sit like that. We don’t feel the passage of time if something isn’t being done; it was very vexing to sit like that.” IDI 2 Narasaraopeta

Overall, the proportion of participants who reported anal sex with clients in this study (two-thirds of respondents) was much higher than other districts in India (Mumbai and Mysore), where we have completed similar qualitative studies. In addition, quantitative special behavioural surveys studies completed in six Indian districts between 2007 and 2008 on random samples of FSWs found that although between 42% and 99% reported ever being asked for anal sex, in Guntur 32.2% of participants reported ever having had anal sex, a rate much higher than the other districts (21.0% Mumbai, 17.2% Bellary, 16.8% Belgaum, 10.0% Bangalore, 3.3% Mysore) (Table 2).

Perceptions of the NGO and the HIV prevention programme

Participants had extremely positive perceptions of the NGO and the programme interventions, and frequently expressed appreciation of the various services available to them. They described helpful, kind, peer educators and outreach workers, who had taught them about condoms, provided free condoms and strongly encouraged them to use condoms with all their sexual partners. They also appreciated the NGO clinic available to them, with many explaining how kind and thorough the clinical doctor was during examinations:

“...Medical facilities have been arranged specially for people in this profession. They themselves come and remind us. They tell us to come for the test. If we don’t go, they ask why we didn’t come. The lady doctor does an internal examination also very well [speculum examination]. Each time she does it, she tells us what to do to prevent getting diseases. They distribute condoms. If we don’t like them we can buy scented condoms. What else does one want?” FGD Narasaraopeta

Some also mentioned CBO’s and using the drop-in centres and the way that the staff have helped empower them to some extent:

“The lady doctor at the organisation talks to us very nicely and examines us very patiently. It is because of her we feel a bit brave” FGD Tenali

Peer educators were also reported to encourage frequent visits to the HIV VCTC centre, reminding those who had not been tested or who were overdue, to attend for testing. In
addition, some described visiting the drop-in centre, to meet and discuss issues or difficulties in their lives:

“If I feel mentally upset or feel lonely, I go there. It is nice to sit there and share our problems.” IDI 2 Piduguralla

Some also reported recently joining their CBO (community-based organisation), with the hope or promise of loans in the future.

**HIV/AIDS awareness and practices**

Most participants reported that before the start of the HIV prevention programme 4-5 years before, they had not heard of HIV/AIDS. They reported douching with kerosene, petrol, Dettol, chillies and various other concoctions to treat and prevent STIs:

“In our days, we hardly knew anything. We didn’t have the fear of AIDS. We used to get VDs (STIs). We didn’t know of any medicines for them and used herbal medicines and other things. We even would rub in kerosene and petrol.” FGD Narasaraopeta

Information has since been provided by peer educators from the NGOs but in our study we found that levels of HIV knowledge were still poor amongst many participants. Whereas a few had comprehensive knowledge about HIV, others had heard only that there was a disease that could kill them but either could not provide any further details or were unsure how it was transmitted:

“I heard about AIDS. But I don’t know how it affects. I heard someone had died due to AIDS. I am unaware how it comes to us” IDI 8 Tenali

“I am afraid of contracting HIV/AIDS. I do not know much [about HIV]. I heard some information given by the organization. I listen to them but cannot remember the details properly.” FGD12 Piduguralla

One participant who was nursing her husband who was dying of AIDS-related tuberculosis, seemed unaware that she could also be HIV infected:

“My husband had relations when he was working, and he contracted AIDS. He is bed-ridden with that disease, and may not live for long time. I feel sorry for him, as I am his wife...” IDI 3 Piduguralla

This lack of HIV knowledge meant that many participants reported high-risk activities for HIV transmission. Thus, although the majority knew that condoms were needed for vaginal sex to prevent HIV and were aware of the increased vulnerability of sex workers to HIV infection resulting from unprotected intercourse with multiple sexual partners, few knew that to prevent HIV transmission, condoms also needed to be worn during anal sex:

“I wear condom when I do sex from normal position. We won’t get AIDS/HIV and other sexual diseases for the other positions.” IDI 13 Narasaraopeta

“For the last four years, I have always been using condoms... I do not use condoms when having anal and oral sex. There is no need. Some clients wear condom when doing anal sex. That is up to them. For normal sex, there is no way of doing it without condom even if clients offer more money.” IDI 9 Piduguralla

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3 Dettol is a locally available mild antiseptic, commonly used for household cleaning
It seems clear from the sex workers’ testimonies that there is considerable lack of awareness that unprotected anal sex is a risk factor for HIV and STI transmission. Bearing in mind that clients are more frequently asking for this, and that reported condom use for anal sex is worryingly low, we suggest that unprotected anal sex is a major problem in Guntur. In addition, there was frequent misunderstanding about HIV prevention with many reporting vaginal douching with Dettol and other substances to prevent HIV transmission in situations when condoms had not been used:

“If I think that they will pay less or that he is the sort who goes to lots of women, I refuse him. If he pays more, I will do it without a condom and wash up with Dettol later on.” FGD Narasaraopeta

Some also thought that the periodic presumptive treatment (PPT) for STIs provided monthly by the NGOs could also protect them from HIV transmission:

“It is said that sex workers get AIDS. It appears as sores and itching develops near the vagina when one has AIDS. It cannot be cured with medicines. The organization gives medicines to prevent such things from happening.” IDI 5 Piduguralla

“To have sex without a condom and to avoid AIDS, one should wash thoroughly with hot water and use good medicines.” IDI 3 Tenali

Misinformation also existed around HIV symptoms, with some agreeing to unprotected intercourse because they thought the client was safe, either because he was young, old, rich or ‘clean’:

“There is no need for it. They are very dignified persons... I don’t require all these things. They are so healthy and fresh. They are very clean. I don’t require these things. I have 5 condoms with me since long time and never required with even one.” IDI 11 Piduguralla

“I told them [NGO] I used them, just to satisfy them. I don’t use them. Old men don’t need them. Old people don’t know anything about such diseases. Youngster just come and just touch this and press that, there is no such trouble with them.” IDI 2 Narasaraopeta

Amongst some younger sex workers, ignorance persists despite them reporting frequent contact with peer educators and the NGO doctor. As one explained:

“...We don’t use it [condom] during sex with people we like. It [HIV/AIDS] affects people who are old, without capacity/strength. It doesn’t affect us. We spend a large part of what we earn on trying to get food that gives us strength.” FGD Tenali

**HIV testing**

Interestingly, many participants reported regularly attending government run VCTC services (every 3-6 months) to be tested for HIV infection, suggesting a missed opportunity for HIV awareness education. They reported that peer educators encouraged women to attend:

“They remind us of going for blood tests, if we didn’t go, they ask why we didn’t come.” IDI 2 Narasaraopeta

For the few women who had never been HIV tested (about one quarter of the sample), the primary reason given was the fear of a positive HIV test result:
“... The people from the organization came very often and requested me to come, I refused to go. I am scared of the outcome. You are coughing a lot, you are nothing but a lot of bones, come we will get a blood test done, they say. Even then I refuse.” IDI 7 Narasaraopeta

Others refused to be tested because they do not feel unwell:

“Everybody told me many times to go for blood test. I go to clinic to get medicine. If I start to suspect I have I will get a blood test done.” IDI 10 Tenali

In summary, although awareness about HIV/AIDS has increased since the NGO began education outreach work 4-5 years ago, many misconceptions and lack of knowledge persist. Despite many participants reporting contact with the NGO, regular HIV counselling and testing, and condom availability, high rates of unprotected anal intercourse with clients means many FSWs remain extremely vulnerable to HIV and STI infection in this setting.

