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Behavioural changes of women in sex work in Kolar District

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ABSTRACT

India is a country with low HIV prevalence; it has the third largest number of people living with HIV/AIDS. The Indian epidemic is concentrated among vulnerable populations at high risk for HIV. The concentrated epidemic is driven by unprotected sex in female sex workers, men who have sex with men, and injecting drug use. Karnataka state with an adult HIV prevalence of approximately 1% in several districts ranks in the top four states in India with regard to epidemic severity. Heterosexual contact is the main route of transmission, with commercial sex work a key area of concern. The line listed universal is 1376 Female sex workers out of which data collected from 257 FSWs.

Age is a critical criterion in the profession of sex work. 46 percentages of women are in 36-55 years of age. The sex work is a never ending process in the society and along with the general population, number of women in sex work also in progressing trend. Educational qualification is an important indicator to measure the social layers. It can be an important influence for female sex workers to get into the profession which is evident from the findings of this study as majority (46.69% percent) of the respondents reported is illiterate. Studies show that the women with STIs are prone to get infected with HIV. The women have been motivated by her Peer educators to undergo the STI screening once in three months to diagnose the STIs with or without symptoms and treated by a qualified doctor. As a result of early diagnosis and the complete treatment of STIs the STIs have come down in these women after a period of time.

The profession has demand only till the women gets in to forties and then she has to survive without any income in her old age. In the long run the women also thought about the savings as they get older there will be no income through sex work to survive. Hence they started savings and small loans and finally linked with many nationalised banks. Currently the women are receiving loans for their children education, children marriages and income generating activities etc. Thus these groups made them self-sustain, gave more power to advocate with different stake holders and also formed the Community Based Organisation to become professionally unite and to manage them.

Keywords: Behaviour, Kolar, Sex work, Sex worker, Women

INTRODUCTION

India is a country with low HIV prevalence; it has the third largest number of people living with HIV/AIDS. HIV epidemic in country like India is concentrated in nature and heterogeneous in its spread. The HIV prevalence among Female Sex Workers is about 18 times higher than the general population (NACO annual report 2017).

According to WHO, An estimated 0.8% of adults aged 15–49 years worldwide are living with HIV in 2018, although the burden of the epidemic continued to vary significantly between several countries and regions. Sub-Saharan Africa rests most severely affected, with closely 1 adult in every 25 adults living (3.9%) with HIV and accounting for over two-thirds of the people living with HIV worldwide.

Based on HIV Sentinel Surveillance 2017, it is estimated that India has an adult prevalence of 0.22 percent with 21.40 lakh people infected with HIV. The estimates highlight an overall reduction in adult HIV prevalence, HIV incidence (new infections) as well as AIDS related mortality in India.

The Indian epidemic is concentrated among vulnerable populations at high risk for HIV. The concentrated epidemic is driven by unprotected sex in female sex workers, men who have sex with men, and injecting drug use. It is estimated that there are 7.76 lakh Female Sex Workers, 2.65 lakh Men who have Sex with Men with high risk behaviour and 1.51 lakh Injecting Drug Users in India. Sex work continues to act as the most important source of HIV infection in India due to the large size of clients who get infected from sex workers. Clients of sex workers further transmit HIV infection to general population particularly low risk women.

In India, women account for 8.79 lakhs out of 21.40 lakhs estimated number of people living with HIV/AIDS. Their heightened vulnerability has both biological and socio-economic reasons. Early marriage, violence and sexual abuse against women are the major socio-economic reasons of their vulnerability to HIV infection (NACO HSS 2017). Their biological construct makes them more susceptible to HIV infection in any given heterosexual encounter.

The major drivers of HIV epidemic in Karnataka are Female Sex Worker, Men who have Sex with Men

and to small extend Injecting Drug User. There are 1, 37,180 FSWs, 40603 MSM and 2147 IDUs registered under various targeted intervention programmes in Karnataka (NACO annual report 2018).

India was estimated to have 21.4 lakh people living with HIV in 2017. HIV stands for human immunodeficiency virus. HIV is a virus that attacks on immune system, which is our body's natural defense against any illness. The virus destroys white blood cells in the immune system called CD4 cells. As HIV destroys more CD4 cells and makes more copies of itself, it gradually weakens a person's immunity system. This means that someone who has HIV, and is not on treatment, will find it harder to fight with infections and diseases.

