COMMUNITY PARTICIPATION IN HIV PREVENTION: PROBLEMS AND PROSPECTS FOR COMMUNITY-BASED STRATEGIES AMONG FEMALE SEX WORKERS IN MADRAS

SHEENA ASTHANA¹ and ROBERT OOSTVOGELS²
¹Department of Social Policy, University of Plymouth, Drake Circus, Plymouth, PL4 8AA, U.K. and ²AIDS and Anthropology Group, Anthropological Sociological Center, University of Amsterdam, Oudezijds Achterburgwal 185, 1012 DK Amsterdam, Netherlands

Abstract—The concept of strengthening community action within the context of HIV prevention is gaining popularity among health circles, with organizations such as gay volunteer groups in the U.S. providing positive evidence of the potential role of community participation in HIV/AIDS prevention and care efforts. Care must be taken, however, in assuming that participation can easily be achieved among all high-risk groups. This paper examines problems and prospects for participation in HIV prevention strategies among commercial sex workers (CSWs) in Madras. Based upon the experiences of a pilot project established by the Tamil Nadu State Government AIDS Cell and WHO, it finds that the organization of the commercial sex trade in Madras is not highly conducive to collective action. Identifying factors that have frustrated attempts to promote community-based strategies in the city, the paper suggests that this approach is unlikely to succeed unless there are significant changes to the institutional arrangements that keep sex workers in a position of subordination and exploitation. Copyright © 1996 Elsevier Science Ltd

Key words—AIDS, community participation, commercial sex workers, India

INTRODUCTION

Since the Alma Ata Conference in 1978, there has been widespread support for the promotion of 'community participation' (CP) in the planning, implementation and management of health projects in developing countries. The enthusiasm expressed for the active involvement of local communities in family planning, child survival and other health and development programmes has more recently been extended to policies relating to HIV/AIDS prevention and care among vulnerable groups. According to the World Health Organization’s Global Programme on AIDS (GPA), for example, support should be given to integrated community-based strategies which involve peer educators and support groups and which seek to take into account the wider social, cultural and economic factors associated with risk behaviour. To this end, the programme encourages the involvement of non-governmental organizations (NGOs) committed to the active empowerment of high-risk groups by activists working at the local level [1].

Although a growing number of HIV/AIDS projects claim to incorporate community participation as a central component, few state explicitly what they mean by CP and what they expect it to achieve. Nor are problems faced in promoting participation fully considered in practice. This paper starts with the premise that if the potential of participation to play a valuable role in HIV prevention and care efforts is to be realistically assessed, such conceptual and practical issues must be confronted. It therefore begins by outlining the arguments for CP in HIV/AIDS programmes and identifies some of the practical difficulties of translating the rhetoric of participation into reality. Arguing that much of the inspiration for participative approaches in HIV/AIDS programmes came from the gay community in North America, the question is raised as to whether this example can be easily replicated among different groups in different social contexts.

This issue is addressed in the main section of the paper which focuses upon attempts to promote CP among commercial sex workers (CSWs) in Madras. Briefly reviewing public policy and legislation relating to AIDS in India, it finds that the concept of strengthening community action for HIV prevention is gaining popularity. However, as little is known about the nature and organization of commercial sex in Indian cities, insufficient attention has been paid to organizational and structural constraints to participation by Indian sex workers. In Madras, for example, CSWs are highly heterogeneous. Hailing from diverse backgrounds and operating in a wide range of establishments and outlets, they lack a sense of communality. The ability of sex workers to organize is also limited by the fact that the vast majority are locked into unequal power relationships with brothel-owners, madams and pimps and are too isolated and too powerless to act individually or...
collectively. This example suggests that if community-based strategies for HIV prevention and care are to succeed, more attention should be paid to factors enabling or constraining participation among specific target groups.

COMMUNITY PARTICIPATION IN HIV/AIDS PROGRAMMES: CONCEPTUAL AND PRACTICAL ISSUES

Means definitions of participation in HIV/AIDS programmes

As with participation in rural, urban and health service development [2–4], the perceived benefits of CP in HIV/AIDS programmes range from the practical and economic advantages of project effectiveness, relevance and efficiency to the more political goal of empowerment. At a practical level, for example, the fact that vulnerable groups such as injecting drug users (IDUs) and CSWs are often stigmatized and marginalized makes them difficult to reach. Enlisting the participation of group members can thus facilitate access to the targeted population. The use of peers can also help to elicit cooperation from the target audience who, on the basis of past experience, may be suspicious of ‘top-down’ involvement and more willing to trust individuals who share common experiences and who face common risks. There is a growing consensus, for example, that peers are more likely to share the needs and perceptions of the target group, they make more effective educators than outsiders [5–10].

Peers are also valued for their ability to represent their group effectively and to help others to voice their concerns. In the needs assessment stage of an HIV prevention project, for instance, they may play a critical role in mediating communication between the target audience and project staff. This enhances the ability of the latter to design programmes and procedures that are appropriate, acceptable and which respond to felt needs. Other ways of ensuring project relevance include the use by staff of participatory appraisal methods. A Mexican programme for CSWs, for example, drew upon qualitative research to design its campaign around the concerns expressed by women for their children if they themselves became ill or died [7]. The experience of AIDS action-research in Zaire similarly found that the self-esteem of targeted sex workers and their awareness of the need to avoid sexual risk was enhanced when they recognized their responsibility to dependents [11]. There is a growing recognition that the dissemination of information about risk practices is not in itself sufficient to change risk behaviour, especially when targeted groups feel that they have little control over their lives. Indeed, poorly designed education programmes can provoke anxiety, denial and a sense of fatalism. Information needs to be transmitted in a way that is culturally sensitive and appropriate to the educational level of the target audience. Thus, the most effective way of delivering messages is to tailor their content and language to the specific needs of different communities [12–14].

Notions of project efficiency often relate to the objective of lowering costs, although this is one of the most controversial aspects of participation. Community fundraising and the use of volunteers in education, counselling and care is often necessary in the absence of official support or funding. In the U.S. in the early 1980s, for instance, the mushrooming of community-based volunteer organizations among gay men was in part a response to the indifference of the federal government and medical establishment to their health care needs [15]. In the developing world, governments are struggling to deal not only with AIDS but also with other health needs and tough decisions about resource allocation have to be made. Given the impossible task of meeting the overall costs of AIDS prevention, diagnosis and care in many low-income countries, proponents of community financing argue that the only feasible response to the growing challenge of HIV is to develop community- and home-based schemes [16].

Ends definitions of participation in HIV/AIDS programmes

In the approaches outlined above, participation is seen primarily as a means to get something done, whether this be the enhancement of project effectiveness, project efficiency, the sharing of costs or a combination of these goals. Because such predetermined objectives imply the presence of ‘top-down’ planning, they are usually associated with ‘vertical’ programmes that focus exclusively on sexually transmitted disease (STD) control and HIV/AIDS prevention or care. It is often argued, however, that programmes that are so specific take insufficient account of the wider social context that puts targeted individuals at risk in the first place [17]. Individual vulnerability to HIV is generally increased by poverty, lack of education, lack of access to information, poor self-esteem, poor health and nutrition (associated with increased need for blood transfusions or injections), low social status and lack of sexual autonomy [18]. These factors cannot be addressed by a selective approach to HIV/AIDS but demand an integrated and comprehensive approach that concentrates on broader development issues and empowerment.

