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# Community-Based Strategies as Transformative Approaches for Health Promotion and Empowerment among Commercial Sex Workers in India

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**Abstract:** The current paper examines the utilization of community mobilization as a strategic health communication technique in an intervention to reduce human immunodeficiency virus (HIV) and sexually transmitted infections (STI) rates among marginalized and at-risk populations such as commercial female sex workers in a red-light district in India. The research documents the struggles of a historically exploited community in India to mitigate its marginalization through implementation of a multilayered strategy of capacity building and economic empowerment. Semi-structured interviews of 37 commercial female sex workers were conducted in a red-light district of India. Qualitative analysis of the interview transcripts showed the prevalence of three themes which demonstrated the different facets of the community mobilization framework within the context of a health communication intervention. The findings of this research delineate how STI risk reduction as well as participation and empowerment can be achieved through a community-based health promotion project targeted towards commercial female sex workers within the context of their lived realities of marginalization and oppression.

**Keywords:** commercial female sex workers; health promotion and awareness; HIV/STI risk reduction



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## 1. Introduction

Community-based communication can challenge institutionalized inequalities and generate empowerment among disenfranchised populations. Community mobilization can serve as an effective process of community-based communication among marginalized populations, generating active social engagement [1]. The current paper examines the utilization of community mobilization as a strategic health communication technique in an intervention to reduce human immunodeficiency virus (HIV) and sexually transmitted infections (STI) rates among marginalized and at-risk populations such as commercial female sex workers in a red-light district in India. The said red-light district is situated in the metropolitan city of Kolkata, and is the location of the *Sonagachi Project*, which is a health intervention program targeted towards commercial sex workers [2–4]. A brief description of the *Sonagachi Project* follows.

### 1.1. Sex Workers in India

In India, the majority of transmissions of HIV is attributable to the heterosexual route and one of the common modes of transmission is through commercial sex workers. Female commercial sex workers are at the core of the HIV epidemic along with men who have sex with men and injection drug users [5]. India has one of the largest number of people living with HIV, and HIV prevalence among commercial sex workers exceeds 5% [6]. Sex workers in India are also highly vulnerable to prevalence of bacterial STIs such as chlamydia, gonorrhea, and trichomonas [7].

HIV and STI prevalence is associated with harms of sex work including stigma, physical violence, sexual assault, and economic exploitation [8] The perpetrators of physical and sexual violence against sex workers generally involve a variety of agents including

pimps, intimate partners, brothel owners, clients, local criminals and law enforcement. Violence consistently remains one of the primary contextual factors that significantly raise sex workers' HIV/STI risk through being pressured by a client into unprotected sexual intercourse [9]. Besides negatively affecting their mental health and emotional wellbeing, violence against sex workers can heighten their vulnerability to HIV and other STIs [8]. Sex workers who are victims of violence report higher numbers of sex partners [8], less frequent condom use [10] and demonstrate higher risk of STIs than those who have not been victimized by violence [8]. Exposure to violence also results in increased alcohol use, illegal drug use and injection drug use [10].

### *1.2. The Sonagachi Project*

The *Sonagachi Project* is a sexually transmitted infections (STI) risk reduction intervention program conducted in a red-light district of Kolkata, India. The project owes its name to its location in the district which has the same name. *Sonagachi* has more than 50,000 sex workers residing and working within its boundaries, and is the one of the largest red-light districts of South and Southeast Asia. The *Sonagachi Project* began in 1991 to reduce HIV/STI infection rates among sex workers in and around the *Sonagachi* district in Kolkata [4]. The project was initially funded by a national healthcare research institute and later by the state-based West Bengal AIDS prevention council [4]. However, from 1995 onwards, the project was spearheaded by the sex workers themselves.

The original aim of the project was HIV/STI risk reduction and health awareness generation among sex workers. The implementation of the project saw a significant reduction in STI infection rates and a significant increase in condom compliance in *Sonagachi*. In addition to the targeted goals, the project managed to generate outcomes including establishment of cooperative banking and vocational training centers for the sex workers, and managed to unionize the sex workers [3]. The union of the sex workers is called *Durbar Mahila Samanway Committee* (DMSC). DMSC has its office in the red-light area itself and other parts of Kolkata. The *Sonagachi Project* is still ongoing as a peer outreach-based development and empowerment program that is being spearheaded by the sex workers themselves.

Below is a discussion of community mobilization as a strategic health communication practice, especially in the context of STI interventions among vulnerable populations.

