WOMEN SEX WORKERS IN AIZAWL: A SITUATIONAL ANALYSIS

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WOMEN SEX WORKERS IN AIZAWL: A SITUATIONAL ANALYSIS

By

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Department of Social Work

Submitted
in partial fulfillment of the requirement of the Doctor of Philosophy
in Social Work of Mizoram University, Aizawl.

Dedicated To

My Mother who had gone to a better place

Sinners Friend Society

Those who have prayed and supported me to continue my education

All Recovering Addicts

“When I can work in safe and fair conditions

When I am free of discrimination

When I am free of labels like 'immoral" or "victim"

When I am free from unethical researchers

When I am free to do my job without harassment, violence or breaking the law

When sex work is recognized as work

When we have safety, unity, respect and our rights

When I am free to choose my own way

THEN I am free to protect myself and others from HIV”

Porn and Liz, Empower, part of the Network of Sex Work Projects, XV International AIDS Conference, July 2004

DECLARATION

Mizoram University

16th May, 2013

I, Samuel Lalzarlawma Sailo, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

This is being submitted to the Mizoram University for the degree of **Doctor of Philosophy in Social Work.**

(Samuel Lalzarlawma Sailo)
Research Scholar
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Date: 16th May, 2013
Place: Aizawl

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CERTIFICATE

This is to certify that the thesis "Women Sex Workers in Aizawl: A Situational Analysis" submitted by Samuel Lalzarlawma Sailo had been written under my supervision.

He has fulfilled all the required norms laid down within the Ph. D regulations of Mizoram University. The thesis is the result of his own investigation. Neither the thesis as a whole nor any part of it was ever submitted to any other University for any research degree.

(KALPANA SARATHY)
Head of Department

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Date: 16th May 2013
Place: Aizawl

ACKNOWLEDGEMENT

My utmost gratefulness is to our gracious God, who is always there for us

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

First and foremost i would like to thank all the women who kindly gave their time to participate in this research. Many of these women did so in the hope it would improve their working lives and i hope that this research, in some way, makes a positive contribution.

I am very grateful to my Supervisor Dr. Kalpana Sarathy, Associate Professor and Head, Department of Social Work, Mizoram University, for her motivation, kindness, intellect and support. Her contribution extends beyond this thesis.

I would also like to warmly thank Dr. E. Kanagaraj, Associate Professor, for helping me in Data Analysis without whom i could not have finished my work.

I wish to thank the esteemed Mizoram University as well as the Department of Social Work, Mizoram University for giving me the opportunity to pursue research in my area of interest.

I would also like to thank all the staffs of Volunteers for Community Mental Health (VOLCOMH), Protective Home (Reception Centre) and New Life Home Society (NLHS) for allowing and supporting me to conduct this research among their inmates and clients and also like to thank all the Key Informants for willing and open to sharing their experiences with me.

I am also grateful and deeply indebted to Rinhlua, President, Mizoram Professional Social Workers Association (MPSWA) for his technical assistant and encouragement throughout this thesis.

Last but not the least my sincere gratitude is expressed to my dear wife, parent, siblings, friends and colleagues for their constant prayer, encouragement and unwavering support. Thank you also for tolerating my absences, bad moods and preoccupations over the past years.

(SAMUEL LALZARLAWMA SAILO)
Aizawl, Mizoram.

Date: 16th May, 2013

LIST OF TABLES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
BCC	Behaviour Change Communication
BPL	Below Poverty Line
CADS	Central Anti-Drug Squad
CBO	Community - Based Organisation
CHAN	Community Health Action Network
CKTP	Central Kristian Thalai Pawl (An Apex Body of Presbyterian Youth Federation)
COYOTE	Call Off Your Old Tired Ethics
CRS	Catholic Relief Service
CSW	Commercial Sex Worker
CYMA	Central Young Mizo Association
DAPCU	District AIDS Prevention and Control Unit
DIC	Drop-In Centre
DMSC	Durbar Mahila Samanwaya Committee (The committee of women for equality)
Dr.	Doctor
Ed.	Editor
Eds.	Editors
Et.Al.	*et alii*, and others
Etc.	*et cetera*, and so forth
FBO	Faith-Based Organisation
FGD	Focus Group Discussion
FIWDC	Ferrando Integrated Women Development Centre
FSW	Female Sex Worker
FXB	Francois-Xavier Bagnoud
GUS	Genital ulcer syndrome
MHIP	Mizo Hmeichhe Insuihkawm Pawl (Mizo Women Association)
HIV	Human Immunodeficiency Virus
HR&LS	Human Rights and Law Network
HSCL	High School Leaving Certificate

ICMR	Indian Council of Medical Research
ICPS	Integrated Child Protection Scheme
ICTC	Integrated Counseling and Testing Centre
IDU	Injecting Drug User
IEC	Information Education Communication
IPC	Indian Penal Code
JAC	Joint Action Committee (Local vigilante in urban area of Mizoram)
KHPT	Karnataka Health Promotion Trust
KI	Key Informant
KS	Khawpui (City) Service
MUP `	Mizo Upa Pawl (Mizo Senior Citizen Association)
MSACS	Mizoram State AIDS Control Society
MSD&RB	Mizoram Social Defence and Rehabilitation Board
NACO	National AIDS Control Organisation
NACP	Natianal AIDS Control Programme
NCRB	National Crime Record Bureau
n.d.	No date
NGO	Non-governmental Organisation
NLHS	New Life Home Society
NLUP	New Land Use Policy
OST	Oral/Opiod Substitution Therapy
ORW	Outreach Worker
P.	Page
PE	Peer Educator
PP	Pages
PPTCTC	Prevention of Parent to Child Transmission Centre
Pvt.	Private
RITC	Residential Institute and Training Centres
sic	Placed in brackets to indicate that the preceding word statement, etc is correctly quoted,etc even though this seems unlikely or is clearly incorrect.
SLL	Special and Local Law
SPSS	Statistical Package for Social Sciences

STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
SUI	Sex Under the Influence of Substance
TI	Targeted Intervention
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nation Office on Drug and Crime
VAMP	Veshya AIDS Mukabla Parishad (The committee of Women of Prostitutes to Combat AIDS) In 1998, VAMP changed its name from Veshya AIDS Muqabla Parishad – to Veshya Anyay Mukti Parishad (Prostitutes' Collective against Injustice)
VDS	Vaginal discharge syndrome
VDP	Village Defence Party
Viz.	*Videlicet*, namely
VOLCOMH	Volunteers for Community Mental Health
YMA	Young Mizo Association **(**www.centralyma.org**)**

List of NGOs for Sex Workers

DMSC	Durbar Mahila Samanwaya Committee (The committee of women for equality) came into existence in 1995 as a collectivization of 65000 sex workers in Kolkata. Its functions as an exclusive forum of female, male and transgender sex workers in West Bengal, India. The committee is very active in identifying and challenging the underlying socio-structural factors that help perpetuate stigma material deprivation and social exclusion of sex-workers. It is a forum exclusively set up and managed by sex workers and their children with the objective of creating solidarity and collective strength among the sex worker community and other marginalized group. Since 1999 they managed and run a programme called STD/HIV Intervention Programme (SHIP).
NLHS	New Life Home Society was established in Aizawl on the 7th March 1990 by a group of committed men and women to give life, hope and shelter to those women in need. At present the organization looks after two projects viz. Jeriko Khualbuk and Targetted Intervention for Female Sex workers. Jeriko Khualbuk is a 15 bedded De-addiction –cum- Rehabilitation Centre for women substance users, sex workers, positive women and other women in difficult circumstances. They run the Female Sex Worker project since 2007 in Aizawl. This NGO has been a resource Organisation for this doctoral study.
SANGRAM	Sangram is a voluntary organization working with women in prostitution and sex work from South Maharashtra and North Karnataka since 1992 and has fanned out among diverse populations. SANGRAM is based in Sangli district, which has the highest incidence of HIV/AIDS in Maharashtra after Mumbai. (http://www.sangram.org/)

SANLAAP	Sanlaap is an Indian feminist non-governmental organization, established by Indrani Sinha in 1987 in Calcutta.Sanlaap is recognised as one of the leading organisations in the area of counter trafficking initiatives in the south asian region. The organisation has mandated itself to provide care, support, assistance and protection of survivors of trafficking and towards the prevention of trafficking in human beings in the south Asian region especially for commercial sexual exploitation. **(**www.sanlaapindia.org)
PRERANA	Prerana is a registered Society established in 1986 in Mumbai. It works to end second generation prostitution and to protect women and children from the threats of human trafficking by defending their rights and dignity, providing a safe environment, supporting their education and health, and leading major advocacy efforts. Prerana's pioneering efforts have been instrumental in supporting victims through the entire cycle from prevention to repatriation.
VOLCOMH	VOLCOMH (Volunteers for Community Mental health) was established in 1992 in Aizawl to take measures, rejuvenate and promote mental health. Since May 2000, it has been running a Refuge Drop In Centre, a project of targeted Intervention among the Female Sex Workers in Aizawl for the prevention and care of HIV/ AIDS among them. (www. Volcomh.org). This NGO has been a resource Centre for contacting FSWs for this doctoral study.

CONTENTS

7. MIZORAM MAP

5. CURRICULUM VITAE

Name	:	SAMUEL LALZARLAWMA SAILO
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Nationality	:	Indian
Category	:	Schedule Tribe (ST)
State of origin	:	Mizoram
Proficiency in languages	:	Speak, read and write English, Mizo (mother tongue), Manipuri, Hindi (spoken only)
Educational qualification	:	MSW (community development) (NET, UGC) Dissertation "The problem of substance abuse among the youth of Mizos"
Current title	:	Training Co ordinator, State Training and Resource Centre (STRC)
Current duty station	:	Aizawl, Mizoram.

WORK EXPERIENCE

A. Jan 1996 - Dec 1997: Counselor and Asst. Director

Jan 1998 - Dec 2000: Honorary Director in a De addiction cum Rehabilitation Centre run by Sinners' Friend Society Sihphir, Mizoram.

B. Dec 2003- Oct 2006: Project Manager in a Female Sex Workers Drop In Centre run by Volunteers for Community Mental Health (VOLCOMH), Sikulpuikawn, Mizoram. The project focuses on Prevention and Care of HIV/AIDS/STI among Female Sex Workers in Aizawl. It was a T I Phase II project under Mizoram State AIDS Control Society(MSACS).

C. Nov 2006-June 2008: Training officer under UNODC, CHARCA Aizawl targeting young women from 13 to 25 years of age. Conducted trainings for peer educators, NGOs partners and CBOs in five districts viz. Aizawl, Champhai, Kolasib, Mamit and Serchhip. Supervised 300 femal Peer Educator, 10 Master Trainers trained by UNODC CHARCA in three districts viz. Aizawl, Champhai and Kolasip.

D. July – Oct 2008: Consultant to NGOs implementing T I projects NACP Phase III working in the field of HIV/AIDS and substance abuse. Trained community as per Operational Guidelines (OG) NACP III and capacitated Oral Substitution Therapy (OST) programme.

E. Oct 2008 – March 2012: Training officer and presently as Training Coordinator (from December 2012), in State Training and Resource Centre (STRC) covering Mizoram and Arunachal Pradesh. The primary objective of STRC is to build capacities of the project functionaries of NGOs implementing TI under State AIDS Control Society.

F. OTHER EXPERIENCES:

1. EDUCATION:

1. High School Leaving Certificate Examination, 1985 under Mizoram Board of School Education, Mizoram.
2. P.U (Arts), June 1988 under NEHU (North-Eastern Hill University).
3. B.A (Hons), July 2000 under NEHU (North-Eastern Hill University).
4. M.S.W (Master of Social Work), April 2003 under University of Pune.
5. NET under UGC, 2003

2. GUEST LECTURER IN MIZORAM UNIVERSITY SOCIAL WORK DEPARTMENT.

Work as a Guest Lecturer and field work supervisor in Mizoram University, Social Work Department in between Aug 2003- July 2006

3. **Master Trainer** on Gender and HIV related issues under UNODC CHARCA from Oct 2005 - Oct 2006

List of professional societies and activities in civil, public affairs:

1. President, Association of professional social workers in Mizoram (APSWIM) from 2006- September, 2012.

2. Asst Secretary, Federation of NGOs working in Drugs and AIDS Prevention and Care (FONWIDAPAC) in 2006.

3. Executive committee member of Volunteers for Community Mental Health (VOLCOMH).

4. President of Republic Body Building and Health Club, Aizawl from 2007- till date.

5. Founder Secretary of Ray of Hope Society.

Activities so far

- Night Vigil – to reach the un reached
- Detoxification Camp in partnership with Mizoram Excise Dept' GOM.
- Moral Education Camp for Female Sex workers and Lesbians in needs.
- HIV and Drug Abuse Awareness among Sunday school goers.
- Run a halfway Home for a Lesbian in difficult circumstances at Zarkawt in Aizawl.

6. Senior Adviser in Society for Recovering Addicts (SORA) in Mizoram.

7. One month block placement at Calcutta Samaritan De addiction and Half Way Home at Kolkata in 2003

8. 6 months field placement at Amednagar Kolewadi village for community organization training as a part of MSW Course.

9. Attended Training on "Gender justice and inclusive communities" at Ecumenical training Centre, Nagpur from Jan 19 to March 3, 2001 organized by World Council of Church and National Council of Churches in India.(NCCI)

10. Attended Training workshop for NGO Representatives on Prevention, Control and Management of AIDS organized Rajiv Gandhi Foundation and MSACS on 29th and 30th Jan 2004.

11. Attended the 8th National Convention of the Indian Network of NGOs on HIV/AIDS (INN) held between Feb-22nd and 24th, 2004 at Ganna Kisan Sanstha Auditorium, Lucknow.

12. Attended Training for NGO Representatives on Five Days Training for Integration of HIV/AIDS Prevention activities into the Substance Abuse Prevention Programme organized by RRTC, MSD & RB in collaboration with MSJE and NACO on 23rd and 27th March 2004.

13. Attended Training for NGO Representatives on Three Days Training for Management Development Programme organized by RRTC, MSD & RB in collaboration with MSJE and NACO on 29th and 31th March 2004.

14. Attended Training of Trainers on Gender and HIV organised by CINI and UNIFEM at Kolkata held between the 25th – 30th Oct 2005.

15. Attended Training of Trainers for Young Professionals in Mizoram on Training for Engendered Mental Health Intervention organized by SHARTHAK DELHI and VOLCOMH in March 2006.

16. Attended Master Trainer Trainning on Legal Literacy organized by MARC Delhi and UNIFEM at Aizawl in 2006.

17. Attended the 2nd CHARCA PE Conference held at Kanpur on the 14th and 15th Sep 2006.

18. Participated in a talk show in Doordarshan Aizawl Kendra and local channel programme in Mizoram on 'Do Drug control your life' on the 26th June 2007.

19. Participated in a talk show in Local channel programme in Mizoram on 'Do Drug control your life' on the 26th June 2008.

20. Participate in the Two Days Training cum Worshop on 'Strengthening of SHGs through partnership organized by NABARD and Department of Social Work Mizoram University held between 24th and 25th Sept 2007.

21. Resource persons in a Two Days workshop on data collection and issues related to HIV, IDUs and risk reduction activities in Mizoram organized by RRTC,MSD&RB under the project of UNODC IND/I81

22. Participated in Holistic Camp for Female Sex Workers organized by CKTP (Central Youth Christian Group Apex body of Presbyterian Youth in Mizoram) as a Support and Resource Person which was held on the 1st – 15th Sep 2008.

23. Resource persons in Two Days (2 batches)conferences with Young Mizo Associaltion (YMA) to advocate community acceptance towards risk reduction initiative in Champhai district organized by FIWDC and UNODC IND/I81 on 14th – 17th Oct 2008.

24. Resource persons in Three Day Training on "Integrating Gender Sensitive Services in the TI programme for IDUs in Mizoram during 29th – 31st October 2008 at Agriculture Deptt. Conference Hall under Project IND I – 81 (HIV/AIDS project in four NE States of India)

25. Attended 3 days training on harm reduction conducted by SHALOM, Manipur and ORCHID Project organized by Mizoram SACS on the 26th -28th November, 2008 at Yatri Niwas,Aizawl, Mizoram .

26. Attended Training and Work plan Development of STRC Kolkata-6th to 9th Jan 2009 organised by NACO, Delhi

27. Resource persons in Three Days State Level Training on Social Defence organized by Social Work Department, Mizoram University in collaboration with National Institute of Social Defence, Ministry of Social Defence and Empowerment Government of India on the 1st April, 2009 on topic " Humanistic Approach to HIV prevention – Towards a stigma free society".

28. Attended Training Development Workshop of STRC, Delhi-19th to 22nd May 2009, organised by NACO, Delhi.

29. Participate as an OBSERVER representing SACS and NACO in the Evaluation of Targeted Intervention Programme (2008-2009) implemented by NGOs in the State of Mizoram and Arunachal Pradesh.

30. Attended TOT on ORW Module organized by NACO, NERO 9th -13th Dec 2010.

31. Attended TOT on Harm Reduction Module Organized by NACO- NERO – 13th -17th Sept 2010.

32. Attended TOT for Peer Educators Module Organized by NACO at N.Delhi – 7th -12 Nov, 2010.

33. Attended a meeting to review the Narcotics/drugs/alcohol policy of the state government on the 23rd May, 2012 at Chief Secretary's Conference Room. Presented a PP presentation on the initiative of MSD&RB on behalf of the Social Welfare Department, Mizoram.

34. Attended a sensitization workshop on "Drug use, Health and HIV/AIDS – Moving towards a health centric and rights based approach to drug use" on the 24th May.2012. Presented a PP presentation on the "Magnitude of Drug abuse and response through Demand Reduction in the state of Mizoram" .

35. Attended a two day regional workshop on evolving effective strategies for alcohol advocacy and prevention organized by National Institute of Social Defence (NISD) Ministry of Social Justice & Empowerment, Govt. of India in collaboration with Indian Alcohol Policy Alliance (IAPA), New Delhi and Mizoram Social Defence & Rehabilitation Board (RRTC NE – III). The training was held on the 20th and 21st June 2012, at I&PR Auditorium, Aizawl.

36. Attended three day capacity building workshop on Ethic in HIV/AIDS Research organized by NACO in collaboration with Srimanta Sankaradeva University of Health Sciences from 26th to 28th July, 2012 at the National Institute of Rural Development NERC, Guwahati.

37. Attended a one-and-a-half-day Workshop on Substance Abuse at State Guest House, Aizawl on the 17th -18th December, 2012. Participated as one of the selected speakers in the workshop on the session of 'Content and process of preparation of IEC materials on substance abuse and HIV/AIDS for spread of awareness and prevention of their incidence as also other interventions which are needed in the area of prevention of substance abuse and HIV/AIDS'.

DECLARATION

I certify that the above information is true to the best of my knowledge.

(SAMUEL LALZARLAWMA SAILO)
Research Scholar
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6. PARTICULARS OF THE CANDIDATE

NAME OF CANDIDATE	**:**	**Samuel Lalzarlawma Sail**
DEGREE	**:**	**Ph.D**
DEPARTMENT	**:**	**Social Work,** **Mizoram University**
TITLE OF THESIS	**:**	**Women Sex Workers in Aizawl** **A Situational Analysis.**
DATE OF PAYMENT OF ADMISSION	**:**	**15/12/2005**
APPROVAL OF RESEARCH PROPOSAL	**:**	
1. BPGS	**:**	**17th May 2006**
2. SCHOOL BOARD	**:**	**23rd May 2006**
REGISTRATION NO. & DATE	**:**	**MZU/Ph.D/116/23.5.2006**
EXTENSION	**:**	**AC:22:4(19) Sl. No. 11** **Dated 13th June 2012**

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CHAPTER I

INTRODUCTION

1.1. Concept of Sex Work

This study explores the situation of sex workers in Aizawl. The term 'sex work' and 'sex workers' is used as a synonym or euphemism for words like '*Prostitute*' or '*Prostitution*' or '*Female Sex Worker*' or '*Woman in Prostitution*' or '*Commercial Sex Workers'*.

Conceptual clarity regarding Sex Work is imperative to help understand the various factors responsible for its continuation for over three thousand years, besides being condemned as a vice since its inception specially so since the emergence of the civilized society.

According to Havelock Ellis (2002) "Prostitute (sic) is a person who makes it a profession to gratify the lust of various persons of the opposite sex or the same sex". Kingsley Davis (1937) "distinguishes prostitution (sic) by the element of hire, promiscuity, and emotional indifference".

International Encyclopedia of the social sciences (1968) defines Prostitution (sic) "as the granting of sexual access on a relatively indiscriminate basis for the payment either in money or in goods, depending on the complexity of the local economic system".

According to Block's Law Dictionary "Prostitution (sic) is performing an act of sexual intercourse for hire, or offering or agreeing to perform an act of sexual intercourse or any unlawful sexual act for hire. The act or practice of a female of prostituting or offering her body to an indiscriminate intercourse with men for money or its equivalent".

The suppression of Immoral Traffic in women and Girls Act, 1956 (SITA) defined prostitution (sic) "as the act of a female offering her body for promiscuous sexual intercourse for hire whether in money or in kind, whether offered immediately or otherwise."

On the other hand, The Immoral Traffic (prevention) Act, 1986 (which is an amendment of the above mentioned Act) defines prostitution "as the sexual exploitation or abuse of persons for commercial purposes".

A *female sex worker* is an adult woman, who engages in consensual sex for money or payment in kind, as her principal means of livelihood (NACO, 2007)

Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally and who may or may not consciously define those activities as income-generation"(UNAIDS,2002).

The word 'Prostitute' is derived from the Latin term '*prostitutus*', meaning 'up front' or 'to expose' and was used by the Romans to differentiate a particular type of woman from 'decent' women in society (Zaplin, 1998).

Historical constructions of the 'Prostitute' were associated with women of poor character who accepted payment for sexual acts or who sold their abilities, talents or names for unworthy purposes. However, the term was also used more broadly as a derogatory label (Hawkes & Scott, 2005).

1.2. Nomenclature used

The concept of "sex work" emerged in the 1970s through the Prostitutes' rights movement in the United States and Western Europe (although sex worker's movements are not exclusive to the United States or Western Europe). The term emerged as a counterpoint to traditionally derogatory names, to emphasize the legitimacy of sex work as a form of labor and the rights of sex workers as working people (Kempadoo, K.1998).

Carol Leigh, the founder of a sex worker advocacy group, *Call Off Your Old Tired Ethics* (COYOTE) as the creator of the term "sex work". (Delacoste and Alexander, 1987)

"Unlike the word 'prostitute', with its connotations of shame, unworthiness, or wrong doing, the term 'sex worker' tries to suggest an alternative framing (Bernstein, 2007).

'Sex work' was conceived as a non stigmatizing term, without the taint of the words 'whore' and 'prostitute'. The point of the term was to convey the professionalism of the sex worker rather than her lack of worth as seen by much of society (Ditmore, M. (Ed,) 2006). (Ditmore, M.(Ed). 2006)

Sex work includes high risks, including legal liability and exposes those who work in it to violations and vulnerabilities that are specific to sex work and place this work outside the mainstream labor market (Sanders, 2005). According to Sanders (2005), occupational risks in sex work include violence, criminalization, marginalization, exposure to health-related concerns, exclusion from civil and labor rights, and ostracism from local communities. Davies (1936) also argues that sex work cannot be seen through the same economic lens as mainstream business because of the global moral condemnation of women who sell sex. In addition to being condemned morally, the illegal status (in most states) and the continued presence of sex work, creates a quasi legal and semi-tolerated environment for sex work. Not only does the illegal status of the work increase risk associated with the work, but also creates a need for sex workers to hide their status, reducing their access to health and social services. Vanwesenbeeck (2001) views sex work as legitimate work and acknowledges that the illegal status creates consequences that often violate the civil and workers' rights and integrity of sex workers.

Ditmore.M, (Ed.) (2006*)* in *Encyclopedia of Prostitution and Sex Work* defend the appropriateness of using the term " Sex work". Ditmore argue that phrase was created in the last 30 years to refer to sexual commerce of all kinds. Prostitution has varying definitions in different contexts. Some of these are based on the definition of prostitution in law, or what is illegal. Legal definitions change over time and place, leading to great confusion if one relies on one definition from the criminal code or one from the civil code, as they do not travel well. Despite the difficulty of terminology, prostitution as a sexual exchange for money or other valuables is the general definition of prostitution for this work.

The woman we know as the prostitute has many names in English: prostitute, prostituted woman, whore, sex worker, commercial sex worker, sex trade worker. In the several languages of India, one finds different names depending on the time period and the region in which they worked. Sanskrit literature describes them as *veshya* (prostitute), *sadharani* (public woman), *rupajiva* (one who earns a living by using her charms), *ganika* (enjoyed by one person or many persons living in a group), *rupadasi* (enslaved by her physical beauty) and so on. In colonial times, in Bengal for example, they were called *baijee* (dancer), *nautch girl* (dancer), *raanr* (widow or prostitute),

randi (prostitute), *baishya* (prostitute—the Bengali version of a veshya) and so on (Prabha Kotiswaran, 2001).

Language shapes beliefs and may influence behaviours, and considered use of appropriate language in promotion of sexual health and human rights of sex workers can be used as advocacy instrument.

(TAMPEP, (n.d.). (Retrieved from http:// resources .tampep.eu/documents /sw _ glossary_EN.pdf)

"*Prostituted*"(sic) clearly indicates that prostitution is something done to a person, not something that can be chosen, and "survivor" implies someone who has escaped a harrowing ordeal. Customers are labeled as prostitute users, batterers, and sexual predators (Ronald Weitzer, 2005).

Until recently, women's groups in India shunned words like commercial sex worker or sex trade worker because these words imply the commercialization of sex. Most women's groups, however, insisted that in their conversations with prostitute women, the latter do not view themselves as sex workers. In acknowledgement of the fact that most Indian prostitutes are forced into prostitution, the term least objectionable is thought to be prostituted *woman* (Prabha Kotiswaran, 2001).

The term 'commercial sex worker' is no longer used, primarily because it is considered to be saying something twice over in different words. (TAMPEP, (n.d.). Retrieved from http://resources .tampep.eu/documents /sw_glossary_EN.pdf)

*The term **'Women'** of the phrase **'Women Sex Worker'** is being used in this thesis to consider the sex workers as part of a general body of women even though there is an understanding that being 'good' is a necessity to be considered as a women. Women sex workers are stigmatized as 'evil, deviant, debouch, worthless'; they are not considered as part of the general body of women (R. Sahni, V.K. Shankar and Hemant Apte (eds.), 2008). The underlying philosophy in the thesis is that there is more to a woman than being a sex worker and that there is more to work that they do than being 'commercial'. The word **'Woman'** is also being used in this thesis to emphasize that there is more to a woman than being "female".*

The term 'sex worker' is intended to be non-judgmental, less offensive and stigmatizing, focusing on the conditions under which sexual services are sold.

1.3. History of Sex Work

The practice of Sex work is perhaps as old as the civilization. Historically, religious beliefs and social custom prevalent in society from time to time provide the earliest accounts of its origin. Sex work (*Prostitution* as it was earlier referred) is often described as "the world's oldest profession".There are even references in literature to the the system of substitution of rights of God for the rights of a husband that let many primitive and ancient people practice religious prostitution. For instance, the priestesses of the African West Coast considered themselves to be wives of the gods whom they served; in their sexual excesses dedicated to the gods were not regarded with reproach. In India it was the Brahmins of Bengal and the Nambudari Brahmins of Kerala – who styled themselves as holy men , the earthly representatives of God to be welcomed for coition by women belonging to castes lower than theirs (Tandon, 1987).

The Devadasi system , found in some parts of India , was yet another form of religious prostitution .These *dasis* (slaves) were dedicated and symbolically married to *Deva* (God) to dedicate their lives to religious services. The religious belief of the tantric cult that spiritual union with God can be best be attained through sexual union in flesh had further given sanction to prostitution. In such sects promiscuous intercourse was spoken of as an act of devotion to the deity and was regarded as obligatory for all members. Since union with low caste women, dancing girls or prostitution marks the collapse of caste barriers, their spiritual merits were considered great. In ancient times the prostitutes and their relatives had definite rights , duties and prerogatives as illustrated in Kautilya's *Arthashastra,* Vatsyayana's *Kamasutra* and a number of sex manuals, such as Damodaragupta's *Kuttani Mata* or " Lessons of a prostitute" *and Kshemendra's Samaya Matrika* or the "Prostitute's Breviary"(Tandon,1987) .

History tells us that during the Indus Valley Civilization as well as in the Vedic Age, prostitution was a recognized institution. In ancient India, post Vedic and after, this institution was not only recognized but acquired more and more prestige.

Prostitution could wield great noblemen, courtiers and other aristocrats in the city. In fact, a certain area in the plan of a city in ancient India was marked out for prostitutes only. They were known as Nagar Vadhus (Chatterjee, 1990).

During the Muslim period a new development was visible. These were the *'tawaiyafs'* who were trained in dancing, music and singing. Their primary duty was to perform '*Mujrah*' either in their own '*Kothas*' (houses) or in palaces and courts whenever they were invited or engaged by a customer. They were different from the prostitutes, as prostitution was secondary to them. Though rich and powerful, these *tawaiyafs* were not treated as a part of society. Among Muslims this institution was an antithesis to the institution of family (Chatterjee, 1990).

The public assessment of the growing practice of Sex work is divided into two polemic views-(i) Sex work is morally wrong,(ii) it is necessary (Pawar,1991). According to the 'Central Social Welfare Board' of India at least 500,000 women in India are engaged in prostitution. At least 25,000 children are engaged in prostitution in the major metropolitan cities; Bangalore, Calcutta, Delhi, Hyderabad, Madras, Mumbai (Kanh, 1998). Estimates suggest the Participation of more than 2 million women in sex work of which 25 percent are below 18 years. More than 90 percent of them are of Indian origin, and about 5 percent from Bangladesh and Nepal. 61 percent of *Female Sex Workers* in India belong to *Scheduled Tribes* (Sen, 2000). An overall estimate in the country by an expert group in January 2006 revealed the presence of 830,000 - 1,250,000 Women Sex Workers in India (NACO, 2011). According to NACO (2012) states fact sheets on the implementation of National AIDS Control Programme phase III, NGOs implementing Targetted Intervention had covered 1424 *Female Sex Workers* in Mizoram.

Crime in India reported that in 2006, Immoral Traffic (Prevention) Act has registered 4,541 cases, a decline of 23.1% as compared to the previous year (5908). 38.1% (1,732) cases were reported from Tamil Nadu which also reported the highest crime rate of 2.6 as compared to the National average of 0.4. Out of UT's, Delhi reported maximum cases i.e. 112 out of 124. 231 cases of Procuration of minor girls (Sec. 366A IPC) were reported in the year 2006. West Bengal has reported (77) such cases indicating a share of 33.3% at national level followed by Andhra Pradesh and Kerala (35 each). 67 cases of Importation of Girls (Sec. 366B IPC) were reported

during the year 2006. Bihar (42) and Orissa (12) have reported highest number of such cases accounting for 62.7% and 17.9% respectively of total such cases at the National level. 35 cases of 'Buying of girls' and 123 cases of 'Selling of girls' for Prostitution were reported in the country during 2006. Maharashtra (23 out of 35) has accounted 65.7% of total cases of 'Buying of Girls' and West Bengal has accounted for 92.7% (114 cases out of 123 cases) of the total cases of 'Selling of Girls' for Prostitution reported in the country (Matiyani, H., & Chattoraj, B.N., 2010).

While sex work is a universal phenomenon, it is also frequently illegal and, therefore, clandestine. This makes it difficult to determine the true extent of the sex work industry, although it is acknowledged to be substantial and has apparently been increasing in recent years. This increase has been attributed to various factors, including changes in political, civil and socioeconomic conditions and increased population mobility (UNAIDS, 2002).

According to *Sanlaap*, a Kolkata based NGO: assuming there are 20,000 sex-workers in Calcutta, each with a gross average earning of ` 100 a day, the total turnover per day is ₹ 20,000,000 and ` 6,00,00,000 per month and an average turnover of ` 720 million. Only a small part goes to sex- workers, the rest to recruiters, middlemen, agents, pimps, brothel-keepers, live-in partners, liquor sellers, the underworld and the Police (Sahni, R., & Shankar, V., 2008).

Constracting similar estimates for 5,000 sex workers in Pune's Red Light Area: it was found that on an aggregate, they provided service to about 5,000-20,000 clients every hours and the charges range between ` 30 to ` 100. This results in an approximate daily turnover of ` 1, 50,000 to ` 20, 00,000 directly due to sex work alone (Sahni, R., & Shankar, V., 2008).

The lure of high profits from this trade has encouraged the exploitation and seduction of women from the poor and *tribal communities* and even other sections of the population who never practiced this profession but become victims because of poverty and migration into urban center (Chatterjee, 1990). The International Congress on Prostitution (1953) concluded that economic and social factors are

amongst the most important causes of Sex work. While poverty and backwardness are by and large the main reasons for the continuance and increase of this practice, women enter in this profession in ways(1) *Voluntary prostitution* women adopt this profession voluntarily for lack of any other means of livelihood. In most cases families are aware of it and often promote it. (2) *Forced prostitution*-women are force into this profession through religious and customary practices, kidnapping and rape, and sale of their bodies by intermediaries (Chatterjee, 1990). According to a survey conducted under Government of India, about eighty per cent of the girls who were in this profession entered it as children and due to difficult circumstances, such as poverty, illiteracy, ignorance, and deception (Mukhopadhyay, K.K., 1995).

The report of World Health Organisation (2005) clearly highlighted the magnitude of violence against sex worker in the world. In Bangladesh, the national HIV surveillance (1999-2000) found that between 52% and 60% of street-based sex workers reported being raped by men in uniform in the previous 12 months and between 41% and 51% reported being raped by local criminals. In Namibia, 72% of 148 sex workers who were interviewed reported being abused. Approximately 16% reported abuse by intimate partners, 18% by clients, and 9% at the hands of the police. In India, 70% of sex workers in a survey reported being beaten by the police and more than 80% had been arrested without evidence. Violence against sex workers is not only widespread, but is also perpetrated, legitimized, and accepted by many. Law enforcement authorities and laws governing prostitution have, in some cases, increased the risk of violence against sex workers rather than protected them against it. Violence is also perpetrated by some gatekeepers, clients, family members and intimate partners (WHO, 2005).

Sex work should be viewed in the context of the over all situation of the status of women in India and elsewhere. Old cultural and religious practices, superstitions, illiteracy and patriarchy are generally responsible for the exploitation of women in every way, i.e. financially, psychologically and sexually. Sex work thus is a symptom and not a malady. Thus the solution to the problem cannot be sought in isolation. Neither education of the women nor the eradication of poverty alone can actually change this situation. Besides, in India, many women and children come from that section of society, known as *the scheduled caste and schedule tribe*. This vulnerable

section of society being backward is exposed to brutality, abuse, mutilation, sexual exploitation and sale (Chatterjee, 1990).

Women are more at risk of HIV/AIDS infection than men because they had difficulty in negotiating condom use, avoiding non-consensual sex and violence. Married women in particular reported the most difficulty in condom negotiation. Condom use and perceptions of HIV/AIDS risk are significantly associated with caste, religion and wealth status (Leone, Tiziana & Coast, 2008).

In Kenya Youth Peace Summit 2009, Dr. Mamy explained why women are more vulnerable to HIV and AIDS than men by dividing the reasons into two categories; physiological and socio-economic reasons. Among the latter category the reasons listed were, the viral load in semen is higher than in vaginal mucus. The vaginal membrane is thinner than penile tissue**.** Semen remains longer in the vagina. Young women are more prone to micro lesions. From the socio-economic perspective, the reasons are; Women accept pain and discomfort. Social pressure to bear children. Vulnerability of younger women/adolescents. Women lack knowledge in sexual issues and are unable to express their opinions on such. Inability to negotiate for safe sex. The only way to deal with this grave situation is to empower women to be able to take up more active roles in sexual relations and issues that surround them (http://peacesummit2009.wordpress.com/2009/04/18/why-women-are-more-vulnerable-to-hivaids-than-men/).

Sex work is often a common income-generating activity for some drug users, and female injecting drug users involved in sex work form another subgroup. These females are at an increased risk for HIV because of unsafe sexual practices. Some female injecting drug users who exchange sex for drugs or cash may not perceive themselves at risk of HIV infection because they do not identify themselves as sex workers. In addition, the fact that injecting drug use is highly stigmatized among sex workers could lead to further concealment of unsafe injecting, again increasing the risk of HIV infection (UNODC, 2006).

The initial reports of HIV infection in India were among *Female Sex Workers* in Chennai, Tamil Nadu (Kakar, D.N. and Kakar, S.N., 2001). In the late 1980s and early 1990s, HIV was widely perceived as a threat that would primarily affect ‘high-

risk' groups like *Female Sex Workers*, Men having sex with Men (MSM), and Injecting Drug Users (IDU).Female Sex Workers remain one of the most affected high-risk sub-groups in the predominantly heterosexually driven Indian HIV epidemic, as is evident from persistently high sero-prevalence rates. Pattern and nature of sex work (brothel-based, street based, non-brothel based or trade-route linked), concurrent sexual relationships and partnerships, type of sexual practice adopted(vaginal, oral and anal) may explain the differences and determinants of the geographic variation of the HIV epidemic in India (Sahasrabuddhe,V. & Mehendale,S., 2008).

Even in settings where injecting drug use related transmission is still the predominant mode of HIV transmission, the HIV prevalence among sex workers is high and evidence suggests that drug-use and sex work are often dual-risk factors for *Female Sex Worker* in this region (Agarwal, A.K., Sigh, G.B., & Khundom, K.C. et al., 1999).

Women sex workers living with HIV carry *'double' or 'Multiple' stigmas* and suffer extreme forms of discrimination. *Stigmatization and discrimination* due to HIV/AIDS have a strong negative public health impact. They impede and slow down HIV prevention, care and support initiatives, and depersonalize the epidemic while at the same time exacerbating its burden and impact on individuals, families, and communities (Bharat,S., 2004).

Besides STD's, AIDS and other infectious diseases a *Female Sex Workers* also suffer from chronic pelvic infection, back ache etc. The main victims of the institution of Sex Work were their children. Born with the stigma of being' illegitimate' majority of this children are isolated from the mainstream and deprived of a normal life. They are shunned by society for no fault of theirs (Rao, 1990). These children are vulnerable to the ways of the trade right from their birth and every stage of growing up (Patkar,1991).Many people think women in sex work deserve to get infected because of their occupation (Ramakrishna, 2004).

The Sex Worker Freedom Festival: ***the alternative International AIDS Conference 2012 event for sex workers and allies.***

The International AIDS Conference is the premier gathering for those working in the field of HIV, as well as policy makers, persons living with HIV and other individuals committed to ending the pandemic.

The first International AIDS Conference was held in the year 1985. The Conferences were held annually until 1994, but are now held every two years. The last conference was held on the 22nd to 27th July 2012 at the Walter E. Washington Convention Center. The conference was organized by the International AIDS Society in partnership with a number of international bodies including UN Agencies. The AIDS 2012 programmed presents new scientific knowledge and offer many opportunities for structured dialogue on the major issues facing the global response to HIV. A variety of session types – from abstract-driven presentations to symposia, including the Global Village, satellite meetings, exhibitions and cultural program was the main feature of the event (DMSC, 2012).

Due to financial, timing and/or immigration constraints many individuals and organizations were unable to attend the conference. To ensure that an organization / community do not miss out on the conference momentum, discussions, materials and networking opportunities, a conference hub: Sex Worker Freedom Festival was held in Subhavmi, Salt Lake, Kolkata(DMSC, 2012)

This was the first of its kind in India. The Kolkata Conference Hub was hosted by Durbar Mahila Samanwaya Committee in collaboration with the Global Network of Sex Work Projects with support from International Aids Society and other UN agencies. This event coincides with the 20 years completion of the Sonagachi Intervention Program which is a unique effort of and by the sex workers' community showcasing the rights / dignity and ability of sex workers to curb transmission of a HIV which is pandemic in nature.

The festival programme focuses on freedoms that all sex workers entitled to:

- Freedom of movement and to migrate;

- Freedom to access quality health services;
- Freedom to work and choose occupation;
- Freedom to associate and unionise;
- Freedom to be protected by the law;
- Freedom from abuse and violence; and
- Freedom from stigma and discrimination.

(In www.durbar.org/html/conf-hub2012.doc)

1.4. Mizoram Scenario

In the Mizo society, prostitution was never visibly present from the beginning. Immorality has, however, been all along existing as in other societies. Chawngtinthanga (2000) Deputy Secretary of law and judiciary claimed that there was an incident reported on women surrendering themselves to the lushful desires of soldiers during insurgency period. According to him, the deployment of the Army in Mizoram during the last 20 years of insurgency and a sudden switch from primitive economy to modern-day system are the main reasons for the spread of prostitution in the State.(sic)

The Mizo people refer to the sex workers as "*Nawhchizuar*", (Lalruatfela Nu, 2004).

By the late 1960's and first part of 1970's, the first sign of open prostitution was visible in Aizawl, Mizoram. One woman, who may be easily identified since she was well known, opened a sort of brothel in a central locality which was unlicensed and an unauthorized brothel. After mid 1970's she stopped her trade and there seems to be no such kind of open brothel since.

When there was rapid growth of population and development in Aizawl, in the first part of1980's all sorts of tourists were attracted to Aizawl from across borders, mainly from Burma .Then there were talks of some girls available for those who wanted them on payment. They operated in cheap hotels and in the outskirts of the

town where thatched houses were constructed. Dark corners of the town also became ideal as operating places. These girls were reportedly mainly of the Burmese origins and there were also some Mizos from broken families. By mid -1980's these girls had got a notorious name 'K.S' (meaning *Khawpui service* literally meaning *Town Service*).They could be easily identified on the streets through their ways of behaviour and their clothing. When years went by these *K.S girls* developed some sort of group and had leaders under whom they operated at different places (Zoramawia, 1998).

Lalparmawii, (1998) expressed that there was a grave concern over the growing of trafficking of women from the north-eastern States and need for coordinated efforts by all the state governments in the region to combat the problem. Not only poor women but even college educated girls were being lured away into prostitution with the promise of jobs in Cities. The North Eastern States became one of the most vulnerable area of Immoral trafficking and the reasons included lack of good support system. Some of the Mizo girls too were caught in this hideous trade (Lalparmawii, 1998). Neither the Mizo community nor the Government officials believed trafficking for commercial sexual exploitation as big concern before 2005, the state Police Crime Department recorded 30 cases since 2000 (Mizoram Gazette, 2012).

Commercial sex workers, or people who have casual sex, or have multi partner sex are most likely perceived as transmitting HIV/AIDS infection according to the CHARCA, UNODC 2002 report.

Survey and Case studies conducted by Protective Home and Human Rights and Law Network suggested the factors to be conductive to prostitution in Mizoram, viz, Broken family, lack of parental skills and neglect of children, delinquency, bad influences by peer, illegitimate pregnancy, illicit sexual urge, desire for easy life, loose character, poverty, unemployment, Alcohol and Drug addiction, Domestic violence (In Lalruatfela nu, 2004). According to the report of Australian Agency for International Development (AusAID) in 1999, Commercial sex workers in Kolasib, North Mizoram are often divorced women. They sell alcohol as an associated means of income.

In Mizoram, according to a report, Sex Workers enter into this profession voluntarily due to various reasons. Most of them came from a broken family and have behavioural problems. They have a close link with use of any kind of intoxicants such as Alcohol, Heroin, Dendrite, and whatever available within their reach. To maintain their addictive behaviour they have to engage in sex work (VOLCOMH, 2003). In other parts of India, studies reveal that women are likely to suffer greater consequences than men due to drug abuse (Murthy, 2002). Similarly, it has been noted that while drugs was one way to hook them to a life of sex work, unwanted pregnancy was another (Mukhopadhyay, K.K., 1995).

The Sex workers in Mizoram get money for buying drugs, clothes, ornaments and make up. They rarely save and are not in the trade for many years at a stretch so they are different from Sex workers in other metropolitan cities.(C.A.R.E,World Vision,2003).The attitude of the community towards sex workers is negative, and there is discrimination and stigma towards this population. The level of unofficial ostracism is still very high. At present, sex workers using drugs in Aizawl suffer double stigma, a stigma attached to drug users and sex workers. (FXB,2004).A rapid situational assessment of the current drug abuse and HIV/AIDS scenario amongst substance users in Mizoram conducted by Regional Resource and Training Centre (RRTC) Mizoram in 2005 and it shows that many Male Injecting Drug Users have unprotected sexual contact with the Female Sex workers in Mizoram.

Efforts have been made by different Community-Based Organizations (CBO) in their respective localities, like the Joint Action Committee (JAC)'s, Young Mizo Association (YMA) etc. to curtail the problems of sex work. Their retributive measures often exceed limits like shaving off their hair, making tattoos in their face, chopping of their private parts, expulsion from their locality (vengs) and locking them into their houses. The harsh actions of these organizations have not eradicated the practice of immorality by these girls except that their operating places were shifted from one place to another (Zorammawia, 1998).

In 1950, India signed the International Convention for the suppression of immoral traffic in women and girls. In pursuance of this, there is a Central act known as the *Immoral Traffic (Prevention) Act 1956*. The purpose of enactment was to inhabit or abolish commercialized vice namely the traffic in persons for the purpose

of prostitution as an organized means of living. This Act (of 1956) was subsequently amended in 1978 to remove lacunae which affected its effective enforcement. The philosophy reflected in the Act is that the law should take cognizance only when women and girls are exploited and dragged to lead a life of vice; persons derive monetary gains from the earnings of prostitutes; and where it is practiced in public places causing a public nuisance (Tandon, 1987).

To understand and to search for solutions to the growing menace of Sex work, several studies have been conducted. Sanger, (1986) has traced the history of Prostitution. Sanger discusses the problem of Prostitution in different parts of the globe in which he gave much important to France and Great Britain. Joarder,(1984) has looked into Sex work in the 19th and early 20th centuries in Kolkata .There are few studies on the causes of Sex work also (Mukherji,1979;Singh and Singh,1980).Some scholars have attempted to classify Female Sex workers into different categories (Punekar and Rao,1962) Shankar (1990) has made a sociological analysis of the devadasi cult.Khan and Singh (1987) have viewed Sex work in the light of human Rights, law and voluntary action. There are also studies on the extent of child prostitution in the country and law related to prostitution and their enforcement(Pawar,1988,1992 ;Patkar,1990)and some scholars studies the clients of the Female Sex workers(Gokhale, Master, and Gokhale, 1997)

There are also a number of studies based on a particular regions and areas like the study of prostitution in Bombay (Punekar, and Rao, 1962) Sonagachi: Red Light District of Calcutta, India (UNAIDS Case study, 2000).

1.5. Causes of Sex Work

Reasons for entering sex work are more directly relevant to prevention than to exiting interventions, but they can persist as reasons for remaining in the sex industry. The literature shows a combination of *'push' and 'pull'* factors in entering sex work. Push factors – particularly for young street workers – can include abuse, breakdown in caregiving, school exclusion, homelessness, and lack of money. Pull factors can include excitement, encouragement from other sex workers, and freedom to work one's own hours to accommodate other responsibilities. Most important, though,

seems to be that sex work can offer more money than 'square jobs' (Mayhew, P.&Mossman,E. (ed), 2007).

This fact is glaringly revealed from the analysis of the factors forcing women into prostitution in the empirical study of New York city by W.W.Sanger (1986), between 1955-58, among 2000 prostitutes studied by him , *the predominant cause for 525 was destitution, 513 – inclination, 258- seduced and abandoned, 181 – drink and desire for drink, 164- ill treatment by parents, relatives or husbands, 124- an easy life, 84 – bad company, 71- persuaded by prostitution, 20-too idle to work ,27- violated, 16- seduced on emigrant ship and 8 as were also seduced in boarding house* .

Entry into marginalised lifestyles such as street-based sex work is influenced by many factors common to other forms of marginalisation including homelessness, violence, unemployment, familial abuse and breakdown, childhood abuse, care system, debt, low levels of academic qualification, mental and physical health issues, substance misuse and poor social networks (UKNSWP, 2008).

More or less the same is revealed by the famous study of prostitutes in Bombay undertaken by S.D. Punekar and Kamala Rao (1962), who studied in all, 350 prostitutes among whom, 113 were Devadasis a tradition coming from tenth century in India specially in South India where parents dedicated girls to temples, who beside performing temple duties also resorted to prostitution, and 237 non- Devadasis, were led to the life of prostitution as a result of 26 factors.

Promila Kapur (1978), in her widely read and well written study of call- girls through the sample of 150 respondents selected on the basis of convenience sampling from Delhi, Calcutta, and Bombay cities, states that "it is the multiple factors as operate to push women into a life of prostitution".