The empowerment approach regards participation not as an instrumental means but as a dynamic and unpredictable process to be valued as an end in itself [3, 4]. It is based upon the recognition of conflict and inequality within society and suggests that, because those who control and benefit from the dominant order have little interest in bringing about fundamental change, minority and powerless groups will only attain justice if they seize authority, autonomy and power from below [19]. To this end, emphasis is placed on grassroots mobilization and on the building up of pressures for change from below.
By definition, empowerment defies the search for pre-defined goals. In HIV/AIDS-related work, however, its potential can be broadly identified at three interrelated levels: personal, community and societal. Personal empowerment implies that a vulnerable individual has not only the knowledge and means, but the motivation and power to implement and sustain behavioural change. Improved access to condoms, for example, will have a limited impact on sexual practices if targeted individuals cannot insist upon their use. Many authors have highlighted the particular problems that women face in negotiating safe sex [20–26], the stereotype of the ‘good wife’ rendering many women powerless to protect themselves against HIV, either because they are under pressure to conceive or because to suggest the use of condoms, even to husbands with many outside sexual contacts, would imply that they themselves have other partners. The stigmatization and discrimination experienced by men and women involved in the commercial sex industry also results in a lack of sexual autonomy. In Thailand, for example, there have been reports of sex workers being physically abused for demanding that their clients use condoms [27].

Several studies suggest that empowerment strategies can play a useful role in enhancing the self-esteem of CSWs and thus their confidence to demand that they have control over their working conditions and practices. Projects such as CONNAISSIDA in Zaire [11], Empower in Thailand [28], Halfway House I [29] and Pegacao in Brazil [30] have drawn upon the theories of the Brazilian educator Paulo Freire [31] to develop a ‘critical awareness’ among participants of the role that society has played in determining their life chances. By rebuilding feelings of self-worth, this approach can reduce the sense of hopelessness that prostitutes feel regarding their ability to control their situation. Thus, rather than internalizing societal stereotypes (in which CSWs are blamed and stigmatized as reservoirs of disease), sex workers learn to respect themselves and to demand respect from others.

In addition to enhancing self-respect and self-autonomy, conscientization can be a first step in the mobilization of collective action. The sharing of experiences, it is argued, contributes not only to greater consciousness, but to greater solidarity. At a community level, therefore, empowerment implies that participants have the strength in numbers to withstand structures of oppression and, through political or economic leverage, to mobilize for change. Good examples of this type of communal action to prevent HIV and to support people with AIDS come from within the gay community. In North American and European cities, gay men with experience of campaigns for gay rights have used their existing community infrastructure, skills and resources to set up supportive networks, carry out educational programmes, influence patterns of counselling and care and lobby for funding for AIDS services [6]. There are also examples of effective organization among CSWs and IDUs although, like the most active gay movements, these come disproportionately from the developed world. Drug users groups have organized in Amsterdam, New York City and Sydney. The Dutch Junkies’ Union, for instance, has initiated a range of activities including education, needle exchange (and, more recently the promotion of ‘chinezen’ or smoking heroin and cocaine) and social support, as well as mobilizing drug users to take part in demonstrations over drug policies [6, 7]. The Scarlet Alliance of sex workers’ organizations in Australia is similarly involved in both local and national level issues. In addition to providing information on safe sex negotiation, condom distribution and needle exchange, coalition members are taking an active role in human rights campaigning, political lobbying and international networking [26].

The fact that many grassroots organizations focus their attention not only on local concerns, but on the broader social, economic and political context of AIDS, reflects growing recognition of the need for empowerment strategies to press for change at the societal level. This is, in part, a response to the domination of AIDS research and policy design by a medical discourse in which solutions to the problem of HIV transmission are conceptualized in terms of individual behaviour rather than social change [32]. As a result, the significant role played in the transmission of HIV by economic structures, cultural traditions and social, legal and political institutions tends to be obscured [33]. AIDS in sub-Saharan Africa, for instance, cannot be fully understood without reference to the impact of colonialism on rural economies, migrant labour and family separation [21, 34, 35]; the current economic crisis and the effects of structural adjustment of policies on rural productivity, urban employment prospects and health care provision [35–37]; the impact of war and political instability on population displacement and violence against women [38]; and gender status and roles together with the cultural mores that prescribe sexual attitudes, practices and rights [39].

As a strictly medical approach to HIV prevention does nothing to address such determinants of risk, empowerment theorists argue that more attention should be paid to incorporating HIV/AIDS prevention and care efforts into broader development strategies which aim to bring about an end to economic exploitation, gender subordination, racial, ethnic and nationalistic conflict and human rights abuse. To this end, local level efforts have been directed at bringing about multisectoral improvements in people’s lives. In East Africa, for instance, ACORD, an international consortium of non-governmental agencies, is integrating HIV/AIDS programmes into other areas of work, including credit and agricultural extension schemes; income
generation initiatives; health, nutrition and sanitation programmes; educational campaigns; women's projects; and community development [40]. At a national and international level, attention has focused on political lobbying and advocacy for policy change; on networking to support community groups and help initiate programme development; and on the use of mass media, demonstrations and other educational campaigns to challenge entrenched stereotypes and structures of sexism, racism and homophobia. While there is still much to be done to meet the needs of the least powerful and the most vulnerable to HIV infection, there is optimism about the potential of such efforts to bring about fundamental change. Seidel, for example, suggests that it is because power is not only expressed but constituted through ideology that a discourse of rights and empowerment can present a real challenge to dominant power relations [32].

Participation in practice: critical issues

There is intrinsic appeal in an approach that depicts vulnerable groups not as passive victims but as an untapped source of social and political power. It is therefore not surprising that empowerment has become a buzzword in HIV/AIDS policy and research. Recognizing the potential of community-based organizations to play a major role in prevention, counselling, care and community development, bilateral and multilateral agencies are increasingly lending financial and technical support to local NGOs. Many governments, too, are acknowledging and incorporating the role of non-governmental involvement in their national plans for AIDS control. The strengths of NGOs, it is argued, reflect the fact that they are smaller in scale and less bound by red tape and bureaucracy than governmental organizations. This allows a greater freedom and flexibility to respond to local needs and initiatives, to address controversial issues and to experiment with new techniques. Because community-based NGOs are often staffed by community members, they also have more credibility with and understanding of the communities they serve. Thus they are more likely to reach marginalized groups, to respond to perceived needs, to attract community participation and to transform community attitudes, beliefs and practices from within [41].