### *1.3. Community Mobilization*

A community is identified as a group of individuals who share a common socio-cultural and economic background [11]. Community can be a significant factor in shaping public health behavior [12].

According to Campbell and Jovchelovitch (2000) [13], communities with members who perceive themselves in control of their lives are likely to take charge of their health, actively pursue healthcare-seeking behavior and strive to obtain health resources. A collection of individuals who have a high perception of control over their lives and health needs can result in a community that participates in health enhancing behavior and health promotion practices. In other words, as Basu and Dutta (2008, p. 71) noted, "situating a health communication model within a participatory community-based framework empowers members of the community to articulate their needs, map resources available, mobilize them in the production of positive health outcomes, and engage in health sustenance behaviors" [2].

Jana et al. (1999) [3] called community mobilization one of the guiding principles of reproductive health intervention among vulnerable communities and observed that the most effective and sustainable mechanism to address structural barriers to development is through and by the community. The community mobilization framework in health communication was noted by Person and Cotton (1996, p. 92) [14] to have two major characteristics. The first is its characterization of the relationships between individual, group, and organizational roles within a community that are utilized in a campaign. The

second basis of the model focuses on the nature and extent of the involvement of the community members, which included a "continuum of involvement, ranging from simple endorsement to building active coalitions" [14].

The idea of community participation is related with the concept of social commitment. An increased level of commitment towards remaining healthy within a community results in the generation of positive health practices by the individual community members. Contrarily, individuals who are members of a community with scant social commitment to pursue health, would have poorer health than those in a community with a higher degree of commitment towards health [2,15]. In STI intervention research, this model suggests that community mobilization can generate a higher degree of commitment towards a healthier life [16].

The basic tenets of participation inherent in community mobilization can precipitate free dialogue and collective engagement. Participation of community members ensures that "individuals have a voice in the decisions that affect them" [17]. "Subject-subject dialogue" in peer communication has the potential to disseminate knowledge, precipitating active social involvement and participatory action [18]. Dialogue can generate critical consciousness which can challenge oppressive and restrictive power structures.

A health promotion intervention based on community mobilization and community participation is notably different from the top-down model of health communication. The underlying conception of the top-down model is that the disseminator of information is the expert who knows what is best for the passive audiences and can take decisions on the latter's behalf. In contrast, a growing body of health communication researchers emphasizes the need of a community-based approach to rearticulate health and focus on the voices of the marginalized communities across the world [2].

As Inagaki (2007, p. 7) [1] noted, "by including the voices of the marginalized and underprivileged, communication processes can become more inclusive and open-ended rather than goal-oriented, and may provide a venue to directly address structural problems (for example, gender inequality) rather than just immediate issues (such as unprotected sex)". The element of participation in the community mobilization framework is noted to generate a discourse that bases itself on the aspirations of the people. Below are some of the strategies of community mobilization such as peer outreach communication and negotiation with stakeholders.

### *1.4. Peer Outreach Communication*

Peer outreach-based community projects involve the mobilization of some of the community members as peer educators who, in turn, educate and interact with their cohorts. Peer outreach usually entails interpersonal communication that is horizontal and not vertical as with top-down communication models. Community mobilization based on peer outreach methods can be more effective than top-down communication interventions in STI interventions among marginalized populations [3,4,17]. For example, a 2008 study observed a 40 percent decline in the combined rate of sexually transmitted infections in a group of commercial female sex workers in Cambodia who undertook participation-oriented peer outreach-based community mobilization, compared to an intervention that provided top-down educational information only [19]. Peer outreach education and communication are noted to be effective techniques for health promotion and awareness interventions among marginalized high-risk groups such as sex workers [3,4,17,19]. Community participation through peer outreach allowed the sex workers to "learn and practice skills that are tailored to their personal situations instead of simple listening to a lecture" and to "identify for themselves the barriers to safer sex and discuss potential solutions as part of their goal setting" (Sopheab et al., 2008, p. 242) [19].

### *1.5. Negotiation with Stakeholders as a Collaborative Partnership in a Community Setting*

Stakeholder negotiation involves actively engaging and interacting with all the stakeholders in a collaborative partnership to ensure favorable outcomes in a project. The

utilization of community mobilization and stakeholder negotiation can act as a strategic mechanism in HIV/STI interventions.

An example of a health promotion campaign successfully implementing community mobilization and stakeholder negotiation is the national AIDS program in Uganda. The Uganda program was characterized by "concerted and integrated efforts made at community level, including mobilization of local groups, widespread participation of several nongovernmental organizations (NGOs) in HIV prevention, collaborative partnerships with religious groups and community activists, ample funding, and openness about the scale of the problem and commitment to tackling it at the highest political level" [20]. The Ugandan project was successful in not only significantly decreasing HIV/STI rates but also precipitating effective risk reduction behavior and creating an empowering environment for confronting the epidemic [21].

