

UNIVERSAL ACCESS FOR WOMEN AND GIRLS

Accelerating Access to HIV Prevention, Treatment,
Care & Support for Female Sex Workers and
Wives of Migrant Men

Research Study Report
January, 2012



ICRW

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This report provides the results of a study undertaken by the International Centre for Research on Women (ICRW) with support of the United Nations Development Programme (UNDP). The ICRW conducted this study to understand barrier to access HIV services for women through a gender lens. We implemented this study in two sites of India; among two equally vulnerable populations – female sex workers and wives of migrant men in Pune, Maharashtra and Ganjam, Orissa respectively.

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January, 2012



Ms. Aradhana Johri

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Message

The International Centre for Research on Women (ICRW) have over the years, through their work, contributed to the process of aiding women overcome barriers that restrict them from participating as equal members in society. Health and access to health related services, of women, is a significant component that determines their ability for the same. The study titled “Universal Access for Women and Girls: Accelerating Access to HIV Prevention, Treatment, Care and Support for Female Sex Worker & Wives of Migrant Men” looks at identifying the barriers faced by women and girls in India in accessing HIV related services. Taking into consideration the social positioning of women in the Indian society, knowledge about the disease & available services, access to the services and power to negotiate their right to protection from the disease may not be universally available. Hence it was deemed important to recognise the barriers that become a constraint to such a universal access. The study has provided greater focus by concentrating on the barriers faced by female sex workers and wives of migrants.

At the threshold of the fourth National AIDS Control Programme (NACP), the National AIDS Control Organisation (NACO) recognises that our challenge no longer lies only in ensuring availability of services but in overcoming social and economic barriers that restrict people from availing these services due to lack of knowledge, lack of decision-making power and access to resources that connect them to the available services. This study attempts to get a better understanding on such issues. I would like to acknowledge the contribution of UNDP and ICRW in this endeavour.



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Foreword

In low and middle-income countries worldwide, HIV is one of the leading causes of death and disease in women in reproductive age (ages 15-44). In sub-Saharan Africa, 60% of those living with HIV are women. These disparities are the result of biological, structural, and cultural conditions that place women and girls at a greater risk for acquiring HIV, such as gender norms that impact expectations and behaviors, as well as differences in access to resources that limit prevention and mitigation of the disease. Women living with HIV in particular, face further discrimination which prevents them from accessing HIV services and being able to act on prevention and treatment information.

While there has been significant progress towards universal access in recent years, this progress remains frail. Universal Access for Women and Girls Now! (UA Now!) is a global initiative to improve and achieve universal access to HIV prevention and treatment services for women.

The efforts of the Government of India are noteworthy to ensure universal access. Under National AIDS Control Programme NACP 3, National AIDS Control Organisation (NACO) has provided free ART to PLHIV, yet on the ground there are access related inequities faced, especially by women and girls. It is evident that there is an urgent need to understand the barriers faced by women and girls in accessing services. UNDPs research work indicates that lack of privacy, fear of breach of confidentiality, constraints related to time, care work, resources, distance plus supply side disabling factors like non-availability of female doctors, insensitive health delivery personnel are some of the barriers in accessing treatment. It is widely acknowledged that women are not a homogenous group and for effective programming, it is critical to have a comprehensive understanding of barriers to HIV prevention, testing and treatment services in different settings of risk and vulnerability if we are to make steady gains on universal access targets.

This study *Universal Access for Women and Girls: Accelerating Access to HIV Prevention, Treatment, Care and Support* attempts to build on the past research and delves deeper into the barriers faced by two groups of women – female sex workers in Pune, Maharashtra and spouses of migrant men in Ganjam, Orissa. The report provides concrete recommendations in form of an action plan to ensure universal access for women and girls. We believe that the report, rightly, stresses the need to accelerate context-specific and coordinated efforts to address the issues of women and girls if we are to achieve the MDGs by 2015. The findings and recommendations will be useful for governments, practitioners and other stakeholders as we all move towards the fourth phase of the National AIDS Control Programme.

We congratulate the research team at the International Center for Research on Women for bringing out a valuable study.

Caitlin Wiesen
Country Director
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PREFACE

The International Center for Research on Women has been on the forefront of developing evidence and research agenda to reposition policy dialogues and debates on key public health problems, including HIV/AIDS. Our research has a focus on the larger social, economic and cultural context of public health and social behavioral issues and gender barriers within those contexts.

Within HIV/AIDS, ICRW's global research has highlighted new evidence on the factors that affect their vulnerability and risk to HIV/AIDS and conducted cutting edge research on property rights of HIV positive women that demonstrated the need to address legal matters, thus, calling for a wider ambit of HIV programs. Other studies we have conducted have articulated and provided evidence for the critical role of gender based violence, masculinities and gender inequities in contributing to HIV infection in general, and in increasing the burden of infections among women. Through our research and evidence, now stigma reduction is well placed on the global map of HIV/AIDS thinking.

With a scaled up policy response to HIV/AIDS, that includes a broad range of institutional and community based services, there has been a global concern about the access to HIV services by vulnerable groups, especially women. The Universal Access Now initiative (UA Now) has provided us a unique opportunity to understand barrier to access HIV services for women through a gender lens. We implemented this study in two sites of India; among two equally vulnerable populations – female sex workers and wives of migrant men in Pune, Maharashtra and Ganjam, Orissa respectively.

Dr Ravi Verma

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The UA Now study was successfully completed due to the effort and involvement of numerous organizations and individuals at the national and state levels, at different stages of the study.

The team gratefully acknowledges the immense help received from Maharashtra State AIDS Control Society (MSACS), Mumbai. A special thanks to Mr. Devkar, P.D, MSACS, Mr. Santosh Vani, ICTC in charge and additional in charge of TIs, Dr. Vidyun Mala Agarwal (Consultant, Pathfinder) for their valuable inputs and support at the initial stage of the project. We are also thankful to Ms. Neeta, Dr. Rao, Mr. Praful from Avert Society, Mumbai, Dr. Darshana Vayas and her team at Pathfinder, Pune for their cooperation and support during the study. Thanks to Mr. Rajeev Kumar, Khurshid Bhalla; Deepak Khismatrao from Pathfinder, Pune for their continuous support during the survey period.

It would have been difficult and impossible to complete the study without support from all the NGOs working in Pune with female sex workers who not only provided us with valuable information about the existing programme but also opened the doors of the community for us. We gratefully acknowledge the support from Akhil Budhwar Peth Devdasi Society, Kaya Kalp, Vanchit Vikas, John Paul Slum Development Society, and Saheli, the only CBO engaged in working with the female sex worker community in Budhberpeth, Pune.

The study would not have been successful without the cooperation from Orissa State AIDS Control Society, ActionAid, and the Ganjam based NGO, Aruna.

We acknowledge the help and support provided by Ms. Shweta Banker who had been consistently in the field from the onset of the project in Pune and helped in completing the qualitative research. We acknowledge the support of GfK Mode for carrying out the survey in both the communities in Pune and in Ganjam. Our sincere thanks goes to Ms. Swagatika Das, Ms. Anwishika Das and Mr. Balaram Mishra who helped us in completing the in-depth interviews and focus group discussions in Orissa.

The contribution of Ms. Aprajita Mukherjee and Ms. Manveen Kohli who were part of the ICRW at the time of conceptualization of the project is greatly acknowledged.

Last but not the least, credit goes to all the eligible women and men who participated in the study and gave us time in completing the survey and qualitative interviews with great patience and eagerness.

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List of Abbreviations

ANC:	Antenatal Care
BPL:	Below Poverty Line
CBO:	Community Based Organization
NACO:	National AIDS Control Organization
NGO:	Non Government Organization
PLHIV:	People Living with HIV
STI:	Sexually Transmitted Infections
UNDP:	United Nations Development Programme

Executive Summary

As part of the global initiative Universal Access for Women and Girls (UA Now!) to improve and achieve universal access to HIV prevention and treatment services for women, the International Center for Research on Women (ICRW) implemented a research study to expand the evidence base on access to services for two key populations- female sex workers and wives of migrant men. These two populations were selected based on an extensive literature review. The review highlighted that while there were a few studies on access to HIV prevention, testing and treatment services by female sex workers, a comprehensive understanding of access barriers (both perceived and actual) was lacking.

The main objectives of the research study were to explore barriers to HIV services experienced by the study populations, and based on the findings, to identify entry points for improving HIV services among women in India more broadly. The study used a cross-sectional design among two populations of women (female sex workers and the wives of migrant men) in different geographical sites, Pune and Ganjam, respectively. The research team collected quantitative data by administering a survey tailored to each sub-population. The survey examined access to barriers to various HIV services (prevention, testing and treatment) and reproductive health services (ANC, STI). The survey included questions about service availability (physical access), acceptability (socio-cultural access) and affordability (economic access). In addition, the researchers conducted select observations of health services delivery and qualitative in-depth interviews (IDIs) with a small number of women from the two groups, as well as service providers, NGO staff and spouses and partners of the female sex workers and wives of migrant men. A total of 530 women were sampled from 42 villages through a multi stage sampling procedure, while 329 female sex workers (FSW) were sampled from brothel as well as non brothel settings.

The key findings from the survey with female sex workers suggest that there is, indeed a high level of awareness of HIV, condom use as a prevention method, and a high uptake of HIV testing among both sex worker populations. It was also found that while peer outreach workers are the most important source of condoms for non-brothel based sex workers, more must be done to reach this population since nearly half of these women surveyed didn't identify the outreach workers as a source for condoms. NGO clinics play an important role in STI management and HIV testing for female sex workers. But increased attention needs to be paid by these and other health facilities to educating and counseling women about STIs and also ART when they are tested for HIV. It is evident that female sex workers face structural barriers to accessing services, including restricted mobility (particularly for young, brothel-based sex workers), violence, stigma and discrimination and a lack of social support (mainly non-brothel-based women).

In case of wives of migrant men, it was found that HIV information and testing is yet to be universally accessed by the wives of migrant men. There is low awareness of STIs and consequently treatment seeking is minimal among those who have experienced an STI symptom. Due to their low decision making ability, limited household income, and restricted mobility, women are constrained in accessing health care for STIs and ART. Inequitable gender norms impact on women's access to information, health-seeking behavior, and experiences of stigma. The fact that link workers prefer talking to women in the absence of their husbands points to deeply entrenched gender norms prevalent in the community. These findings point to the need for interventions at the individual, health service delivery and structural levels.



Introduction

Universal Access for Women and Girls (UA Now!) is a global initiative to reinvigorate progress toward achieving universal access to HIV prevention, treatment, care and support for women and girls. The initiative uses a country-led and multi-stakeholder process to develop action plans for addressing challenges and bottlenecks in scaling up HIV responses for women and girls and promoting gender equality in national AIDS responses.

The International Center for Research on Women (ICRW) is leading research efforts in India, one of 10 countries worldwide implementing the initiative, to improve access to HIV services by women and girls. ICRW's work centers on expanding the evidence base on the barriers faced by two key populations – female sex workers and the wives of migrant men – in accessing HIV services. These two populations were selected based on discussions with NACO and UNDP, and on a literature review. The review showed that while there were some studies on access to HIV prevention, testing and treatment services by female sex workers, a comprehensive understanding of access barriers (both perceived and actual) was lacking. The review also suggested that similar studies had not been carried out among the wives of migrant men in source settings¹.

The HIV Epidemic in India

The national adult HIV prevalence in India is approximately 0.34 percent, amounting to 2 to 3 million people living with HIV in the country, of which 39 percent are women². India has a concentrated HIV epidemic as evidenced by high HIV prevalence among samples of risk groups, such as men who have sex with men (7.4%), injecting drug users (7.2%), and female sex workers (5.1%). In fact, HIV prevalence among these groups is six to eight times higher than among the general population³. Given that heterosexual transmission is the primary mode of HIV transmission, the Indian HIV epidemic is expanding to adolescent girls (married and single); married women of reproductive age, including the wives of migrant men; pregnant women; and women survivors of gender based violence, sexual abuse and rape. Although HIV prevalence is not high in these groups, recent trends point to their vulnerability and therefore highlight the need to consider them in any analysis of the barriers to accessing HIV services.

Objectives of the Study

The objectives of the study were to:

- Explore barriers to HIV services experienced by female sex workers – both brothel-based and non-brothel-based – in one district in Maharashtra (Pune);
- Explore barriers to HIV services experienced by wives of migrant men in one district in Orissa (Ganjam);
- Based on the findings, identify entry points for improving access to HIV services by the study populations specifically and by women in India more broadly.

¹ A source setting is a place of origin of individuals; in this case it is the native place of men who migrate to other cities or towns for employment.

² NACO (2008): Mainstreaming HIV and AIDS for Women's Empowerment. India: National Aids Control Organisation, Government of India.

³ NACO (2008): HIV Sentinel Surveillance and HIV Estimation in India 2007. A Technical Brief.



Methodology

The study used a cross-sectional design to explore barriers in accessing HIV services by two populations of women (female sex workers and the wives of migrant men) in different geographical sites, Pune and Ganjam, respectively. The research team collected quantitative data by administering a survey tailored to each sub-population. The survey examined access barriers to various HIV services (prevention, testing and treatment) and reproductive health services (ANC, STI). The survey included questions about service availability (physical access), acceptability (socio-cultural access) and affordability (economic access). Table 1 summarizes key information about the survey respondents.