Although the recent proliferation of NGOs working in HIV/AIDS is often given as positive proof of the potential for a grassroots approach to play a major role in the effort to combat AIDS, care does need to be taken in making unrealistic assumptions about what participation can achieve. Amidst almost universal support for CP in primary health care, for example, a growing number of researchers have pointed out that the ideal of 'empowerment' is rarely achieved [42–44]. Explanations for this gap between rhetoric and reality tend to highlight either structural obstacles to participation or to focus on contradictions at the community level. One theme, for instance, is that the participatory model promoted by the international health community is based on western ideas of democracy, equality and self-reliance and that such values may not find ready expression in different socio-cultural contexts [45, 46]. Another problem concerns the morality of demanding self-reliance from the most disempowered groups, several workers suggesting that a participatory rhetoric can be used to release governments from their responsibilities to share power and resources [47, 48]. Others point out the difficulties of arriving at a meaningful definition of 'community'. The terms 'community', 'village' and 'neighbourhood' tend to be used interchangeably. However, social interaction and group solidarity do not necessarily follow from neighbour- hood proximity and even among 'communities' which are defined on the basis of social or behavioural criteria, there is no guarantee that members will identify common interests or be disposed to mobilize collectively.

Such reservations have particular resonance when one considers that much of the inspiration for community-based strategies in HIV/AIDS came from the gay community in the U.S. In the transition from national experience to global strategy, attention must be paid to whether this particular model can be replicated among different groups in different socio-political settings. A number of observers have suggested, for example, that a penchant for volunteering and forming community organizations is a long-standing characteristic of American society which, through its emphasis on both individualism and egalitarianism, promotes a belief in the potential of even individual efforts to make a valuable contribution to community affairs [15]. In other social contexts, attitudes to collective action are quite different. In many parts of Asia, for example, traditional authority relations continue to dominate rural and urban life, the tendency being to follow strong leadership rather than to act individually or collectively [49–51]. Another possible explanation for the activism of gay volunteer groups in the U.S. relates to their ability to mobilize resources (in the form of leadership skills, money, contacts and facilities). According to resource mobilization theorists, shared interests or concerns are a necessary but insufficient condition of collective action. Rather, group mobilization depends upon the amount of resources a potential social movement can make available to itself in order to get started. The consequence of this is that social movements are, like the gay rights movement, primarily a middle-class phenomenon [52, 53]. Questions thus need to be asked about the participatory potential of groups who are vulnerable to HIV infection by virtue of their poverty and powerlessness. Finally, gay volunteer groups in the U.S. could build upon an existing sense of 'community' in the country's larger cities where active gay media together with the day-to-day contact enjoyed in venues
such as saunas, bars and theatres had promoted a common social identity. Other vulnerable groups may lack this sense of communality. Nutbeam et al. note, for example, that injecting drug users have few formal organizations and their informal organization is not well adapted to collective action [6]. Similarly, CSWs are a highly heterogeneous group who hail from diverse backgrounds, who operate in a wide range of establishments and outlets, and who have varying access to formal and informal support structures [54]. In North America, for instance, working conditions and social relationships vary greatly between street prostitutes (the most targeted sector of the commercial sex industry), escorts and part-time sex workers [55]. Studies in The Gambia [56] and Thailand [27] similarly reveal differences in the living and working conditions of women who practice commercial sex. Significantly, the scope for community participation among different types of sex worker is also likely to vary. Thus, although the potential of community-based strategies in HIV/AIDS programmes is now well accepted, care must be taken in assuming that CP can easily be achieved among all vulnerable groups. The rest of this paper focuses upon attempts to develop participatory strategies among different sectors of the CSW population in Madras. It describes the considerable variation that exists, not only in the organization of commercial sex in the city, but in the nature and extent of support networks among sex workers and the power structures they are part of. The implications of the way in which commercial sex is organised and constructed for health promotion are then considered.

AIDS IN INDIA: EVOLUTION OF COMMUNITY-BASED STRATEGIES

Although the numbers of recorded cases of HIV and AIDS in India are still relatively low, the rapid increase in seropositivity rates among sentinel populations suggests that the scale and pace of HIV transmission in the country is already significant. By March 1995, 2,505,704 people in India had been screened for HIV infection. Of that total 18,222 were found to be seropositive using the Western blot method and 1108 individuals have developed full blown AIDS [57]. Seventy-nine per cent of recorded

![Recorded HIV cases per million population, India, March 1995.](image-url)
HIV positive cases are located in the four states of Maharashtra, Tamil Nadu (including Pondicherry), Manipur and Karnataka (Fig. 1). This partly reflects the more advanced medical and HIV screening facilities in Bombay, Madras, Vellore and Bangalore. Thus, if the data are adjusted to take account of numbers screened, relatively high prevalence rates are also found in the southern states of Goa, Kerala and Andhra Pradesh, together with Uttar Pradesh, Punjab/Chandigarh and Delhi in the north (Fig. 2).

Significantly, 23 of the states or union territories in the country have already reported cases of full blown AIDS. Tamil Nadu heads the list with 372 cases (an increase of 101% from March 1994), followed by Maharashtra (288 cases, +23%), Manipur (77 cases, +234%), Kerala (76 cases, unchanged from the previous year), Delhi (75 cases, +56%) and Punjab/Chandigarh (71 cases, +51%). As information on both HIV and AIDS prevalence in India is subject to problems of data reliability, care must be taken in interpreting these figures. Nevertheless, they do suggest that HIV infection is already a problem on a national scale.

Whilst the highest rates of seroprevalence—54%—have been found in IDUs in Manipur [58], the dominant mode of HIV transmission in India is sexual intercourse. The strong double standard that expects women to preserve their pre-marital virginity and to remain exclusively faithful to their husbands, but which tacitly accepts that men may engage in pre-marital or extramarital intercourse has resulted in a sizeable demand for prostitution. At the same time, there are large numbers of impoverished women who find few opportunities for economic survival other than commercial sex. Low levels of condom use and high rates of client turnover have facilitated the transmission of STDs (including HIV) among this sector. Prevalence rates of HIV among selected samples of female prostitutes in Bombay and Madras and among regular clients of prostitutes in Madras now stand at 38% [59], 15% and 4% [60], respectively.

Research in Madras and Bombay also suggests that there is a significant potential for the spread of HIV among men who have sex with men. Whereas most homosexual activity in these cities is non-commercial, transsexual prostitutes (hijra and ali) tend to have a very high turnover of clients and partners. In the larger Indian cities, transsexuals
constitute a relatively small proportion of the overall prostitute population. However, in rural areas and smaller towns, they are often the only available outlet for commercial sex. Thus their clients include men who otherwise consider themselves to be heterosexual.

Trends in HIV prevalence among CSWs and IDUs have commanded the most attention of both the Indian media and government officials. However, evidence suggests that HIV is firmly entrenched in the general population. The number of people infected by blood and blood products is unknown, although this factor currently accounts for more full blown AIDS cases than intravenous drug use. CSWs and their clients also provide a point of contact for HIV transmission between large numbers of otherwise disconnected people. As a result, growing rates of seroprevalence are being observed in so-called low-risk groups. Extrapolating on HIV prevalence rates in pregnant women and blood donors, GOI and WHO suggest that the AIDS epidemic in India will exceed that of neighbouring Thailand. By the end of 1992, more than one million people in the country were estimated to be infected with the virus. This figure is expected to double or even triple by 1996 [61].