Another example of a successful health intervention project that utilized community mobilization and stakeholder negotiation was in Thailand. That project was marked by coordination between government agencies, public health workers and brothel owners. There was no endeavor for eradication of sex work or rehabilitation of sex workers. The project managed to significantly reduce HIV/STI incidence in addition to generating a sustainable commitment towards safe sex and sexual health risk reduction practices [20]. In another instance, the *Soul City* entertainment–education initiative in South Africa triggered community mobilization at multiple levels targeting the issues of domestic violence and HIV/STI [22].

Community mobilization, peer outreach techniques and engaging the external stakeholders in a cooperative effort to achieve effective and sustainable harm reduction remain a viable mechanism of intervention among high-risk populations [20,23]. As Wellings et al. [20] noted:

> *Addressing of structural determinants, particularly poverty, demands the involvement of social as well as health sectors, and so requires co-ordination and collaboration across sectors and agencies . . . the range of people to be engaged in partnership is broad and includes economists, politicians, industry, the judiciary, and NGOs. A way of ensuring that joint action takes place is to make it not merely a generalised goal of interventions, but an explicit component of the program.*

Cooperation and support by stakeholders in the sex work industry can precipitate positive changes. Kerrigan, Moreno and Rosario (2006) [24] showed that positive workplace sexual health practices—including supportiveness by brothel owners and government agencies—is associated with increased condom use in the Dominican Republic. Lack of support from brothel owners and peers actively jeopardized condom use negotiation among sex workers in Singapore who were unable to resist client pressure for economic reasons [24].

Stakeholder negotiation does not always ensure genuine community participation and egalitarian democratic discourse. The disparity of power among stakeholders involved in a participation-oriented intervention can jeopardize its effectiveness [1]. The majority of international development initiatives involve, as Inagaki (2007, p. 13) [1] notes, "foreign organizations, foreign experts, national agencies and other 'official' actors that perform tasks according to their organizational guidelines and specific programmatic designs". Such an approach towards development can create a conflict between the target population and the external actors regarding who gets to set the agenda of the development program. The marginalization of stakeholder groups in the decision-making process can occur when the sense of project ownership does not materialize among the lay participants, thereby impeding the coalition building efforts among all the project stakeholders [25]. Stakeholder negotiation is expected to precipitate an egalitarian and mutually collaborative process of deliberation, but hierarchical and exploitative social relations can prove to be disruptive.

Community mobilization is a strategic approach to health and development projects and serves as a critical counter to "top-down" programs centered on the individual paradigm. "Based on important critiques of an undemocratic and unequal development

process which had often produced locally unpopular and thus ineffective projects, the involvement of the local people was intended to produce better-designed projects that had the endorsement of local communities, through an egalitarian and democratic discourse" (Cornish and Ghosh, 2007, p. 497) [26].

### *1.6. Community Based Health Approaches among Sex Workers in India*

Community empowerment has increasingly gained importance as one of the key strategies for tackling the challenge of HIV/STI among commercial sex workers. While there is still a dearth of large-scale implementation of community empowerment-based programs in India, there are several initiatives that have produced success. The most popular and well-documented community-based HIV/STI initiative among sex workers is the current *Sonagachi* project implemented in the Kolkata red-light district [27]. Another example is *Avahan*, the AIDS initiative which was funded by Bill and Melinda Gates Foundation and took place in the states of Andhra Pradesh, Tamil Nadu, Karnataka and Maharashtra, Manipur and Nagaland in India [28]. Other examples of community-led projects among sex workers include the initiative conducted by the Belgaum Integrated Rural Development Society in Karnataka [29] and *Ashodaya Samithi*, also in Karnataka [30].

## 2. Objectives

The current paper explores the application of community mobilization as a strategic health communication technique in HIV/STI intervention among vulnerable and marginalized populations such as those at the *Sonagachi Project*. It is examined how the utilization of techniques such as peer outreach education and communication, stakeholder negotiation and multiple level capacity building can create a strategic process of community-based communication that can promote HIV/STI risk reduction and empower the sex workers. It is analyzed how HIV prevention through the community can incorporate behavior change communication with a focus on the wider context that increases HIV/STI risk, including existing institutional inequalities and structural oppression.