Karnataka state with an adult HIV prevalence of approximately 1% in several districts, ranks in the top four states in India with regard to epidemic severity. Heterosexual contact is the main route of transmission, with commercial sex work a key area of concern.

In India it is estimated that the number of FSWs as 7.76 lakh in 2019. In Karnataka state recent estimates shows that 37,180 FSWs in 2019, with almost an equal proportion of FSWs in urban and rural areas.

HIV prevalence is 7 or more times higher among various risk groups: 1.56% among female sex workers (FSWs) according to HSS 2017. HIV prevalence among FSWs in Karnataka has come down from 14.4 in 2003 to 5.1 in 2010 and reduced to 3.33 in 2017.

Though Kolar has been labeled as an "A" category district by NACO, the prevalence in ANC population continuously for 4 years (surveillance data) has been below 1%. In 2007, the prevalence dipped to 0.38%. In 2008, the ANC prevalence is 0.5% and by 2017 the ANC prevalence is 0.07%.

Provision of health services related to STI/RTI care services is a very important strategy to prevent HIV transmission and promote sexual and reproductive health under the National AIDS Control Programme (NACP) and Reproductive and Child Health programme (RCH) of the National Rural Health Mission (NRHM). The project for reduction of transmission of HIV/STIs among Female sex workers (FSW) and their sexual partners was initiated by the NGO since 2004 covering FSWs across all Taluks of the district. The efforts to promote a local level institution to take over responsibility of its community's health needs were realized with the formation of small affinity groups at the site level, federations at taluk level and the registered CBO of FSW at the district level.

Objectives:

- To study the health seeking behaviour of women in sex work
- To study the services available and deficiencies of the services to the FSWs in Kolar district.
- To explore the vulnerability of family and self to get into sex work, Socio-Economic conditions of FSWs.
- To study the utilisation of the project services by the women in sex work

METHODOLOGY

This study comprised a line list data from April 2017 to March 2017 and qualitative data of discussions with the affinity groups of women in sex work in the kolar district. Unpublished mapping data is used for estimation of FSWs in the district by the donor and the implementing agency. The line listed universal is 1376 FSWs out of which data collected from 257 FSWs. The overall study was conducted in two phases; qualitative research and the quantitative research by using the questionnaires.

RESULTS

Profile of FSWs

Age:

Age is considered an important dimension in social profile. Age is also the critical criteria in the profession of sex work. The study has done with 257 women in sex work in kolar district of Karnataka. Among them 9 percent are in below 25 years of age, 40 per cent are in 26-35years of age, 46 percent are in 36-55 years of age and remaining are above 45 years of age. The Project has been working with the women for the last 10 years and more and more women are getting registered every year.

The sex work is a never ending process in the society and along with the general population, number of women in sex work also in progressing trend. The women in sex work most of them reside in rural areas, are married, mobile and have a small income-earning occupation, in addition to sex work. All these women visit urban areas due to several reasons out of which, one reason is to get the handsome income through sex work and the diversified urban society where the women can be anonymous. Most of these women are in 25-55 years of age group.

