



Understanding Barriers to Sexual & Reproductive Health for FSW

**An SRH Needs Assessment
among Female Sex Workers
in Andhra Pradesh, India**

Executive Summary

About India HIV/AIDS Alliance

India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organisations and communities to support sustained responses to HIV in India. Complementing the Indian national programme, we work through capacity building, knowledge sharing, technical support and advocacy. Through our network of partners, we support the delivery of effective, innovative, community based HIV programmes to key populations affected by the epidemic.

Our Vision: A world in which people do not die of AIDS.

Our Mission: To support community action to prevent HIV infection, to meet the challenges of AIDS and build healthier communities.

With support from the Bill & Melinda Gates Foundation, the India HIV/AIDS Alliance is implementing the Avahan programme in Andhra Pradesh that aims to reduce prevalence of HIV and sexually transmitted infections (STI) among female sex workers (FSW) and men who have sex with men (MSM) through behavior change communication, promotion of safe sex practices and provision of STI treatment using peer approach. While effective in addressing vulnerability to HIV and other STIs, these interventions do not directly address sexual reproductive health (SRH) needs of FSW.

A qualitative research study was conducted by Alliance through focus group discussions with 144 FSW in Andhra Pradesh (AP) to identify their SRH needs. The focus group discussions were conducted after getting written consent from the participants.

The major findings of the study are: condom use was low with regular partners; significant number of participants had unprotected anal sex; misconceptions about condom use existed; forced sex, harassment, demand for free sex and group sex by local rowdies, auto drivers, and the police were common; unintended pregnancies were common, even when a third of respondents reported use of oral contraceptives; self-induced abortions with post-abortion complications were also common; and only a third of the respondents felt they have the right to make decisions related to their pregnancy.

There is a need to provide services beyond STI and HIV prevention and treatment, including those related to dual protection and contraceptives, safe abortions, and safe pregnancy. Establishing good linkages with service providers and advocating with key stakeholders to create an enabling environment are essential for better access to SRH services by FSW.



Background

Female sex workers (FSW) face considerable vulnerability to STI and HIV infection due to their occupation, social marginalization, and lack of control over condom use.¹ They also lack access to information and services due to actual or perceived fear of rejection, stigma and discrimination by health care providers. The same factors also make them vulnerable to unintended/unwanted pregnancies, resulting in high rates of abortion.^{2, 3}

With support from the Bill and Melinda Gates Foundation, the India HIV/AIDS Alliance has been implementing HIV and STI prevention interventions for key populations such as female sex workers (FSW), men who have sex with men (MSM), and transgender populations in Andhra Pradesh. Interventions have focused on STI control through treatment, condom use, promotion of safe sex practices, and behaviour change communication. Community centered STI clinics, called Mythri clinics, were set up to provide services related to STI, HIV, counseling for risk perception and risk reduction. The programme currently does not address broader sexual and reproductive health needs of the key population (KPs) such as family planning, screening for cervical cancer, safe abortion, and maternal and child health services.

Anecdotal evidence from the field points to unmet sexual and reproductive health (SRH) needs and vulnerability among FSW. As Mythri clinics provide a platform for integrating SRH services into existing HIV/STI services, the India HIV/AIDS Alliance undertook a qualitative study to identify SRH needs of FSW.

Study Objectives

The purpose of the study was to identify the SRH needs of female sex workers.

Specific objectives of the study were:

- Identify the SRH needs (access to information and services, knowledge levels, practices, etc) of FSW, including HIV-positive FSW.
- Determine factors that contribute to increased vulnerability and rights violation of FSW with regard to SRH.
- Determine barriers to access to SRH services by FSW.

1 WHO, HIV technical briefs, Strengthening linkages between Sexual and Reproductive Health and HIV, April 2007.

2 Convergence of HIV and SRH Services in India Impacts on and implications for key populations. Path Convergence Project, Jan 2007.