Women's lack of economic choice is a key reason for entry into 'marginalised' lifestyles including street-based sex work and associated issues of homelessness and problematic poly drug use (McNaughton & Sanders, 2007).

Commercial sex work is rarely a preferred option for women but often is a consequence of their social, cultural and economic vulnerabilities (UNAIDS, 2002).

Sex work is known to be further influenced by development policies promoting tourism, Male attitudes and perceptions of women in society, and women's unequal socio-economic status (Abraham, 2001). It is difficult to enumerate or identify all the factors conducive to Sex work, because Sex work has its roots deep in the fabric of society (Arimpoor, 1990). According to the "Committee on the Status of Women in India" important among the causes of prostitution were dowry, high-bride price and consequent debts (GoI, 1974). In effect, the Sex work was looked upon more as a cause than an effect of the uncongenial conditions in society (Vaidyanathan, 1990).

The numbers of male clients visiting Female Sex Worker are estimated to be between 9 and 13 per cent of the adult (15-64 years) male population, nearly 30-40 million men per year. The total number of visits (averaging about 36-50 per client per year. And the frequency of average number of sexual contacts with clients (ranging between 390 – 790 per year) are other important indicators that have been estimated, based on many assumptions, indirect evidence and modelling. Although there is lack of hard-data regarding these estimates, social science and ethnographic research has often substantiated the overall validity of these findings (Sahasrabuddhe, V. & Mehendale, S., 2008).

Even though we have a good number of studies on Sex work in our Country, systematic survey and an in-depth study has not yet been conducted to asses the extent of the problem in the state of Mizoram. Baseline surveys which have been directed by Sex workers project implementing agencies are both immediate and specific, and the product tend to be particularistic and ephemeral. The entire problem relating to Sex work is generally known to the people in Mizoram, particularly the concerned Government officials, NGOs, and experts, but in bits and pieces (Kanh.A, 1998). There are some authentic papers on Sex work and related issues presented on a seminar organized jointly by some senior Government officials of Mizoram and the leading NGOs in the year 1998.They attempt Situational Analysis (Kanh.A,1998), Legal aspect (Marli.V.,1998), Historical aspect of Immoral Traffic (Zorammawia,1998),Immoral Trafficking (Lalparmawii, 1998).

Most of the writings and presentations related to Sex work refers to the Social Welfare Department document in 1995. These documents are based on the case study

of 122 inmates admitted in Protective Home .This study ,is quite indicative of the situation that prevails in Mizoram .At the same time one of the most important suggestions of this study is that there is a need for a systematic and an in-depth study and significant research(Lalparmawii,1998). Some of the drawbacks of this study is that it does not categorise the causal factors responsible for Sex work in Mizoram and also the consequences of the same. Since most of sex workers are invisible and many other cases are handled by CBOs & NGOs ,it can be easily proved that the known cases are the proverbial *tip of the unknown iceberg* and cannot represent the Sex workers operating all over Mizoram. Apart from this, the study does not include causes of the perpetuation, recurrence and continuance of Sex Work.

A study of "Commercial Sex Workers in Mizoram" was conducted based on a sample of 30 Female sex workers as a sample. The study was a dissertation for the degree of Master of Social Work, submitted to the Department of Social work, Mizoram University. The study examines the socio-economic status, family strength, self esteem level and exposure to media (Vansangpuii, C., 2004). Another study focusing on the health aspect of the Female Sex worker was also conducted based on 45 persons (Esther, V., 2005). Even though, these studies follow a scientific methodology and throw lights for further studies, due to the small sample size, the findings cannot be generalized.

The Human Right and Law Network has conducted a survey on Sex workers identifying 218 Sex Workers. Based on this survey they published a book as to create awareness on Sex work and other related issues. The identified Sex workers were classified into different categories and also identified several causal factors for sex work in Mizoram (Ruatfela nu, 2004). The study is however not very reliable since it lacks scientific methodology (Vansangpuii, C., 2004). However, it has importantly thrown light on an issue that is generally not discussed in Mizoram. This paucity of relevant literature reveals that there is need to systematically document the problems and needs of Women Sex workers in Mizoram.

Mizo Women Sex Workers, are very mobile and are a floating population in nature, a systematic and appropriate methodology should be followed and employed, in order to know the real and genuine situation of these women.

1.6. Rationale of the problem

Systematic survey and an in-depth study has not yet been conducted to asses the extent of the problem in the state of Mizoram. Baseline surveys which have been directed by Project implementing agencies are both immediate and specific, and the studies tend to be particularistic and ephemeral. The problem is intensified due to the lack of Research based intervention.

At the present situation, there is a need to formulate policies and effective programmes catering to the needs of Sex workers in Mizoram. The existing policies and programmes are not successful in prevention, protection, rehabilitation and after care of Sex workers in Mizoram. The results of the present research will be useful to both social policy making and social work practice. Policy makers and planners will be sensitized about the magnitude and the risk factors associated with Sex work in Mizoram. They will also be made aware of the vulnerability and risk of immoral trafficking of the tribal women in the North eastern border States of India. Stakeholders such as Police, Judiciary, administrators, CBOs, opinion leaders will be informed and sensitized about the issues by presenting them the findings of the study. As a result suitable policies for prevention and intervention to the problems would make it possible. The study will help in designing a cost-effective and socio-culturally appropriate intervention programme and also in building an inclusive and supportive community for the sex workers in Mizoram. The findings of the present study will also enhance the capacity of the existing service providers to the Sex workers .It will increase their knowledge of understanding about the problems and result in effective implementation of their ongoing programmes. Since, the study focuses on the Psycho-social problem of Sex Work, the findings will equip and enrich the Social workers with more knowledge that will enable them to device their intervention strategies more efficiently and effectively. It will also enhance their skills to play their role effectively as an advocate, enabler, mobiliser, caretaker, liaison, organiser, counsellor, facilitator etc. whenever they intervene at different levels *viz* micro, meso, macro and professional.

1.7. Statement of the Problem

The present study attempts to understand problems of Women Sex workers in Mizoram. The study will examine the present situation, magnitude and vulnerability of Sex work in Aizawl. The study will attempt to identify the structural and dynamic factors responsible for Sex Work in the context of Mizoram.

This study will examine nexus between HIV/AIDS and Sex work. Initially drug users occupied the limelight of attention but recent reports shows that HIV transmission is now highest through sex. The latest Mizoram State AIDs Control Society (MSACS) official report of *April, 2012* shows that out of 1,91,398 number of blood tested 6,905 are positive and 65.4 % (4519) is attributed to sexual transmission (MSACS). The incidence of STD among Female Sex workers and their life style offers a very fertile breeding ground for HIV/AIDS infection and there is a concerned about the possible role of Sex work in the spread of HIV infection (Singh, 2004). The prevalence of HIV infection among Female Sex workers in Mizoram in 2008 is 9.2% **(**http://mizoramsacs.nic.in/newsite/hiv_status/hiv&vdrl%20sentinel.html**)** whereas at a national level it is 2.68% (NACO, 2010).

According to Mukherjee (1990), Sex work in majority of the cases has negative impact on the Sex workers, which may find expression in the form of insecurity, inferiority, fear from police, mental disturbances, loneliness and guilt. The impact of Sex work on Health will be studied. Sex workers also suffer from physical strain furthered by frequent & unwanted pregnancies and abortion. Besides this, social ostracism, stigma, low social status, deprivation of family life, isolation from the mainstream and mental illnesses are consequences of Sex work. Sex work is known to have some positive impact on their economic life and many of the Sex workers family are dependent on this income only.

Thus, the present study attempts to describe the problems of Women Sex Workers in Mizoram. It also analyses the dynamic and structural factors as well as the consequences of Sex work.

1.8 Operational Definitions

Client: Women Sex Workers commercial sex partner (those purchasing sexual services).

Condom : Male condom

Detoxification : Either Medically or non medically assisting withdrawal.

Drug User : This term is used in preference to 'drug addicts' or 'drug abuser's , which are seen as derogatory and which often result in alienation rather than creating the trust and respect required when dealing with those who used drugs.

Injecting Drug User (IDU) : The term 'Injecting Drug User', which is abbreviated as 'IDU' refers to drug user injecting non- prescriptive use of mind-altering injectible or non-injectible substances in a lifetime/ last 12 months.

Paid/ commercial sex: Payment in the form of money or kind for the exchange of sex.

Red Light Area: An Area where houses of sex work is frequent and where sex workers solicit.

Regular Client: Sexual encounter at least twice in a month (last month's recall)

Regular Sex Partner (RSP): Intimate male partner with whom women sex workers have sex regularly. Regular Sexual Partner can be a husband, cohabiting, non-paying or a boyfriend.

Safer Sex: Sex with barrier i.e. with condom.This term is used in preference to 'safe sex' which may imply complete safety. The term safer sex more accurately reflects the idea that choices can be made and behaviours adopted to reduce or minimise risk.

Sex : Penetrative Vaginal intercourse.

Sex Under the Influence (SUI): Intoxicated by any mood altering substances while having sex.

Sex Work : Negotiation and performance of sexual services for remuneration.

Substance Use : The term 'substance use' in the document refers to non-prescriptive use of mind-altering substances.

Regular Client : Sexual encounter at least twice in a month (last month's recall).

Women Sex Worker : Female adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally and who may or may not consciously define those activities as income-generation.

Women Sex Workers in Aizawl : It refers to the current study that is done in partial fulfillment towards award of doctoral degree in social work.

Objectives

1. To study the personal and social characteristics of Women sex workers and to prepare a profile.

2. To examine the nature of sex work in Mizoram and arrive at a categorization of Women Sex Workers in Mizoram

3. To understand the impact of Sex Work on their health, children and social support.

4. To understand the gap between the existing services and the needs of Women Sex Workers.

CHAPTERIZATION

The theoretical and methodological concerns together with the observations of the study were used in the following chapter of the thesis.

Chapter 1 Introduction: Sex Work in India with Specific Reference to Mizoram

Chapter 2 Review of Relevant Literature

Chapter 3 Methodology

Results

Chapter 4 Women Sex Workers in Aizawl Results

–A Profile, Nature of Sex Work and Categoristion

Chapter 5 Impact of Sex Work on the Health of Women Sex Workers
Impact of Sex Work in relation to Children of Sex Workers

Chapter 6 Social Support and Services for Women Sex Workers

Chapter 7 Focus Group Discussion, Key Informant Interviews and Case Studies

Chapter 8 Conclusion and Suggestions

CHAPTER II

REVIEW OF LITERATURE

The present study aims to understand the literature that is available on the nature, causes, health impact and services of women sex worker in different parts of the world.

2.1. Nature

2.1.1 Socio Demography of Women Sex Workers

Teela Sanders(2004) in a paper on '*A continuum of risk - The management of health, physical and emotional risks by female sex workers'* describes the findings from a 10-month ethnographic study of the female sex industry in a large British city, during 2000-2001.

The author spent over 1,000 hours observing the indoor sex markets such as licensed saunas, brothels women working from home or as escorts and, some street prostitution. The sample was purposively selected using three criteria. All the respondents defined their involvement in prostitution as voluntary; they were all aged 18 years or over and British citizens. They were all able to choose how to manage many aspects of their occupation. This group was captured through 55 in-depth interviews with the following women: 23 sauna workers, 10 women who worked in brothels, 8 women who worked alone from rented premises, 5 street workers, 4 women who worked from home, 3 sauna owners and 2 receptionists

The socio-demographic details of the sample reflect the general characteristics of the indoor sex market in the local area. The majority of women were White European (45 of 55), six others described themselves as Asian and a further four were of African-Caribbean origin. The age range of respondents who sold sex was 18–52 years, and the oldest respondent was 55 years old. The average age of entry into prostitution was *23.1 years* – higher than that found in other studies because of the concentration of indoor workers in the sample. The mean age was 33.5 years, reflecting the general older profile of women who work in indoor markets. The average age of entry into prostitution was 23.1 yrs – higher than that found in other studies because of the concentration of indoor workers in the sample. Only four women confirmed they were using heroin and/or cocaine and all of these were currently on the street. Twenty-eight women lived with their partner while 11 others described themselves as single. Forty-one women were mothers and of these 21

described themselves as lone parents. Thirteen respondents said they kept their prostitution secret from their partner. Fifteen had histories of sexual abuse in childhood and had been in the local authority care system. Thirty-three respondents had worked in more than one market and 16 women had had experience of the street. Virtually all of the interviewees had had other jobs. Often these jobs were unskilled, manual work such as cleaning, catering or caring. Eight women, however, had professional qualifications in education, nursing, psychology and middle management

J. F. Blanchard, J. O'Neil,B. M. Ramesh, et al.,in their study compare the sociodemographic characteristics and sex work patterns of women involved in the traditional *Devadasi* form of sex work with those of women involved in other types of sex work, in the Indian state of Karnataka.

Data were gathered through in-person interviews. Sampling was stratified by district and by type of sex work.

It has been found that out of 1588 female sex workers (FSWs) interviewed, 414 more than a quarter (26%) reported that they had entered sex work through the *Devadasi* tradition. *Devadasi* FSWs were more likely than other FSWs to work in rural areas (47.3% vs. 8.9%, respectively) and to be illiterate (92.8% vs. 76.9%, respectively). *Devadasi* FSWs had initiated sex work at a much younger age (mean, 15.7 vs. 21.8 years), were more likely to be home based (68.6% vs. 14.9%), had more clients in the past week (average, 9.0 vs. 6.4), and were less likely to migrate for work within the state (4.6%vs. 18.6%) but more likely to have worked outside the state (19.6% vs. 13.1%). *Devadasi* FSWs were less likely to report client-initiated violence during the past year (13.3% vs. 35.8%) or police harassment (11.6% vs. 44.3%).

Based on the findings the study team concluded that differences in socio behavioral characteristics and practice patterns between *Devadasi* and other FSWs necessitate different individual and structural interventions for the prevention of sexually transmitted infections, including human immunodeficiency virus infection (Blanchard J. F., O'Neil J., Ramesh B. M., et al, 2005).

Rohini Sahni & Kalyan Shankar, (2011) conducted a pan-India survey. A common research tool was constructed for the survey. The questionnaire incorporated diverse regional realities. The questionnaire was constructed in several sections that reflect different facets of sex workers' lives.

The questionnaire was constructed with sex workers' participation to gauge whether they found the questions relevant. During the next three months, a pilot survey was conducted and the questionnaire was finalised. It was then translated into several regional languages such as Hindi, Marathi, Gujarati, Telugu, Kannada, Tamil and Bengali. The translated questionnaires were carefully assessed for accuracy and conveying the precise meaning intended. A concept note was circulated across organizations working with females in sex work either through HIV/AIDS programmes or violence against women programmes. Training sessions were conducted for those administering the questionnaire. Data collection began in mid-2009. Most collection was done in regional languages. Interviews were conducted in various locations including brothels, streets, beauty parlours, bus stands, railway stations, public toilets and residences of sex workers. The time taken for the interviews was reported to be up to two hours per person.

The sample of female sex workers comprised of 3000 females – a sex worker had to be at least 18 years of age in order to be included in the survey. Of the 3000 females who were surveyed: less than two-thirds (60%) were from rural family backgrounds, more than a third (35%) from urban family backgrounds; almost two-thirds (65%) were from poor family backgrounds, less than a quarter (26%) from middle-class family backgrounds; more than two-thirds (70%) were Hindu, a sixth(20%) Muslim, less than a tenth (6%) Christian and less than a tenth (0.4%) Buddhist; half(50%) had no schooling, less than a tenth(7%) had primary schooling up to class four, less than a sixth(13.4%) had secondary schooling up to class seven, less than a tenth(6.5%) had schooling up to class ten and more than a tenth(11.3%) up to class twelve; more than a quarter (26%) came from Dalit backgrounds.

Sumati Karmakar (2001) reported a state-wise study in order to formulate programmes and policies for the effective control and prevention of trafficking in girls and women. The study carried out was exploratory, multi-dimensional and action-oriented in nature. It was confined to 28 of the 56 districts bordering Madhya Pradesh

and Rajasthan. A total of 4,098 respondents were covered under the study including government officers-208; police officers-125; social and political leaders- 152; victims- 1,000; procurer-102; and household heads-2,511.

Selection of all the respondents was made on the basis of random sampling, except in the case of *procurers* who were selected purposively because they evaded identification. The data for the study was collected through documentary sources, observation, and interview with the help of schedules.

The observations and findings emerging out of the study classified the victims into two types, namely prostitutes, and singing and dancing girls/women. Victims are mostly from the lowest socio- economic groups suffering from multiple problems like illiteracy, ignorance, poverty, deprivation of opportunities, etc. Teenage (13-18 years) is the most vulnerable age for girls/women forcibly becoming victims of the trade; about 58% of the total victims were minors at the time of their entry into the trade. The study also revealed that 72% of the victims belong to low income/ caste communities, about 82% of them are illiterate and 50% of them lived below the poverty line, prior to their entry.

The study of Demography and sex work characteristics of female sex workers in India conducted by Rakhi Dandona, Lalit Dandona et al. (2006) was done through confidential interviews of 6648 FSWs in 13 districts in Andhra Pradesh. The demography of FSWs was compared with that of women in the general population.

A total of 7251 FSWs were contacted, of whom 6648 (91.7%) participated in the study. Among these, 5010 (75.4%), 1499 (22.5%), and 139 (2.1%) were *street, home,* and *brothel-based*, respectively. The study revealed that the proportion of those aged 20–34 years (75.6%), belonging to scheduled caste (35.3%) and scheduled tribe (10.5%), illiterate (74.7%), and of those separated/divorced (30.7%).

Eighty six percent of all the FSWs who participated in this study were between 15 to 34 years of age. The mean age at first vaginal intercourse was 15.1 years. *The mean duration of sex work was 4.21 years*. *The brothel- and home-based FSWs tended to be younger as compared with the street-based FSWs*. The brothel houses usually employ young women and girls, as these women/ girls can be kept in their services for a longer duration. It has also been found that there is a possibility

that the earning potential in sex work for the poor and illiterate women is larger to what th ey could earn through other types of work.

The proportion of those belonging to scheduled caste and scheduled tribe was higher among FSWs and the proportion of single women was higher among the FSWs. The proportion of never married FSWs was higher among the brothel- and home-based FSWs as compared with the street-based FSWs.

Joe Arimpoor (1990) reported that in a research conducted by Bosco Institute of Social Work in Tirupattur in a city with an estimated size of 400 sex workers, more than half (57%) were found to be between the ages of 20 to 30 years; over two-thirds(68%) were illiterate; more than half(55%) were married; more than a third(35%) were unmarried, while the rest were either widows or unwed mothers. More than three-quarters (80%) of the married prostitute's husbands were aware of what their wives were doing; less than two- thirds (64%) maintained normal relationship with their husbands in spite of this and less than three – quarters (73%) of the husbands were agriculture laborers receiving wages below Rs. 150/- per month.

Gilada (1990) reported that Indian Health Organisation, known for their dedication and championing the *Devadasi* prevention campaign had conducted an intensive survey among the *Devadasi* by employing various methods like organizing health camp, meeting key person and video recording event of dedication ritual to Goddess *Yellamma-Renuka*. 780 *Devadasis* were interviewed over a period of 7 years. Less than half (48%) women belong to 20 to 30 years age group; more than a tenth (14%) to 20 years age group. Less than overwhelming majority (88%) girls were dedicated before 10 years of age. *Devadasis* in prostitution in Mumbai consist of more than a tenth (15%), in Delhi, Nagpur, Hyderabad a tenth(10%), Pune a half (50%) and in the urban areas in bordering districts of Maharashtra and Karnataka 70 to 80 %, respectively. An overwhelming majority (95%) were illiterate.

In an ethnographic study of community based sex work among *Nats* conducted by Swarankar (2008) in Jaipur, attempt was made to profile the socio-cultural and economic background of the *Nat* community. The type, extent and network of interaction and inter-relationship among the women practicing sex work from the community, their clients, sex traders and caste groups.

Both secondary and primary data using qualitative as well as quantitative methods were used in the study. As secondary data- literature, directly and distantly related to the objectives of the study mentioned above- was reviewed. Primary data of qualitative and, to some extent quantitative types were collected from the respondents by trained investigators during November 1999 and October 2000.Research tools such as observations related to commercial sex activities, key informant interviews, in-depth interviews, semi-structured and structure interview schedules were used to gather information from the field.

The *Nat* were traditionally entertainers, but prostitution or commercial sex has now become the primary occupation of *Nat* women. The caste panchayat governs the socio-sexual behaviour of the *Nats.* Nat FSW cannot make nuptial alliance with the community, but she is allowed to marry outside the community and Nat boy is not allowed to have sex with *Nat* FSW. Although the family structure of the *Nats* is patriarchal, the women, particularly the FSW, are the axis of the economy of the entire family. Despite the FSW being an earning member of the family, she is considered lower in status than married women and looked down upon by the people living in the nearby villages. *Nat* FSW earns to meet the expenditure of the marriage of her brothers.

The study was concluded by emphasizing the importance of acknowledging that *Nat* women are sex workers not by the social sanction of the caste panchayat alone but more due to the society, patriarchy, freedom to the males to have sex outside the family and caste and the involvement of sex traders.

Pande (2008) in her paper examines the institution of ritualized prostitution, namely the devadasis. It looks at the transformations of this institution on account of the historical forces that have mutated it into a form that has few but striking resemblances to the original institution. Presently known as *Jogins* in Andra Pradesh, the paper analyzes five case studies of this form of *Devadasis*, drawing from a fair amount of oral history and contextualizing the same against the background of their living tradition.

The interviews with the *Jogin* were carried over a period of three years and through several visits. The findings of the study reveal that most of the *Jogins* hails from the most deprived social groups of the society. A large majority of them were landless, their labour is underpaid, and they are a socially distinct group with alternate mores and values and in adherence to the same, some girls are married to the deities. Cornered by compulsions of an inherited social tradition, these girls are suck into the vortex of concubinage and satiate the lust of the village landlords. Once the landlord abandons, they turn from concubinage to prostitution. This is a much localized and regional variant of the *devadasis* who were the temple dancers. However there is a lot of difference between the *devadasis* of the past and the *Jogins* of today. The devadasi system was not confined to a particular caste but spread all over. Unlike Jogins, the devadasis in the past were not treated as untouchables.

In a study on Kolkata's *Call girls* by Ishita Majumdar and Sudipta Panja (2008), a disproportionate, stratified, random sampling method was adopted in order to develop a generalized view of the homogenous strata and cluster sampling was adopted for the heterogeneous strata. The sample consists of 136 participants of whom 100 were chosen for questionnaires and administration and 36 for interviews. Empirical data was collected through – in-depth interviews, questionnaire and focused group discussions.

Overwhelming majorities (93%) of the *Call girl*s are Hindu and belong to the upper-caste. All of them were fluent in Bengali and comfortable with both Hindi and English. Husbands of many have good income, family income for more than a half (56%) ranging between ₹ 8,000 – 10,000. The parents of some are well placed. Over three- quarters (76%) were married, some of them separated, divorced or widowed.

They work as beauticians, sale girls, masseurs, tailors and private tutors and also ran shops and boutiques. Next in line were house wives and a larger section was of high school and college students. Less than two-thirds (60%) of the girls have a professional identity which helps them to conceal their link with the sex trade.

Lalparmawii (2000), reported that there are 120 women sex worker inmates ever registered in Protective Home, under Social Welfare Department. Of the 120 brought to Protective Home less than a fifth(16.6%) were between 13 to 17 and more

than a less than a half(45%) between 18 to 21 years of age. More than a tenth (12.5%) were illiterate and half (50%) were found educated below Class-VII level. Less than three-quarters (72.50%) were divorced or widowed and more than a fifth (21.6%) single. Similarly, less than three- quarters (74%) of the parents of the inmates were either divorced or widows/widowers. More than a third (41.5%) of them came from a broken family. She further stated that these women were stigmatized and discriminated by the society and holds a position which is lower than the drugs using community. Most of them used Alcohol and drugs and some of them were addicted to it.

Conclusion : It is evident that most studies involving sex workers with a few exceptions seem to suggest a younger age group in the profile of respondents. Most of the Indian studies seem to reflect that women in sex work are illiterate or have studied very minimally. Regarding the marital status, studies revealed that there were unmarried, married, divorced and widowed women sex workers. Age of first sexual intercourse very low and age of entry into sex is also very low especially among the jogins and Nats Women Sex Workers community. To sum up, according to the various studies reviewed the Women Sex Workers are mostly from the lowest socio-economic groups suffering from multiple problems like illiteracy, ignorance, poverty, deprivation of opportunities, etc.

2.2 Pattern of sex work

2.2.1 Category of sex workers

Ronald Weitzer (2009) in his article 'sociology of sex work' review and examines key dimensions of contemporary sex work, particularly prostitution to demonstrates how research on these topics can enrich our understanding of contemporary sex work. In the article he presented the typology of prostitution and associated characteristics. The focus is largely but not exclusively on Anglo-American societies.

The categorized women sex workers were *Call girl*s who are independent operators; *Escort* who operated through the escort agency in a private premises and hotel; *Brothel worker, Massage parlor worker*, *Bar* or *casino* worker and *Street worker* those who can be contacted in the street. The price charged by *Street worker* is

low but exploitation by third parties, risk of violent victimization is high and the impact on community is adverse. In the case of the other typologies it is moderate to very in the parameter characteristics mentioned with the exception of the price charged by Call girl which is high.

Wathinee Boonchalaksi and Phillip Guest(1994) in their study to understand the sex sector in Thailand describes the historical development of the sex industry, the different sectors of the industry, the legal framework under and the Thai socio-cultural structure circumscribing the commercial sex industry. It also examined prostitution by comparing the activities of two sectors of sex industry: rural brothels and urban massage parlors by interviewing 106 women.

In the report they have identified 8 sectors where prostitution is being practiced viz. traditional brothels, hotels and motels, tea-rooms, massage parlors, call-girl and escort-girl services, Bar and night clubs, public places and other places such as golf clubs, discos, and pubs. It has been found that there has been an expansion of indirect prostitution where they are paid directly by the clients. The findings show that there are significant differences in the operations of different sectors of the sex industry, and among women from different regions. Most women work willingly and the main reason is a desire for money

Raluca, Buzdagan, Shiva, et al., (2009) conducted a Systematic review of the typology of female sex work in India. Published and unpublished studies (1986–2008) were identified through electronic databases, hand searching and contacting experts. The review assesses the appropriateness of the existing typologies from a programmatic perspective and identifies their strengths and limitations. It indicates there is conceptual confusion around the typology and that none of the existing typologies are exhaustive, in that none includes all types of sex work doocumented in India.

The typology developed by the National AIDS Control Organization (NACO) is the most comprehensive. The typology is based on the primary place of solicitation and categorizes female sex workers (FSWs) as *brothel-based, street-based, home-based, lodge-based, dhaba-based* and *highway-based FSWs*. However, this typology has its limitations. First, it does not include all categories of FSWs

documented in the literature, such as indirect-primary (primarily solicit clients at their places of work, which are venues where facilitating sex work is their main purpose e.g. massage parlours, bars), indirect-secondary (primarily solicit clients at their places of work, which are in non-sex work related industries e.g. agriculture, construction) and *phone-based FSWs* (primarily solicit clients through phones). Second, the methodology used to develop the typology pro-posed by NACO or by any other researchers is not explicit. In addition, the extent to which the typology captures the HIV risk variability between FSWs types is not explored.

The study concluded that there is a need to develop an evidence-based, inclusive typology which takes account of HIV risk for researchers and programmers.

Raluca Buzdugan, Andrew Copas, Stephen Moses et al.(2009) in their study examined the extent to which an existing sex work typology captures human immunodeficiency virus (HIV) risk in Karnataka and proposed a systematic approach for devising evidence-based typologies.

The proposed approach has four stages: (i) identifying main places of solicitation and places of sex; (ii) constructing possible typologies based on either or both of these criteria; (iii) analysing variations in indicators of risk, such as HIV/sexually transmitted infection (STI) prevalence and client volume, across the categories of the typologies; and (iv) identifying the simplest typology that captures the risk variation experienced by female sex workers (FSWs) across different settings.

Analysis is based on data from 2312 participants in integrated biological and behavioural assessments of FSWs conducted in Karnataka, India. Logistic regression was used to predict HIV/STI status (high-titre syphilis, gonorrhea or chlamydia) and linear regression to predict client volume.

The study suggested that the most appropriate typology in Karnataka consists of the following categories: brothel to brothel (i.e. solicit and have sex in brothels) (more than a tenth(11%)of sampled FSWs); home to home, less than a third (32%), street to home, more than a tenth (11%), street to rented room, less than a tenth(9%), street to lodge,more than a fith (22%), street to street, less than a tenth (9%) and other FSWs, less than a tenth (8%). Street to lodge FSWs had high HIV, less than a third (30%) and STI prevalence, less than a quarter (27%), followed by brothel to brothel

FSWs (34 and 13%, respectively). The proposed typology identifies street to lodge FSWs as being at particularly high risk, which was obscured by the existing typology that distinguishes between FSWs based on place of solicitation alone.

National AIDS Control Organisation (2007) developed an operational guideline for the implementation of Targeted Intervention under National AIDS Control Programme phase (NACP) III among High Risk Groups including FSWs. The guideline stated that in any given geography, sex workers are not a homogeneous group. Sex workers can be categorised into 6 main typologies, based on where they work and more specifically on where they recruit or solicit clients and not where they live or actually entertain the clients.

The major typologies of FSW in India are *Street-based sex workers* are those who solicit clients on the street or in public places. *Brothel-based sex workers* are those whose clients contact them in recognised brothels, that is buildings or residential homes where people from outside the sex trade know that sex workers live and work. This includes sex workers in Kamathipura in Bombay and Sonagachi in Calcutta, and also smaller scale brothels in Districts such as Sangli, Bagalkot and Guntur. *Lodge-based sex workers* are those who come and reside in what is known as a lodge (a small hotel) directly and their clients are contracted by the lodge owner, manager or any other employee of the lodge on the basis of sharing the profits. These sex workers do not publicly solicit for clients. *Dhaba-based sex workers* are those who are based at dhabas (roadside resting places for truckers and other long-distance motorists) or road-side country motels. Like *lodge-based sex workers*, these sex workers do not publicly solicit clients, but rather are accessed by clients who come to these locations. In some cases, *dhaba-based sex workers* are also contracted by the dhaba owners and could move from dhaba to dhaba based on their contracts. *Home-based* or *"secret" sex workers* operate usually from their homes, contacting their clients on the phone or through word of mouth or through middle-men (e.g. auto drivers). Generally, they are not known to be working as sex workers within their neighbouring areas. In fact, they could have an entirely different "public" identity – e.g. housewife, student. While many sex workers operate "secretly" given the level of harassment, violence and stigmatisation they experience from the police, the rowdies and the members of general public, for the purpose of TIs, the term "secret" sex

worker refers to a specialised category of sex workers, as explained above. They are only "secret" or "anonymous" in terms of their identity in their immediate context (e.g. family, neighbourhood) – not in terms of accessibility to programmes or their clients. *Highway-based sex workers* are those who recruit their clients from highways, usually from among long distance truck drivers.

There are other sex workers whose primary occupational identity may vary, but a large proportion of their occupation group, *but not all*, often engages in commercial sex regularly and in significant volumes. *Bar girls, Tamasha artistes* and *Mujra dancers* come under this category.

The categories used here are often overlapping and fluid. A sex worker may be street-based for some time and then go into a contract with a lodge owner to become-lodge based. Or a *brothel-based sex worker* may move to another town or city temporarily and work as a *street-based sex worker*.

Lalparmawii (1998) in her paper presented in a 'one day seminar on immoral trafficking of women, HIV/AIDS and Drug abuse' reported that there is *no Brothel* and *a Brothel based sex workers* in the state of Mizoram. She had categorized sex workers operating in the state with a rough estimation of the population in 1995. The categorization was made on the basis of social status of their customer, nature and place of operation. The first category of the women sex workers were *High class group* entertaining only the elite group of the society and they are estimated to be 300 in number. The second were the *Low class sex workers* who were street and hotel based and 470 populations were estimated. *Secret sex workers* who have other stable source of income which constitute the third category of sex worker were estimated to be 70 and the fourth category were married women known as *Senior sex workers* and the number of this population was estimated to be 40.

Conclusion: Based on the above studies Women Sex workers were mainly categorized based on where they work and more specifically on where they recruit or solicit clients and not where they live or actually entertain the clients. There are also Women Sex Workers primarily soliciting clients at their places of work, which are venues where facilitating sex work is their main purpose e.g. massage parlours, bars, and primarily soliciting clients at their places of work, which are in

non-sex work related industries e.g. agriculture, construction and also phone-based Sex workers primarily soliciting clients through phones.

2.2.2. Functionaries in Sex Work

Formal sex work frequently involves more people than sex workers and clients. There are management and staff of commercial sex venues; partners and families of sex workers; support staff such as maids, cleaners, receptionists, security staff; drivers, vendors, tourist guides, touts and hotel staff. In more informal settings families and others play these intermediary roles. Such people are often referred to as *"third parties"*. Some provide protection, spaces and services to sex workers, many exploit or abuse them. They often have significant influence over factors that determine HIV vulnerability (International HIV/AIDS Alliance, 2004).

Fiona Scorgie, Matthew, F. et al., (2011) in their study systematically analyzed the socio demographic characteristics and behavioural risk factors of female sex workers(FSW) in sub-Saharan Africa by reviewing 128 articles.

Globally, sex work takes place in a wide variety of settings, ranging from established, formal brothels to more informal venues such as bars, hotels, roadside truck-stops, or at home. Where sex work is more formal, managers or controllers (‘‘pimps’’) may act as gatekeepers or intermediaries between the sex worker and client, with contracts stipulating what portion of the sex work fee is ceded to these intermediaries, either as rent, or for drugs and protection.

In South Africa, at the top of the hierarchy are better paid sex workers at escort agencies, then those at hotels and finally the poorest work on the streets. Sex work in this region predominantly occurs without intermediaries, with FSW accepting money directly from the client, a setup that potentially gives them better control over their resources and the number of clients they accept. An interesting exception is the presence of middlemen on the trans-African highway in East Africa, who commonly arrange sex workers for truck drivers, and receive some payment from both parties for this intercession (Gysels, M., Pool, R., et al., 2001. In Scorgie, F., Chersich,M.F., et.al., 2012).

The pattern of recruitment into the sex trade includes cross-border movements and a significant number of young girls, approximately less than a sixth(15%) under the age of 15 at the time of the project began entered in that way. The sex industry is controlled by police, politicians, local hoodlum gangs, brothel owners, madams and pimps. While some sex workers are independent, others, particularly those newer to the trade, have madams and /or pimps. Some madam- controlled sex workers known a *chhukris* are completely bonded and each one is obliged to earn enough to pay off an advance given to her or, more often, to the persons who 'sold' her into the trade. Another madam-controlled arrangement is called the *adhia* system, in which the sex worker turns over a half (50%) of her income to the madam. Pimps take a quarter (25%) of the sex worker's income and are organised in a hierarchical and regulated system headed by mukia, or political headmen. Room are rented at high rates. The sale of sex is legal in India if it takes place 'within a room'. In order to avoid arrest, freelance or 'flying sex workers' must also rent rooms at high hourly rate. In addition, many sex workers have babus, men who begin as clients and then form longer-term relationships (Jenkins, C. (Ed)., 2000).

In a study conducted in 28 districts of the 56 districts of Uttar Pradesh, the functionaries of the sex trade was mentioned in the conclusion of the findings and observations. Procurers, pimps, brothel keepers, touts, etc. were the masters of the trade, each supporting and supplementing the other for a common cause, i.e. deriving economic benefit and power out of the trade while performing their respective roles and assignments in the trade management.

Procurers identify girls/women, procure and supply them to the brothel keeper. The *brothel keepers* are placed at the apex of the hierarchy of the brothel administration. They play the roles of trainer, educator, settler of disputes, purveyors of justice, protectors, financers, accountants, managers and security officers all at once, even though the ownership of the brothel may not always be with them. *The pimps, intermediaries and tauts* hold a pivotal position in the trade, because they are instrumental in business promotion and rendering necessary support. While the pimps have a close relation with the brothel emotional and sexually, the intermediaries and tauts are generally engaged in other occupations and associated with the trade from a distance (In Karmakar, S., (Ed.). 2001).

Ishita Majumdar and Sudipta Panja (2008), in the background of their study on Kolkata's *Call girls* describe a well structured networking system of sex work. According to them each agent has about 10-15 call girls working for him and sometimes a call girls might work for different agents or event develop her own net network, therefore playing the dual role of call girl and agent. The exchange of call girls between agents is also common when agents feel that the women working under him do not exactly match the demand of the client. He then borrows a call girl from another agent.

The *Call girl* in Kolkata has two distinct variations based mainly on areas of operation-the intra city network and the inter-city network. The intra- city network involves less than an overwhelming majority (85%) of the total call-girl population and the inter-city network sustains more than a tenth(15%).

The intra-city network comprises two distinct sub-networks: the core city network and the suburban network, each accounting for less than two-thirds (62%) and more than a third (38%) of the intra-city call girls respectively. Each sub-network serves a different class of clients. Their modes of contact also differ according to their personal/parallel identities. It may be through phone-calls, agents, massage-parlours, bars, hotels, the glamour world, and the like.

The inter-city network embraces cities like Bangalore, Hyderabad, Delhi and Mumbai. The network in Mumbai is most active with the highest rates in the country and draws a large number of call girls from Kolkota and other cities. The modus operandi is simple- local agents sign contracts with the girls and then contracts are drawn up with their counterparts in Mumbai. Once in Mumbai, however the call girls are answerable only to their Mumbai agents. The chain of *'contacts'* often extends to Dubai where Mumbai agents tie up with sex-trade networks in the city

Conclusion: Based on the above studies sex work involves more people than sex workers and clients. It is clearly evident that in both the formal and informal sex work there are gatekeepers or intermediaries between the sex worker and client who have shares from the fee. The functionaries of the sex industry consist of the police, politicians, local hoodlum gangs, brothel owners, madams and pimps.

2.3 Clientele: Demand Factors

The definition of Prostitution "as the sale and purchase of sexual relations" would have been more appropriate if it had been defined as "purchase and sale of sexual relations" as demand invariably preceded the supply. What are the factors that are generally responsible for causing a demand for the prostitute? What functions do prostitute fulfill as otherwise cannot be met by any approved mode of sexual satisfaction, pressures or processes in the social structure they have survived for the last three thousand years, beside all the condemnation, sanctions, ridicule, ostracization, humiliations and exploitation that she has undergone, there must be structurally inbuilt factors, responsible for her emergence, perpetuation and support (Bedi, M.S.,1990).

According to Kinsey (1948), around 3.5 to 4 percent of the total sexual outlet of the total male population (single and married) is drawn from relations with female prostitutes. Whereas married males get 11 percent of the extra-marital and 1.7 percent of the total sexual outlet from the prostitutes, prostitutes provide a tenth of the male's total pre-marital intercourse. The extent of their use further increases by males that continue to be unmarried and among those divorced, widowed or separated. In India as a result of marriage being universal and at early age and existence of sizable promiscuity especially in lower castes sexual outlet through prostitute for all males would not be more than two percent of the total sexual outlet.

According to Kingsley, sex is reality and it can be conditioned but not extinguished. Human beings unlike animals have no season of sexual dormancy except that pregnancy and menstrual period of women puts limits to sex life. His studies revealed that human beings are sexually active from young age of 8 years, till very late age i.e. even up to 85 years. The pre-adolescent and adolescent seek this outlet largely through masturbation or nocturnal emission heterosexual outlet forming only minimal source. There are six chief sources of orgasm for human male such as masturbation, nocturnal emissions, heterosexual petting, heterosexual intercourse (which includes prostitutes both females and males) homo-sexual relations and intercourse with animals. According to Kinsley most people depend upon two or more sources of outlet and the mean being between 2 to 3 as revealed in his sample of 5000 males (Kingsley,D., 1966).

S.K. Ghosh (1996) discusses why men visit prostitutes by referring to Schuarz, O., the factors include-

- Teenagers in the experimental stage, adolescents, young men, college students, etc. For them, it is the opportunity to experience a new sexual contact;
- Insufficient marital relations; married men with frigid wives; failure of wives to provide sexual desire of husband;
- Married men sexually isolated from wives for time being or for a long time such as tourists, soldiers, sailors, salesmen, foreign visitors, etc.
- Widowers who are sexually isolated and do not have any other means to satisfy their sexual appetite;
- Wives living in adultery or husbands and wives living separated as divorcees;
- Unmarried men economically poor and who do not have means to maintain their wives and family.

Belinda Brooks and Gordon (2010), in their article critically examine the regulation of clients of sex worker in England. The article highlighted the study conducted by NATSAL in 2000 where 11,161 were investigated. The survey shows that less than a tenth (4.3%) of the male population paid for commercial sex in the previous five year. The men who had paid for sex in the previous five years were more likely to aged 25-34, to be previously or never married, and to be resident in London. In an analysis of lifetime recourse to prostitution(LRP) in nine repeated representative cross-sectional surveys from 1987 to 2000, age-specific estimates of LRP were made. It was reported that ‘there was no consistent increasing or decreasing trend over the years’.

It was also reported in the paper that the prevalence of men who are clients of female sex workers varies across continents. In a study of 78 national household surveys, nine city-based surveys, and behavioural surveillance serveys in a total of 54 countries, prevalence was lowest in Western Europe with less than a tenth(3%) men going to sex workers. In China and Hong Kong it was more than a tenth(11%); Central Africa, a sixth(15%); and in Zimbabwe, more than a quarter(29%). In

Rwandan and Zambian truck drivers, prevalence was high at 47 per cent and 30 per cent respectively. Also in urban areas where incomes were higher, among men with high-mobility occupations such as migrant workers, police, military, drivers and truckers, more men paid fro sex (25-30 per cent).

In a study conducted to formulate programmes and policies for the effective control and prevention of trafficking in girls and women reported by Sumati Karmakar (2001), according to the observations and findings clients were categorized into three groups based on the purpose of their visits, namely, those who fulfill a basic need, those who indulge in it for sheer fun and those use it as a means of business and personal promotion.

The first type cover men (industrial workers migrant labourers, army and police personnel, etc.) who are normally separated from family and feel compelled to visit women to release their sex urge. They are basically patrons of the prostitute.

The second type constitute a sizeable section of the total clientele in tourist and religious centres like Agra, Varanasi, Dehradun, Mathura, Ayodhya, Haridwar, Allahabad, etc. They visit both the prostitutes and the singing and dancing girls/women.

The third type of customers use the trade as a means to an end and depend on it for achieving their goals either in business, or profession or politics.

Fiona Scorgie, Matthew, F., Chersich, et al.,(2011) in their study systematically analyze the socio demographic characteristics and behavioural risk factors of female sex workers(FSW) in sub-Saharan Africa by reviewing 128 articles.

Data was collated from both qualitative and quantitative research studies among FSW and their clients. The databases Medline, Web of Science and Anthropological Index were searched for relevant English articles published between January 2000 and April 2010. To be eligible, articles had to contain socio-demographic or behavioral information about FSW in sub-Saharan Africa. The search identified 1,200 articles. Following the screening of article titles, abstracts and, in some cases, the full text of articles, 128 articles remained for inclusion in the review.

They came across a few study surveys of the clients of FSW in sub-Saharan Africa, possibly because accessing these groups is difficult. Innovative methodologies have been applied to overcome this challenge—such as 'exit interviews', where clients in West Africa were interviewed while leaving brothels. What is apparent from available literature is that while clients of FSW are often drawn from specific groups of men, overall, they represent a broad cross-section of society. Nevertheless, particular situations do increase demand for sex work and generate specific client groups, for example, mobile men separated from their families and social networks for extended periods of time, such as seasonal agricultural workers, truck drivers, men on board ships and in the military or employed as migrant workers. However, clients are not only from these transient groups; they often are also frequently residents of the surrounding local areas, a pattern that may sustain local HIV diffusion pathways.

According to Elmore-Meegan, Conroy, R.M., et al.,(2004),in sub-Saharan Africa, sex work is not typically based in the large-scale brothels that are common in Asia—with some exceptions, largely in West Africa, especially Nigeria. In one Kenyan study, only 6% of the FSW interviewed worked in brothels; these were run by a group of women as a business. The study found higher client numbers for FSW in Nairobi urban townships (a median nine clients per week), than in rural towns (only four per week).In a survey of sex work in urban and rural Kenya, a significant portion reported being raped (35%) or physically assaulted (17%) by a client. Girls living near to areas with an especially high demand for sex workers may enter the trade at a younger age. Examples of this can be found in the study where *urban* sex workers in Nairobi and Kisumu were younger and had begun sex work an average of 4 years before their *rural* counterparts.The average age of sex workers mostly fell between 24 and 31 years, with estimates lower among urban sex workers in East African countries such as Ethiopia and Kenya

Conclusion: Women Sex Workers were provider of sexual outlet for people who are in need of their services and this is the reason for her emergence, perpetuation and support. Studies show that clients of Women Sex Workers comprises of Teenagers, Unmarried men, Married men and Widowers. It is also evident in the above studies that the prevalence of men who are clients of Women Sex Workers varies across continents. There were clients who visited Women Sex

Workers to fulfill their basic need, those who experiment and indulge in it for sheer fun. The *patrons of the prostitute* are those who are normally separated from family and feel compelled to visit women to release their sex urges.

2.4 Causes For Entry And Continuing Sex Work

2.4.1 Factors Responsible For Sex Work

"The need for prostitution arises from the fact that many men are either unmarried or away from their wives on journeys, that such men are not content to remain continent, and that in a conventionally virtuous community, they do not find respectable women available. Society therefore sets apart a certain class of women for the satisfaction of those masculine needs which it is ashamed to acknowledge yet afraid to leave wholly unsatisfied"(Bertrand Russell, 1929).

In London, Merrick (In Havelock.E., 1937) found that of 16,022 prostitutes who he encountered as chaplain at Millbank prison, 5061 *voluntarily* left home or situation for "a life of pleasure;" 3363 assigned poverty as the cause; 3154 were "seduced" and drifted on to the street; 1636 were betrayed by promises of marriage and abandoned by lover and relations. On the whole, Merrick states, 4790, or nearly one-third of the whole number, may be said to *owe the adoption of their career directly to men*, 11,232 to other causes.

The analysis of the factors forcing women into prostitution in the empirical study of New York city by W.W. Sanger (1986), between 1955-58, among 2000 prostitutes studied by him , the predominant cause for 525 was destitution, 513 – inclination, 258- seduced and abandoned, 181 – drink and desire for drink, 164- ill treatment by parents, relatives or husbands, 124- an easy life, 84 – bad company, 71- persuaded by prostitution, 20-too idle to work ,27- violated, 16- seduced on emigrant ship and 8 as were also seduced in boarding house .

Fiona Scorgie,Matthew F. Chersich and Innocent Ntaganira et al.(2011) in their study of the socio demographic characteristics and behavioural risk factors of female sex workers(FSW) in sub-Saharan Africa revealed that despite country-specific variations in the way that sex work is organized, a number of commonalities are nonetheless evident across the region. *Similar factors motivate women to enter sex*

work: while poverty and the experience of a disadvantaged background are unsurprisingly common, other factors feature equally prominently, such as seeking financial independence or escaping boredom, abuse or marital breakdown. The literature consistently portrays the lives of FSW in sub-Saharan Africa as marked by the effects of harmful legislation and human rights violations, which include coercion, stigma, poor access to information and prevention services, as well as frequent exposure to violence and hazardous alcohol use

S.K.Ghosh (1996) in his book highlighted that *poverty is one of the dominant factors* of prostitution. He related to various studies that have shown that many parents in the third world countries sell their daughters and husbands sell their wives or allow their wives to prostitution to sustain starving families. In the Philippines and Thailand women and girls belonging to unemployed poor rural families are seduced for employment and airlifted to rich countries for the purpose of prostitution. According to him, Governments in those countries turn a blind eye to the sexual exploitation of their poverty-stricken women and girls. Survey has also shown that in Sri Lanka, thousands of girls and boys from the rural poor families seek their living by prostitution and depend entirely on opportunity to get the child away to reduce the already existing burden is covertly and sometimes overtly appreciated by parents.