Table 1: Survey respondents

Type of Respondent	Inclusion Criteria	Sample Size	Sampling Procedure	Number of Sampling Units
Brothel-based female sex workers	Aged 18 to 49, selling sex from a defined structure (building)	154	Two-stage systematic sampling, Pune city	400 brothel buildings
Non-brothel-based female sex workers	Aged 18 to 49, selling sex not from a defined structure (building)	175	Time location sampling, Pune city	10 physical sites
Wives of migrant men	Currently married women aged 15-35 who had given birth in the last 4 years or were currently pregnant and whose husbands had migrated outside the state for at least 6 months prior to the survey	530	Multi-stage sampling, Ganjam district	42 villages

In addition, the researchers conducted select observations of health services delivery and qualitative in-depth interviews (IDIs) with a small number of women from the two groups, as well as service providers, NGO staff and spouses and partners of the female sex workers and wives of migrant men. All respondents provided informed consent prior to participation in the study. The research team worked with a number of NGOs and CBOs involved in carrying out HIV targeted interventions in the study sites to recruit study participants and develop a list of health and social service referrals for respondents, as needed.



Sample Design and Sample Sites

Study Sites

Pune District, Maharashtra

The research with female sex workers was carried out in Maharashtra, a high HIV prevalence state in India. Studies among female sex workers there have found HIV prevalence as high as 59 percent (Ramesh, 2008). The research was centered in Pune, an industrial city in Maharashtra with a population of 3 million. The city has an estimated population of 4000 female sex workers residing in brothels and an additional 2000 who are non-brothel based (Dasgupta, 2011). The brothel based sex workers solicit and entertain clients in the brothel buildings within the Budhwar Peth area while the non-brothel based sex workers mainly solicit around streets/highways, railway stations, a few buildings and market areas and entertain their clients mostly in lodges or in rented brothel rooms.

Female sex workers, considered a risk population by NACO, have been targeted by HIV interventions for many years. The current targeted intervention, known as “Mukta,” has been in operation since 2004 and includes comprehensive healthcare services and behavior change communication provided through health care providers, mobile medical outreach and a network of peer educators.

The health care system in the study area is quite dense. The available health care services consist of a Government clinic about half a kilometer from the study area, a dense network of private practitioners and two NGO run, full-fledged clinics with HIV and STD testing facilities.

Ganjam District, Orissa

Ganjam is one of the most populous, underdeveloped districts in Orissa, with a population of more than 31 million, per the 2001 census, and a sex ratio of 978 females to 1000 males. It consists of 22 blocks and 3 sub-divisions, with a geographical area of 8071 sq km. Ganjam has the highest HIV prevalence in Orissa. In 2006, a study of 9200 women found that 0.55 percent of the population was positive. Among STI patients, 1750 were tested and 2.34 percent positive cases were detected. Ganjam alone contributes 38 percent of the state’s PLHIV and 37 percent of AIDS deaths. Latest figures from Orissa State AIDS Society estimate HIV infections among 7637 people, of whom 281 are from ANC centers, and 531 are children, while AIDS related deaths are reported to be 461 until now. There is a huge proportion of males who migrate to Gujarat, Andhra Pradesh, Maharashtra, and Uttar Pradesh for work in shipyards, mills and diamond cutting industries, leaving behind their spouses/wives in Ganjam. Ten community health centers and 15 primary health centers are distributed across the district in different blocks. There are five ART centers in the state of Orissa, including one at the M.K.C.G. Medical College in Berhampur, the district’s major city, and another four link centers in the district recently introduced by the state AIDS society. Ganjam district has 26 functional individual counseling and testing centers (ICTCs).



Literature Review

HIV in India

The most recent estimates from 2007 suggest that the national adult HIV prevalence in India is approximately 0.34 percent, amounting to 1.8 to 2.9 million people living with HIV in the country¹. Of these, an estimated 39 percent are women and 3.5 percent are children. India has a concentrated HIV epidemic as evidenced by high HIV prevalence among samples of risk groups, such as injecting drug users (IDU) (7.2%), men who have sex with men (MSM) (7.4%), female sex workers (FSW) (5.1%) and STD clinic attendees (3.6%) and low prevalence among ANC clinic attendees (0.48%)². In fact, HIV prevalence among FSWs, MSM, and IDUs is 6 to 8 times higher than among the general population. Given that heterosexual transmission is the primary mode of HIV transmission in the country, the Indian HIV epidemic is expanding to non high-risk groups that include adolescent girls (married and single); married women of reproductive age; sexually active single women; pregnant women; and women survivors of gender based violence, sexual abuse and rape. While statistically HIV prevalence is not high in these groups, recent trends point to their vulnerability to HIV and therefore highlight the need to consider these groups in any analysis of the barriers to accessing HIV services.

HIV and AIDS affect all segments of India's population, from children to adults, businessmen to homeless people, female sex workers to housewives, and gay men to heterosexuals. There is no single 'group' which is not affected by HIV. However, HIV prevalence among certain groups (sex workers, injecting drug users, truck drivers, migrant workers, men who have sex with men) remains high and is currently around 6 to 8 times that of the general population (UNGASS, 2008).

It is thought that HIV has spread among the general population in India because the epidemic has followed what is known as the 'type 4' pattern (UNGASS, 2008). This is where new infections occur first among the most vulnerable populations (such as injecting drug users and female sex workers), then spread to 'bridge' populations (clients of sex workers and sexual partners of drug users) and then finally enter the general population (UNGASS, 2008).

According to the National AIDS Control Organization (NACO), the HIV epidemic in the country is increasingly affecting women and young girls, more so in places where heterosexual sex is the main mode of transmission (NACO, 2007). Out of the estimated adults living with HIV in 2007, 38.4 percent were females (NACO, 2008) and this proportion has increased from approximately 27 percent in the year 2001.

Female Sex Workers

In September 2005, 191 UN member states endorsed the goal of universal access to HIV prevention, treatment, and care for all who need it. This universal access agenda provides a useful framework for advocating and measuring progress in the response to HIV among Female Sex Workers (FSW). Since then several tools and frameworks were developed and adopted in putting the universal access agenda into practice by different development partners, NGOs and local CBOs to achieve universal access for HIV prevention, treatment and care among the FSW population survived under each interventions.

¹ NACO (2008): Mainstreaming HIV and AIDS for Women's Empowerment. India: National AIDS Control Organisation, Government of India.

² NACO (2008): HIV Sentinel Surveillance and HIV Estimation in India 2007. A Technical Brief.

Looking at the broad program initiatives under the National AIDS Control Program and other initiatives trying to address the access for universal HIV prevention, treatment and care services for female sex workers, it is found that each of these programs is trying to reduce the HIV infection among this high risk group through different packages and components and through different combinations. The main components which derived out the literature review can be broadly defined as:

- Female sex workers are not homogeneous group and there is some difference between the brothel and the non brothel based in term of prevalence of HIV and knowledge and acceptance of health services.
- Comprehensive prevention programs that include components such as peer education, medical services, and support groups, can be effective in enabling sex workers to adopt safer sex practices and reduce likelihood of HIV infections.
- Clinic-based interventions with outreach workers and clinic set-ups in the vicinity can be effective in increasing condom use among sex workers.
- Introducing smart cards to maintain follow up and referral system and also to track the medical details of the Female sex workers
- Integrating STI services in the National HIV program

Female sex workers are not homogeneous group and there is some difference between the brothel and the non brothel based in term of prevalence of HIV and knowledge and acceptance of health services.

HIV prevalence among sex workers varies among districts and states, although there has been a general decline in prevalence in recent years (UNGASS 2008). At the state level, HIV prevalence among Female sex workers is very high in Maharashtra (17.91%), followed by Manipur (13.07%), Andhra Pradesh (9.74%), Nagaland (8.91%) and Mizoram (7.2%). Among the other states, Gujarat, Karnataka, and West Bengal have HIV prevalence greater than 5 percent among FSW. The percent of HIV positive among the Female sex workers shows a highest concentration in Pune FSW sites with 59 percent (NACO, 2008).

While another recent study found prevalence ranged between 2 percent and 38 percent (averaging at 14.5 %) among districts in the four high prevalence South Indian States - Andhra Pradesh, Maharashtra, Tamil Nadu and Karnataka (Ramesh et. al. 2008).

The National AIDS Control Organization (NACO) in their study (BSS, 2006) illustrated the differences of uptake of services as well as prevention mechanism among the two groups of female sex workers namely the brothel and non-brothel based across different states in India. The study highlighted the consumption of alcohol as well as use of injecting drugs was found to be higher among the non-brothel based Female sex workers than brothel based Female sex workers. The awareness and prevention of HIV&AIDS along with knowledge and recognition of STD symptoms among the non-brothel based Female sex workers was much lower than brothel based Female sex workers. The prevalence of self reported STDs and lower consistent use of condom with clients as well as intimates partners was also observed among the non-brothel based Female sex workers in the same study. Thus, it is important to note here that the non-brothel based Female sex workers who have lower knowledge and awareness, high prevalence of STDs and low consistent condom use, lower HIV testing uptake with high consumption of alcohol and other injectables drugs make them much more vulnerable and at risk. Though it is essential to mention here that the entire FSW population is highly vulnerable and at risk and among them those who are from non-brothel sector, specifically those operated from streets, highways, lodge and homes, who considers themselves at lower risk and are less likely to be part of program interventions around STI/HIV/AIDS than their counterparts are in fact at much higher risk of acquiring the infection.

Comprehensive prevention programs that include components such as peer education, medical services, and support groups, can be effective in enabling sex workers to adopt safer sex practices and reduce likelihood of HIV infection.

NGO-operated Female sex worker collective programs are often managed by older sex workers and not only provide members with condoms and STIs/HIV education, but also offer literacy training, medical care, and legal support for sex workers. A cross-sectional study found that the collectivization of Female sex workers was correlated with better HIV knowledge and increased condom use. The Female sex workers who were either members of collectives or had been in touch with peer outreach workers “has knowledge that condom use can prevent infections and HIV” (Halli et al., 2006).

The Sonagachi project in India which provided free access to STI treatment, condoms and peer education was successfully replicated, including community organization and advocacy; peer education; condom social marketing and establishment of a small clinic. Providers initiated awareness and an offer of services³ at sex work sites through sex worker peer education, mobile VCT camps and community level task forces. The community empowerment model implemented in Sonagachi since 1992 has increased consistent condom use to 85 percent and HIV prevalence among sex workers has remained stable below 10 percent. Sonagachi has established high rates of partner notification through cohabitating partners acting as male peers for mobilizing clients for STI screening and promotion of safe sex; evening clinic hours for clients. Starting in 1992 and with sex workers in control of the project since 1999, the project has grown from 12 peer educator sex workers reaching 3,500 sex workers to 450 peer outreach workers reaching 45,000 sex workers.

Many research studies around the services as well as impact of the program shows the increase in VCT rates, consistent condom use, partner treatment and reduction in HIV prevalence among the Female sex workers (Jana et al., 2008; Ray, 2008; basu et al., 2004; Saha, 2006).

A study conducted by Saha (2006) on the barriers to HIV prevention and treatment found that there were belief among the sex workers that testing positive was a death sentence which was mainly due to lack of treatment literacy; and stigma by health provider.

An HIV prevention program developed a training program to enhance self-esteem, communication and leadership among sex workers in Karnakata, south India shows an increase in STI service utilization from 75 clinic visits per month in 2005 to over 900 clinic visits in 2007 following the intervention among the Female sex workers (Lakkappa et al., 2008).

Clinic-based interventions with outreach workers and clinic set-ups in the vicinity can be effective in increasing condom use among sex workers.

A study by Basu et al. (2004) suggested that a relatively low cost intervention focusing establishment of clinic within the vicinity of sex workers area to provide STD treatment as well as delivery of prevention messages and promoting condom usages has significantly established reduction of HIV risk among this group as well as increased the health utilization of related HIV services.

The Mukta program in Pune brothel and non-brothel setup plays a major role in providing health care services related to HIV and STDs. They have a well integrated system encompassing of peer outreach workers and HIV/STD clinics. In the brothel areas the Mukta project has partner with a few NGOs. They have been assigned the outreach activities and clinical services for the brothel based sex workers. Their clinical services include diagnosis of STDs and HIV testing and counseling. This testing is done every three to four months for women in sex work. The women identified positive under this program is then referred to the ART clinics in the government health care set up such as Sassoon Hospital and Civic Hospital in Deep Banglow Choak.

³ VCT; initiating antiretroviral therapy with escorting to follow-up at government clinics; treatment for opportunistic infections and TB; nutritional support; and support for a network of positive women.

In case of non-brothel set ups the Mukta project has identified a number of pre-existing medical practitioners in the identified areas with partnerships with the NGO. The women identified positive here are further referred to Sassoon Hospital, Yashwantrao Chavan Memorial Hospital in Pimpri or Civic Hospital in Deep Banglow Choak.