In response to demands from both international agencies and indigenous organizations, the Government of India (GOI) is reviewing public policy and legislation relating to HIV and AIDS. During the 1980s, the official response was largely one of denial and complacency with AIDS being regarded as a problem confined to foreigners and highly marginal groups [62]. Although the National AIDS Control Programme (NACP), launched in 1987, was responsible for health education and care as well as screening and surveillance, more emphasis was placed in the programme’s early years on surveying so-called high-risk groups for HIV antibodies than on raising general awareness about the disease and developing support structures for those with HIV or AIDS. Less than a year after the first case of HIV had been detected, for example, the Indian Council of Medical Research had established a nationwide network of AIDS Surveillance Centres [63, 64] and between 1987 and 1991 85% of the national AIDS budget was devoted to the screening of individuals, blood and blood products [61]. By contrast, in 1992 there were only five government centres for the care of AIDS patients in the whole of the country [66]. Health education activities were also woefully inadequate and relied on the limited number of NGOs who were willing to work in AIDS prevention.

Charged with collecting blood samples from high-risk groups, surveillance centres have tended to target the inmates of jails, remand homes and ‘vigilance homes’ for prostitutes, as well as patients at public STD clinics. Unlike the controversial testing of foreign students in India (which is mandatory), this screening is technically ‘voluntary’. However, questions have been raised about the quality of counselling provided by the surveillance centres and it is doubtful whether the consent of screened individuals is always obtained and whether they have the knowledge and freedom to refuse to be tested. The official response to HIV-positive individuals and AIDS patients has also come under attack for violating human rights [67, 68]. In 1988, for example, HIV-positive sex workers arrested under the Immoral Traffic Prevention Act in Madras were found to have been kept under detention even after serving their official sentences. The following year over 700 sex workers were sent under police escort from Bombay to remand homes in Madras in a so-called ‘rescue mission’ [69]. Deported with the help of a Bombay NGO, many of the women were HIV-positive. Both cases provoked a strong response from local activists and in 1990 the Madras High Court ordered the release of five prostitutes who had been illegally detained at the Government Vigilance Home [70].

In the face of both international and national pressure, GOI has revised its AIDS policies [71, 72]. Since the creation in 1992 of the National AIDS Control Organization (NACO) and the expansion of NACP into the National AIDS Prevention and Control Programme (NAPCP), all sections of society are to be targeted rather than merely stigmatized groups [73]. Thus, although some emphasis is still placed on targeted surveillance, NAPCP now acknowledges the need to promote greater awareness among the public as a whole, to ensure a policy of non-discrimination towards individuals with HIV or AIDS and to focus more resources upon HIV prevention activities. To this end, the programme aims to encourage safer sex practices and condom use among the general public as well as vulnerable groups; to improve STD prevention activities and increase access to health care for these STDs; to ensure that HIV-positive individuals and AIDS patients are provided with care, counselling and support in order to live their lives in dignity; and to integrate AIDS information, education and communication (IEC) programmes with existing health programmes including mother and child health and family planning and with other sectoral programmes in education, youth affairs, women’s issues, welfare, urban development and labour affairs. In order to implement this comprehensive approach, NACO explicitly calls for intersectoral and NGO collaboration together with grassroots mobilization [61].

NACO suggests that grassroots approaches are particularly relevant to the development of targeted programmes for groups practising high-risk behaviours (sex workers, their clients and employers; IDUs; men who have sex with men; school-leavers; migrant labourers and prison inmates) and identifies NGOs as major partners in such initiatives. It accepts that no standard formula can be applied to commu-
nity-based strategies and that programmes should be adapted to local level circumstances.

With its commitment to project integration, community participation and non-governmental involvement, GOI’s response to AIDS has undoubtedly changed for the better. Nevertheless, the extent to which its participatory rhetoric can be translated into reality remains to be seen. Attitudes to CSWs, for example, are still contradictory. The Suppression of Immoral Traffic Act of 1956 (SITA), amended in 1986 (PITA), did not originally seek to abolish prostitution, but to abolish the practice of exploitation of women by others. However, the client is not an offender under the Act and sex workers can be penalized under Sections 7 and 8 for soliciting. In practice, however, it is prostitution rather than exploitation that is targeted for legal action with over 90% of the 15,000 or so cases that are registered annually under PITA being taken against sex workers rather than pimps and procurers.

Attempts to implement the new policy objectives have also been frustrated by the fact that very little is known about the Indian commercial sex industry. This problem stems from both the cultural taboos surrounding sexual behaviour in India and the tendency in the past for Indian health personnel to view AIDS as a medical problem. The subsequent neglect of the socio-cultural, economic and political context of HIV transmission left planners poorly equipped to design and implement HIV prevention strategies. Recognizing the need for detailed information about the socio-demographic characteristics and social structures of CSWs, NACO acknowledges that targeted interventions must be preceded by operational research. With technical and financial assistance from WHO, pre-project assessments have been initiated in several major cities. The experience of one of these projects, in Madras, will now be explored further.

THE COMMERCIAL SEX INDUSTRY IN MADRAS

Until recently, little was known about the commercial sex industry in Madras. To perhaps an unusual extent, research efforts have been hindered by problems of identifying, gaining access to and eliciting cooperation from sex workers and their affiliates. Due to the relatively conservative nature of Tamil culture, the institutional response to commercial sex in the state is extremely repressive. Sixty per cent of arrests under the Prevention of Immoral Traffic Act (PITA) are made in the State of Tamil Nadu alone and at the city level, Madras ranks second in the country in terms of arrests, exceeded only by Bombay which has a much higher concentration of sex workers. Thus, whilst only 3000 women are estimated to work in the city on a regular basis, 1500 cases are registered annually under the PITA. This figure does not include the many women who are caught while soliciting or during police raids on brothels but who pay off police officers in cash or kind.

Due to repression, taboo and social stigma, much of the sex trade in Madras takes place in an underground circuit. Prostitution is dispersed throughout the city which, unlike Delhi, Calcutta and Bombay, lacks a geographically discrete red light area and access to sex workers is controlled by varied forms of ‘middlemen’. Thus, whereas street prostitutes may be approached directly, they account for fewer than a quarter of the CSW population. The majority of sex workers are engaged in disguised prostitution and obtain their clients through a small circle of contacts. Vulnerable to stigmatization, criminal prosecution and, in some cases, blackmail, they are naturally suspicious of attempts to obtain information about their working lives.

With little relevant information on which to design appropriate health promotion strategies, progress in targeting HIV prevention efforts at sex workers has been slow. Between 1986, when the first case of HIV infection was detected in Madras, and September 1992, the few HIV/AIDS prevention programmes to have been initiated by NGOs in the city focused either on raising awareness among the general population or targeted their activities at potential clients of sex workers, such as truck drivers. A pilot project established by WHO and the Tamil Nadu State Government AIDS Cell in September 1992 was therefore the first in Madras to identify and target different sectors of the sex worker population.