## 3. Method

Semi-structured interviews were mainly used for this project. Before starting the data gathering phase, the researcher communicated with the members of DMSC over email and telephone and next, spent two months in the red-light area to work on the logistics. The researcher reviewed project documentation that was provided by DMSC. These included research papers, internal project reports, unpublished manuscripts given by DMSC members and a best practice synopsis collected from the area. These reports provided data on the rates of condom compliance and HIV/STI infection rates of the sex workers in the area.

The researcher visited sex work sites in North Kolkata localities that formed the heart of the red-light district. There were concentrated pockets of sex work zones that co-existed with mainstream neighborhoods in these areas. Interviews were conducted with DMSC committee members, peer educators, and non-peer sex workers from these areas.

As part of a participant observation strategy, the researcher spent extended periods of time observing DMSC members in their offices and respective outreach sites. Prolonged interaction with the sex workers in their own settings allowed the researcher to develop a rapport which facilitated free and open conversation with them. Prior permission was obtained from DMSC's central governing committee before the commencement of any research work and interviewing. Institutional Review Board (IRB) research approval was also obtained from the researcher's institution.

A total of 37 interviews with commercial female sex workers were obtained. Among the 37 interviewees, 30 were either current or past members of DMSC administrative committees or peer outreach workers. The participants were interviewed in the DMSC offices located in the heart of *Sonagachi* and in project sites within *Sonagachi* and adjoining areas. No incentives were given and participation was purely voluntary.

The researcher employed semi-structured interviews which included open-ended questions. The researcher utilized a guideline for questioning but interviewees did not limit their conversations to answering questions. Each of the interviews lasted between one hour and one and a half hours on average. The interviewees spoke in Bengali which was the native language of the interviewees. A sample questionnaire, which is a translation from the original Bengali version, has been provided in the Appendix A.

The researcher's intention was to maintain a reflexive-empiricist stance, as evident in post-modern interviewing [31]. As Gubriem and Holstein (2003) [31] noted:

> *Interviewers have become more conscious about issues of representation seriously asking questions such as whose stories are we telling and for what purpose? . . . Respondents are no longer seen as faceless numbers whose opinions we process completely on our own terms. Consequently there is increasing concern with the respondent's own understanding as he or she frames or understands an "opinion."* (p. 52)

Ideally, such a stance should work towards minimizing the distinction between the interviewer and the respondent. Perhaps this is easier said than done considering the socio-economic discrepancies between the researcher and the interviewees. The researcher emphasized her linguistic and cultural commonality with the sex workers. Her entry into the testimonies of the women of *Sonagachi* was partly located in her own subjectivity as a woman who grew up in the same city as they did. However, such commonalities between the researcher and her interviewees could not obfuscate the obvious separation between their lives. The distinction was diminished to an extent by mutual endeavors but in reality, hierarchical social relations cannot be wished away easily.

The transcripts were recorded in Bengali and no videotaping or audiotaping took place. The transcripts of the interviews were translated and comprised 187 pages of text. Twenty-five of the interviewees provided their full names, whereas 17 of the interviewees gave their first names only. During the interviewing process, no identifying information such as age, family background, years in the profession, or health status was obtained. The names provided by the interviewees are not their actual names since sex workers tend to use pseudonyms in their profession.

The transcripts of the recorded interviews were examined using open coding and axial coding to develop an understanding of the emergent discourses [32]. A research assistant who was a native Bengali speaker reviewed the translated transcripts and the coded categories. The qualitative analysis was conducted manually and no analytical software was used. A grounded theory approach was used to code the transcripts [32,33]. Themes and concepts that emerged from the data helped to develop an understanding of the emergent discourses. During open coding, the data were broken down, examined, and compared for similarities and differences. The themes that were found to be conceptually similar or related in meaning, were grouped into categories as units of analysis. It was analyzed whether the emerging codes aligned with theoretical concepts that were being investigated. The initial concepts were then checked and validated. Three primary themes identified by the author and validated by the research assistant are discussed below.

## 4. Findings and Discussion

The interview transcripts show different facets of community mobilization as demonstrated in the three themes that emerged from data analysis. Strategies such as common definition of a problem at a community level—by emphasizing on disease burden and vulnerability of the sex workers—and unionization of the latter, helped to reinforce the health communication aspect of a peer outreach initiative. Overall, HIV/STI prevention occurred through behavior-change strategies delivered through peer outreach. The peers also disseminated health information on STIs and risk reduction, and distributed free condoms. Stakeholder negotiation as a strategy helped to reduce violence, increased sustainability of a HIV/STI intervention and established a multilayered strategy of capacity building. A cooperative banking program that gave microcredit loans precipitated as a sustainable economic strategy aided in the empowerment of a historically marginalized community.