**Male condom use with clients**

Before the start of the HIV prevention programme 4-5 years before the study was conducted, most participants who had worked in brothels reported that they did not know about condoms and that condom use was rare:

“Condom was never used [in the brothels]. I never knew that there was such a thing as a condom. Even the boys who visited us never brought any along...” IDI 6 Tenali

Even when clients occasionally provided their own condoms, participants explained that they were unclear why condoms were being used. After the programme was established, this situation changed and FSWs started using condoms with their clients especially for vaginal sex. Indeed, some reported that now they would not have sex unless the client agreed to a condom:

“If the client listens, he stays. If he doesn’t listen, I ask him to go away. Once I tell them to use a condom, I put it on for them. I tell them that health is important to me and they will listen.” IDI 4 Piduguralla

FSWs reported peer educators had taught them how to use a condom correctly including removing the condom straight after ejaculation to prevent condom slippage, and reports of condom breakage or slippage were rare. However, opinions of the free NGO (and government) condoms were frequently poor with virtually all thinking that they were too thin. Almost all the respondents reported that they used two male condoms at a time to address this concern:

“I used to purchase condoms from shops those days and kept with me. They were very good and strong... The condoms provided by organisation people are thin. Because of this we use two condoms for protection.” IDI 7 Tenali

Some respondents told us that they preferred shop condoms to the condoms provided by the NGO, perceiving these as thicker and of superior quality:

“I use condoms mostly that are available in shops... Condoms that are given by the organization will melt due to heat and slip during sex... Costly condoms are good. More money means more quality.” IDI 4 Tenali

As well as ignorance about the risks of unprotected anal sex, several other barriers to safe sex exist, with a few confessing that although they know about condoms and tell the NGO that
they are using them, this is often not the case. Particularly for older sex workers, a key obstacle to condom use was poverty, with women often agreeing to unsafe sex because they were desperate for money and worried that clients may leave if they insisted on condom use:

“I get scared that, if I say tell them that I will not have sex without condoms, they will leave. I know that I might get AIDS but have to do for my children.” IDI 10 Tenali

“They tell us that having sex with several people without Nirodh,¹ one gets AIDS. But because of our need for money, we have to do what they ask…” IDI 3 Tenali

“The person who pays us has a right [to have the kind of sex they want], even if we face problems because of this.” FGD Tenali

For some participants, the immediate need to provide for their families sometimes superseded fears about the known possibility of dying from AIDS at some point in the future:

“I take a decision depending on my circumstances. But the fear of AIDS always haunts us. But it appears that one lives for 10 years after acquiring AIDS. Now my daughter is in the 4th class. Even if I contract AIDS and by the time I die, she would have completed her degree. She will get a small job and will be able to support herself.” FGD Narasaraopeta

For others, the fear of an unintended pregnancy was greater than the fear of HIV/AIDS as a pregnancy risked exposing their sex work to their husbands, in-laws and families:

“I use condom with them… due to fear of pregnancy. I do not have the fear of AIDS, but have the fear of pregnancy more” IDI 7 Tenali

**Male condom use with non-paying partners**

Condom use with husbands, permanent partners and lovers was generally low, both for vaginal as well as other types of sex. The key barriers to condom use with these men included trusting (and being in love with) their partner, the fear of arousing suspicion about their sex work if they requested condom use and the fear of, or actual, violence. Some also described being in love with their partner and being untroubled about the risks from unprotected intercourse:

“I do not use condoms with both of them [husband and lover]. As I am still young, nobody will suspect me even if I get pregnant. God has given me life and I have decided to enjoy it completely.” IDI 10 Piduguralla

Many married FSWs were afraid to suggest condom use to these partners as they did not want to arouse suspicion about their sex work:

“I never used a condom with my husband. My husband never asked for sex from behind. If I ask him to use a condom, he will ask me how I have come to know of them and want to know from where I got them. That is why I don’t use a condom with the husband.” IDI 5 Narasaraopeta

“Because, he is a constable, he goes around with other girls. He used condoms when he goes to other girls. If asked to use a condom at home, he would become suspicious and beat me saying, are you still going out with others that you ask me to use condoms? That is why I don’t use them with my husband.” IDI 9 Tenali

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¹ Nirodh is the name of the free condoms provided, but is often a term used to describe any condom
For participants who had violent partners, condom use was very difficult. As one woman who was regularly stripped and raped by her permanent partner when she was at work explained:

“Morning he [permanent partner] takes me to the open place and in front of company [other workers] he asks me to do oral sex and from back also [anal sex]. Again he wants in the afternoons. He does not leave me even in the evening, he remove my clothes and bites my full body by doing sex either oral or from back…. I cannot keep the condoms which the organization gives me… I cannot hide anywhere. He removes my cloths every time. I cannot hide somewhere and take in the evening since evening also he doesn’t leave me…”  IDI 8 Tenali

Only two women reported condom use with their husbands, and this was for family planning, or because they suspected their husband had been to other women.

“My husband as a lorry driver may be going to other women. So, I use condom with my husband also. I am doing like this for the last four years.”  IDI 2, Tenali.

In summary, the respondents reported that condom use with husbands, partners and lovers was extremely low, for vaginal as well as anal sex. The risk of partners discovering they sold sex, coupled with feelings of intimacy and trust were key barriers. When FSWs had violent partners, safe sex became impossible.

Female condom use

Compared with FSW populations elsewhere in India, rates of female condom use were relatively high in this study population. Although around one third of participants had no knowledge of female condoms, of those who had seen a female condom, around half reported using them interchangeably with male condoms:

“I use condoms with every client. If they do not use, we have condoms for females. If we buy such condoms, we also get prizes. It is better to use these condoms instead of pleading with the clients to use condoms. I never fight with clients. All I need is money.”  IDI 11 Piduguralla

Opinions varied about female condoms but among FSWs who used them, despite some initial difficulties getting used to them, they reported finding them useful, especially when clients did not want to use a male condom:

“Yes, I have heard and used. It is good. In the beginning I felt inconvenient inside. Once I used it. It is very good. With these condoms I feel protective on outside than inside. Even during menstruation I can have sex without worry by using these condoms. When these condoms, sex workers don’t need to fear of AIDS.”  IDI 7 Tenali

Barriers to use among those who knew about female condoms but did not use them included having to pay for them (they are not free unlike male condoms), difficulties in inserting them, not understanding how to use them, fears of them getting lost inside their vaginas and diminished sexual pleasure when wearing one:

“I have heard of it and seen also. But, I don’t like it. It looks big, that should be inserted deep inside!? We don’t know what if something happens inside. Men

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5 Referring to a marketing strategy designed by the NGO
condoms are visible on the outside and if something happens we would knowing clearly.” IDI 11 Tenali

“Yes, organisation showed that. They provided gift programme for using them also. It is very difficult to insert that inside. After that also it is very painful and like hell. If it stick to that pubic hair, it is very difficult to bear. We lost interest in sex if we wear that. So I never went that side.” IDI 8 Narasaraopeta

**Pleasure from sex work**

Another theme to emerge from this study was for some participants, the importance of personal sexual pleasure during sex work:

“Maybe one will give money and one won’t. If one does sex the way I like it, I won’t take money from him. I ask him to come again. Money does not matter to me. Satisfaction is important.” IDI 14 Narasaraopeta

Indeed, a few reported starting sex work because they enjoyed sex. Moreover, for participants who started sex work to alleviate poverty or to escape violent spouses, some described how despite dreadful, violent early sexual experiences, they had since discovered how pleasurable sex with the right lover could be:

“I learnt one thing… Sex should give pleasure and not pain is what I understood. Sex should not be done mechanically or considered like a business commodity. Both should feel satisfied… It is applicable not only to the people who come to us, but also to us. That is why I don’t keep quiet if the client is satisfied and I am not.” IDI 3 Narasaraopeta

Middle-aged clients were reported to be better lovers than younger or older clients, with some participants increasing or reducing their charges depending on how skilful the client was:

“The youngsters do it in a jiffy. The middle aged people do it in a way that it is satisfactory to both… The elderly have desires, but they are unable to do anything about it, and are unable to satisfy the women. It all takes a longer time.” IDI 2 Narasaraopeta

One woman who was married and did sex work secretly explained how the emotional connection she experiences with her husband is quite different from the physical pleasure she gets whilst having sex with clients:

“…my husband also becomes a matter of routine when he has sex with me. Just pumping something into me but I won’t be satisfied. But after that I feel so much love and affection for him. But with customers it is mechanical even though I get sexual satisfaction.” IDI 10 Narasaraopeta