3 Morineau G, Neilsen G, Chancy P et al. Falling through the cracks: addressing the reproductive health needs of female sex workers. IXth International Conference on AIDS in Asia and the Pacific, Bali, Indonesia, 9-13 August 2009.



Methodology

A qualitative study was conducted in June and July 2011 in five districts of Andhra Pradesh (Ananthapur, Chittoor, Nalgonda, Khammam, and Karimnagar) where the India HIV/AIDS Alliance is presently implementing the Avahan programme. A total of ten focus group discussions (FGDs) – in two sites in each of five districts – and one-to-one interviews with Mythri service providers were conducted and documented by the Alliance team. Each FGD consisted of around 15 participants, resulting in 146 participants in total whose age ranged from 22 to 46 years. Site selection was purposive and was based on the number of young sex workers, a mix of rural and urban sites, and a mix of static (project owned clinics) and referral clinics (STI/RTI services provided to FSWs at the nearest public health centers, community health centers, area hospitals or available private clinics).

Participants were randomly selected from the line lists of the project, covering a range of sub typologies (street based, home based, brothel based, and lodge based sex workers). A list of 30 unique ID numbers was generated of which the first 15 were identified for participation in each FGD. Street based, home based and brothel based sex workers were proportionately represented in the study sample.

A questionnaire, developed by the Alliance team and pre-tested in Miryalguda in Nalgonda district, was used to conduct FGDs and one-to-one interviews. The questionnaire covered areas such as the knowledge levels and practices of the community regarding basic health issues, particularly relating to family planning (commonly used contraception to avoid unwanted pregnancies and birth spacing), safe abortions, institutional deliveries and menstrual hygiene, STI/HIV, access to SRH services and information, and factors that increase the vulnerability of FSW and lead to violation of their SRH rights.

Interviews were conducted with seven doctors from Mythri clinics on the following key issues:

- Level of comfort and capacity in providing services to FSWs for the most common SRH related issues other than STIs
- Practices used for referrals for various SRH needs (including safe abortions, health and nutrition support for newborns and mothers, pre- and post-natal care and contraception)
- The most common SRH-related issues treated in the Mythri clinics (physiological, pathological, lack of personal hygiene, sexually transmitted infections)
- Their recommendations for improving the services provided in the Mythri clinics to address SRH issues

Written informed consent was taken from all the participants before conducting FGDs and interviews. The respondents were informed about the purpose of the study, and were assured of confidentiality. They were also informed that they could refrain from answering any questions if they were not comfortable answering them.



Major Findings

Menstruation

More than two-thirds of respondents were aware that vaginal discharge and a burning sensation during urination could be caused by infections related to lack of personal hygiene. However, awareness on personal and menstrual hygiene was not universal.

About a fifth of the respondents reported problems related to menstruation including irregular cycles, menorrhagia, dysmenorrhea, and pain during sexual intercourse. The majority of respondents were aware of hygiene practices to be taken during menstruation and reported frequent changes of sanitary pad/cloth to maintain hygiene. Nearly a fourth of the respondents reported using cloth during menstruation. Those reusing cloth were aware of the need to wash it with warm water and soap, to dry it in the sun and to store in a clean place. A few respondents reported suffering from pain or lumps in their breasts and reported knowing incidents of abscesses among other sex workers.

Majority of them mentioned they do not get time to clean the vagina after sexual intercourse, especially if the sexual act happens in the street or in open area, as they do not have toilets and water available at these sites. During home or lodge-based sex work, water, soap and in a few cases, Dettol are used for cleaning between sexual intercourse. Douching practices were not reported by any respondent.

The majority of the respondents reported receiving hygiene-related information from peer educators and outreach staff of the Avahan programme. Khammam district was an exception, where women reported receiving this information from government clinics. Overall, the respondents from this district appeared to be more comfortable accessing information from government hospitals.