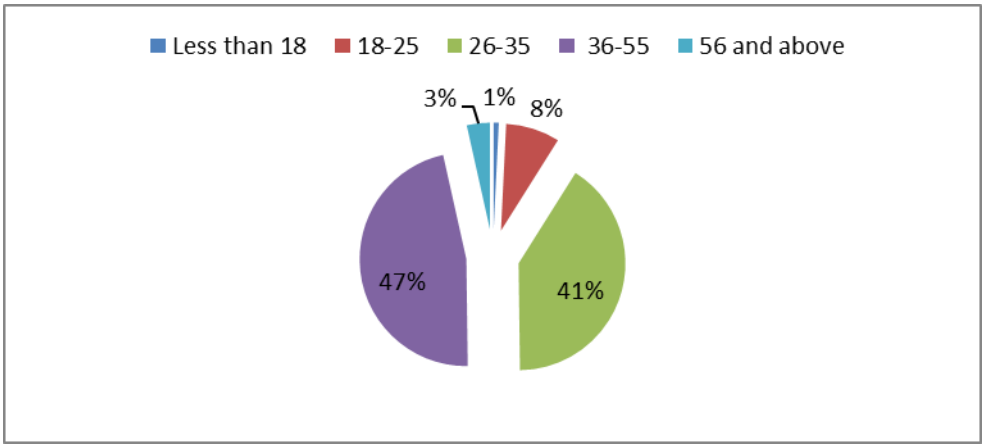

Fig1: Distribution of women by age

EDUCATION

Educational qualification is an important indicator to measure the social layers. It also decides the opportunities of employment for the individuals. Moreover it also defines the contextual and social space of the respondents. It can be an important influence for female sex workers to get into the profession which is evident from the findings of this study as majority (46.69% percent) of the respondents reported are illiterate and 34.24% reported that they have completed primary education while few 3.50% of them completed intermediate/+2 education.

The low level of literacy can be an interpretation of economic constraints within their families which could be the reason of many women and girls to join the profession of sex work, which is increasing with due course of time. It also restricts their access to various awareness supplies and facilities apart from the range of professional choices of the respondents. This in turn emphasizes the continuation in the profession of sex work. The level of their education may also impact the awareness of the respondents in terms of accessibility to the information regarding STI/HIV and care and support services, which are otherwise important for the prevention of the infection.

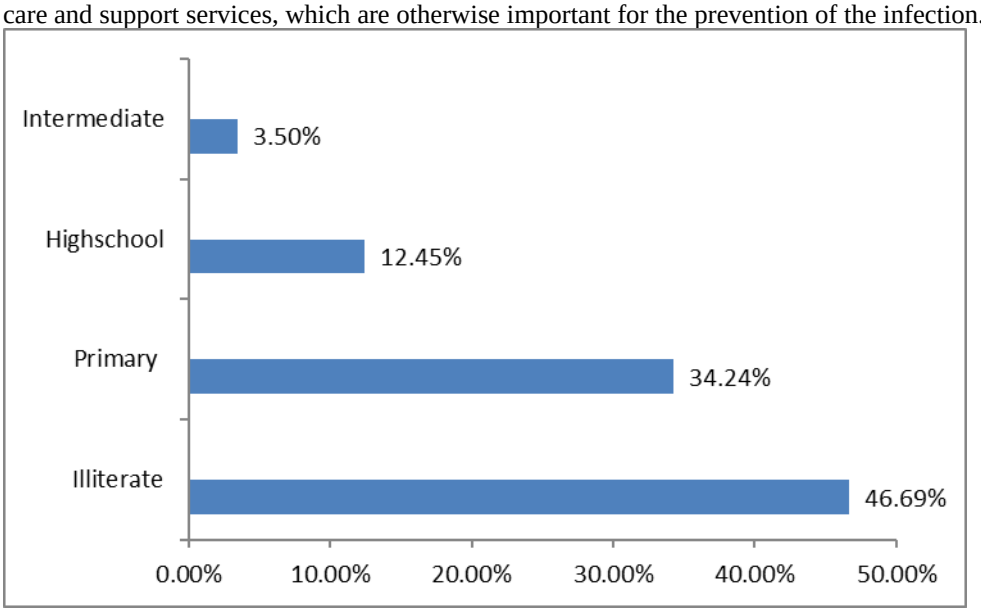

Fig 2: Distribution of women by education

INCOME

Income of the family is a measure to assess their financial status and social status as well. Many times income of the respondents itself could be an explanation of many factors like joining time in the profession and the reasons to continue the profession. Looking at the income of the respondents through the activity of sex work is seen that half (50.97 percent) of the respondents earn below 1000Rs per week i.e. Rs 143 per day on and average though they are commercial in nature. Only 1.17% respondents earn above 5000 Rs per week.