**Sex worker empowerment**

The closure of the brothels, forced reduction of street solicitation and the introduction of mobile phones has meant that participants have more autonomy than they did when controlled by madams, pimps and husbands. In addition, there was evidence of other types of empowerment. Since starting sex work, many women reported that they had gained financial independence and had used their income from sex work to improve their children’s and their own lives. This included, feeding, clothing, educating and finding spouses for their children, renting or buying their own house, and buying themselves saris, gold and other luxuries:
“There is a lot of difference between the financial situations between then and now. Then I had left my child at my mother’s place and had nothing to eat. Now I have saved a lot of money. I have bought a cot, TV, a gas stove and many more things. I have put my daughter in a good school. In a short time, I will also buy a house” IDI 1 Piduguralla

One even described how she had used her earnings from sex work to educate her son, who was now married and working for a private company:

“I have educated my son well. He now works in a private company; he fell in love and got married. He has taken a house near the company and is living now happily in Hyderabad.” IDI 2 Narasaraopeta

In addition to financial independence, many participants reported independence from male partners, with two-thirds now separated from their husbands and most deciding not to engage in another intimate relationship because of the demands of most permanent partners. One woman who did have a permanent partner explained how she had asserted her right to continue selling sex, whilst remaining in the relationship:

“My husband came to know and questioned why I did such work. I said “You never give me money to live. You will come only to sleep. If I do this work, I earn at least Rs 500. I will quit this work right now if you promise to look after me. If you dislike, you can leave.” He became silent since then, and often comes to see me.” IDI 7 Piduguralla

In addition, many of the younger women were adamant they would not take a permanent partner:

“No sex worker allows a client to stay permanently. The client who stays permanently doesn’t allow us to have sex with others, only with him. They don’t give money. They ask us to earn for them. If we [women] work, he just sits there doing nothing and will insist that I don’t do sex work. From where should I get money to give him? That is why I never go for such an arrangement.” IDI 5 Piduguralla

Thus most FSWs were more financially independent than when they started sex work, had more autonomy over their lives and were able to be more selective about the relationships that they choose to have. However, for older sex workers, those with a violent partner and those sick with AIDS, their situation appeared to be rapidly deteriorating.

Violence

There were several reports of participants experiencing extreme violence earlier in their lives, usually at the hands of their husbands, permanent partners or when they were working in brothels:

“He [husband] would beat me up saying that I didn’t cook this and that, you didn’t cook meat, didn’t cook curry”... “He [partner after husband] would suspect me of sleeping with others and cut me with blades. I lived with him for 2 years, putting up with all the torture...” IDI 1 Piduguralla

“He [husband] would pour hot water on my private parts. Coming to sex, he was unbearably cruel. He would pull my legs apart and bite my private parts hard... Once, he bit me so hard that he bit off the little projection there [clitoris] and ate it
up. He is such a fiend. There was blood everywhere... I suffered for many days....”  
IDI 3 Narasaraopeta

Some women reported that they had been raped by older men or by gangs, and this had often precipitated their entry into sex work:

“They closed the door. There was nowhere to go. Even if I shouted, no one would be able to hear me... I pleaded with them. They did not listen to me. They gave me cool drink mixed with alcohol. The four of them raped me... We [her husband and her] separated after that. Maybe no man would have let me stay. I don’t know which of the four had the disease, but I got it [HIV]” IDI 2 Piduguralla

Two women described how they had been ‘owned’ by rich, powerful, permanent partners, who were physically, sexually and emotionally abusive towards them, using them as sex slaves for themselves and their friends:

“He [permanent partner] would have it in the mouth, from behind and all over my body. He would torture me in ways I cannot describe... He would bring 4 or 5 friends. If I asked for money they would throw me in a room and beat me... The day was full of sex. I had no energy due to lack of food. They would bring chicken and mutton to eat while drinking, but they would eat it up. His friends didn’t use a condom when they would force me to have oral sex. ‘This is the only food for you, eat it’...” IDI 1 Piduguralla

One described how she was forced by her family to become the mistress of a powerful businessman and politician after he raped her when she was 14 years old and working in his factory. She shared with the interviewer that he continues to retain complete control over her to the extent that she recently had her uterus removed to stop menstruation, so that she would be available for sex whenever he demanded it:

“I have removed my uterus... He goes on tours most of the times and suddenly he may call me on his return. But if I have menstruation that time, I cannot satisfy him. So with his permission, I got it removed.” IDI 11 Narasaraopeta

However, despite the high levels of violence many experienced early in their lives from their husbands, permanent partners, and other in the sex work network, the levels of violence for many participants had fallen as they had found the courage to separate from their early violent partners. Moreover, the closure of the brothels has meant that sex work has become hidden and this has inadvertently reduced the violence perpetrated by police:

“How can police know what is happening in the mill. When we did sex work at madam’s house, nobody will doubt us [nobody can doubt what we do there].” IDI 15 Narasaraopeta

In addition, the NGO has conducted advocacy efforts with the police and set up systems to help sex workers during times of crisis, which has also helped reduced police violence:

“Change has come with police. In those times they used to catch us very frequently and half of the amount used to go to them. Now it is not like that. If they catch us, the members of organization [NGO] come and release us.” IDI 14 Narasaraopeta

Participants described how community mobilisation and empowerment has helped them stand up to and defend themselves against violent clients so that now there is less tolerance of violence and it is rarely seen:
“I will not keep quiet if they abuse me. I will beat them.” IDI 8 Piduguralla

“...If any such thing happens to one of us, all of us unite and we make a lot of fuss” IDI 1 Piduguralla

“If they torched me physically I will beat and send them out...If anybody is strong, friends will be there we all together will beat them.” IDI 7 Tenali

For FSWs who still experienced violence, the main perpetrators were their husbands and permanent partners.

“I am very much scared of my husband’s harassment. He beats me...” IDI 12 Piduguralla

**Alcoholism**

Despite increased independence and reduced violence, rates of alcoholism were high with several women reporting daily drinking. Some had started drinking alcohol to keep their clients company, or when they were working in the brothels. Others started to escape the feelings of regret and hopelessness they felt about doing sex work or to numb the pain of anal sex:

“It [anal sex] is painful. I have a habit of taking liquor. We drink together.” IDI 4 Tenali

“They ask me to drink. I drink to forget my troubles. The fact that I have sex with different people troubles me. I have to show my body to each and every client every day. This troubles me a lot. That is why I drink.” IDI 5 Piduguralla

Among those who said they do not drink, disliking the taste, feeling responsible for their children, and wanting to stay alert and in control when they were with their clients were some of the reasons cited for staying sober:

“The clients come to me only when they are drunk. They drink and ask me to drink. In fact, I do not drink. I am resorting to this work for the welfare of my children. I never do such kind of drinking and nonsense.” IDI 6 Piduguralla

“If both the client and me drink and have sex may be we do not know if condom is properly used or not. The situation is not good due to diseases. Due to this reason, I refuse to drink even if the client forces me. I always tell them I do not like to drink but they can drink” IDI 9 Piduguralla

As well as negatively affecting their mental health, women who drank regularly said that this also impacted on their physical well-being. Women who drank daily reported skipping meals or not eating at all, instead prioritising earning enough from sex work to afford the ‘daily drink’. Negotiating or remembering to use condoms with clients also became less important with one woman describing how sometimes she has no memory about what has happened to her:

“... Sometimes I don’t remember how many people do the sex with me... Once they made me to have drunk heavily and I fell asleep. It seems more than 10 persons had sex with me. A girl nearby my house saw this and told me... I would be intoxicated and unconscious. They bite, scratch and torture me like a hell. I have all the scratches all over my body there isn’t any place where there are no scratches. I would be in an awkward position by the time I woke myself. After I become normal I would have the body pains like hell. Sometimes they would have done sex from backside also. Once my private parts were full of bleeding, I was unable to walk.” IDI 9 Narasaraopeta
One woman shared with us how alcoholism impacted her children:

“I never bother about them [her 5 children] whether they are working begging. They all stay together themselves. They feed themselves and sometimes they feed me. I never bother about them. When no one bothers about me why should I bother about someone?” IDI 9 Narasaraopeta