Introducing smart cards to maintain follow up and referral system and also to track the medical details of the Female sex workers

One way in which authorities are trying to tackle the epidemic among sex workers in Mysore is through a 'smart card' scheme. Sex workers are provided with cards that contain their medical details, which must be presented at a health check-up at least once every three months to remain valid. On the condition that these appointments are attended, the card can be used to get discounts for food and clothes in certain shops (TOI 2006).

Integrating STI services in the National HIV program

Another area of investigation among many scientist/researchers around accessing HIV related services among this group is the STI prevalence and service utilization (Evans and Lambert, 1997; Desai, et.al., 2003; Ramakrishnan, et. al., 2010).

The study covering the districts of Avahan program found that around 70 percent to 75 percent of the FSWs were using condoms with their occasional and regular clients and STI treatment seeking was as high as 90 percent (Ramakrishnan, et. al., 2010). Through a cross sectional study in a red light area in Surat, Gujarat, Desai, et. al., (2003) found that prevalence of different STIs and HIV among the FSWs in the area was quite high despite high use of condom among them with their clients. Syndromic case management is missing a large number of asymptomatic cases and providing treatment in the absence of disease.

While it appears that most of the interventions with the FSWs tried to focus mostly on the prevention services yet the testing and treatment related to HIV services as well as related health services were not covered well or covered at all. In case of STI treatment also most of the literatures focused on whether the treatment was sought but barriers to seek the treatment were not a part of any of these studies. Although these programs are trying to provide HIV services through a comprehensive package but none of the program have documented the barrier which these vulnerable women are facing in accessing the services and also while accessing the services the difficulties and barriers that they need to go through during the entire process.

Married Women including Pregnant Women

Given the concentrated epidemic in India and the identification of Groups Most at Risk, Married Monogamous women as a group have not constituted the focus of the National Response to HIV in the country.

However, given the increasing acknowledgement of the gendered nature of the epidemic and the underlying social and cultural norms and practices that fuel it, recent literature have attempted to map the varied constituency of 'married monogamous women' through research studies which are quantitative and qualitative in nature.

A review of this literature illustrates that most studies (that were included in the review) have attempted to understand the levels of awareness and knowledge of HIV amongst married women as well as map their perceptions of risk to HIV which was found to be quite low (Kunte et al. 1999, Chaterjee and Hosain 2006, Sinha et al. 2008, Rogers et al. 2006).

Four out of the six studies were situated in a rural setting mostly at the clinic level (Samuel et al. 2007, Rogers et al. 2006). Lack of knowledge regarding HIV and its modes of transmission along with the low perceptions of risk are identified as major barriers to access services specifically related to prevention and testing. It is important to note

that for married women, service providers to reinforce the low perceptions of risk by not providing information about HIV at contact points like for instance at routine checkups at antenatal clinics (Sinha et al. 2008). Thus, low perception of risk is identified as a critical barrier for testing (Solomon et al. 2006, Sinha et al. 2008) which is also corroborated by studies (under this review) with Women living with HIV which shows that testing is/was contingent on their spouse's positive status.

A review of the literature illustrates that the domain of inquiry for married women has largely been around awareness of HIV and perception of risk with limited exploration on how these act as barriers to access services.

Women Living with HIV/AIDS

A review of the literature highlights the gender differences in accessing HIV treatment and care. In a multi clinic study across four states in India, women were 30 percent less likely than men to initiate ART (Ramchandani et al. 2007).

HIV care services include government-subsidized, district hospital-based ART clinics, private sector HIV specialists and NGO administered community clinics. In a community based study examining sex differentials in the uptake and process of HIV testing in three high prevalence districts in India, it was found that men were more likely to test in the private sector while more women reported being tested in a public sector facility (Joseph et al. 2010). Private clinic attendees were almost 4 times more likely to be on ART (35% versus 9%), more likely to be male, have a higher education, be partnered, have a higher income, and have had a CD4 or viral load (Ramchandani et al. 2007).

The most common reported reasons for HIV testing was either because of symptoms or referral from a physician and the partner being diagnosed with HIV (Ramchandani et al. 2007, Pallikadavah et al. 2005, Joseph et al. 2010).

A few studies highlighted the low levels of ART knowledge among people living with HIV/AIDS particularly among rural population (Pallikadavah et al. 2005, Ramchandani et al. 2007).

A review of the literature also pointed out to some of the barriers to taking ART and its adherence and identified them as cost, lack of knowledge of ART, deferral by physician and stigma. In a qualitative study with 60 HIV positive patients receiving HIV primary care at an NGO administered treatment facility in Chennai, individuals reported resorting to drastic measures to obtain medicines. These measures included selling family jewels, going further and further in debt, and sacrificing other important costly resources. Additionally, individuals reported taking drug holidays due to cost, with a cycle of taking pills when money was available, and not taking them when money was not available (Kumarasamy et al. 2005).

Stigma emerged as another major barrier to ART adherence. Fears of stigmatization because of their HIV status often deter HIV patients to disclose their HIV status to others (Ramchandani et al. 2007, Kumarasamy et al. 2005, Bharat et al. 2001). In a rural household study, HIV infected men reported greater medical and social support, whereas infected women emphasized that HIV disease limited their ability to care for others (Pallikadavath et al. 2006).

Social support systems are major facilitators of adherence. The specific social support systems that emerged are (1) family, (2) spouses, and (3) friends (Kumarasamy et al. 2005)

The review of literature is interesting as it provides gender differentiated experiences of men and women living with HIV. However it does not provide a comprehensive understanding of barrier at all levels for men and women that impinge on their ability to access information and treatment on HIV.

Based on the review of the literature we have conducted there is no one comprehensive study on barriers to access HIV services where barriers have been fully conceptualized as social, economic and physical barriers at the demand end of access and additionally as quality and stigma by providers at the supply end. There are elements of some of these barriers that have been studied in most of the articles reviewed. In addition most of the studies only use one HIV service (condom promotion, HIV testing, provision of ARTs) and not a range of prevention and testing services that might be important to explore as there are various entry points for HIV services for various populations. What's also important is that there are no studies published on the group wives of migrant men. Based on this assessment our recommendation is to conduct a more comprehensive barriers study to access STI/ RH and HIV testing services on the wives of migrant men.

Results

Key Findings: Female Sex Workers

Demographic and Socio-economic Characteristics, Knowledge, Behaviors and Experiences

Survey respondents lacked the ability to make decisions about their health care and choice of clients.

Most sex workers in the survey sample were 25-34 years of age, illiterate and currently married. Many women were recent migrants to Pune, particularly the non-brothel based sex workers. Only about half of brothel-based sex workers and a third of non-brothel-based sex workers had savings, either in a bank, self help group or other private agency. Providing remittances to family members was very common despite low levels of income. A small proportion (13%) had access to any health insurance or a government scheme.

Health care decision-making was limited among respondents. Non-brothel based sex workers had greater autonomy than brothel-based sex workers (51% vs. 35%). Still, a half to two-thirds of respondents said they had no role in health care decision-making. When asked about the right to choose clients, only 14 percent among all the women surveyed (16% among brothel and 13% among non-brothel) reported being able to do so. This is an important indicator of women’s ability to negotiate safe sex with clients as well as protect themselves from violence and other abuse.

Although the study site is served by peer outreach workers who distribute condoms, knowledge of condom access points was relatively low.

Both brothel-based and non-brothel-based sex workers are served by peer outreach workers who distribute condoms and raise awareness about them as part of a targeted HIV prevention intervention. Yet, only about half of non-brothel-based sex workers and 39 percent of brothel-based respondents knew that peer outreach workers were a source of male condoms (Table 2). One possible reason for the lower level of awareness among brothel-based sex workers is that some brothel managers and owners take the condoms from the peer outreach workers, restricting the women’s interactions with them.

Knowledge of female condoms was high, but they were not as well accepted as male condoms.

The social marketing program of Hindustan Latex Family Planning Promotion Trust provides female condoms to local NGOs and CBOs operating in the brothel and non-brothel areas. These female condoms are then sold to the sex workers at a relatively low price (INR 2.50). Almost all survey respondents knew about the female condom (Table 2), but the qualitative data revealed that the women had varying views about the product. Some highlighted its value when a paid customer doesn’t want to use a male condom.

Table 2: Knowledge of condoms and access points for male condoms by place of business

Knowledge	Brothel (n=154) percent	Non-Brothel (n=175) percent
Knowledge about Condoms		
Male Condoms	100.0	99.4
Female Condoms	94.2	92.0
Knowledge of Access points		
Public Health Sector	21.4	16.0
NGO clinic/center (Peer outreach)	39.0	55.4
Private health Sector	29.9	32.0

According to a 25-year old brothel-based sex worker:

“I use it [a condom] every time I have a customer. I make it compulsory. Sometimes some of the customers don’t like to put it on so I always keep a female condom handy. When they don’t listen even after telling them I tell them I want to go to the toilet and slip in a female condom and come out.”

Other women complained about its price, as it was more expensive than the male condom. There was also wide variation in the reporting of the price the women paid for a female condom. Some informants mentioned that the women were not willing to try something new and feared its compatibility with their anatomy.

Condom use by sex workers was inconsistent, either because the women did not use condoms with intimate partners or some clients offered more money to have unprotected sex.

All brothel-based and non-brothel based sex workers surveyed reported consistent use of condoms with paying clients. However, the in-depth interviews revealed that women were sometimes forced to forego safe sex practices by brothel owners in light of a potential higher price for sex without a condom. According to a 30-year old, brothel-based sex worker:

“So, if the customer says, to do without a condom, then the gharwali accepts his request on a condition of higher rate. The customers have never returned from here without having sex as the options of availability of sex workers are more and is increasing day by day.”

Only 13 percent of survey respondents reported consistent condom use with intimate partners. Consistent condom use with intimate partners was slightly higher among non-brothel based sex workers (15%) compared to brothel-based sex workers (12%). Older women used condoms less consistently than younger women. Being literate and able to make decisions about choice of clients were significantly associated with consistent condom use with intimate partners.

The in-depth interviews revealed reasons behind women’s inconsistent use of condoms with intimate partners. According to a peer educator:

“Many men say, I am not infected with HIV. I have got my tests done and my results are negative. I don’t have sex with anywhere else other than you. But if you are insisting so much, you must be having more partners. The women then feel it’s always better not to use the condom then answer this question. They think, this man gives me money, helps me whenever I require help, he must be really very good. Then when it’s with other men, I do use the condom. So it’s okay with him.”

Reports from male partners indicated they had unprotected sex with other women. They also sometimes justified their non-use of condoms with sex workers they were intimate with by noting that these partners used condoms consistently with all their other partners so they did not feel at risk.

Many female sex workers were unaware of symptoms as being signs of a sexually transmitted infection (STI), despite the majority having experienced such symptoms in the last 12 months.

Almost all of the surveyed sex workers had heard of STIs. But when asked whether they recognized certain symptoms as signs of an STI, many were unaware of such linkages. For example, less than a third (32.1%) recognized a foul smelling discharge as an STI symptom. Only about 29 percent were aware that genital sores/ulcers may indicate an STI. When asked if they had suffered from such symptoms as genital discharge, genital ulcers/sores, pain during intercourse, lower abdominal pain or burning pain during urination and others during the last 12 months, nearly two-thirds (64%) reported that they had had at least one symptom. Higher income, recent migration to Pune, and inability to make decisions about clients were significantly associated with the reporting of an STI symptom in the last 12 months. These associations may be explained by a higher level of risk. For example, sex workers with a higher income may have had a greater number of clients overall or a greater number of clients

who paid a higher fee for sex without a condom. But the study also found a significant association between reporting of an STI symptom and ability to make health care decisions. The higher reporting of STI symptoms may be due to greater body awareness and ability to recognize symptoms, among these women rather than understanding the risk in acquiring infections.

Most women sought treatment for STI symptoms, yet the treatment received was not always complete.

When asked about the last 3 months, 29 percent (i.e. 97 women), reported having had an STI symptom. Nearly three-fourths (72%) of these sex workers sought treatment. The most common source of treatment was from NGO run clinics or health centers (used by 84% of the women who sought treatment). Some (around 12%) used the Government hospital and very few women went to a dispensary, STI clinic or private doctor.

Each woman who had experienced an STI symptom in the last three months and had gone to a health provider was asked about the type of treatment she received in addition to a clinical exam. Most women reported that they received only counseling (41%). But more than a fourth (i.e. 28%) said they were not given any advice or drugs, nor asked by a health provider to undergo laboratory tests.

During observation of services provided by the five NGOs in the study area, we found that the counselors did not play a major role in STI management and treatment. In many instances, the counselors just sent the clients directly to the doctor for a clinical exam. In the few cases where the counselor spoke to the clients it was only about transmission of HIV and prevention through condom use.

During the in-depth interviews with female sex workers, none could report what was actually discussed by the counselor during the counseling sessions. This suggests that the role of the counselor in the context of STI prevention and management may have been overstated by survey respondents who may have perceived any interaction with the counselor as “counseling.”

Almost all respondents knew about HIV testing and condoms as an HIV prevention method, yet other prevention strategies and antiretroviral therapy (ART) were less well known.

Awareness of HIV, HIV testing, and places that offer HIV testing was near universal among surveyed sex workers. Almost all survey respondents knew that condoms prevented HIV, yet other means of HIV prevention were not widely recognized. Only about a third knew that abstaining from sex prevented HIV. About 56 percent of non-brothel based sex workers and 40 percent of brothel-based sex workers reported that limiting the number of sex partners was an HIV prevention strategy. Few said that avoiding kissing or mosquito bites prevented HIV.

