Barriers to Exercise Rights of Female Sex Workers in Chittoor District

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Abstract

Female Sex workers in Chittoor district face multifaceted challenges in exercising their rights due to a complexity of legal, social, economic and structural barriers. Despite constitutional protections and human rights frameworks, these women remain among the most marginalized groups in society HIV Prevention interventions recognize the need to protect the rights of key populations and support them to claim their rights as a vulnerability reduction strategy. This study explores knowledge of human rights, and barriers and facilitators to claiming rights among female sex workers who are beneficiaries of community mobilization intervention in Chittoor district.

Keywords: Sex work, Female sex workers, Human rights, Barriers, HIV, Community mobilization

Introduction

Key populations, such as female sex workers face a disproportionate burden of HIV. Studies from India document that female sex workers experience widespread human rights violations, including sexual and physical violence, Unlawful arrest and detention, HIV related stigma and discrimination and are deprived of social benefits and entitlements otherwise access by the general population. These human rights violations are pervasive, undermining HIV prevention efforts and directly or indirectly elevating HIV vulnerability. Forced unprotected sex results in injuries that increase HIV transmission, a recent study indicates that elimination of sexual violence alone could avert 18-21% % of HIV infections among sex workers and clients over the next decade in settings such as Kenya and Canada. Lack of access to banking services increases female sex workers vulnerability to theft as well as to debt to informal providers (such as money lenders, madams and pimps), reducing their ability to negotiate sexual exchange, and stigma and discrimination in health care settings are documented barriers to accessing HIV testing services among key population.

Economically, the majority of female sex workers (FSWs) belong to marginalized caste communities and low-income backgrounds. Their entry into sex work is largely driven by poverty, limited access to education, and the lack of viable livelihood options (Swendeman et al., 2009, NACO, 2015). These economic pressures, when combined with social stigma and exclusion, make FSWs particularly vulnerable to client coercion- such as being compelled to engage in unprotected sex in exchange for higher payments – which significantly increases their risk of HIV infection (Panchanadeswaran et al.,2008; Beattie et al., 2010). Societal perceptions further deepen this marginalization, as public narratives in India often equate sex work with immorality or human trafficking, disregarding the autonomy of adult women who choose sex wok as a means of survival or livelihood (Kotiswaran 2011). Such framing strips FSWs of fundamental human rights, including the right of dignity, bodily autonomy, and protection from violence and discrimination.

Objectives

1. Examine the extent of female sex workers awareness regarding human rights.
2. Determine the proportion of FSWs who actively exercise or assert their rights.
3. Explore the key obstacles that hinder FSWs from claiming their rights.
4. Identify the enablers and support mechanism that assist FSWs in accessing their rights.

Methods

Research Design: The study is situated in the former Chittoor District of Andhra Pradesh, India, a region characterized by a notably high HIV prevalence among female sex workers (FSWs). Our research specifically targets FSWs, excluding

other key populations such as men who have sex with men (MSM) and injecting drug users (IDUs), due to the HIV epidemic in Chittoor being predominantly driven by FSWs. Data for this study were derived from the Behavioural Tracking Survey, a cross-sectional survey conducted to monitor critical aspects of HIV prevention activities, including condom usage, and to evaluate awareness of specific human rights, the exercise of these rights, and the obstacles and facilitators in claiming them

Sampling

The survey was conducted among female sex workers (FSWs) from three Mondal's in Chittoor district, Andhra Pradesh, India. These Mondal's were purposefully selected to represent diverse geographical and socio-cultural characteristics. A target sample size of 100 completed interviews was established for each region, determined by the prevalence of consistent condom use. The sampling frame was constructed using the number of FSWs registered with community organizations (COs) in each region. A two-stage random cluster sampling method was employed to select respondents. In the first stage, COs within different clusters were chosen using a probability proportional to size procedure. In the second stage, the required number of FSWs was randomly selected for interviews within each selected CO. Ultimately, a total of 300 FSWs were interviewed.