**Mental Health**

In addition to alcoholism, poor mental health was also evident in some respondents, with some expressing feelings of depression and hopelessness:

“When you talk to me in such a kind way, I feel like crying. Because no one talks to me in this way, I do not share my troubles with anyone.” IDI 3 Narasaraopeta

This was often associated with poverty, destitution and regret about sex work:

“...I am a family woman. Because of ill-fate I have become as prostitute... Sometimes I think of running away from here to any rehabilitation/spiritual centre. And sometimes, I think it would be better if god takes me to him right now [if she commits suicide]” IDI 16 Narasaraopeta

Participants who were elderly, who remained in violent relationships and / or who were HIV positive were particularly likely to have poor mental health. As one woman who was destitute and HIV positive explained:

“I sell flowers. If anybody approaches me for sex, then only I go with him. I take some money which is not enough to meet my minimum expenses... I do my work. I take care of my child. I just eat and go to sleep... I am tired madam. Isn’t it over yet?” IDI 1 Tenali

Another, who had a violent permanent partner and a drunken useless husband, expressed similar feelings of hopelessness:

“I want to leave him [her permanent partner] but he is not willing and doesn’t allow me to leave. It is unbearable for me at this old age. He is not willing to do sex from front position [i.e. he wants only anal sex]. He says it has become loose. He can do for sex for even ten time’s day. Since I have accepted to keep him permanently I have to bear all these things... My situation is the worst. No proper food. I haven’t married my children. My husband earlier used to weave saris. Now he just eats lives without any work. Very difficult life.” IDI 8 Tenali

**Stigma and discrimination from neighbours and families**

Sex work is highly stigmatised in Indian society though a large component of the Swagati programme is to fight such stigma. Despite this, the sex workers continue to experience stigma and discrimination from their own families and the community:

“Society has very low opinion and low status for this work. They even not bothered to talk to us and will not give any value to our words.” IDI 12 Tenali

“I have separated from my people long ago. I have no connections with my people any more.” IDI 5 Piduguralla
Experiences of discrimination included, being ‘looked down upon’ and ‘taunted’, being blamed for ruining families and being called ‘bitches’ or other names as they walked along the street:

“When we passing on the road they scold us. Ladies scold saying why this bitch has come here and how many families she spoils.” IDI 7 Tenali

Some reported frequently being evicted by landlords because they sold sex:

“People feel even if they talk to me, their reputation will be spoiled. So, I don’t talk to anyone. In our society people keep a distance from us [sex workers]. They will not give house for rent. I have to vacate my rented house each month.” IDI 10 Tenali

Most participants were estranged from or disowned by their families because of their sex work even though their families had used the money raised from sex work to educate and marry off other family members:

“My sisters and brothers all are come to a good position with the money which is sent by me by doing sex work. Now no one is talking to me because they feel I am a loose character. They don’t care about me at all. I don’t have food also but nobody gives me even single rupee also… I looked after all and never saved money so now it's very hard to get food… Even in school my children are not getting food. I feel very bad for that.” IDI 10 Tenali

The sex workers sometimes told us that to help ensure that stigma associated with sex work did not affect their children’s ability to marry; they would send their children away to hostels or to other family members, and cease to have contact with them, while selling sex in order to pay for everything and provide a better life for them:

“I never go there [to visit her children]. No one should know that they have such a mother. They [children] do ask me to come… I don’t go because I don’t want to lower their standing in society” IDI 1 Narasaraopeta

“Both the children are grown up. They had some sort of education and are living on their own. I don’t visit them and I ask them not to visit me. Because, if people come to know that their mother is in this profession, they will not have a good standing in society.” IDI 1 Piduguralla

FSWs who were HIV infected faced the ‘double’ stigma of selling sex and of having HIV/AIDS. The lack of familial or social support meant they were reliant on sex work to survive:

“Nobody would come to me if they know that I had AIDS. Others even won’t allow me to sell flowers. They will threaten me to kill, if I go like this. I would be forced to lose this small work also.” IDI Tenali

In addition, the fear of discrimination and violence meant they had told no-one about their HIV positive status:

“They [clients] say that if anybody do sex with AIDS infected woman, they get the disease. That is the reason women with AIDS are to be beaten with stones to death, they say.” IDI Tenali

In summary, the continued stigma associated with both sex work and HIV means that FSWs frequently experienced discrimination from society at large and from their own families. For
many this means they are completely alone, with no-one to care for them emotionally or financially.

**Difficulties associated with livelihood sustainability**

Some of the respondents used to be brothel-based, where they were paid a monthly wage regardless of the number of clients they entertained. As the brothel owner took a large cut of their earnings, the amount they earned per client was lower than now. However the brothels did provide a constant supply of clients as well as financial security. Since the closure of the brothels, FSWs have lived with no guarantee of clients or income. However, for most, earning between 30-3000 rupees per sex act, they can earn far more from sex work than they could ever do in low paid unskilled jobs such as working in the fields or factories:

“What will I do if I quit the trade? If I go to hard labour, I get Rs. 50 [US$ 1 per day]. I need to pay house rent, power bills, and for cable television. Three people have to live in this house. The children are to be educated. Will I be able to meet all these expenses with Rs. 50?” IDI 5 Piduguralla

Some FSWs also worked in the fields or factories, but they explained that their wages from these jobs were not enough for them to survive. Thus, even when women said they would like to stop sex work, most could not contemplate giving up:

“I never considered putting a stop to sex work. My family runs on what I earn. What I get by work on fields is not enough. That is why I will not stop sex work till the children grow up and get married.” IDI 5 Piduguralla

“If I stop, what do we eat? How can we survive? If we had some other means of livelihood, we would stop.” IDI 3 Tenali

However, older women told us that they were now finding it much more difficult to find clients, or to have them referred by middlemen. As information about, and access to, savings schemes or pension plans are not available to sex workers, many older participants now struggle to make enough money to survive, even when giving in to unprotected vaginal and anal sex:

“In those days the business was good... The money was sufficient to pay the rent and for bringing up the children. Nothing was saved. Now, boys are not visiting me much... My income has thus fallen drastically. Making ends meet has become difficult... On the whole, in a month I get around RS. 1500. All these are from sex from behind [anal sex]. I have not used the condom even once in this month. What can I do? All for the sake of money.” IDI 3 Tenali

“I used to get lot of clients when I used to them from brokers. Now I am hardly getting clients. I hardly get one client in a week. Brokers are also not calling me... I call the brokers and clients whose numbers I have and beg them to send any client... It is very difficult to get 4-5 persons for a month.” IDI 10 Tenali

Many respondents thought that many new young women were entering the profession and that this had contributed to reductions in client demand for them. In addition, paradoxically, although mobile phones have enabled FSWs to solicit clients independently, they may also have negatively impacted on demand for some women, as clients are able to browse the internet for new ‘hot’ sex workers or as male friends pass on details of sex workers they like:
“Those days communication facilities were very less. Once they came to me, they kept coming to only me because they didn’t know where other sex workers were available. Nowadays all have cell phones and all are aware of everybody. They didn’t know where other sex workers were available. Now men prefer young girls. Girls coming to sex work from the age of 18 itself. They are more in demand.”  IDI 7 Tenali

The inability to earn substantial money through other means, coupled with the lack of savings and familial support, means that as women become elderly or sick, they have no other way to survive:

“As long as we have stamina, this will go on. That is why this should also be considered a profession and arrange for a pension. That too only for people who can be considered as being considered useless for this profession. Our lives are like glow beetles. We are seen as long as we glow. No one can recognize us in the dark. When they can’t fly, they don’t glow. Even our lives are like that.” FGD Piduguralla

A repeated request from participants was for savings and pension schemes to be made available for sex workers, so that they can be more financially secure in their old age.