Given widespread knowledge about HIV, it was surprising how few women knew about ART (23% of brothel-based and 16% of non-brothel based sex workers). Women who were literate, had been in Pune longer, and could make decisions about their health care and choice of clients were significantly ($p < 0.05$) more likely to know about ART.

Levels of HIV testing were high while perception of risk was low.

Only 11 percent of the surveyed female sex workers considered themselves at risk of HIV infection; risk perception was more than twice as high among the non-brothel based respondents (15%) than the brothel-based women (6%). The most common reason for not feeling at risk was that the women used condoms consistently with their clients (90%).

Overall, 88 percent of respondents had undergone HIV testing in the last 12 months – 86 percent among the non-brothel based sample and 92 percent among the brothel-based sex workers.

The corresponding figures from the 2006 BSS for each type of sex worker at the state level (Maharashtra) was 58 percent and 74 percent, respectively.

HIV testing was significantly associated with several key variables, as shown in Table 3.

Women who were literate, earned more income, worked in a brothel, had been in Pune longer, had greater decision-making ability, had learned about HIV and HIV testing from a peer outreach worker and used condoms consistently with an intimate partner were significantly more likely to have been tested.

NGO clinics played a key role in HIV testing of sex workers.

In the qualitative IDIs, female sex workers reported they underwent HIV testing periodically. Some said they got tested when they were ill or when their condoms broke during sex. Others sought HIV testing because they felt responsible for their children. As one street-based sex worker remarked:

...the reason I go in for regular testing is that I have a very big responsibility and that is my children. It is my responsibility to stay healthy. If I don't and something happens to me then, I will have to take care of myself and in that case, I will fall short to take care of my children. I don't want this to happen.

But mostly, they underwent testing because it was a process put in place and facilitated by the NGOs for brothel-based and non-brothel-based sex workers. According to a brothel-based sex worker:

They come to call us. They tell us come to the clinic. Some of the girls go, especially those who understand the importance of it. The people from these organizations come to call everyone. The first time when I went there, they had come to my house to call me. They said, come to the doctor for a check-up. Get it done regularly. You will not fall ill. It is nothing much. You just have to go and get your blood tested."

The survey data corroborated this key role played by the NGOs in HIV testing. About half (49%) of respondents underwent testing at an NGO clinic; but a third (34%) did not disclose where they had been tested. Regardless of where they had been tested, most women were satisfied with the HIV testing services they received.

Most sex workers disclosed their test result to someone, most often to a peer outreach worker and rarely to an intimate partner.

The vast majority of women (84%) went back to the clinic to receive their test results. In IDIs, the sex workers said they were eager to get the results because of its implications for the women's work.

Table 3: Proportion of women who reported taking HIV test by background characteristics

Background Characteristics	HIV Testing percent	P Value
Education		0.007
Illiterate	86.5	
Literate	94.1	
Income		0.001
Lowest (< 3000)	77.6	
Second (3001 – 6000)	85.7	
Third (6001 – 9000)	93.0	
Highest (>9000)	94.7	
Place of business		0.008
Brothel	91.6	
Non-brothel	85.7	
Migration Status		0.000
< 1 year	76.8	
1-5 years	95.2	
5-10 years	92.2	
10+ years	97.7	
Decision regarding obtaining own health care		0.009
Yes	93.7	
No	84.4	
Source of knowledge about HIV		0.000
Peer outreach workers	91.5	
Others	61.8	
Source of knowledge about HIV testing		0.000
Peer outreach workers	90.7	
Others	65.5	
Consistent use of condom with husband/partner		0.000
Yes	90.9	
No	72.7	
(Number Tested)	(291)	

Around 60 percent reported that they disclosed their HIV status to someone. Disclosure was more common among women who had tested at an NGO clinic than another type of facility, named or unnamed. More than three-fourths (76%) of sex workers who disclosed shared their results with a peer outreach worker, followed by a counselor (27%) and then a doctor (11%). Disclosure to an intimate partner was negligible (3%).

Women feared breaches in confidentiality and reacted negatively to having had their blood tested for HIV or STIs without their prior knowledge.

Women were concerned about the confidentiality of test results. As one female sex worker stated:

“The fear is among everybody regarding spread of words about our status as we take the tests. If someone tells me today I would go tell another two who in turn would tell another five and so it would keep on spreading. It affects our business as everybody comes to know we were here for the testing of HIV and it spreads everywhere. Then people start having doubts about our health status and the customers reduce. It is a problem even for the doctor as she has to disclose the result in front of everybody including the peer leader (didi) who accompanied us.”

Sex workers feared that disclosure of a positive status to brothel owners and managers could result in being thrown out of the brothel. The two women who disclosed their positive status during the IDIs said they hid their status and the treatment they were taking for fear of being forced out of the brothel. They noted that adhering to treatment, as they were, could be a big hurdle for many positive female sex workers as disclosure could lead to financial distress. Those who could afford to, visited private services for HIV tests to ensure confidentiality.

In the qualitative interviews, women complained about being tested for HIV without being adequately informed. According to one sex worker:

“The first time I went there for testing I did not know that I was being taken there for HIV testing... There I gave my samples and then they got the report to tell me that my blood was good and there was no problem. I did not know what was in the report as I can't read and write. One day there was a new didi who came in and she was telling us about HIV. She asked me if I had anytime got my blood checked. I told her I got it checked because I had fever but not for HIV. She asked me to get the report and then she told me that I was also checked for HIV at that time. I got very angry with these people.”

Observations in the field suggested that the NGOs might have been overly concerned with testing targets and not placed enough emphasis on informing the women prior to testing.

Availability, Acceptability, and Affordability of Services

Peer outreach workers played an important role in making condoms available, particularly among sex workers who were not based in brothels, had the lowest income and were new to the area.

Nearly two-thirds (64%) of the surveyed sex workers obtained condoms from NGO peer outreach workers, while the remaining women obtained them through someone else or bought them themselves.

As shown in Table 4, non-brothel based sex workers particularly relied on the peer outreach workers for condoms: 92 percent of these sex workers availed condoms from the outreach workers compared to 55 percent of brothel-based sex workers. Women with the lowest income took the most advantage of condom distribution by the outreach workers: 86 percent of women in the first income quartile compared to 39 percent of women in the fourth income quartile. More than three-fourths (77%) of new migrants to Pune obtained condoms from the outreach workers, a greater proportion as compared to the women who had been in the city longer. Consistent condom use with intimate partners also showed a significant positive relationship with availing condoms through peer outreach workers.

The peer outreach workers were also an important source of information on condoms and HIV/STDs for about half the survey respondents, but more so for the non-brothel based sex workers (54%) than the brothel-based sex workers (46%).

Sex workers sought treatment for STI symptoms at NGOs clinics primarily because of their close proximity to the women’s workplace and their free or low cost services.

About 61 percent of women who had experienced an STI symptom in the last three months, availed services from an NGO clinic; and among those who sought treatment, 56 percent were non-brothel based and 44 percent from brothels. The main reasons cited by more than half the survey respondents for choosing these services were that they were close to the sex workers’ work places and were reasonably priced. More than a third (35%) highlighted the quality of the services and 27 percent mentioned a stigma free environment as the reasons for preference. Responses were similar for the brothel-based and the non-brothel-based sex workers.

Sex workers who got tested for HIV at NGO clinics were satisfied with the facilities’ close proximity, free or low cost services, non stigmatizing setting and quality of care.

More than six in 10 women tested at an NGO facility mentioned distance, cost, setting and quality of care as reasons for accessing the service. The quality of care (i.e. privacy, treatment and timing) was particularly attractive to the non-brothel-based sex workers (86%). The qualitative data revealed an important positive aspect of the NGO services: good rapport between the peer outreach workers and the female sex workers.

Government facilities were more highly rated for their free or low cost (mentioned by 88% of respondents who had used these services), but much less so for distance (mentioned by only 40% of respondents).

When asked whether there was any facility that they would avoid for HIV testing, more than nine in 10 women mentioned a private doctor or private hospital. The main reasons were they did not know the provider (80%), potential name calling/stigmatization/identity issue (57%), poor quality of services (46%), and the cost (31%).

Transport and opportunity costs were significant barriers for women needing to access health services, including ART.

The local NGO clinics do not offer ART, so HIV-positive women must travel to Sasoon Hospital, a government hospital, for treatment. In addition there are opportunity costs involved as a result of poor transport options and long lines, cutting into their time for business. As noted by one female sex worker:

“The only problem, it is far and we have to stand there in long queues. That wastes a lot of time and also money. There is no frequent bus service that goes there so we have to take the rickshaw. That costs us almost Rs. 80/- to and fro. Then

Table 4: Proportion of women who obtained condoms from peer outreach workers by background characteristics

	Peer Outreach Workers percent	P value
Income		0.000
First quartile	86.0	
Second quartile	68.6	
Third quartile	55.1	
Fourth quartile	39.0	
Place of business		0.000
Brothel	54.9	
Non-brothel	91.9	
Migration Status		0.003
< 1 year	76.8	
1-5 years	52.4	
5-10 years	57.8	
10+ years	62.8	
Consistent use of condom with Husband/partner		0.000
Yes	68.8	
No	34.0	
(Number)	(329)	

when we are there we have to stay for long and that wastes almost half a day and we lose customers here. Thus we tend to avoid going there."

As reported by a peer outreach worker:

"If ever coincidentally, a woman from the brothel comes out with us for treatment or check-up and in her absence, if her customer comes there, the brothel owner/manager scolds her as she loses the commission. Hence, many times the women agree to have sex with their customers without condoms as they pay her extra and that compensates for the amount she had lost the last time she was out with us visiting the clinic or at the follow-up center."

Structural Issues: Mobility, Stigma and Discrimination, Violence, Social Support

The mobility of young, brothel-based sex workers was often restricted, thus compromising their access to information and health services.

While the age of study participants for the survey was 18 and above, the qualitative component shed light on some of the key barriers facing very young sex workers (even less than 18), such as restricted mobility. According to informants, these sex workers were often restricted for two reasons: 1) they or their families owed large debts to the brothel owners; hence, their mobility was curtailed until the debts were paid off, and 2) they were secluded until they were engaged by the highest bidders for their sexual services. This restricted mobility impeded the young women's exposure to the outside world, compromising their access to health services from the NGO clinics or even meeting the peer outreach workers who visited the brothels to talk about condoms, HIV/AIDS or other STDs. As noted by a key informant:

"They owe the owners a lot of money, some up to Rs. 1-1.5 lakhs. When the women owe so much of money and they're young and beautiful, the manager doesn't allow them to step out or even come to the common room in the same house. They're kept inside a small room where only special clients can go, who can pay a high rate. They don't even allow the peers of the NGOs inside when they've girls like these. They sit on the door steps and keep the girls behind the curtains. They take the box of condoms and ask them to leave. They don't even allow the girls to talk to them"

Because of their restricted mobility and contact, these young women may not be aware of HIV/AIDS and may not be practicing safe sex. The same informant continued:

"... these women, when they are new or young they are not exposed to a lot of people. They are restricted from interaction not only from outsiders but also within the brothel. They are kept cut off from every possible interaction. This results in the women not knowing anything about what is happening or even how they are to do the business. These women, no rather I would say girls are the ones who are abused even by the customers in the beginning as they know nothing about what they are into. The owner or manager who is present there is the one who has to tell the girls about all the business principles. At the most the girl is given the condoms to use, but I tell you I doubt if they are even told how to use them."

Peer outreach workers recounted how some brothel owners acted as strict doorkeepers and did not allow them in to distribute condoms or explain how to use condoms to these girls. The outreach workers were also unsure whether the girls even got the condoms that they left for them. Health care providers were also concerned about the vulnerability of the youngest sex workers because of their restricted mobility. According to a private health care provider:

"But the problem is the girls who are cut off from the entire outside world. These are the girls who suffer the most. They have access to the medical facilities only when some doctor gives them a home visit and that too is through a call from the manager's side. When they have less access to the healthcare facilities, do you think they will be aware of HIV healthcare facilities?"

More than half of survey respondents had experienced both social and verbal stigma, with non-brothel based sex workers more affected than brothel-based women.

Survey respondents were asked a series of questions to measure enacted social stigma, which included loss of identity, exclusion from family and community, loss of friends and loss of respect. Verbal stigma was also measured which entailed ridicule, insults and blame.

Figure 1 shows that both types of stigma were common. Non-brothel-based sex workers were more affected by social and verbal stigma than brothel-based women. This may be due to the fact that these women live in residential areas, are often married and live in a family, thus they have more potential encounters with individuals who learn of the women's livelihoods and hold stigmatizing views. So they need to be careful to prevent others from learning what they do to earn their incomes.

A peer outreach worker who worked with non-brothel based sex workers recounted how the women hesitated to access a mobile van for HIV testing for fear that their identity would be discovered.

"This van used to come and stand in the square next to the bus stand which is a crowded place. Once these women started going there, people came to know about the purpose of the visit and started judging the character of these women. The simple fact is that the women who visited the van for check-ups were sex workers. They stopped coming there."