As a first step towards developing IEC and condom promotion programmes, a local team under the guidance of a WHO consultant carried out ethnographic research to establish patterns of prostitution in the city. The principal method used in this assessment exercise was participant observation, at first covert and then revealed. Researchers were selected who had some prior knowledge of and who were willing to become part of the underground sex circuit. By establishing a rapport with sex workers, regular customers and affiliates who were willing to act as key informants and to negotiate access to other members of the target population, the team gradually gained detailed knowledge about this hitherto unresearched area. A detailed map was produced of pick-up points, cruising areas, brothels, lodges and other locations where commercial sex takes place. An inventory of numbers of female sex workers, customers and affiliated target groups of brokers, pimps, brothel keepers and police in the city was also compiled.

The team identified five main categories of sex worker in Madras [74] and developed interventions for four of these groups. The fifth, which comprises high class call girls who operate in three- to five-star hotels and whose clients normally come from the higher echelons of society, were not targeted for attention. Estimated numbers of each category are as follows: street workers: 700; brothel-based women: 400; ‘family girls’ or housewives: 1700–1800; ‘all’:
200–250; and call girls: 200. There are also small numbers of men who sell sex as 'family boys', independent street workers and call boys. However, if the sexual activity of ali (who are regarded as a third gender) is excluded, most homosexual activity in Madras is non-commercial.

Even within the four main categories of CSW, there is considerable diversity. Among street workers segregation by time and space takes place along socio-economic lines. Women working in the nighttime tend to be poorer than those who work the morning shift. For the former, prostitution is often the only source of family income whereas women who solicit clients during the day include housewives who are supplementing their incomes without the knowledge of their families. In the beach area and Mount Road (on which several cinemas are located), comparatively cheap sex is provided by older prostitutes who sell 'hand jobs' and occasionally perform oral sex on their clients. Prices are also low in the city's major railway stations where homeless or migrant women are concentrated and where the platforms or railway tracks are used for sexual relations. In all three areas, therefore, sex often takes place at or near the pick-up point itself. By contrast, prostitutes working in the residential areas to the south and south west of the central city (where bus depots are commonly used for pick-up points) and in the central hub of the old city, Parrys Corner, are of a higher socio-economic status and demand higher prices. Their clients are usually taken to a lodge or small hotel where, in addition to paying for the room, they are expected to treat the prostitute to dinner and drinks.

The independent solicitation of clients by street workers presents potentially higher risks of violence or exploitation. Abduction and rape, for example, are problems commonly cited by this group, together with extortion by local police. However, street prostitutes are the most assertive and vocal group of sex workers in the city. Operating independently of brothel-owners and pimps, they enjoy greater occupational and financial autonomy than brothel-based women and family girls. Many have worked in the profession for years and have developed strategies for coping with difficult situations. Indeed, rather than relying on the protection of middlemen, street workers often help and support each other. Notwithstanding the fact that individual competition inhibits collective activity, informal support structures have emerged among this group of prostitutes, often on the basis of shared territory.

Whereas the shared space of brothel-based women also promotes solidarity, the organization of this form of prostitution in Madras works against the development of community support networks. Brothels are smaller than commonly found in Indian cities, most establishments housing no more than three to four women at any one time. Brothel-based prostitution is characterized by a high degree of mobility. Over 30% of women in this sector come from the neighbouring state of Andhra Pradesh where bosses target pockets of rural poverty in order to recruit young girls. Unable to speak or understand Tamil, young Andhra prostitutes are often isolated from their peers and highly dependent upon their brothelkeepers. Movement of sex workers between different establishments also undermines collective solidarity. Women rarely stay in one brothel for more than 6 months and contracts are more commonly made out for 1–3 months. Finally, the premises in which brothels are housed regularly shift in response to police raids or complaints from neighbours. Thus, due to the secretive, shifting nature of brothel prostitution, clients are normally procured through brokers.

Brokers also play a central role in prostitution practised by 'family girls'. These are women who continue to live within regular households and who often sell sex without the knowledge of their families and neighbours. Many family girls do not consider themselves to be 'prostitutes', but decent women making some extra money for their households. They therefore distance themselves from and consider themselves superior to street workers and brothel-based women who are open about their profession and who serve larger numbers of clients.

Whereas some family girls will solicit in areas where nobody knows them, the vast majority obtain their clients with the help of a broker or a circle of close friends. The close secrecy that these women maintain about their working lives makes them vulnerable to blackmail, a problem exploited by brokers who charge up to 50% commission for their services and who attempt to extend their control over women by becoming their pimps. Female brokers or 'aunties', however, are reported to have good relations with family girls and are often regarded as friends. Successful aunties may organize clients for up to 20 family girls. Thus, whereas this sector of the prostitute population is the most isolated, the aunty provides a central focus for the development of informal networks.

Another circuit of commercial sex is formed by 'ali'. Regarded as neither male nor female, men who want to join the ali community go through a rite of passage in which castration is an essential part (although some may forego hormonal treatment in order to retain their sexual ambiguity). Others who do not opt for the ritual but who wish to dress and act like women are adopted by these groups as daughters. Ali are a longstanding phenomenon in Tamil society. Traditionally regarded as bestowers of blessings and curses, they continue to perform rituals at weddings and births and can earn a livelihood as temple servants. The main source of income for this sector of society is, however, prostitution. Because of their social and sexual ambiguity, ali often initiate younger men who do not regard themselves as homosexuals but who are shy of women. Feminine enough
to be sexually interesting, but masculine enough to be socially familiar, ali are also regarded as being more 'skilful' at sex. Most of the sex sold by this sector is fellatio. Anal sex is, however, quite prevalent.

The potential for community participation among ali would appear to be high. Marginalized by society, they share a very strong common identity. By choosing their way of life, ali have surrendered the ties of caste and form new clans and live in small communities. Groups of 10 or so are often led by a guru chela or spiritual leader. Advice is sought from this individual regarding sexual and other practices and in close clans earnings are pooled and distributed by the clan head. Such social ties are reinforced through regular religious festivals.

Because much of the sex trade in Madras is hidden, brokers play a key role in mediating contacts between CSWs and their clients. An estimated 250 brokers who work in the city, 175 part time. Many are auto- or cycle-rickshaw drivers who take their passengers to outlets or sex workers they know in the area. Full-time brokers hang out in front of cabaret theatres, cinemas and hotels, and at bus depots and train stations. Because brokering is their only source of income, they will often operate from regular locations in order to cultivate clients. Full-time brokers therefore constitute one of the more stable elements of an otherwise fluid sex industry.

Brokering obviously comes at a price and, as both clients and sex workers usually pay a commission to their intermediaries, commercial sex in Madras is relatively expensive. This has given rise to the widespread practice of 'group booking' where groups of up to four or five men will book a single street worker or brothel-based woman for the night and share the costs. As each client may have two to three 'shots' (vaginal intercourse) over the course of the evening, street and brothel-based prostitutes in Madras may have a higher average number of commercial sexual encounters than their counterparts in other Indian cities where sex is normally sold on a 'per shot' basis.