Barriers to health such as stigma, violence and economic exploitation were thus addressed through structural and community mobilization strategies such as stakeholder negotiation and a cooperative banking system.

### *4.1. Community Mobilization and Peer Outreach in Sonagachi*

Community mobilization is one of the primary strategies implemented in the *Sonagachi Project*. Community mobilization was undertaken at three concurrent levels—community, group and individual. At the community level, the HIV/STI incidence was defined as a problem for the entire local community and its mitigation was articulated as the responsibility of all members. At the group level, the sex workers were mobilized as peer outreach workers. The latter were given requisite training to serve as sources of preventive health information and knowledge of safe sexual practices among their colleagues. The information on health awareness and prevention was initially provided by healthcare professionals associated with the project. The information was subsequently disseminated among sex workers through peer outreach initiatives. The peer worker framed the obtained healthcare information in her colloquial jargon and transmitted it to her colleagues. At the individual level, the intervention generated the involvement of the individual sex worker in multiple ways.

Highlighting a common problem at the community level resulted in the facilitation of community dialogue and collective action. To maximize community participation, the *Sonagachi Project* prioritized meeting the personal needs of the sex workers instead of gearing the campaign towards an occupational health initiative. Initially, the project put its focus on the process of imparting free healthcare services to the sex workers by forming mobile care centers within the red-light area. Distribution of free condoms was also actively conducted. However, emphasis was put on fulfilling the healthcare requirements of the sex workers rather than stressing individual-level behavior change such as condom usage. Subsequently, information about HIV/STIs was imparted through an elaborate process of peer outreach education and communication [4].

The interviews with the sex workers delineated the importance of the implementation of peer outreach in the *Sonagachi Project*. The interviewees highlighted why peer outreach was deemed essential as the appropriate method for information transmission, confidence building and collective interaction. The preference for peer outreach appears to stem from existing wariness among the sex workers about outsiders. The latter include social workers, non-government organizations (NGOs), and healthcare professionals. In contrast to the mistrust against external agents, the sex workers held confidence in the empathy assured by their peers.

The problem of distrust towards outside agencies was reiterated by Bharati:

> *One must ask the questions, what NGOs are doing for us. If you ask me, it is nothing. They want to save us, and rehabilitate us. But we don't ask to be saved or rehabilitated. They think we hate ourselves for our professions, they think we live in shame for being sex workers. But we ask for respect for our profession, respect and recognition of our worker rights. So look, we and the NGO s do not even have a common standpoint! How can organizations which do not see eye to eye with us work for our benefit? The NGOs need to ask themselves what they are doing wrong. How come the girls they are rescuing from sex work keep running away, how come the sex workers are so reluctant to go to NGOs and yet eager to communicate with their colleagues to solve their problems?*

Bharati's statements highlight the trust deficit between the sex workers and outside organizations, especially NGOs. The lack of confidence towards international agencies had also been exacerbated by the making of the movie "*Born into Brothels*" (2004) by Zana Briski. The movie, which won an Academy Award for best documentary, chronicled snapshots from the lives of a few sex workers' families in *Sonagachi* and their children. According to the interviewees, the movie falsely depicted the sex workers as callous and immoral beings, and unconcerned and abusive mothers—it was a portrayal that infuriated the residents of *Sonagachi*.

The interviewees alleged that most of the movie was shot stealthily and without obtaining permission from the portrayed sex workers. Bharati said "we don't trust these filmmakers at all, they come here to make money. They have no qualms in showing a distorted picture, they will scream about their privacies but do not care about ours." The animosity towards the documentary that won international accolades and the allegations of false portrayal against the filmmaker appeared to have evolved in wariness towards foreign individuals. The interviewees emphasized the self-sufficiency of the sex workers to survive without much international aid. Here, another reason for engaging in peer outreach is highlighted—the empathy and understanding of a fellow colleague that is missing in outside agencies. Madhabi said:

> *You are a researcher right? You are educated and you know of many scientific facts. But if you come to me to talk about STDs will I open up to you? No. because I don't think you will be able to understand my point of view. My health is not due to me alone, it is due to my profession, my family, my life conditions. Nobody will understand that better than a fellow sex worker. She has been through the same life as I have been; she has been through the same situations as I have been. For that we need our colleagues to work as peer support groups. We learn best from our colleagues, as they are our peers, not our teachers. They are not better than us, they do not look down upon us. Our peers are us.*

Peer outreach is deemed essential as the appropriate method for information transmission, confidence building and collective interaction. STIs and sexual health are taboo topics and discussing them with strangers is an unfeasible proposition in India. For sex workers—who are also socialized to not to speak about their sexual health problems in public—there are sometimes scant resources that are available and many choose to self-medicate when it comes to treatment of STIs [27]. Essentially, peer outreach programs can break the culture of silence that surrounds the discourse on women's sexuality, especially for a hyper-marginalized and stigmatized population such as sex workers in India [27].