Sex workers expressed self-stigma about their work, while also perceiving high levels of health system related stigma and discrimination.

Survey respondents were asked whether they agreed, somewhat agreed or disagreed with a series of statements designed to measure perceived social and health-related stigma and discrimination (Table 5). Ninety percent of women reported feeling ashamed of their profession. Three-fourths of sex workers perceived that they were the main HIV transmission route to men. And more than seven in 10 women agreed that they faced violence as a result of their profession.

At least six in 10 respondents agreed with each of the statements around perceived health system related stigma and discrimination, with small variations according to the place of business.

Twice as many non-brothel based sex workers experienced stigmatizing and discriminatory treatment by health providers as brothel-based sex workers.

As noted above, perceived health system stigmatization and discrimination was relatively equal between the two groups. However, when asked about actual incidents, the non-brothel-based sex workers were twice more likely to have experienced stigmatizing and discriminatory treatment than brothel-based sex workers (48% vs. 23%). Examples of discriminatory behavior included avoiding touching the patient during a check-up, making the sex worker wait longer to be seen than other patients, not asking the sex worker's opinions and not asking for her consent prior to a procedure.

Figure 1: Social and verbal stigma experienced by female sex workers

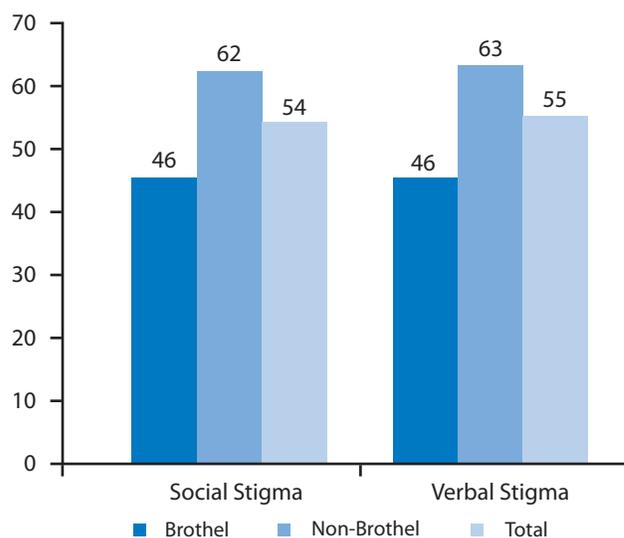


Table 5: Proportion of female sex workers reporting stigma and discrimination

Stigma and Discriminatory Statements	Brothel percent	Non-brothel percent	Total percent
Social stigma and discrimination			
■ I feel ashamed of my work as sex worker.	87.7	92.0	90.0
■ Sex workers are the main carriers of spreading HIV infection among men.	69.9	81.1	76.0
■ A man needs to use condom only when he has sex with a sex worker.	53.9	62.3	58.4
■ Women with loose character becomes sex workers	37.7	38.9	38.3
■ Sex workers are the ones with loose morals and would sleep with anyone for money.	24.7	21.1	22.8
■ Sex workers don't have any value of life.	32.5	24.0	28.0
■ Sex workers more often indulge in drinking.	48.1	38.3	42.9
■ Sex workers always force her client to drink before having sex.	69.5	55.4	62.0
■ Sex worker are more stigmatized by women in the society then men.	70.1	82.9	76.9
■ Sex workers face violence because of their profession	61.0	78.9	70.5
Health system related stigma and discrimination			
■ Health practitioners discriminate against sex workers because of their profession.	62.3	69.1	66.0
■ Health workers often reveal sex workers' identity to everyone and make fun of that.	57.1	65.1	61.4
■ Sex workers are forced all the time to take STI tests whenever they fall ill.	63.0	65.7	64.4
■ Sex workers are forced all the time to take HIV tests whenever they fall ill.	57.1	68.0	62.9
■ Sometime without conducting blood test and specifically HIV tests doctors and other health professionals refuse to admit sex worker in the hospital.	57.1	66.9	62.3
(Number)	(154)	(175)	(329)

According to the male partner of a sex worker:

".....besides Doctor and nurse, other patients look badly at us (buri tarah dekhate hai) and sit at longer distance. Doctor first calls for check-ups and at the end he examines her."

Sex workers experienced violence ranging from verbal abuse to physical violence to economic exploitation, with the police being the most common perpetrators.

Around six in 10 survey respondents reported any kind of violence; a greater proportion of non-brothel based sex workers (67%) experienced violence than brothel-based women (51%). Police were the most common perpetrators, with non-brothel based sex workers being the most vulnerable. According to a 25-year old female sex worker who solicited in the street:

"These police pick us up from the roadside when we stand there for our customers. Once the police take us to the chowky (police station) no one gives us respect there. They treat us very bad, use filthy language to abuse us. They do

not physically beat everyone but if someone cries a lot, screams or talks or back answers to them, then they at least give one slap.”

In addition to police, women in brothels faced violence from a number of sources, as described by a peer outreach worker:

“...there are different types of violence that take place here, violence from the partners, brothel manager and among the girls in the house. The violence from the partner or the girls in the house does not affect them much. But violence from the owner/manager does hamper their access to health care facilities. They are the doorkeepers and the mobility of the girls is all controlled by these managers with directions from the owners.”

Though violence by a madam, pimp, or Gharwali as they are usually known, was not widely reported by survey respondents, the female sex workers who participated in in-depth interviews often mentioned a violent incident perpetrated by a Gharwali, either against them or a peer. Beating or verbal abuse by a Gharwali against a girl new to the brothel was quite common. Other reasons for abuse included a girl becoming pregnant or not satisfying a customer. A 30-year old female sex worker recounted:

“A new girl came to my brothel and as most of us do she also refused to have sex with customers. After knowing that she refused having sex with the customer she was beaten up so badly by the Gharwali that she became unconscious... whenever I look outside from my room I see her (gharwali) beating the same girl everyday. She is very young and also 6-7 months pregnant. The main reason for the violence is basically due to her inability to satisfy the customers.”

Non-brothel based sex workers received less support from their sex work community during a time of crisis than brothel-based sex workers.

As noted previously, a targeted intervention run by NGOs has been active in the study area for many years. Survey findings showed that more than a third (35%) of respondents regularly participated in meetings held by the NGOs and another 58 percent did so occasionally. There was little difference in meeting attendance between the brothel-based and non-brothel based sex workers.

Women were also asked how frequently they received support at a time of crisis from either an NGO or from others in their sex work community (e.g. other sex workers, brothel madams/*gharwalis*). As shown in Table 6, non-brothel-based sex workers received less support from either group than brothel-based sex workers. Since their working environment is unstable, they move about frequently which makes it a challenge for outreach workers to contact them. Even when they visited NGO clinics, because of their reluctance to give contact information, it was often difficult for the NGOs to reach them for follow up visits. Some of these women do not disclose their occupation to their spouses, which makes them afraid to seek services and support. As a key informant said:

“As most of the husbands are not aware of the wife’s involvement in sex work, they question the wife on visiting the clinic periodically as we have here once every month. The wife usually replies saying, ‘I am not feeling well’. The husband doubts this and says to her that she looks fine, hence why she needs to visit the doctor so often. Due to this botheration too the women avoid coming here. When I ask them why they are late or why they could not attend the last visit they give me these reasons. They even reveal the instances of violence to me many a times.”

Table 6: Proportion of female sex workers reporting social support in times of crisis

Place of Business	NGO percent	Community percent
Brothel		
Not usually/Never	23.6	35.7
Non brothel		
Not usually/Never	47.9	42.9

Conclusions

- There is a high level of awareness of HIV, condom use as a prevention method, and a high uptake of HIV testing among both sex worker populations.
- Peer Outreach Workers are the most important source of condoms for non-brothel based sex workers. Yet, more could be done to reach this population since nearly half of these women surveyed didn't identify the outreach workers as a source for condoms.
- NGO clinics play an important role in STI management and HIV testing for female sex workers. But increased attention needs to be paid by these and other health facilities to educating and counseling women about i) STIs when they visit a clinic with an STI symptom, and ii) ART when they are tested for HIV.
- Distance to the ART center, opportunity costs in procuring treatment and the need to hide their treatment from brothel owners and others compromise positive female sex workers' adherence to ART.
- Female sex workers face structural barriers to accessing services, including restricted mobility (particularly for young, brothel-based sex workers), violence, stigma and discrimination and a lack of social support (mainly for non-brothel-based women).

Key Findings: Wives of Male Migrants

Demographic and Socio-economic Characteristics, Knowledge, Behaviors and Experiences

Most wives of migrant men said they couldn't meet household expenses in their husbands' income and had low decision-making ability.

The majority of women in the sample were between 20 and 29 years of age. About 41 percent had no schooling and another fourth (24%) had only 1-5 years of education. Eight in ten women belonged to the category "other backward castes", whereas 18 percent belonged to the "scheduled caste."

The women's husbands tended to be older and more literate than their wives. Most men were between 25 and 34 years of age and only about a fourth (26%) had no schooling. About 42 percent had six or more years of schooling.

When asked about their husband's migratory status, 71 percent of the women reported that their husbands had been out of the village for more than five years. For two-thirds of the women, there was no specific schedule as to how often their husband visited. The most common reason stated for visiting was that "he felt like meeting us." Other major reasons for a visit were festivals and family illness. About a third (32%) would stay up to a month and another 56 percent would stay from two to five months.

Table 7 provides data on remittances sent home by husbands, according to their wives. Almost all

Table 7: Husbands' Income and Remittances

Survey Item	Percent
Husband sends money home	97.0
To whom	
Parents	50.1
Wife	48.4
Frequency of sending money	
Monthly	24.5
Quarterly	14.9
No specific time	55.3
Husband's monthly income-reported by wife	
Doesn't know husband's income	4.9
800 to 5000 rupees	67.9
5001 to 10000 rupees	24.0
More than 10000 rupees	3.3
Amount of money husband sends to wife or family (Monthly)	
Doesn't send money	3.0
Sends 200-2000 rupees	43.3
Sends 2001-5000 rupees	41.3
Sends 5001-10000 rupees	10.0
Sends more than 10000 rupees	2.4
Amount sent by husband is sufficient to meet HH requirements	
Can save money from husband's income	11.4

Table 8: Women and household decision-making

Type of Decision-making Ability	Percent
Spend money on your children's basic health	45.5
Spend money on self	33.5
Send money to natal family	35.2
Spend own earning on siblings' weddings/ natal family needs	14.0
Obtain health care for self	27.2
Go to other cities for work	5.7

could make was spending money on their children's basic health care. But only 27 percent indicated they could obtain healthcare for themselves.

Overall, women's awareness of STIs was low, yet those with greater education, income and partner communication were more aware of STDs.

According to the DLHS-3, 2007-08, only 10 percent of women in Ganjam district were aware of sexually transmitted infections (STIs). In our survey, the figure was higher – 23 percent – yet still quite low. Of those who had heard of STIs, only 16 percent could identify any symptoms. The most common symptoms mentioned were genital discharge, genital itching and loss of weight.

Not surprisingly, women and their husbands who had more years of schooling were significantly more likely to be aware of STIs (Figure 2). Women whose husband's duration of migration was the longest were also more likely to know about STDs. This might be due to the exposure of the women and their husbands to HIV interventions, which also focus on STI testing and treatment, in source and destination settings.

Women whose husbands' income was above INR 8000 were twice as likely to be aware of STIs than women in the poorest group earning INR 3000 or less (56% vs. 26%). More than a third (35%) of women who had discussed about HIV with their husbands had heard of STDs compared with only 20 percent who never discussed the topic. Finally, women who knew about condom access points tended to be much more aware of STIs than those who didn't know where to obtain condoms (44% vs. 14%).

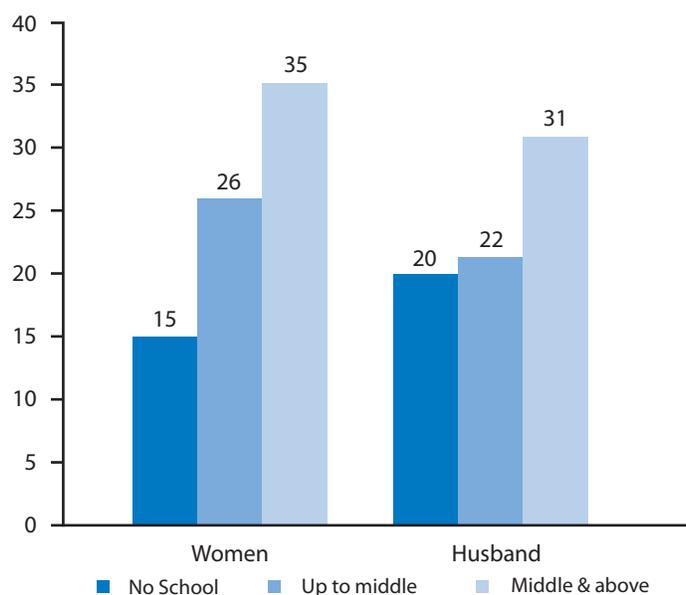
Nearly four out of 10 women reported suffering at least one STI symptom in the last six months.