Niranjan Saggurti, Shagun Sabarwal, Ravi K. Verma, (2011) in their study documents the reasons and processes for involvement of women into sex work in India. The study is based on in-depth interviews with a cross-section of commercial sex workers in four Indian states – Maharashtra, Tamil Nadu, Karnataka and Andhra Pradesh. *It shows that most women enter sex work due to a complex set of reasons as opposed to any one single over-riding reason*. While abject poverty was cited as the main cause by almost three-fourths of the women interviewed, lack of education, financial freedom, domestic violence, family responsibility, lack of support by family members and harassment and abuse in society and in the workplace, were other inter-linked factors facilitating involvement into sex work. Some women reported that they were pushed into sex work by deception or force by known or unknown persons. Many women who initiate sex work are not forced physically, but do so because of reasons over which they had little or no control. In this sense, initiation into sex work

is far more complicated than a simple distinction of ‘voluntary’ and ‘involuntary’ as explained by other studies in India and around the world

Bedi, (1990) in a theme paper presented in a workshop analyses several studies on the causes of prostitution in India. The findings revealed that there is a combination of deprived, deceived, depraved and disturbed background as a causal factors. This is revealed by the famous study of prostitutes in Bombay undertaken by S.D. Punekar and Kamala Rao, who studied in all 350 prostitutes among whom, 113 were Devadasis a tradition coming from tenth century in India specially in South India where parents dedicated girls to temples, who beside performing temple duties also resorted to prostitution, and 237 non- Devadasis, were led to the life of prostitution as a result of 26 factors.

These factors were again regrouped under 6 major heads, namely, (1) demise of earning member,(2) destitution and poverty; (3) ill treatment, negligence, unfaithfulness of husband or otherwise unhappy marriage;(4) deception, kidnapping, connivance of parents or other relatives, tradition and heredity;(5) sexual urge; illicit sexual relation, illegitimate pregnancy and rape and (6) last group of causes included factors such as desire for easy life, love and adventure, hatred for marriage, ignorance, low-moral values and desire for revenge. These causes reflected the social, moral, economic, environmental conditions of the prostitute as also about their families and surroundings.

Similarly Joardar, (1984) in his study of prostitution in Calcutta city has listed ten potent factors such as- ill-treatment by husband resulting in desertion of separation; death of husband or father; deception; environmental influence; introduced by husband, brother or father’s brother, desire for easy life, illegal pregnancy, poverty and neglect. He felt that some of these factors also acted as contributory factors in combination with potent factors.

Promila Kapur, in her widely read and well written study of call- girls through the sample of 150 respondents selected on the basis of convenience sampling from Delhi, Calcutta, and Bombay cities, states that “it is the multiple factors that operate to push women into a life of prostitution”. According to her it is the whole process of the individuals faulty or inadequate upbringing and socialization, the social

institutions, systems, attitudes and behaviour that play a very significant part in this complex phenomenon of a girl's becaming and continuing to be a Call girl. Hence, besides economic reasons, there are various other socio psycho-situational factors and motivations behind girl or woman taking the decision to become and continue to be a call girl (In Bedi, M.S., 1990).

Pande, R., (2008) through case studies concluded that the main cause of converting young girls to *Jogins* are recurring deaths of children in a family, regular occurrence of diseases in the house or village, outbreak of disease in the village or pure lust of landlords. The nexus between caste and forced prostitution is quite strong and the devadasi system. Most Indian girls and women in India's urban brothels come from lower-caste, tribal or minority communities. Like other forms of violence against women, ritualized prostitution, is a system designed to kill whatever vestige of self- respect the untouchable castes have in order to subjugate them and keep them underprivileged.

Joe Arimpoor (1990) in his paper on 'The history of prostitution' highlighted some of the findings of high level committees on the causes of prostitution. The International Congress on prostitution (1953) concluded that economic and social factors are amongst the most important causes of prostitution. The Advisory Committee on Social and Moral Hygiene pointed out that among women found in brothels many had come from poor but respectable families and that they were driven to prostitution by economic necessity due to unemployment. According to the "Committee on the Status of Women in India" important among the causes of prostitution were dowry, high-bride price and consequent debts. It is difficult to enumerate or identify all the factors conducive to prostitution, because prostitution had its toots deep in the fabric of society.

An extensive body of literature suggests that individuals involved in prostitution often come from abusive and neglectful childhood backgrounds. However, the mechanisms that lead from childhood abuse and neglect to involvement in prostitution are not well understood. Helen W. Wilson and Cathy Spatz Widom (2010) in their paper examines 5 potential mediators: early sexual initiation, running away, juvenile crime, school problems, and early drug use.

Using a prospective cohort design, abused and neglected children (ages 0–11) with cases processed during 1967–1971 were matched with non abused, non neglected children and followed into young adulthood. Data are from in-personal interviews at approximately age 29 and arrest records. Structural equation modeling tested path models.

Results indicated that victims of child abuse and neglect were at increased risk for all problem behaviors except drug use. In the full model, only early sexual initiation remained significant as a mediator in the pathway from child abuse and neglect to prostitution. Findings were generally consistent for physical and sexual abuse and neglect. These findings suggest that interventions to reduce problem behaviors among maltreated children may also reduce their risk for prostitution later in life.

Plumbridge, L. and Abel, G. (2001) assess differences in personal circumstances, risk exposure and risk-taking among female sex workers in different sectors of the New Zealand sex industry in regard to issues of sexual safety, drug use, violence and coercion. A cross-sectional survey of 303 female sex workers was carried out in Christchurch, New Zealand, May-September 1999. observed the existence of *'push' and 'pull'* factors in entering sex work. Push factors – particularly for young street workers – can include abuse and neglect, a breakdown in care giving, school exclusion, homelessness, and lack of money. Pull factors can include excitement, encouragement from others involved in sex work, and a way of seeking affection. Freedom to work one's own hours to accommodate childcare or study responsibilities is another pull, particularly for off-street workers.

There are an estimated 1800-3500 sex-workers in Dimapur, the commercial capital of Nagaland, which is the second-highest HIV prevalence state in India. The HIV prevalence among these sex-workers has increased from 4.4% in 2004 to 16.4% in 2006, highlighting their vulnerability. The present study of Alexandra Devinea, Kathryn Bowena, et al,(2009) aims was to contribute to understanding of the pathways to sex-work for women in Nagaland in order to inform the development of effective HIV prevention strategies.

A *convenient* sample of 220 female sex-workers was taken to complete a cross-sectional survey, and 30 female sex-workers participated in semi-structured in-depth interviews during mid 2007. Participants were asked about their life situation at the time of initial engagement in sex-work and circumstances of the first occasion of sex-work. The four main pathways into sex-work were identified as: (1) to obtain money to meet basic needs for self and family (less than a half (45%) of survey and less than a half(43%) of interview participants); (2) to obtain money to purchase drugs or alcohol (less than a fifth(15%) of survey and more than a quarter (27%) of interview participants); (3) being coerced, tricked or forced into sex-work (more than a tenth(13%) of survey and less than a third (30%) of interview participants); and (4) for pleasure (more than a tenth(12%) of survey and no interview participants). Women from each of these pathways were significantly different from each other in relation to a range of socio-cultural variables (e.g., ethnicity, marital status and education), and HIV risk factors (e.g., drug and alcohol use, age of sexual debut and HIV awareness). This diversity has implications for HIV prevention strategies, including the willingness and capacity of sex-workers to mobilise as a community and NGO capacity to ensure that the interests of all sex-workers are adequately captured and represented (Alexandra Devinea, Kathryn Bowena, et al., (2009).

The Human Right and Law Network, Aizawl conducted a survey on Sex workers identifying 218 Sex Workers. Based on this survey they published a book to create awareness on Sex work and other related issues. The identified Sex workers were classified into different categories and they also identified several causal factors for sex work in Mizoram. Human Rights and Law Network suggested the factors to be conductive to prostitution in Mizoram, viz, Broken family, lack of parenting skills and neglect of children, delinquency, bad influences by peer, illegitimate pregnancy, illicit sexual urge, desire for easy life, loose character, poverty, unemployment, Alcohol and Drug addiction, Domestic violence. (In Ruatfela nu , 2004)

Conclusion: It is evident from the above studies that there are multiple factors which pushed and pulled women into the profession of sex work and they are invariably inter-related. Economic, social and psychological causes were greatly responsible for women's entry into sex work. It is also clearly evident that Women Sex Worker enters into sex work *voluntarily* for lack of any other means of livelihood

or to sustain their substance dependency. Involuntary or forced Women Sex Workers enter into the profession through religious and customary practices, kidnapping and rape, and sale of their bodies by intermediaries.

Push factors included abuse and neglect, a breakdown in care giving, school exclusion, homelessness, and lack of money. Pull factors includes excitement, encouragement from others involved in sex work, and a way of seeking affection.

2.4.2 Trafficking in Person for Commercial Sexual Exploitation

On June 1, 2012, the International Labor Organization released its second global estimate of forced labor, which represents what the U.S. Government considers to be covered by the umbrella term “trafficking in persons.” Relying on an improved methodology and greater sources of data, this report estimates that modern slavery around the world claims 20.9 million victims at any time.

The ILO’s first estimate of forced labor, in 2005, was 12.3 million victims of forced labor and sex trafficking.

Unlike the 2005 estimate, this new finding does not disaggregate human trafficking victims as a subset of the global forced labor estimate. This recognizes that human trafficking is defined by exploitation, not by movement.

The ILO estimates that 55 percent of forced labor victims are women and girls, as are 98 percent of sex trafficking victims.

The ILO identified a higher percentage of sex trafficking victims, than in the 2005 Report.

By region, the Asia and the Pacific region (which includes South Asia) remains largest in terms of number of victims, though the estimate of trafficking victims in Africa has grown since the 2005 estimate.

Crime in India reported that in 2006, Immoral Traffic (Prevention) Act has registered 4,541 cases, a decline of 23.1% as compared to the previous year (5908). 38.1% (1,732) cases were reported from Tamil Nadu which also reported the highest crime rate of 2.6 as compared to the National average of 0.4. Out of UT's, Delhi

reported maximum cases i.e. 112 out of 124. 231 cases of Procuration of minor girls (Sec. 366A IPC) were reported in the year 2006. West Bengal has reported (77) such cases indicating a share of 33.3% at national level followed by Andhra Pradesh and Kerala (35 each). 67 cases of Importation of Girls (Sec. 366B IPC) were reported during the year 2006. Bihar (42) and Orissa (12) have reported highest number of such cases accounting for 62.7% and 17.9% respectively of total such cases at the National level. 35 cases of 'Buying of girls' and 123 cases of 'Selling of girls' for Prostitution were reported in the country during 2006. Maharashtra (23 out of 35) has accounted 65.7% of total cases of 'Buying of Girls' and West Bengal has accounted for 92.7% (114 cases out of 123 cases) of the total cases of 'Selling of Girls' for Prostitution reported in the country (Matiyani, H & Chattoraj,B.N., 2010).

This National Crime Record Bureau under the Ministry of Home Affair in India is collecting data under the following heads of crime which are related to human trafficking.

IPC (Indian Penal Codes)Crimes

(i) Procuration of minor girls (section 366-A IPC)

(ii) Importation of girls ((Sec. 366- B IPC)

(iii) Selling of girls for prostitution (Section-372 IPC)

(iv) Buying of girls for prostitution (Section -373 IPC)

SLL(Special and Local Laws) Crimes

(i) Immoral Trafficking (Prevention) Act 1956

(ii) Child Marriage Restraint Act, 1929

A total of 3,422 incidents of crimes under various provisions of laws (for which data is being collected for this report) relating to human trafficking were reported in the country during 2010 as compared to 2,848 during 2009 recording an increase of 20.2% during 2010. 4,997 cases relating to human trafficking were reported during 2006 as compared to 3,991 and 3,029 cases reported in 2007 and 2008 respectively (NCRB, 2011).

S.K.Ghosh(1996) in his book “the world of prostitution(chapter 30- Victim of sex trade)” reported that there is a high concentration sex workers of Nepalese origin living in Bombay brothels, over 20,000 according to Sanjukta Satya Sodak Pidit Nepali Mahila sangha, an organization of Nepalese prostitute in Bombay. The largest migration of women from Nepal take place between the months of June and August known as the “hungry months” . The intolerable life of utter poverty in the mountaneous villages where agricultural work is inadequate and seasonal compel the women to migrate to India. Through extensive interviews it was found that over 50 per cent of them working in Bombay were duped into the trade by village headmen known as “gallawals” and even close relatives. In 1987, the annual rate of trafficking in Napalese women to India was estimated at 5000-7,000. Prostitution is a crucial issue for Nepalese women today.

(Trafficking & HIV/Aids North East Report by *Nedan Foundation* (n.d.).

Retrieved from http://nedan.in/reports-1/trafficking-and-hiv-north-east-report**)**

The information about trafficking and HIV/AIDS is limited in North East Region. Nedan Foundation (n.d.), conducted a Rapid assessment to understand the causes and consequences of trafficking and HIV/AIDS and its magnitude in North East Region.

The report was assembled based on the data/information received from the questionnaires sent out to CSOs. The review of the relevant published and unpublished documents/ reports were also done to collate information. The project associates reviewed articles, websites, journals and Government reports and other sources such as observations, mapping and standardized questionnaires with Commercial Sex Workers (CSWs).

The principal sources were interviews with primary sources (victims, sex workers, returnees’ domestic worker) along with telephonic conversations with other stakes holder such as in-charge of state run short-stay home, children homes and state wise women cells. The meeting with parents of the missing girls within the 25 existing relief camps were carried out in order to collate first hand information on numbers of missing girls and unsafe mobility of the women and girls from such potential trafficking areas. The report states that “Every year, an average of 22,480

women and 44,476 children are reported *missing* in India. Out of these, every year, an average of 5,452 women and 11,008 children are *not traced*. A recent report, *Action Research on Trafficking in Women and Children in India - 2002-2003* indicates that many of the missing persons are not really missing but are instead trafficked.

The combination of poverty, ethnic conflict, unemployment, gender inequality (the low status of girls children) inadequate legislation and law enforcement enables trafficking in girls to thrive in North East. Seven factors were identified as to why girls and women were trafficked viz. Prostitution, Sexual purposes, Smuggling, Bonded labourers, Entertainment industries, Drugs/arms trafficking, and cheap domestic labour.

With the advent of the security forces, prostitution has emerged as a growing menace in North East region. Added to these are the means of drugs and alcohol available in the states. Despite denial by the government authority, it is a fact that trafficking network exist, connecting to other South East Asian countries. Local residents confirm the presence of middle men (kingpins) who deal the girls. The victims are mostly the women and girls from the indigenous groups that are especially vulnerable to trafficking in North East region.

(Trafficking & HIV/Aids North East Report by *Nedan Foundation* (n.d.).

Retrieved from http://nedan.in/reports-1/trafficking-and-hiv-north-east-report**)**

Guri Tyldum (2010) in an article pointed some common pitfalls and particular challenges in research on human trafficking by presenting some of the challenges in identifying observable populations and behaviours, arguing that primary data collection in the trafficking field should focus on former victims, and not current victims or persons at risk. Some of the factors that have inhibited the development and use of explicit operational definitions of trafficking are also discussed. Thirdly, he presented some of the challenges in identification of trafficking victims, when the victims themselves do not want to identify with the trafficking label and finally, the usefulness of different research strategies in the trafficking fields for the current knowledge needs is discussed.

The article concludes that there will always be some limitations and biases in empirical research in the trafficking field. However, as long as we acknowledge these limitations and make them explicit in our research, sound empirical research that enhances our knowledge in this field is possible.

The best potential for good quality research lies in small-scale, thematically focused empirical studies, while attempts to describe worldwide trafficking across regions and arenas is less likely to be successful.

Conclusion: The above studies clearly indicates that the magnitude of trafficking for Commercial Sexual Exploitation is very high. The combination of poverty, lack of protective environment, ethnic conflict, unemployment, gender inequality (the low status of girls children) inadequate legislation and law enforcement enables trafficking in girls.

2.5 Consequences

2.5.1 Economic Consequences

Wathinee Boonchalaksi and Phillip Guest (1994) in their study to understand the sex sector in Thailand examined two sectors of sex industry: *rural brothels and urban massage parlors* by interviewing 106 women.

In the study it has been found that most of the sex workers entered the occupation for *economic reasons*. In exchange for working in an industry which is disapproved by most of society and which can have severe and well recognized health risks, the workers expect to obtain an income greater than they could obtain in other occupations for which they would be qualified. Result shows that the sex work sectors far exceed anything that might be in other occupations by women who commonly have only a primary school level of education. The majority of women at equivalent levels of education were engaged in the agricultural sector or were self- employed in the service sector. The vast majority of respondents were conscious of the income loss they would face if they moved to another occupation.

According to Sanlaap, a Kolkata based NGO: assuming there are 20,000 sex-workers in Calcutta, each with a gross average earning of ` 100 a day, the total

turnover per day is ` 20,000,000 and ` 6, 00, 00,000 per month and an average turnover of ` 720 million. Only a small part goes to sex- workers, the rest to recruiters, middlemen, agents, pimps, brothel-keepers, live-in partners, liquor sellers, the underworld and the Police.

Constracting similar estimates for 5,000 Women Sex Workers in Pune's Red Light Area: it was found that on an aggregate, they provided service to about 5,000-20,000 clients every hours and the charges range between ` 30 to ` 100. This results in an approximate daily turnover of ` 1, 50,000 to ` 20, 00,000 directly due to sex work alone.

Abhijit Dasgupta (1990) conducted a research in three major stages. The first involved defining the study universe as precisely as possible, the second was designed to know where the women came from, and the third stage was to know why they came. The study was conducted in and around kolkata among a brothel based sex workers. In the selected eight recognized brothel areas, 408 premises which housed 6,698 prostitutes. These women, at 1987-88 rates, earned approximately ` 18 crores annually as fees. Almost half the earning of the women reach the hands of the organizers of the business directly. According to the study team rough estimation prostitution is a ` 500 crores industry in India, out of which at least half the amount accrues to procurers, pimps, brothel-keepers and brothel-owners. Since, an average rural women receives ` 475/- per month on account of her being in prostitution, this becomes a strong enough reason for the rural poor to make their women sell sex if they had the proper "introductions".

In a study on Kolkata's call girls by Ishita Majumdar and Sudipta Panja (2008), the sample consisting of 136 participants of whom 100 were chosen for questionnaires and administration and 36 for interviews, empirical data was collected through – in-depth interviews, questionnaire and focus group discussions.

In their study the result shows a high level of job satisfaction which was reported in the findings. Most of the call girls seemed happy with their profession.

Even though all had economic reasons for pursuing it, not all seemed to have been driven into it. Many were from well-to-do families. Some call girls were proud of their profession. It was giving them 'economic security, food for the family, education for children and helping them to survive with dignity'. They refused to belittle their profession and questioned on why they are called 'bad persons'. A large chunk of the income earned was spent on themselves, mainly on clothes, cosmetics and other items of personal consumption. For some sex trade help them to overcome adverse situations and achieve what they wanted. More than three-quarters (85%) of the women interviewed said that this profession gave them easy cash in the absence of other job opportunities.

Conclusion: Based on the above studies it has been found that most of the sex workers entered the occupation for economic reasons and has some positive impact on their economic life and many of their family are dependent on this income only. It is also evident that the sex work sectors far exceed anything that might be in other occupations by women who commonly have only a primary school level of education. For most of the Women Sex Workers, Sex Work enables them to have economic security, food for the family, education for children and helping them to survive with dignity. As a whole, even though the earning through Sex Work might seems to be huge but only a small part goes to sex- workers, the rest to recruiters, middlemen, agents, pimps, brothel-keepers, live-in partners, liquor sellers, the underworld and the Police.

2.5.2 Health: HIV/STI/ Substance Use

Augustine Ankomah, Godpower Omoregie, et al.,(2011) in their study based on 24 focus group discussions held among brothel-based sex workers in four geographically and culturally dispersed cities in Nigeria. It was found that sex workers underestimated their risk of infection and rationalized, defended, or justified their behaviors, a typical psychological response to worry, threat, and anxiety arising from the apparent discrepancies between beliefs and behaviors. To reduce dissonance, many sex workers had a strong belief in fatalism, predestination, and faith-based invulnerability to HIV infection. Many believed that one will not die of acquired immune deficiency syndrome if it is not ordained by God. The sex workers also had a high level of HIV-related stigma.

In this study, most sex workers considered risk reduction and in particular condom use as far beyond their control or even unnecessary, as a result of their strong beliefs in fatalism and predestination. Therefore, one critical area of intervention is the need to assist sex workers to develop accurate means of assessing their personal vulnerability and self-appraisal of HIV-related risk.

Gajendra K Medhi**,** Jagadish Mahanta**,** Michelle Kermode, et al.,(2012) in a cross–sectional study among FSWs which was conducted in the Dimapur district of Nagaland from February to April 2006, reported that among the 426 FSWs in the study, about 25% (n=107) reported having ever used illicit drugs. Among 107 illicit drug users, 83 (77.6%) were non-injecting and 24 (22.4%) were injecting drug users. Drug-using FSWs were significantly more likely to test positive for one or more STIs (59% vs. 33.5%), active syphilis (27.1% vs. 11.4%) and Chlamydia infection (30% vs. 19.9%) compared to their non-drug using peers.

Fiona Scorgie, Matthew F. et al., (2011) in their study of the socio demographic characteristics and behavioural risk factors of female sex workers (FSW) in sub-Saharan Africa by reviewed 128 articles. The articles reviewed presented the findings of the studies on behavioral risk factors for HIV nfection among sex workers in sub-Saharan Africa.

Sex work vulnerability stemming from the contextual factors described above takes tangible expression in sexual behaviors, which in turn predict levels of biological risk. From a biomedical perspective, the risk for HIV infection is determined by the efficiency of HIV transmission and the total number of unprotected sex acts with an HIV-infected partner. In the sex worker context these include inconsistent condom use, higher client number, duration of sex work, STI co-infection, and type of sexual activity (e.g., anal intercourse). The burden of STIs other than HIV among FSW in sub- Saharan Africa is high, with half to two-thirds typically having a curable STI at any one time. In some settings, a tenth (10%) or more have an active genital ulcer and less than a third (30%) have reactive syphilis serology

Although very few studies reported actual number of unprotected sex acts, a large body of evidence from sub- Saharan Africa shows that the risk for HIV infection

is lower among sex workers who use condoms consistently. Overall, evidence suggests that where sex workers are poorly organized and have few alternative sources of income, they are less able to refuse a client who is unwilling to use a condom. Likelihood of condom use therefore may be undermined by competition and lack of cohesion among sex workers in a particular area. *Pro condom campaigns* will have diminished impact unless FSW are able to ‘‘present a united front’’ in refusing clients who reject condom-use. Indeed, refusal by clients remains the most important reason for condom non-use. In a study in Ghana, women cited client refusal less than three-quarters (73%) and client brutality less than a half (43%) as reasons for not using condoms. About one in five sex workers in Antananarivo, Madagascar, reported that in the past month they had wanted a client to use a condom but were too afraid to ask. Nearly three quarters of sex workers in that study also reported having had sex with a client who refused their request for condom use, and few believed that their co-workers would decline a client who rejected condoms. Condom-use may also be influenced by controllers, or ‘‘pimps’’. A study in Ethiopia found that less than a tenth (7%) Sex workers commonly report that economic necessity or fear of violence makes it difficult for them to avoid or refuse male clients with an obvious STI, such as a genital ulcer.

Drinking patterns in much of Africa are characterized by sporadic heavy episodes of drinking, often in the form of *weekend binging*. Global opinion is gradually accepting the view that these patterns of drinking have independent effects on sexual decision-making, and on condom-negotiation skills and correct condom-use. Studies have shown that women with heavy episodic drinking patterns (more than five drinks on one occasion) are more likely to use condoms inconsistently and incorrectly; experience sexual violence; and acquire an STI, including HIV. Research in three cities in South Africa found that alcohol and other drugs are commonly used by FSW to lower inhibitions, increase courage to approach clients and help them cope. In a Ethiopian study, out-of-school youth who reported chewing khat were six times more likely to exchange sex for money than non-users. High alcohol use was found among female food and recreational workers in areas of Tanzania adjacent to mines, and half of these women sold sex. Another study in Nairobi, Kenya, found that while 35.3% of home-based FSW consumed alcohol daily, much higher percentages of FSW who were club-based (53.3%) and bar-based (60%) did so.

Rosenthal, D., Oanha, T.T., (2006) in their qualitative study assessed HIV/AIDS knowledge and frequency of and influences on condom use with clients and regular, non-client partners among female sex workers (FSWs) in Khanh Hoa, a tourist-oriented province of central Vietnam where sex work is common. Data were collected via semi-structured interviews with *indirect* (n = 16) and *direct* (n = 9) FSWs. Although the majority of respondents were well informed about HIV/AIDS transmission, about one-third had inaccurate beliefs about HIV-positive people as well as the mechanisms by which HIV is transmitted from mother to child. Condom use was inconsistent. More direct than indirect FSWs reported using condoms most of the time with clients but none used condoms all the time. With regular partners, most respondents reported that they never used condoms. Around one-third of women hid their sex work from their regular partners, who made the decision to use or not to use condoms. The most frequently reported reasons for not using condoms with clients were because clients offered a higher price, clients insisted on condom-free sex, and possession of condoms as evidence of sex worker status. For regular partners, the reasons were familiarity, condom use being dependent on partner's decision, and condom use as evidence of sex worker status. There was no apparent relationship between HIV knowledge, time in sex work, and safe sex practices.

Lau, J.T., Zhang, J., Zhang, L., et al., (2007) in their study compared the prevalence of condom use with clients and regular sex partners between female sex workers (FSWs) who were or were not injecting drug users (IDUs). Behavioral surveillance data (2002-2004) conducted in Sichuan, China were analyzed. Mapping exercises were done. About 250 to 400 FSWs were anonymously interviewed from selected establishments in 19 surveillance sites. Of the 15,379 FSWs studied, 3.2% were IDUs. Higher sexual risk behaviors were found among FSWs who were also IDUs, when compared with those who were non-IUDs. A double-risk bridging population for HIV transmission thereby exists is concluded by the study.

Purnima Madhivanan, Alexandra Hernandez, et al., (2005) investigated whether men who were under the influence of alcohol when visiting female sex workers (FSW) were at greater risk for sexually transmitted infections (STI) and human immunodeficiency virus (HIV).

A cross-sectional analysis using baseline data from a randomized controlled trial of an HIV prevention intervention for high risk men in Mumbai, India. The overall HIV prevalence among 1741 men sampled was less than a sixth(14%); less than two-thirds(64%) had either a confirmed STI or HIV; an overwhelming majority(92%) reported sex with an FSW, of whom two –third(66%) reported having sex while under the influence of alcohol (SUI). *SUI* was associated with unprotected sex. *SUI* was independently associated with having either an STI or HIV. The study concluded that men who drink alcohol when visiting FSWs engage in riskier behavior and are more likely to have HIV and STIs. Prevention programs in India need to raise awareness of this relationship.

Qing Li, Xiaoming Li and Bonita Stanton, (2010) reviewed the patterns, contexts and impacts of alcohol use associated with commercial sex reported in the global literature by identifying peer-reviewed English-language articles from 1980 to 2008 reporting alcohol consumption among female sex workers (FSWs) or male clients. They retrieved 70 articles describing 76 studies, in which 64 were quantitative (52 for FSWs, 12 for male clients) and 12 qualitative.

The result of the review shows that studies increased over the past three decades, with geographic concentration of the research in Asia and North America. Alcohol use was prevalent among FSWs and clients. Integrating quantitative and qualitative studies, multilevel contexts of alcohol use in the sex work environment were identified, including workplace and occupation-related use, the use of alcohol to facilitate the transition into and practice of commercial sex among both FSWs and male clients, and self medication among FSWs. Alcohol use was associated with adverse physical health, illicit drug use, mental health problems, and victimization of sexual violence, although its associations with HIV/sexually transmitted infections and unprotected sex among FSWs were inconclusive.

The study concluded that Alcohol use in the context of commercial sex is prevalent, harmful among FSWs and male clients, but under-researched. Research in this area in more diverse settings and with standardized measures is required. The review underscores the importance of integrated intervention for alcohol use and related problems in multilevel contexts and with multiple components in order to effectively reduce alcohol use and its harmful effects among FSWs and their clients.

Moira, L., Plant, Martin, A., et al.,(1989) in their paper reviewed the evidence concerning the extent to which prostitutes or 'sex industry workers' appear to be heavy or dependent users of alcohol, opiates or other drugs. In addition the role of prostitutes in spreading HIV infection is also discussed.

The study team concluded that both the latter are associated with 'high risk' sexual activities and that heavy drinking and illicit drug use are commonplace amongst prostitutes and their clients. Outside Africa evidence suggests that in some, though by no means all, areas prostitutes have low or zero levels of HIV seropositivity.

Further, the team emphasis on the need to increase information on the pattern of AIDS-related knowledges, beliefs, attitudes and behaviour amongst male and female prostitutes and their clients. They suggested the urgent needs for vigorous policies to increase levels of knowledge about AIDS risks amongst prostitutes and their clients and to foster the adoption of 'safer sex' practices.

Desai, V. K., Kosambiya, J. K., et al., (2003) conducted a study to measure prevalence of selected sexually transmitted infections (STI) and HIV among female sex workers (SWs) in the red light area of Surat, India, and to evaluate the performance of STI syndrome guidelines (for general population women in India) in this group against the standard aetiological diagnosis of STIs by laboratory methods.

It is a cross sectional study, where 124 out of an estimated total of 500 SWs were mobilised to a health camp near the red light area during 2000. After obtaining consent, a behavioural questionnaire was administered, followed by clinical examination and specimen collection for different STIs. 118 SWs completed all aspects of the survey. HIV testing was unlinked and anonymous.

In the study it has been found that the mean number of different sexual partners of SWs per day was five. An overwhelming majority (94.9%) reported consistent condom use with the clients. More than a half (58.5%) of SWs had no symptoms related to STDs at the time of examination. Prevalence of laboratory confirmed STIs were syphilis in more than a sixth (22.7%) (based on reactive syphilis serology tests), gonorrhoea in less than a sixth(16.9%), genital chlamydial infection in less than a tenth(8.5%), and trichomoniasis in more than a tenth(14.4%). HIV

prevalence was less than a half (43.2%). The performance of Indian recommended treatment guidelines for vaginal discharge syndrome (VDS) and genital ulcer syndrome (GUS) against aetiological diagnosis was poor.

The study team concluded that prevalence of different STIs and HIV among the FSWs in the Surat red light area is high despite high reported condom use with clients. Syndromic case management is missing a large number of asymptomatic cases and providing treatment in the absence of disease. Therefore, it is necessary to explore alternative strategies for control of STIs in female sex workers. STI services need to be improved.

The anaysis of the epidemic based on HIV sentinel surveillance 2010-11 by NACO (2012) reported that the Female Sex Worker (FSW) HIV prevalence in India is 2.67 per cent. It was observed that there is a declining trend of HIV prevalence among FSW at national level as well as in Southern High Prevalence States. A stable trend of HIV prevalence among FSW in Manipur, Tamil Nadu and Rajasthan. The HIV prevalence among FSW is rising in low prevalence states and high prevalence state Nagaland.

The analysis shows that HIV prevalence increases with the increase in duration of sex work. Dual risk due to sex work and injecting drugs increases the chance of acquiring HIV infection leading to higher prevalence among those with dual risks. Brothel and Home-based sex workers have higher prevalence at a national level.

Conclusion: The above studies clearly reveal that prevalence of different STIs and HIV among the FSWs is very high. Effective preventive and curative STI services for sex workers are key to the control of sexually transmitted infections, including HIV, and are highly synergistic with other HIV prevention efforts. The studies have shown that women using substances regularly are more likely to use condoms inconsistently and incorrectly; experience sexual violence; and acquire an STI, including HIV and those who are injecting drugs are with dual risks of infecting HIV.

2.5.3 Violence

The report of World Health Organisation (2005) clearly highlighted the magnitude of violence against sex workers in the world. In Bangladesh, the national HIV surveillance (1999-2000) found that between 52% and 60% of street-based sex workers reported being raped by men in uniform in the previous 12 months and between 41% and 51% reported being raped by local criminals. In Namibia, 72% of 148 sex workers who were interviewed, reported being abused. Approximately 16% reported abuse by intimate partners, 18% by clients, and 9% at the hands of the police. In India, 70% of sex workers in a survey reported being beaten by the police and more than 80% had been arrested without evidence.

Violence against sex workers is not only widespread, but is also perpetrated, legitimized, and accepted by many. Law enforcement authorities and laws governing prostitution have, in some cases, increased the risk of violence against sex workers rather than protected them against it. Violence is also perpetrated by some gatekeepers, clients, family members and intimate partners. It undermines HIV prevention efforts and increases sex workers' vulnerability to HIV transmission in several ways.

- Rape, particularly by high-risk individuals can directly increase sex workers' risk of infection due to vaginal trauma and lacerations resulting from use of force and transmission of other STIs.
- Some gatekeepers may force sex workers to take more clients or forego condom use threats or through actual use of violence.
- Sex workers, especially street-based sex workers, may be forced to exchange unpaid and unprotected sex with some law enforcement authorities in order to escape arrest, harassment, obtain release from prison, or not be deported.
- Sex workers may experience violence at the hands of some clients and intimate partners, preventing them from negotiating safer sex.
- Sex workers may not use HIV/AIDS services due to hostility and abuse by health care providers.
- Sex workers who inject drugs or injecting drug users who sell sex face risks from both unsafe needles and unprotected sex. They may also experience

increased violence related to buying, sharing or selling drugs, which further undermines their ability to protect themselves.

- The constant threat or experience of violence may be linked to sex workers experiencing anxiety, depression, loss of self-esteem and in some situations giving lower priority to health and HIV prevention over more immediate concerns for safety and survival.

Teela Sanders and Rosie Campbell,(2007) in their study examine differences in the extent and nature of violence experienced between women who work on the street and those who work from indoor sex work venues. The study brings together extensive qualitative fieldwork from two cities in the UK to unpack the intricacies in relation to violence and safety for indoor workers.

Amongst the 90 respondents to the survey in Merseyside over three-quarters (71/90) said they had not experienced violence from clients in the course of their work. From the interviews in Birmingham 34 of the 45 indoor sex workers had not experienced physical or sexual violence at work.

However, looking behind these figures is important because in the interviews sex workers, receptionists and managers explained that there were various types of nuisances and violations experienced from clients because of the precarious nature of the environment as a clandestine and unregulated industry.

The types of violence women experience in indoor venue were *Robbery, non negotiated sex act, attempt to or removal of the condom, offensive language, rudeness, disruptive behaviour and financially ripped off.* The study requested being for a safety strategy through managing the environment, individual protection mechanisms and collective control.

In this study Marina A. Barnard, (1993) looks at the issue of violence in the context of streetworking prostitutes and their clients in Glasgow, Scotland. Street prostitutes routinely face the threat and reality of violence in their work which suggests that the health risks associated with prostitution need to be considered not only as public health issues but also in terms of occupational health.

Data was collected from semi-structured interviews as well as observation. The paper focuses on the dynamics of the client/ prostitute encounter. A particular focus is on the ways in which prostitutes try to establish and maintain client compliance throughout the commercial sex encounter. Prostitutes in this study framed control over the encounter as being a critical issue, particularly in terms of limiting the potential for violence to occur. Instances where prostitutes were unable to secure client compliance through intimidation on the part of the client are discussed. The strategies used by women to reduce the likelihood of client violence are considered. The paper ends with a reflection of possible policy initiatives to reduce the likelihood of client violence against prostitutes. The potential for change to take place is clearly limited by the illegalities surrounding prostitution and the highly stigmatized nature of the work.

The women interviewed in this study had been confronted with violent clients on at least one occasion. Many women had been attacked by clients more than once. The frequency with which the women reported client violence indicated that there were certain structural features of prostitution which increased the likelihood of violence occurring. Closer inspection of the dynamics of the commercial sexual encounter suggest that it is fraught with issues of power and control. These may be made more acute by the fact that the women are actively asserting their intention to be in control of the transaction. In their overt adoption of such a role prostitutes directly contradict normative expectations of the sexually assenting and submissive female role. Prostitution itself, however, appears to be an intrinsically risky activity since most commercial sex contacts are between strangers. Inevitably then it contains a large element of unpredictability which cannot ever be wholly removed, even despite the various means prostitutes use to try to decrease the likelihood of violence happening. The greater physical strength of most men relative to most women further places the women in a position of some disadvantage where clients become un co-operative or violent.

Conclusion: It is evident from studies above violence against Women Sex Workers is not only widespread, but is also perpetrated, legitimized, and accepted by many. Violence is also perpetrated by some gatekeepers, clients, family members, law enforcement authorities and intimate partners. Street based and Drug using Women

Sex Workers are more vulnerable to violence. Any form of violence impedes the prevention efforts and increases sex workers' vulnerability to HIV transmission in several ways.

2.5.4 Mental Health

Teela Sanders (2004) in a paper on ‘A continuum of risk? The management of health, physical and emotional risks by female sex workers’ describes the findings from a 10-month ethnographic study of the female sex industry in a large British city. The paper made an argument that sex workers construct a continuum of risk which prioritizes certain types of dangers depending on the perceived consequences and the degree of control individuals consider they have over minimizing the likelihood of a risk occurring. The author raised a point that sex workers are more concerned with preventing emotional risks because the risks related to health and violence can be effectively managed. Although health-related matters are a real concern to many women, because they generally have comprehensive strategies to manage health risks at work, this risk category is given a low priority compared with other risks. The risk of violence is considered a greater anxiety because of the prevalence of incidents in the sex work community. However, because of comprehensive screening and protection strategies to minimize violence, this type of harm is not given the same level of attention that emotional risks receive. Most of the women in the study said that ‘being discovered’ was sometimes more important than preventing violence: they could recover from a beating but if loved ones discovered the truth, the personal and emotional loss would be insurmountable. The emotional consequences of selling sex require sustained psychological processes throughout a woman’s social relationships. The paper suggested that the emotional consequences of selling sex should be considered as much as the tangible, physical risks of prostitution.

Women experience higher rates of depression and anxiety in the general population. Some researchers linked increased anxiety or depression rates of women to health damaging psychosocial factors like high job demands and low decision latitude in work. As a marginalized group, sex workers are normally expected to experience poorer health than comparable age groups of the general population. Ro¨ ssler. U.Koch, et al., (2010) responding to the limited information available about the mental health of female sex workers, aimed to make a comprehensive assessment of

the mental status of female sex workers over different outdoors and indoors work settings and nationalities.

Sex workers were contacted at different locations in the city of Zurich. They were interviewed with a computerized version of the World Health Organization Composite International Diagnostic Interview. Additional information was assessed in a structured face-to-face interview.

In the result of the study the 193 interviewed female sex workers displayed high rates of mental disorders. These mental disorders were related to violence and the subjectively perceived burden of sex work. Sex work is a major public health problem. It has many faces, but ill mental health of sex workers is primarily related to different forms of violence.

Praveen Kumar Katarki & Anil Kumar, (2010) in their paper examines the levels of mental health status among female sex workers in Mumbai and then analyze the effect of various social determinants on mental health.

They use purposive snowball sampling, where 150 female sex workers were interviewed for gathering data on background details and social determinants while General Health Questionnaire (GHQ-28) was used to assess the mental health status. Bivariate analysis was used to study the association between various characteristics and possible determinants on mental health. The effect of social determinants was further studied using multiple regression analysis.

The result of the study showed that high proportion of female sex workers had low mental health status. Many of them were probably suffering from some sort of mental illness. Multivariate analysis showed that social determinants, especially violence and discrimination significantly affected the mental health of the female sex workers. Mental health status observed in female sex workers is low, raising concerns about the welfare of this marginalized group. This study highlights the importance of focus on mental health in interventions directed at the welfare of female sex workers.

Maryam Shahmanesh**,** Sonali Wayal**,** et al**.,**(2009) in their study examine suicidal behavior prevalence and its association with social and gender disadvantage, sex work, and health factors among female sex workers in Goa, India.

By using respondent-driven sampling, they recruited 326 sex workers in Goa for an interviewer-administered questionnaire regarding self-harming behaviors, socio demographics, sex work, gender disadvantage, and health. Participants were tested for sexually transmitted infections. They used multivariate analysis to define suicide attempt determinants.

The study result shows that nineteen percent of sex workers in the sample reported attempted suicide in the past 3 months. Suicidal behaviors among sex workers were common and associated with gender disadvantage and poor mental health.

Conclusion: The above studies suggested that mental health of most of the Women Sex Worker is low. *The emotional consequences of selling sex needs to be considered*. Mental illness health of sex workers is primarily related to different forms of violence. It is evident that all the studies highlight the importance to focus on mental health in the interventions for the welfare of Women Sex Workers.

2.6 Stigma

HIV and AIDS-related stigma and discrimination are rooted in shame and fear. Shame because of the taboos surrounding the modes of transmission, namely sex and injecting drug use, and fear because the disease is known to be deadly, and because of lack of knowledge about the disease.One of the major sources of stigma comes from the moral judgement about sexual behaviour that is responsible for the infection. Female sex workers and men who have sex with men also face severe forms of stigma because they are commonly labelled as the carrier of the virus (In Samuels.F, Verma.R.K, et al., 2006).

A landmark study dating back to the early 1960s points out the role of stigma in societies to confirm the ‘normalcy’ of the majority through the devaluation of the ‘other’ (Goffman, 1963). Goffman goes on to describe three types of stigma**:**

- ‘abominations of the body’, or stigma related to physical deformities;

- stigma related to ‘blemishes of individual character’, such as people who are considered to be weak-willed, to have unnatural passions, or to be dishonest; and

- ‘tribal stigma’, or stigma relating to race, nation or religion, or membership of a despised social group.

Goffman, E., *Stigma: notes on the management of spoiled identity*. New York, NY, Prentice-Hall, 1963.

Compound stigma (also referred to as multiple stigma) is HIV stigma that is layered on top of pre-existing stigmas, frequently toward homosexuals, sex workers, injecting drug users. In summary, stigma can be understood from a variety of perspectives and can be seen as enacted, perceived and self-internalized. As it is multidimensional in nature, has deep rooted causes and represents a vicious cycle of increasing stigmatization, it must be tackled in a holistic and multidisciplinary fashion (In Samuels, F., Verma, R.K., George, C.K., et al., 2006).

Fiona Samuels, Ravi K. Verma and C.K. George, (2006) in their study on stigma, discrimination and violence amongst female sex workers and men who have sex with men in Andhra Pradesh, India, used interview, focus group discussion and verbatim quotes as tools for collection of data from the study population.

The finding specifically related to female sex workers on the various form, consequences and source of stigma were: There are a variety of terms in local languages that are used to stigmatize female sex like *paitalu, lanja, chedindi, thirugumothulu* and *lanjalu*. These are extremely demeaning terminologies to imply that a woman who engages in sex work is highly demoralized and morally corrupt. The stigmatizing terms used for female sex workers have strong moral underpinning and arise from the construct of a femininity that is expected to remain devoted to one man and one family. Most respondents were subjected to various forms of stigmatizing comments or gestures in their every day life. Of these, degrading comments which are perceived as bringing shame or loss of honour, labelling or addressing the respondents by demeaning terms ridiculing or making fun of their identity and criticism are more commonly reported. Other forms reported include: sarcastic comments, teasing, hatred and contemptuous looks.

Female sex workers are also stigmatized for belonging to a particular caste, which is labelled for accepting and encouraging female sex work, the *Bhogam* and *Dommara* castes. Some of the respondents reported that although they do not belong to a particular caste, they are often referred to by the name of the caste in order to imply that they deserve to be sex workers.

Both the groups reported having experienced avoidance and isolation, expulsion from rented homes, denial of services, opportunities and support. Avoidance and isolation are the most common forms of discriminatory behaviour reported by sex workers: refusing to speak with the respondent; severing existing ties once their identity is revealed; not inviting respondents to social functions or attending functions organized by the respondents; not touching objects used by respondent; and not allowing respondents entry to their houses and not entering houses of the respondents.

An overwhelming majority of the respondents reported that they were stigmatized and subjected to violence by clients. Some sex workers reported that clients who had sex with them previously would abuse them in public and reveal their identity to others. Most of them reported varying degrees of violence at the hands of clients. They were beaten up, forced to have sex with multiple clients, robbed of their money and valuables, raped, coerced to have sex without condom or payment, forced to have unnatural sex, abused and harassed by clients. Some of the men reported that clients sometime threatened to reveal the respondents identity to their family and blackmailed them.

Perpetrators of stigma as reported by the respondents include: family members, spouses/partners, friends, health care personnel, government officials, house owners, colleagues, police and rowdies (noisy troublemakers).

Respondents reported that they experienced degrading comments about their choice of work, physical abuse by husbands/partners, and coercion by husbands/partners to part with the earnings, and forceful abortion when the husband suspects that the child is not his.

Female sex workers were found to have a very limited number of friends. Of those who did, they were females and often peers, and were usually reported as persons in whom the respondent could trust and confide.

The majority of the respondents from both groups said that they felt 'sad', 'bad', 'upset' 'scared' or 'ashamed' when faced with stigma and discrimination. Some reported that they felt 'angry', 'depressed or 'helpless'. Some said that they 'felt like dying', a few attempted suicides in an acute reaction to stigma and discrimination, and some said that they felt like giving up sex work

A significant number of the respondents said that they retaliate when faced with stigmatizing behaviour and abuse from the community (In Samuels, F., Verma, R.K., George, C.K., et al., 2006).

Meena Saraswati Seshu (2008) in her paper ' Surfacing voices from the underground' reported eight years experiences in the field of HIV/AIDS prevention programme with sex workers. According to her the need to protect family members especially children from stigma, is an everyday struggle in the life of a mother who is a sex worker. Some of the rights denied due to discrimination are freedom from physical and mental abuse, the right to education and information, health care, housing, social security and welfare services. But the most fundamental of all denials is the right to practice the 'business of making money from sex'. It is the *randi* (whore) stigma that pushes women in prostitution outside the rights framework, effectively cutting them off from the privileges and rights supposedly accorded to all citizens, irrespective of what they do for a living.

It was also highlighted in the paper that an increasing violence faced by the women in prostitution has resulted in a mandatory nexus with the brothel-owner/pimp/malak/police/criminal elements, which is almost impossible to avoid.

The criminal aspect of stigmatization is also clearly visible in form of legal repression through misinterpretation of Law to make the women in prostitution that they are working in an 'illegal business'. Women react, not to 'making money from sex' per se, but to the violence they experience within the institution of prostitution. It was also observed that the children faced hostility when interacted with the

mainstream in every milieu which proved that the children are not spared of the stigmatization the women are inflicted with.

She further cited in paper that medical and paramedical staffs at government hospitals have a callous, indifferent and often humiliating attitude. Irrelevant and embarrassing questions about sexual position etc. are often asked. Forced free sex with doctors and social workers is commonplace. Doctor often refuse treatment and admit women to hospital claiming that they are HIV carriers. Apart from the stigma already attached to their work, society has further marginalized them as core transmitters of HIV infection (In Seshu, M.S., 2008).

A report by the NCW (National Commission for Women),(1997) regarding health care concern for women in prostitution from the states of Andhra Pradesh, Karnataka, Maharashtra, Tamil Nadu, Kerala and the Union Territories of Goa and Pondicherry stated that assessing health care is a major concern for women in prostitution and sex work. While the immoral 'whore' image makes it very difficult to get good medical treatment; illiteracy, ignorance and fear of the medical establishment renders them open to exploitation and extortion of money and resources.

According to the report given by FXB, (2004) in their baseline, the general attitude of the public community in Mizoram towards FSW's is negative, and there is discrimination and stigma towards this population which is documented. Level of unofficial ostracism is still very high. At present, sex workers using drugs in Aizawl suffer double stigma, a stigma attached to drug users and sex workers.

Conclusion: Women sex workers face severe forms of stigma, apart from the stigma already attached to their work, society has further marginalized them as core transmitters of HIV infection. Perpetrators of stigma include: family members, spouses/partners, friends, health care personnel, government officials, house owners, colleagues, police and rowdies (noisy troublemakers). Some of the rights denied due to discrimination are freedom from physical and mental abuse, the right to education and information, health care, housing, social security and welfare services. The most fundamental of all denials is the right to practice the 'business of making money from sex'. Studies shows that Women Sex Workers retaliate when faced with stigmatizing behaviour and abuse from the community.

2.7 Children of Women Sex workers

Deepa Das, (1991) in a paper ‘Giving the Children of Prostitutes their Due’ made a critical comment the plight of prostitutes children in India. Little attention has been paid to these children who are victims of their circumstances from birth, denied the opportunity to be free of their background, and deprived of an environment conducive to healthy physical and psychological development. The children suffer from nutritional deficiencies, minimal health care, non availability of basic needs, and social handicaps. Although government has initiated measures to improve conditions for these children, their status isolated them from the mainstream and places them on the lowest social rung. They are also likely to follow in their mothers footsteps, and eventually engage in procurement or pimping. Discrimination among the children is exhibited in education where boys are given priority, in denial of choice in joining a trade for self development, and/or in inheritance where prostitution earnings accrue to sons. The estimate 5,000,000 children of prostitutes in India deserve priority treatment.