FACTORS ASSOCIATED WITH HIGH-RISK BEHAVIOUR IN MADRAS

Although there is considerable diversity in the working conditions and social networks of different types of sex worker in Madras, and although factors such as the high turnover of clients among brothel and street-based prostitutes and the relatively higher incidence of anal sex among ali may lead to varied potential risks of HIV infection between the different categories, a number of general contextual features place all of the groups at risk. One problem stems from the relatively conservative nature of Tamil culture which condemns pre- and extra-marital sex, homosexuality and the display or discussion of sexual matters in public. Until very recently, whenever AIDS was discussed in the Tamil press it was not linked with sex. Similarly, both governmental and non-governmental organizations have been slow to mount publicity campaigns aimed at raising public awareness about the disease. As a result, levels of knowledge about HIV and AIDS are low, even among highly vulnerable groups such as sex workers, their clients and others with multiple partners. A survey of 50 female sex workers undertaken by the team in January 1993, for example, found that although 81% knew that HIV was transmitted by sexual contact and 62% by contaminated blood, misconceptions were also very common. Forty-three per cent of respondents, for example, believed that AIDS could be transmitted by mosquito bites (the rest did not know); 29% by infected food or water or by sharing toilets; and 52% said that AIDS could be spread by kissing. Only 52% agreed that an infected needle could transmit the disease. A survey of 80 clients found similar gaps in knowledge. Although 97% had heard about AIDS and 79% knew that it could be sexually transmitted, 54% identified kissing as a cause of transmission and only 31% believed that anal sex was riskier than vaginal intercourse.

Low levels of knowledge about AIDS are compounded by even lower rates of condom usage. Eighty-seven per cent of the sex workers surveyed claimed to have used condoms in the past. However, only 4% did so in every client encounter. The fact that 73% relied on their clients to bring condoms confirmed qualitative reports that the choice of whether to have protected sex or not lies overwhelmingly with the customer. Low condom usage is also revealed in interview reports with peers (which at the time of examination included data on 119 female sex workers). Only 12% of women claimed to use a condom in every encounter. Twenty-one per cent suggested that they never had protected sex with their customers and only one of the 11 women who participated in anal sex said that she insisted that condoms were used with her clients.

Unfortunately, the client survey undertaken by the team revealed little enthusiasm for safe sex, only 9% of respondents claiming to use condoms in every encounter with sex workers and 20% occasionally. The vast majority of non-users (40%) claimed that condoms affected their enjoyment of sex (a belief that reflects the poor quality of condoms that have until recently dominated the Indian market); a further 37% claimed only to visit girls who looked healthy. Neither clients nor sex workers associate condoms with protection against STDs or AIDS, instead relying on a mixture of folk remedies and antibiotics to control venereal disease. Many brothel owners, for example, arrange for their girls to have weekly injections from private doctors. Other women and clients rely on less scientific solutions which range from washing one's genitals after intercourse in urine, soda water or lime juice to curing sexually transmitted disease by, in the case of men, penetrating an animal and in the case of women having intercourse with a male virgin. Still others believe that one can ward off
sexually transmitted disease in the first place. One idea, for example, is that whereas intercourse by a roadside or railway track encourages the spread of disease, sex in a confined room is risk-free. Another is that women who have given birth cannot transmit disease. For many clients, particularly those who hire the services of a prostitute in a group, it is simply not macho to use a condom. Some respondents suggested, for example, that as they are too fit and strong to contract a common cold, they are bound to be protected against STDs. Whereas such notions relate to the ineffectiveness of condoms, a more worrying belief is that condoms are unhealthy or harmful. One client, for instance, suggested that they caused heat to be retained in the body which could then be transferred during intercourse to one’s wife. Several female sex workers expressed the fear that condoms would be lost in the vagina. Others were unhappy about the thought of condoms prolonging the sexual encounter.

Given such low levels of condom usage in commercial sex, it is hardly surprising that very high rates of STDs have been reported among the general population and sex workers in particular. According to a baseline survey conducted in 1992 of selected population groups in Madras and rural Tamil Nadu, STDs are a significant problem. Rates were highest among female remand prisoners (a group likely to comprise a high proportion of CSWs), 36% of whom were infected. However, 10% of antenatal clinic attenders were found to suffer from a sexually transmitted disease, and 2% from syphilis. STDs are also prevalent in rural Tamil Nadu, 6% and 4% of men and women, respectively, being affected [61]. As the presence of an STD exacerbates the risk of the HIV virus being transmitted during unprotected sex, the stigma associated with both providing and seeking medical treatment for such complaints is unfortunate. Less than 1% of registered general practitioners in Madras openly advertise STD services and those that do charge relatively high prices for often low quality services. Patients who attend either municipal dispensaries or government health posts are referred to one of the four government hospitals which provide STD treatment. However, attendance at these public departments is very low because of the stigma attached to going to such places. Patients also complain of the lack of respect, privacy and confidentiality given in the public hospitals. Women who are arrested under PITA, for example, are given mandatory treatment at one of the government hospitals during which they are kept in a separate ward which is heavily guarded by watchwomen. As neither private nor public services are perceived as easily accessible to STD sufferers, a significant number of people go directly to drug sellers, where both diagnosis and case management are often inadequate. As the provision of medical care has done little to decrease the prevalence and incidence of STDs and consequently, the transmission rate of HIV, current proposals by NACO to improve access to health care for STDs by extending STD services to primary level centres are timely.

Medical attitudes and practices regarding family planning have also played a role in increasing risks for HIV infection among vulnerable groups. Until recently, sterilization and intra-uterine devices (IUDs) were the most popular forms of contraception advocated by family planning agencies in the city, followed by oral contraceptives and finally condoms. The latter, it was argued, were too unreliable to be widely promoted among low income and illiterate groups and tended only to be promoted as a last resort. Thus, family planning practice has contributed to the generally negative image that sexually active people hold about condoms. Given that IUDs are contra-indicated for women who are at risk of contracting STDs, including HIV, the active promotion of this form of contraception was also problematic. Following collaboration between NACO and the Department of Family Welfare, a decision has now been made to promote the condom as a ‘dual benefit product’, protecting against both conception and disease. It is hoped that this will counter the generally negative image that sexually active people hold about condoms.

HIV PREVENTION IN MADRAS: THE PILOT PROJECT

Given the high turnover, the rates of STDs and the low level of condom use that characterize the commercial sex industry in Madras, there is a pressing need for interventions designed to prevent the transmission of HIV among sex workers and their clients. As described above, GOI has recently reviewed its policies relating to HIV and AIDS and has given its active support to the development of integrated community-based strategies. Questions have been raised, however, about the scope for strengthening community action in the absence of a meaningful ‘community’. In Madras, for example, there is no formal organization of commercial sex workers and a lack of informal organization (especially among brothel-based women and family girls) makes CSWs very difficult to reach.

Notwithstanding these difficulties, the research experience did demonstrate that much could be achieved with pragmatism, flexibility, enthusiasm and imagination. Thus, having gained access to the underground sex circuit and having built up relationships of trust with sex workers and their affiliates, the team went on to design and test community-based strategies in a limited geographical area (Vadapalani, Kodambakkam and KK Nagar). This lies to the south west of the city centre and, at the time of the pilot project, comprised 500 sex workers. The largest category was that of family girls, an estimated 300 women working through part-time brokers (aunties or auto-rickshaw drivers) or through circles of friends. The concentration of brothels in the interven-
tion area was also relatively high and accounted for a further 100 sex workers. In contrast to other parts of town, brothel-based prostitution was stable, several establishments having been in existence for over 3 years. This reflected the local dominance of two families whose political connections had protected them from official sanction. The remaining 100 sex workers belonged to the street worker category. Operating from adjoining slum settlements, they offered comparatively cheap sex compared to street women in other parts of the city. The total turnover of clients in the intervention area was estimated by the team to be approximately 800 per day. This flow was mediated by approximately 40 female and 35 male brokers.