**Heightened vulnerability of HIV positive FSWs**

A few participants disclosed during the interviews that they were HIV positive. One woman learned she was HIV positive after her husband died of AIDS. Another thought that she had been infected when she was gang raped; a third discovered she was HIV positive following an HIV test during pregnancy. All three were rejected by their husbands and/or families and were selling sex in order to survive:

“...Doctors in the Government hospital tested me and told me that I had AIDS... They told me that the baby is not affected. He [husband] went away from me the moment I delivered my baby... I was just blank and started selling flowers. While I was selling flowers, train cleaners asked me whether I could have sex with them. Likewise, rubbish collectors on streets also approached me for sex. One day, I could not sell any flowers. I knew that my baby was crying at home for food. At that stage, a rubbish collector approached me and I accepted for that [accepted to have sex with him]. He gave me Rs. 100. That was how I started as a sex worker.”  IDI 1, Tenali

These women were living in extreme poverty, with their mental health clearly affected by their circumstances:

“After my husband’s expiry I came to know that I got AIDS from him and he expired due to it. I know very well that me and my daughter also die one day.”  IDI 12 Tenali

“As of now, I have nobody. I am alone.”  IDI 1 Tenali

As they struggled to earn enough money to survive, these women were desperate for clients and sometimes agreed to unprotected anal and vaginal intercourse:

“Before this [learned she had HIV] I never used to wear condom. I am using condom for the last two years. Now I use condom for people who likes it, otherwise, I will not use... If they still refuse and leaving me I will go with them without condom. I need money, right?”  IDI 12 Tenali

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They also described feeling sick, fragile and exhausted, with no alternative way to support themselves:

“The problem is that sometimes I don’t feel well all of a sudden. Then I don’t do anything... If anyone wants their eyebrows shaped, I do it. I am unable to do any tailoring work. I do embroidery work. All those involve a lot of hard work. One needs energy to do those things. Moreover I feel very easily exhausted nowadays. Even while having sex, I sometimes wish that it is over very fast.” IDI 2 Piduguralla

Interviewer: “You look very weak and have AIDS. Are you thinking of giving up sex work?”

Respondent: “I need money for my house hold needs. If someone come with money to have sex. I do accept for my needs. I know it is wrong but I am helpless owing to my financial situation and for my daughter’s survival.” IDI 12 Tenali

It is clear from their accounts, how the interplay of extreme poverty, lack of familial or social support and stigma can fuel the spread of HIV/AIDS:

“Mostly, they ask whether I could do sex from back [anal sex]. They also ask whether I could do oral sex. Some people do both…. I am telling you the truth. If I am given more money I will accept for sex even though they did not use condom.” IDI1 Tenali (HIV positive)
DISCUSSION

This study conducted with 60 FSWs in 3 mandals of Guntur district in Andhra Pradesh aimed to expand the findings from earlier quantitative IBBA and SBS surveys conducted earlier in the NGO intervention programme (IBBA May 2006 and SBS January 2007), which found high levels of NGO contact and HIV testing, yet low levels of HIV knowledge and risk perception, low levels of condom use with non-commercial sexual partners, fairly high levels of anal sex with occasional clients, and high levels of reported STI symptoms in the year before the survey (8). In addition, this study aimed to provide in-depth understanding of issues not covered by the quantitative surveys such as FSW relationships with their sexual partners and other actors in the sex work network, FSW experiences of the HIV intervention programme and FSW experiences of violence, stigma and discrimination.

Persistent poor knowledge and misconceptions

A key finding from this qualitative study was that low levels of knowledge and high levels of misconceptions around HIV/AIDS persist, despite many participants reporting frequent contact with peer educators, NGO clinic doctors and VCT counsellors. In particular, there was a general lack of awareness that HIV could be transmitted during unprotected anal intercourse. There were also misconceptions that the periodic presumptive STI treatments provided by the NGOs and vaginal douching with Dettol after sex, could offer alternative methods to protecting against HIV and STI infection when condoms were not used. This lack of knowledge, together with high rates of reported unprotected anal intercourse with clients, husbands and other sexual partners suggests that many FSWs are continuing to engage in high-risk sexual activities. Clear prevention messages regarding unprotected anal intercourse are urgently needed (9). In addition, given that many unskilled labourers in the fields and factories are migrant workers coming from other districts and states in India, and given that FSWs reported a lack of HIV/STI awareness and high rates of unprotected intercourse with these clients, there remains a real potential for HIV and other STI’s to spread from sex workers and their clients back to the general population when these migrant workers return to their wives and families (10, 11). It is clear therefore that HIV prevention education interventions which target men in these low literacy settings are also required to promote safer sex messages and to support FSW negotiation of condom use in workplace settings (11).

High risk sub-groups

Those FSWS who were older and/or HIV infected reported living in extreme poverty and struggling to find enough clients to survive. Despite awareness of the risks, many were having unprotected vaginal intercourse (as well as unprotected anal sex) as they were anxious not to lose any clients by trying to negotiate condom use. Until the extreme poverty faced by older and sick FSWs is addressed, it seems unlikely that these women will ever be able to practice safe sex, as the immediate need to provide for themselves and their family will continue to override the need to protect themselves and others from HIV / STI infection (12, 13). Thus, alongside HIV education and condom promotion, structural interventions which help alleviate social inequity and the extreme poverty of the most vulnerable FSWs are also urgently required to reduce the reliance of these women on sex work for survival, and the vulnerability of themselves and their sexual partners to infection (9, 14).

Unprotected anal sex

Anal sex was reported by all participants to be the key commodity in the sex worker market in Guntur district, a fact which has not been previously reported in Andhra Pradesh, or anywhere else in India (7, 15, 16). Indeed, data from the IBBA survey conducted in 2006 found 30% of FSWs in Guntur reported ever having anal sex with clients, and the quantitative
SBS, conducted in 2007, reported rates of 20% with clients (and 32.2% with any partner). This is in stark contrast with our study in 2009, where at least two-thirds of participants reported regular anal sex with their clients. With a sensitive topic such as anal sex, it could well be that social desirability bias has resulted in under-reporting of anal sex in previous quantitative studies (17). Alternatively, it may be that requests for anal sex from clients are a new phenomenon, influenced by their recent exposure to pornography via the internet and other technologies, and this would have been missed by these earlier studies. Indeed, participants who had been working in the industry for longer suggested this may be the case, with clients in their early days of sex work only requesting vaginal sex. In addition, it is clear from these sex worker testimonies that misconceptions exist and that many think that HIV cannot be transmitted during anal sex.

**Evolving means of solicitation and sexual mixing**

Alongside the changing sexual preferences of clients, it was clear that in recent years there have also been substantial changes to the main ways that clients are solicited. Following the closure of brothels, police crackdowns and the late-night curfews implemented in some areas, most participants reported soliciting clients either at home or at their place of work such as in the fields, railways or factories, instead of in brothels or on the streets (18). Moreover, the introduction of mobile phones has enabled FSWs to solicit clients directly, instead of through middlemen, pimps or madams and for cell phone numbers to be passed between clients and their friends (19). Community camaraderie amongst FSWs means clients are often shared between women, so that if one sex worker is busy she will pass clients onto another who is free. This situation has enabled greater independence from middlemen in the sex work circuit (20) but, coupled with the high rates of unprotected anal (and vaginal) intercourse with clients, husbands and other non-paying partners means substantial sexual mixing is likely occurring in this setting (9). Furthermore, the closure of the brothels and the use of mobile phones to solicit clients may drive sex work further underground, making these populations harder to reach by the HIV prevention programmes. As both the types of sex solicited and the methods of solicitation change it will be critical that the approaches used by HIV prevention programmes keep pace with these changes and are able to adapt accordingly (9).

**Alcohol and violence**

The levels of reported violence by clients, the police, madams and others on the sex work circuit were extremely low, despite many experiencing high levels of violence earlier in their lives. Participants attributed this fall to the closure of the brothels and violence interventions by the NGO, including sensitisation training of the police and the introduction of 24 hour crises management teams to support FSWs who experience violence (21). In addition, collectivisation and community mobilisation of the sex worker community has meant that many reported they now feel able to stand up to perpetrators and to protect one another when clients became violent (14, 22, 23). Most participants had left early marriages to violent, drunk husbands and due to the financial independence afforded to them from sex work, resisted new relationships with ‘permanent partners’, precisely to avoid re-introducing violence and harassment back into their lives. Indeed, amongst those who still reported physical and sexual violence in this study, domestic violence predominated. Condom use becomes extremely difficult to negotiate in the context of a violent intimate relationship, and domestic violence has been associated with increased risk of HIV/STI infection elsewhere (24-27). A significant proportion of women in our study also reported daily alcohol use, with links to depression, feelings of hopelessness and poor mental health. Negotiating condom use and staying safe from attack or rape becomes more difficult than when sober and sex under the influence has been associated with unprotected intercourse and HIV/STI infection elsewhere (28). Strategies which address both alcohol dependence and violence within domestic relationships are needed within the broader HIV prevention programme to enable
these women to be able to correctly and consistently use condoms and to reduce their vulnerability (14).