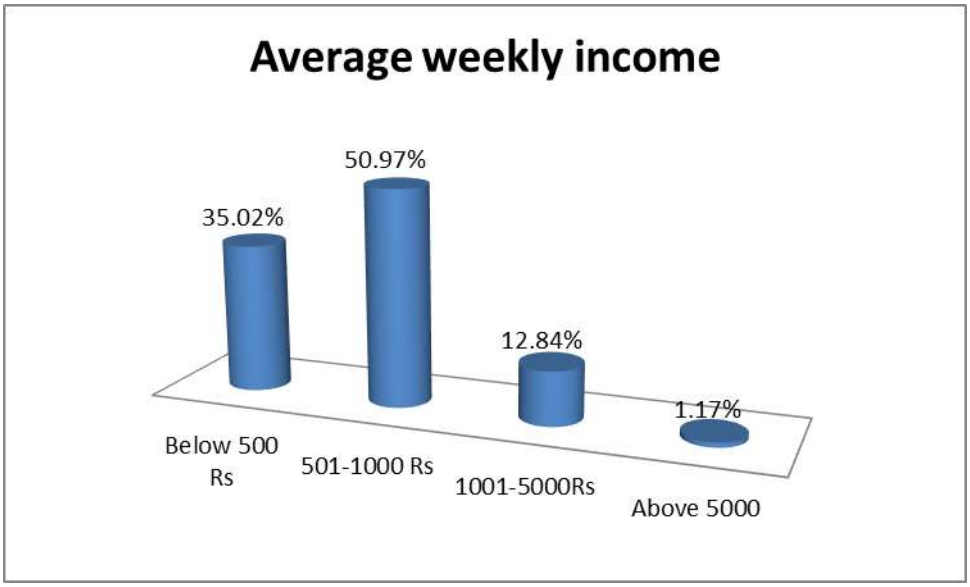

Fig3: Distribution of women by weekly income

HEALTH SEEKING BEHAVIOUR

The project is continuously working with the women in sex work from 2004 to till date. The women have undergone all the difficulties in the field and finally reached to a stage where they started perceiving their risk and their future about them and their family. The project is continuously outreaching to change the women behaviour in terms of their health and public health. The women were educated on prevention of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STIs) by educating them on consistent and correct condom use in each sexual encounter either with the paid client or unpaid client or the regular partner. In the process 10 private and government doctors were identified, sensitised and trained to treat the STIs among the women in sex work. Studies show that the women with STIs are prone to get infected with HIV. The women have been motivated by her Peer educators to undergo the STI screening once in three months to diagnose the STIs with or without symptoms and treated by a qualified doctor. As a result of early diagnosis and the complete treatment of STIs the STIs have come down in these women after a period of time. However the women are self motivated to go for the routine check up. Currently the women are very comfortable to go to the government hospital and tested themselves for any unseen STIs and demand for the proper care from the government set up.

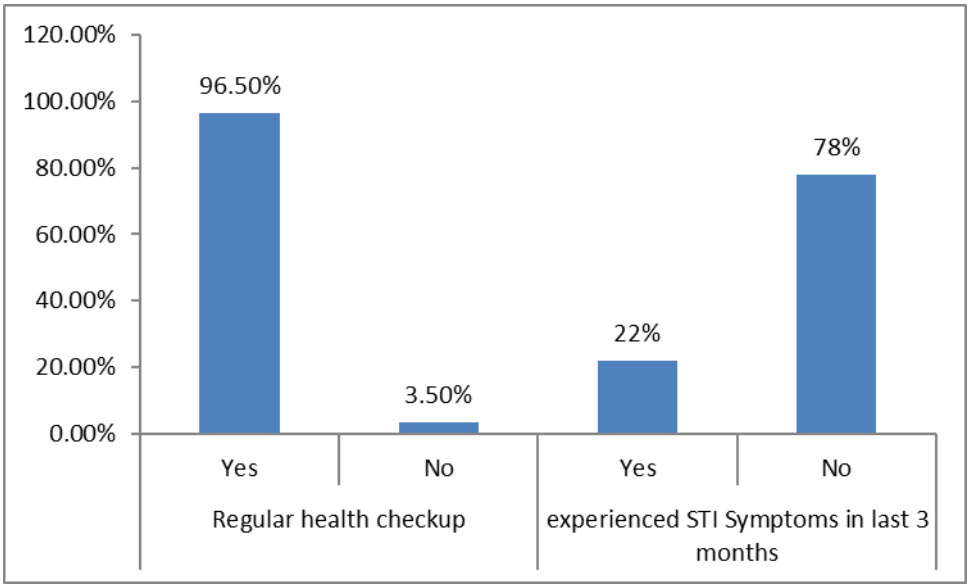

Fig 4: Distribution of women by Regular health check-ups and the STI

As part of the HIV prevention program the women have been educated to get counselling and testing for HIV at the Integrated Counselling and Testing Centre (ICTCs). It helps the women for early diagnosis and treated with Anti Retroviral Treatment (ART) for further care. Since these women are involved in risky activities they are educated to get repeat testing for HIV once in six months.