All surveyed women were asked whether they had suffered from genital discharge, genital ulcer/sore, pain during intercourse, lower abdominal pain or burning pain during urination and a few other symptoms during the last 6 months preceding the survey.

Thirty-nine percent of the women reported that they had suffered from at least one symptom in the last six months. There were no significant relationships between the demographic and socio-economic and program variables except for

husbands sent money home and about half of the women (48%) received money directly. Less than three in ten women said they could meet household expenses based on what their husbands sent. Only 11 percent could save money from their husbands' income. Nearly half owed 20,000 rupees or more.

Less than half the women could make any of the decisions asked about in the survey (Table 8). The most common decision survey respondents reported they

Figure 2: Awareness about STIs by education

the husband's income. As the husband's income increased, so did the proportion of women who reported an STI symptom.

Treatment seeking for STI symptoms was low among women respondents, mainly because of cost and the belief that the symptoms would go away.

Only 18 percent of women who reported having had an STI symptom sought treatment in the last six months. Of those who sought treatment, most reported that they went to a health provider on the same day while a third went within one or two days and the rest after two days.

But the vast majority of women did not seek treatment. The most common reason given for not seeking treatment was cost and the belief that treatment was not necessary or customary. Upon probing in the in-depth interviews, it was found that women believed that the infection would go away by itself or through home remedies. As one woman shared during an in-depth interview:

"Sometimes I have some itching problems but I never take any medicine for it. I just use some warm water and it was treated. There is no need to rush to doctor. It just heals up on its own."

Qualitative interviews also pointed to husbands' lack of attention to the severity of the problem. Men tended to ignore such complaints and tell women that the symptoms will go away on their own.

As reported by a woman during interview

"I told about the problem (burning micturation) to my husband. But he said that it is not a big problem. So, do not to worry about this. I did not go anywhere for any medical help. After 15 days, I was fine. Neither I nor my husband consulted any doctor nor took any medicine for that problem."

Poor economic conditions and limited mobility coupled with lack of husband's support also contributed to women's poor treatment seeking. According to an HIV-positive wife of a migrant man who disclosed her status:

"Yes, I know about white discharge and also I face the problem. I am still suffering from it. I cannot go anywhere for my treatment. I can't reach out to any doctor on my own. My husband is anyway upset with me. My husband remains angry with me. How can I go out for any treatment? I just bear it."

The in-depth interviews with women revealed that the villages were poorly served by public transport. Most of the time women reached the health facilities by cycle or motorcycle with their husband or relatives, even during pregnancy. For a distant health center they took an auto, which cost Rs. 200/- for a round trip journey. Women also had debt and did not receive money regularly from their husbands. In such situations, they paid more attention to repaying the debt and spending money for essential domestic needs than seeking care. As one woman said:

"The conveyance cost is more. As we are poor to go Berhampur and bringing medicines from there is costly for us. Sometimes we delay our treatment."

For many women it was not customary to access medical help to treat STIs. They preferred home-based remedies to treat them. As shared by one woman during her interview:

"I had never any such problems. If it will happen then we eat some sugar and mishri. I am not required to go anywhere for this reason. This gets cured on its own. We do not need to go to doctor for such reasons."

During focus group discussions with migrant men, one said,

"Women perceive white discharge is a common problem and a normal thing. It happens due to heat and when you fast. They do not seek treatment because of lack of proper knowledge. Another reason for not seeking treatment is lack of money to spend on transport / lab tests / medicines. As they are dependant on their husband's income and they don't get money regularly, money is a problem."

Treatment for STI symptoms was often incomplete.

When asked about their place of preference for STI treatment, women preferred government and private facilities in almost equal proportions. Yet, despite their preference, women often did not receive complete medical services.

Of the 34 women who sought treatment, less than a third (10 women) reported that the health provider had explained the reason for their possible infection. Only in a few cases did the care provider ask about the women's sexual history. Although most were asked to undergo laboratory testing, 13 chose not go for testing. The main reason given for not undergoing testing was that the women thought it wasn't necessary. Other reasons were the high cost and poor quality of services.

Testing for STIs and sharing the report with spouses is essential for treatment to be effective and avoiding re-infection. Of the 21 survey respondents who underwent testing, 19 learned their test results, and 18 of these women shared their test results with their husbands.

Knowledge of HIV testing centers and condom access points was limited.

Only 26 percent knew where to go for HIV testing, and when asked about specific places, the majority of these women (79%) reported knowing a public sector medical facility. More women knew about places to get condoms: slightly more than half (55%) reported knowing a condom access point.

HIV testing was associated with age, education, and HIV-related variables.

More than a third (37%) of survey respondents had ever been tested for HIV. Of these, 12 percent underwent testing in the last 12 months. All those who had been tested did so during their ANC visit. Regardless of where they had been tested, only 19 percent returned to get their test results.

Women who had ever been tested were more likely to be younger and more educated and have younger and more educated husbands. Younger women also tended to go back for their test results compared to older women.

Women who had some form of economic stability such as ownership of land were also more likely to undergo HIV testing.

We found associations between testing for HIV and variables that capture women's HIV-related knowledge/awareness and partner communication (Table 9). Knowing about condom access points, being aware of STI symptoms and that NGOs provide HIV services, and having discussed HIV with a husband were positively associated with being tested.

The NGOs providing HIV-related services to the study population include efforts to increase knowledge and awareness of STIs, HIV prevention, and HIV testing. Spousal communication also proved to be significantly associated with the uptake of HIV testing, suggesting that the husband may play a role. However, what is not clear is whether the communication occurred as a result of the woman getting tested or it happened prior to the testing.

Table 9: Proportion who undertook HIV testing by HIV-related variables

Variable	Percent	P value
Knowledge of condom access points*		
Yes	62.6	0.000
No	25.5	
Awareness of STI symptoms*		
Yes	73.8	0.000
No	29.4	
Awareness of NGOs providing HIV services*		
Yes	54.1	0.012
No	35.2	
Ever discussed with husband about HIV*		
Yes	61.5	0.000
No	30.6	
Place of visit of last ANC		
CHC/PHC		
Govt municipal/UHC	52.5	0.000
Private	5.2	
Anganwadi/subcenter	20.2	
(Number)	22.5	

We were also interested to see whether there was any difference in the type of ANC facility that offered HIV test. We found that the majority (83%) of women visited government health facility for antenatal care, and most among them (52%) who visited community and primary health centers undertook HIV test as against 23 percent who visited anganwadi and sub centers.

The main reason for undertaking HIV testing, given by 80 percent of survey respondents who had been tested, was that a health provider had advised that they be tested. Another 14 percent reported that it was required for them to undergo the testing.

Key informant interviews revealed bottlenecks with accessing HIV testing by the study population such as unresponsiveness of ICTCs to referrals from NGOs, and lack of adequate lab technicians and test kits. According to an NGO worker:

"Referral slips are provided to the beneficiaries and they are encouraged to go to an ICTC for HIV testing. ICTC counselors, doctors and other hospital staff behave badly with these people. ICTC counselors do not conduct testing for all people we send and then blame us for sending general population for testing who do not need HIV testing. We send people as we know their behavioral background, so they should just do the testing. It is not possible for that person to open up about themselves in just 5 minutes talk. So they discourage people and send them back. There are 150 ICTCs and there are 85 vacancies for lab technicians. So this makes a huge number of ICTCs defunct. The kits for HIV testing are also not available on time. Whenever kit 1 is available, the Kit 2 and 3 is not available or vice versa. This also makes the testing center not run properly doing its all activities." (NGO worker)

Less than four in 10 women were informed by an ANC health provider about HIV testing during pregnancy and among these women, few were given additional information about HIV transmission and prevention.

When asked specifically about antenatal care, only 38 of the women surveyed said that a health provider spoke to them about HIV testing. The vast majority of these women (89%) were told only to undergo the test, resulting in a missed opportunity to talk about other information, such as the difference between HIV and AIDS, modes of HIV transmission, prevention methods, and treatment for HIV.

Receiving information about HIV testing during pregnancy varied by demographic characteristics. Women who were younger (less than 25 years) and more educated (completed education above middle school) were more likely to have received information from an ANC provider. Younger and more educated women may have better recall or the health providers may think they would be more likely to understand information given to them.

During qualitative interviews women reported that since they mostly stayed indoors and had little interaction with outsiders, they did not receive much information on HIV/AIDS. In the absence of their husbands who are migrants, their mobility tended to be severely restricted and thus their exposure to information is limited. In a sense, if they are not informed about HIV during ANC visits there is hardly any other source or means to get that information. An HIV-positive woman said:

"I do not know much about HIV. I am not aware of how the disease enters in the body. I asked my husband about this but he did not talk to me in this regard. We do not know how the disease came to our body. We are the simple villagers. How could we know about it."

Key informants, such as NGO and Link workers, maintained that despite innovative strategies to reach out to women with HIV information, most women and their husbands were still not fully informed about HIV prevention methods. According to one Link worker, part of a new cadre of outreach workers who are supposed to facilitate linkages between family planning, HIV testing, PPTCT and ANC services:

"There is lack of awareness regarding STI and HIV among migrant men and their wives, which results in unsafe sexual practices....when we do awareness programs sometimes we use English terms, which becomes difficult for them to

understand. For example, when we tell them HIV is a virus, they say what is this, is it an atom bomb? Thus we need to use easy local language which makes them completely understand the issue."

NGO workers suggested that for people to be better informed about HIV, there is a need to introduce other topics such as the public distribution system, children's education, employment, which helps in retaining people for further discussion about HIV:

"During the village meeting action we also talk of issues of interest of villagers which is beyond just health services. This is a proven successful strategy. This helps us to get better acceptance among villagers, gain their trust. It takes time and patience to talk on personal life styles with people and make them understand about the need for health seeking. And then with HIV it has to be more cautious so that people do not start misunderstanding us, or start making stories of people with whom we have to work more."

Both HIV pre and post-test counseling were deficient.

Almost all of the women who had been tested, whether at ANC or elsewhere, reported that they had been counseled prior to the test (93%). However, when probed about the content of the counseling session, most reported that the session was only in terms of asking them to take the HIV test, without being informed about any other aspect of the test or HIV infection.

Our qualitative findings substantiate the results from the survey. Both male and female informants said they were asked to undergo a blood test without receiving any information about the test. According to a wife of a migrant worker:

"No. I don't know. When we went to Chatrapur government hospital, the doctor just wrote on the paper and we went for the tests."

Another female respondent reported that during an ANC visit, the ICTC staff informed her that she would not be offered any medical services without an HIV test.

Despite little or no information being given to the women, their consent was at least asked for, although what it signified was not always well understood. One woman recounted:

"Yes, the lab person did ask me to sign and I signed a form before Blood check up. I did not ask anything about the cause of signature. But the medical staff told us that it is a consent form for HIV test. Without signature the test cannot be done. Both of us agreed for the test and after the test I asked is there any HIV problem with us? The doctor confirmed that there is no problem in our blood."

An HIV positive woman narrated this incident:

"I didn't know about testing earlier. I just know that that doctor asked me to go for test. Now I know about it. It happens if you have relationship with other women. If you go to bad places to the wrong girls. During test they ask me for signature. But I am illiterate. I don't know what paper was that and what was written there. I gave my thumb impression"

The findings thus indicate that although some form of counseling was offered prior to HIV testing, the information provided was likely to be extremely meager. Also, it appears that there was a lack of informed voluntary choice when it comes to HIV testing. The situation, thus, represents a missed opportunity for prevention messages among this very vulnerable population.

While pre-test counseling, in whatever form, was reportedly provided, only 53 percent of the women received post-test counseling. Women whose husbands were migrants for more than 10 years and also earned a higher income were more likely to receive post-test counseling than their counterparts.

Qualitative data revealed that although post-test counseling was not consistent, when test results were positive, clients did receive post-test counseling, although its adequacy was inconsistent. Most of the HIV positive men

and women reported during IDIs that they were informed about abstaining from sex as well as instructed on condom use for sexual encounters. However, little information was provided on other aspects such as nutrition. One woman on ART reported that while her husband was advised about following safe sex practices, she herself was not informed about anything by the service provider:

"The doctor told everything about HIV to my husband, not to me. I do not know about this. Now my first preference is to work hard, save money for my children and to secure their future. I do not think about my disease."

Another woman said:

"He (doctor) asked me not to keep any physical relation with husband without condom. He also advised me not to become pregnant for the 2nd time. After my first delivery I did not even breastfeed my daughter. Till now she has to depend on outside food and milk. Apart from that, I did not receive any other advice."

Regarding privacy and confidentiality of HIV test results at health care settings, we found mixed responses from different respondents in our qualitative interviews. In a few cases, men received confidential disclosure of test results. As told by one HIV positive male migrant:

"They called me to a different chamber and told me secretly about the report."

However, NGO representatives shared just the opposite scenario regarding privacy and confidentiality. They reported that generally ASHAs accompany most of the pregnant women to PHCs for health check-up and lab tests, including HIV testing. The test results are not given on the same day and the women are asked to return the next day. As women are reluctant to spend more money on transport to reach the health center, it is the ASHAs who collect everyone's test reports. Thus, not only do women miss the opportunity to receive post-test counseling, but there may well be breaches in disclosure of their HIV status.