Another reason for preferring the peer outreach system was the location of the peer worker within the perimeters of the sex work sites. Residing in the same red-light district was noted to be a distinct help in handling local problems and resolving issues within the local context. Sapna remarked, "if we employ outside people to work with us, they will work from 9 a.m. to 5 p.m. and then leave. If I have a problem to deal with at 9 p.m. the outside people will not be here. But the peer educator will be here to help. She is not only my colleague but also my neighbour and friend".

Initially, peer outreach in *Sonagachi* was intended to promote HIV/STI risk reduction and health awareness generation, and provided preventive care to the sex workers. However, peer outreach evolved to precipitate community development which challenged the barriers to health and empowerment. Peer outreach workers distributed free condoms and disseminated information on HIV and STIs such as syphilis, gonorrhea, hepatitis B, genital warts, trichomoniasis, herpes, candidiasis and pelvic inflammatory disease. Posters were handmade and circulated by peer workers in order to serve as teaching tools. Peer workers also convinced their colleagues about the advantages of becoming members of a union, the importance of participation in board elections for choosing the leadership of the union, the resources offered by DMSC including educational and vocational centers and the cooperative banking system.

### *4.2. Negotiation with Stakeholders*

Community intervention in the *Sonagachi Project* involved a focus on the interdependencies between the sex workers and the local agents of the red-light district. The interdependent dynamics include the process of identification of and interaction with stakeholders within the sex work industry. The stakeholders included individuals both within and outside the realm of sex work such as landowners of sex workers, pimps, clients, law enforcement agencies and members of political parties. Cornish and Ghosh [26] elaborate on the importance of engaging the local agents in a community:

> *What holds community members together is not simply the fact that they live in the same locality, nor that they necessarily share an identity, nor that they are equals, but they are part of an interdependent system in which their actions have effects on each other by virtue of their participation in a joint activity. Thus, the membership of a community includes people with divergent and even conflicting interests, worldviews and identities. From this perspective, the boundaries of the community in a community health project include all of the actors who take part in shaping the project, including members of the marginalized social group, health and development professionals, and other local interest groups. A community intervention is an intervention into this structured ecology of power relations.*

One of the objectives of the *Sonagachi Project* was the emphasis on the status of sex work as a labor industry and focusing on the losses of the stakeholders in case of a high incidence of HIV/STI infection among the work force. Jana et al. (1999) [3] observed that such an initiative also helps to form public opinion against harassment of sex workers by agencies such as police, brothel owners and pimps. The project facilitates an active engagement and relationship between the sex workers and the stakeholders. Such a relationship was achieved by framing sex work as useful in upholding the long-term financial interests of the stakeholders by maintaining a viable and healthy workforce [3].

An integration of the interests of the stakeholders and the target population facilitated an understanding of issues relevant to a successful health and development initiative. From the interviews, it became apparent that most of the stakeholders, including police, pimps, brothel owners, political party members, and local hoodlums—with the noted exception of clients—have served as sources of harassment, violence and oppression against the sex workers. Yet, the communication processes set in motion through negotiation created empathy towards the sex workers and focused on the importance of abstaining from harassing the latter. The importance of free communication with external agents is explained by Sadhana:

> *Working with the external agents is necessary. We are vulnerable to the workings of the outside agents. Our vulnerability is our weakness. We will have difficulty in going on with our project if the outside people refuse to act with us. We need to talk with them, tell them about our problems and learn about theirs. We need to maintain communication with them. Such talking can generate mutual trust and lessen violence. Even arguments and counterarguments are better for knowing about each other's point of view than no talking at all.*

As a strategy of the peer outreach program, the sex workers were also given "on-the-job training sessions" [18]. These sessions also inspired the sex workers to combine and form an exclusive platform for the sex workers. Referred to as the *Durbar Mohila Samnwaya Committee* (DMSC), the sex workers' collective evolved out of the *Sonagachi Project* and offered them an opportunity to assert their collective voices. The DMSC was noted to increase "in-group recognition among sex workers, and the articulation and demand for their rights as workers" [4]. *Durbar*'s mission is articulated by the following excerpt from one of its publications entitled *Durbar Bhabona* [34]:

> *Durbar strives to enhance a process of social and political change in order to establish rights, dignity and improvement of social status including quality of lives of all sex worker communities of the world as part of the global movement to establish rights of marginalized people through a) improvement of image and self esteem of marginalized communities b) influencing existing norms, policies and practices operating at all levels of society c) empowering communities through a process of collectivization and capacity building d) addressing power relations within the sex sector and outside e) formal and informal alliances with individuals, groups, institutions and movements.*

Cornish et al. (2007, p. 505) [26] noted that historically existing institutional inequalities can create conflicting and unequal set of relationships among community members. "In such instances, the contradiction of involving more powerful others is necessary to

the extent that those others either have power to put a stop to the project, or can offer it support without which it can fail. Ideally, as the participatory project develops capacity, independence from the other groups grows". The sex workers in the *Sonagachi Project*, while negotiating with external stakeholders for the sake of sustainability of their initiative, also endeavored for autonomy and empowerment by implementing policies such as unionization and establishing a multilayered strategy of capacity building for the sex workers.

### *4.3. Ensuring Economic Empowerment*

Ensuring economic empowerment of the sex workers by forming a cooperative banking society was one of the major steps of the *Sonagachi Project*. The interviews with the sex workers emphasized the financial uncertainty that characterized lives in the red-light area. The economic insecurity was chiefly exacerbated by extortionate money lending practices that exist traditionally in Indian sex work sites. The interviewees noted two specific kinds of oppressive money lending techniques in sex work sites: chit funds and usurers in gold and pawn shops. Project documentation and interview notes establish a picture of the operations of such chit funds and pawn shops.

The chit funds generally assured an interest rate of half of the deposited money after three years and a quarter after two years. Yet, in reality, many of these funds would close down after one year, embezzling the money of the sex workers. The latter had little recourse against such fraudulent misappropriation of their hard-earned savings. Most of the sex workers were illiterate and did not have the means or ability to register a complaint against such criminal funds. Secondly, being designated an illegal and criminal group themselves, the sex workers often desisted from seeking redress from law enforcement agencies against such fraudulence. Usury in gold and pawn shops of the red-light area is also a prevalent practice. Locally referred to as *dadan*, the interest rates charged by such money lenders were exorbitant and varied between 72% to 720% a year. "As a result, we could not save our incomes and it was impossible for many of us to escape debt traps. Between the chit funds and the *dadan* we were trapped in a cycle of perpetual poverty and hopelessness," noted Sadhana.

The Usha Multipurpose Co-operative Society Limited, a cooperative banking system, was formed to tackle the issue of economic disempowerment faced by the sex workers. It was formed by six sex workers of *Sonagachi* in 1995 and catered solely to sex workers. *Usha* was identified as the first cooperative banking system operated by sex workers in Southeast Asia [3,4]. Membership in the *Usha* cooperative banking was granted only to the sex workers. *Usha* ran a micro-credit program for the sex workers and also marketed condoms. "Sex workers are often overcharged when they buy condoms from outside shops. *Usha* ensures that good quality condoms are available to sex workers at economic rates," said Soma. *Usha* also started the marketing of sanitary napkins and cosmetic products. Bharati noted that the cooperative endeavored to generate employment opportunities among sex workers' children and retired sex workers by giving these groups preference in terms of employment at the bank office.

The cooperative banking society appears to be a significant step in facilitating empowerment of the sex workers. Mrinal remarked:

> *Usha is for the sex workers and by the sex workers. During August 1995, we persuaded the Government of West Bengal to modify the co-operative law so that we could register Usha as a co-operative of sex workers rather than being passed off as one by housewives. The registration of the co-operative marks an important step for us sex workers in our struggle to redefine our occupation and earn respect and legal status.*

Thus, the formal recognition of *Usha* by a state institution as the cooperative banking society of sex workers was seen as a strategic advantage for DMSC to bolster its campaign for the social and legal recognition of sex workers, and sex workers' entitlement to labor rights. Being a cooperative run by sex workers, the decision making and functioning of *Usha* were conducted by a marginalized and economically disempowered group. Krishna

observed, "since *Usha* is a co-operative its ownership and benefits are equally distributed among us. *Usha* is an organized movement of us, the sex workers, to gain financial reliance and recognition in a hostile society".