Data collection

To qualify for participation in the FSW (female sex worker) survey, individuals were required to be female, at least 18 years old, and to have engaged in sexual activity in exchange for cash or kind during the month preceding the survey. and actively seeking clients by moving between locations or frequenting known public spots such as street corners, highways, or other pickup areas within the study's operational boundaries. Interviews were carried out by trained personnel fluent in both spoken and written Telugu, the local language of Andhra Pradesh. The survey questionnaire was initially developed in English and then translated into Telugu. Prior to the main data collection, the interview schedule was pilot-tested in communities resembling those targeted in the survey

Integrity Policy: Prior to participating in the interview, all respondents provided verbal consent. To ensure confidentiality, no personal identifiers such as names or addresses were recorded on the questionnaires. Participants were informed of their right to withdraw from the survey at any point without any consequences. While there was no monetary compensation for their time, participants were directed to relevant services offered by the implementing agencies in the study district.

Measures

Demographic and Lifestyle Factors:

- **Age**: Categorized as <30 years and ≥30 years.
- **Formal Education**: Distinguished between those with no formal education and those with formal education.
- **Marital Status**: Classified as never married, currently married, and widowed/divorced/separated/deserted.
- **Usual Place of Practicing Sex Work**: Grouped into rural and urban/semi-urban locations.
- **Current Living Status**: Defined as living with spouse/family members, living with others, and living alone.

These variables were selected to provide a comprehensive understanding of the participants' backgrounds and behaviours in relation to the study's objectives.

Awareness of Human Rights among respondents

In this study, respondents' awareness of human rights was evaluated using a single yes/no question asking whether

they had ever heard of human rights. Those who answered "yes" were further prompted to name specific rights they were familiar with. Their spontaneous responses were categorized into five pre-defined groups: the right to access healthcare services, the right to dignity and equality, the right to education, the right to property, and the right to live free from stigma and discrimination. Based on their responses, participants were divided into two groups: individuals who named two or more of these rights were considered to have greater knowledge of human rights, while those who identified only one or none were considered to have limited knowledge.

Exercising Rights and Identifying Barriers and Drivers:

Participants who indicated they were aware of human rights were asked whether they had ever attempted to exercise or claim these rights. Those who responded affirmatively were then asked to identify the individuals or organizations that had supported them in this process. Their answers were categorized into seven groups: community organizations (COs), health clinics (including ART and STI/RTI clinics), the District Collector, legal or paralegal professionals (such as staff from District Legal Service Authorities or para-legal volunteers), staff from the District AIDS Prevention Control Unit (DAPCU), the police, and others.

To understand the challenges in claiming rights, respondents were also asked to name perceived barriers. Their spontaneous responses were classified into the following seven categories: neighbours, regular partners or spouses, lack of awareness, stigma, government officials, the judiciary, and other factors.

Collective Efficacy

In this study, collective efficacy was evaluated by asking female sex workers (FSWs) the following direct question:

"How confident are you that sex workers can organize to speak for their rights?"

Responses were categorized as follows:

- **Not confident or somewhat confident**: coded as 1 (not confident)
- **Very confident or completely confident**: coded as 2 (very confident)

This approach aligns with methodologies used in similar studies assessing community mobilization and empowerment among FSWs in India.

Results

Respondent Profile

Notable variations were observed in certain sociodemographic characteristics among female sex workers (FSWs) (Table 1). A majority (57%) of FSWs were aged 30 years or older, 56% had no formal education, and 67% were currently married. Regarding living arrangements, 77% resided with their spouse or family members, while 11% either lived alone or with others.

No significant differences were found in the usual location of sex work across the three regions, with just over half of the FSWs reporting that they typically practiced sex work in urban areas.