Few wives of migrant workers surveyed perceived that they were at risk of HIV infection.

Only 3 percent considered themselves at risk of HIV infection. Women whose husbands had lower income were more likely to perceive themselves at risk compared to those with higher income.

The most common reason given for having a low or no risk of infection was that the women had only one partner (87%) followed by their husbands having only one partner (45%). Only 5 percent said they used condoms with their husband and thus had a lower risk of acquiring HIV infection. When asked about whether they have ever discussed HIV prevention methods with their husbands, more than three-fourths of the women (80%) said they trusted their husband and did not feel the need to discuss these matters. According to one woman:

"Our blood is not bad so why we should we go for testing our blood? My husband is staying outside, so are you saying that my husband is going to another lady? Does he have HIV? See, my husband is not like that, he is very good person. I have full trust on him. He visits us every 4-5 months. He has wife, children, then why should he go to other woman. Doesn't he have a wife, then why should he go anywhere else."

Another woman talked about her reluctance to insist on condom use by her husband even though she feared infection as he worked in Surat, a name synonymous with HIV:

"If I insist him to use condom then he might be mentally depressed. He may not be happy with me for this reason. He will feel bad. However, once I was told him to use condom & he was also ready to accept my suggestion but after some time I withdraw my word & never impose him to use condom till now. I don't want him to not feel satisfied with me. So I don't want him to feel bad in this regard. I can talk with my husband regarding HIV. Because it is not a shame to discuss with husband. In Surat, so many people died because of HIV. But he assures me that he is very much aware of that problem. Also he promises me that he will never go to other lady because he loves me & children a lot. I did not take the discussion further."

Availability, Accessibility and Affordability of Services

Quality of care was the most important reason why women chose a health facility, although transport costs and service fees were also key factors.

The main reason why women choose a particular health facility is the quality of services (reported by 74% of respondents). Other important factors are proximity to their home (40%), free services (31%), and low cost services (26%). About 14 percent reported that they were unaware of any other choices.

Qualitative findings indicate that transport costs often force women to not seek services in distant places, such as the district hospital. Given that more than half (55%) of the women surveyed don't receive money from their husbands regularly, their ability to seek services on their own is compromised. Women often have to depend on their natal family or other family members for help, which is also not ensured every time. According to one HIV positive woman:

"I am poor. I don't have money always with me. When I am sick and have no money with me, I don't go to hospital. Sometimes my parents help me. They give me money and take me to doctor."

Indeed, during qualitative interviews, some of the HIV infected women narrated their difficulties in accessing medication from distant hospitals. This respondent described her delivery experience as follows:

"During my 2nd delivery we needed some money. But there was nobody inside the village to help us. That's why I gave my earrings to my husband to keep as security & get some money for medical treatment. He went outside of this village to arrange for money. Then when we went to Aska (hospital) for delivery, no auto driver would take us there. Then, one agreed and asked for Rs. 500/- one way. The Auto fair from our village to Aska is Rs 120/- normally. He charged high to us because we are an HIV positive family. He said that you are HIV family, so you have to pay more. If we got some medical facility near by our village, then it will be more effective for us. We have to travel long distance for medical treatment. It's too costly for us."

An interview with a member of an HIV positive network revealed that fear of identification inhibited PLHIV from accessing cheap transport services:

"It is impossible for poor women and especially from BPL families to reach out to the facilities. As the facilities are not so near to their residential areas, it's too costly for women to come to the health centers for any activity. Also, disclosure of her illness is a major threat. The transport concession made by government for PLHIV does not work. People fear disclosure of their infection status would further hamper their reach to the health centers. They won't be allowed to go by public transport"

Women faced several obstacles to HIV treatment, including lack of information, high travel costs, and limited opening hours of ART centers.

Very few women were aware of any treatment for HIV that reduces the risk of spreading the infection. Only 7 percent of women reported that a health provider informed them about drugs for HIV.

When asked about ART in particular, only 2 percent or 10 out of 492 women said they were aware of ART. The qualitative interviews indicated that there was also poor knowledge of ART services among HIV positive women. They were dependent on the local NGOs to provide them with information. A positive woman noted:

"We know the availability of that medicine only at Berhampur through the staff of ARUNA."

During qualitative interviews, the HIV positive men said that they received detailed information about the medications and messages on positive prevention from the ART centers. The positive women were generally not aware of ART centers as they did not accompany their husbands to the centers. Although the only female informant that was on ART appeared to be satisfied with the health providers in the district hospital where she went to collect

ART, she also reported that the provider only talked to her husband about HIV while she was not provided with any information.

Adherence to ART may not be optimal due to missed follow up visits. According to a member of Orissa State AIDS Society, discontinuation of ART is high among women because they fail to keep up with their medication when their husband dies. This is probably due to the high travel costs, as ART is available only at select district hospitals and due to lack of family support and restricted mobility. Additionally, the hours for which the ART centers were open were not suitable for many women and were often the reason for missing follow up visits.

“Regular functioning of ART is an issue in the state. It closes at 2.00 pm. When patients come from remote villages, travelling a long distance, they reach ART centers after 2.00 pm and by that time the center closes. They feel frustrated and go back home and don’t feel like coming again and spending money on travel. Many times the medicines are not in supply, and then sometimes doctors are not available. ART needs 24X7 doctors availability, which is yet not possible here. Timings of ART center at times are not suitable for all beneficiaries. Many patients miss out follow-up visits.”

Spousal communication around HIV was limited by women’s trust in their husbands, and for HIV positive women, by their husband’s unwillingness to discuss the source of infection.

Only 20 percent of the women surveyed had ever discussed HIV with their husband. As shown in Figure 2, the major reason for not discussing HIV was that they trusted their husband, followed by women who did not feel at risk. Few said it was because their husband would get violent.

However, during qualitative interviews with HIV positive women, we found that when women attempted to talk with their husbands about how they got infected, they were met with either silence or abuse, as cited in the following quotes:

“When I asked about it to my husband he said God knows how it has happened. First when I asked him he was very angry with me. He would abuse me verbally and intended to beat me as well. Because he was weak, he could not do much. Then people in Bombay also told me that he cannot live for more days so I stopped asking him anything further. Anyways whenever he is angry, he becomes more violent and that time I kept quiet.”

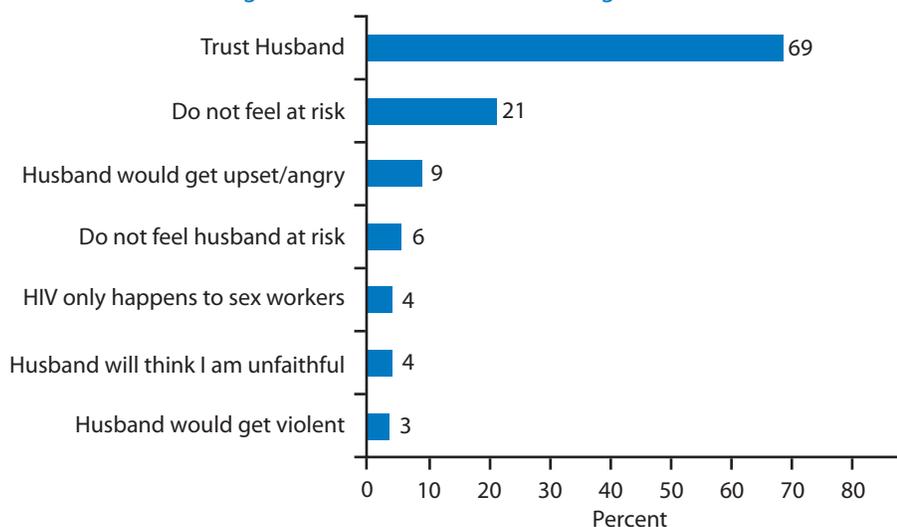
Another woman reported:

“I asked my husband about this but he did not talk to me in this regard. We do not know how the disease came to our body. We are simple villagers. How could we know about it.”

Lack of spousal communication was further intensified by an absence of partner counseling in ICTCs as well as social norms that compelled health educators to talk to women in their households only in the absence of their husbands, as reported by one Link worker,

“Couple counseling is not happening properly in Ganjam district because of husband’s migratory status. In ICTCs also when wife comes husband does not come and vice versa. There are rare cases where both husband and wife come

Figure 3: Reasons for not discussing HIV with husband



together for counseling to the ICTC. When the NGO workers go and counsel the PLHIV in the village, they counsel the women in the absence of husband, otherwise the husband will become furious and can beat (their wives) thinking what nonsense they are talking to my wife.”

Structural Issues: Stigma and Discrimination, Violence and Social Support

Stigma and discrimination is a major barrier to accessing services for people living with HIV. Qualitative findings from our study highlighted the various dimensions of stigma and discrimination that wives of migrant men perceived and experienced.

HIV-positive women experienced a range of stigmatizing attitudes and behaviors, and consequently feared disclosure of their status.

Community based stigma manifested in the form of social exclusion. Villagers stopped interacting with HIV positive families, even refusing help in some cases. As shared by one HIV positive woman:

“All the villagers knew about our disease. For this only, they do not want to keep relations with us. No one talks to us or comes to our house. Everybody in the village, all tell us that if they will keep relations with us, then the disease will be spread to them. No one behaves properly with us. We don’t get any help from the village people. When we need some financial help then we have to depend upon the outsiders of the village. No one comes to our help for any emergency as well.”

It becomes expedient on the part of the infected women to keep their status hidden in order to avoid discrimination from the community, as well as not to lose a source of income:

“As I am the daughter in-law of this village, I cannot go out to work. I have these products – bangles, artificial jewelry, toys for children here – I sell these products. This is our income. Women from the village come here, as they know I do not have HIV. Whenever he is at home, no one comes. He goes out to work daily and in the day time, women come to buy these products.”

Women also expressed their fear of being identified as HIV infected due to the presence of interviewers which may be interpreted by the neighbors as people from HIV NGOs:

“Nobody in the village knows about our disease. You have come to my home. After your departure when my neighbor asks me about you I will convince them that you are from a finance agency & came to our home regarding sanction of loan for our business.”

HIV positive women were often blamed for bringing the disease into the family, impeding their access to property and health services.

The suffering of HIV infected women after the death of their husbands was described by a member of a positive people’s network functioning in Orissa who reported that these women were denied all rights on their husband’s property and most were thrown out of the marital homes. At such a point, when a woman had no means to support herself, even her natal family sometimes refused to help.

One HIV positive woman, whose husband was negative, described how violence from her husband obstructed her from accessing health care:

“From the time of my first delivery during ANC I came to know from the doctor that I am HIV positive. But during my first child pregnancy, my husband was negative. After knowing my test result my husband behaved rudely towards me. From that time he has become depressed & started to take alcohol & cigarettes. You can see that I am inside the house and can’t go out. Now my baby is so young. My husband remains angry with me. How can I go out for any treatment?”

I just bear it... Always my husband asks me what is the cause of my HIV positive. He beats me as well for my status. I can not do anything. I have to listen and bear all these things."

Most of the time, women were blamed for the spread of HIV infection, according to a Link worker:

"Women get HIV (in the destination state) and husband brings her back to village and leaves her behind. Gradually women develop relationship with other young men in the village and HIV spreads. These kind of sex happen secretly mostly among the young man of neighbors or close family friends/relatives. Women exchange sex for pleasure or for any other help, but not for money. When a woman gets HIV, generally the blame goes to the women only. Jab aurat ko HIV ho jata hey, jadata log usko hi dosi mante hey (a woman is always blamed for her infection)."

Stigma affects the income potential of the family.

Disclosure of a positive status has a significant impact on the economic situation of the family. HIV positive people found it difficult to find jobs as nobody was willing to hire them. As one HIV positive man shared:

"By profession I am a carpenter, but because of my HIV status villagers don't give me jobs. I paddle cycle almost 15 to 20 kilometers every day to get jobs from nearby villages and some times work as a daily wage laborer."

HIV positive migrant men often returned to their villages after losing their jobs either due to discriminatory behavior of their employers or due to their deteriorating health. Once they were back in their villages, it was difficult for them to find jobs or retain jobs due to their ill health and decreasing ability to work. According to the wives of positive migrant workers:

"We are very poor and have had to face more difficulties for money because my husband is sometimes working and some times not. He sometimes goes for some agricultural work and most of the times he stays at home because doctor suggest him not to work at our fields. He has become too weak."

"We are in poor conditions; my husband does not get job on all days. People, who get to know of our HIV status, don't allow him to work on their site. He drinks and smokes a lot. So most of his earning is spent on that. I don't know what will happen ahead."

A lack of post exposure prophylaxis (PEP), health workers' fears of infection, and lack of privacy fosters stigma at health care settings.

Narratives of the women were full of reports of stigma and discrimination encountered in health care facilities. According to an HIV-positive woman:

"As I am having HIV, and after showing my test result the doctor refuse to provide any treatment to me. He just asked me to go to Gopalpur's Bahadurapintha hospital." [IDI, HIV positive woman, Ganjam, Orissa]

Due to the absence of PEP, doctors and nurses hesitated to attend to HIV patients. Lack of awareness and fear of infection contributed to stigma by health care providers. As related by an NGO worker:

"There is lots of stigma and discrimination at the Health center. Doctors do not respond to the HIV patients properly. More than what is in community. Patients are highly victimized here. Medical teams do not have access to PEP (post exposure prophylaxis) here, which is one of the reasons of them saying NO to providing treatments. But overall there is a lot of passive discrimination and general fear with no base."