The mothers' backgrounds divide the children into several categories children of mothers dedicated as Devadasis or jogins to fulfill parental religious belief, to combat poverty, or because of social pressures; children of those belonging to communities where prostitution is an accepted practice; those pursuing singing and dancing careers and who are attached to men as concubines for a longer period of time; and those who are hoodwinked into joining the trade.

Prostitutes bear children out of a desire to enter into a tangible human relationship that is genuine, meaningful, and lasting. Sometimes children are economic and emotional necessities. There have been government efforts to provide benefits to Devadasi children. In addition, Chapter III of the Juvenile Justice Act attempts to protect neglected juveniles. Other approaches needed are Development Care Centers in every red-light district. Mothers need to realize the importance of keeping children away from the trade. They must also be informed of government programs and learn to value education. A cooperative effort must be undertaken by government and nongovernmental organizations and organizations of prostitutes to improve the future for these children.

As is evidenced by some studies, many women who engage in street sex work experience pregnancies and become mothers. Unfortunately, little research has examined how their pregnancies and parenting impact themselves as street sex workers and their street sex work. Christine M. Sloss, and GaryW. Harper, (2004) in their qualitative research studied 16 mothers who were currently involved in street sex work in a Midwestern city of the United States participated in semi structured interviews. Like other working mothers, they must manage their occupational responsibilities while dealing with parenting demands. These mothers discussed how being pregnant or parenting while regularly working the street caused them to feel ashamed of themselves and their work and anxious for their own and their children's safety. Pregnancies and parenting responsibilities reportedly altered their working productivity and practices. Given how frequently they had been separated from their children, they also talked about ways in which these separations resulted in them having more free time and need for drugs, which led to them increasing the amount they worked the street. It is evident from these interviews that street sex workers who are mothers have unique needs and experiences that must be considered by researchers, policy makers, and service providers.

Priti Pai Patkar, (1990) in a paper examined what makes the prostitutes children more vulnerable and deserve special treatment on a priority basis. The paper elaborately presented the socio environment and the vulnerabilities of the children**.** It was cited in the paper that these children are vulnerable to the ways of the trade, right from birth and at every stage of growing up. Born with the stigma of being 'illegitimate', these children seem to be always shunned away from the society. The children from the 'Red-light area' of Bombay grow up in an environment which comprises of pimps, brothel keepers, the *hafta* receiving police, the procurer, the bootlegger, the alcoholic, the drug peddler, the drug addict, the smuggler, the shady customer and all these people make their 'normal environment'. The tiny children are put to sleep (often using opium in order to avoid disturbance) below the beds which is used by the mother. In cases where children share the sleeping quarters with their mother, they often see their mothers in the sexual act which frequently entail rough scenes. Children are exposed to this traumatic and frightening experience from the age of three and by the time they are six they know all the facts of sexual life.

Poor environmental conditions, lack of proper nutrition and defaultation in the medical treatment, results in these children constantly suffering from health problems like fever, cold, dysentery, diarrhea, ulcer, scabies, tuberculosis, anemia etc. many times sexually transmitted diseases transmitted by the mother during pregnancy have been found among children. And now they are under the risk of acquiring AIDS. For all the male children the closest role models are the pimps, the smuggler, the bootlegger, the drug peddler, the drug addict, the gambler. Due to lack of education and employment or any kind of constructive recreational activities and also due to the kind of environment they are in those male children receive training to play the necessary supportive roles in trade management like pimping and procuring, besides acquiring proficiency in other underworld activities.

The author further examined the condition and future of the girl child of the prostitute. Unlike in other communities which dreads the birth of girl child and idolizes sons, here she is very much wanted and welcomed by her mother, brothel-keeper, the pimps, the dalals. She is very much wanted because she is the source of security for her mother in her old age, a source of income to the brothel keeper and the money lender sees her as a pawn. One in thousand girls manages to get a 'decent' education because of support and strong determination of their mother. But even out of these handful not many manage to continue. The closest role-model for a female child is her mother. Most female children, by the time they have reached puberty have had some sort of sexual experience according to the author.

Reed, E., Silverman, J.G., Stein,B., et al., (2012) in their study examine whether the challenges of motherhood among female sex workers (FSW) are linked with vulnerability to sexual risk factors for HIV. FSW at least 18 years of age (n = 850) were recruited through respondent driven sampling for a survey on HIV risk in the Rajahmundry area of Andhra Pradesh, India. Logistic regression models adjusted for demographic characteristics were used to assess the relation between reported caretaking challenges and sexual risk indicators for HIV. In adjusted logistic regression models, FSW who reported three or more children in their household or current child health concerns were significantly less likely to report consistent condom use and more likely to take more money for sex without a condom. Women who reported current child health concerns were also more likely to report an STI

symptom in the past 6 months. Findings suggest that challenging responsibilities related to caretaking of children are associated with heightened vulnerability to HIV risk among FSW. Such findings add to the cumulating evidence urging for the implementation of HIV prevention interventions that consider the multiple challenges across various domains of women's lives.

Conclusion: The above studies reveal that many Women Sex Workers are often working mothers who experience a distressed motherhood. Women Sex Workers who are mothers show less health seeking behaviour. Their children are the victims of their circumstances from birth, denied the opportunity to be free of their background, and deprived of an environment conducive to healthy physical and psychological development. Moreover, female children, by the time they have reached puberty have had some sort of sexual experience.

2.8 Responses

2.8.1 Legal Responses

S.K Ghosh, (1996) in his book 'The world of Prostitution' mentions three approaches adopted globally based on the social attitude of their citizen. The first towards complete ban, declaring prostitution as illegal. The second in towards regulation, which involves government control of prostitution through registration and licensing of prostitutes, their fingerprinting and carrying of identification cards and mandatory medical checks. The third, promoted by the United Nations 1949 Convention, known as abolition system, eliminates administrative and police regulations; forbids soliciting in public places; prohibits pimping and establishment of organized prostitution; provides protection for those vulnerable to prostitution; and helps reintegration into society of those who wished to renounce prostitution. The majority of nations adopted the UN 1949 Convention.

Karmakar Sumati, (2001) in a chapter of the Immoral Traffic (Prevention) Act, 1956 of a book Red Light Area: the social environment of sex workers, discussed the transformation of the Act and the object. The present Act in India enacted by Parliament in pursuance of ratification by India of the International convention of the suppression of traffic in persons and of the exploitation of the prostitution by others, signed in New York in 1950, on May 9.

Under Article 23 of the Constitution traffic in human beings is prohibited and any contravention of the provision is an offence punishable in accordance with law. Under Article 35, such a law had to be passed by the Parliament, as soon as may be, after the commencement of the Constitution. It is to be noted that neither the International convention nor does Article 23 of the Constitution refer to "Traffic in women and girls". They refer to "traffic in human beings" which would include both the sexes. Recently the Act has been amended by Act No. 44 of 1986. By this amending Act the title of Act has been changed from "Suppression of Immoral Traffic in Women and Girls Act", to "Immoral Traffic (Prevention) Act", and the words "women and girls" and "women or girls" wherever they occur in the Act, the words "persons" and person" have respectively been substituted. Now the Act prohibits traffic in human beings and not traffic in women and girl alone.

What is aimed at under this Act, is not abolition of prostitutes and prostitution as such and make it per se a criminal offence or punish a person because she prostitute herself. The purpose of the enactment was to inhibit and abolish commercialized vise namely the traffic in persons for purpose of prostitution as an organized means of living. But there has been some exception and that is found in Section 7 and 8 of the Act. Section 7 of the Act makes punishable the practice of prostitution in or in the vicinity of certain public places such as places of public religious worship, educational institutions, hospitals etc. (In Sumati, K., 2001).

Usha Vaidyanathan, (1990) in a paper analyses the historical development of laws related to prostitution. The article cited that the British had a law relating to prostitution because of their concern for the health of their soldiers. The interests of the British were prompted by the public health and law and order aspects of the problem. While the prostitute became the central figure in explaining the problem, the protection was envisaged for her customers against the evils of prostitution, no doubt in the larger interest of society. In effect, the prostitution was looked upon more as a cause than as an effect of the uncongenial conditions in society.

Licensing system exist some time in the late 19th and early 20th centuries. In Bombay city, these measures were briefly tried in the 1880's, but were discontinued when they were found a complete failure. The licensing system was completely

abolished in India in 1929, and it was never fully enforced at any time except in a few big cities, as it involved considerable expenditure to Government.

The laws relating to Devadasis and special communities viz. UP Nayak Girls Protection Act 7 of 1929, UP Minor Girls Protection Act 8 of 1929, Bombay Devadasi Prevention Act 10 of 1934 and Madras Devadasi (Prevention of Dedication) Act 31 of 1947 dealt with special identifiable categories of women among whom prostitution was a common practice, either traditionally or in a religious context, the study quated.

The study examines the movement from “Abolition” through “suppression” to “prevention” as seen as a legislative journey in law and society reaction. It is hard to find in its midst concern for the plight of prostitutes, or even for the reduction of its incidence. The law reflects a bias aimed at keeping out of the public eye and public mind the unsavory aspects of prostitution. Yet it is commonly acknowledged that women in prostitution are subjects of exploitation. If the law is to reduce the incidence of prostitution, to protect the unwilling victim and to rehabilitate the focus of the law should shift to protection and prevention (In Vaidyanathan, U., 1990).

Harshad Barde, (2008) in the article highlighted and examined the drawbacks of the ITPA Act enacted in 1987. The paper highlighted prominent cases which show the apathy of the courts and their insensitivity in implementing the provision of the Act. Many activists and NGOs have criticized the provisions of Section 8 of the ITPA and advocate for its removal from the act. The section deals with seducing or soliciting for purpose of prostitution and has been misused by the enforcement authority to re-victimize the victim. Right to privacy is another fundamental right that is often violated by officials under Section 20 of the ITPA.

The study reports that the private residences of sex workers are raided by corrupt police officials everyday and money extorted from them under a variety of allegiances that the prostitutes do not comprehend but pay up merely out of fear of prosecution. The approach to be adopted towards prostitutes with respect to the ITPA should be sensitive and practical. Abolition of the Act is not an option and neither is the banning of prostitution. The approach adopted by courts in India is justifiable because they follow strict procedures while considering the cases. Most cases never

reach even the Magistrate level and are solved by the police. Arousing public awareness and sympathy is of immense importance, according to the author.

Drawing on recent empirical work that considers the relationship between different legal approaches to the `problem' of prostitution, Jane Scoular,(2010) in her article argues that the frequently drawn distinction between apparently diametrically opposed positions, such as prohibitionism and legalization, is certainly less significant than is often assumed and may, in fact, be illusory. This lack of distinction raises serious questions as to law's role in regulating sex work. In response to claims that law is `merely' symbolic in its influence, the author argue that these similarities arise precisely because law does matter (albeit in a different way from that assumed by a sovereign-centred understanding of the legal complex), and offer a complex and critical account of the role of modern law in regulating sex work.

The author concluded that rather than expel law, we need a more complex analytical framework to understand its contemporary relevance. Such a framework can be developed by applying insights from theories of governmentality to the studies on the regulation of sex work. This offers a fuller appreciation of the wider legal complex, and its role in regulating and authorizing the spaces, norms, and subjects of contemporary sex work. It also explains law's role in maintaining the systems of governmentality, across legal systems, that exacerbate these injustices and forms of bare life that have become hallmarks of late- industrial capitalist societies. For the continued relevance of law the author do not intend to reinstate an imperialist, uncritical positivist position. She argues instead for its strategic use in order to `pursue a deconstructivist agenda within legal arenas and discourses'. This requires an acute understanding of law as a mode of regulation as well as an understanding of how it could be how harnessed as a tool of resistance. Law does matter in the regulation of sex work and could matter, albeit in a different way than was thought before.

Prabha Kotiswaran, (2001) studies the reform of prostitution laws in India. Beginning with an outline of the current legislative framework available in this regard it critically evaluates the various alternatives to the framework that have been proposed through the 1990s by the Indian government, universities and research institutions, the Indian women’s movement and sex-worker organizations. After undertaking an historical examination of prostitution laws in India from colonial times

up to the present, the author recommends the decriminalization of prostitution with a strong emphasis on the protection of the civil rights of prostitute women as a matter of policy. More importantly, the author challenges the underlying assumptions of much Indian feminist theory and practice on the issue, critiques the politics of representation in the law reform process and seeks to highlight the agency of Indian prostitutes in the debate on prostitution laws. The paper suggested that feminist legal theory should welcome a variety of feminist positions on any given area, both in the theoretical as well as political realms, without insisting that one of them is more complete or true than the rest. In so doing, it should assume that even fundamental differences between these approaches would not derogate from feminist struggles, but rather would enrich feminist debate on a given issue and make possible more options in addressing the realities of women's lives. Meanwhile, Scarlot continues with her civil disobedience.

Geetanjali Gangoli,(2008) in a paper pointed out some trends within feminist analysis on prostitution in India.Prostitute Right groups in India have implicitly questioned the right of ' main are those sex workers and activists who draw on the experience of hurt, anguish, violence and coercion that form a part of their lives.stream' feminism to speak on their behalf. Organisations like Durbar Mahila Samanwaya Committee (literally the Committee of Women for Equality; henceforth DMSC) and Veshya AIDS Mukabla Parishad, Sangli (literally the Committee of Prostitutes to Combat AIDS; also called VAMPS) in India aim to emphasize on, and thus recast the identity of women in prostitution from their own perceptions and experiences.

The author identifies three ways in which Indian feminists have addressed the issue of prostitution. The first one is *silence approach* which analyzes the prostitute and the 'prostitute body' without reference to their experience. The second as *hurt and violence* are those sex workers and activists who draw on the experience of hurt, anguish, violence and coercion that form a part of their lives. This would include, in the Indian context, representatives of organizations like the Calcutta-based Sanlaap and Bombay-based Prerana. The third as *potential choice and liberation*, which suggested that prostitution should be seen as work. The author suggested that all these perspectives are limited, in that they do not necessarily take in the wide range of

experiences that women in prostitution encounter. And in different ways, they may well feed into mainstream patriarchal views on prostitution.

The article suggested that feminists in India and elsewhere have had to confront challenges not only from the state, but also from women who identify themselves as working against aspect of patriarchy, but rejecting the hegemonic claims of women's organization. These enrich and give a deeper hue to feminist politics

Conclusion: It is clearly evident that there have been three different trends in regard to state involvement with Sex Work viz. complete ban, the regulation and abolition. There are laws which dealt with special identifiable categories of women among whom Sex Work was a common practice, either traditionally or in a religious context. Studies highlighted that Section 8 and 20 ITPA Act enacted in 1987 has been misused by the enforcement authority and activists and criticized the provisions of the ITPA and advocate for its removal from the act.

In India there are various alternatives to the legislative framework that have been proposed by the Indian women's movement and sex-worker organizations. Decriminalization of Sex Work with a strong emphasis on the protection of the civil rights of Women Sex Workers as a matter of policy is crucial.

2.8.2 Addressing the Health Issues by Mobilizing the Women Sex Workers Community

Prabhakar Parimi**,** R.M Mishra**,** et al., (2011) in their study assessed the association between female sex workers' (FSWs) degree of community collectivisation and self-efficacy, utilisation of sexually transmitted infection (STI) services from government-run health centres in Andhra Pradesh, India.

Cross-sectional analyses of 1986 FSWs recruited using a probability-based sampling from five districts of Andhra Pradesh during 2010–2011.

The findings reinforce the need for stronger community mobilisation for better utilisation of government health facilities for STI and HIV prevention interventions.

Mobilization of the FSW community into groups and training them in savings and income generation activities have emerged as innovative HIV/AIDS prevention strategies. A lack of economic power increases the vulnerability of FSWs, reducing their ability to negotiate safe sex or to access care. Efforts to reduce economic vulnerability and improve the sex workers' access to additional sources of income have shown positive impacts such as decreases in client volume and STI, reduced economic dependence on sex work and improved condom use. Study conducted by Karnataka Health Promotion trust examine the impact of two vulnerability reduction strategies - collectivisation and participation in savings activities - on HIV risk reduction among female sex workers across three districts in Karnataka - Shimoga, Bellary and Bangalore Urban.

The study concluded that FSWs who benefited from group membership and participation in savings activities would be more likely to adopt safer sex practices

In all the three districts, community mobilisation of female sex workers has led to increased knowledge about condoms, STI and the risks involved in unprotected sex, enhanced perception of self and enabled a positive clinical environment and experience However, differences remain in the ability of the members and non-members to negotiate in situations of forced sex and demands for free sex, deal with violence, resist stigma and discrimination and reduce vulnerability due to economic dependence on sex work(Chaujar,P. (Ed.)., 2012).

Conclusion: The above studies suggested that Mobilising Women Sex Workers Community increases their ability to negotiate safe sex and utilization of health facilities for STI and HIV prevention interventions.

2.9 Exit Factors

Srivastava,S.P., (1982) in study to examine the reasons for the failure of efforts to prohibit prostitution and to rehabilitate prostitutes in India and delineates a rehabilitative approach felt to be more likely to succeed. Correctional institutions for prostitutes have failed to rehabilitate them because they provide the poorest possible preparation for a successful reentry into society and often merely reinforce patterns for further deviance. Among these institutions' problems which were identified in the 1956 Report of the Committee on Social and Moral Hygiene were the cramped

accommodations, lack of trained personnel, and absence of meaningful activities for the inmates. The traditional rehabilitative philosophy is based on numerous faulty assumptions, including confusion over goals, the dominance of punitive considerations over reformative considerations, and the belief that the public will actively support efforts to rehabilitate prostitutes. However, contemporary rehabilitation workers are becoming more selective in their approaches and prefer to focus on the prostitutes who dislike the profession and want to leave it. They also advocate a replacement of the traditional approaches with a balanced rehabilitation program which includes such components as behavior therapy, education, vocational training, and aftercare.

In a qualitative research study conducted by Valandra, (2007), eight African American women who were receiving culturally specific services at an Afrocentric agency participated in a focus group and in-depth semistructured interviews.. The analysis revealed seven categories of experience: (1) a legacy of violence and underreporting, (2) family and self-preservation, (3) kinship support and spirituality, (4) hitting rock bottom, (5) barriers to recovery, (6) helpful and harmful services, and (7) a prism of oppression. The finding suggests that social workers and policy makers need to recognize the interconnections among prostitution and racial, class, and gender oppression. Despite experiences of sexual and physical violence in childhood and later adulthood, the women in this study, like many women, were reluctant to seek help. Physical safety issues are a critical consideration in supporting women's efforts to leave prostitution. The reluctance to report violence is compounded when providers of legal and social services question, minimize, and otherwise dismiss the legitimacy of women's experiences. Service professionals should receive training in cultural competence and prostitution-related issues.

When appropriate, *kin* should also be engaged as collaborative allies in supporting women's recovery as well as prevention efforts. Substance abuse and treatment programs should be designed around not only addiction issues or drug use but also around women's life experiences. Services around the country that are staffed by prostitution survivors and advocates for survivors are proving to be effective and critical to women's recovery. Treatment programs that are characterized by unrealistic

expectations, insensitive and threatening counselors, and the lack of culturally specific prostitution related programming can hinder women's recovery (Valandra, 2007).

Laksmana, G. et al.(2010) in their study described the social support among the women sex workers by assessing the socio demographic characteristics and the level of perceived social support available for them. The article suggested that the organizations, professionals and welfare workers who are actively working in this field need to focus in this area and may try to enhance their social support.

Shekar,S., (1986) in his study suggested that the courts should commit women convicted of prostitution to special homes that provide the skilled staff and program activities tailored to the rehabilitative needs of the women. The inmate-staff ratio should permit the development of close relationships between staff and inmates, and staff should be trained to develop relationships with the inmates that foster self-esteem and facilitate the adoption of normative values, attitudes, and behavior. Staff members should be familiar with the background of each inmate and relate to her accordingly. Institutional activities should encourage independence within a normative structure. Priority activities include education, vocational training, gardening, instruction and counseling on sex and marriage, and preparation for living in the community through prerelease and aftercare programs. The staff should hold regular case conferences to review each inmate's development. Based on these case conferences, treatment plans may be modified if current approaches are not having their intended effect.

The Encyclopedia of Social Work (Vol II) discusses that one of the significant obstacles that come in the way of girls wanting to leave prostitution is *society's attitude of contempt*. Society is not willing to forgive them and accept them back as respectable human beings. By and large men refuse to marry these girls; husbands refuse to take back their wives who may have been involved in Prostitution (Hoon, R.S.,1987).

Some studies conclude three main issues pertinent to *exiting*. The first issue is that many sex workers want to exit *in principle* at least. Secondly, it is difficult to exit and lastly exiting is *far from a one-off process*, but rather typified by *stops and starts*. There is general consensus that it is difficult to exit. Many things that lead people into

sex work also act as barriers to exiting. Social circumstances such as inadequate housing and drug addiction can be prominent barriers. People may also be deterred from exiting if service provision does not meet their needs at the time they seek help. Women's partners may live off their earnings and may encourage (or insist on) continuing involvement in prostitution. Many, too, have lost the social support networks that would ease transition into more 'normal' society. Indeed, some *gain* social support *within* sex work. The research literature and recorded practitioner experience strongly suggests that a wide range of issues usually needs to be addressed to achieve any reasonable chance of success in exiting (Mayhew, P. &Mossman, E. (Ed.), 2007).

Exit and the desire for change are triggered by well documented factors: violence, increased competition and low prices often due to the intense policing of the beat areas, increased risk of arrest, health crisis, drug crisis, age, loss of children and pregnancy (UKNSWP, 2008).

In order to offer genuine choices to people in prostitution, programs which claim to offer assistance must offer more than condoms and safer sex negotiation skills. These are not only insufficient, but they have been shown to result in increased violence against prostituted women. It is necessary to look at the vast array of social conditions in women's lives which eliminate meaningful choices. In order to understand prostitution, it is necessary to also understand 1) incest and other childhood sexual assault; 2) poverty and homelessness; 3) the ways in which racism is inextricably connected with sexism in prostitution; 4) domestic violence; 5) post-traumatic stress disorder, mood and dissociative disorders as sequelae of prostitution; 6) chemical dependence; 7) the need for culturally-relevant treatment; and 8) the fact that the global nature of the commercial sex industry involves interstate and inter-country trafficking as a necessary part of its profitable operation.The most urgent need of girls and women escaping prostitution was housing. Both transitional and longterm housing was needed. As part of intake assessments, health service providers should not only inquire about history of sexual assault, violence, and addictions. The vocational needs of women escaping prostitution are complex and long-term. Women leaving prostitution in their twenties and thirties may have been in prostitution since they were very young, and may never have had a job other than prostitution.

Vocational counselors should be able to articulate the impact of prostitution on a woman's vocational identity. Vocational rehabilitation counselors must be expert in labor market issues (Melissa Farley & Vanessa Kelly, 2000)

Conclusion: Based on the above studies it may be concluded that exit and the desire for change are triggered by a number of factors; it is difficult to exit Sex Work and many things that lead people into sex work also act as barriers to exiting. One of the significant obstacles that come in the way of girls wanting to leave prostitution is society's attitude of contempt. In order to offer genuine choices to people in Sex Work It is necessary to look at the vast array of social conditions in women's lives which eliminate meaningful choices. Treatment programs that are characterized by unrealistic expectations, insensitive and threatening counselors, and the lack of culturally specific prostitution related programming can hinder women's recovery. The above studies also suggested a rehabilitation program which includes such components as behavior therapy, education, vocational training, aftercare and strong social support network.

CHAPTER III

METHODOLOGY

The study is exploratory in nature. The study combines quantitative and qualitative methods in data collection. Structured interview schedule, key informant interviews and focus Group discussions were used for collection of primary data. The study also utilised various published and unpublished data for *secondary sources* based on the reliability, suitability and adequacy of the data. Case studies are also included to highlight the nature of sex work in Mizoram as well as to document the impact of sex work on the life of the sex workers.

3.1 Sampling

The present study covers Aizawl city which has been selected purposively. Aizawl was selected by virtue of having the highest population of Women Sex Workers in Mizoram. According to rough estimations made by the Protective Home (under Social Welfare Department,GOI) in 1997, there were more than 800 Women Sex Workers in Mizoram with a majority of these being in Aizawl district. However, most other studies have estimated a number ranging between only 200-250 Women Sex Workers within Aizawl. Human Rights and Law Network, and NGO identified 218 Sex workers in Aizawl City in their 6-month survey.

All the women sex workers registered at the three Service providers in Aizawl serve as the universe. The three service providers are Volunteers for Community Mental Health (VOLCOMH), New Life Home Society (NLHS) and Social Welfare Department, Mizoram. In the absence of reliable data on size estimation of sex workers and further, since this is *a hard-to-reach population* , the study was restricted to sex workers availing services from the Centre that provide a range of health and other services for sex-workers in Aizawl. All the registered clients in these agencies who have availed services in the last three years were included in the sampling frame. 101 Women Sex Workers from adolescent age onwards, who are in Sex work for more than one (1) year were randomly selected on the basis of simple random sampling to serve as subjects for the study. Few women who refused to participate or did not complete the interview were replaced by the next women on the random sampling list.

3.2 Ethics

The study design is based on concepts to ensure that the process is conducted 'ethically' and responsibly and ensures protection of privacy to avoid psychological, social, physical or economic harm of the respondents. The ethical guidelines in this study are adapted from National Guidelines on Ethics for Researh on HIV/AIDS, NACO.

The respondents/ women sex workers were assured of anonymity. All the Interview schedules were nameless and coded. In the informed consent form the participants were asked to sign a name (not necessarily their own). Checklist before starting the interview was also included in the Interview Schedule. Participants interviewed reviewed and signed informed consent forms which were attached to the Interview Schedule and verbal consent was obtained from each participant of the FGDs and Case Studies. Before requesting an individual's consent to participate in the study, they were provided with the following information in the language she or he is able to understand which should not only be scientifically accurate but should also be adaptive to their social and cultural context :

1. Introduction and purpose of the research
2. Expected duration of the participation
3. Benefits that might reasonably be expected as an outcome of research to the participant or community or to others
4. Extent to which confidentiality of records could be maintained ie., the limits to which the investigator would be able to safeguard confidentiality and the anticipated consequences of breach of confidentiality.
5. Responsibility of investigators.
6. Compensation to participants for participation in the study.
7. Voluntary participation
8. Freedom of individual/family to participate and to withdraw from research any time.

9. Identity of the research scholar with addresses and phone numbers so as to ensure that they receive clarification on any queries they had during the study and in the future.

3.3 Pilot Study

A pilot study was conducted to explore the feasibility of conducting the study in the selected agencies before the initiation of the actual study. Interviews were held with women sex workers, chief functionaries and staffs of the selected agencies. The Pilot Study confirmed the suitability of the agencies for study.

3.4 Pre – Testing of Tool

The tools were pre-tested on 12 respondents- 4 from each of the selected agencies before commencing formal data collection. Suitable modifications were made after examining the filled in Interview Schedule and feedback from the respondents.

3.5 Source of Data

Both primary and secondary data have been used. Primary data was collected from the sex workers through interview schedule. FGDs, Case Studies and Key Informant interviews also gave valuable information. The secondary data was collected from books, journals, local newspapers, magazines etc**.**

3.6 Tools of Data Collection

Interview schedule, Key informant interviews and focus group discussions (FGDs) were used to collect data from the Women Sex Workers in Aizawl. Key informant interviews was conducted among the law enforcement officers, government officials, Health Care Providers, NGOs, CBOs and Church officials.

The *interview schedule* had four parts viz. respondent' characteristics, nature and problems of Sex Work, impact of sex work on family and other relationships, services utilisation and social support etc. The interview schedule was developed in English and translated in Mizo. During the translation an extensive discussion was held with the staff of the NGOs about appropriate phrasing in Mizo, to ensure the

meaning of the questions was adequately captured. Outreach workers of the NGOs and professional social workers were recruited and trained to assist the Research Scholar in the collection of data through Interview Schedule.

Interview guides were used for focus group discussions and key informant interviews. Focus group discussions was conducted with 4 groups of women sex workers. The first group had 12 participants, the second 13, the third 10, and the fourth 11. The first group was conducted during a women sex workers' gospel camping organized by CKTP (an apex body of Presbyterian youth federation), the second at Protective Home run by Social Welfare Department, Mizoram, the third and the fourth were conducted at a Female Sex Workers Drop in Centre run by New Life Home Society at *Ramhlun veng** and VOLCOMH Soceity at *Sikulpuikawn**(**names of localities in Aizawl*). The main objective of the FGD was to examine their responses on how they are being perceived by Health Care providers, general community members and the Church. The group comprised of the two typologies of Women Sex Workers in Aizawl viz. Street Based and Secret Based.

A total of 27 Key informants (KIs), 15 men and 12 women each were selected and interviewed. KIs interviewed comprised of Law enforcement officials, Concerned Government officials, functionaries of NGOs, CBOs and FBOs, Church Leaders of different denominations and Media persons.

KIIs and FGDs were conducted to hightlighted :-

- Magnitude of the problem of sex work in Aizawl
- Nature, Pattern and Impact of sex work
- Issues and challenges need to be address
- service and support system of sex workers and suggestions

Case Studies was conducted and documented by conducting in-depth interviews with 4 women sex workers representing the different typology in order to understand the nature and impact of sex work on the life of women sex workers. Case studies have been presented to understand the situation, causes and consequences of sex work in Mizoram

3.7 Data Processing and Analysis

The collected data was coded, edited and processed with the help of computer software Statistical Package for Social Sciences (SPSS) and Excel. Simple proportions and percentages were used to analyse the data.

3.8 Limitation of the Study

Inspite of rigorous methodological discipline in the study certain limitations are inevitable.

1. The study is restricted to Sex workers who avail services as a registered clients and therefore *the invisible and hard to reach population* is not being included.

CHAPTER IV

RESULTS
WOMEN SEX WORKERS IN MIZORAM : A PROFILE, NATURE OF SEX WORK AND CATEGORIZATION

4. Profle of Women Sex Workers in Aizawl

4.1 Socio- Demographic Data

4.1.1 Age of Respondents

Age is a very important characteristic when studying profile of respondents particularly in a study that involves sex workers. *The mean age of respondents was 23.4 years* reflecting that most of the respondent in this study were of an extremely low age. Of a total of 101 a fifth of them were between the ages of 12 to 18 years old. Of these more than a quarter (28.1%) were **not** injecting drug user, indicating that injecting drug use is not a factor that influences entry into sex work. Further less than a half (47.5%) were between the ages of 19-25 years. There was an almost equal distribution between those who injected and those who did not. More than a quarter (29.7%) of the respondent belonged to the age group of 26 to 35 years. Only a small number (2%) were above the age of 36 years. *It is alarming to see that an overwhelming majority (98%) are in the category of youth while a significant number involves adolescent girls.*

All the information was sought regarding distribution across injecting and non-injecting drug use behaviour. More injecting drug users were seen between the ages of 19 to 36 years and above. The maximum number of IDUs were seen in the age group of 19 to 25 years. (refer table 1)

Teela Sanders (2004) in a study describes the findings from a 10-month ethnographic study of the female sex industry in a large British city, during 2000-2001. Wherein 1,000 hours were used in observing the indoor sex markets such as licensed saunas, brothels women working from home or as escorts and, some street prostitution. The age range of respondents who sold sex in this study was reported to be 18–52 years, with the oldest respondent being 55 years old.

In an Indian study in the state of Tamil Nadu, Joe Arimpoor (1990) reported that more than half (57%) of the respondent were found to be between the ages of 20 to 30 years.

Fiona Scorgie, Matthew F. Chersich, et al. (2011) in their study systematically analyzed the socio demographic characteristics and behavioural risk factors of female sex workers(FSW) in sub-Saharan Africa by reviewing 128 articles.

Data was collated from both qualitative and quantitative research studies among FSW and their clients. In the studies reviewed, the average age of sex workers mostly fell between 24 and 31 years, with estimates lower among urban sex workers in East African countries such as Ethiopia and Kenya and higher averages recorded in Senegal , and some studies in Ghana (median 37 years) and Kenya (mean 35 and 41.1 years).

It is therefore evident that most studies involving sex workers with a few exeptions seem to suggest a younger age group in the profile of respondents. *This study in Mizoram seems to have a younger age range of respondents as compared to studies quated above.*

4.1.2 Educational Status

Educational status of the sex worker is an important aspect while studying the profile of sex workers. Of the total respondents less than two-thirds (60.4%) had studied between the classes of V to VIII. More than a quarter (28.7%) had attained the level of between class I to VI indicating that they had not studied beyond primary education. Tragically only 4% of the total respondents had studied beyond higher secondary and all these respondents were non injecting drug users indicating that injecting drug use had possibly interfered with educational attainment. Of the total 37 respondents who were injecting drug users all had completed upto standard VIII indicating a drop-out there after. Among the non injecting drug users a sixth of the 64 respondents had studied between classes XI and HSLC. *The pattern of educational attainment when compared across injecting and non- injecting drug users reveals that more among the non-injecting drug users had completed education levels.* (refer table 1)

Joe Arimpoor (1990) reported that in Tirupattur in a city with an estimated size of 400 sex workers, over two-thirds (68%) were illiterate.

J. F. Blanchard, J. O'Neil, et al.,(2005) in their study comparing the socio demographic characteristics and sex work patterns of women involved in the traditional *Devadasi* form of sex work with those of women involved in other types of sex work, in the Indian state of Karnataka observed that out of 1588 female sex workers (FSWs) interviewed, those who were illiterate were higher in rural than in urban areas (92.8% vs. 76.9%, respectively).

Another Indian study by Rakhi Dandona, Lalit Dandona et al. (2006) in Andhra Pradesh compared the demography of FSWs with women in the general population and found that of total of 6648 respondents almost three-quarters(74.7%) were illiterate.

Sex work has to be understood in the larger context of exploitation and abuse and therefore socio demographic aspects like education assume significance. Most of the Indian studies seem to reflect that women in sex work are illiterate or have studied very minimally. Seen in this context, even this study in Mizoram suggests the poor educational achievement of sex workers. *In this study on women sex workers in Aizawl, it was seen necessary to include education because Mizoram enjoy the status of being the second highest state in literacy (91.58% census 2011). This perhaps explains the slightly higher status of education attained by the respondents as compared to other studies in India.*

4.1.3 Marital Status

Marriage has often played an important role in reference to stability as well as happiness for men and women. Women in sex work are often compelled to make choices that they are not comfortable with. In this study on Women Sex Workers in Aizawl, less than a tenth (8.9%) were married while the overwhelming majority (91%) of respondents were single. Of the single respondents a majority had never married while a quarter had had experienced unstable marriages and were divorced at the time of data collection. A very insignificant minority (3%) of the total respondents were widowed. *Interestingly of the 64 non- injecting drug users more than two-thirds (70.3%) had never married*. Correspondingly among the 37 injecting drug users almost half (48.6%) had never married. *More injecting drug users as compared to their counterparts were divorced*. Similarly there were twice the number of widows

among the injecting drug users as compare to non- injecting drug users. Almost a tenth of the non-injecting drug users were married. Among the injecting drug user however it was less than a tenth (8.1%) who were married. (refer table 1)

In the study by Fiona Scorgie, Matthew, F., et al., (2011) FSW in sub-Saharan Africa are very commonly reported to have a background of marital disruption . In their systematic review of 128 studies, the authors report that most studies reveal that between one and two-thirds of FSW were divorced or separated. The authors also report a large study in Senegal wherein 63% of sex workers were divorced and cited consequent economic factors and lack of occupational choice as reasons for entering sex work . A study in Kenya reported by the same authors found that half of the FSW interviewed who had ever moved residence had done so following divorce, either looking for work as a single woman, or trying to escape divorce-related stigma.

In the current study on Mizoram, marriage seem to have been an option for only a small number of the respondents and divorce has been indicated in over a quarter of the respondents. Single women in any society are likely to face problems in relation to support structures but the preponderance of a single status among sex workers is likely to be doubly problematic in term of support offered.

4.1.4 Age of Marriage

Age at marriage is an important variable since it reveals the development status in a society. Later adjustment in marriage, coping and social support are all linked to the age at marriage and the younger a woman at the age at marriage the more difficult her adjustment in marriage and poorer the coping.

In this study as discussed above almost two- thirds (62.4%) had never married. Of the remaining 38 respondents two- thirds (65.7) had married between the ages of 15 to 20 years. With less than a quarter (23.6) between the ages of 21 to 25 years and only tenth (10.5) of the respondents got married between the ages of 26-30 years. In both the group of the injecting and non injecting drug using sex workers, more had got married between the ages of 15 to 20 years. More injecting drug users (3 out of 4 respondents) had got married at a later age of over 26 years. (refer table 1)

4.2 Religion and denomination:

The state of Mizoram which is located in the North East of India has a population that is predominantly tribal in origin and is characterized by a Christian population (95% according to the census, GOI 2011). The religious denominations in Mizoram include the Presbyterian, The Salvation Army, United Pentecostal Church, Baptist, Roman Catholic, Seventh Day Adventist as well as local church denominations.

4.2.1 Religion

In this study "Women Sex Workers in Aizawl: A Situational Analysis", not too surprisingly there was just one Muslim respondent while the remaining 100 were all Christians. All the injecting drug users among the total of 101 respondents were Christians. (refer table 2)

Rohini Sahni & V Kalyan Shankar, (2011) conducted a pan-India survey with a common research tool. The questionnaire incorporated diverse regional realities. The questionnaire was constructed in several sections that reflect different facets of sex workers. Of the 3000 females who were surveyed: (70%) were Hindu, a sixth(20%) Muslim, less than a tenth (6%) Christian and less than a tenth (0.4%) Buddhist backgrounds.

In a study on Kolkata's call girls by Ishita Majumdar and Sudipta Panja (2008), a disproportionate, stratified, random sampling method was adopted in order to develop a generalized view of the homogenous strata and cluster sampling was adopted for the heterogeneous strata. The sample consisted of 136 participants of whom 100 were chosen for questionnaires and administration and 36 for interviews. Empirical data was collected through – in-depth interviews, questionnaire and focused group discussions.

Overwhelming majority (93%) of the call girls in the Kolkata study were Hindu.

4.2.2. Denomination

In reference to denomination a majority (70.3%) were Presbyterian followed by the Salvation Army while a smaller number each professed allegiance to UPC, Baptist and Roman Catholic denominations. Two individuals belong to local denomination such as Isua Krista Kohhran and Lairam Isua Krista Baptist Kohhran. (refer table 2)

In Mizoram, according to the Statistical Handbook 2010 published by Directorate of Economics and Statistics, Mizoram, the break-down of the main Christian denominations in the year 2009 - 2010 are; *Presbyterian* (4,63,185), *Baptist Church of Mizoram* (1,43,083), *UPC* (1,34,260) *Salvation Army* (54,697), *Evangelical Church of Maraland* (37,463) Seventh Day Adventist (27,218), Lairam Isua Krista Baptist Kohhran(22,778) Roman Catholic(19,080). Therefore the study findings corroborate the statistics.

4.3 Birth Place and Residence

The information on origin of Sex workers as well as birth place and domicile details was sought to assess whether trafficking and /or migration influence the profile of the respondents.

4.3.1 Place of Birth

The state of Mizoram is located in the southern most tip in the North East of India. Therefore a large part of the territory of Mizoram shares boundaries with Bangladesh and Myanmar. The borders between these countries with Mizoram are porous and *Mizos* live in Myanmar as well. Many of the respondents are currently living in Mizoram but their families have migrated from Myanmar prior to their birth.

In the current study almost all the respondents (97%) were born in Mizoram while only 3 were born in Myanmar. *Almost all the injecting drug users barring one respondent were born in Mizoram.* (refer table 3)

4.3.2 District of Domicile

Mizoram has eight districts (Aizawl, Lunglei, Kolasib, Serchhip, Mamit, Lawngtlai and Saiha). Aizawl is the most populous district followed by Lunglei. Most residents of Mizoram would visit Aizawl since it is the capital and has fluid opportunities and infrastructures.

In this study an overwhelming majority (93.1%) domiciled at Aizawl while a small number each lived in Champhai(3.0%), Serchhip(2.0%), Kolasib and Mamit (1%) each. (refer table 3)

4.3.3 Area of Residence

It is important to understand the dynamics of sex work in a remote state in the North- East. It is with this intention that information was sought from respondents with regard to their residence in urban/rural area.

In this study on a women sex workers in Aizawl, a vast majority (85.1%) reported that they lived in urban areas as compared to the remaining (14.9%) who reported that they lived in rural areas. Among the injecting drug users only a tenth (10.8%) lived in rural as compared to the vast majority (89.2%) who lived in urban areas. Among the non-injecting drug users, the sex workers who reported residence in rural area was higher (17.2%) as compared to their IDU counterparts. (refer table 3)

Rohini Sahni & V Kalyan Shankar, (2011) in their study on a sample of 3000 female sex workers observed that less than two-thirds (60%) were from rural family backgrounds, more than a third (35%) from urban family backgrounds.

Rakhi Dandona, Lalit Dandona et al. (2006) in their study 6648 FSWs in 13 districts in Andhra Pradesh studied the mean age at starting sex work (21.7 years) and gap between the first vaginal intercourse and the first sexual intercourse in exchange for money (6.6 years) and observed that the mean age was lower for FSWs in the rural areas as compared with those in large urban areas (23.9 years and 8.8 years, respectively). Therefore it is interesting to understand how area of residence impacts sex work.

4.4 Family Particulars

Young women in sex work often have little or no family support even when they are in sex work due to compulsion or exploitation. This table explores the marital status of the parents of the respondents to determine the stability of the family. Further it indicates the size of the family which determines the social support that a person might enjoy.

Niranjan Saggurti, et al.,(2011) in their study documenting the reasons and processes for involvement of women into sex work in India state that while abject poverty was cited as the main cause by almost three-fourths of the women interviewed, lack of education, financial freedom, domestic violence, family responsibility, lack of support by family members were also major factors.

The analysis of the factors forcing women into prostitution in the empirical study of New York city by W.W. Sanger (1986), between 1955-58, among 2000 prostitutes has also reported ill treatment by parents as one of the factors.

Reported below are the findings of the study on Women Sex Workers in Aizawl: A Situational Analysis.

4.4.1 Marital Status of Parents

In this study of women sex workers in Mizoram, more than a third each reported their parent's marital status as being '*married'*(36.6%) and '*divorced'*(34.7%). More than a sixth (17.8%) reported that their parents had been '*remarried'* while a little more than a tenth (10.9%) had a parent who had been '*widowed'*. It is evident that almost three quarters of the respondents belong to broken, reconstituted and/ or single parent family indicating that stability in the family of origin is poor(Refer Table 4). Of the injecting drug users less than a third reported that their parents remain *married* while almost a fifth reported re marriage of their parents. Less than half (43.2%) of the IDU respondents reported that their parents had divorced indicating broken families. Among the non-injecting drug users more parents were reported as being married while more than a quarter (29.7%) came from families where the parents had divorced. (refer table 4)

4.4.2 Size of family

More than half of the total respondents (58.4%) reported average sized family ranging from 4 to 6 members. Larger families ranging from 7 to 9 members were reported by more than a tenth (10.9%) while a small number (2%) reported more than 10 members. A little over a quarter (28.7%) belonged to small families upto 3 members (refer table 4). More of the non-injecting drug users hail from moderate to large families. The *mean size of the family* was 4.5. (refer table 4)

4.5 Occupation prior to sex work

It is important to understand what occupations were held prior to engagement in sex work. The range of responses in the study were from sex workers having no occupation prior to sex work and salaried workers, self employed persons etc.

Less than a third (29.7%) were unemployed and had taken to sex work as their first occupation. Almost a sixth each had worked as domestic workers (14.9%) or had engaged in peddling/selling of drugs/alcohol (14.9%). A little more than a tenth (11.9%) had been self employed while a little less than a tenth(9.9%) had tried working as sales women. A very small percentage each reported that they were '*daily labourer'(5.9%), 'Salaried workers'(5.9%)*or as *'street vendors'(5%).* One respondent each reported that they had worked in a Drop- in Centre or had been on student status.

A larger percentage of injecting drug users (24.3%) had worked as domestic workers as compared to only a tenth (9.4%) of the 64 non-injecting drug users. Similarly more injecting drug users had worked as sales women prior to a sex work and three times the number of IDUs as compared to non-IDUs had been '*street vendors'* . A greater proportion of IDUs had peddled drugs or sold alcohol among the 37 respondents. (refer table 5)

Rohini Sahni & V Kalyan Shankar, (2011) found that for many females, sex work was not their first tryst with work in general. To the contrary, even for females who started engaging in sex work in their mid- to late-teens, it emerged as an activity much later in their working life. They found that 1,488 females had worked in other

labour markets before entering sex work, while 1,158 females entered sex work directly.

At the same time according to the author for someone who became a sex worker directly, it would not remain her sole interface with work. They report that there are cases of women getting into other labour markets as they grew older and started finding it difficult to generate clients.

The authors report that most females who enter sex work come with a history of very poor incomes in the other labour markets: the median value of incomes across most of the occupations hovers in the range of ` 500 - 1,000 per month. The survey found that there is an overwhelming predominance of economic reasons for females to have left their jobs in the informal markets -- comprising responses such as low pay, insufficient salary, no profit in business, no regular work, seasonal work, not getting money even after work, could not run home with that income – "*is kaam se pet nahin bharta"*.

4.6 Monthly Household Income

It is generally perceived that sex work is taken up by women to augment the family income or due to financial reasons. It is however not common to see families in Mizoram that lived in abject poverty.

In a study on Kolkata's call girls by Ishita Majumdar and Sudipta Panja (2008), the husbands of many call girls have good income, family income for more than a half (56%) ranging between ` 8,000 – 10,000. It was also observed that the parents of some are well placed.

4.6.1 A sixth of the respondents (16.8%) reported that their monthly household income ranges from ` 1,000 - 5,000 indicating that these families could be considered as '*poor*'. Less than half (45.5%) of the respondents belong to families that earned between ` 6,000 - 10,000 the remaining more than a third reported monthly household incomes over ` 11,000. The *mean monthly household* income was ` 12,516/-.

A comparision across IDUs and non-IDUs among sex worker respondents reveal that almost a fifth (18.9%) of the IDUs had poorer income ranging between ` 1,000 to ` 5,000 per month. However, more injecting drug users (8.1%) reported monthly household income of over ` 31,000/.(refer table 6)

S.K.Ghosh (1996) in his book highlighted that poverty is one of the dominant factors of prostitution. The study quotes Philippines and Thailand women and girls belonging to unemployed poor rural families who are seduced for employment and airlifted to rich countries for the purpose of prostitution. Therefore income and poverty has a lot of implications on sex work.

4.6.2 Type of House

Income levels do not always reveal the quality of life of individuals and therefore information on type of housing was sought to determine the quality of life socio economic status of sex workers.

A large majority of the respondents report living in a *semi-pucca* house (22.8%) or in *Assam type* (50.5%) house which is also a *semi-pucca* one raised on stilts, and made of bamboo, tiles and /or tin. It is interesting to note that despite having higher family incomes (refer earlier table), only a sixth (15.8%) of the respondents belongs to *pucca houses* (Floor, roof and walls cemented). Almost a tenth of the respondents (9.9%) report that they have either runaway or left their homes and therefore lived on the *'street'* since they spent their daytime at the NGOs and conducted sex work during night time. (refer table 6)

4.7 Pattern of Substance Use

Lallianzuala,(2007) reported that the first alarming incident of substance abuse prevalence in Mizoram was heard in 1984 when a young man died of Herion overdose.In 1989, the first overdose death due to injection of pharmaceutical non-injectible drug Spasmo proxyvon occurred. The initial drug of abuse was Heroin till the late 90s. Currently, apart from Heroin, prescription drugs like dextro-proproxyphene (Proxyvon/Parvon spas) a synthetic opioid pain killer, sedatives – hypnotic like Benzodiazipines (nitrazepam, diazepam, alprazolum..) and Codeine in a

form of cough suppressant drugs have became the major drug of abuse since the year 1988.

The use of non-injectible dextro-propoxyphene (Commercial name Proxyvon/Parvon spas) by IDUs has been associated with a higher risk of abscesses, non-healing ulcers and amputation, thus increasing the morbidity of drug users. The first HIV infection was detected in 1990 among the drug users community.Currently the HIV prevalence among the Injecting Drug Users is 11.63%. Hepatitis C among IDUs in Mizoram is more than 70 %.

He also quoted in the report that in 2004, MSD&RB in collaboration with YMA branches and Village councils conducted rapid survey on the population of Drug users. According to this report there was already 25,500 (approximately) drug users in the state and out of this 10,500 were injecting drug users. Female account for 7.5 % (1,912) of the total estimated.