**Sexual pleasure**

A somewhat surprising outcome from this study was the place of personal sexual pleasure during intercourse with clients, reported by some participants. This has not been reported in other studies from India but was mentioned several times during the interviews, with some women reporting that they adjust their fees depending on the sexual skill of the client. Again, this appeared to be a new phenomenon, with those who described their early years in the brothels recounting sex as pain rather than pleasure. It is unclear what has prompted pleasure to appear on the agenda of FSWs but many described the surprise they had experienced when a particular client or lover had awakened their sexual desire following miserable early sexual experiences. The empowerment of sex workers though the NGO intervention programme and/or the exposure of FSWs to pornographic movies by their clients may have helped bring pleasure into the consciousness of some participants.

**Study limitations**

One limitation of this study was the purposive selection of mandals and means the findings from this study may not be representative of other mandals in Guntur district. The sex workers within these mandals were selected based on the programme registers. Although the implementing NGO feels that 90% of FSWs are registered with the programme, this still means that 10% are not. Clearly there may be differences between those who are registered and those who are not, but we felt this was the best way to be able to randomly select study respondents and that this outweighed the cost of not trying to find unregistered women. Also, most of the women who were selected for the IDIs turned out to be mostly those labelled by the programme as low or medium risk, rather than high risk women. This is particularly disconcerting given the levels of high risk behaviour that they reported in this study. In addition, social desirability bias may have influenced the reporting on sensitive topics such as violence, HIV infection and unprotected intercourse (17). This could be particularly true during focus group discussions when sex workers are asked to openly discuss sensitive issues in front of their peers. To try to address this, this study comprised individual as well as group interviews, with the three HIV disclosures occurring during the individual interviews only. Finally, as in most studies of this nature, there may have been some recall bias, although the consistency of reporting of the main themes across the interviews suggests this is unlikely to have impacted greatly on the results from this study.

**Conclusions**

Overall, the findings of this study extend those of earlier quantitative studies in Guntur district and suggest that despite concerted peer education outreach efforts and frequent visits to the NGO and VCT clinical services, low levels of accurate HIV knowledge, high levels of misconceptions and high rates of unprotected intercourse persist, even in women thought by programme definition to be at low or medium risk for HIV. In particular, the high rates of unprotected anal intercourse amongst participants urgently needs to be addressed, with evidence of much sexual mixing currently occurring between sex workers, their clients and their non-commercial partners. In addition, in response to the introduction of mobile phones and changes to the main modes of client solicitation, HIV prevention programmes will need to be flexible and creative in their approaches if they are to continue to reach effectively this target community. Reducing the social inequity and extreme vulnerability of older and HIV-infected sex workers, as well as addressing the domestic violence still experienced by some sex workers will also be crucial if HIV prevention efforts are to succeed, and is key to protecting their basic human rights.
REFERENCES

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Table 2. Proportion of female sex workers reporting anal sex across 6 districts in India: quantitative Special Behavioural Surveys

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APPENDIX 1

GUNTUR FSW FGD Guide

1. Meaning of HIV/AIDS:

In this section, try to bring out attitudes and knowledge of HIV/AIDS among sex workers. The point is to understand the meaning of HIV/AIDS in sex workers’ life- how does this attitude affects their sex work, behaviour and practices with clients and other partners. Also it is important to see how this perception has changed over time. What were sex workers saying about HIV/AIDS ten years ago and now what are they saying? If there is a change, what are the reasons? Similarly, has the knowledge changed? If so, how? Some questions to start could be...

- When sex workers first heard of HIV/AIDS, how did they react? What did they think it was?
- Changes in the perceptions over time- what is the reaction now when sex workers hear the word AIDS or come to know what it is? What are the reasons for this change?
- What kind of knowledge do sex workers have about HIV/AIDS (about transmission routes, prevention)

Try linking if there has been a change in attitude/perceptions of HIV to the intervention. In other words, how (if any) has the intervention affected their knowledge and attitude towards HIV. Secondly, how do sex workers perceive HIV as a problem in their lives compared to perhaps other problem. How relevant/irrelevant is it in their lives?

- How do sex workers perceive HIV after being exposed to the intervention? How did they perceive it before and now?

Sometimes they might suggest alternate methods of prevention as in taking particular tablets/pills, tradition medicine etc. Probe accordingly to whatever crops up.

Explore if perceptions differ among older sex workers compared to younger ones. If group consists of mostly older, more experienced sex workers probe what they know about younger sex workers who might have recently start.

- How do experienced sex workers perceive younger girls who have just started? Why?
- What do younger sex workers know and think about HIV/AIDS? What are the reasons for this?
Explore if younger sex workers acquire some sort of “sex education” with regards to behaviour with clients, sex acts that are practiced, knowledge/awareness of HIV/AIDS, condoms etc. This may differ from brothel based sex workers to street-based sex workers.


2. Changes in life and behaviour

Make a connection of the previous topic of MEANING OF HIV/AIDS to how this has affected the lives of sex work. Do they think HIV/AIDS has increased or decreased over the years? Why? Explore relationships that sex workers have with different partners in light of HIV/AIDS? Are sex workers more or less hesitant to have sex with clients, what kinds of partners are they more or less likely to entertain? Try to understand the behaviours and practices of sex workers and their partners because of how they perceive HIV/AIDS.

- How has AIDS as such affected the sex workers?
- What changes have there been in personal life (discuss relationships with non-commercial sex partners like husbands, lovers, boyfriends)?
- What changes have been there within sex work (behaviors of sex workers and clients; what do clients say about HIV/AIDS and how does this affect sex worker)?

This could be anything from their health, burden on family, frequency of clients and other partners to use of condoms, awareness of prevention & programs, accessing more health services, etc.

This might have to do with condom use, sex practices, convincing strategies to using condoms, frequency of clients so are more/less clients being entertained (have they seen any changes in this respect); what is the trend in activity/frequency level that they have noticed over the years.

- Are sex workers more or less willing to do certain sex acts because of HIV/AIDS?
- Changes with other gatekeepers in the sex work (police/madams/pimps/brokers/lodge owners and managers). What do they have to say about HIV/AIDS; how do their perceptions affect sex workers and their behaviour in sex work?

For example, sex workers might be able to garner more support from madams or pimps against clients who are unaware of HIV and unwilling to use condoms.
3. Stigma

Explore how sex workers are treated in relation to HIV/AIDS and otherwise. Several topics may arise here. For instance, participants might talk about general ill treatment from society towards sex workers/prostitutes or more closely link sex work with HIV/AIDS (i.e. they might say that sex workers are blamed for HIV/AIDS, as in it came about because of prostitution but do not necessarily lead with this.) Explore both possibilities. How are sex workers perceived by others (general public, health providers, clients, madams, pimps, police, and other gate keepers whom they come in contact)? Also try to get at the different forms of stigma faced by sex workers. Note that this topic might even be brought out during the previous topic. Some starting questions could be...

- How are sex workers generally treated or looked upon? By whom? Why is this so?
- Probe if and how you experience stigma? How often? By whom? Why do they think this is the case?
- What has been the experience of infected sex workers?

Explore whether infected sex workers readily disclose their status and how does this affect her sex work. Where do infected sex workers go for treatment? What do they have to say about health providers? What do clients say? Are families aware?

4. Risk perception

This topic is to understand whether sex workers feel if they are at risk of getting HIV infection. If so, what are they doing about it? In other words, does their perceived risk affect their behavior in sex work with relation to condom use, other prevention methods, and activity with clients or certain partner?