An observation of a health facility by our investigators revealed that due to patient load, there was virtually a queue inside the doctor's room which rendered it impossible to maintain any privacy or confidentiality. Thus, this may be one of the potential ways in which the HIV status of a person gets disclosed to others at a health center.

Fear of identification keeps PLHIV from using government schemes.

Orissa has a scheme to provide Rs. 200/- per month to all PLHIV. People felt that their positive status would get disclosed to all villagers if they applied for the scheme and they would then face discriminatory behavior from them. The same was true of availing cheap transport facilities as PLHIV perceived that carrying a card, even though it held no information about their status, could identify them, which would lead to further stigma and discrimination. As an NGO representative and a member of an HIV positive network shared, respectively:

“People fear of getting identified while applying for Madhu Babu Pension scheme. So at times they hesitate to apply for such government beneficiary schemes.”

“It is impossible for poor women and especially from BPL families to reach out to the facilities. As the facilities are not so near to their residential areas, it’s too costly for women to come to the health centers for any activity. Also, disclosure of her illness is a major threat. The transport concession made by government for PLHIV does not work. People fear disclosure of their infection status would further hamper their reach to the health centers. They won’t go by public transport.”

Although their reach was still small, NGOs played key roles in HIV prevention, care, support and treatment efforts.

We found that NGOs played a significant role in creating awareness and providing support structures to people at risk as well as those living with HIV. However, their reach was limited as our survey results showed that only 7.5 percent of women were aware of any organization working to support women living with HIV in their area.

On the other hand while talking with NGOs we got to know that they are making huge efforts to reach out to the target population to create awareness and link them to relevant government facilities or schemes. As one NGO representative shared:

‘We reach out to all HIV positive families and provide information about HIV, link them with ART center, provide nutrition packets and also try best to link them with the Madhu Babu Pension Scheme.’

NGOs were working on the ground through different strategies to be able to create more awareness among people. An NGO representative noted that under NACO’s link worker scheme, they have recruited outreach workers at each gram panchayat. They have hired both males and females in neighboring gram panchayats so that they can work in teams and help each other to reach out to male and female groups.

NGOs were also working to provide livelihood opportunities to HIV positive families. NGOs were providing seed money to families to begin a new or expand their existing businesses, thereby helping positive people gain confidence and lead a healthy life.

With the mandate of targeted interventions, only migrant men were covered until now in HIV prevention and treatment efforts. This left out the men’s wives. Although HIV testing during pregnancy was instituted in ICTCs, we found that there were gaps in the provision of services in terms of HIV related information. Wives of migrant men who were not pregnant or were not likely to be pregnant would usually be left out of any intervention.

Conclusions

- HIV information and testing is yet to be universally accessed by the wives of migrant men. Slightly over a third of the surveyed women were informed of HIV testing as part of ANC and almost as many undertook the test.
- There is low awareness of STIs and treatment seeking is minimal among those who have experienced an STI symptom. Very little counseling is provided, nor is there any attempt to ask for a patient’s sexual history.

- Due to their low decision making ability, limited household income, and restricted mobility, women are constrained in accessing health care for STIs and ART. If the facility is at a distance, then cost of transportation also inhibits access.
- Pre-test HIV counseling that goes beyond encouraging a client to get tested is almost non-existent. Post-test counseling is somewhat better, particularly for those who test positive. But less than a fifth of women return to collect their test results.
- Although NGOs facilitate access to HIV testing, prevention methods, information, and treatment, their overall coverage is limited.
- Inequitable gender norms impact women's access to information, health-seeking behavior, and experiences of stigma. The fact that link workers prefer talking to women in the absence of their husbands points to deeply entrenched gender norms prevalent in the community.
- Perceived stigma is a major barrier in accessing social benefits such as travel concessions and pension schemes. The social and economic costs of being HIV positive are doubly borne by women. Fear of disclosure is a recurring theme in the qualitative interviews with positive women.
- The findings point to the need for interventions at the individual, health service delivery and structural levels.



Action Plan

Female Sex Workers

Objective 1: To improve consistent condom use among FSWs with clients and regular partners

Strategies:

- a. With FSWs the exiting program needs to address
 - i. Enhance knowledge of access point for male and female condoms among female sex workers
- b. With the Gharwalis (Madam/or in-charge of Brothel)
 - i. Involve Gharwalis into the TI programs to reach FSWs, especially younger women, and also build her capacity to be the focal point for HIV reduction program among this group
 - ii. Work with Peer Outreach Workers to build their capacity in negotiating with the brothel gate keepers to enable access to FSWs so that they can engage with them directly for prevention and awareness programs.
- c. Skill building on negotiating condom use for FSWs with
 - i. Clients
 - ii. Intimate male partners

Targeted Intervention Partner: To address these components the TIs need to build the component of building capacity of Gharwalis and also strengthen the role and capacity of Peer Outreach Workers in the existing program.

NACO & SACS: Modify and rework on the component of Peer led program initiatives under the National HIV program.

Objective 2: Increase the awareness, prevention and treatment seeking for STIs among FSWs.

Strategies:

- a. Counselor and counseling process
 - i. Recruit trained counselor and provide in-service training on STI prevention among sex workers especially secondary prevention
 - ii. Group counseling sessions on recognizing signs and symptoms of STIs and prevention at clinics while women are waiting to see a doctor
- b. Involvement and training of Health service providers
 - i. Sensitization training doctors at private clinics on STI prevention and emphasis on secondary prevention (condom use with clients and partners)

Targeted Intervention Partner: To address these components the TIs need to build the component of building capacity of the counselor and engage them in every aspect of the program intervention.

NACO & SACS: In-service training program for Health professionals and counselors through NACO and SACS

Objective 3: Enhance knowledge about risk assessment among FSWs on STI and HIV

Strategies:

- a. There needs to be dialogue about risk assessment with
 - i. Different sub-group of female sex workers
 - ii. Most vulnerable groups

Targeted Intervention Partner: To address these components the TIs should build capacity of the NGOs & CBOs at the grass root level who works with this population group.

NGOs & CBOs: NGOs and CBOs should conduct program with peer educators and FSWs to make them aware about risks related to sex work and HIV and STI. Individual level dialogues needs to be established between peer educators and FSWS on a regular and sustained basis.

Objective 4: Improve correct knowledge of HIV testing and enhance HIV testing services for women

Strategies:

- a. Skills of providers and counselors around consent and confidentiality and privacy component needs to be enhanced as that is a deterrent for seeking services for sex workers
- b. Strengthen role of post-test counseling especially on disclosure if positive
 - i. At the clinic level
 - ii. Peer outreach workers
 - iii. Messages on prevention need to be reinforced

Targeted Intervention Partner: Peer outreach workers and ICTC counselors training on confidentiality, consent and privacy.

NGOs & CBOs: NGOs and CBOs should conduct program with Peer educators around confidence building and provide social support to FSWs

NACO: NACO need to make it mandatory for all TIs to adopt their guidelines.

Objective 5: Increase awareness around ARTs (HIV treatment) and encourage positive FSWS to be compliant with ARTs

Strategies:

- a. In all testing sites group sessions on ART and adherence needs to be implemented with FSWs involving health providers and para health service providers

- b. To provide better services and follow-ups with the positive FSWs
 - i. Strengthen the role of counselor on ART and adherence
 - ii. Strengthen the role of peer outreach workers on treatment monitoring
- c. Discontinuity of ART due to fear of loss of job
 - i. Fear of disclosure and adherence due to absence from brothel to get the ART services. Need to identify a treatment supporter for brothel based FSWs
- d. Getting ARTs has a time costs and services are at a distance for FSWs thus enhance the role of NGO run clinics that provide HIV testing services with ART centers for refills of ART for positive FSWs

Objective 6: Reduce economic vulnerability of FSWs

Strategies:

- a. Introduce or make functional the saving schemes for FSWs with banks
- b. Enhance access to government saving and loan schemes as well as life insurance schemes
- c. Explore SHGs involvement for FSWs in brothel and non brothel set-ups through NGOs
- d. Introduce medical insurance scheme for FSWs

NACO: NACO need to identify NGOs specialized in each category and strategically link them with the TIs.

Objective 7: Non-brothel FSWs

Strategies:

- a. Outreach workers from the same community need to be engaged and not necessarily who are in the same profession
- b. NGO/CBOs who provide varied services in the community needs to be included as partners and HIV services should be integrated in their existing programmes
- c. Mainstreaming HIV services for this group of women in the general health system which will reduce stigma
- d. Adopt best practice methods to increasing coverage to non brothel based FSW, by linking private health facilities with HIV prevention and treatment programmes

Targeted interventions: Outreach workers from same community need to be included. Linkage with private facilities in providing HIV prevention and treatment services

NGOs & CBOs: Local agencies working in different development spheres need to integrate HIV into their programmes

Wives of Migrant Men

Objective 1: To increase HIV prevention coverage including HIV testing among wives of migrant men

Strategies:

- a. Expand and strengthen ASHA, Anganwadi workers, Multipurpose workers programmes in order to improve linkages with ICTC, ANC and anganwadu centers
 - i. Examine particular challenges faced by NRHM workers in delivering services and address these challenges
 - ii. Follow up training on HIV/AIDS, STD, RTI to be conducted with NRHM workers on a regular basis
- b. Integrate ICTC in anganwadi centers and sub centers
- c. Evaluate link worker scheme
- d. Scale up NGO interventions so that more geographical area is covered
- e. Expand TI among migrant men to include their spouses and partners

NRHM & NACO: Better integration and instituting systems of monitoring and supervision of NRHM workers in HIV service delivery

NGOs & CBOs: NGOs and CBOs should have scale up plans built into their intervention. Increased advocacy to government to increase coverage

Objective 2: To improve quality of pre and post-test counseling

Strategies:

- a. Evaluation of current counseling process/methods/content
- b. Supervision and recurring training of ICTC counselors
- c. Content of counseling to include positive prevention, treatment literacy, partner disclosure
- d. Focus on couple counseling
- e. Ensure privacy of counseling environment
- f. Ensure national guidelines of NACO followed when mainstreaming into general health services

Targeted interventions, SACS, NGO and private hospital: ICTC should be strengthened in terms of improvement in quality of counseling- counseling content and material, staff strength, counseling environment.

NACO: NACO should ensure that national guidelines are followed by all ICTC.

Objective 3: To empower women, as well as to strengthen HIV and STD service delivery in order to promote safe behaviors, to increase women's access to knowledge of HIV/STI and to health facilities, and to reduce drop out rates.

Strategies:

- a. Gender sensitization along all levels of policy making and service delivery

- b. Gender mainstreaming in HIV programmes so that the unique position of women in terms of control and access to resources is understood and addressed, in order to achieve the goals laid out in NACP III, namely to halt and reverse the spread of HIV among women and girls, and to provide equitable access of services to women
- c. Focus on Couple counseling in order to encourage spousal communication and mutual decision making in terms of safe behaviors
- d. Decentralize STD facilities in order that women can easily access and avail of STD diagnosis and treatment without having to travel to district hospitals
- e. Train doctors in STD facilities to provide information and counseling and /or link STD departments with ICTC to provide information

NACO: NACO should provide leadership in introducing/continuing gender sensitization and gender perspective in the design and planning of its programmes.

SACS: Training on gender dimension of HIV should be provided to all workers including outreach and link workers

NGOs & CBOs: Community based campaigns on gender norms should be conducted

ICTC both private and public: Couple counseling should be encouraged and the role of men as equal partners in responsible decision making should be ensured

MOHFW, NACO, STD department in district hospitals: National guidelines on STD diagnosis and treatment protocol should be followed. STD facilities need to be decentralized to CHC level.

Objective 4: To reduce economic vulnerability of women so that they have improved access to HIV prevention and treatment services

Strategies:

- a. Expand current SHG to cover more wives of migrant men and other vulnerable women
- b. Adopt best practices of local NGOs in income generation schemes
- c. Ensure HIV positive women avail of pension schemes and travel concessions so that it reduces their economic burden

Ministry of Rural Development, NACO, SACS: There should be convergence with MRD in order that SHG be expanded and secured for vulnerable women

NGOs: Advocate for scaling up income generating schemes among positive people. Conduct community based stigma reduction campaigns so that positive women can avail themselves of government schemes

Objective 5: To reduce stigma and discrimination at the family, community, and health care setting.

Strategies:

- a. Stigma reduction intervention in the community and family through mass media campaigns
- b. Stigma reduction intervention in health care settings through workshop sessions and adoption of hospital policies around stigma reduction
- c. Self stigma reduction interventions among PLHIV through awareness campaigns, workshop series with PLHIV focusing on building self esteem skills, and income generating schemes to promote economic independence

- d. Ensure that Universal Precaution guidelines prepared by NACO are disseminated to all health settings and followed.

NACO: There should be a Stigma Reduction Strategy that provides guidelines on standards of care at health care settings, innovative stigma reduction campaigns in community settings and working with PLHIV groups.

NGOs & CBOs: Conduct stigma reduction campaigns in community and family settings

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