It was reported by Amod K.Kanth (1998) that studies in Mizoram, elsewhere in India and abroad almost cent per cent of women in sex work are also victims of some kind of drug addiction.

The analysis of the epidemic based on HIV sentinel surveillance 2010-11 by NACO (2012) reported that the Female Sex Worker (FSW) HIV prevalence in India is 2.67 per cent. Dual risk due to sex work and injecting drugs increases the chance of acquiring HIV infection leading to higher prevalence among those with dual risks.

4.7.1 In this study on women sex workers in Mizoram an overwhelming majority of IDUs (97.3%) report consumption of tobacco while even among the non-IDUs tobacco consumption was very high (81.3%). Across both the groups, alcohol consumption was exceedingly high (92.1%). Proxyvon and Heroin were the choice of drugs for injecting purposes. More than half (51.4%) of the respondents among IDUs have been injecting with *Heroin* while more than three quarters (78.4%) inject using *Proxyvon/Parvon*. This indicates that poly drug use is fairly common even among the drug of choice for injecting. Even among the non-IDUs, 3 repondents have attempted injecting themselves with Proxyvon on at least one occasion in the past. A fifth of the total number of respondents (20.8%) had abused pills and cough syrup. Over a tenth of the respondent reported abuse of solvents 10.9%) and cannabis (12.9%). *Poly drug*

use in general and use of almost all the drugs except alcohol in particular were abused more among IDUs as compared to non-IDUs (refer table 7).

Research elsewhere in three cities in South Africa reported by Fiona Scorgie,Matthew F. Chersich and Innocent Ntaganira et al.(2011) found that alcohol and other drugs are commonly used by FSWs to lower inhibitions, and to increase courage to approach clients as well as in helping them cope . In an Ethiopian study, out-of-school youth who reported chewing *khat* were six times more likely to exchange sex for money than non-users. High alcohol use was found among female food and recreational workers in areas of Tanzania adjacent to mines, and half of these women sold sex. Another study reported by the same authors in Nairobi, Kenya, found that while 35.3% of home-based FSW consumed alcohol daily, much higher percentages of FSW who were club-based (53.3%) and bar-based (60%) did so.

Volunteers for Community Mental Health (VOLCOMH), (2003) reported that in Mizoram, Sex Workers have a close link with use of any kind of intoxicants such as Alcohol, Heroin, Proxyvon, Pills, Dendrite (inhalant), and whatever available within their reach.

A rapid situational assessment of the current drug abuse and HIV/AIDS scenario amongst substance users in Mizoram conducted by Regional Resource and Training Centre (RRTC) Mizoram in 2005 shows that many Male Injecting Drug Users have unprotected sexual contact with the Female Sex workers in Mizoram (RRTC,2005).

It is evident from the research studies quoted above that use of substances and sex work among women has had a long association. Since the customers are often injecting drug users themselves the risk and vulnerability of women sex workers in Mizoram assumes importance.

4.8 Sexual History

A very small study profiling Sex work in Mizoram conducted a decade and a half ago on 122 girls reveals some startling results.In terms of age a sixth of girls were between the ages of 13-17 years. There is very little data in Mizoram in terms of actual nature of sex work and therefore this study has looked into this aspect.

4.8.1 First Sexual Experience

It is important to understand how young women enter into sex work particularly in societies where there is no trafficking. Younger ages at first sexual experience are important factorr in understanding later life occupation such as sex work.

Helen W. Wilson and Cathy Spatz Widom (2010) in their paper examine 5 potential mediators: early sexual initiation, running away, juvenile crime, school problems, and early drug use.

Using a prospective cohort design, abused and neglected children (ages 0–11) with cases processed during 1967–1971 were matched with non abused, non neglected children and followed into young adulthood. Data are from in-person interviews at approximately age 29 and arrest records through 1994. Structural equation modeling tested path models.

Results indicated that victims of child abuse and neglect were at increased risk for all problem behaviors except drug use. In the full model, only early sexual initiation remained significant as a mediator in the pathway from child abuse and neglect to prostitution.

In the current study on women sex workers in Mizoram a vast majority (83.2%) had a *first sexual encounter before attaining the age of 18 years* with one young woman reporting a sexual experience even before the age of 11 years. A sixth (15.8%) had sexual experience for the first time between the ages of 18 to 25 years while one young woman had her first experience after the age of 25 years. This finding was interestingly almost similar across both the groups of IDUs and non-IDUs. The *mean age* of first sexual encounter is 15.84. The findings of this study is more alarming as compare to studies done in India and Nepal as reported below. (refer table 8)

Anita. A. M., (2012) in a country representative cross- sectional study used site mapping and time-location sampling (TLS) and sample size consist of 1,338 FSWs and the data was analysed using descriptive, bivariate and multivariate

analysis(logistic regression model) and found that the mean and median age at first sex were 17 and sex work 20.

In a study by Bhatta, P., Thapa, S., et al. , (1994) in Nepal, the average age of first sexual intercourse was 16 years; and, at entering the sex trade, 18 years.

4.8.2 First Sexual Partner

In *this study* over half of the respondents (50.5%) reported that their first sexual partner was a boyfriend/partner/lover. Interestingly a fifth (19.8%) are currently staying with the first sexual partners as a spouse/current partner. More than a tenth (13.9%) had a *relative* as their first sexual partners. In most instances *relative* included a cousin brother or an uncle. Almost a tenth (8.9%) had a *stranger* as a first sexual partner while a small number each reported that their first sexual partner was *neighbour* (2.0%) and *customer* (1.0%). A small number did not wish to specify who their first sexual partner was. More among the IDUs were actually continuing to stay with their first sexual partner. In the non-IDUs group there were more responses that indicated that their first sexual partner was a *boyfriend* or a *relative*. (refer table 8)

Despite an extensive review of literature there are no studies that have indicated the first sexual partner; therefore it is difficult to draw comparision.

4.8.3 Nature of First Sexual Encounter.

An extensive body of literature suggests that individuals involved in prostitution often come from abusive and neglectful childhood backgrounds. However, the mechanisms that lead from childhood abuse and neglect to involvement in prostitution are not well understood.

In a study done earlier results indicated that victims of child abuse and neglect were at increased risk for all problem behaviors except drug use. Only early sexual initiation remained significant as a mediator in the pathway from child abuse and neglect to prostitution. Findings were generally consistent for physical and sexual abuse and neglect (Helen W. Wilson and Cathy Spatz Widom, 2010).

Geetanjali Gangoli,(2008) raises an interesting question while quating a document by *Sanlaap,* Kolkota based NGO enquring how something can be called 'work' when it had begun with violence and force.

In this study of women sex workers in Mizoram, more than three- quarters (77.2%) had had their first sexual encounter through consensual choice, however over a fifth (22.8%) reported that their first sexual encounter was done with the application of force or against their will. (refer table 8)

Nature of Sex Work and Categorisation

4.9 Sex Work History

One of the high risk factors for contracting HIV for women sex workers categorized by National AIDS Control Organization was below 25 years of age (NACO, 2009).

The age and looks of a sex worker are considered important in determining the range of price fixed by her. The younger she is, the higher is the basic price per act as well as for each longer duration (Sahni, R.and Shankar, V., 2008)

In a study by Bhatta P**,** Thapa S**,** Neupane S, et al., (1994) in Nepal it was observed that the average age of entering the sex trade is 18 years.

Swarankar, R.C., (2008) reports that age at initiation into sex work among *Nats* is generally considered ideal between the ages of 13 to 16 years and there is a heavy amount of money that is received in lieu of first time sex.

In the study by Rakhi Dandona, Lalit Dandona et al. (2006) they observed that the mean age at starting sex work was 21.7 years.

According to a survey conducted under Government of India, about eighty per cent of the girls who were in this profession entered it as children and due to difficult circumstances, such as poverty, illiteracy, ignorance, and deception (Mukhopadhyay, K.K., 1995).

Roy,A., Rajaram,S.,et at.,(2010).in a quantitative 'special behavioural surveys' (SBS) and 'integrated behavioural and biological assessment' (IBBA) surveys among

FSWs to examine sex work characteristics, condom use, and sexual behaviours with regular partners and clients, alcohol and drug use, and knowledge and use of the HIV prevention programme's services. Street based street soliciting participants started selling sex at an average age of 24 whereas, women of the Brothel based brothel soliciting samples had started selling sex at a younger age on average (20.4 years).

An ethnographic profile of female sex workers in Dharwad, Karnataka by Kowlgi.A., and Vijay Kumar Hugar,(2008) reports a unique age of sex workers in this region since most of the sex workers who enter Dharwad come to begin sex work here after retiring from other Cities in India and are therefore older.

4.9.1 Age at First Sex Work

In this study on women sex workers in Mizoram more than half (56.4%) report having begun sex work between the ages of 12 to 18 years. The figure is higher among non-IDUs (62.5%) as compared to IDUs. A third (33.7%) began sex work between the ages 18 to 25 years. This figure was much higher proportionately in the IDU group (45.9%) as compared to the non IDUs group (26.6%). Almost a tenth (8.9%) began sex work as adults between the ages of 25to 35 years. The mean age of first sex work is 19.27. (refer table 9)

4.9.2 Person who Introduced Respondent to Sex Work

This information was sought to understand the dynamics of sex work in Mizoram. Interestingly an overwhelming majority (92.1%) were introduced into sex work by their women friends. Among the IDUs, the number of such instances was exceedingly high(94.6%) and even among the non-IDUs (90.6%) the women friends seems to have played a large role in getting the respondent into sex work. One respondent each reported that they were initiated into sex work by their men friends (2.0%). A small percentage each (3.0%) were introduced into sex work by a *stranger* or a *relative*. As *friends* seem to have played a huge role in initiating sex workers in general, and IDUs in particular, it is probable that sex work has been a way of increasing income to support a drug habit or the drug use helps in increasing those network bases of persons who are already in sex work.

4.9.3 Initiation of Sex Work

A large majority (87.1%) were initiated into sex work through their consent, however a tenth (9.9%) were drugged or intoxicated and had not given consent. A small number (3.0%) had been forced into sex work. Among the IDUs a large number (89.2%) had given consent whereas over a tenth (12.5%) were initiated into sex work without their knowledge. (refer table 9)

4.9.4 Mode of Payment

Almost all the respondents with the exception of one non-IDU reported that *the mode of payment is in cash*. This raises an interesting question with regard to monetary benefits and sex work. This finding aso prompts or raises questions for further research. (refer table 9)

4.9.4 Family member Sex Worker

Information was sought on this aspect to understand pathways and dynamics of sex work in the family of respondents and a large majority (87.1%) did not have a family member who is a sex worker. This was higher in the non-IDUs (93.8%) as compared to IDUs (75.7%). Among the IDUs respondents almost a quarter had a sister (10.8%) or a relative (13.5%) working as a sex worker. (refer table 9)

In the ethnographic study of community based sex work among Nats conducted by Swarankar (2008) in Jaipur, it was reported that the joint family of the Nat community, may have one or more FSWs and that they are the axis of the economy of the entire family.

4.10 Nature of Sex Work

Ronald Weitzer (2009) in his article 'Sociology of Sex Work' reviews and examines key dimensions of contemporary sex work, particularly prostitution to demonstrate how research on these topics can enrich our understanding of contemporary sex work. He presents the typology of prostitution and associated characteristics. The focus is largely but not exclusively on Anglo-American societies.

The categorized women sex workers were *Call girls*, *Escort*, *Brothel worker, Massage parlor worker, Bar* or *casino worker* and *Street*.

Wathinee Boonchalaksi and Phillip Guest(1994) in their study to understand the sex sector in Thailand *have identified 8 sectors* where prostitution is being practiced viz. traditional brothels, hotels and motels, tea-rooms, massage parlors, call-girl and escort-girl services, Bar and night clubs, public places and other places such as golf clubs, discos, and pubs. It has been found that there has been an expansion of indirect prostitution where they are paid directly by the clients. The findings shows that there are significant differences in the operations of different sectors of the sex industry, and among women from different regions. Most women work willingly and the main reason is a desire for money.

Raluca Buzdagan,Shiva S.Halli and Frances M.Cowan,(2009) conducted a Systematic review of the typology of female sex work in India.Published and unpublished studies (1986–2008) were identified through electronic databases, hand searching and contacting experts. The review assesses the appropriateness of the existing typologies from a programmatic perspective and identifies their strengths and limitations. It indicates there is conceptual confusion around the typology and that none of the existing typologies are exhaustive, in that none includes all types of sex work documented in India.

The typology developed by the National AIDS Control Organization (NACO) is the most comprehensive. The typology is based on the primary place of solicitation and categorizes female sex workers (FSWs) as brothel-based, street-based, home-based, lodge-based, dhaba-based and highway-based FSWs. However, this typology has its limitations. First, it does not include all categories of FSWs documented in the literature, such as indirect-primary (primarily solicit clients at their places of work, which are venues where facilitating sex work is their main purpose e.g. massage parlours, bars), indirect-secondary (primarily solicit clients at their places of work, which are in non-sex work related industries e.g. agriculture, construction) and phone-based FSWs (primarily solicit clients through phones). Second, the methodology used to develop the typology pro-posed by NACO or by any other researchers is not explicit. In addition, the extent to which the typology captures the HIV risk variability between FSWs types is not explored.

The study concluded that there is a need to develop an evidence-based, inclusive typology which takes account of HIV risk for researchers and programmers.

Roy, A., Rajaram, S., et at.,(2010) in their study examine sex work characteristics, condom use, and sexual behaviours with regular partners and clients, alcohol and drug use, and knowledge and use of the HIV prevention programme's services. Street based street soliciting had worked an average of seven years; whereas, women of the Brothel Based Brothel Soliciting samples worked for an average of nine years.

Ishita Majumdar and Sudipta Panja (2008), in their study of call girls in Kolkota reported that almost two-thirds (65%) of 136 sample were in their profession for less than 2 years.

The anaysis of the epidemic based on HIV sentinel surveillance 2010-11 by NACO (2012) reported that the Female Sex Worker (FSW) HIV prevalence in India is 2.67 per cent. The analysis shows that HIV prevalence increases with the increase in duration of sex work.

Gajendra K Medhi**,** Jagadish Mahanta**,** Michelle Kermode, et al.,(2012) in a cross–sectional study among FSWs which was conducted in the Dimapur district of Nagaland from February to April 2006, reported that the average duration of sex work was longer for drug-using FSWs compared to non-drug-using FSWs (*6 years vs 4.8 years).*

4.10.1 Duration of Involvement in Sex Work

The respondents in this study on women sex workers in Mizoram had spent a *mean 3.8 years* of duration in sex work and this figure was higher for the IDUs group at *4.2 years* as compared to the non-IDUs group. Less than half of the total respondents (49.5%) had averaged between 3 to 4 years in sex work. A little more than a fifth (20.8%) had spent a shorter duration of one to two years in sex work and this figure was higher in the non-IDUs group (26.6%). More than a fifth (22.8%) had spent 5 to 6 years in sex work and a small number (6.9%) had spent more than 7 years .(refer table 10)

4.10.2. Place of Operation for Soliciting

More than half (59.4%) are operated from the street and maybe refer to as *street based sex workers (SBS)*. In-depth interview reveals that many of this category of sex workers are operating from highways, Taxi stands, secluded streets and other areas identified as *hotspots***.** Probes in interviews reveal that most the street based sex workers are able to directly negotiate with clients at their locations.

Over a quarter of the respondents (26.7%) operate at hotels in the city for reasons of anonymity as *Hotel based soliciting*. In this study, over a third of non-IDUs (34.4%) operate from hotels while in the IDUs respondents the number is smaller (13.5%). It is evident from the interview that for this category of people who solicit from hotels, the role of *intermediary* is crucial in attracting clients. Such intermediaries include hotel staffs, former clients and others. Over a tenth of the sex workers reported that they solicited their clients from within the confines of their homes. (refer table 10).

In-depth interviews reveal that there is a need to maintain secrecy and anonymity among these group and they are akin to *Call girls* described elsewhere. Who operate using telephone as a main source of contact and are virtually invisible due to a more clandestine mode of operation (Ishita Majumdar and Sudipta Panja, 2008).

4.10.3. Venue of Sex Work

In Mizoram which is a very close knit society, anonymity and confidentiality become crucial. A large majority (81.2%) offer sex inside hotels for these reasons, however it involves an additional expenditure since they have to pay to the intermediary as well as for the venue. A tenth(9.9%) therefore prefer secluded areas *on the street* as a venue for sex work while a smaller number prefers the *home* (6.9%)or the *parked car*(2.0%) as venues. (refer table 10).

4.10.4. Frequency of Change in Place of Operation

Almost two-thirds of the respondents report that they changed the venue of sex work *often.* Interview probes reveal that this is done in fear of law enforcement particularly local vigilante groups such as the Village Defence Party (VDP)* Joint Action Committee (JAC)*, Young Mizo Association (YMA)** etc. or to protect themselves and maintain confidentiality. All the IDUs in the study report that they change their place of operation, however over a tenth (12.5%) of the non-IDUs report that they had *never* changed their place of operation. (refer table 10).

* The Village Defence Party (VDP) and Joint Action Committee (JAC) are local vigilante, formed and organized voluntarily by the community in distinct units at the level of individual villages and urban towns. Domestic security is its main objective.

** Young Mizo Association (YMA) is a non-political, voluntary organization, established on the 15th June 1935 at Aizawl, Mizoram. It is the biggest Community-Based Organisation in Mizoram.

4.11. Factors in initiation and maintenance of Sex work

The analysis of the factors forcing women into prostitution in the empirical study of New York city by W.W. Sanger (1986), between 1955-58, among 2000 prostitutes studied by him , the predominant cause was destitution (525), inclination513, seduced and abandoned (258),drink and desire for drink(181), ill treatment by parents, relatives or husbands (164), an easy life (124), bad company(84), persuaded by prostitution(71), too idle to work(20), violated (27), seduced on emigrant ship (16) and as were also seduced in boarding house(8).

Havelock Ellis (2002) in 'Studies in the Psychology of Sex' quoted a study in Italy conducted by Ferriani in 1881 among 10,422 inscribed prostitutes. The causes of prostitution were classified as follows: Vice and depravity, Death of parents and husband, seduction by lover, seduction by employer, abandoned by parents and husband, love of luxury, incitement by lover or other persons outsite family, incitement by parents or husband and to support parents or children,

In study of Alexandra Devinea, Kathryn Bowena and Bernice Dzuvichua, et al,(2009) a convenient sample of 220 female sex-workers completed a cross-sectional

survey, and 30 female sex-workers participated in semi-structured in-depth interviews during mid 2007. The four main pathways into sex-work were economic, drugs, coerced and pleasure.

The Human Rights and Law Network in Mizoram conducted a survey on Sex workers identifying 218 Sex Workers. They had suggested the following factors to be conductive to prostitution in Mizoram, viz, Broken family, lack of parental skills and neglect of children, delinquency, bad influences by peer, illegitimate pregnancy, illicit sexual urge, desire for easy life, loose character, poverty, unemployment, Alcohol and Drug addiction, Domestic violence. (In Ruatfela nu, 2004)

4.11.1 Initiation into Sex Work

This study on women sex workers in Mizoram probed into the factors that contributed to the initiation and maintenance of sex work. In less than two-thirds (59.4%) of respondents, the response indicated that they were '*attracted by the lifestyle'*. Probes revealed that the money for fashionable, fast life and risk involved in sex work in fact attracted a large number of them. Over half (55.4%) attributed a friend as motivating factor responsible for the initiation of sex work. In over a third (33.7%) of the respondents, financial reasons were cited as the main factor contributing to initiation of sex work. Less than a third (30.7%) describe a pathway of drug addiction that led to sex work. Interestingly over half (54.1%) of the IDUs had began sex work following drug addiction. Women who had been divorced (16.8%) or lost their spouse (3.0%) form a smaller group. In the case of one respondent who is an IDU herself, she reports that after having overstayed at a friends house following a party, she was disallowed to rejoin her family by her family members and therefore by '*default'* she ended up beginning sex work. (refer table 11).

4.11.2 Factors Contributing for Continuing Sex Work

It is always important to know what factors contribute in maintaining persons in sex work. Over half (61.4%) of respondent interviewed reported that they continue sex work due to the clear *financial benefits*. This response was proportionately higher among the non-IDU as compared to the IDUs. Over a third (34.7%) of the respondents reported that their drug addiction was the main reason for continuing sex work since they needed the additional money to support their *addiction to drugs/*

substances. Not too surprisingly over half (56.8%) of the IDUs cited this reason while only over a fifth (21.9%) of the non- IDUs cited the same. Over a tenth across IDUs (10.8%) and non-IDUs (17.2%) reported that lack *of alternate employment/work* was a reason to continue with sex work. A very small number (2.0%) interestingly reported that they continued sex work because they happen to *enjoy* what they are doing (not sex per se but the companionship of peers and clients.) (refer table 11).

4.12. Sex Work Pattern

This section deals with the nature and pattern of sex work engaged in by the respondents. The table describes frequency of sex work, number of clients and regularity of clients**.**

4.12.1. Frequency of Sex Work in a Week

In this study it was observed that over half (50.5%) the respondents offered sex between 3 to 4 days in a week. This number was higher among Non-IDUs respondents (57.8%) while among IDUs this number was smaller (37.8%).Less than half across both groups offered sex only 1 to 2 days per week and this was higher among the IDU group (59.5%). A small number (5.9%) offered sex more than five days per week and there were more among the non IDUs who reported the same. (refer table 12)

This finding is quite similar to the findings of Ishita Majumdar reported below. Interviews reveal that since the IDUs continue sex work to support their drug addiction, they do not offer sex beyond 1 to 2 days as the money they earn from those two days suffices for their needs regarding drug use.

Roy, A., Rajaram,S., et at.,(2010).A Comparison Of Programme Exposure and Sexual Behaviours Between Street and Brothel Based Female Sex Workers in Mumbai, Maharashtra State, were dependent on sex work for their livelihood, and sold sex for an average of 21 days per month and had approximately three clients on the last working day.

Ishita Majumdar and Sudipta Panja (2008), in their study of call girls in Kolkota reported that the usual work pattern for more than three–quarters (81%) of

call girls in Kolkota was 2-3 encounters a week .A tenth(10%) of them work thrice a week and just four per cent worked four days a week.

4.12.2 Number of Clients per Day

In this study less than two-thirds (61.4%) reported that they service *less than 3 clients* per working day. More non-IDUs reported the same. A third (33.7%) reported that they average between 3 to 5 clients in the day and this figure was higher among the IDUs(45.9%) as compared to the non-IDUs (26.6%). A very small number claimed that they have 5 or more clients per working day and this number was higher among non-IDUs (6.3%) as compared to IDUs. (refer table 12).

Gajendra K Medhi**,** Jagadish Mahanta**,** Michelle Kermode,et al.,(2012) in **a**cross–sectional study among FSWs which was conducted in the Dimapur district of Nagaland from February to April 2006, reported that the drug-using FSWs reported more clients compared to non-drug-using FSWs in the last working week (*7.7 clients vs. 5.7 clients*).

4.12.3 Regularity of Clients

Less than two-thirds (61.4%) reported they have upto 5% clients who may be considered as *regular clients*. Almost a fifth (19.8%) reported that between 5 to 10 per cent of their clients are regular. A small percentage of non-IDUs reported that they have over 15 per cent client who are regular. (refer table 12)

The data revealed that most of them are exposed to strangers and this has the implication of risk vulnerability to various form of violence.

In the study of Kolkata's call girls, Ishita Majumdar and Sudipta Panja, (2008) reported that, of the 136, almost three-quarters (71%) did not have fixed clients, followed by 13 per cent who had two regular clients. Less than a tenth (7.0%) confirmed that they had a fixed client and nine per cent were handling 3 to 6 clients.

4.13. Type of Sex

Information on the type of sex sought by clients as well as type of sex offered by sex workers was obtained with the objective of understanding the risks involved and the dynamics that sustain sex work.

4.13.1 Type of Sex Sought by Clients

All respondents (100%) reported that *vaginal sex* was sought by their clients. *Oral sex* was demand by a vast majority of clients (80.2%).And among the IDUs the number of clients demanding oral sex was higher (83.8%). *Anal sex* was also demanded by a huge majority (70.3%). This number among the non- IDU was much higher (73.4%). Over two-thirds reported that their clients demanded *genital stimulation* (69.3%). Clients demanding *all of the above* was reported by over half the respondents (61.4%). (refer table 13).

Interviews reveal that oral and anal sex demands are of more recent origin (in the last five years) and a number of the older FSWs report that this was not demanded by clients earlier. They attribute this demand to the increasing use of pornography. Despite the fact that clients are willing to pay more for oral or anal sex, respondents are unwilling to offer this since they do not enjoy the act, themselves.

4.13.2 Type of Sex offered

All respondent offer *vaginal sex* (100%). Over a third of respondents offer oral sex (38.6%) and only one respondent who is an IDU is willing to offer *anal sex*. Almost a tenth (9.9%) offer *genital stimulation*. For every IDU who offers genital stimulation there are 4 non-IDUs who offer the same. Most of the respondents reported that they do not prefer offering genital stimulation since they get a very paltry amount for the same amount of time they would spend on other type of sex. *Anal sex* was not *offered by an overwhelming majority (99%) because the respondents do not like the act or found it to be painful and further,* ***no*** *NGO provided them with lubricants to ease the pain during intercourse*. Another factor that deterred them from offering anal sex was the fact that it held a higher risk for contracting HIV/AIDS. (refer table 13).

Bhatta, P., Thapa, S., et al., (1994), in their paper present the most frequently reported type of sexual activity is vaginal intercourse followed by anal intercourse.

Roy, A., Rajaram.S, Singh.D.P,et at.,(2010), in their study examined the relation between programme exposure and sexual behaviours between street and brothel based female sex workers in Mumbai, Maharashtra State. Although vaginal sex was the main type of sex sold to clients, approximately a sixth (16%) of the participants from the Brothel Based Brothel Soliciting and more than a tenth (12.6%) of the women from street based Street Soliciting reported having had anal sex.

Carol Jenkins, (2000) in a study of 117 clients of sex workers in a Red light area, Sonagachi, reported that while vaginal intercourse was most common, 47% also enjoyed oral sex. Anal sex was reported as rare, and 4% paid to be masturbated.

4.14 Income from Sex Work

More than a quarter (29.7%) reported an earning of upto ` 5,000/- per month as income from sex work. Over a sixth (16.8%) reported an income of ` 5,000 - ` 7,500/-. Over a quarter of the respondent (25.7%) earn between ` 7,500/- to ` 10,000/- . About a sixth earn between ` 10, 000/- to ` 20,000/- . The earning in the case of over a tenth (12.9%) is quite high at over `₹ 20,000/- per month from sex work alone. (refer table 14).

Steven D. Levitt and Sudhir Alladi Venkatesh, (2007) combining transaction-level data on street prostitutes with ethnographic observation and official police force data, theye analyzed the economics of prostitution in Chicago. It has been found that street prostitutes earn, roughly four times their hourly wage in other activities, but this higher wage represents relatively meager compensation for the significant risk they bear.

Ishita Majumdar and Sudipta Panja (2008), in their study of call girls in Kolkota reported that the money charged per sexual encounter ranges from ` 1,000 to

` 10,000 and sometimes it goes up to beween ` 20,000 to ` 30,000. The rates usually doubled at night.

Wathinee Boonchalaksi and Phillip Guest (1994) in their study to understand the sex sector in Thailand examined two sectors of sex industry: rural brothels and urban massage parlors by interviewing 106 women.

Result shows that the sex work sectors far exceed anything that might be in other occupations by women who commonly have only a primary school level of education. The vast majority of respondents were conscious of the income loss they would face if they moved to another occupation.

In a study conducted by Abhijit Dasgupta (1990) in and around kolkata among brothel based sex workers, observed that since, an average rural women receives ` 475/- per month on account of her being in prostitution, this becomes a strong enough reason for the rural poor to make their women sell sex if they had the proper "introductions".

The general accounting system of division in a typical brothel splits the incomes such that the sex worker gets only 50 per cent of her total earnings, while the remaining 50 per cent has to be surrendered to the brothel manager/ owner (Sahni.R, and Shankar, V., 2008).

4.14.2 Pattern of Spending Income from Sex Work

The responses related to pattern of spending of the income earned through sex work was quite interesting as the responses were not mutually exclusive. More than three quarters (79.2%) reported that they spend their income towards the satisfaction of their *personal needs.* This number was higher among the IDUs as compared to non-IDUs. Personal needs included *purchase of clothes, drugs, alcohol, medical expenses as well as purchase of food, snack* etc. Within the personal expenses, an overwhelming majority reported that they spent their income from sex work towards the purchase of drugs, alcohol and other substances. In the case of IDUs all the respondents reported that they used their income from sex work for the same. More than three-quarters (79.2%) reported that the large part of their income is spent toward

purchase of clothes, accessories and cosmetics. About a tenth (8.9%) report that they spend towards medical expenses and health care. Almost all the respondents reported that income from sex work helped them in their purchase of food, snacks etc. Interestingly almost a fifth (19.8%) reported that their income from sex work was invested in the form of *savings.* This number was higher among the non-IDUs as compared to IDUS.

Over a third of the respondents (36.6%) reported they utilize the money from sex work towards *satisfaction of family needs.* More among the non-IDUs as compared to IDUs reported the same.

Over a sixth (16.8%) reported income earned from sex work is utilized specifically towards *satisfaction of needs of their children*. This number was higher among the IDUs (29.7%) as compared to non-IDUs (9.4%) and included items such as school, health and recreation needs. (refer table 14)

In term of investment, sex workers are reported to buy gold. However, savings as such are not very high, resulting in meager investments (Sahni.R, and Shankar, V. 2008).

A study comparable to this study in Mizoram is the one conducted in Dimapur at Nagaland by Alexandra Devinea, Kathryn Bowena and Bernice Dzuvichua, et al,(2009) using a convenient sample of 220 female sex-workers through a cross-sectional survey, and where 30 female sex-workers participated in semi-structured in-depth interviews during mid 2007. More than a tenth (15%) of 220 surveyed FSWs and more than a quarter (27%) interviewed of the 30 FSWs reported that they are in the sex work to obtain money to purchase drugs or alcohol. Nagaland and Mizoram are both have high use of substances by FSWs and theirfore the income from sex work is often used to support a drug or alcohol dependence. However the heads for expenditure may vary across regions as evident by the study reported by the ethnographic study of community based sex work among Nats conducted by Swarankar (2008) in Jaipur, where it has been observed that although the family structure of the Nats is patriarchal, the women, particularly the FSW, are the axis of the economy of the entire family. Nat FSW earns to meet the expenditure of the marriage of her brothers.

4.15 Clientele

Sex work is sustained because of the demand for sex by clients. It is based on this understanding that information on socio-demographic characteristics was sought**.**

4.15.1 Average Age of the Client

Less than half of the respondents reported that their clients are between the ages of *25 to 35 years*. Over a quarter (27.7%) of the respondents reported that their clients are between the ages of *18 to 25 years*. An almost similar number (29.7%) reported that their clients were *above the age of 35 years*.

Discussion with the respondents revealed that there are often older clients also who visit them. (refer table 15)

Carol Jenkins, (2000) in a study of 117 clients of sex workers in a Red light area, Sonagachi, the age of the clients ranged from 15 to over 40, with a tendency of younger clients to visit the more expensive women.

4.15.2 Marital Status of Client

A large majority (77.2%) report that they have *married* clients while a fifth (20.8%) report that their clients are of single status. Two of the clients among the non-IDUs report having clients who are migrants, *married* but are *single* in their working life in Aizawl. This finding is quite similar to findings reported in other studies. (refer table 15).

Anita, A.M., (2012) in her paper presented at the 2nd International Workshop on HIV & Women, reported that the most frequent clients of sex workers in Rwanda were married men(66%) widower (21%) and single client (13%).

4.15.3 Religion of Clients

A majority (71.3%) of the clients are reported to be *Christian*, over a fith(16.8%) are *Muslim* and over a tenth(11.9%) are *Hindu*. Interestingly interviews with key informants as well as respondents reveal that there has been a change in the profile of clients in that there is an increasing local population now seeking sex work where as in the 1990s the clients were predominantly *Vai (outsider)*. While the

Christian population in this study may be seen as '*locals*', the *Muslim* clients are likely to be working life migrants from Bangladesh or petty traders/labours from neighbouring areas. The *Hindu* clients are likely to be a people whose employment/business has brought them to Mizoram. (refer table 15)

4.16. Client Characteristics

Almost three quarters (73.3%) of the respondents report that they had had clients who are Migrants. More non-IDUs (82.8%) offer sex to Migrants as compared to their IDU counterparts. Almost two-thirds of the respondents (62.4%) describe their clients as *rural clients* and the number of IDUs reporting this is far higher (83.8%). Across both the groups of IDUs and non-IDUs *tourists* figured among less than half of the descriptions (46.5%). This category of tourists includes casual visitors, business visitors, tradesmen, official and others. Over a sixth (16.8%) of the respondents describes that they have serviced the *commercial drivers* (includes trucking populations, interstate maxi cab drivers etc. Over two-thirds of the respondents (66.3%) report that they have had clients who were *adolescent or unmarried youth* at sometime. This number was much higher among the IDUs.

Among the personal client characteristics information was sought on use of *alcohol, drugs and clients with sexual dysfunction*. While more than two-thirds(70.3%) of the respondents report that they had predominantly had clients who were *alcohol users* only a fifth(19.8%) have had clients who had *drugs users* and understandably this number is higher among the drugs users. *There were an equal number of respondents (6 each) who reported that they had interacted with clients who reported sexual dysfunction*. (refer table 16)

Belinda Brooks and Gordon (2010), in their article reported that in a study of 78 national household surveys, nine city-based surveys, and behavioural surveillance serveys in a total of 54 countries, prevalence was lowest in Western Europe with less than a tenth(3%) men going to sex workers. In China and Hong Kong it was more than a tenth(11%); Central Africa, a sixth(15%); and in Zimbabwe, more than a quarter(29%). In Rwandan and Zambian truck drivers, prevalence was high at 47 per cent and 30 per cent respectively. *Also in urban areas where incomes were higher,*

among men with high-mobility occupations such as migrant workers, police, military, drivers and truckers, more men paid for sex (25-30 per cent).

Anita, A.M., (2012) in her paper presented at the 2nd International Workshop on HIV & Women, reported that the most frequent clients of sex workers in Rwanda were married men (66%) widower (21%) and single client (13%).

Carol Jenkins, (2000) in a study of 117 clients of sex workers in a Red light area, Sonagachi, the age of the clients ranged from 15 to over 40, with a tendency of younger clients to visit the more expensive women. Of the clients, 87% were literate and 44% were businessmen. Others were wage-earners, professionals, drivers, students and police. Most were alcohol drinkers and spent time entertaining themselves in wine bars.

As evidenced from the studies above clients in urban areas where sex work is more likely to occur are usually migrants, businessmen, both married and single clients as well as clients who consumed alcohol or use drugs and the same was found in this study of women sex workers in Mizoram. Additionally, this study has observed that over a tenth of respondents have had clients with sexual dysfunction.

4.17 Source of Referral of Clients

In a city like Aizawl where there is no Red light area or Brothel based sex work, it is important to know how clients and sex workers meet and interact. The respondents use multiple sources of referral. Over three-quarter among both groups reported that *other WSWs* are a major source of referral. In over a third of the respondents the clients are known to themselves and therefore this may be treated as *self referrals*. This case includes friend, partners and acquaintances. In over half the respondents (56.4%) clients approach WSW directly. This manner of *direct approach* is much higher among IDUs (83.8%) as compared to non-IDUs (40.6%). During interviews the respondents the clientele itself became an important source of referrals. While this manner of referral was reported in over half of the non-IDUs group the number of IDUs reporting the same was just over the third. This finding may be related to the earlier findings regarding frequency of change in place of operation (refer table 10) where an overwhelming majority of IDUs reported that they changed their place of operation often thereby reducing their chances of referral by earlier

clients. Since a large number clients and WSWs solicit sex through *hotels* it is not too surprising that in over a third (37.6%) of the respondents the source of referral is a hotel staff or *other agents* who are connected to hotel staffs. (refer table 17).

Similar findings on sources of referral have been reported from other studies such as the one by Ishita Majumdar and Sudipta Panja (2008), who in their study of call girls in Kolkota reported that they operated both intra and inter city by developing a chain of contact through phone-calls, agents, massage-parlours, bars, hotels, the glamour world, and the like. More than three-quarters (80%) of the women work agent and a fifth (20%) work directly.

Globally, sex work takes place in a wide variety of settings, ranging from established, formal brothels to more informal venues such as bars, hotels, roadside truck-stops, or at home. Where sex work is more formal, managers or controllers (‘‘pimps’’) may act as gatekeepers or intermediaries between the sex worker and client, with contracts stipulating what portion of the sex work fee is ceded to these intermediaries, either as rent, or for drugs and protection (Scorgie,F., Chersich, M.F.,et al.2011).

4.18 Risk Behaviour

There are several risks faced by women in sex work.Over a third of the respondents (37.0%) are injecting drug users and they are placed at an even higher risk. The section below describes use of condom by clients, drug and alcohol use by clients as well as FSWs. Perception related to sexual experience following substance abuse, presence of ‘protectors’ as well as information on STI/RTI. Information related to violence experience has been tabulated in the next chapter although it would merit attention as a risk.

4.18.1 The use of a condom minimizes the risks of contraction of HIV/AIDS and therefore the information on this aspect was sought by the study. In this study less than three quarters (71.29%) reported that they *always* use condoms during sexual intercourse however less than a third report that they use condom only *sometimes*. This number was higher among the non-IDU group. (refer table 18)

Fiona Scorgie, Matthew F. Chersich et al., (2011) in their study, observed that a large body of evidence from sub- Saharan Africa shows that the risk for HIV infection is lower among sex workers who use condoms consistently. Nearly three quarters of sex workers in that study also reported having had sex with a client who refused their request for condom use, and few believed that their co-workers would decline a client who rejected condoms.

Rosenthal, D., Oanha. T.T.,(2006) in their qualitative study in Khanh Hoa, a tourist-oriented province of central Vietnam reported the most frequently reported reasons for not using condoms with clients were because clients offered a higher price, clients insisted on condom-free sex, and possession of condoms as evidence of sex worker status.

4.18.2 Drugs, Alcohol and Sex work.

There has been much literature that suggests that increase in risk behaviour occurs following use of drugs and alcohol. In this study sex was offered in exchange for drugs *sometimes* by a third of the respondents. A small number (2.9%) in fact *often* exchange sex for drugs. The number was understandably higher among IDUs as compared to non-IDUs.

Clients under the influence of alcohol being a very common occurrence was reported by two-thirds of the respondents (62.38%)

Less than a third reported that they *sometimes* have clients who were under the influence of alcohol.

Clients who *often* engage in sex under the influence of drugs were reported by a fifth of all respondents (19.80%) and surprisingly the number of non-IDUs reporting this was higher. Across both groups half the respondents reported that they have entertained clients under the influence of drugs sometimes.

Information was also sought on both the client and FSWs being under the influence of alcohol during sexual encounter since this is likely to lead to increase in risk behaviour. Over a third of the respondents (37.62%) and over half of them report

that both their clients and they themselves have been under the influence of alcohol *often* and *sometimes* respectively

Alarmingly a tenth (9.90%) report that they and the clients have been under the influence of drugs *often* during sexual encounter. On such occasion however a majority (71.29%) have used condoms *often* while less than a third (28.7%) have used condoms *sometimes.*

The use of condom is possibly higher with IDUs FSW since clients want to protect themselves due to the risk involved.

All respondents (100%) report the use of some form of substance during sexual encounter. (refer table 18).

4.18.3 Perceptions related to Substance Abuse and Sexual Experience

All the IDU FSWs and a majority of non-IDUs (70.31%) report that the use of alcohol and drugs during sexual encounter alters the sexual experience and two-thirds (62.38%) perceived that drugs/alcohol use prior to sex makes the experience more enjoyable while less than half (42.57%) perceived that sex is less painful when under the influence of drug/alcohol and over half the respondents believe that they gain confidence and become less anxious during sexual encounter. (refer table 18)

Purnima Madhivanan, Alexandra Hernandez, et al., (2005) concluded their study in Mumbai, India that men who drink alcohol when visiting FSWs engage in riskier behavior and are more likely to have HIV and STIs. *A prevention program in India needs to raise awareness of this relationship*.

Qing Li, Xiaoming Li and Bonita Stanton.(2010) reviewed the patterns, contexts and impacts of alcohol use associated with commercial sex by retrieving 70 articles describing 76 studies, in which 64 were quantitative (52 for FSWs, 12 for male clients) and 12 qualitative.

The result of the review shows that alcohol use was prevalent among FSWs and clients. Alcohol use was associated with adverse physical health, illicit drug use, mental health problems, and victimization of sexual violence, although its

associations with HIV/sexually transmitted infections and unprotected sex among FSWs were inconclusive.

The study concluded that Alcohol use in the context of commercial sex is prevalent, harmful among FSWs and male clients.

Fiona Scorgie, Matthew F. Chersich et al., (2011) in their study, observed that a large body of evidence from sub- Saharan Africa shows that the risk for HIV infection is lower among sex workers who use condoms consistently. Nearly three quarters of sex workers in that study also reported having had sex with a client who refused their request for condom use, and few believed that their co-workers would decline a client who rejected condoms. Further their studies reveals that women with heavy episodic drinking patterns (more than five drinks on one occasion) are more likely to use condoms inconsistently and incorrectly; experience sexual violence; and acquire an STI, including HIV. Alcohol and other drugs are commonly used by FSW to lower inhibitions, increase courage to approach clients and help them cope.

4.19 Presence of 'Protector'

Scorgie. F., Chersich, M.F., Ntaganira, I., et.al., (2012), in their study mentioned that in Cape Town, South Africa, 'pimps' played a protective role for street-based FSW, performing tasks such as safeguarding their money, facilitating their access to health services and noting the registration numbers of clients' cars.

It is important to understand whether WSWs have their own safety strategy to protect themselves from violent clients and also who are their protector. Over half (54.5%) of respondent interviewed reported that they have no protector while soliciting, negotiating, during and post sexual episode. This response was proportionately higher among the IDU (67.6%) as compared to the non- IDUs (46.9%). Among the respondents who have protectors, a sixth (15.8%) reported that their protector were their sex work partner, Accros both the group they cited that their protector were their female lovers (7.9%) and male drug use partner (7.9%). 6.9 per cent of the respondent have Male lover as protector, 4 per cent have Pimp and 3 per cent have female drug use partner as protector. (refer table 10)

A probe reveals that when sex takes place in the client's space, for example in his car or room, sex workers' vulnerability to violence or forced unprotected sex is often magnified.

4.20 Risk Behavior with Regular Sexual Partner.

Rosenthal & Oanha(2006), in their qualitative study assessed HIV/AIDS knowledge and frequency of and influences on condom use with clients and regular, non-client partners among female sex workers (FSWs) in Khanh Hoa. With regular partners, most respondents reported that they never used condoms. Around one-third of women hid their sex work from their regular partners, who made the decision to use or not to use condoms. The most frequently reported reasons for not using condoms with regular partners were familiarity, condom use being dependent on partner's decision, and condom use as evidence of sex worker status.

Kathleen,N.,Parnita Bhattacharjee, Janet.B., et al.(2011),in their study revealed important patterns and interpersonal determinants of condom use within noncommercial partnerships of FSWs. Integrated structural and ommunity-driven HIV/STI prevention programs that focus on gender and reduce sex work stigma should be investigated to increase condom use in non-commercial partnerships.

S.K Singh(2011), in a paper on " prevalence of STIs in intimate partner relationship among FSWs in Nepal" highlighted the need to work on intimate partner relationship and empower women to improve their condom negotiating power which will enable them to bargain condom use with their husband or regular partner. It also highlights the need to innovatively campaign condom and addresses any stigma that may be attached to using condom in intimate relations. Also, there is a need to project condom as a mean of sexual stimuli and not just mean of family planning.

4.20.1 Regular Sexual Partner

Over half of the respondents (57.43) had no Regular Sexual Partner. Among the Non- IDU group almost a half (45.31) and among IDU group more than a quarter (37.84) have Regular Sexual Partner. (refer table 20).

4.20.2 Drug Use of Regular Sexual Partner

Among the respondents who had RSP more than three quarters (83.72) had RSP who used drugs. Among the Non-IDU more than half (60.46) and less than a quarter (23.25) among IDU had Drug using sexual partner.A sixth (16.27) across both group do not have Drug Using Regular Sexual Partner. (refer table 20).

4.20.3 Consistency of Condom Use with RSP

The use of a condom minimizes the risks of contraction of HIV and other Sexually Transmitted Infections (STI) and therefore the information on this aspect was sought by the study. In this study a fifth (20.93) always use condoms while more than half (53.48) and a quarter (25.58) never use condom. (refer table 20).

CHAPTER V

RESULTS
IMPACT OF SEX WORK ON THE HEALTH OF WOMEN SEX WORKERS AND IMPACT OF SEX WORK IN RELATION TO CHILDREN OF SEX WORKERS

5. Impact of Sex Work on the Health of WSWs

5.1 Impact on the Health

William Spice (2007) in his paper of an in-depth review of the *management of sex workers and other high risk groups* states there are four main categories of health risks faced by workers in the commercial sex industry. *These relate to the acquisition of sexually transmitted infections (STI), harm through violence from clients or pimps, factors associated with the use of drugs and mental health.*

5.1.1. Experience of Violence

The report of World Health Organisation (2005) clearly highlighted the magnitude of violence against sex worker in the world. In Bangladesh, the national HIV surveillance (1999-2000) found that between 52% and 60% of street-based sex workers reported being raped by men in uniform in the previous 12 months and between 41% and 51% reported being raped by local criminals. In Namibia, 72% of 148 sex workers who were interviewed, reported being abused. Approximately 16% reported abuse by intimate partners, 18% by clients, and 9% at the hands of the police. In India, 70% of sex workers in a survey reported being beaten by the police and more than 80% had been arrested without evidence.

Teela Sanders and Rosie Campbell,(2007) in their paper examine differences in the extent and nature of violence experienced between women who work on the street and those who work from indoor sex work venues. The types of violence women experience in indoor venue were *Robbery, non negotiated sex act, attempt to or removal of the condom, offensive language, rudeness, disruptive behaviour and financially ripped off.* The paper suggested for a safety strategy is managing the environment, individual protection mechanisms and collective control.

In this study Marina A. Barnard, (1993) looks at the issue of violence in the context of street working prostitutes and their clients in Glasgow, Scotland. It was observed that the street prostitutes routinely face the threat and reality of violence in their work which suggests that the health risks associated with prostitution need to be considered not only as public health issues but also in terms of occupational health.

Plumbridge, L. and Abel, G. (2001) in their study among 303 female sex workers in New Zealand sex industry in regard to issues of sexual safety, drug use, violence and coercion observed and reported that there is a high levels of violent experiences were reported, but street workers reported more, and more extreme forms of, violence than indoor workers.

In this study almost all respondents (98.02%) have experienced violence in their life. Of those who have experience verbal violence (98.02%), more than a fifth have experience it 'sometimes' but three-quarters have experienced it 'often'(75.25%).

A small number has never experienced physical violence(5.94%) however the remaining majority has experienced it with over half of them saying that they have experienced it 'sometimes'(52.48%) and less than half(41.58%) saying it was 'often'.

Less than a quarter (23.76%) had never experienced violence during sexual encounter however three-quarters have. Two-thirds (64.36%) have had sexual violence 'sometimes' and over a tenth (11.88%) had 'often' experienced sexual violence. (refer table 25).

5.2 Perpetrator Characteristics

Voilence was perpetrated by a range of persons that included parents (77.23%) of respondents. Less than half reported that the perpetrator had been a spouse/ partner; Clients were perpetrators in less than half the responses (44.55%). Friends had perpetrated violence in over a third (38.61%) while local vigilante groups had been perpetrators for a third of the respondents (33.66%); relative (32.67%) police in less than a fifth (18.81%); siblings (19.80%); neighbors (12.87%) employee (3.96%) and pimp(1.98%).(refer table 26).

5.3.1 Violence Under the Influence of Substances

In less than half of the respondents(40.59%) sexual violence had occurred when perpetrator had been under influence of alcohol/drug while in almost a third(32.6%) it occurred only 'sometimes'. (refer table 27).

5.3.2 Physical Injury as Consequences of Sex Work

In over half(57.43%) of the respondent reported physical injury as a consequence of sexual violence occurred 'sometimes' while in almost a fifth (14.82%) it occurred 'often'. (refer table 27).

5.4 HIV Related Risks

All respondents (100%) have knowledge regarding HIV/AIDS. Over a quarter (27.72%) have received such information through interpersonal communication while the remaining (72.28%) received through mass media and interpersonal sources. Over a quarter (25.74%) reported that their current sexual behaviour places them at risk. Less than a quarter (23.76%) report that the current sexual practice of their regular sexual partner is at risk and than a third (30.69%) report that the current sexual practice of their clients are at risk.