- Do sex workers feel they are at risk for getting HIV/AIDS? Why/why not?
- What do sex workers do if/when they feel they are at risk? [What are the prevailing practices among sex workers to prevent HIV/AIDS?]
- Do sex workers get tested for HIV? Regularly? In what situations more likely to get tested? [be clear in asking about HIV testing and not STI testing]
- How does this affect their sexual practices/acts with their partners (clients, husbands, boyfriends, lovers, police, rowdies, etc)

Some alternative methods to condom use might crop up for the above question, as in taking pills or injections.

- Who according to them are most at risk? Why?
5. Condom use and sexual experience

This section will be long and will have to include several components. Begin by trying to understand general views on condoms. When did sex workers first hear about condoms? What were they saying? Why? Now has this perception changed over the years? Why? Do they think sex workers are using more or less condoms regularly? Sometimes participants will suggest that certain sex workers will not use condoms regularly (i.e. perhaps younger ones because they are less confident or inexperienced; those who will take more money and not use condoms; sex workers from a certain location or brothel) Do they think it is effective? Start with questions such as..

- When did sex workers first start using condoms? When did they become easily available/or given out freely?
- What were sex worker’s initial reaction when they learned of condoms or when they first used them? What were the experiences? What do sex workers say about condoms now? Has there been a change it how condoms are perceived [try linking this change to intervention exposure]? Has this change come about because of the intervention?
- Do sex workers use any form of lubrication? What are they? How often are they used? What do they like about it?
- What do sex workers like and dislike about condoms?
- What problems do sex workers experience using condoms?
- How often do sex workers experience condoms breaking? Why does this happen?

Most often participants will say they like that condoms keep you healthy and prevents HIV/AIDS and pregnancy and that’s why they like it. It is also important to understand what sex workers prefer or not prefer about condoms as in that it is easy/difficult to use, it feels good/bad during intercourse, flavours, comments on lubricant in condom, preference of bought condoms versus those distributed freely. Also discuss availability- how easy is to get condoms and from where sex workers access condoms?

Here probe for those sex workers who aren’t using condoms according to participants and why they think so.

After exploring some relevant background, move on to topics of clients and condoms. Information on what clients have to say about condoms and sex workers’ experience with clients using condoms is important. Simultaneously try to incorporate discussions of sexual experiences and practices with clients. How often do sex workers have sex with clients? How long in terms of time do they spend with each client? What kind of sex do clients ask for (vaginal, oral, anal, hand jobs, thigh job, etc)? Some questions could be...

- According to you what proportion of sex workers are using condoms regularly? Why?
- With whom do sex workers prefer using condoms? Why?
- What do clients have to say about condoms? Why? Has this attitude changed over time? What were clients saying before about condoms and now what are they saying? If any change, why?
- How do sex workers convince clients to use condom?
• Do clients readily wear condom? Why? How do sex workers handle difficult clients?

This is an important part and requires careful and persistent probing. Probe for tactics such as particular sex acts/favors or methods of coaxing used to change partners’ minds. Which strategies are more or less successful? Do clients readily accept to wear condoms? Subsequently, explore inconsistent condom use...

• Under what circumstances do sex workers normally compromise using condom with clients?

This could be situations where clients offer more money, forced sex, violence, when drinking is involved, there is no protection from gharwali, pimp, madam, etc.

• What do sex workers do in such situations? How often do they happen?

After generating some discussion on clients, move on to condom use among other partners such as HUSBANDS, REGULAR PARTNERS, PIMPS, BOYFRIENDS, POLICE, and ROWDIES. Follow similar line of questioning...what do these partners have to say about condoms, how does this affect whether condoms is used or not during sex with that partner, frequency of condom use among these partners, reasons for not using condoms, and tactics used to convince partner to use condoms. Also probe for sexual practices and experience with these non-commercial partners. How often do sex workers have sex with non-commercial partners? How long in terms of time do they spend with each non-commercial partner? What kind of sex do these partners ask for (vaginal, oral, anal, hand jobs, thigh job, etc)?

Some sex workers might have experience with using female condoms. Generate a discussion that gets at what sex workers are saying about the female condom and how they feel about it.

• Have sex workers seen or heard of the female condom? What do they think and feel? What are sex workers saying about it? Why?
• Where do they get the female condom? Is it affordable?
• What do sex workers like or dislike about the female condom? What has been their experience using it? Is it easy or difficult to use
• What do clients or other partners say about it? What do clients and other partners like or dislike about the female condom?
Try incorporating some questions about contraception in this section. Try to see if women try to link condoms as contraceptive and as well as preventative measure. No need to emphasize or excessively probe. If women are readily forthcoming, let the discussion take that direction. Do not focus too much as time may not allow it.

- What BCM do sex workers normally use? Why is this so common or preferred?
- Access to BCM? Easy or difficult? Where?
- What BCM do you prefer? Why? What is common practice?
- Connection between contraception and HIV prevention:
  - How are condoms perceived as a BCM? Do sex workers prefer this or other BCM? Is condom perceived more as a prevention method rather than a BCM?
- Sterilization and condoms: more or less likely to use if sterilized?

6. Mobility

Try to understand how mobile sex workers are. It could be that sex workers are highly mobile, traveling to places and events like festivals, Yatras, where they deviate from their normal sexual behavior. Try to get at if there is any behavior change from doing sex work in their normal places versus those places they visit occasionallly or habitually. For example, they might be less likely to use condoms when doing sex work other than their “normal” brothels or places. Begin by asking where else do sex workers go, travel for sex…

- Where do sex workers travel for sex? Other than place you normally do sex work, do you go to other places? Why?
- How often do sex workers go there? Why?
- At such places, who are the partners (are they clients, lovers, boyfriends, others?)
- What is different about doing sex work in these places versus doing sex work in the place you generally/normally have sex? [This could be anything from use of condoms, clientele, prices may vary, it is nicer place, no gharwali or brokers to deal with, etc. Probe for anything that may crop up]
- Do sex workers use condoms during these times? Are they more or less likely to use condoms?
- Which places do they prefer doing sex work? Why?

7. Violence

Though it could be that discussions of violence might have already cropped up previously, probe accordingly if otherwise. Try to understand if sex workers face violence within the realm of sex work.
• Are sex workers ever beaten or forced to have sex? How often does this happen? From whom do they experience violence (clients, lovers, husbands, pimps, madams, police)?

• Do sex workers ever feel threatened? In what situations? Why? How do they handle such situations?

• What has been done to reduce violence that sex workers face? By whom? For how long? What changes are there now because of this?

• Are condoms used in such situations?

8. Perceptions of intervention

In this section, obtain information regarding their knowledge and perceptions about the intervention programs (PROVIDE NAMES). Try to understand how familiar women are with these programs and how they perceive it. Also probe for specific services provided by the programme such as the clinic, staff, treatment, etc. One way of evaluating how sex workers perceive these services is ask what they like and dislike about the services? Accordingly probe why and what are the reasons for this and how it can be improved.

• Are sex workers aware of (PROVIDE NAMES OF PROGRAMMES)? For how long?
• How did they come to know about this? From whom did they hear?
• What do sex workers think about this programme? What are they saying about the programme? Why? **Probe accordingly to whatever crops up in discussion**
• How has sex workers’ lives in terms of their sex work, relationship with partners, health, etc changed because of the program?
• What kind of information is given by the programme? Regarding prevention, STI, condoms (demonstration), safe sex practices?
• What goes on during condom demonstration and what kind of tactics for using condoms are disclosed during these demonstrations? Do women think this is useful? Why?
• What kind of support do they receive?
• How are sex workers treated by the staff…the nurses, doctors, counselors, peer educators?

**Obtain information which reveals the relationships between staff and sex workers? Is it an open relationship where sex workers are comfortable to speak open with doctors and counsellors? Or are they hesitant to disclose their problems? Do sex workers seek support from programme in their sex work (i.e. if sex worker face violence in their sex work, do they seek support from program).**

• In what capacity are peer educators helpful or supportive? What kinds of information do they receive from peer educators?
• Probe specifically about drop-in centers, clinic, the treatment they receive…the presumptive treatment?
Sometimes women will report dissatisfaction about the PPT because of the severe reactions women at times suffer. Probe for what women are saying about the treatment and what kinds of treatment they prefer.