Sexually Transmitted Infections (STIs)

The vast majority of respondents had adequate knowledge of STIs and related symptoms, their transmission, prevention and treatment. They preferred consulting peer educators or outreach workers and sometimes the clinic ANM for information on STIs. All respondents were aware of the Mythri clinics and the STI-related services provided there. Almost all respondents preferred seeking services from the Mythri clinics for STI/RTI related issues as compared to other available services.

Around one-fifth of the respondents reported STI-related symptoms in the last three months. Symptoms experienced included vaginal cervical discharge and occasional genital sores. Service providers confirmed that the most common STI symptoms observed among FSW were vaginal cervical discharge and lower abdomen pain. Very few cases of genital ulcers were seen and were mostly viral (herpetic).

The most common issues reported by the community, other than STIs, were delayed, prolonged, painful periods and severe myalgia; one case of cervical cancer was reported two years ago and the patient expired due to delayed diagnosis.



“I had to agree to unprotected anal sex by my client because he was paying me more.”

Radha, a 30-year-old home-based sex worker

Condom Use

Most of the respondents identified regular condom use as a method for protection from unwanted pregnancy as well as STIs. However, only three-fourths of the respondents reported consistent condom use with their clients. Condom use with their regular sexual partners was reported by very few participants. Women in Godavarikani and Nalgonda districts reported having anal sex, often against their own liking, following the request of clients. About a third of respondents in these sites reported having anal sex without using condoms. Women reported experiencing forced and group sex, which made negotiations for condom use hard. More than half of the respondents also reported consuming alcohol before having sex with clients. In some cases, the clients forced them to consume alcohol and forced them to have sex without a condom. The sex workers also experience violence by clients at times, especially when the clients do not want to pay the sex worker for her services.

While more than half of the respondents identified the female condom as useful to avoid unwanted pregnancies and STIs, others reported difficulties with the use of female condoms, including pain, burning sensation and bleeding. Overall, approximately 10% of respondents reported using double condoms, showing there are misconceptions about correct condom use.

“I was taking contraceptives without medical advice, never knew OCPS can lead to health hazards.”

Chinni, a 32-year-old rural sex worker

Contraceptive Use

Respondents had knowledge of various contraceptive methods, including condoms, oral contraceptive pills, and intrauterine contraceptive device (copper-T). Two thirds of the respondents were aware of the emergency contraceptive pill (through advertisements on TV), but did not show awareness of related side effects.

Oral contraceptive pill (OCP) was the most common method of contraception used to avoid unwanted pregnancies. Most respondents reported not using condoms with their regular partners, and only five of the respondents reported using copper-T. Even though respondents were aware of the copper-T, its use appeared overall to be low due to side effects, including excessive bleeding and pain during sexual intercourse. Only four respondents identified surgical methods as their preferred contraception. This is a significant finding because tubectomies are common in AP – 60% of women over 25 years of age in AP who want to stop childbearing have undergone a tubectomy.⁴

Service providers also stated that the demand for oral contraceptive pills is high. While the Mythri clinics currently cannot provide OCPs directly, doctors can prescribe them. They also noted that in many cases, women have requested OCPs after having already experienced an unintended pregnancy and an abortion (often with home remedies).

4 DLHS3, Survey for 2007-08, Ministry of Health and Family Welfare, Government of India



Maternal Health (including Safe Abortion)

A third of the respondents said that they had the right to, and that they could plan well, their pregnancies. However for more than half of the study participants, the decision did not lie with them but with their husband and other family members.

Unintended/unwanted pregnancies were common, reported by nearly one third of the respondents. Most of them have resorted to abortions in these situations, sometimes repeatedly. Two respondents reported having had 4-5 abortions in a period of two years. Post abortion complications, including continuous bleeding for more than two months and lower abdomen pain, were frequently reported by the respondents. Around 10% of all abortions were self-induced at home after consulting only a pharmacist (using pills for medical abortion) or using plant extracts or some other home remedies.