An overwhelming majority (93.07%) has tested for HIV status. Almost a fifth (17.82%) had reported that they were '*positively*' tested for HIV (17.82%) while a tenth (11.88%) did not return for confirming results or did not know their status. 4(3.96%) of the respondents reported that there were HIV *'positive'* among their clients and all others (96.04%) reported that they were unaware of their clients HIV status. (refer table 28)

5.5 STI Status of Respondents and Regular Sexual Partner

In reference to understanding risk behaviour information on presence of STIs was sought with regard to both the respondent as well as a regular sexual partner. In reference to respondents between a fifth and third of respondents reported presence of pain during sexual intercourse(24.75%) difficulties, pain, burning during urination(21.78%) frequent urination (36.63%) and significant weight loss(12.87%).

In relation to RSPs and their problems over a fifth (22.77%) had RSPs who had experienced pain during urination and a fifth (19.80%) had partners with wounds, sores and abscesses in the penis clearly indicating that risk of sexual transmission of STIs was high. (refer table 29)

5.6 Mental Health

W. Ro¨ ssler. U.Koch, C.Lauber, et al.,(2010) responding to the limited information available about the mental health of female sex workers, aimed to make a comprehensive assessment of the mental status of female sex workers over different outdoors and indoors work settings and nationalities. In the result of the study the 193 interviewed female sex workers displayed high rates of mental disorders. These mental disorders were related to violence and the subjectively perceived burden of sex work. Sex work is a major public health problem. It has many faces, but ill mental health of sex workers is primarily related to different forms of violence.

Praveen K., & Anil Kumar, (2010), in their paper examines the levels of mental health status among female sex workers in Mumbai and then analyzes the effect of various social determinants on mental health. The result of the study showed that high proportion of female sex workers had low mental health status. Many of them were probably suffering from some sort of mental illness. Multivariate analysis showed that social determinants, especially violence and discrimination significantly affected the mental health of the female sex workers.

Maryam Shahmanesh**,** Sonali Wayal**,** et al.,(2009) in their study examine suicidal behavior prevalence and its association with social and gender disadvantage, sex work, and health factors among female sex workers in Goa, India. They used multivariate analysis to define suicide attempt determinants.

This study result shows that Nineteen percent of sex workers in the sample reported attempted suicide in the past 3 months. Suicidal behaviors among sex workers were common and associated with gender disadvantage and poor mental health. There is a strong relationship between mental ill-health and risk-taking behaviours (drug use or sexual practices) among CSW [39]. Several studies have reported higher levels of psychological distress levels in CSW, than a non- CSW control group,

5.6.1 Perceived Mental Health (A)

Mental health of persons is important and information on this was sought from sex workers, who are often exposed to high risks and stress.

Only 4 respondents (3.96 reported they were not unhappy while an overwhelming majority (96.04%) were ‘unhappy’ or ‘depressed’. In over a fifth (21.78%) it was moderate while in almost three quarters it was ‘rather more than usual’ (62.38%) or ‘much more than usual’ (11.88%).

Only a small number (6.93%) had reported being less confident while over half reported being ‘rather more than usual’ (51.49%) and almost a tenth (8.91%) ‘much more than usual.

Almost half the respondents (40.59%) reported feeling worthless ‘rather more than usual’. (refer table 30)

5.6.2 Perceived Mental Health(B)

Ability to concentrate a task in hand was reported as being much less than usual by almost half the respondents (43.56%) and almost two-thirds (62.38%) reported that they had lost more sleep than usual over worry. Over half reported that they felt they were playing useful part in activities much less than usual and almost half said they were less able to face up to problems. (refer table 30)

5.6.3 Perceived Mental Health(C)

Over half the respondents felt less capable of making decisions. An overwhelming majority (75%) ‘felt much more than usual’ under strain. And over half (55%) felt they could not outcome difficulties with almost two thirds expressing that they were less (51.49%) or much less than usual(8.91%) able to enjoy normal activities. (refer table 30)

5.6.4 Perceived Mental Health (D)

Almost a sixth of the respondents (14.85%) reported that they were ‘never’ unhappy and hopeless while more than half (56.43%) ‘Sometimes’ felt that life is not worth living and among IDU group it is almost two-thirds (62.16%). More than a quarter (28.7%) of the respondents ‘felt that life is not worth living’.

More than a fifth (21.78%) had 'often' (more than twice) attempted to commit suicide and almost a half (42.57%) attempted 'sometimes' (once or twice). Across the groups, IDUs have attempted to commit suicide *more* than their counterpart Non-IDUs. And interviews reveal that the mode of attempt to commit suicide was through 'overdose'.

A third of the respondents (33.66%) reported that they had 'never' attempted to commit suicide in their lifetime. (refer table 30)

Impact of Sex Work in Relation to their Children

5.7 Particulars of Children

Deepa Das**,** (1991) in a paper 'Giving the Children of Prostitutes their Due' made a critical comment the plight of prostitutes children in India. Little attention has been paid to these children who are victims of their circumstances from birth, denied the opportunity to be free of their background, and deprived of an environment conducive to healthy physical and psychological development.He also mention to priorities the needs of an estimated 5,000,000 children of prostitutes in India.

Christine M. Sloss, and GaryW. Harper, (2004) in their qualitative research study, 16 mothers who were currently involved in street sex work in a Midwestern city of the United States participated in semi structured interviews. It is evident from these interviews that street sex workers who are mothers have unique needs and experiences that must be considered by researchers, policy makers, and service providers.

Priti Pai Patkar, (1990) in a paper examines what makes the prostitutes children more vulnerable and deserve special treatment on a priority basis. Poor environmental conditions, lack of proper nutrition and defaultation in the medical treatment, results in these children constantly suffering from health problems like fever, cold, dysentery, diarrhea, ulcer, scabies, tuberculosis, anemia etc. many times sexually transmitted diseases transmitted by the mother during pregnancy have been found among children.

5.7.1 Number of Children

Over two-thirds of the respondents (66.34%) had no children. Among the third who did have children only one respondent had four children while the rest had one (23.76%) or two (8.91%) children. (refer table 21)

5.7.2 Bereavement of Child

Two of the sex workers (one each from the IDUs and non-IDUs group reported that they had had a child who passed away. (refer table 21)

5.7.3 Number of induced abortions

Over a tenth have reported induced abortion (12.89%) and of this, a small number among the non-IDU group had reported inducing abortion on two occasions (1.98%).(refer table 21)

5.8 Violence experienced by children

In this study of Women Sex Workers in Aizawl there were 34 respondents who have children. Information on experience of violence by the children was sough through the respondents.

5.8.1 Children experience of Physical Violence

Almost a two-thirds (64.70%) of the respondents reported that their children had never been exposed to physical violence while more than a third(35.29%) said that their children experienced physical violence. (refer table 22)

5.8.2 Experience of Verbal Abuse by children

More than a tenth (11.76%) reported that their children never experienced verbal abuse. More than three quarters (76.47%) reported that their children experienced verbal abuse ‘sometimes’ and four respondents had experienced it ‘often’. (refer table 22)

5.8.3 Witnessing of Violence in Family by Children

Of the thirty four respondents who have children thirty three reported that their children witness violence 'sometime' while one respondent reported the witness 'often'. (refer table 22)

5.8.4 Impact of Sex Work affects Children

Of the respondents who have children, more than three quarters(76.47%) acknowledge that the sex work affects to some extent while over a quarter (26.47%) there is a great extent of impact on the life of their children. (refer table 22)

5.9 Worry about Children

Only third of the total sample had children. Parenting as an area of great concern was expressed by half (52.94%) of the respondents who had children. Perceived neglect by them towards their children was a major worry expressed by almost two-third (64.70%) of the respondents who had children. Almost all the respondents with children listed 'finance' as a major worry (58.82%) or as worrying about it to some extent (41.17%). Almost similar results were expressed in reference to worrying about the future. Significant is the finding that suggests that social acceptability is a major worry by most respondents (70.58%) and a minor worry by 29.41% of respondents

Exposures of their children to drug and alcohol abuse is a major source of worry in over half of the respondents (52.94%) and more among the IDUs express this as a major worry.

The safety and security of their children too is a major source of concern in over half of the respondent (52.94%). A vast majority across both groups and interestingly all the IDUs with children fear risk of exposure to violence by the children. (refer table 23)

5.10 Needs of Children

Information on concern with refercence to basic needs of their children was sought and it was interesting to learn that all of them have concerns regarding food/nutrition needs to a greater (47.05%) or lesser (52.94%) extent; education (58.82%) and Health (58.82%).(refer table 24)

CHAPTER VI

RESULTS
SOCIAL SUPPORT AND SERVICES WOMEN FOR SEX WORKERS IN AIZAWL

6.1 Awareness level of Services and Support

Hawkes and Santhya(2002) in their paper reported that Health-care seeking behaviour among women sex workers depends on their perceived seriousness of symptoms, the availability and accessibility of local health care, their perceptions about the qualitiy of care,costs of treatment, and beliefs about the appropriate providers to consult. The proportion of women sex worker seeking care is highly variable, and delays in seeking treatment are often substantial.

William Spice (2007) in his paper suggested that services aimed at harm reduction need to address the four main areas of risk discussed, namely, sexual health, physical violence, drug use and mental health.

Information on services awareness by women sex workers was sought and all had been outreached by Female peer educators while over three quarters reported Gender Sensitive IEC (80%) awareness of sterile needles and syringes (85%), voluntary HIV testing and counseling (86.14%), Diagnosis and treatment of STI (85.15%) services awared by a smaller member included ART for female drug users (37.62%), services for PPTCT (60%). Vocation training (22.77%) microfinance programmes for women (7.92%), legal support (14.85%), Safe housing and shelter, nutritional supplementation programmes (32%) and services for children (31.68%).(refer table 31)

In-depth interview reveal that a more quality and comprehensive, user friendly mental health services, legal services, and facilities like female condoms is essential in the present intervention.

6.2 Treatment for Substance Abuse

Information on treatment for substance abuse accessed by women sex workers was sought in this study titled 'women Sex Workers in Aizawl"; an overwhelming majority (89.11%) across the groups and all (100%) in IDUs had sought treatment atleast once in a lifetime.

Less than half (44.55%) have gone through a drug harm reduction based counseling and more than half (58.42%) in drug abstinence based counseling. More

than half (58.42%) entered residential rehabilitation, an over- whelming majority (89.11%) had been to Health and moral education camp.More than a tenth (12.87%) received treatment for physical problems including abscess and 3.96% drug substitution programme.

Among all respondents Non Government Organisations are accessed as service provider by an overwhelming majority (89.11%), with Faith Based Organisation reported by more than three-quarters (79.21%), Government Organisation only a third (33.66%), home based detoxification a fifth (20.79%) and Traditional healers was accessed by an insignificant minority (2.97%). All the IDUs respondents utilized the NGOs facilities for treatment. (refer table 32)

6.3 Support Sought and Received when faced with violence

In a qualitative research study conducted by Valandra, (2007), eight African American women who were receiving culturally specific services at an Afrocentric agency participated in a focus group and in-depth semi structured interviews. The finding suggests that social workers and policy makers need to recognize the interconnections among prostitution and racial, class, and gender oppression. Despite experiences of sexual and physical violence in childhood and later adulthood, the women in this study, like many women, were reluctant to seek help.

In this study information on support sought and received when violence was faced by women sex workers in Aizawl was obtained ; half (50.50%) of the respondents never sought help and endured silently, more than a third (40.59%) *sometimes* and less than a tenth(8.91%) *often* received support.

Almost a third (32.67%) received support form friends, more than a half (51.35%) among the IDUs availed help from the NGOs and CBOs and less than a third (31.68%) of the respondents from both the groups received help from the same agencies. More than a tenth (14%) have received support from a doctor, below a tenth (9.99%) from siblings, (8.91%) from religious leaders, (6.93%) from parents, (5.94%) from neighbors, (3.96%) from police, (1.98%) from in-laws. (refer table 33)

CHAPTER VII

RESULTS
FOCUS GROUP DISCUSSIONS, KEY INFORMANT INTERVIEWS AND CASE STUDIES

7. 1 Result of Focus Group Discussions

Focus Group Discussions was conducted with 4 groups of women sex workers. The first group had 12 participants, the second 13, the third 10, and the fourth 11*. The first group was conducted during a women sex workers' gospel camping organized by CKTP (an apex body of Presbyterian youth federation), the second at Protective Home run by Social Welfare Department, Mizoram, the third and the fourth were conducted at a Female Sex Workers Drop- in Centre run by New Life Home Society at Ramhlun veng and VOLCOMH Soceity at Sikulpuikawn. *The main objective of the FGD was to examine their perceptions related to how they are being perceived by Health Care providers, general community members and the Church*. The group comprises of the two typologies of Women Sex Workers in Aizawl viz. Street Based and Secret Based. Their age ranged between 18 and 30 years, with the majority being in their mid-twenties. Interview guide was used to facilitate the discussion. There were some similarities as well as variations in responses from each group. Ground rules were set at the beginning of each group discussion and the participants were assured of the confidentiality of their personal identity. Ice breaking, brainstorming and probing method was utilized during the FGD.

* **See table no. 34**

7.1.1 Women Sex Workers Perceived by Health Care Providers

Most of the participants in all the groups agreed that they are being perceived by the Health Care Provider as *the at most risk and vulnerable population* to HIV and STI, practicing an unsafe sex behaviour which needs to be change. It was clear from the discussions that sex workers were offended when they were considered as being at elevated risk of HIV infection. They rejected being treated with suspicion and ostracism as disease vectors or conduits for the spread of AIDS, especially by health care providers. The group argued that the problem of AIDS was not confined to them and that it was everybody's problem that HIV could and does affect "ordinary" people as well: *"It is affecting everybody, it does not know rich, or poor; anybody can catch it."* During the discussions it was also mentioned that they were always considered to have a very low health seeking behaviour. Drug using Sex Workers, during the

discussion explained that they felt the need to prioritize their habit of drug use (how to get fixed) and the activities related to it.

Majoritiy of the participants from all the groups indicated that NGOs provide services and they considered them to be women in difficult circumstances who need legal, emotional, social and economic support. The general perception of the *service providers according to them was very professional, understanding, enabling and supportive*. They admitted very clearly that most of the NGOs understand their problems and seek to solve it. It was also mentioned that they had been perceived as victims who need to be rescued.

However some of the members mentioned the presence of condescending, judgmental and moralistic attitudes among some of the staff working in NGOs, Private and Government health care settings. *"Thinlung taka min pui duhtu, kan dinhmunte min hrethiam tute chu kan hai bik lo" (We know those who understand our condition and wanted to help us genuinely).* It was also mentioned during the discussion that sometime they have a feeling that they are being used by the service providers in order to achieve the target set by funding agencies. Most of the group members also expressed the need to participate in the decision making process related to planning and implementation of the programme which was meant for them. Most of them have the opinion that they have the requisite potential and should be consulted in designing their welfare and health programme in the state. They wanted the Health Care Service Providers to believe in the potential and capacity that they have in spite of the life which they choose to live at present.

7.1.2 Women Sex Workers as Perceived by General Community

Majority of the participants in each group expressed in consensus that they were perceived by the general community as people who were showing

- Deviance from accepted social codes of behavior.
- Deviance from traditional expectations of the roles of wife, mother and family nurturer.

- People who made the environment unsafe for other women, promoting adultery and as people who should be banned.
- Persons of loose characters and sexually perverted seeking only pleasure and easy money.
- Criminals who should be put to jail and should be '*nipped in the bud'*.
- Good for nothings and the ones who spread HIV and AIDS.
- As those deserving to be beaten and sexually assaulted.
- Deserving to be punished in public.
- A '*gone case fallen till her last breath*' inspite of attempt made to exit sex work.

During the discussion, many of them felt that the society should also recognize the contribution that they had made in gratifying the sexual needs of the male population. *"Min dem ngawt lo hian engvanga in zuar a inzawrh chhunzawm zel nge kan nih tih te hi ngaihtuah ve rawh se"* (*Before putting every blame on us, they should examine all the factors and motivation which made us become and continue to be a sex worker).* They have the opinion that anything can happen to women if they are placed in a position and situation that they themselves have gone through in their life. Some of the participants in the group confessed that it is the attitudes and behavior of the general public which made their exit to the mainstream complicated. They all agree that the local law enforcers are too judgmental and lack empathy. They also emphasised that it is not the sex but the lifestyle and financial security that sex work provide that they enjoy most**.**

7.1.2 Women Sex Workers Perceived by Church : All the participants from each group believe that the Church in Mizoram as a whole perceived them as a sinner, enslaved by the spirit of lust and evil, immoral condemned by the Law of God to be punished and deserve to suffer in Hell after life. They all agree that in the eye of the church they are outlaws and temptresses with whom the church community should not mingle.

According to them, the consequence of these perceptions lead to salvation camping for their lost souls or a redemption campaigns to rescue them from evil sexual bondage. *"kan nunphung, sum lakluh dan hmang leh thiante kalsan tir hi Kohhran tum leh tuina ber niin a lang"(The church's main focus and interest is exit – exit from our lifestyle, our source of income and also from our like minded friends*). "*Kohhran hian kan thatna tur – hriselna leh himna lam hi an tui zawng a ni lo*" (The churches were not interested in our well- being- our health and safety). Each group responded strongly *by pointing out that they cannot be forced to change all of a sudden and transform from sinner to saint. "Bul tan that tumin han beih ve tang tang pawhin kan tluk leh hun tur thlirin rinhlelhna mitin min en thin"*(*Even when we are ready to start a new life we are looked upon with suspicious eyes, ready to witness our falls*). The care and support of the church or the programmes under the church were very seasonal and have a weak follow-up, absence of support system necessary for proper settlement on a long term basis. *"Kohhran hmalakna hi chu Tharau chhanchuahna chauh a ni, kan hlim a zo a, a ngaiah bawk kan lut leh thin, piangthar der, tum tak tak lo te min ti zui leh a. Thuruk vawn chungchangah counsellora an hmante hi ka ring zo lo"*(*The church initiative is to rescue us spiritually, we relapse the moment our spirit is down and we are labeled as faking it or having a weak will. I don't trust some of the spiritual counselors in maintaining confidentiality)*. They also expressed their feeling by saying that the programmes, whether short or long were beneficial and the intention was good but those who fail the programme were branded as the one who have a very weak will, lack perseverance, ignoring the grace of God and taking side with the devil. *"Kohhranho chu an programme(e.g. Gospel camp) huang chhungah chuan an tha, mahse chumi pawn lamah chuan ensan, ngaihsakloh, thinhrik leh endawng kan hlawh thin a ni"(The hospitality of the church confines within their programme(e.g. Gospel camp) and outside the programme we are isolated, victimized, stigmatized and discriminated)*. The main issue according to them was that the church tries to *fix them* before listening.

During the discussion they mentioned some Faith Based Organization like CKTP (Apex body of the Presbyterian youth federation), Community Health Action Network (CHAN) run by the Salvation Army, Catholic Relief Service (CRS) etc., and also same Evangelical teams. Also mentioned were the Short Stay/Detox/Rehab Home run by Presbyterian Church and Salvation Army. All participants acknowledge

and appreciated the efforts and financial investment made toward them by the church. *"Kristian kan thatna tur duh tak tak tu leh mihring pangngai anga min en an awm. Inzuar mah ila mihring ka la ni tho alawm, tuman min chawm lo a, ka thu thu in ka awm a, ka lungawi ve tawk a ni"*(*There are Christians who genuinely care for our well- being and treat us with dignity*." *"So what if I am a sex worker. I have my own self-dignity and respect. Despite being in sex work, I am happy. I am doing something on my own. I am very happy with my life*...). They wish that the church did not fight sex work but target stigma, isolation, and economic disenfranchisement associated with sex work. They also hope that the church community perceived and recognized them as a Person who has the same goals as mainstream society- security, marriage and family. *"Keini inzuar thinte hian thlarau lam chauh nilo in, taksa, rilru leh nun hona atana tul mamawh kan nei ve bawk a sin" (We are sex workers having not only spiritual need but also physical, social and psychological needs).*

Many of the participants had a strong religious beliefs and a spiritual inclination. Most of them were aware of the teaching of Jesus Christ, attended gospel campaigns and church meetings. *"Ka tawngtai fo a, Pathianin min ngaithla a min hnar bik lo tih ka hria" (I often pray and I know that I am being heard and not rejected by God).*

7.2 Result of Key Informants Interviews

A total of 27 Key informants (KIs), 15 men and 12 women each were selected and interviewed. KIs interviewed comprises of Law enforcement officials, Concerned Government officials, functionaries of NGOs, CBOs and FBOs, Church Leaders of different denominations and Media persons.* Open ended questions and probing was utilized to assess the knowledge and attitude of the KIs on the focus areas related to sex work in Aizawl. In some case repeated interviews were held.

* **See table no. 35**

The KI interview was focused on the following 7 (seven) issues:-

- Magnitude of sex work in Aizawl
- Nature and pattern of Sex work

- Key issues to be addressed
- Challenges
- Support systems for sex workers
- Services
- Suggestions

7.2.1 Responses on Magnitude of sex work in Aizawl

KLs	Responses on Magnitude of Sex Work In Aizawl
Law enforcement officials	● There is an increasing trend in the number of women sex workers in Aizawl. ● Factors motivating sex work – financial and addiction ● They are operating both openly and secretly. ● There might be some women who are being forced to sell sex. ● Most of them are unmarried and divorced women. ● Most of them are using Alcohol and drugs. ● They are not safe from HIV and STI. ● There is a report of physical and sexual violence incidents but only few cases were filed. ● The society does not accept sex work and they often ostracized women sex workers from their locality.
Government officials	● The magnitude is huge as seen from the visible population and the presence of not reach hidden sex workers is obvious. ● **Ever registered inmates in Protective Home = 643 as on February, 2013.** ● The number sex workers are increasing. ● Factors motivating sex work – family disoriented, financial and addiction. ● Majority of the sex workers are street based and they operate at night. ● They are unmarried, married and divorced women, widow, office going, and students. ● They use drugs and some of them even inject drugs. ● Less incidence of new infection of HIV but STI rate still high.
NGOs staff and functionaries	● HIV prevalence is highest among sex workers in Mizoram. ● The number sex workers are increasing. ● Factors motivating sex work – lure of easy money and addiction. ● A *common room* jointly hired by sex workers for supporting their operations and residential needs can be seen from time to time. It is very temporary due to ostracism faced by the sex workers from the locality by the Local Vigilance Group.

NGOs staff and functionaries	● Majority of the sex workers are street based and they operate at night. Home based (secret) sex workers constitute 7% of the total population covered. ● Majority of the sex workers are strictly unmarried but most of them have regular sexual partner. ● There is a high prevalence of sex worker cheating clients and steal money from them. ● There are many incidence of violence recorded and reported. FIR was lodge but most of the cases were not filed. The reasons were mainly lack of compliance to court procedure by the sex workers. Taking these into consideration, most cases were settled in the presence of the victim (sex worker), perpetrator, and Police and NGO social worker to avoid the long trial of court. ● Sex workers are also sometimes intimidated and rob by strangers ● Sex work in Aizawl is closely related with alcohol and drug use. ● Less incidence of new infection of HIV ● Most of the sex workers are subjected to harassment from the local vigilance, male addicts and the clients themselves ● There are many clients of sex worker who prefer not to use condoms. ● From close observation, it has been found that the spouses of sex workers ever married were mostly an alcoholic or drug addict whose contribution to the family income is meager. ● The most common crisis that women sex workers faced in their profession is client unwilling to pay or paying less amount after the session is over.
Community Based Organisation Leaders	● It is a bad image for the locality if sex workers operated in their area. ● Estimated population according CBO ESTHER was 600 plus. **(**Esther, facilitated by VOLCOMH was formed on 24 January 2009 in Aizawl and the number of members ever registered is 120 as on October, 2012). ● The number of sex workers are increasing but these days most of them are admitted to a moral education camp by YMA. ● Factors motivating sex work – Broken family, attracted by easy life style and addiction. ● There are no clearly defined red light areas, only few soliciting spots. They operated secretly and they are very mobile. ● There are also a college students and women who already have another occupation. ● Sex work in Aizawl is closely related with substance abuse and HIV. ● Most of secret sex worker have a legitimate source of income.

Community Based Organisation Leaders	• Majority of the sex worker attempt to exit their professions fails. • There is strong stigma associated with sex work in Aizawl. • The incidence of physical and sexual violence has increased.
Faith Based Organisation Leaders	• The presence of a huge number of sex worker, their addiction to drugs and their involvement in selling drugs and alcohol has became the concern of the Church specially the youth wing. • The problem maybe much more than what is seen or perceived. What can be observed is just a tip of the iceberg. • The efforts to transform them from sinner to saint do not work out as expected. The relapse rate is very high. • Factors motivating sex work – pressure of the modern materialistic world, broken family, Divorce, attracted by easy life style and addiction. • There are sex workers who have their basic needs but needed more money to lead a fashionable and fast life. • Addict sex workers often exchange sex for drugs. • No red light area or brothel system • They can be easily seen negotiating with clients at night time. • The do not have a constant soliciting spot, it changes frequently. • There might also be some regular church member. • Since sex is the main route of HIV transmission the number of positive sex workers is also very high. • Sex trafficking activities also has been found which related to abuse of innocent girls like rape. • Pornography aggravated the problems related to sex work in Mizoram.

*"Mizoramah hian Nawhchizawrna hi kum 1980 hma lam kha chuan sawi tur a vang khawp mai. Fur khaw thiang tak thawklehkhata chhumin a rawn bawh chuk ang mai hian a rawn hluar ta hluai mai ani ber. Kan khawtlang nun in thlak danglam thut, nasa tak mai ina a hrin niin ka hria" (*Sex work was a rare phenomenon in Mizoram till 1980s.Their appearance is like a monsoon mist which was not there awhile ago but would soon cover the whole valley. I think they are the outcome of the society which is in suddent and drastic transitions).

7.2.1 Responses on the nature and pattern of sex work

KLs	Responses on the Nature and Pattern of Sex Work
Law enforcement officials	● The presence of pimp is more visible these days. ● Today, mobile phone facilitates sex work. ● The place for entertaining the client does not confined to Hotel alone but scattered to any places like open roadside to taxi back seat. ● There is no red light area or Brothel but some hotspots.
Government officials	● During the insurgency period there are few sex workers "Nawhchizuar" operated secretly to cater the needs of the army. By mid -1980's a new nomenclature 'K.S' (meaning *Khawpui service* literally meaning *Town Service*) replaced the tradition name "Nawhchizuar". At first they are girls who just love to have fun like riding, drinking, partying and easily available for those who can buy them a drink and give them a ride but commercialization of sex as such was not clearly visible. Flirtatious roaming/hang out which mean *fawr* in Mizo slanguage was a very common term associated with K.S. The presence of organized sex work with madams operating in hotels can be clearly seen just before the implementation of Total prohibition of Liquor Act in 1987. This kind of operation was all close down when the Total Prohibition was in force. The streetwalkers (sex worker soliciting in the street) who use different type of drug began to appear. They can be contacted face to face and negotiated directly. At present we have also secret sex workers who can be contacted through phone call. ● More adolescent girls are observed recently ● Before, majority were those who had moved into the city from rural areas. Now, it has shifted to the urban poor. ● Rather than Hotels, Taxis and secluded places as well as clients residents are becoming the venue for sex-work. ● The street based sex workers have regular sexual partner/boy friend who are mostly addict. To sustain their drug habit they have to work even in a bad physical/ health condition. ● Before, most sex workers were addicted to drugs and alcohol. These days, many do not have such addiction problems. The main reason seems to be for monetary gain and comfort. ● The presence of pimp in a form of taxi driver, male addict partner, hotel manager and waiter is a well known today. ● These days, mobile phone facilitates sex work. ● The place for entertaining the client does not confined to Hotel alone but scattered to any places like open roadside to taxi back seat. ● We still do not have a red light area or Brothel. ● The functionaries of sex work in Aizawl besides the sex workers include pimps, the conveyors, the clients and boyfriends or girlfriends of sex workers.

NGOs staffs and functionaries	● Most common pattern of sex work is street based. They are contacted directly by the clients.Recently, the year of initiation of sex work begin at a very early age. ● Estimates of population size are also complicated by the large number of 'part-time' sex workers who are less likely to self-identify as a 'sex worker' because the job does not constitute their sole or primary source of income. More importantly, where women selling sex do not consider themselves as 'sex workers', their vulnerability to HIV may be heightened. ● Some of the sex workers became more professional and smart. ● Negotiation patterns has become mostly through Mobile phones. They fixed the place for picking up and head for a consensus venue for sex. ● Pimps these days were taxi driver, male partner, hotel/restaurant manager and waiter, lesbian friend, ex sex worker. They are the custodial of the sex workers phone number and they made arrangement for contact with sex workers. ● Most of the street based sex worker operate in group or have a partner as a protection strategy. ● Price tag: the price depends on the duration of the appointment. ● 1. quick session (Zuai)(restricted to one episode of sex) ● 2. Normal session (half day/ night) ● 3. One Night / Day 4. Escort ● These days, sex workers operated at night, day and also escort officers, business man etc. on tour inside and outside the state. ● The clientele in Aizawl: They are client who wish to fulfill their basic needs, who indulge in it for sheer fun and for experimenting and client who use it as a means of business and personal promotion. ● As perceived by new sex workers, sex work in Aizawl is associated with easy money, partying, drugs, peddling, ride, wine, lovers, dress, jewelry, shopping, latest gad get etc. ● Most of the secret based are educated, sophisticated and aristocratic type who are smartly dressed and mix freely in society. But most of them are so hidden that they cannot be reached by most of the service providers. They are very selective and have more control in choosing their clients. ● Most of the women sex workers opted for a pre paid sex in order to avoid non payment of under payment. ● The most common sex cruising sites are World Bank road, Capital Complex and Ranvamual.
CBOs Leaders	● Most common pattern of sex work is street based. ● Some of the sex workers are very young and some teenager boys were also often seen buying sex. ● Some workers are becoming more professional and smart. ● There are some sex workers operating in other state through a professional network.

CBOs Leaders	● Mobile phone has made it easier for both the client and the sex worker to arrange their activities. It has been observed that the secret sex workers change their sim card occasionally to maintain their secrecy and avoid mass exposer to network of clients. ● Majority of the pimp were Taxi Driver, they have their share for being a middleman, using his car for transportation or for the venue of sex. ● Sex workers live in a rented house sometimes used the house as a venue for sex work. ● There are also sex workers who accompany Govt' officers, contractors, suppliers when they are on tour or visiting their field. ● Sex workers who are more professional than other are also being used to please Big Govt' officer, business partner, their boses in order to gain something. ● Men with wealth and influence, nowadays, go in more and more for secret based due to the secrecy it involves. ● Before most clients of the street walkers were non mizo but these days majority are from the mizo community.
FBOs Leaders	● Before we have hotel and Bar acting almost like a brothel where madam control the sex work. It was close down when the production and sales of liquor was prohibited in 1988. ● Most the sex workers were streetwalker (street Based) till today. ● Since 2005 onward the presence of secret sex workers (Call Girls) is clearly evident. They use direct phone call for arranging their assignments/engagements and fixing their appointment. The local Taxi driver, Hotel Managers and agents are the guardian of their secret contacts numbers. ● The secret sex workers mainly operate in hotels, guest houses, government circuit and guest houses and give company to tourists, company executives, politicians, government officials, etc. who take them out for evenings or even weekends. ● The secret sex workers are college and school girls, working unmarried women and even housewives. They enjoy greater degree of autonomy compared to the streetwalkers as they can operate more independently and secretly without any disturbance from the legal authorities and local vigilances.

"Red light area kan nei lo na a, a duh tan chuan a ruk deuh emaw ualau deuh pawhin dawr theihin an awm reng ang a ni. District hrana mite pawhin Aizawlah KS an awm tih leh a dawr dan vel chu an hria tih a chiang "(Eventhough we do not have a specific Red Light Area, the services of a sex worker can be avail secretly or openly somewhere around the corner if desire. It is evident that the presence of sex workers

and the strategy to avail the services in Aizawl City is well known even in other districts.

" Hmeichhe tleirawlte thenkhatte chuan changkang loh hi an han hlau khawp a thawmhnaw changkang, mobile phone leh top up nan te hian an in zuar duh tawh a ni"(The pressure to lead fashionable life is so much that a young woman would be willing to sell herself to buy trendy cloths, mobile phone and even top up coupon).

7.2.3 Responses on Key issues to be addressed

KLs	Responses on Key Issues to be addressed
Law enforcement officials	● Ignorance of legal Rights ● Risk and vulnerability to any type of violence. ● Trafficking. ● Care and support for their children. ● Stigma and discrimination.
Government officials	● Alternate source of income which may be generated ● through skill building. ● Life skills and education needs. ● Absence of Night shelter. ● Lack of saving their income for future. ● Stigma and discrimination.
NGOs staffs and functionaries	● Prevention of HIV/AIDS and STI ● Need to focus more on the injecting drug users. ● Drugs related harm reduction. ● Binge drinking behaviour by clients and sex workers associated with improper condom usage. ● Children of sex workers ● Alternate source of income. ● Life skills and education – most of them are school drop- outs. ● Absence of Night shelter. ● Lack of saving their income for future. ● Stigma and Discrimination. ● Violence. ● Negotiating power. ● Low Risk Perceptions. ● There is a report on the clients unwilling to use condom.
CBOs Leaders	● Prevention fo HIV/AIDs and STI among women sex workers ● Children of sex workers ● Alternate source of income. ● Absence of Night shelter. ● Low morale, self esteem. ● Stigma and Discrimination. ● Violence. ● Addiction.
FBOs Leaders	● Attitute towards Sex workers ● Prevention of HIV/AIDs and STI among women sex workers.

FBOs Leaders	● Children of sex workers ● Alternate source of income. ● Absence of Night shelter. ● Low morale, self esteem. ● Stigma and Discrimination. ● Half way Home. ● Addiction. ● Pornography

"Khawtlangina kan hmuh/ngaih dan tlangpui chu mi sual, HIV thehdarh tu, mi hur, mi bawlhawh leh tangkai lo ang a ni a. He kan hmuh dan hian an nun a ngawng pawi thui em em a, kan in en fiah a ngai khawp mai" (The society perceived them as a sinner, vectors of HIV, whore, garbage and useless. This attitude towards them have a profound impact in their life and as a society we needs to introspect ourselves)

"*In zawrh hi atirah an thlang bik lo amaherawhchu chhungkaw kehchhia, ruihhlo ngaihna emaw nun inthlahdah ina a hrin chhuah a ni*."(sex work in Aizawl is rarely a preferred option for women but often is a consequence of a broken family and their addiction to substances or a careless/free lifestyle.)

7.2.4 Responses on Challenges

KLs	Responses on Challenges
Law enforcement officials	● Protection of their Rights. ● Capacity building of Law enforcement official directly dealing with sex worker. ● Good network with service providers. ● Prevention of trafficking and rescuing the victim.
Government officials	● Not adequate infrastructure for their economic rehabilitation. ● Lack of community intervention programme (Prevention etc.). ● Absence of Night shelter.
NGOs staffs and functionaries	● Covering all Female injecting drug users. ● Advocacy. ● Economic disenfranchisements. ● Sensitize the general community to accept Night shelter. ● Behaviour change. ● Sponsorship. ● Professionalism in sex work. ● Sex work without drugs and alcohol. ● Compliance with the court procedure.
CBOs Leaders	● Women empowerment. ● Sensitize the general community to accept sex workers as they are. ● An enabling environment for social re integration of sex workers.

FBOs Leaders	● Stigma and discrimination ● An enabling environment with the church community for social re integration of sex workers. ● Restoring dignity, image of God, self esteem. ● Creating a true Christian family. ● A separate budget for dealing with sex workers. ● To create an inclusive church community.

"Hmeichhe inzuar thinte mahni inrintawkna nei tur leh intodelh tura buatsaihte, chumaibakah HIV hna thawhna lama hmang tangkai tura buatsaih hi thil cho awm tak a ni. Hriselna ngaipawimawha tanpuina awm pan duhna thinlung nei tura siam puitlin pawh hi thil huphurhawm tak tih ngei ngai si a ni bawk" (Mobilising the Women Sex Worker Community to be confident, self sufficient, and also to be a part of solution in area of HIV intervention is a big challenge. To develop a health seeking behaviour is also another big challenge)

7.2.5 Responses on Services

KLs	Responses on Challenges
Law enforcement officials	● A separate women cell at Police station in Aizawl. ● Counseling and referral services at women cell. ● Legal guidance and awareness.
Government officials	● A 25 bedded Reception Centre/Protective Home for rehabilitating women sex workers. ● Two Detoxification and rehabilitation Centre. ● Observation Home. ● Integrated Child Protection Scheme (ICPS). ● Residential Institute and Training Centres (RITC) for women who are in need of care, protection and training for their security and self-employment. ● Women commission. ● Swardar a scheme for women in difficult circumstances. ● Targetted Intervention Programme for Female Sex Workers.
NGOs staffs and functionaries	● Peer community outreach programme. ● Drop in Centre. ● Needle Syringe Exchange Programme. ● Condom distribution. ● Abscess management. ● STI syndrome management. ● Psychological counseling. ● Referral to ICTC, PPTCTC, STI clinic, TB DOT, Detox, OST. ● Vocational training centre for livelihood initiative. ● Services to protect Human Rights.
CBOs Leaders	● Counselling ● Refferal. ● Orphanage Home in collaboration with Adoption cell, SWD. ● Facilitate Moral education camp

FBOs Leaders	● Detox and Rehabilitation Home. ● Refferal services. ● Prevention of Human Trafficking. ● Orphanage Home. ● Moral education camp. ● Pastoral/spiritual counseling. ● School of Theology ● Multipurpose training centre. ● Social workers.

"Kristiante chuan kum 2000 kalta a Isua Krista hmalakdan en chungin khawtlang ina mi sual ti a an hnawl te chu hmangaihtaka tuamdama tichak tur kan ni. Thiamloh chantir lovin hmangaih leh beiseina siamsak zawk tur kan ni. (As a Christian, we should consider the approach of Jesus Christ, who 2000 years ago loved, healed, and empowered those rejected by society as sinful. We are called not to judge but to love and offer hope.)

7.2.6 Responses on Suggestions

KLs	Responses on Suggestions
Law enforcement officials	● Red light area for a better monitoring of their health. ● Good coordination among key stakeholders. ● Formulate strategy to eliminate force and child sex work. ● Provides alternative income generation and long term support system. ● Concerted effort to eliminate stigma and discrimination associated with sex work. ● Educate them on safer sexual practice and to inculcate health seeking behavior. ● Detoxification and Rehabilitation for those who wanted to exit sex work. ● Right based approach.
Government officials	● School drop out prevention need serious attention. ● Family education at the community level for preventive measure. ● Setting up Night shelter. ● Providing livelihood options. ● Providing livelihood options. ● Protection from any form of violence. ● Sensitizing the general community not to stigmatize and discriminate sex workers but to understand them. ● Sensitizing the public on Human Trafficking. ● Rigorous outreach programme for the prevention of HIV and STI among sex workers. ● Sex Education and Parenting.

NGOs staffs and s functionarie	● Right attitude towards sex workers– non judgmental and inclusive. ● Creation of employment opportunities and job placements. ● Setting up Night shelter. ● Providing livelihood options. ● Protection from any form of violence. ● Sensitizing the public on Human Trafficking. ● Support the existing service providers morally, technically and financially. ● Innovative outreach strategies for the prevention of HIV and STI among sex workers. ● Normalize condom use. ● Sex education ● Sensitizing local vigilante.
CBOs Leaders	● Red Light Area. ● Moral Education Camp. ● Fight stigma and discrimination associated with sex work. ● Help the addict sex worker to recover. ● Support service providers. ● Sex education. ● To voice their needs through media.
FBOs Leaders	● Technical input to capacitate the social programme taken up by the church. ● Moral Education and Gospel Salvation Camp. ● Fight stigma and discrimination associated with sex work. ● Help the addict sex worker to recover. ● Support service providers. ● Economic empowerment/opportunities. ● Sex education.

7.3 CASE STUDIES

7.3.1 Case study (1): Parteii*

Mrs Parteii is a 35 yrs old woman, 5.2 ft. with curly hair and a fair complexion who hails from a family that migrated from a neighboring state in the early nineties. Her parents were divorced and she along with her mother and siblings migrated to Mizoram to begin life anew. When they reached Aizawl, they met one person who was her mother distant relative. He supported them whenever they needed help. He used to run a hair cutting saloon and Parteii used to run a pan shop nearby with his support. Parteii cherishes memories of the three years spent at school before her parent got divorced. She wanted to go to school but her mother did not encourage it. *"School uniform nena naupang school kal ka hmuh changte hian ka kal ve chak lutuk hi ka lung a chhe thin"(Sometime I feel like crying when I saw school children*

dressed in uniform on their way to school). She got married at the age of 19 years and continues to live in Aizawl with her husband and a 7 year old step daughter from previous marriage. Her husband used to be in government service and had been married before he married the client. He lost his previous wife in a road accident. Her mother remarried and began living in another village. Her brothers returned to the home state while her sister moved to another district in Mizoram. Some years ago, her husband was admitted to the hospital for dysentery and during his illness he began showing signs of fear for many things including darkness, death & medicines. He was diagnosed with psychiatric illness and admitted to the Psychiatric ward. Since then he has been unable to perform his role as bread winner in the family. On discharge he took to compulsive gambling. With Parteii's support, her step daughter is now married and she has 2 children & is expecting the third child.

Parteii started sex work in the year following her husband's hospitalization. One day, when she was on her way to buy her husband medicines and groceries, she lost all her money because her purse was stolen. In order to cover for this loss, she started selling herself. Her first client was introduced to her by her friend who has been working as *a secret sex worker*. She continued her sex work from that day onward as a secret sex worker. Her husband does not know her profession. He is under the impression that she engages in petty trade –Commissioning various articles like clothes, traditional lungis, and sometimes even sells alcohol (army issue). To authenticate, she even brings bottles of the alcohol and sells it to some of her trusted neighbors. She had experimented with alcohol in her early tender year but never continued its practice. There were many occasions when her client wanted to share a drink but she always refused them politely. She never abused other type of drugs and she is a very health conscious person.

Since she is a *secret* sex worker, she can be contacted only between 9:30 AM – 3:00PM. She is contacted mostly through Phone (cell) by her clients. She has also some friends working in hotels who were the custodians of her contact number. Her client base consists of men-in uniform posted here in the city & business men & Masons (*Mistiries*). She is very particular about her client base and protection of her privacy. In order to ensure her secrecy, she has never slept with a local man. She is fluent in Hindi and has no problem communicating with her clients who do not speak

her language. Her rates differ according to her clients. Some men pay her ` 500/- per act while others pay her between rupees ` 200 to 300/-. Parteii claims she usually has four to 5 clients per working day and she works 6 days a week and 4 weeks a month. Since she is a church goer she does not work on Sundays. Parteii says that she varies the location of her work depending on her clients. Sometimes a hotel is engaged when the client is able to pay and for others, it varies between hotels and rented accommodations of the clients. Duration of contact with her regular clients does not exceed more than a year since most of them are either mobile or transferred to other places.

Mrs. Parteii has had a good relationship with her clients- some of them keep in touch with her even after their transfer to other cities. She will remember one of her clients whom she likes very much as he is very caring and gentle and he also seems to long for her company. They will share together their joys and sorrows and even deep family matters. They were still in contact even though he had been transferred to other cities. She has never experienced any kind of violence from her clients. Though clients sometimes demand oral sex she has not been asked to perform any unusual sex. There are some clients who have tried to pay less on ground that they could not reached the climax.

A few years ago she came into contact with an intervention programme as she has a friend who is working as a Peer educator in an NGO working with FSWs. It was from them that she learnt about safe sexual behavior, HIV/ AIDS and the need for regular checkups. Ever since then, she has been having regularly tests and checkups.

She had a miscarriage within six months of her marriage and had to undergo 3 major operation including one for ovarian cyst over the last couple of years. She is very health conscious and ensures that she takes all her medications. Her clients usually carry condoms however, she usually carries her own supply as well. However, in order to avoid any mishaps like running out of a stock of condoms, she usually ensures that the hotel where she operates is also well stocked with condoms.

Marital problems including the fact that her husband gambles most of her hard earned money, has lead her to consider ending her marriage. She has also undergone

training in tailoring which also included a stipend of ` 600/- per month. Further, she has also been selected as one of the beneficiaries under piggery in the Government of Mizoram's NLUP Scheme. She dreams of giving up her sex work and opening a tailoring business one day.

Discussion

The case above illustrates how a product of a broken family, followed by unstable family environment, risky neighbourhood environment and lack of education have lead to *Parteii*, a young woman making poor choices in her marriage and ending up single after nearly fifteen years of marriage and pursuing sex work. Her lack of stability in the home and environment , followed by the fact that she had no role models in the environment have all culminated in her being unable to make the right choices. Further, a marriage with an unreliable husband has compelled her to take to a means of livelihood that offers her easy money despite having a poor education and virtually no skills set. Her struggle to maintain a family , raise a step daughter and fulfill both social and religious duties reveal the determination of a woman who has refused to give up. She maintained anonymity at all costs in respect of her sex work and lead a family life that raised no eyebrows. She has dreams like any other woman despite the fact that her life has been dreary and dull.

Parteii * (Fictitous Name)

7.3.2 Case study (2): Linda*

Linda is a dark complexioned woman, born in Aizawl to a *vai (*Non-Mizo) father and a Mizo mother. Her parents used to sell alcohol (Bootlegging) but got divorced when she was very young. Her mother continued selling liquor and remarried a few years later. Being born to a mixed marriage, Linda was beautiful and tall. However, her neighbors and schoolmates always branded her as being of weak morale and sinful because of her family business and her behavior. She was expelled from different schools mostly on ground of truancy and drugs related issues. She dropped out from school while studying in class X standard. When she was in her teens, her stepfather started showing his sexual attraction towards her. Her mother was aware of this fact & would show signs of jealousy. *"hemi avang hian inchhung*

nuam ka ti lo a, ka him bawk si lova khawlaia chhuah ka thlang zawk thin ani"(Because of this, I did not feel happy or safe at home and preferred going out instead). Since she spent most of her time with her friends, she started having sex and drinking alcohol & taking drugs from the age of 16 years. Since her mother was a bootlegger, she herself was also not faithful to her husband. She taught her daughter the art of seduction. When Linda was a teenager, she met a few men who were willing to marry her, but she was never encouraged to marry these men because her family preferred that she sells herself and earn money for the family. "*Nu tam ber chuan an fate tana tha ber tur an duh thin a,ka nu lawman ber erawh chu ka inzawrh a chhunkuaa sum ka theh luh chauhin a ni*" (*Most mothers want what is best for their child, but in my case my mother is most happy when I sell myself and contribute to the family income*). Linda started her career as a drug user at a very early age. She was already addicted to alcohol at the age of 15 years and also started to inject at the age of 17 and became a multiple drug user.

Linda usually operated from hotels and streets. Some few years back she even stayed in one such hotel occupying a single room and entertaining an average clientele of 5-8 per day. The hotel was raided and closed down thereafter so since then, she had to change the place of soliciting mostly to the street. Her clientele consists of men from various walks of life, of which officers were the most common. She was also often hired by businessmen/women to please high ranking officials & big suppliers in order to clinch business deals. The venue of sex varied depending on the client's choice (inside Cars, alleys, parks, highway, hotels and even private premises). Her income through sex work depended and varied as per sexual episode or duration of time spent with client. It ranges from ` 500 to 1000/-. *She has also been paid for being just a companion i.e. without sex*. There were also some clients who were very violent and some of them do not pay completely or as per agreement. She called this kind of incidence as 'bad date'. "*Mi dawrtute fel tak tak an awm lain, a fel lo tawn palh chu a hreawm thei khawp mai. Sum min pek duh loh chu thu hran nise, mi sawisak hrep duh tlat hi an awm thin" (Most of my clients were good but I have also come across some bad clients who are very violent and it is always painful. Refusal to pay is one case, there were clients who enjoy to harm us physical and sexually*). Taking these experiences as a lesson learnt she always opted for pre paid sex.

She was caught several times by the law enforcers due to possession of illicit drugs and selling drugs. Since it was always in small quantity she opted for a de-addiction centre instead of jail term. As soon as she got discharged from the centre she immediately continued her 'old' life again. This was her pattern of life before she had a regular boyfriend. At a very young age she eloped with her boyfriend and began living with him. They have been thrown out of the locality because she would be caught selling alcohol and drugs. She had been arrested & imprisoned because of this on many occasions. Many times the problem was compounded by the action taken by a local vigilance group. She was ridiculed, beaten; her hair cut off and kicked out from rented houses number of times. She has to start her business all over again in another locality and when that locality got aware of her status and business she would be thrown out again. She had attempted many other clean petty trades but always ended up bankrupt.