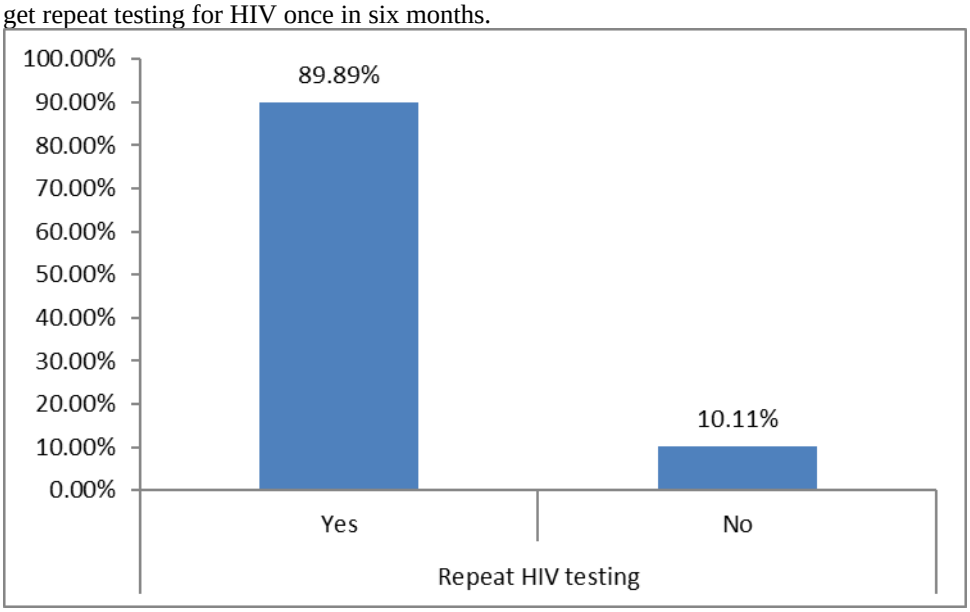

Fig 5: Distribution of women for HIV repeated testing

SELF HELP GROUPS

Though the women are involved in risky activities the women in sex work too have problems like other general women have and in fact it is more. These women are not only vulnerable for health and also vulnerable to family problems, stigma and discrimination and more to poverty. The younger women have more income along with more vulnerability to all kind of health problems as per focus group discussion analysis. The profession has demand only till the women gets in to forties and then she has to survive without any income in her old age. The women are more exploited by the pimps, brokers, regular partners, family and all kind of power structures. All these factors made women to come together and form their affinity groups with ten to fifteen members. It gave them good platform to discuss about their personal and professional problems, as all of them are involved in sex work. With the unity they were able to improve their self confidence and power to face the problems with their families, police and the pimps and brokers. In the long run the women also thought about the savings as they get older there will be no income through sex work to survive. Hence they started savings and small loans and finally linked with many nationalised banks. Currently the women are receiving loans for their children education, children marriages and income generating activities etc. Thus these groups made them self sustain, gave more power to advocate with different stake holders. All these site level self affinity groups formed the Taluk level federation and all taluk federations formed the district level federation which is registered under the societies registration act. Now the Community Based Organisation (CBO) has been recognised as the powerful structure at the district level. The groups and the federations are looked as health groups than the sex workers groups by the external people. These women don't need the Peer educator to motivate them for either regular STI screening or repeat testing for HIV. The group itself is a motivating factor to get all the health services as the primary objective of the group is to be healthy.

The CBO Soukhya Samruddi Samasthe itself is partnering with Karnataka State Aids Prevention Society (KSAPS) to implement the program of prevention of HIV/Aids among their members.

CONCLUSION

Targeted Intervention with the women in sex work had achieved high scale of coverage, accurate knowledge, and consistent condom use with the clients, improved health seeking behaviour among women in sex work. The impact of the long time intervention with the women shows the women empowerment through groups, group interaction and the registered body at the district level.

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