Recognizing the diversity in the organization of commercial sex in the city, health promotion strategies had to be adapted to reach out to different sectors of the sex worker population and their specific clienteles. One such strategy was the training and support of peer educators. These individuals were to be selected on the basis of their contacts with others in the sex trade and their personal characteristics (including communication skills and assertiveness about condom use). Where possible, prostitutes or ex-prostitutes would be identified as peers. As the recruitment of effective peers from brothels and networks of family girls could prove problematic due to the relative isolation of these groups, a second approach was to test strategies which involved close affiliates of the target groups such as aunties and brothel-keepers. The need to include clients in outreach efforts was also highlighted since their cooperation in using condoms is essential. Brokers were identified as a potential conduit for the dissemination of AIDS information and condoms among this target group. Finally, the cooperation of a wide range of players with more peripheral links with the sex industry was sought. These included local police; general practitioners who provide STD services; the employees of cinemas, wine shops and bars; political and religious leaders and the local media.

Acknowledging the importance of empowerment at both personal and community levels, the team’s objectives ranged from the short-term goal of raising awareness about HIV/AIDS and promoting condom use among sex workers and clients to the long-term goal of developing community-based organizations which were themselves capable of sustaining health promotion activities. Both IEC and condom promotion programmes were initiated in order to promote changes in individual behaviour. Consulting CSWs, male brokers and other affiliates who had been recruited during the research exercise, the team designed educational materials for use by peer educators and the local media. These included illustrated leaflets and posters (which were to be put up near cinemas, wine shops, bars and bus stops), flash cards, comic books, audio cassettes and street theatre. Due to high levels of illiteracy among the target population and a lack of interest in written leaflets, much of the IEC material was pictorial or audible. It was also designed to entertain the target audience and to promote the idea that safe sex is fun. For example, the condom instruction leaflet designed by the team portrayed an elephant with a condom on its trunk.

In March 1993, the pilot project was formally launched in a cinema theatre at the heart of the intervention area. Over 1200 attended, including 400 CSWs, brokers, aunties and a large number of regular clients, tickets for the programme having been distributed by sex workers and their affiliates. Banners, posters and a condom sales and exhibition stall were set up in the theatre lobby and IEC materials distributed to participants. The programme agenda was designed by the local partners themselves and included a brief introduction by the Secretary of Health (Tamil Nadu State Government) and a folk dance performed by both professional artistes and sex workers which was designed to convey AIDS messages in a colourful and humorous way. Throughout the programme, efforts were made to combine educational messages with entertainment. The main feature, for example, was a popular film starring the superstar of the Tamil film industry. This, however, was interspersed with short films on AIDS in Tamil and an audio cassette of well-known film songs containing more health information.

The launch was partly designed to generate interest and curiosity among the target population about the pilot project and its activities. An equally important purpose, however, was to bring the implementing team, including the local partners, closer together as there was a definite objective to be fulfilled which required a group effort. The involvement of local partners at all stages of the launch programme made them feel important, enhanced their commitment to the project and increased their social standing within the community. The participation of target group members in the folk dances also provided a useful opportunity for the promotion of self-esteem. Such considerations were important, for the local partners were regarded as the cornerstone of the pilot project. It was they who facilitated access to and who mediated communications between the target audience and project staff; and they who were directly responsible for working with the target group by giving them correct information and selling them condoms.

By May 1993, nine female peers/affiliates, eight male brokers and four brothel owners had been recruited to the project. One woman, a family girl, had dropped out. Ranging from 18 to 45 yr of age, the remaining women included four aunties, two family girls, a street worker and a brothel-based prostitute. Two of the women were from Andhra Pradesh, and were thus able to communicate with Telugu-speaking migrants. All were articulate, resourceful and, with the exception of the brothel-based woman, had extensive contacts in the sex industry. The brokers,
especially the auto-rickshaw drivers, were similarly well placed to disseminate information. With between 6 and 30 years experience of the trade, these men had a good knowledge of the various outlets of commercial sex in the area, maintained friendly relations with sex workers and were well versed in delivering messages to their clients. Like the female peers/affiliates, the brokers were recruited to the project by a range of methods. Some had been identified during the research exercise; others were brought to the team office by existing recruits; and the rest had been at the launch or had heard of the project and its activities through word of mouth and visited the office out of curiosity.

In order to train peers and affiliates for outreach work, educational sessions were conducted by project staff on HIV and AIDS in Madras, people's misconceptions about the disease, the relationship between STDs and HIV, the need to use a condom in every sexual encounter and on methods of promoting condom use. Drawing on the experience and advice of the local partners, the decision was made to appeal to sex workers' need to survive in the long term, if not for their own sake for the sake of their children. Client motivation, by contrast, would emphasize the idea that sex with a condom is fun. Leaflets were issued to the outreach workers, together with lubricated coloured condoms. Reasoning that if people paid for condoms they were more likely to use them, the peers and affiliates were asked to sell the condoms provided by the project rather than to distribute them freely.

The main role of the brokers recruited by the project was to motivate their clients to practice safe sex. Between being approached by a client and escorting him to a brothel or sex worker, the broker would discuss HIV/AIDS, explain the importance of preventing transmission and then attempt to sell the client condoms. The female recruits, by contrast, were encouraged not only to educate individuals they encountered during the course of their own work in the sex trade, but to seek out and gain access to new networks. As they reported to staff members two or three times a week, giving descriptions of the contacts they had made, their outreach work became a useful source of qualitative data. In March 1993, for example, the five female peers/affiliates then working for the project approached 70 sex workers at bus stands, cinemas, markets and other pick-up places as well as brothels and women's homes. After introducing themselves as workers for an AIDS prevention project, the women would typically ask about the sex worker's background, their knowledge of HIV/AIDS and condom use and about how they were coping with STDs before providing information regarding HIV risk behaviours and attempting to sell condoms. Sex workers who expressed an interest in the pilot project were commonly brought to the project office, introduced to project staff and invited to drop in at any time.

This open door policy was one of a number of methods proposed by the team to promote feelings of solidarity among CSWs. Faced with the challenge of building up a sense of community among groups which are diverse, dispersed and highly mobile, the team proposed to foster community development by providing meeting places for CSWs; reinforcing existing informal networks through the activities of peers and affiliates; and responding to perceived needs. In addition to encouraging informal association at the project office, the team regularly held semi-formal sessions, including film shows, educational talks and focus group discussions with CSWs, brokers and other affiliates. Various proposals were made to respond to sex workers' priority needs, including the provision of STD services and a local crèche (staffed by aunties). Unfortunately, none of these proposals were acted upon, despite its promising beginnings, the nature and content of the project was soon to change.