One event that she would like to remember is the time that she had spent in a government Home. It is the place where she learned how to control her craving for drug and also other life skills. She will never forget the emotional support that she had received specially from the counselor. It was from here that she learnt about safe sexual behavior, HIV/ AIDS and the need for regular checkups. It is a turning point for her life; a life without drugs. After her term was over in Protective Home she had attended moral camps organized by the YMA (CBO) and CKTP (FBO) for women like her and has emerged from these experiences with a positive spirit to help her peers.

Inspite of her effort to stop sex work she however continued although she believes that she has become more responsible to protect herself and others from HIV and STI. She has a friend who is working as a PE in the NGO from whom she avails all services including regular medical check up. So, far she is STI & HIV free. Inspired and motivated by the programme and staffs of the TI project she started her career in the field as a Volunteer and soon as a Peer Educator. *"Ka thiante tanpui thei tura Peer educator hna kan thawk tan kha chu ka phur ngei mai. Chakna thar ka nei niin ka inhria a chhan chu HIV laka keimah leh ka thiante himna atana hriat tur tul ka hriat tawh avangin" (When I join the programmes as a Peer Educator, I was so excited to experience the position that enable me to help my friends. I feel so*

empowered because I am now equipped with the necessary knowledge and skills in HIV prevention). As a Peer Educator she was known for her regular and meaningful contacts, wide knowledge of the context community network and her inherent skills in communication.

She has been working as a Peer Educator in the NGO run TI since 2009 and has stopped selling illicit drugs or alcohol earning her living by petty trade and piggery and she is now involved in the NGO and is a very active member of a CBO. She wishes that one day she will have prosperity and a good home.

DISCUSSION

The case above highlights that Linda born to a mixed married experienced a dysfunctional family due to her parents divorce at a very young age under the environment where alcohol is the main source of income compounded by sexual advances made by her step father. Stigma and ridicule affected her education, health and social life. A clear linked is seen between a broken home, neglect and multiple drug abuse and sex work.

The case also presents an environment of sex worker where violence plays a significant role, and is beyond her control. The case also highlighted a very close link between substance abuse, selling of drugs and sex work. An inhumane approach to eradicate sex work like ostracism, punishment in front of public, brutal beating carried out by some local vigilance group serves to only aggravate the problem leading to Sexually Transmitted Diseases viz. HIV.

Linda* (Fictitous Name)

7.3.3 Case study (2): Nutei*

Mrs **Nutei** was born in Myanmar, her parents divorced while her mother was pregnant with Mrs Nutei because of the father's drinking & violent behavior. When she was 3 years old, she went to live with her father who was an army man. She lived with her father and step mother for 13 years. She studied till class VIII. She spent most of the 13 years under constant abuse from her step mother. She was never allowed to play among other children. She came to Mizoram in 1988 with her father's

friend. On her way, she had a common cold and was given half a bottle cough syrup. Once she was senseless, she was gang raped. On reaching Aizawl she got employment as a house maid. The son of the employer started making sexual advances towards her. She therefore ran away to live with one of her friends who had also come from Burma. Her friend was employed by someone who owned a restaurant. This friend was working as a housemaid cum waitress. The restaurant was selling alcohol and was often used as soliciting place. The owners were evicted from the locality by the local community. It was from here that she started bootlegging (selling alcohol). One of her regular customers fell in love with her and took her home. However, once there she realized that he had been married many times in the past & his family was not interested in legitimizing the union with her. Even he was not making any efforts to make the relationship legal. She lived with him for about a month. At this point of time she met the owner of the restaurant where her friend was working previously. This woman informed her that she was now working as a manager in one hotel and told her to come and meet her if she needed a place to stay. She therefore left her partner and went to live with this woman. Since she did not have any job, the friend requested her to keep her hotel guests entertained by chatting with them & sometimes even having food. On one occasion, her fruit juice was laced with alcohol and she was made to sleep with one of the hotel guest who was a middle-aged man. It was from here that she started sleeping with guests in the hotel. Soon she developed excessive drinking behavior and most of her clients were indulge in binge drinking. The manager (her *friend*) dealt with all the financial transactions; She was never paid any money. At that point of time she was not aware of the importance of Condom use and it was dependent largely on whether her clients had it with them or not.

She was married in 1996 and had two children, who unfortunately died of pneumonia & Malaria. At this point of time, she had given up her sex work. However, four years later, she was divorced. From then on, she started selling alcohol again (bootlegging) & selling sex.

Her birth mother remarried and migrated from Myanmar to champhai twenty years ago. Mrs Nutei would, whenever possible send her mother money which was not very often. Later she brought her mother to Aizawl. It was to her that she would

run to whenever she was in trouble or ill. She was tested positive in 2008, after a prolonged illness. She was shocked, ashamed and devastated to learn that she was positive and became very bitter & resentful. *She wanted to infect as many persons as possible*. However, with the effective counseling that she received, she had a change of heart. However, her mother and her house owners refused to accept her back home. Project staff working among FSWs did their level best to help by providing her employment as PE and some even opened up their home for her.

After this, in spite of her status, she met a driver, who was willing to marry her. They have no children. Unfortunately, her husband died shortly after their marriage. She has however, been able to draw a monthly income of ` 6000/- pm from her husband's pension. With this income, plus other benefits that she received upon his death, she has brought her father (who is now paralyzed) from Myanmar and is now looking after him. She also supports her mother when ever needed. She has now decided that she would inform all her sexual partners about her status and encourage them to live a healthy sexual life.

Nutei * (Fictitous Name)

DISCUSSION

Family dysfunction has played a major role in the initiation and maintenance of sex work by the respondent. This case illustrates the very sad and tragic exploitation that women from vulnerable circumstances undergo. Being tricked into sex work (lacing her glass of fruit juice) manipulated to enter the trade (manager suggest and she entertains guests with company) and being placed at risk (not educated on condom use) or having sex under influence of drugs have lead to a dismal scene.

Despite parents being such poor role models and exercising no skills of parenting, Mrs Nutei has done her best to care for her parents. Her risk and exploitation have culminated in the contraction of HIV and her marriage has lead to some regular financial support. The case of a woman has been lead to a life of ill health, risk and exploitation who tries her level best to contribute in helping other people is indeed touching.

7.3.4 Case study (4): Bzi*

Ms **Bzi** is a 22 year old woman living on the outskirt of Aizawl. Her parents were divorced when she was 3 years old due to her father's infidelity. She has four siblings who are all married and living separately. She is the only one living with her father. After his divorce from Ms Bzi's mother, her father has been remarried several times. These women have always been alcoholics and her relationship with them was always bitter. Since childhood, she has always been a very lonely child. She had completed her education up to class V standard but could not continue due to financial reasons. She has to help her step mother to do the household chores and has to earn something doing labor work. When she was 12 years old, her friend took her to a neighbor's house where her friends drank. Here some of the people tried to assault & rape her, but they were unsuccessful. Her sexual debut was at the age of 16 years where she had consensual sex with her boyfriend. Her relation with her boyfriend ended when she discover that he has been cheating on her. She had an induced abortion secretly and the expenses was paid by her boyfriend. It was through this experience that she began to realize the important of barriers in sex. She was not happy at home and she always felt unwanted. When she was 17 years old, she fell from a rooftop and hurt her back. She did not receive any treatment because her family was not concerned. Since then her capacity to do hard work has decreased and this was always termed as 'bad behavior'. Her father has evicted her from the house several times. She used to take refuge in her elder brother's house but her brother who was supposed to help her also used to torture her when he was in a drunken state. When it was unbearable and severe she spent her nights in a relative or friend's house. She was disheartened and depressed and often thought of committing suicide.

Once during her early teens, while she was out with her friends, some people caught her & shaved her head. (This punishment is usually given by CBOs to women they consider as 'whores' or as someone exhibiting *improper* behavior). She however is not sure which organization the people who shaved her head represented. She stayed in her friend's house for more than one week and when she returned home she was battered badly and as a punishment she was not given proper food and confined to the house for one month. She started her sex work at the age of 18 years when one

of her friend introduced her to the trade. She started to contribute to the family income which made her parents very happy. Since then, she used to operate as a 'secret' sex worker not only in Aizawl but also in many parts of the district.

She has friends who were the custodian of her contact number and more often she operated independently catering to a few selected clients. The venue of sex is usually in a hotel and/or private premises. She has also a friend who acts as her pimp and who also provides or arranges a venue in his residence for her to offer sex to clients. The clients were a mixture of mizo and non mizo, mostly from middle class group. Even though she is not addicted to any type of drugs, she would not hesitate to take a few sips of wine if the client insists. Her rate/charge is as per sexual encounter or time spent with client i.e. whole night/day or as a companion to a tour and it ranges from ` 700 to 5000/-. The money is divided equally if the negotiation and arrangement is made by her contact holder. She works 4 days a week and 2 weeks a month. Her monthly income ranges from ` 10,000/ to 20,000/-. Most of her clients were married men and about 5% of them were her regular clients for the past 1 year.

Two years back, an outreach worker working in a Female Sex Workers Drop in Centre met her during her field visit. After a month of this incident she was persuaded to get STI and HIV test by the counselor. She got tested and was found to be positive in both STI and HIV. It took her as long as a month to recover from this shock on the diagnosis. From that day onwards she was linked to the DIC and ART centre from which she avails all services including regular medical check up. She is registered in ART Centre and has started her ART. Even in a weak health condition, she has to continue her work due to the pressure from her step mother. She often ran away from her home in order to avoid the pressure of sex work but when her savings was exhausted she had to return again to face the same problem. She has become weak physically and has few resources to attend to her health needs. The problem was compounded when she revealed her status to her parents. Her only source of strength is her boyfriend who is also *positive.*

She wanted to attend the camp organized by the YMA (CBO) for women like her. She dreamed of one day becoming a reformed woman. Her dearest wish was to be able to get married live in her own house with full dignity.

Her last days: In February 2012, the only NGO she linked up with received call from her step mother reporting that Ms Bzi has been sick for several days. She had been advised to take medicine from ART centre using card and inform her about Community Care Centre at Durtlang and Seventh Day Tlang. The NGO received this call on a Saturday and thought that the family will take necessary action. When the Outreach worker and counselor follow up the case on Monday it was learnt that nothing has been done to treat Ms. Bzi. She had died the next day.

DISCUSSION

This case also is and illustration of a woman who hails from a broken family, where morals and ethics were weak. The abandonment of her mother following the parents divorce was the start of a very tragic life that saw the respondent receive step motherly treatment, abuse exposure to bitter, contested relationships with step mothers, exposure to risk and violence as well as negligence.

Violent and aggressive behaviour in society leading to tonsuring of her hair and domestic violence culminated in her being forced to take to sex work. Ironically this lead to some happiness and stability as her income from sex work was appreciated by the family and actively encouraged by her step mother who wanted her income.

A woman who wished to live a life of dignity died tragically following the contraction of HIV/AIDS particularly because of poor home care and social support at home.

Bzi* (Fictitous Name)

CHAPTER VIII

CONCLUSION AND SUGGESTIONS

8. Conclusion and Suggestions

This study titled Women Sex Workers in Aizawl: A Situational Analysis is an attempt to explore the situation of sex workers and understand their profile, their socio-economic background, the causes for entry into sex work and implications of sex work in their life.

The previous chapter presented the results of the quantitative as well as qualitative study and discuss the results in the light of interpretation that were corroborated with earlier and relevant literature. The objectives of this study were to examine the nature of sex work in Mizoram and arrive at a categorization of women sex workers; to study the personal and social characteristics of women sex workers and to prepare a profile; to understand the impact of sex work on their health, families, societal relationship and social support and the last objective was to understand the gap between the existing services and the needs of women sex workers

The Methodology employed by the study included using a exploratory design that combined quantitative and qualitative method in data collection. All the registered clients in three agencies who have availed services in the last three years were included in the sampling frame. A total of 101 Women Sex Workers from adolescent age onwards, who are in Sex work for more than one (1) year were randomly selected on the basis of simple random sampling to serve as subjects for the study.

The main conclusion in this study are being presented in relation to the objectives.

8.1 Profile of Women Sex Workers in Aizawl

- The profile of Women Sex Workers in Mizoram reveal that an overwhelming majority of the respondents are below the age of 35 years. A fifth of the WSWs are in their early and late adolescent
- More than a third indulged in injecting drug use
- A majority of women sex workers have studied up to high school level.

- There are no injecting drug users who had studied beyond class 10
- In reference to marital status two-thirds of the respondents across both IDU and Non -IDU had never married.
- Women Sex workers who are married at a very young age, often below the age of 20 years indicating their vulnerability to exploitation and abuse.
- The conclusion with reference to religion does not reveal much diversity. However, among the Christians diversity is seen across denomination.
- Birth place and residence reveal interesting dynamics sharing international boundaries with Myanmar as at least some of the women sex workers admit to their birth origin in Myanmar. It is often being discussed that trafficking and porous borders contribute to the complex social problem in Mizoram and this finding therefore is testimony to it.
- Not all sex workers in Aizawl are domiciled in this district. This finding reveals that women are soliciting sex work in Aizawl even when they belong to other districts.
- Most of the women offering sex in this sample lived in urban areas and it therefore may be concluded that the profile of WSWs in Mizoram is largely urban.
- More than two- thirds of women sex workers belong to family where the parents had divorced, remarried or were widowed indicating that only a third came from a stable families.
- Interestingly a sixth of respondents were peddling alcohol/ drugs prior to entry into sex work. Almost two-thirds of the respondents were in occupations that rendered them vulnerable to exploitation and abuse prior their entry into sex work. Such occupation included domestic work, daily labour and sales jobs or street vending. This occupational profile of the respondents prior to sex work clearly outlines their vulnerability and exposure to jobs that are exploitative.

- Income and socio- economic background of respondents reveal that a more than half of the respondents belong to a low socio- economic background and lived in semi pucca, Assam type houses or on the street.

- When it comes to personal characteristics in relation to substance abuse, it may be concluded that over a third of WSWs are injecting drug users. In addition an overwhelming majority consume tobacco and have begun tobacco consumption at the age of 13 years. Almost all of them consume alcohol with a mean age of beginning alcohol consumption at the age of 16 years. Narco-analgesics are consumed by over a quarter of all respondents and over a fifth consumed pills orally and cough syrups indicating that there is a high level of drug abuse among respondents.

- An overwhelming majority had their first sexual experience before the age of 18 years indicating that initiation into sex has occurred very early in this sample of respondents. The first sexual partner in over half of the respondents was a boyfriend and in only a fifth of the cases they continue to be with their first sexual partner still. A large majority have had consensual sex during their first sexual encounter. However in more than a fifth forced sexual encounter took place indicating again the vulnerability of a woman in sex work is very high.

Based on the above it may be concluded that the average profile of woman sex workers is of someone young in age, not studied below class 10, has not married or married very young, Christian, belongs to Mizoram or Myanmar and is domiciled largely in Aizawl and has an urban residence. They belong to the lower socio economic background, broken family origin, high level of poly drug use and a third indulged in injecting drug use. In addition they had early sexual experience before 18 years of age by choice and exposed to jobs that are exploitative before entry into sex work.

8.2 Nature of sex work

- First sex work was begun by more than half of the respondents below the age of 18 years revealing that the sex workers in Mizoram are very young when they initiate sex work in Mizoram.

- An overwhelming majority were initiated into sex work by a women friend. Sex work in Mizoram seems to be largely consensual since most of them have reported that they had given consent before they began sex work.

- In almost all the cases except one, payment in sex work is done in cash revealing that monetary reasons are a major factor.

- Over a tenth of the sex workers had relatives who were also in sex work.

- In reference to nature a large majority have been involved in sex work for duration between one to six years.

- Less than two-thirds had initiated to sex work because they were attracted by the lifestyle it offered.

- Causes for sex work include peer pressure, financial reasons, drug addiction, family instability etc. Factors maintaining sex work also are largely to do with financial benefits and drug addiction.

- The client profile revealed that over two-thirds are between the ages of 18 to 35 years and maybe classified as youth. Most of them are married with only a fifth of them reporting that they have had single status client. Interestingly while almost all WSWs were Christians, clients belong to different religions (Hindu, Muslim and Christian). A large majority describe that their clients are either migrants or tourists/ visitors/ commercial drivers. Clients are also reported as being alcohol users in a majority of cases and drug users in a fifth of the sample. This increases the vulnerability of WSWs to violence, demands for sex that is not preferred by WSWs.

- A large majority of respondents offers sex at the frequency of one to four days and service up to five clients per day highly increasing their exposure and vulnerability to HIV/AIDS and other sexually transmitted diseases.

- Type of sex sought by client and type of sex offered reveal interesting differences. While vaginal sex is sought and offered by clients/ sex workers, anal sex is sought by a majority of clients and yet only one sex workers offered the same. Similarly there is a huge gap between the number of client who seek oral sex or genital stimulation and the number of sex workers who are willing to offer the same. This is likely to increase the vulnerability of sex workers to violence and force when they are unable to offer what clients demand.

- Income from sex work in a majority of a cases is between ` 5000/- to 20,000/- with a mean monthly income of ` 9384/-. This is a huge factor that initiates and maintains sex work in Mizoram.

- Conclusions regarding Risk Behaviour of WSWs reveal that a significant number of WSWs report that their clients use condoms only *sometimes* . A third admit to having had sex in exchange for drugs. Sex under the influence of alcohol and drugs by both clients and respondents reveal that it is an exceedingly common occurrence. Proves regarding use of condoms in situation where either or both were under the influence of drugs/ alcohol reveals that almost all of them have had the experience of not using during a sexual experience when either or both were under the influence of substances thereby increasing their risk.

- Less than half admit to having a 'protector' (sex work partner, female or male lover, male or female drug use partner and pimp). The role of protector is to ensure safety, ensure that payment is made, procure client when necessary and therefore it is interesting to know that over half of them have no such person to look after them for their interest.

- More than half of the respondents do not have a regular sexual partner which would indicate that they solicit and offer services to different partners daily. With reference to those who admit having regular sexual partners only a tenth admit to the use of condoms *always.*

8.3 Categorization of women sex workers in Aizawl

- Based on pattern of substance abuse two categories of WSWs in Mizoram are observed. Injecting drug users and non injecting drug users. The first category (IDU) are abusing Spasmo Proxyvon/parvon and Heroin. The second category of respondent do not inject however abuse other drugs orally or otherwise.

- Sex workers may be divided into three categories based on the place of operation for soliciting. The categories are Street based soliciting, Hotel based soliciting and Home based soliciting. Visibility of street based is more obvious, hotel based is partial and home based is secretive or invisible.

- The third categorization is based on venue of actual sex work which is again corresponds to the same three categories (Street based, Hotel based and Home based).

8.4. Impact of Sex Work

8.4.1 Impact on Health

- Alarmingly almost all have experienced violence in their life as a sex worker. A majority have experienced verbal violence often while less than half have experienced physical violence often and more than a tenth admit to often having experienced sexual violence. This finding corroborates the vulnerable and weak position of women sex workers whose lower socio- economic background, low levels of education, origin in broken families have all added to the position of vulnerability. Perpetrators of violence against WSWs reveal that parents, spouse/ partner, clients and friends are all included. Not too surprisingly a large majority have had sexual violence inflicted upon them when the perpetrator was under the influence of drugs or alcohol.

- Health of sex workers cannot be discussed without reference to their HIV status. A sixth of the respondents are HIV positive as per the study. Almost all the respondents report that they are unaware of clients status while a small number admit to being aware of more than one client who is HIV positive.

- Sexually Transmitted Infection (STI) is another major health concern among WSWs. All of them have had STI and almost all of them are aware of STI in their partner.

- Mental health of WSWs reveals that a tenth report feeling unhappy or depressed, losing self confidence, feeling worthless much more than usual following sex work. Similar observations have been substantiated from the case studies. Inability to concentrate, loss in sleep being under strain etc have also being reported and it may be reasonably concluded that WSWs do face tremendous amount of stress. Shockingly this is borne out by data that suggest that over two-thirds have attempted to commit suicide.

8.4.2 Impact of Sex Work on Children

- Only a third of the respondents has had children. Over a tenth reveal that they have had induced abortions in order to avoid the responsibility of bringing up children.

- Almost all the children have witnessed violence in the family at sometime. Verbal abuse is more common as compared to physical violence however almost all the children are perceived as being affected by the nature of work according to the respondents, indicating that there is a tremendous impact of sex work on children.

- Parenting is a main worry reported by WSWs and over a fifth of WSWs who had children also report that neglect of their children by themselves is a major area of concern that leads to psychological disturbance. All of them report that social acceptability of their children, financial constraints and the future of their children are major worries.

- Safety and security of their children, violence at home and abuse of drug and alcohol by children are sources of concerns of WSWs because of the impact of the nature of their work on the nature of their children.

- Food and nutritional needs, education and health of children are also major areas that get affected due to the nature of sex work.

8.5 Treatment for Substance Abuse

- An overwhelming majority across the groups and all in IDUs had been treated.

- Less than half have gone through a drug harm reduction based counseling and more than half in drug abstinence based counseling. More than half enter residential rehabilitation, an over- whelming majority to Health and moral education camp.More than a tenth received treatment for physical problem including abscess and less than a tenth availed drug substitution programme.

- Among all respondents Non Government Organisation are accessed as service provider by an overwhelming majority, with Faith Based Organisation more than three- quarters, Government Organisation a third, home based detoxification a fifth, and Traditional healer less than a tenth. All the IDUs respondents utilized the NGOs facilities for treatment.

8.6 Social Support of Women Sex Workers when Faced with Voilence

- In conclusion only a tenth admit to seeking social support *often* while more than half have never sought help. The sources of support are parents, siblings and relatives (primary social support); neighbours, friends (secondary social support) and NGO/CBO/Police/Health Care Providers and Religious Leaders (tertiary social support).

8.7 Awareness of Services in relation to needs of WSWs

- All respondents were aware of the community outreach programme while an overwhelming majority report awareness to gender sensitive prevention of HIV/AIDS materials, sterile needles and syringes, ICTC, Diagnosis and Treatment of STI, ART, PPTCT.

- Awareness of services for economic empowerment, legal support, Health and mental health, shelter and with regard to children is also rated as fairly good.

- Access of treatment of substance abuse was enquired because an overwhelming majority report having been treated for substance abuse. Such services was sought from a variety of settings.

8.8. Case Studies, Focus Group Discussions and KIIs.

- Four Case studies have been included and they illustrate the vulnerability factors that compel women to begin sex work. These factors include unstable family environments, risky neighborhoods, lack of education, alcoholism and substance abuse, poor role models, weak parenting, abandonment and abuse.
- Four groups of women sex workers participated in FGDs and discussed perception related to sex workers. They expressed that general community tend to perceive WSWs as deviant, criminals and those deserving of abuse and assault. Health care providers in NGOs were perceived as professional, understanding, enabling and supportive. The Church play a very important role in Mizoram and their perception is considered to be very important. In the opinion of WSWs, the Church considers them as sinners and were more interested in reforming them than in helping them.
- A total of 27 Key informants (KIs), 15 men and 12 women each were selected and interviewed comprising of Law enforcement officials, Concerned Government officials, functionaries of NGOs, CBOs and FBOs, Church Leaders of different denominations and Media persons. Open ended questions and probing was utilized to assess the knowledge and attitude of the KIs on the focus areas related to sex work in Aizawl. In some case repeated interviews were held. The results reveal there is an increasing trend in the number of sex workers that HIV prevalence and STI are high although many believed that the

incidence of new infection in HIV is decreasing. Factors motivating women into sex work reveal attraction to easy lifestyle and addiction. Vulnerability of WSWs to violence, stigma and trafficking are important. 'Secret based' sex work adds to the vulnerability of women and in the absence of a brothel or red light area in Mizoram, most WSWs operate in unsafe spaces. Key issues and challenges to be addressed include increasing care and support for WSWs and their children, life skill education, stigma and discrimination, violence, addiction and empowerment.

8. 9 Suggestions

The following are suggestions with social work implications that emanate from the findings of the research conducted and suggestions drawn from Key informants.

The suggestions of the study were broadly divided into three major heads viz. Efforts to stop entry of women in sex work, Protection and health-promotion for those involved in Sex work, Efforts to assist Women Sex Workers to exit from sex work at individual, community and policy level. This framework is adapted from Sahasrabudde, V and Sanjay Mehendale, 2008.

8.9.1 Individual level: *At the individual level the approach will be individual empowerment through appropriate education, access to healthcare and socio-economic development.*

Efforts to stop entry of women in sex work

- Information education and communication (IEC) materials and activities by providing correct, factual, evidence based information about Human Trafficking, legal Rights, Substance Abuse, HIV/AIDS to reach vulnerable population.

- The IEC should focus on decreasing the glamorous role of Women Sex Workers, drug use since most sex workers admit to entering sex work due to the attraction of lifestyle that it offers. Such efforts should increase knowledge

of the risks and danger involved in sex work and help in understanding all aspects of prostitution including recruiting tactics.

- Church ministers, volunteers and faith leaders can integrate drug prevention messages and activities into their sermons. Faith communities can help influence a teen's decision not to use drugs and other addictive substances.

- Life skills education to adolescent youth is an imperative that emanates from the study since most of the respondents have entered sex work at a very young age or have indulge in substance abuse in adolescence.

- Provision of accessible legal recourse for women who have been subjected to violence, marginalization and other vulnerability as exemplified by the case studies would prevent women from slipping into sex work and other risk behaviour.

- Oral Substitution Therapy for Female Injecting Drug Users is required.

Protection and health-promotion for those involved in Sex work

- Peer IEC approaches, where the peers and outreach workers lead the activities through one on one interaction and group session among the Women Sex Workers.

- Information Education and Communication (IEC) materials are developed to further augment safer sex and injecting practices and most importantly to inculcate health – seeking behaviour.

- Encourage savings for future security and also for more bargaining power during condom/ safe sex negotiation.

- Some Women Sex Workers, particularly those who work on the streets, struggle with mental health issues. The high levels of violence and abuse faced by street-based sex workers and witnesses can severely traumatize them. Surviving this by self-medication, including street drugs is common and inevitably leads to more complex mental health issues. *Addressing Mental health issues therefore is crucial.*

- *Safe work practice education and training* for the Women Sex Workers, community and the staff of the service providers to minimize the occurrence of any forms of violence, intimidation, coercion or exploitation from perpetrators. Development of safe work practice tool kits applicable for different categories of Women Sex Workers in Aizawl for ready reference.

- *Mitigation of associated problems* like alcoholism and substance abuse through specialized gender-responsive drug dependence treatment, including substitution treatment, for female drug users with and without children

- *Education and health promotion* for male clients and regular partners

- *Mobilising Sex Workers Community* for ownership of the programme for optimum use of services which is meant for them and also to increase their participation in the planning, implementation and monitoring of the programme. The Women Sex Workers themselves need to internalize this responsibility, by mobilizing themselves.

Efforts to assist Women Sex Workers to exit from sex work

- Sex workers need to have choices generated however they have to make their own decisions. This may be especially important for young sex workers.

- *Access to Women specific Detoxification, Rehabilitation and Social Re-integration programme*. It would be ideal if a more concrete economic rehabilitation scheme could be set up to increase the success rate of re-integration to help enhance their 'economic status'.

- *Psychological counseling* to address the entrenched lifestyle, low self esteem and feelings of social exclusion.

- *On leaving sex work, mental health services* should be available to support individuals with any psychological damage that they may have sustained whilst in the Sex Work.

- Development of personal skill sets to facilitate social re-integration.

- Development of Spirituality. Observation findings show that faith plays a critical role in their pathway to exits Sex Work therefore this need have to be beter addressed.

- Kin engagement as collaborative allies in supporting the exit process.

- Access to social, economic development and health services.

- Education and training to improve employment opportunities but also in helping to build self-esteem.

8.9.2 Community Level: *Broaden intervention in a community- development framework*

Efforts to stop entry of women in sex work

- Awareness education programme through public media on the nature of sex work and its consequences.

- Family education on substance abuse, HIV/STI, sex and sexualily, adolescent health, parenting skills etc.

- Sensitizing the general population on sex work, HIV/AIDS and Drug Abuse

- Promotion of broader gender- equality interventions

Protection and health-promotion for those involved in Sex work

- Identity formation, mobilization efforts and empowerment of Women Sex Workers to play proactive role in implementation to have ownership of the programme, thereby putting the protection and health promotion responsibility on those who are themselves at risk.

- Enabling environment: Creation of a non stigmatized and discriminated environment which facilitated access to information, services and commodities by Women Sex Workers. An effective enabling environment creates a reinforcing atmosphere for sustenance of safe practices and behaviour reducing their vulnerability.

- Condom promotion campaign.
- Providing emergency shelter (night shelter).
- Promotion of Oral Substitution Therapy for Female Injecting Drug User.
- Providing care for Women Sex Workers living with HIV/AIDS
- Providing care for children of Women Sex Worker
- Building linkages and networking among service providers and other key stakeholders like the Police, Social Welfare Department. Health department, Treatment Centres, NGOs working with Women Sex Workers, YMA (Young Mizo Association), MHIP (women organization) and the Churches.

Efforts to assist Women Sex Workers to exit from sex work

- Public Education to counter the idea that those in sex work do not deserve support, and to raise awareness of the issues associated with prostitution. Projects should make it clear that they aim to develop routes out. They should have good communication 'tools'.
- Training and awareness-raising sessions with statutory and other agencies to break down stereotypes and stigma.
- Greater involvement of the Church leaders and the faith youth groups in the rehabilitation and social re- integration efforts.
- Based on the case study IEC Interventions to mitigate stigma and discrimination are called for.
- Providing care and support for children of Women Sex Workers since most of the sex workers who have children are majorly concerned with regard to their childrens' future, needs and safety.
- Involvement of Church Leaders and Health care professional to improve the way society deals with Women Sex Worker.

8.9.3 Policy level: *Developing and sustaining policy frameworks that support individual and community- based interventions*

Efforts to stop entry of women in sex work

- Laws and policies for poverty alleviation, socio-economic development and gender equality

Protection and health-promotion for those involved in Sex work

- Establish clear policy framework for sex work, including options for legalization and/or licensing of sex work
- Strict laws against violence and exploitation of women
- Reorientation of health and social support services
- Developing women specific services.

Efforts to assist Women Sex Workers to exit from sex work

- Provision of Holistic intervention
- Provision of development opportunities by affirmative action.
- Making HIV/AIDS and health care provision for marginalized communities a significant agenda for policy makers and legislators

8.8.4 Suggestions for Research

- The mental health of this stigmatized population has largely been ignored as exemplified by the lack of research specific to the area of mental health and counseling services for sex workers.
- Quality research to identify factors that encourage and sustain stigma and discrimination in Society.
- Women sex Workers experiences high incident of Violence; a specific research to assess the situation is required.

APPENDICES

1. TABLES

1: Socio - Demographic Details

Sl.No	Characteristic	Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**N = 37**	**N = 101**
I	**Age of Respondents**			
	12 to 18 yrs	18	3	21
		(28.1)	(8.1)	(20.8)
	19 to 25 yrs	26	22	48
		(40.6)	(59.5)	(47.5)
	26 to 35 yrs	19	11	30
		(29.7)	(29.7)	(29.7)
	Above 36 yrs	1	1	2
		(1.6)	(2.7)	(2.0)
	Mean Age	22.8	24.6	23.4
II	**Educational Status**			
	Class I - IV	21	8	29
		(32.8)	(21.6)	(28.7)
	Class V - VIII	32	29	61
		(50.0)	(78.4)	(60.4)
	Class IX - X	7	0	7
		(10.9)	(0.0)	(6.9)
	HSSLC and above	4	0	4
		(6.3)	(0.0)	(4.0)
III	**Marital Status**			
	Married	6	3	9
		(9.4)	(8.1)	(8.9)
	Divorce	12	14	26
		(18.8)	(37.8)	(25.7)
	Never Married	45	18	63
		(70.3)	(48.6)	(62.4)
	Widow	1	2	3
		(1.6)	(5.4)	(3.0)
IV	**Age at Marriage**	**Injecting Drug User**		
		Yes	**No**	**Total**
		n = 19	**N = 19**	**N = 38**
	15 - 20	13	12	25
		(68.4)	(63.1)	(65.7)
	21 - 25	5	4	9
		(26.3)	(21)	(23.6)
	26 - 30	1	3	4
		(5.2)	(15.7)	(10.5)

Source: Computed. Figure in parentheses are percentages

2: Religion and denomination

Sl.No	Characteristic	Injecting Drug User		
		No	Yes	Total
		n = 64	n = 37	N = 101
I	**Religion**			
	Muslim	1	0	1
		(1.6)	(0.0)	(1.0)
	Christian	63	37	100
		(98.4)	(100)	(99.0)
II	**Denomination**			
	Presbyterian	46	25	71
		(71.9)	(67.6)	(70.3)
	The Salvation Army	6	6	12
		(9.4)	(16.2)	(11.9)
	UPC	6	1	7
		(9.4)	(2.7)	(6.9)
	Baptist	4	2	6
		(6.3)	(5.4)	(5.9)
	Others	1	1	2
		(1.6)	(2.7)	(2.0)
	Roman Catholic	1	2	3
		(1.6)	(5.4)	(3.0)

Source: Computed. Figure in parentheses are percentages

3: Birth place and residence

Sl.No	Characteristic	Injecting Drug User		
		No	Yes	Total
		n = 64	n = 37	N = 101
I	**Place of Birth**			
	Mizoram	62	36	98
		(96.9)	(97.3)	(97.0)
	Myanmar	2	1	3
		(3.1)	(2.7)	(3.0)
II	**District of Domicile**			
	Aizawl	58	36	94
		(90.6)	(97.3)	(93.1)
	Champhai	2	1	3
		(3.1)	(2.7)	(3.0)
	Serchhip	2	0	2
		(3.1)	(0.0)	(2.0)
	Kolasib	1	0	1
		(1.6)	(0.0)	(1.0)
	Mamit	1	0	1
		(1.6)	(0.0)	(1.0)

III	**Area of Residence**			
	Urban	53	33	86
		(82.8)	(89.2)	(85.1)
	Rural	11	4	15
		(17.2)	(10.8)	(14.9)

Source: Computed. Figure in parentheses are percentages

4: Family Particulars

Sl.No	**Characteristic**	**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Marital Status of Parents**			
	Married	25	12	37
		(39.1)	(32.4)	(36.6)
	Divorcee	19	16	35
		(29.7)	(43.2)	(34.7)
	Remarried	11	7	18
		(17.2)	(18.9)	(17.8)
	Widow or Widower	9	2	11
		(14.1)	(5.4)	(10.9)
II	**Size of Family**			
	1 to 3 members	15	14	29
		(23.4)	(37.8)	(28.7)
	4 to 6 members	41	18	59
		(64.1)	(48.6)	(58.4)
	7 to 9 members	7	4	11
		(10.9)	(10.8)	(10.9)
	10-12 members	1	1	2
		(1.6)	(2.7)	(2.0)
	Mean Size of Family	4.6	4.3	4.5

Source: Computed. Figure in parentheses are percentages

5: Occupation prior to sex work

Sl.No	Occupation	Injecting Drug User		
		No	Yes	Total
		n = 64	n = 37	N = 101
1	No Occupation	24	6	30
		(37.5)	(16.2)	(29.7)
2	Domestic Workers	6	9	15
		(9.4)	(24.3)	(14.9)
3	Drugs/Alcohol Peddling	9	6	15
		(14.1)	(16.2)	(14.9)
4	Self employed/Small Business	10	2	12
		(15.6)	(5.4)	(11.9)
5	Sales Women	3	7	10
		(4.7)	(18.9)	(9.9)
6	Daily Labourer	4	2	6
		(6.3)	(5.4)	(5.9)
7	Salaried Worker	5	1	6
		(7.8)	(2.7)	(5.9)
8	Street Vendor	1	4	5
		(1.6)	(10.8)	(5.0)
9	Drop - in Centre	1	0	1
		(1.6)	0.0	(1.0)
10	Student	1	0	1
		(1.6)	0.0	(1.0)

* Responses are not mutually exclusive

6: Monthly Household Income

Sl.No		Injecting Drug User		
		No	Yes	Total
		n = 64	n = 37	N = 101
I	Monthly Household Income (in Rupees)			
	1000-5000	10	7	17
		(15.6)	(18.9)	(16.8)
	6000-10000	30	16	46
		(46.9)	(43.2)	(45.5)
	11000-15000	13	5	18
		(20.3)	(13.5)	(17.8)
	16000-20000	5	4	9
		(7.8)	(10.8)	(8.9)
	21000-25000	3	1	4
		(4.7)	(2.7)	(4.0)
	26000-30000	2	1	3
		(3.1)	(2.7)	(3.0)
	31000 and Above	1	3	4
		(1.6)	(8.1)	(4.0)

	Mean Monthly Household Income (in Rupees)	11477	14314	12516
II	**Type of House**			
	Pucca	11	5	16
		(17.2)	(13.5)	(15.8)
	Semi- Pucca	15	8	23
		(23.4)	(21.6)	(22.8)
	Assam Type	33	18	51
		(51.6)	(48.6)	(50.5)
	Street	5	6	11
		(7.8)	(16.2)	(10.8)

Source: Computed. Figure in parentheses are percentages

7: Pattern of Substance Use

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
1	Tobacco	52	36	88
		(81.3)	(97.3)	(87.1)
	Mean age of begining Tobacco use (in years)	12.33	15.16	13.37
2	Alcohol	59	34	93
		(92.2)	(91.9)	(92.1)
	Mean age of beginning Alcohol use	15.55	16.97	16.07
3	Spasmo Proxyvon(SP)	3	29	32
		(4.7)	(78.4)	(31.7)
4	Pills	8	13	21
		(12.5)	(35.1)	(20.8)
5	Cough Syrup	9	12	21
		(14.1)	(32.4)	(20.8)
6	Heroin	0	19	19
		(0.0)	(51.4)	(18.8)
7	Solvent	3	8	11
		(4.7)	(21.6)	(10.9)
8	Cannabis	5	8	13
		(7.8)	(21.6)	(12.9)

*Figures not mutually exclusive

8: Sexual History

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**First Sexual Experience**			
	Less than 11 Years	1	0	1
		(1.6)	(0.0)	(1.0)
	12 to 18 Years	53	30	83
		(82.8)	(81.1)	(82.2)
	18 to 25 Years	10	6	16
		(15.6)	(16.2)	(15.8)
	25 to 35 Years	0	1	1
		(0.0)	(2.7)	(1.0)
	Mean age of first sexual encounter	15.98	15.59	15.84
II	**First Sexual Partner**			
	Spouse or Current Partner	12	8	20
		(18.8)	(21.6)	(19.8)
	Relative	10	4	14
		(15.6)	(10.8)	(13.9)
	Boy Friend (Lover)	33	18	51
		(51.6)	(48.6)	(50.5)
	Neighbour	1	1	2
		(1.6)	(2.7)	(2.0)
	Customer	0	1	1
		(0.0)	(2.7)	(1.0)
	Stranger	5	4	9
		(7.8)	(10.8)	(8.9)
	Other	3	1	4
		(4.7)	(2.7)	(4.0)
III	**Nature of First Sexual Encounter**			
	Consensual	51	27	78
		(79.7)	(73.0)	(77.2)
	By Force	13	10	23
		(20.3)	(27.0)	(22.8)

Source: Computed. Figure in parentheses are percentages

9: Sex Work History

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Age at First Sex Work**			
	Less than 11 Years	1	0	1
		(1.6)	(0.0)	(1.0)
	12 to 18 Years	40	17	57
		(62.5)	(45.9)	(56.4)
	18 to 25 Years	17	17	34
		(26.6)	(45.9)	(33.7)
	25 to 35 Years	6	3	9
		(9.4)	(8.1)	(8.9)
	Mean Age at First Sex Work	18.92	19.86	19.27
II	**Person Who Introduced Respondent to Sex Work**			
	Relative	2	1	3
		(3.1)	(2.7)	(3.0)
	Women Friend	58	35	93
		(90.6)	(94.6)	(92.1)
	Men Friend	1	1	2
		(1.6)	(2.7)	(2.0)
	Stranger	3	0	3
		(4.7)	(0.0)	(3.0)
III	**Initiation of Sex Work**			
	Consent	55	33	88
		(85.9)	(89.2)	(87.1)
	Not knowing	8	2	10
		(12.5)	(5.4)	(9.9)
	By Force	1	2	3
		(1.6)	(5.4)	(3.0)
IV	**Mode of Payment**			
	Cash	63	37	100
		(98.4)	(100)	(99.0)
	Kind	1	0	1
		(1.6)	(0.0)	(1.0)
V	**Family Member Sex Worker**			
	None	60	28	88
		(93.8)	(75.7)	(87.1)
	Sister	1	4	5
		(1.6)	(10.8)	(5.0)
	Relative	3	5	8
		(4.7)	(13.5)	(7.9)

Source: Computed. Figure in parentheses are percentages

10 : Nature of sex work

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Duration of Involvement in Sex Work**			
	1 to 2 Years	17	4	21
		(26.6)	(10.8)	(20.8)
	3 to 4 Years	28	22	50
		(43.8)	(59.5)	(49.5)
	5 to 6 Years	15	8	23
		(23.4)	(21.6)	(22.8)
	7 Years and above	4	3	7
		(6.3)	(8.1)	(6.9)
	Mean Years of Duration of Involvement in Sexwork	3.7	4.2	3.8
II	**Place of Operation for Soliciting**			
	Street	29	31	60
		(45.3)	(83.8)	(59.4)
	Hotel in city	22	5	27
		(34.4)	(13.5)	(26.7)
	Home	13	1	14
		(20.3)	(2.7)	(13.9)
III	**Venue of Sex Work**			
	Street	8	4	12
		(12.5)	(10.81)	(12.12)
	Hotel in city	49	33	82
		(76.6)	(89.2)	(81.2)
	Home	7	0	7
		(10.9)	(0.0)	(6.9)
IV	**Frequency of Change in Place of Operation**			
	Never	8	0	8
		(12.5)	(0.0)	(7.9)
	Sometimes	23	6	29
		(35.9)	(16.2)	(28.7)
	Often	33	31	64
		(51.6)	(83.8)	(63.4)

Source: Computed. Figure in parentheses are percentages

11: Factors in initiation and maintenance of Sex Work

Sl.No	Characteristic	Injecting Drug User		
		No	Yes	Total
		n = 64	N = 37	N = 101
I	**Initiation into Sex Work**			
	Attracted by the lifestyle	40	22	62
		(62.5)	(59.5)	(61.3)
	Friends motivates you into sex work	36	20	56
		(56.3)	(54.1)	(55.4)
	Due to financial reason	25	9	34
		(39.1)	(24.3)	(33.7)
	Drug Addiction motivates into sex work	11	20	31
		(17.2)	(54.1)	(30.7)
	Divorce leads to sex work	8	9	17
		(12.5)	(24.3)	(16.8)
	Death of husband leads into sex work	1	2	3
		(1.6)	(5.4)	(3.0)
	Depression	2	0	2
		(3.1)	(0.0)	(2.0)
	By default	0	1	1
		(0.0)	(2.7)	(1.0)
II	**Factors Contributing for Continuing Sex Work**			
	Financial Benefits	43	19	62
		(67.2)	(51.4)	(61.4)
	Drug addiction	14	21	35
		(21.9)	(56.8)	(34.7)
	No alternate work to generate income	11	4	15
		(17.2)	(10.8)	(14.9)
	Enjoy sex work	1	1	2
		(1.6)	(1.0)	(2.0)
	Absence of Support System for Long term Settlement	0	2	2
		(0.0)	(5.4)	(2.0)

*****Figures not mutually exclusive

12: Sex Work Pattern

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
I	**Frequency of Sex Work in a Week**	**n = 64**	**N = 37**	**N = 101**
	1-2 days	22	22	44
		(34.4)	(59.5)	(43.6)
	3-4 days	37	14	51
		(57.8)	(37.8)	(50.5)
	5 days & above	5	1	6
		(7.8)	(2.7)	(5.9)
II	**No. of Clients per Day**			
	Less than 3	43	19	62
		(67.2)	(51.4)	(61.4)
	3 to 5	17	17	34
		(26.6)	(45.9)	(33.7)
	5 & above	4	1	5
		(6.3)	(2.7)	(5.0)
III	**Regularity of Clients**			
	Less than 5%	36	26	62
		(56.3)	(70.3)	(61.4)
	5% to 10%	13	7	20
		(20.3)	(18.9)	(19.8)
	10% to 15%	9	4	13
		(14.1)	(10.8)	(12.9)
	Above 15%	6	0	6
		(9.4)	(0.0)	(5.9)

Source: Computed. Figure in parentheses are percentages

13: Type of Sex

Sl.No		Injecting Drug User		
		No	Yes	Total
I	**Type of Sex Sought by Clients**	n = 64	n = 37	N = 101
	Vaginal sex	64	37	101
		(100.0)	(100.0)	(100.0)
	Oral sex	50	31	81
		(78.1)	(83.8)	(80.2)
	Anal sex	47	24	71
		(73.4)	(64.9)	(70.3)
	Genital stimulation	45	25	70
		(70.3)	(67.6)	(69.3)
	All (Vaginal, Anal, Oral Genital)	41	21	62
		(64.1)	(56.8)	(61.4)
II	**Type of Sex Offered**			
	Vaginal sex	64	37	101
		(100)	(100)	(100)
	Anal sex	0	1	1
		0.0	(2.7)	(1.0)
	Oral sex	25	14	39
		(39.1)	(37.8)	(38.6)
	Genital stimulation	8	2	10
		(12.5)	(5.4)	(9.9)

* Figures not mutually exclusive

14 : Income from Sex Work

Sl.No		Injecting Drug User		
		No	Yes	Total
I	**Monthly Income from Sex Work**	n = 64	n = 37	N = 101
	Below ` 5000	19	11	30
		(29.7)	(29.7)	(29.7)
	` 5,000 to 7,500	12	5	17
		(18.8)	(13.5)	(16.8)
	` 7,500 to 10,000	15	11	26
		(23.4)	(29.7)	(25.7)
	` 10,000 to 20,000	11	4	15
		(17.2)	(10.8)	(14.9)
	Above ` 20,000	7	6	13

		(10.9)	(16.2)	(12.9)
	Mean Monthly Income from Sex Work	9423	9316	9384
II	**Pattern of Spending Income**			
	For Personal	46	34	80
		(71.9)	(91.9)	(79.2)
	For foods, snacks etc.	62	36	98
		(96.9)	(97.3)	(97.0)
	For Drugs, Alcohol	57	37	94
		(89.1)	(100.0)	(93.1)
	For dressing clothes, materials	50	30	80
		(78.1)	(81.1)	(79.2)
	For Medical expenses	5	4	9
		(7.8)	(10.8)	(8.9)
	For Family	25	12	37
		(39.1)	(32.4)	(36.6)
	For Kids	6	11	17
		(9.4)	(29.7)	(16.8)
	Have any Saving	15	5	20
		(23.4)	(13.5)	(19.8)

*Figures not mutually exclusive

15 : Clientele

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Age of clients(in years)**			
	18 to 25 yrs	18	10	28
		(28.1)	(27.0)	(27.7)
	25 to 35 yrs	22	21	43
		(34.4)	(56.8)	(42.6)
	above 35 yrs	24	6	30
		(37.5)	(16.2)	(29.7)
II	**Marital Status of Client**			
	Single	16	5	21
		(25.0)	(13.5)	(20.8)
	Married	46	32	78
		(71.9)	(86.5)	(77.2)
	Migrant Married single	2	0	2
		(3.1)	0.0	(2.0)
III	**Religion of Clients**			
	Hindu	10	2	12
		(15.6)	(5.4)	(11.9)
	Muslim	13	4	17
		(20.3)	(10.8)	(16.8)
	Christian	41	31	72

		(64.1)	(83.8)	(71.3)

Source: Computed. Figure in parentheses are percentages

4.16 Client Characteristics

		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
	Migrants	53	21	74
		(82.8)	(56.8)	(73.3)
	Rural	32	31	63
		(50.0)	(83.8)	(62.4)
	Tourists/Visitors	27	20	47
		(42.2)	(54.1)	(46.5)
	Commercial Drivers	8	9	17
		(12.5)	(24.3)	(16.8)
	Personal Characteristics of Clients			
	Alcohol user	42	29	71
		(65.6)	(78.4)	(70.3)
	Adolescent and unmarried youth	39	28	67
		(60.9)	(75.7)	(66.3)
	Drug users	7	13	20
		(10.9)	(35.1)	(19.8)
	Client with sexual dysfunction	6	6	12
		(9.4)	(16.2)	(11.9)