- Do sex workers understand why they are receiving the PPT? In general, do sex workers understand why are being given a certain treatment or medication at the clinic?
- What is told to them by the doctors/nurses about treatment and medications?
- What do sex workers know about STIs?

Probe for their knowledge and actions they take to prevent STI or to seek treatment.

[Generate a discussion surrounding improvements in services and generally to better the lives of sex workers. This can be health related, community/organization empowerment, their sex work, economic assistance? What are their ideas of improvements and where do they see themselves in the future? Are sex workers better of today or before? Why? What are the reasons for this?

9. Experience of participating in IBBA, SBS:

- How do sex workers feel about participating in the IBBA and SBS surveys?
- How do they come to know about the survey? Who tells them and what is told to them about the surveys?
- Do they think that the sex workers who participate in the survey give the correct answers (how about the condom related questions)?
- What are the sex workers who participated in any of these surveys saying about them?

Thank you for your time and willingness to participate.
APPENDIX 2

GUNTUR FSW IDI GUIDE

1. History of and current involvement in sex work – general conversation

Start a conversation about how/when she started doing sex work. What were her experiences when she first began having sex with clients? What kinds of issues did she have to deal with? Now, how does she feel about doing sex work; have there been any changes? Try to gauge what her life is like on an everyday basis as a sex worker. What are her experiences? This can include descriptions about her relationship with people whom she comes across within the context of sex work… clients, madams, lodge owners, brokers, other sex workers, police, goondas, MSMs, NGO staff and members. Issues of violence, stigma, condom use, HIV, troubles with police may also come up. How does she get her clients? What kind of people are her clients? Where does she have sex and where does she solicit? Get a general picture of what her world looks like.

This initial description is important because it will set up a framework to probe about other related topics.

2. Relationship with other sex workers, madams, brokers, pimps, lodge managers, lodge boys, etc…

Try to understand her relationship with those people who are involved in her sex work (other sex workers, madams, brokers, pimps, lodge managers, lodge boys, etc). What kinds of problems has she had with them? This could be violence, harassment, free/forced sex from lodge managers/boys, brokers and pimps. Or it could be coercion from madams to have sex without condoms with particular clients. Is she autonomous when it comes to making decisions about condom use or entertaining clients? On the other hand, what kind of support does she get from these people? There might be times when she might rely on them when facing a violent client, to convince a client to use condoms, or bailing her out of jail, etc.

3. Challenges-violence, burdens, stigma, discrimination

Set up a context from the previous section to draw from. She might have already brought up issues of challenges and burdens she has to face as a sex worker. Refer to this and probe what has already been brought up. Remember to get a complete picture by asking to explain the “story.” Always probe: why, how, what are the circumstances, how often does it happen, how does she manage/cope, who supports her, how does she feel. Ask specifically about the following topics:

- Stigma and discrimination-from whom? Why? How do you handle it; who supports you during these times?
- Police harassment-why? Do they ask for free/force sex? Whom does you on for support?
- Violence from clients- why? In what situations? Alcohol/drug use? Other difficulties with clients?
- Violence from other partners (husbands, lovers, non-commercial, goondas) - why? In what situations? Alcohol/drug use? Other difficulties with clients
- Financial burdens – what problems do you have?
4. Mobility

Sex workers in Guntur are very mobile, not only in having sex outside Guntur but within the district as well. First start with her experiences of having sex outside Guntur.

- Do you go to other places for sex? Why?
- How often do you go and with whom?
- Does it work on a contract base or is it seasonal?
- Are there specific times you go to these places?
- How is sex work different in those places compared to Guntur?
- What problems have you had there?
- How are the clients there? Do they pay more or less?
- What about condom use in these places? Do clients use them or are they reluctant?
- If you have stopped going to these places, what are the reasons for this?

After asking her about outside Guntur, probe about mobility within Guntur…where in Guntur district does she do sex work? Why is it like that? Does she know about brothel rotation? How does it work, based on contract? …

5. Condoms

Begin by asking if she uses condoms (and when she started using them), then discussing how she initially felt when she first started using condoms. See if there have been any changes in the way she feels about condoms now and why this is so.

- Who did you first use condoms with?
- What was your reaction to it when you saw it, felt it, to lubrication, the smell?
- What do you like and dislike about condoms
- Double condoms: where did you learn/whom did you learn from to use double condoms? Why do you use double condoms? In what circumstances especially? With particular partners?
- Condoms breakage: how often does this happen? So, what do you do when it breaks?

6. Situations where sex workers compromise using condoms

- How many partners do you have a week (regular non-paying, paying clients (regular and occasional/new), and with how many of them do you use a condom, on average?
- Are times when you cannot or do not use condoms? (This can be with clients and other partners as well, or with different types of sex).
- Why do you use condoms with some people and not others? (Ask her to explain these circumstances, why it is so, and if it is a common occurrence? Also try relating what she has already said about condoms to why she may not use condoms).

7. Partnerships: clients, husbands/cohabiting/lovers, non-commercial

Start by asking what partners she has- husband, lovers, cohabiting partner, clients, others. For each partner, determine the kind of relationship she has with him. Try asking her to compare what she thinks of each partner if this is helpful to pose questions. According to her what are the differences in these partners? Keep in mind the following questions for each partner:
For all partners… (Husband, cohabiting partner, lover/boyfriend, clients)

- How often do you have sex with him?
- What types of sex (oral, anal, body sex, hand jobs, etc)
- Condom use: what do your partners say about condoms, do you use or not use with each partner, what are the reasons for not using, how do you convince him, is it easy or difficult to use condoms with partner?
- Do your partners have sexual relationships with other women (and does he use condoms with them)?
- What other difficulties do you face with them: violence, alcohol use?
- If he is (husband, lover, cohabiting), does he know you are a sex worker? How does this affect their relationship? How does he support you?
- For clients specifically… Is your relationship different with regular and new clients? What are the differences? Who do you prefer? Is condom use easy or difficult with regular/ new clients? What types of sex (oral, anal, body sex, hand jobs, etc) do you have with different clients?

8. Perceptions and attitudes of HIV/AIDS

**Issues around HIV/AIDS will have already come up during discussions of condoms and risk behaviours with partners. Refer to what she has already told you and pose more specific questions:**

- What do you know about HIV/AIDS (transmission routes, misconceptions, perceptions, fear)
- What changes have you seen in sex work as a result of HIV?
- Do you know anyone who is HIV+ or died of this disease (ask for details, what happened to her)?
- Do you think you are at risk? What are you doing to keep safe and lessen your risk?

9. Intervention

- Tell me about which NGO you are currently accessing? What is it called? How did you come to know about it? What do you generally think about this NGO? Why?

**Opinions of care and program as a whole**

- What are your opinions / thoughts / quality of treatment, usefulness – peer educators, clinic, clinic staff, etc (do you trust them, feel as though you can discuss anything with them?)
- Do you think this NGO is helping sex workers? Why/how?
- Do you use the DIC? How often? Why?

**Changes since NGO started work with FSWs**

- Since knowing about this NGO, what are the changes that you have noticed in the community?
- How has it made a difference with respect to your behaviour as a sex worker? With clients, self-confidence, condom use, prices, access to condoms? Condom use?
- What other improvements do you want to see made for sex workers?

**NGO peer educators**
• Have you been approached by a peer educator? In what context? What do you think of peer educators? What kinds of information do they give you? How often are you contacted by them?

**NGO clinic and treatment issues**
• Have you visited the NGO clinic? If yes, how often? For what reasons?
• What do you think of the clinic and the care you have received?
• Have you had a speculum examination? How many times? What is your experience?
• Do you understand the presumptive treatment (treatment for STI which comes in grey packets) – what it is, what do you think about it? What does the doctor tell you about these medicines?
• What else do they give you to make you healthy? What about injections?
• Do they talk to you about birth control? What do you do?
• Have you been tested for HIV? How many times? Where? What do you think about that? Do they tell you the results and give you treatment if needed? What kind of treatment?