Table 1: Sociodemographic Profile respondents (FSWs)

Characteristic	Category	Percentage (%)	Sample Size (n)
Age	≥30 years	57	171
	<30 years	43	129
Formal Educati	No	56	168

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	Yes	44	132
Marital status	Currently married	67	201
	Not married (never married, widowed/divorced/separated)	33	99
Living arrangement	Living with spouse/family members	77	231
	Living alone or with others	11	33
Usual place of sex work	Urban areas	51	153
	Rural areas	49	147

Knowledge of human rights

A significantly larger proportion of female sex workers (FSWs) reported awareness of human rights. Among those aware, notable differences were observed across groups in terms of knowledge, with a significantly larger proportion of FSWs reporting awareness of two or more rights. Knowledge of specific rights was low: in both groups, among those aware of rights, two-fifths or more could not name any of the five specific rights, and only 20% of FSWs were aware of their right to be free from stigma and discrimination. Just over half
(54% of FSWs) were able to name the right to health. A significantly larger proportion of FSWs were aware of the right to education (40%) and the right to property (27%).

Table 2: Awareness of Human Rights Among Female Sex Workers (FSWs)

Indicator	**FSWs(n=300)**
Aware of human rights	83% (249)
Knowledge of two or more rights	38% (95)
Right to access health services	54% (135)
Right to education	40% (100)
Right to dignity and equality	35% (88)
Right to property	27 %(68)
Right to freedom from stigma and discrimination	20%(50)

Rights assertion Among female sex workers (FSWs) who were aware of their rights, 70% reported having the ability to claim them. Regarding collective efficacy, over one-third (33%) of FSWs expressed a lack of confidence in the ability of sex workers to organize and advocate for their rights.

Drivers and Barriers to Human Rights Engagement Drivers:
(fig 1)

- Community Organizations (COs): 60% of FSWs reported that COs facilitated their ability to claim rights.
- Health Clinics: 10–13% indicated that health clinics assisted in claiming rights.

- District Collector: 10–17% mentioned the District Collector as a facilitator.
- Legal/Para-legal Authorities: 10% sought assistance from legal or para-legal authorities.

Barriers: (fig 2)

- Neighbours: 41% perceived neighbours as the main obstacle to claiming rights.
- Regular Partners/Husbands: 24% identified regular partners or husbands as barriers.
- Lack of Awareness: 16% cited lack of awareness as a significant barrier.
- Stigma: 19% reported stigma as a hindrance.

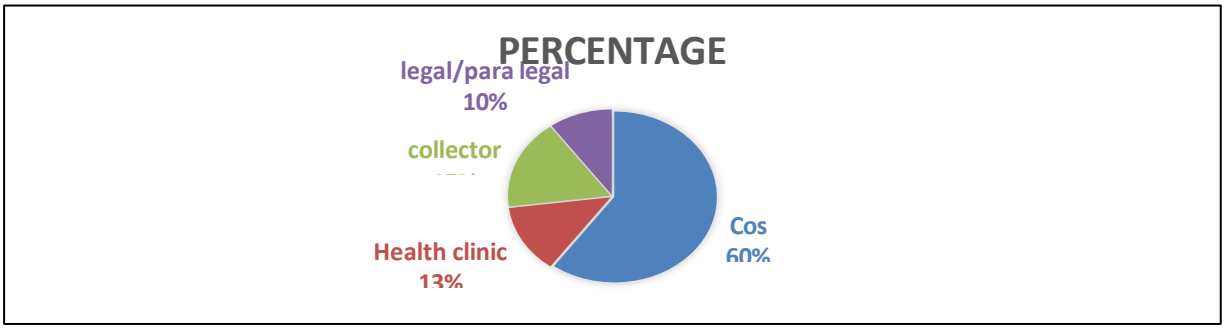

Fig 1 Drivers in claiming rights as reported by female sex workers.