## 5. Conclusions

Commercial sex workers in India suffer significant health disparities due to complex barriers in multiple areas. They have limited access to healthcare including HIV/STI prevention services and remain among the highest risk groups for contracting STIs. Barriers such as poverty, stigmatization, violence, criminalization and marginalization contribute to adverse health outcomes suffered by commercial sex workers in India. Although there is noteworthy evidence that programs utilizing the community mobilization framework can be effective in addressing the socioeconomic barriers that affect sex workers, there is a significant lack of case studies that focus on community-based interventions. The current study endeavors to fill the gap in health communication research on community-based initiatives among commercial sex workers by exploring how HIV/STI risk reduction, health promotion, leadership and resistance can be achieved within the context of the lived realities of marginalization and oppression.

The community mobilization framework utilized by the sex workers enabled them to engage with the hierarchical social inequalities and exploitative structures within which they are situated. The reliance on peer outreach education and communication appears to stem from both apprehension about outside intervention and assurance of understanding and empathy from peer groups. The situation of the sex worker in geographical and socio-cultural space of the red-light district also appears to contribute to the feasibility and practicability of the peer outreach project.

Negotiation with external stakeholders within and outside the realm of sex work helped to integrate the interests of local actors with those of the sex workers. Interaction with the stakeholders notably generated empathy and precipitated a reduction in violence against the sex workers, thereby ensuring the sustainability of the project. Such stakeholder engagement can generate a sustainable project based on community participation that can challenge hierarchical and exploitative power relations.

The various attributes of capacity building were in congruence with the overall aim of the project—to carry out social welfare measures for the sex workers and their children. The notion of cooperative banking was unique, for it served the interest of the sex workers and provided a solution for extortionate money lending practices prevalent in the sex sites. Providing credit for the sex workers also enabled them to run small businesses to supplement their income. The government recognition of the bank as a state institution was feted by the sex workers as a step toward attaining labor rights. The multifaceted capacity building strategies of the *Sonagachi Project* appear to be geared towards achieving socioeconomic empowerment in all possible forms.

Notwithstanding the possibility that the "condition of marginality forces participatory projects to involve and adapt to more powerful groups" (Cornish et al., 2007, p. 497) [26], the sex workers' leadership and involvement in the project cannot be overlooked [6]. The current research documents the struggles of a historically exploited community in India to mitigate its marginalization through implementation of a multilayered strategy of capacity building and economic empowerment.

## 6. Limitations

As noted before, all interviewees were either current or past members of DMSC administrative committees or peer outreach workers. The interviewees were selected by DMSC itself; as a result, there were no non-peer sex worker interviewees. Similarly, all the interviewees were also heavily involved in the administrative work of DMSC. A less than representative picture of sex workers in *Sonagachi* was obtained as a result, and this formed one of the limitations of the research. However, since it was impossible to gain access to the sex workers without the involvement of DMSC, this was perhaps one of the most feasible

methodologies that could be employed. It was also not possible to conclude whether a process of egalitarian democratic participation was precipitated by the *Sonagachi Project.* Most of the interviews that were obtained were those of sex workers or people actively involved in the operations of DMSC. The opinion of the external stakeholders could not be obtained due to time constraints and logistical issues.

## 7. Future Directions

The current project entails an intervention contextualized by the structured ecology of hierarchical power relations and allows for a unique example of the application of the community mobilization framework in HIV/STI risk reduction and health promotion among marginalized communities. The *Sonagachi* framework of community mobilization among sex workers can serve as a model to create successful interventions among high-risk populations in other parts of the developing world. Decriminalization of sex work is also an important step to enable the reduction of violence against sex workers. An understanding of the social acceptability of sexual labor can lead to a recognition of women's fundamental right to make choices regarding their own bodies. Community-based strategies can contribute to this by reconstructing the social norms within the sex work sector and create an inclusive space for hyper-marginalized populations such as sex workers.

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**Data Availability Statement:** No new data were created or analyzed in this study. Data sharing is not applicable to this article.

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## Appendix A

1. How did *Durbar Mohila Samanway Committee* (DMSC), the union of sex workers, form?
2. Can you tell me about some of the work done by DMSC?
3. Can we talk about the peer outreach program implemented at the *Sonagachi* project? What do the peers do? How are peers selected and trained? How do they interact with their colleagues?
4. How do you communicate about sexual health? What are some of the challenges that you face while talking about sexual health?
5. Do you face violence in your profession? If yes, what are some of the steps that you have taken to address that violence?
6. Have you faced economic exploitation in your profession? If yes, what are some of the steps that you have taken to address that?
7. How would you define your role in reducing the of risk of HIV/STI among your colleagues and creating awareness?

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