Many women reported consulting a doctor only when they developed post-abortion complications. Respondents who could afford to go to a doctor preferred private doctors. Government hospitals were not the facilities of choice for abortion as consent of the husband or a relative is a must for carrying out the abortion procedure. Respondent also reported being ill treated, including denial of services by the doctor and other staff in the government clinics because of their sex work.

Service providers in the Mythri clinics shared similar information by stating that sex workers seek guidance in the case of unwanted pregnancies and are referred to private hospitals, easily accessible to FSW.

All those respondents who had had a child in the last three years reported consulting a doctor at least once during the nine months of pregnancy and had safe and institutional deliveries.

Access to Information and Services

Outreach workers, peer educators (PE) and Mythri clinic doctors were identified as preferred sources of information on SRH-related issues. STI services were availed by all from the Mythri clinics. More than two-thirds of the community members were aware of government and private health care facilities in the area. Pre- and post-natal care and delivery services were accessed from government health facilities while private facilities were preferred for services like abortion and family planning. Proximity of the service provider to the hotspot was an important factor for FSW's choice of provider. However, respondents also mentioned that they were not very comfortable going to the government clinics as the staff there were rude and insensitive towards sex workers. In some districts, respondents specifically identified the fear of breach of confidentiality as a reason for not accessing government hospitals.

Violence

Most of the respondents reported experiencing forced sex and harassment, demand for free sex, and experiences of violence by police, local rowdies and auto drivers. Instances of group sex were also reported.

Respondents mentioned that incidents of violence were being addressed by a Core Advocacy Group, community members who are trained to handle at the hot-spot level.

“When I became pregnant, I took medicine from the local pharmacy to get rid of it. That resulted in complications. Finally, a Mythri PE helped me.”

Lakshmi, a 26-year-old urban sex worker



“In spite of all the advocacy efforts we are still facing forced and group sex, especially from the police.”

A respondent from focus group discussion

Conclusions

The study clearly demonstrates that there are gaps in information and services related to sexual and reproductive health needs of FSW. Even after exposure to HIV programming to which STI treatment and condom use are central, safe sex remains elusive. There is hardly any condom use with regular partners and gender inequities make it difficult to negotiate condom use. The situation is further compounded by violence, forced sex and police harassment. Condom is seen as protection from STIs only. Oral pills are preferred for preventing unintended pregnancies, though most FSW are unaware of potential side effects of the pills. The discrimination faced in government clinics and the judgmental attitudes of service providers are barriers to accessing quality SRH services and need to be addressed immediately.

Recommendations

Improve access to information on SRH issues

In HIV prevention programmes, the information provided by PEs to FSW during their one-to-one or one-to-group meetings should also include information about contraceptive options, emphasizing consistent and correct use of condom as the ideal method of prevention for both STIs and unintended pregnancies. In addition, information on correct use of female condoms, access to pills, their side effects and implications of their long-term use, and on post-abortion complications needs to be provided.

Use peer educators and outreach workers as main source of information on SRH-related issues as FSW feel comfortable discussing their needs with them. Mythri clinic doctor and nurse should provide more information about contraceptives, maternal and newborn health, and safe abortions through IEC materials that specifically address the needs of key populations. In rural settings, the National Rural Health Mission (NRHM) Accredited Social Health Activist (ASHA) workers could be a good source of information on SRH.

Strengthen linkages between SRH and HIV services

Linkages with other health facilities should be strengthened to provide comprehensive SRH services through appropriate referrals from STI clinics. Sensitize and train medical officers on KP issues to ensure stigma free KP-friendly services since FSW clearly are wary of accessing at government facilities.

Advocate with key stakeholders on creating enabling environment for SRH needs

To promote consistent condom use and increased uptake of services, provide congenial supportive environment. More emphasis must be laid on advocacy efforts to continue involvement of key stakeholders such as police, service providers, media, legal service authorities and other line departments for vulnerability reduction.

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