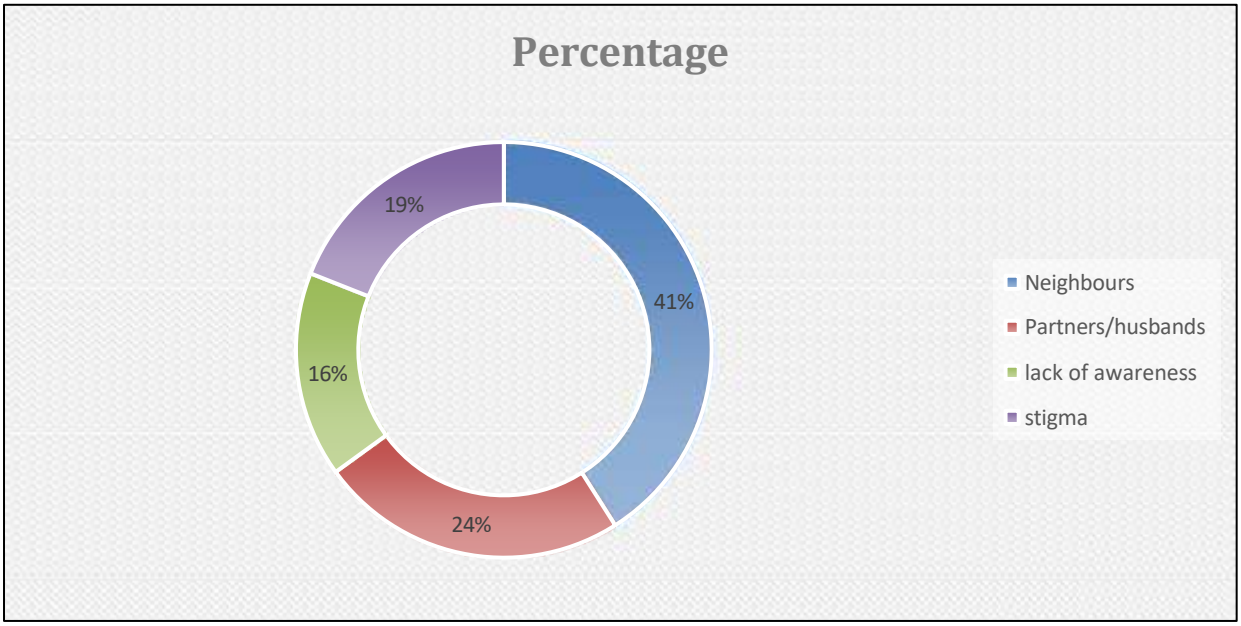

Fig 2 Barriers in claiming human rights reported by female sex workers.

Discussion

Although there is increasing acknowledgment of the importance of safeguarding the rights of vulnerable populations to ensure a sustained HIV response—and despite the fact that international frameworks and national laws guarantee the health, social, economic, civil, and political rights of all individuals—our study reveals that many key populations, especially female sex workers (FSWs) in Chittoor District, remain unaware of these rights. This lack of awareness hinders their ability to recognize when their rights are being violated, which in turn limits their access to legal remedies, support services, and justice. Moreover, many within these groups have not exercised their rights, restricting their control over working conditions, consistent use of safe sex practices, access to non-discriminatory healthcare, and eligibility for social and economic benefits. These gaps ultimately heighten their vulnerability to HIV. These findings are particularly concerning, given that marginalized populations face a higher risk of human rights violations. Promoting rights awareness and ensuring protection for these groups is essential for reducing HIV vulnerability and achieving Sustainable Development Goals (SDGs) 3, 5, and 8, which focus on good health and well-being, gender equality, and decent work and economic growth. "Ensuring access to quality health and well- being, advancing gender equality and empowering women, and fostering inclusive and productive employment opportunities for everyone."