The research assessment and pilot project was designed and coordinated by an external WHO consultant. In May 1993, responsibility for the project was formally transferred to a newly registered NGO comprising a number of local members of the research team. Although the feasibility and impact of key strategies had not been fully tested, the intervention ceased to be viewed as a pilot scheme and became an ongoing programme in its own right. As this occurred, more emphasis came to be placed on programme implementation rather than evaluation, on maintaining existing activities rather than developing new strategies, and on the short term goal of condom promotion rather than the long-term objective of developing community-based organizations.

Although the programme became less ambitious in scope its staff were able to claim some successes. By August 1993, for example, condom sales by recruited aunties and male brokers were meeting 21% of the estimated monthly requirement for sex workers and their clients in the intervention area. Little progress had been made, however, in peer recruitment and community development. Contrary to the initial goal of creating a cadre of peer educators from an informal network of aunties, family girls, brothel-based women, street workers and brokers, outreach efforts continued to rely on the peers and affiliates recruited during the pilot phase and their initial enthusiasm for the project was proving difficult to sustain. Having already lost its momentum, the programme was irreparably damaged in October 1993 when a police crackdown on prostitution in the intervention area caused most of the brothels in the area either to close or relocate to other parts of the city. Rather than moving to where the sex circuit had reorganized, the programme abandoned its targeted interventions for sex workers and their clients and turned its attention to raising awareness about HIV/AIDS among the general public.
PROBLEMS AND PROSPECTS FOR COMMUNITY-BASED STRATEGIES IN MADRAS

The reasons for the demise of the intervention programme are complex. Project characteristics were certainly significant. For example, members of the new NGO lacked both political leverage and practical expertise in programme management. Another problem was that strategies designed to be piloted were not rigorously assessed. As no formal evaluation was carried out of the project's activities, its impact on knowledge and behavioural change can only be gauged from qualitative reports.

The difficulties the programme encountered in sustaining outreach activities, in promoting community organization and in obtaining the cooperation of public order and law enforcement bodies suggest, however, that factors relating to the nature and organization of the commercial sex industry itself played a role in the project's fate. Although the outreach workers were given a monthly honorarium, their initial enthusiasm for the project stemmed less from the extra money they could earn than from a personal satisfaction of doing work that was 'important' and which improved their social standing. Despite attempts by project staff to stress the positive aspects of HIV prevention and to avoid scaremongering, the outreach workers were clearly driven by the novelty of AIDS and the fear that the disease provoked. With time, this fear subsided and the peers and affiliates started to talk about the difficulties of sustaining their own interest and that of the target audience, in a symptomless disease that might manifest itself some time in the future.

That the peers and affiliates were limited in what they could do and achieve also contributed to their growing lassitude. Follow up of sex workers and clients proved difficult due to the shifting nature of the sex trade and, rather than developing trust relationships and promoting community ties, the outreach workers concentrated on providing information and selling condoms. As service deliverers rather than community change agents, they became routinized in their role. Thus, far from being an instrument for community empowerment, outreach became just another way of making money. This paved the way for conflicts between the affiliates' own interests and the objective of HIV prevention. The monthly honorarium was too small to compensate for the workers' loss of earnings through time spent on health education and, because condom promotion was perceived to threaten client interest and satisfaction, the affiliates risked damaging their own business interests.

Problems of client motivation proved a significant obstacle to the project's goal of promoting consistent condom use in commercial sex transactions. The project had no discernible impact on the women's personal empowerment, clients continuing to exercise control over their sexual encounters. Given the highly heterogeneous nature of commercial sex in the city, it is perhaps surprising that client domination is so common. However, the ability of street workers to turn down clients is limited by their poorer market position and the sexual practices of brothel-based women are determined by their business managers who do not want to lose trade to competitors. Family girls who already exercise discretion in the sexual services they offer might be expected to have some power to insist upon condom use. In practice, however, women reported that, in the immediate circumstances of the prostitute-client encounter, it was difficult not to comply with the client's wishes.

Poor client compliance in using condoms can be attributed to a number of factors. Quality checks (using mock clients) of the outreach activities of brokers recruited to the project revealed that they were trying to get health messages across. However, the response of clients to these efforts varied according to their age, marital status and education. According to the outreach workers, older and married clients were more receptive to health messages, especially those that appealed to their responsibility to safeguard the health of their wives and unborn children. In contrast, younger men proved difficult to motivate and indeed berated brokers for spoiling their pleasure. For several reasons, educated young men appear to be the least receptive to outreach efforts. First, college students have come from a highly disciplined regime at school to the relative freedom of college and, knowing that the future holds marriage, employment, children and responsibility, throw caution to the wind. Second, commercial sex is often treated as a group event by college students and to buy and use condoms in front of their peers is not considered to be macho. Third, groups are likely to have spent the evening drinking before they look for a commercial sex worker and alcohol makes them more difficult to reason with. Finally, because students regard brokers as their social inferiors, they are unwilling to listen to their advice.

Whereas greater public awareness of HIV and AIDS would undoubtedly affect client attitudes towards risk behaviours, safer commercial sex is unlikely to become the norm in Madras until CSWs themselves control their sexual encounters. As outlined above, confidence has been expressed in the potential of community organization to provide sex workers with the opportunity to share knowledge, to offer mutual support and collectively to demand self-determination in their working practices. In Madras, however, community organization is very difficult to achieve. This partly reflects the practical problem of mobilizing women who are isolated, scattered and highly secretive about their profession. Family girls and brothel-based women have very limited contact with other CSWs and even among street workers informal gathering is risky due to fear of arrest. However, it is also difficult to convince
CSWs that they stand to benefit from collective organization. Vulnerable to exploitation and abuse from clients and police, the vast majority of sex workers rely on the protection of brothel-owners, auntyes and pimps. Whereas this clearly locks them into unequal power relations, it is a least-risk strategy in extremely precarious circumstances.

CSWs in the city are therefore unlikely to organize effectively until there are significant changes to the institutional arrangements that drive prostitution underground. While the law enforcement bodies continue to target prostitutes and to protect the brothel-owners, procurers and pimps who control the sex trade, sex workers will be too isolated and powerless to control their own health status and to participate meaningfully in community-based programmes. Safer commercial sex in Madras thus demands interventions that do not only target women in prostitution, but also the power structures they are part of. We propose that this would best be achieved through the professionalization of the commercial sex industry. At a more fundamental level, the vulnerability of CSWs in Madras to HIV cannot be separated from broader gender and development issues. In the Indian context, this means confronting the economic inequalities and double standards which result in the strict control of women's sexuality, sexual freedom for men and commercial sex for large numbers of impoverished women. While giving full support to the concept of community participation in HIV/AIDS programmes, we conclude that community-based strategies must be seen as an integral part of—and not a substitute for—efforts to bring about comprehensive changes in the social, economic, legal and political structures that lead to disempowerment in the first place.

Acknowledgements—We would like to acknowledge the important contribution of WHO/GPA to the development of the targeted intervention with CSWs and clients in Madras, and thank the Nuffield Foundation for making this study possible. Thanks too to the anonymous referees for their helpful comments.

REFERENCES

33. Editorial. Reassessing priorities: Identifying the deter-