The effectiveness of HIV prevention relies on the capacity of key populations to assert their rights and access necessary services. Importantly, UNAIDS highlights the significance of legal and rights literacy, as well as access to justice, remedies, and redress, as essential components of human rights programs within the HIV response framework. While the primary aim of the HIV prevention initiative in Andhra Pradesh is to enhance the ability of key populations to comprehend and exercise their rights, this study reveals that a significant number of female sex workers (FSWs) have never asserted their rights. Previous research indicates that abuse occurs without consequence, as key populations encounter obstacles in pursuing justice, and rights violations are seldom reported due to a prevailing sense of hopelessness regarding the punishment of offenders, coupled with fears of additional violence.

Additionally, community mobilization initiatives should tackle stigma by fostering awareness among community members, including families, peers, and sexual partners, about the fundamental rights of key populations, such as those involved in sex work and individuals engaging in homosexual relationships. These initiatives should also encourage the inclusion of these marginalized groups in society by promoting their active participation in public meetings. Community gatherings can serve as platforms for discussions and awareness- raising about stigma and the advocacy of the rights of key populations. Approaches focused on community empowerment are not only cost-effective but have also shown a decrease in stigma and its associated effects. Members of community organizations, including advocacy and crisis response groups in India, have reported a decline in perceived discrimination, violence, and police harassment, alongside improvements in economic empowerment and social support.

In light of the identification of government personnel and the judiciary as obstacles to the assertion of rights, and considering that only a limited number of key populations indicated support from the police, para-legal authorities, and district administration in claiming their rights, it is essential to establish connections with crucial stakeholders—legal authorities, government agencies, and law enforcement—to enable key populations to access services and seek legal remedies for rights violations. Peer educators and outreach workers can effectively disseminate information and services to marginalized groups; existing peer and outreach networks should be leveraged to inform female sex workers about human rights and laws pertaining to HIV and rights infringements, as well as to connect them with legal support and services. Training community members as para-legals to offer legal advice, mediation, and education on rights issues, accompany key populations to health clinics and court proceedings, and assist with bail applications could prove beneficial. Furthermore, programs should aim to educate the police on HIV-related matters, including laws concerning the rights of sex workers, the necessity of engaging with at-risk populations, and addressing domestic and sexual violence along with other rights violations. Additionally,

given our findings that health staff were not significant facilitators in accessing rights, and previous evidence of human rights abuses in healthcare settings, HIV prevention initiatives must enhance awareness among health providers regarding key populations' rights to
informed consent, confidentiality, treatment, and equality and non-discrimination in accessing services throughout the continuum of care.

Conclusion

This research highlights the documented rights abuses faced by key populations, while also advancing the understanding of their awareness and exercise of human rights, as well as the obstacles and supports they encounter in asserting these rights. The results indicate that, despite being part of an enhanced HIV prevention initiative focused on community
engagement, awareness of human rights among female sex workers (FSWs) in Chittoor is not widespread. Many individuals lack knowledge of specific rights, such as the right to health and protection from stigma and discrimination, leading to a significant number not asserting their rights. Consequently, these marginalized groups struggle to seek redress, legal counsel, or support, which hinders their ability to engage in safe practices and access non-
discriminatory services, thereby increasing their vulnerability to HIV. The study also identifies community organizations (COs) as crucial facilitators in the assertion of rights, while the primary obstacles include community attitudes, stigma, government personnel, lack of
awareness, and the influence of regular partners among FSWs. These insights carry
significant implications for program development. To ensure a sustained response to HIV, community mobilization initiatives must focus on enhancing the awareness of rights among key populations and empowering them to utilize services without fear of stigma,
discrimination, or violations of their rights. Interventions should tackle the barriers to claiming rights by offering legal education and support to key populations to facilitate access to justice; empower them to report human rights violations, even those committed by intimate partners; combat stigma through community education on the fundamental rights of key populations; and establish connections with essential stakeholders—including law enforcement, healthcare providers, local government officials, community members, and
legal experts—to foster a secure environment where key populations can access services and seek redress for rights infringements.

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