* Figures not mutually exclusive

17 : Source of Referral of Clients

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
V		**n = 64**	**n = 37**	**N = 101**
1	Other women sex workers	49	28	77
		(76.6)	(75.7)	(76.2)
2	Self referrals	44	23	67
		(68.8)	(62.2)	(66.3)
3	Direct approach by client	26	31	57
		(40.6)	(83.8)	(56.4)
4	Referral by other clients	32	14	46
		(50.0)	(37.8)	(45.5)
5	Hotel staffs and agents	28	10	38
		(43.8)	(27.0)	(37.6)

* Responses are not mutually exclusive

18: Risk Behavior

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Use of condoms by Clients**			
	Always	43	29	72
		(67.19)	(78.38)	(71.29)
	Sometimes	21	8	29
		(32.81)	(21.62)	(28.71)
II	**Drugs, Alcohol and Sex Work.**			
	Had sex in exchange for drugs			
	Never	49	16	65
		(76.56)	(43.24)	(64.36)
	Sometimes	13	20	33
		(20.31)	(54.05)	(32.67)
	Often	2	1	3
		(3.13)	(2.70)	(2.97)
	Clients under the influence of alcohol			
	Never	6	0	6
		(9.38)	(0.00)	(5.94)
	Sometimes	20	12	32
		(31.25)	(32.43)	(31.68)
	Often	38	25	63
		(59.38)	(67.57)	(62.38)
	Clients under the influence of drug			
	Never	30	0	30
		(46.88)	(0.00)	(29.70)
	Sometimes	21	30	51
		(32.81)	(81.08)	(50.50)
	Often	13	7	20
		(20.31)	(18.92)	(19.80)
	Both under the influence of alcohol			
	Never	6	2	8
		(9.38)	(5.41)	(7.92)
	Sometimes	33	22	55
		(51.56)	(59.46)	(54.46)
	Often	25	13	38
		(39.06)	(35.14)	(37.62)
	Both under the influence of drugs			
	Never	51	12	63
		(79.69)	(32.43)	(62.38)
	Sometimes	10	18	28
		(15.63)	(48.65)	(27.72)

	Often	3	7	10
		(4.69)	(18.92)	(9.90)
	Above situations how often you used condom			
	Sometimes	11	18	29
		(17.19)	(48.65)	(28.71)
	Often	53	19	72
		(82.81)	(51.35)	(71.29)
	Do not used any form of substance			
	No	64	37	101
		(100.00)	(100.00)	(100.00)
III	**Perceptions related to Substance Abuse and Sexual Experience**			
	Alter sexual experience			
	No	19	0	19
		(29.69)	(0.00)	(18.81)
	Yes	45	37	82
		(70.31)	(100.00)	(81.19)
	Drugs/ alcohol makes sex more enjoyable			
	No	23	15	38
		(35.94)	(40.54)	(37.62)
	Yes	41	22	63
		(64.06)	(59.46)	(62.38)
	Drugs /alcohol makes sex less painful			
	No	47	11	58
		(73.44)	(29.73)	(57.43)
	Yes	17	26	43
		(26.56)	(70.27)	(42.57)
	Less nervous and become confident during sexual encounter			
	No	34	15	49
		(53.13)	(40.54)	(48.51)
	Yes	30	22	52
		(46.88)	(59.46)	(51.49)

19: Presence of 'Protector'

Sl.No	Present Protector	Injecting Drug User		
		No	Yes	Total
		n = 64	n = 37	N = 101
	Have no protector	30	25	55
		(46.9)	(67.6)	(54.5)
	Sex work partner	13	3	16
		(20.3)	(8.1)	(15.8)
	Female lover	6	2	8
		(9.4)	(5.4)	(7.9)
	Male drug using partner	5	3	8
		(7.8)	(8.1)	(7.9)
	Pimp	3	1	4
		(4.7)	(2.7)	(4.0)
	Female Drug using partner	2	1	3
		(3.1)	(2.7)	(3.0)
	Male lover	5	2	7
		(7.8)	(5.4)	(6.9)

20: Risk Behaviour with Regular Sex Partner (RSP)

Sl.No		Injecting Drug User		
		No	Yes	Total
		n = 64	N = 37	N = 101
I	**Has Regular Sexual Partner**			
	Yes	29	14	43
		(45.31)	(37.84)	(42.57)
	No	35	23	58
		(54.69)	(62.16)	(57.43)
		Injecting Drug User		**Respondents with RSP**
		No	**Yes**	
		n = 29	**N = 14**	**N = 43**
II	**Drug use of Regular Sexual Partner**			
	Yes	26	10	36
		(60.46)	(23.25)	(83.72)
	No	4	3	7
		(9.3)	(6.97)	(16.27)
III	**Consistency of Condom Use with RSP**			
	Never	5	6	11
		(11.62)	(13.95)	(25.58)
	Always	9	0	9
		(20.93)	(0.00)	(20.93)

	Sometimes	15	8	23
		(34.88)	(18.6)	(53.48)

21: Particulars of Children

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**No. of Children**			
	None	48	19	67
		(75.00)	(51.35)	(66.34)
	1	10	14	24
		(15.63)	(37.84)	(23.76)
	2	5	4	9
		(7.81)	(10.81)	(8.91)
	4	1	0	1
		(1.56)	(0.00)	(0.99)
II	**Bereavement of Child**			
	No	63	36	99
		(98.44)	(97.30)	(98.02)
	Yes	1	1	2
		(1.56)	(2.70)	(1.98)
III	**No. of Induced Abortions**			
	None	54	34	88
		(84.38)	(91.89)	(87.13)
	Once	8	3	11
		(12.50)	(8.11)	(10.89)
	Twice	2	0	2
		(3.13)	(0.00)	(1.98)

22: Violence Experienced by Children

Sl.No	Problem	Non IDU	IDU	Respondent with Child
				Total
		n = 15	**n = 19**	**N = 34**
I	**Experience of physical violence by Children**			
	Never	11	11	22
		(73.33)	(57.89)	(64.70)
	Sometimes	5	7	12
		(33.33)	(36.84)	(35.29)
II	**Experience of Verbal Abuse at home by Children**			
	Never	1	3	4
		(06.66)	(15.78)	(11.76)
	Sometimes	10	16	26
		(66.66)	(84.21)	(76.47)

	Often	4	0	4
		(26.66)	(0.00)	(11.76)
III	**Withness of violence in the family by Children**			
	Sometimes	15	18	33
		(100)	(94.73)	(97.05)
	Often	0	1	1
		(00.00)	(05.26)	(02.94)
IV	**Nature of work affects children**			
	To a great extent	5	4	9
		(33.33)	(21.05)	(26.47)
	To some extent	10	16	26
		(66.66)	(84.21)	(76.47)
	Not at all	1	0	1
		(06.66)	(0.00)	(02.94)

Source: Computed. Figure in parentheses are percentages

23: Worry about Children

Sl.No	Main Worry	Non IDU	IDU	Respondent with Child Total
		n = 15	n = 19	N = 34
I	**Parenting**			
	To a great extent	7	11	18
		(46.66)	(57.89)	(52.94)
	To some extent	7	7	14
		(46.66)	(36.84)	(41.17)
	Not at all	1	1	2
		(06.66)	(05.26)	(05.88)
II	**Parental Neglect**			
	To a great extent	11	11	22
		(73.33)	(57.89)	(64.70)
	To some extent	6	6	12
		(40.00)	(31.57)	(35.29)
III	**Finance**			
	To a great extent	9	11	20
		(60.00)	(57.89)	(58.82)
	To some extent	7	7	14
		(46.66)	(36.84)	(41.17)
IV	**Future**			
	To a great extent	7	13	20
		(46.66)	(64.42)	(58.82)
	To some extent	7	7	14
		(46.66)	(31.57)	(41.17)
V	**Social Acceptability**			

	To a great extent	9	15	24
		(60.00)	(78.94)	(70.58)
	To some extent	6	4	10
		(40.00)	(21.10)	(29.41)
VI	**Childrens' behavior**			
	To a great extent	6	12	18
		(40.00)	(63.15)	(52.94)
	To some extent	11	5	16
		(73.33)	(26.31)	(47.05)
VII	**Abuse of drug and alcohol by children**			
	To a great extent	7	11	18
		(46.66)	(57.89)	(52.94)
	To some extent	11	5	16
		(57.89)	(26.31)	(47.05)
VIII	**Safety and Security**			
	To a great extent	7	11	18
		(46.66)	(57.89)	(52.94)
	To some extent	5	11	16
		(33.33)	(57.89)	(47.05)
IX	**Violence at home**			
	To a great extent	9	15	24
		(60.00)	(100)	(70.58)
	To some extent	4	6	10
		(26.66)	(31.57)	(29.41)

Source: Computed. Figure in parentheses are percentages

24: Needs of children

Sl.No	**Needs of Children**	**Non IDU**	**IDU**	**Respondent with Child**
				Total
		n = 15	**n = 19**	**N = 34**
I	**Food/nutrition**			
	To a great extent	6	10	16
		(40.00)	(52.63)	(47.05)
	To some extent	9	9	18
		(60.00)	(47.36)	(52.94)
II	**Education**			
	To a great extent	7	13	20
		(46.66)	(64.42)	(58.82)
	To some extent	8	6	14
		(53.33)	(31.57)	(41.17)
III	**Health**			
	To a great extent	8	12	20
		(53.33)	(63.15)	(58.82)
	To some extent	7	7	14

		(12.50)	(21.62)	(41.17)

* Computed, figures in parenthesis are percentages

25: Impact on Health

Sl.No	Experience of Violence	Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Experience any violence in life**			
	Yes	62	37	99
		(96.88)	(100)	(98.02)
	No	2	0	2
		(3.13)	(0.00)	(1.98)
II	**Experience verbal violence**			
	Never	2	0	2
		(3.13)	(0.00)	(1.98)
	Sometimes	14	9	23
		(21.88)	(24.32)	(22.77)
	Often	48	28	76
		(75.00)	(75.68)	(75.25)
III	**Experienced physical violence**			
	Never	6	0	6
		(9.38)	(0.00)	(5.94)
	Sometimes	35	18	53
		(54.69)	(48.65)	(52.48)
	Often	23	19	42
		(35.94)	(51.35)	(41.58)
VI	**Experience sexual violence**			
	Never	18	6	24
		(28.13)	(16.22)	(23.76)
	Sometimes	41	24	65
		(64.06)	(64.86)	(64.36)
	Often	5	7	12
		(7.81)	(18.92)	(11.88)

*Responses not mutually exclusive

26: Perpetrator

Sl.No	Perpetrator	Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	Parents	48	30	78
		(75.00)	(81.08)	(77.23)
II	spouse/partner	25	21	46
		(39.06)	(56.76)	(45.54)
III	Clients	26	19	45
		(40.63)	(51.35)	(44.55)
IV	Friends	25	14	39

		(39.06)	(37.84)	(38.61)
V	local vigilance	21	13	34
		(32.81)	(35.14)	(33.66)
VI	Relatives	21	12	33
		(32.81)	(32.43)	(32.67)
VII	Siblings	10	10	20
		(15.63)	(27.03)	(19.80)
VIII	Police	11	8	19
		(17.19)	(21.62)	(18.81)
IX	Neighbors	10	3	13
		(15.63)	(8.11)	(12.87)
X	Employer	2	2	4
		(3.13)	(5.41)	(3.96)
XI	Pimp	0	2	2
		(0.00)	(5.41)	(1.98)

* Responses not mutually exclusive

27: Voilence as Consequences of Sex Work

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
I	**Sexual violence when perpetrator is under the influence of substances**	**n = 64**	**n = 37**	**N = 101**
	Never	20	7	27
		(31.25)	(18.92)	(26.73)
	Sometimes	22	11	33
		(34.38)	(29.73)	(32.67)
	Often	22	19	41
		(34.38)	(51.35)	(40.59)
II	**Physical injury as consequences of sex work**			
	Never	22	3	25
		(34.38)	(8.11)	(24.75)
	Sometimes	36	22	58
		(56.25)	(59.46)	(57.43)
	Often	6	12	18
		(9.38)	(32.43)	(17.82)

*Responses are not mutually exclusive

28: Knowledge about HIV

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	Know the Problem of HIV/AIDS	64	37	101
		(100)	(100)	(100)

II	Source of Information			
	Interpersonal Communication	20	8	28
		(31.25)	(21.62)	(27.72)
	Mass Media and Interpersonal	44	29	73
		(68.75)	(78.38)	(72.28)
III	Current Sexual Practice Put you at risk	8	18	26
		(12.50)	(48.65)	(25.74)
IV	Current Sexual Partner at Risk	15	9	24
		(23.44)	(24.32)	(23.76)
V	Clients are at risk	22	9	31
		(34.38)	(24.32)	(30.69)
	HIV Status			
VI	**Ever tested for HIV**	58	36	94
		(90.63)	(97.30)	(93.07)
VII	**HIV Status of Respondent**			
	Positive	5	13	18
		(7.81)	(35.14)	(17.82)
	Negative	50	21	71
		(78.13)	(56.76)	(70.30)
	Don't know	9	3	12
		(14.06)	(8.11)	(11.88)
VIII	**No of clients with HIV**			
	Don't know	62	35	97
		(96.88)	(94.59)	(96.04)
	1 to 2	2	2	4
		(3.13)	(5.41)	(3.96)

Source: Computed. Figure in parentheses are percentages

29 : STI Status

Sl.No	**Problem**	**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	Respondent			
	Pain during sexual intercourse	15	10	25
		(23.44)	(27.03)	(24.75)
	Difficulty, Pain, Burining During Urination	11	11	22
		(17.19)	(29.73)	(21.78)
	Frequent Urination	19	18	37
		(29.69)	(48.65)	(36.63)
	Significant weight loss (more than 15%)	6	7	13
		(9.38)	(18.92)	(12.87)
	Continuous diarrhea	0	4	4
		(0.00)	(10.81)	(3.96)
	Fever, cough lasting more than one month	2	4	6
		(3.13)	(10.81)	(5.94)

	Other Gynaecological Problems	2	3	5
		(3.13)	(8.11)	(4.95)
II	Partner			
	Partner having pain during urination	14	9	23
		(21.88)	(24.32)	(22.77)
	Partner having wounds, sores, abscess in penis	12	8	20
		(18.75)	(21.62)	(19.80)
	Partner having yellowish greenish discharge from penis	5	3	8
		(7.81)	(8.11)	(7.92)

* Responses not mutually exclusive

30: Perceived Mental Health

30.1

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Been feeling unhappy or depressed**			
	Not at all	3	1	4
		(4.69)	(2.70)	(3.96)
	No more than usual	17	5	22
		(26.56)	(13.51)	(21.78)
	Rather more than usual	41	22	63
		(64.06)	(59.46)	(62.38)
	Much more than usual	3	9	12
		(4.69)	(24.32)	(11.88)
II	**Been losing confidence in self**			
	Not at all	4	3	7
		(6.25)	(8.11)	(6.93)
	No more than usual	25	8	33
		(39.06)	(21.62)	(32.67)
	Rather more than usual	32	20	52
		(50.00)	(54.05)	(51.49)
	Much more than usual	3	6	9
		(4.69)	(16.22)	(8.91)
III	**Been thinking as worthless person**			
	Not at all	9	4	13
		(14.06)	(10.81)	(12.87)
	No more than usual	30	11	41
		(46.88)	(29.73)	(40.59)
	Rather more than usual	24	22	46
		(37.50)	(59.46)	(45.54)

	Much more than usual	1	0	1
		(1.56)	(0.00)	(0.99)
IV	**Feeling reasonably happy all things considered**			
	More so than usual	3	1	4
		(4.69)	(2.70)	(3.96)
	Same as usual	13	7	20
		(20.31)	(18.92)	(19.80)
	Less than usual	48	25	73
		(75.00)	(67.57)	(72.28)
	Much less than usual	0	4	4
		(0.00)	(10.81)	(3.96)

Source: Computed. Figure in parentheses are percentages

30.2

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Able to concentrate on what's done**			
	Better than usual	2	1	3
		(3.13)	(2.70)	(2.97)
	Same as usual	32	18	50
		(50.00)	(48.65)	(49.50)
	Less than usual	29	15	44
		(45.31)	(40.54)	(43.56)
	Much less than usual	1	3	4
		(1.56)	(8.11)	(3.96)
II	**Lost much sleep over worry**			
	Not at all	23	9	32
		(35.94)	(24.32)	(31.68)
	No more than usual	2	0	2
		(3.13)	0.00	(1.98)
	Rather more than usual	37	26	63
		(57.81)	(70.27)	(62.38)
	Much more than usual	2	2	4
		(3.13)	(5.41)	(3.96)
III	**Felt that you are playing useful part in things**			
	More so than usual	4	3	7
		(6.25)	(8.11)	(6.93)
	Same as usual	26	12	38
		(40.63)	(32.43)	(37.62)
	Less than usual	34	17	51
		(53.13)	(45.95)	(50.50)

	Much less than usual	0	5	5
		0.00	(13.51)	(4.95)
IV	**Been able to face up problems**			
	More so than usual	6	0	6
		(9.38)	0.00	(5.94)
	Same as usual	35	11	46
		(54.69)	(29.73)	(45.54)
	Less than usual	21	20	41
		(32.81)	(54.05)	(40.59)
	Much less than usual	2	6	8
		(3.13)	(16.22)	(7.92)

* Computed. Figures in parentheses are percentages

30.3

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
I	**Felt capable of making decisions about things**	**n = 64**	**n = 37**	**N = 101**
	More so than usual	4	3	7
		(6.25)	(8.11)	(6.93)
	Same as usual	30	12	42
		(46.88)	(32.43)	(41.58)
	Less than usual	27	21	48
		(42.19)	(56.76)	(47.52)
	Much less than usual	3	1	4
		(4.69)	(2.70)	(3.96)
II	**Felt constantly under strain**			
	Not at all	17	5	22
		(26.56)	(13.51)	(21.78)
	No more than usual	2	1	3
		(3.13)	(2.70)	(2.97)
	Rather more than usual	44	31	75
		(68.75)	(83.78)	(74.26)
	Much more than usual	1	0	1
		(1.56)	(0.00)	(0.99)
III	**Felt couldn't overcome difficulties**			
	Not at all	6	1	7
		(9.38)	(2.70)	(6.93)
	No more than usual	28	11	39
		(43.75)	(29.73)	(38.61)
	Rather more than usual	30	24	54
		(46.88)	(64.86)	(53.47)

	Much more than usual	0	1	1
		(0.00)	(2.70)	(0.99)
IV	**Able to enjoy normal day to day activities**			
	More so than usual	3	0	3
		(4.69)	(0.00)	(2.97)
	Same as usual	28	9	37
		(43.75)	(24.32)	(36.63)
	Less than usual	29	23	52
		(45.31)	(62.16)	(51.49)
	Much less than usual	4	5	9
		(6.25)	(13.51)	(8.91)

* Computed. Figures in parentheses are percentages

30.4

Sl.No		**Injecting Drug User**		
		No	**Yes**	**Total**
I	**Unhappy and hopeless, felt life is not worth living**	**n = 64**	**n = 37**	**N = 101**
	Often	19	10	29
		(29.68)	(27)	(28.7)
	Sometimes	34	23	57
		(53.12)	(62.16)	(56.43)
	Never	11	4	15
		(17.18)	(10.81)	(14.85)
II	**Attempted to Commit Suicide**			
	Often (more than twice)	8	14	22
		(12.5)	(37.83)	(21.78)
	Sometimes (once or twice)	27	16	43
		(42.18)	(43.24)	(42.57)
	Never	27	7	34
		(42.18)	(18.91)	(33.66)

* Computed.Figures in parentheses are percentages

31: Awareness of Services and Support

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
	Community Outreach by Female Peer Educators	64	37	101
		(100)	(100)	(100)
	Gender sensitive HIV/AIDS prevention and care material	46	35	81
		(71.88)	(94.59)	(80.20)
	Access to sterile needles and syringes	48	37	85
		(75.00)	(100.00)	(84.16)
	Voluntary HIV testing and counseling	52	35	87
		(81.25)	(94.59)	(86.14)
	Diagnosis and treatment of STI	51	35	86
		(79.69)	(94.59)	(85.15)
	Antiretroviral treatment for female drug users	15	23	38
		(23.44)	(62.16)	(37.62)
	Services for prevention of mother to child HIV transmission	32	29	61
		(50.00)	(78.38)	(60.40)
	Services related to vocational training & employment of women	17	6	23
		(26.56)	(16.22)	(22.77)
	Micro finance programme for women	5	3	8
		(7.81)	(8.11)	(7.92)
	Legal support and advocacy services for women	8	7	15
		(12.50)	(18.92)	(14.85)
	Safe housing and shelter	31	23	54
		(48.44)	(62.16)	(53.47)
	Mental health services	41	33	74
		(64.06)	(89.19)	(73.27)
	Nutritional supplementation programmes	27	25	52
		(42.19)	(67.57)	(51.49)
	Services for children	22	10	32
		(34.38)	(27.03)	(31.68)

*Responses are not mutually exclusive

32: Treatment for Substance Abuse

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	Treated for substance abuse	53	37	90
		(82.81)	(100)	(89.11)
II	**Process Mode of Treatment**			
	Drug Harm Reduction Based Behaviour Change Counselling	8	37	45
		(12.50)	(100)	(44.55)
	Drug Abstinence Based Counseling	22	37	59
		(34.38)	(100)	(58.42)
	Residential Rehabilitation	22	37	59
		(34.38)	(100)	(58.42)
	Treatment for physical problem including abscess	0	13	13
		(0.00)	(35.14)	(12.87)
	Health and Moral education	53	37	90
		(82.81)	(100)	(89.11)
	Drug substitution	0	4	4
		(0.00)	(10.81)	(3.96)
III	**Agencies Providing Treatment**			
	Receieved traditional healing	0	3	3
		(0.00)	(8.11)	(2.97)
	Government Organistion	15	19	34
		(23.44)	(51.35)	(33.66)
	Non Governmental organisation	53	37	90
		(82.81)	(100)	(89.11)
	Faith Based Organisation	46	34	80
		(71.88)	(91.89)	(79.21)
	Home based detox	2	19	21
		(3.13)	(51.35)	(20.79)

*Responses are not mutually exclusive

33: Support Sought and Received When Faced with Violence

Sl.No		Injecting Drug User		
		No	**Yes**	**Total**
		n = 64	**n = 37**	**N = 101**
I	**Ever Sought Help**			
	Never	37	14	51
		(57.81)	(37.84)	(50.50)
	Sometimes	26	15	41
		(40.63)	(40.54)	(40.59)
	Often	1	8	9
		(1.56)	(21.62)	(8.91)
II	**Source of Support**			
	Primary			
	From parents	6	1	7
		(9.38)	(2.70)	(6.93)
	From friends	18	15	33
		(28.13)	(40.54)	(32.67)
	From siblings	4	6	10
		(6.25)	(16.22)	(9.90)
	From inlaws	2	0	2
		(3.13)	(0.00)	(1.98)
	Secondary			
	From friends	18	15	33
		(28.13)	(40.54)	(32.67)
	From neighbor	3	3	6
		(4.69)	(8.11)	(5.94)
	Tertiary			
	From NGO/CBO	13	19	32
		(20.31)	(51.35)	(31.68)
	From doctor	5	9	14
		(7.81)	(24.32)	(13.86)
	From religious leaders	8	1	9
		(12.50)	(2.70)	(8.91)
	From police	1	3	4
		(1.56)	(8.11)	(3.96)

*Figures not mutually exclusive

34: Socio-demographic particulars of respondents for focus groups

1. *FGD conducted during the gospel camping organized by CKTP*.

SL. No	Name	Category	Age	Marital status	Education	District
1	Jenny	Street based	22	Unmarried	X	Aizawl
2	Betsy	Street based	21	Unmarried	IX	Aizawl
3	Zualboihi	Hotel Based	19	Unmarried	V	Aizawl
4	Sang sangi	Hotel Based	24	Unmarried	VII	Aizawl
5	Nautei	Home Based	26	Divorced	XI	Aizawl
6	Rosi	Street Based	23	Unmarried	X	Aizawl
7	Maseni	Home Based	19	Unmarried	IX	Aizawl
8	Rem Remi	Hotel Based	26	Divorced	XII	Aizawl
9	Mami	Street Based	24	Unmarried	X	Aizawl
11	BKi	Hotel Based	24	Unmarried	VII	Aizawl
12	Amtei	Street Based	19	Unmarried	VI	Saiha

* All names are fictitious to protect identity of respondents

2. *FGD conducted at Protective Home run by SWD, Mizoram*.

SL. No	Name	Category	Age	Marital status	Education	District
1	Teruati	Street based	23	Unmarried	IX	Aizawl
2	Moitei	Street based	23	Unmarried	VII	Aizawl
3	Maengi	Hotel Based	23	Unmarried	VI	Aizawl
4	Asawmi	Hotel Based	32	Divorced	VII	Serchhip
5	Teremi	Street Based	28	Divorced	X	Aizawl
6	Betty	Hotel Based	21	Unmarried	VII	Champhai
7	Zotei	Street Based	23	Unmarried	X	Mamit
8	Dingpuii	Hotel Based	24	Unmarried	X	Aizawl
9	Mimi	Street Based	19	Unmarried	IX	Aizawl
10	Siamteii	Street Based	23	Divorced	VI	Aizawl
11	Makongi	Street Based	27	Divorced	X	Aizawl
12	Nutei	Hotel Based	23	Divorced	VII	Aizawl
13	Lucy	Street Based	21	Unmarried	VI	Kolasib

* All names are fictitious to protect identity of respondents

3. *FGD conducted among Female Sex Workers registered in Female Sex Workers Drop in Centre run by New Life Home Society, Mizoram.*

SL. No.	Name	Category	Age	Marital status	Education	District
1	Bzi	Home Based	22	Unmarried	V	Aizawl
2	Parteii	Home Based	35	Married	VI	Aizawl
3	Sangpuii	Hotel Based	25	Unmarried	VII	Aizawl
4	Gracei	Home Based	24	Unmarried	Graduate	Aizawl
5	Asiami	Hotel Based	28	Divorced	X	Aizawl
6	Tetei	Home Based	21	Unmarried	IX	Aizawl
7	Omteii	Street Based	22	Unmarried	X	Aizawl
8	Mapuii	Hotel Based	24	Unmarried	X1	Aizawl
9	Jenny	Street Based	19	Unmarried	IV	Aizawl
10	Saitei	Street Based	23	Unmarried	V	Aizawl

* All names are fictitious to protect identity of respondents

4. *FGD conducted among Female Sex Workers registered in Female sex Workers Drop in Centre run by Volunteers for Community Mental Health(VOLCOMH), Mizoram.*

SL. No.	Name	Category	Age	Marital status	Education	District
1	Tluangtei	Street Based	22	Unmarried	VI	Serchip
2	Eli	Street Based	25	Unmarried	IV	Aizawl
3	Mimitei	Street Based	21	Unmarried	VII	Aizawl
4	Madawngi	Street Based	19	Unmarried	V	Aizawl
5	Msi	Hotel Based	26	Divorced	X	Aizawl
6	Mazuii	Hotel Based	23	Unmarried	X	Aizawl
7	Ruthi	Street Based	21	Unmarried	V	Aizawl
8	Zikpuii	Hotel Based	22	Unmarried	X1	Aizawl
9	Debo	Street Based	18	Unmarried	V	Aizawl
10	Amtei	Street Based	27	Divorced	V1	Aizawl
11	La la i	Hotel Based	25	Unmarried	VII	Lunglei

* All names are fictitious to protect identity of respondents

35. Particulars Respondents for Key Informant Interviews

Sl.No	Key Informants		Date of Interviewed	Duration
		Designations		
A	**Law enforcement officials**			
A1	*Police personnel*			
	1	Officer in charge of Women Cell, Aizawl	08.12.2011	2:00 hrs
	2	CID Crime, Senior Supdt of Police.	10.01.2012	1: 00 hr
A2	*Judicial Magistrate*			
	1	Member secretary, Mizoram State Legal Service authority	13.12.2011	1:00 hrs
A3	*Excise and Narcotic*			
	1	Asst Commissioner of Excise and Narcotics (enforcement)	16.01.2012	1: 00 hr
B	**Concerned Government Officials**			
B1	*Social welfare department*			
	1	Deputy Director, Directorate Social Welfare Department	13.01.2012	1: 00 hr
	2	Case worker, Protective Home, Social Welfare Department	11.12.2012	2:30 hrs
B2	*Department of Health and Family Welfare*			
	1	Counselor, ART Centre	20.04.2012	2:00 hrs
	2	Counsellor, ICTC	20.04.2012	1: 00 hrs
B3	*Mizoram Social Defence and Rehabilitation Board (MSD&RB)*			
	1	CEO, Mizoram Social Defence and Rehabilitation Board (MSD&RB)	24.01.2012	2:00 hrs
	2	Training Officer, STRC	24.01.2012	2:00 hrs
B4	*Mizoram State AIDS Control Society (MSACS)*			
	1	Asst Director Targetted Intervention Division, (MSACS)	02.12.2011	2:00 hrs
C	**Non- Government Organisation**			
C1	*Volunteers for Community Mental Health(VOLCOMH)*			
	1	Project Director, FSW TI Project	13.01.2012	2: 00 hrs
C2	*New Life Home Society(NLHS)*			
	1	Project Manager, FSW TI Project	18.12. 2011	2: 00 hrs
C3	*Human Rights and Law Network(HR&LN)*			
	1	Chairman	12.01.2012	1: 30 hrs
C4	*Ferrando Integrated Women Development Centre (FIWDC)*			
	1	Director, Peace Home, Durtlang	20.08.2008	2: 00 hrs
D	**Community-Based Organisation**			
D1	*MHIP(Mizo Women organization)*			
	1	President, MHIP General Hdqr. Mizoram, Aizawl	16.01.2012	1: 30 hrs
D2	*Young Mizo Association(YMA)*			
	1	CYMA Treasurer, CADS Department,	12.01.2012	1: 30 hrs

		CYMA office		
D3	*MUP (Mizoram Elderly People Association)*			
	1	General Secretary, MUP General Hqrs.	08.12.2011	1: 30 hrs
D4	*ESTHER (Women Sex Workers CBO)*			
	1	President	15.01.2011	2:00 hrs
E	**Print Media**			
E1	*Zalen (Sunday News Magazine)*			
	1	Editor and Publisher	07.12.2011	1:00 hrs
F	**Faith-Based Organisation**			
F1	*Church Leaders*			
	1	Presbyterian Church: Moderator, Mizoram Synod Office/ Chairman of MKHC(Mizoram Church Leaders Commt	14.12. 2011	1: 00 hr
	2	Baptish Church : Head Assistant, Executive Secretary Office, Baptish House, Aizawl	13. 12. 2011	1: 00 hrs
	3	Salvation Army: Secretary for Programme Administration	15.12. 2011	1: 30 hrs
F2	*Synod Social Front*			
	1	Asst. Coordinator Social Front, Synod Office	16. 12. 2011	1: 30 hrs
F3	*Community Health Action Network(CHAN)*			
	1	Programme Coordinator	07.12. 2011	1: 30 hrs
F4	*Catholic Relief Service(CRS)*			
	1	Project Manager, Main Office, Aizawl	24.08.2009	1: 00 hr
F5	*CKTP (An Apex Body of Presbyterian Youth Federation)*			
	1	CKTP Executive committee member	08.12. 2011	1: 00 hr
	2	CKTP Executive committee member	30.09. 2011	1: 00 hrs

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APPENDICES

INTERVIEW SCHEDULE (ENGLISH)

3. INTERVIEW SCHEDULE (ENGLISH)

INTERVIEW SCHEDULE FOR RESEARCH

on

Women Sex Workers in Aizawl: A Situational Analysis

under the

Department of Social Work

Mizoram University

Supervised by

Dr. Kalpana Sarathy

Associate Professors

Code No.

CONFIDENTIAL FOR RESEARCH PURPOSE ONLY

WSW Consent

Greetings. My name is Samuel Lalzarlawma Sailo and I am a Research Scholar from Department of Social Work , Mizoram University. I am carrying out a study among women sex workers in Aizawl in order to understand the nature of sex work in Mizoram and various problems that they faced. A particular focus will be on trying to understand the impact of Sex Work on their health, families, and social supports. This study would help us to address some of the specific problems that women in such situations face, so that appropriate services can be planned in such situations.

I request you to answer the questions frankly and as truthfully as possible. I can assure you that anything you say will be confidential. Your participation in this study is entirely voluntary and you can refuse to answer any question that you do not wish to answer.

Is there anything you would like to ask me? If I am unable to answer your question, I will clarify the same with the supervisor of this study and provide you the information.

Signature/thumbprint of respondent Signature of interviewer

(Optional)

Date:

Checklist to be completed by interviewer before starting the interview:

(Tick the appropriate boxes)

Introduction and purpose of interview mentioned	
Confidentiality of information emphasized	
Explained that participation is voluntary	
Obtained informed consent	

Women Sex Worker Consent

Greetings. My name is …….…….…….…….…… and I am investigating on a study among women sex workers in Aizawl in order to understand the nature of sex work in Mizoram and various problems that they face. A particular focus will be on trying to understand the impact of Sex Work on their health, families and social supports. This study would help us to address some of the specific problems that women in such situations face, so that appropriate services can be planned in such situations.

I request you to answer the questions frankly and as truthfully as possible. I can assure you that anything you say will be confidential. Your participation in this study is entirely voluntary and you can refuse to answer any question that you do not wish to answer.

Is there anything you would like to ask me? If I am unable to answer your question, I will clarify the same with the Research Scholar of this study and provide you the information.

Signature/thumbprint of respondent Signature of interviewer

(Optional)

Date:

Checklist to be completed by interviewer before starting the interview:

(Tick the appropriate boxes)

Introduction and purpose of interview mentioned	
Confidentiality of information emphasized	
Explained that participation is voluntary	
Obtained informed consent	

Interview Schedule No:

PLACE	
NGO	

Date of Interview: --/--/----
dd/mm/yyyy

1. Personal and Household Information

1.Social – Demographic profile

1.1.1. Name of Respondent _____

1.1.2. Age _____

1.1.3. Status: ☐ *(single response. Record appropriate code)*

1=Old client of the DIC
2=Regular client
3=newly identified

1.1.4. Religion: ☐ (single response. Record appropriate code)

1=Hindu
2=Muslim
3=Christian
4=Others

1.1.5. Religious denomination if Christian: ☐ (single response. Record appropriate code)

1=Presbyterian
2=Baptish
3=Roman Catholic
4=Savation Army
5=UPC
6=others

1.1.6. Area of residence: ☐ *(single response. Record appropriate code)*

1=urban
2=rural

1.1.7. Place of Birth : _____

1.1.8. District of Domicile(living presently) :_____

I am going to ask you some questions regarding your present living arrangements. . Could you please tell me who you live with at present (last six months). Please mention all the members and their relationship to you.

1.2 Household Information

1.2.1. ***How many family members are living together*?** ☐☐

If more than 10, list the 10 oldest members. For coded columns record appropriate code for each person

Relationship to respondent	Age (in completed years)	Sex M=Male F=Female	Completed Years of Education	Marital status 1= never married 2= married 3= presently single (widowed, divorced, separated, deserted etc) 4=re married 5=other
(Respondent)Myself		F		
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

1.2.2 **Tick respondent status as appropriate** (tick only one box)

1= Married ☐

2=Divorcee ☐

3=Never Married ☐

4=Widow ☐

If respondent never married, SKIP to 1.2.4]

1.2.3. ***What was your age at the time of your first marriage?*** ☐☐

1.2.4 ***What kind of accommodation do you presently (last 6 months) live in****?* (tick only one box)

1= Pucca House(Floor, roof and walls cemented) ☐

2= Semi-Pucca (Temporary roof, could be with cemented floor and wall or any one of this) ☐

3= Kuchha (Thatched roof, mud walls, no flooring) ☐

4= Live on the street ☐

5= Others (specify) ☐

1.2.5. ***Please tell me what your approximate household income was last month (calendar month):***

☐☐☐☐☐☐☐

[(Please include income of all household members from salary, business, agriculture, self employment, rent, pension, etc)]

1.2.6. ***What percent of your family income do you contribute?*** ☐

[(Single response. Record appropriate code number from categories indicated)]

1=100%
2= more than 75%, but less than 100%
3=50-75%
4=25%- less than 50%
5= less than 25%
6=none

2. Respondent Substance Use

2.1 ***Many people use tobacco, alcohol or drugs in different forms. The following questions relate to your use of these substances. Please think carefully and answer the following:***

[If all categories of substance had No for ever use (coded 2) SKIP to 3]

Have you ever used any of the following: **(Mention first category of substance. For each ask if ever used. If answer is yes, go through each of the questions. Then go to the next substance category*)**	*Ever used* 1=Yes 2=No	If ever used, *age at first use*	*Ever Injected* 1=Yes 2=No	*Used in last 12 months* 1=yes 2=No	*Mode of Use (last 12 months) Smoking=1 Oral=2 Chasing =3 Sniffing/huffing =4 Injecting =5 Multiple modes, including injecting =6 Other =7 (specify)*	*Using in last one month* 1=daily or nearly daily 2= at least once a week 3= less than once a week 4=never (one response only)
Tobacco						
Alcohol						
Cannabinoids (ganja, charas, hashish, marijuana)						
Sleeping pills (valium, calmpose, alprax, nitrosun)						
Cough Syrup with codeine						
Buprenorphine						
Proxyvon						
Heroin (Brown Sugar)						
Hallucinogens (LSD, magic mushrooms)						
Solvents (petrol, erasex)						
Cocaine and other stimulants						
Others(specify)						

2.2. ***Have you ever been treated for substance abuse?*** (tick one response only)

Yes ☐ No ☐ Don't know ☐ No response ☐

[If No Skip to 3]

2.3. ***What kind of treatment have you received so far?*** (For each prompt tick yes or no)

(Prompt)	**Yes**	**No**
Counselling in Drug Harm Reduction	☐	☐
Counselling in Drug Abstinence	☐	☐
Self Help Group(AA/NA)	☐	☐
Residential Rehabilitation	☐	☐
Treatment for physical problem including abscess	☐	☐
Health and Moral education	☐	☐
Detoxification with medication	☐	☐
Drug Substitution	☐	☐

2.4. ***Where did you receive treatment so far?*** (for each prompt tick appropriate response)

(Prompt)	**Yes**	**No**
Traditional healer	☐	☐
Government organisation	☐	☐
Private health care setting	☐	☐
Non governmental organisation	☐	☐
Faith Based organisation	☐	☐
Home based detox	☐	☐

3. Sexual Partner Information

3.1

I will ask you a questions about your partner. Please answer these questions to the best of your knowledge.

Sl.no	**Statement**	**Yes**	**No**	**I Don't have RSP**
1	I have a partner with whom I regularly have sex			
2	My regular sexual partner abuse substances (Specify)			
3	We used condom consistently during sexual encounter			

4. Children

4.1. ***Do you have any children?*** **(tick one box only)** **Yes** ☐ **No** ☐

4.2. ***Do you have any children who pass away?*** **(tick one box only)** **Yes** ☐ **No** ☐

4.3. ***The following questions are with respect to your living children.***

Gender of child in birth order (M=male, F=female)	Present Age of child	Current educational level or maximum educational level child has attained (in number of years of formal education)	Problems with the child 1= serious physical illness needing hospitalisation 2= behavioural* 3= academic 4=emotional** 5= tobacco use 6 =alcohol use 7= other drug use**(tick all problem categories that apply for each child)**						
			1	2	3	4	5	6	7

**behavioural includes truancy (bunking school), running away from home, lying, stealing, aggressive behaviour, and involvement in petty crime*

*** emotional includes depression, anxiety, being withdrawn, self injurious behaviour*

4.4. ***Have any of your children experienced physical violence at home****?*
(tick one box only)

Often ☐ Sometimes ☐ Never ☐

4.5**.** ***Have any of your children experienced verbal violence at home?***
(tick one box only)

Often ☐ Sometimes ☐ Never ☐

4.6. ***Have your children witnessed violence in the family home?***
(tick one box only)

Often ☐ Sometimes ☐ Never ☐

4.7. ***Do you think that the nature of your work affects your children?***
[**(tick one box only)**]

To a great extent ☐ To some extent ☐ Not at all ☐

4.8. ***Do you worry about your children on any of the following issues:***
[(**For each prompt tick appropriate box**)]

Prompt	**To a great extent**	**To some extent**	**Not at all**
Parenting			
Neglect			
Finances			
Future			
Education			
Safety			
Behavior			
Health			
Food/Nutrition			
Current/ potential drug/ alcohol abuse			
Social acceptability			
Experiencing/ witnessing violence in the home			

5. Reproductive Health

This section is about your reproductive health as well as that of your partner's. Please be frank. If there is something you don't understand, please ask me and I will try to explain.

5.1. ***How many miscarriages have you had?*** (**if none record 00**)

☐☐

5.2. ***How many induced abortions have you had?*** **(if none record 00)**

☐☐

5.3. ***Do you have a choice in determining safe sex method?*** (**Tick only one box**)

Yes ☐ No ☐ Don't know ☐ No response ☐

5.4. ***Have you experienced any of the following in the last twelve months?***
[(For each prompt tick only one box)]

Prompt	**Yes**	**No**	**Don't Know**
Boils/ulcers/warts around vulva			
Low back ache			
Pain during sexual intercourse			
Bleeding after sexual intercourse			
Difficulty/pain /burning during urination			
Frequent urination			
Significant weight loss (more than 15% of your usual weight)			
Continuous diarrhea			
Fever/cough lasting more than one month			
Any other gynaecological problems (please specify)			

5.5. ***Has your partner had any of the following problems in the last twelve months*** **[(For each prompt tick only one box)]**

Problems	**Yes**	**No**	**Don't Know**
Pain during urination			
Disinterest in having sex			
Difficulty in having sex (e.g. Difficulty in erection, early ejaculation etc)			
Wounds/sores/abscess in penis			
Yellowish greenish discharge with smell from penis			

6. Sex Work

The next few questions relate to your Sex work. Please do not feel embarrassed and answer as frankly as possible. Remember that your responses will be kept confidential.

6.1. ***What was your age when you had your first sex? (Refers to penetrative sex)*** (**Single response, in figure)**

_____years old.

6.2. ***With whom was your first sexual experience***

[(**Single response)]**

1= Spouse or current partner
2= Relative
3= Boy Friend(lover)
4= Neighbour
5= Customer
6= Stranger
7= Other. Please specify**.**

6.3. ***Was your first sexual exposure by choice or by force*****?**
[(**Single response. Tick appropriate box)]**

Consensual (by choice) ☐ By Force ☐

6.4. ***What was your age when you had your first commercial sex?*** [(**Single response)]**

_____years old.

6.5. ***What was your payment for your payment for first commercial sex*****?**
[(**Single response. Tick appropriate box)]**

Cash ☐ Kind ☐

If in kind specify_____

6.6. ***How did you initiate into sex work?***
[(**Single response. Tick appropriate box)]**

Knowingly consented ☐ not knowing ☐ By force ☐

6.7. ***Is there any of your family members are already in sex work?***

Yes ☐ No ☐

6.8. ***If yes, who are they?***
[(**Single response. code appropriate category)]**

1= Mother ☐
2= Sister
3= Relative
4= Other. Please specify**.**

6.9. ***Who introduced you to sex work?*** [(**Single response. code appropriate category)]** ☐

1= Mother
2= Sister
3= Relative
4= Spouse or current partner
5= Friend
6= Male Friend
7= Neighbor
8=Stranger

6.10. ***How long have you been to sex work?***

Year _____ Month _____ week _____Day_____

6.11. ***How long have you been to sex work?*** [(**Single response. code appropriate category)]** ☐

1=1- 2 years
2=3- 4 years
3=5 - 6 years
4=7 years and above

6.12. ***Where do you operate?*** [(**Single response. code appropriate category)]** ☐

1= Street
2= Lodge
3= Highway Lodge/catering
4= Hotel in city
5= From Home
6= Other

6.13. ***Where do you you entertain your client most?*** [(**Single response. code appropriate category)]** ☐

1= Street
2= Lodge
3= Highway Lodge/catering
4= Hotel in city
5= Home/Private primises
6= Other

6.14. ***How often did you change your area of operation?*** [(**Single response. code appropriate category)]** ☐

1= Sometime
2= often
3= very often

6.15. ***What was your occupation before you were initiated into sex work?*** **[(Multiple response. code appropriate category)]**

1= No occupation ☐
2= Housemaid/Household job ☐
3= Street vendor ☐
4= Sales women ☐
5= small company ☐
6= Daily wage labourer ☐
7= Salaried worker ☐
8= Self employed/business/trade ☐
9= Drugs peddling ☐
10= Other. Please specify ☐

6.16. ***Did you give up your previous occupation?***

Yes ☐ No ☐ No Occupation ☐

6.17. ***If yes, what made you give up your previous occupation?*** **[(Multiple response. code appropriate category)]**

0 = No occupation ☐
1 = Continue previous work ☐
2 = Irregular work ☐
3= Lack of permanent Job ☐
4= Pressure from family ☐
5= pressure from partner ☐
6= poor/irregular income ☐
7= workplace discrimination ☐
8= Any others, specify ☐

6.18. ***What is your income per month through sex work****?* ☐☐☐☐☐☐☐

6.19. ***How did you spend your income?*** [(**Multiple response. code appropriate category)]**

1= For buying Drugs/Alcohol ☐
2= Personal use ☐
3= Dressing clothes/material ☐
4= For family ☐
5= For medical expense ☐
6= Other. Please specify ☐

6.20. ***Do you have any saving?*** [(**Single response. code appropriate category)]**

1= Yes ☐
2= No

6.21. ***What factor motivates you into sex work?*** [(**Multiple response. code appropriate category)]**

1= Poverty ☐
2= Friends ☐
3= Death of husband ☐
4= Divorcement ☐
5= Drug addiction ☐
6= Husband ☐
7= Lure of easy money and lifestyle ☐
8= Other, Please specify ☐

6.22. ***What are the causes for continuing this sex work?*** [(**Multiple response. code appropriate category)]**

1= Financial ☐
2= No other alternative work to generate income ☐
3= Difficult to come out of it ☐
4= Drug addiction ☐
5= Any other reason (Specify) ☐

6.23. ***How many days do you work in a week when you are regular****?* [(**Single response. code appropriate category)]**

1= Less than 3 ☐
2= 3 – 5
3= 5 and above

6.24. ***How many clients avail your services on an average in your working days****?* [(**Single response. code appropriate category)]**

1= Less than 3 ☐
2= 3 – 5
3= 5 and above

6.25. ***How many clients do you engage on an average in a Month when you work every week?*** [(**Single response. code appropriate category)]**

1= Less than 5 ☐
2= 5 – 10
3= 10 – 15
4= 15 -- 20
5= 20 and above

6.26. ***How many of your clients are regular (sexual encounter at least once in a month during the last 3 months) clients?*** [(**Single response. code appropriate category)]**

1= Less than 5% ☐
2= 5 %– 10%
3= 10 %– 15%
4=15% and above

6.27. ***W the average age of your client?*** [(**Single response. code appropriate category)]** ☐

1=12 – 18 years
2=18 – 25 years
3=25 – 35 years
4=35 years and above

6.28. ***What is the longest duration of contact with a given client?*** [(**Single response. code appropriate category)]** ☐

1=Below 1 years
2=1– 2 years
3=2 – 3 years
4=3 –4 years
5=4 years and above

6.29. ***From where does the demand for sex come from?***
[(Multiple response. code appropriate category)]

1= Truckers ☐
2= Migratory and unsettled male workers ☐
3= Adolescent and unmarried youth ☐
4= Alcohol users ☐
5= Drug users ☐
6= Traveling businessmen and ☐
7= Client with sexual dysfunction ☐
7= Members of criminal gangs ☐
8= Tourist ☐
9= Any other reason (Specify) ☐

6.30. ***What is the referral system of clients for your work?*** [(**Multiple response. code appropriate category)]**

1= Referral by other clients ☐
2= Known to self ☐
3= Through waiter/Agent ☐
4= Through family members ☐
5= through other female sex workers ☐
6= Directly approached ☐
7= ☐

6.31. ***What is the predominant religious background of the clients who avail your services ?*** [(**Single response. code appropriate category)]**

1= Hindu ☐
2= Christian ☐
3= Muslim ☐
4= Any other ☐

6.32. ***What is the predominant marital status of your clients?*** [(**Single response. code appropriate category)]**

1= Single ☐
2= married ☐
3= migrant married single ☐
5= Any other ☐

6.33. ***Do the clients use condoms?*** [(**Single response. code appropriate category)]**

1= Never ☐
2= Always
3= Sometimes

6.34. ***Have you ever had sex in exchange for drugs?***
[(**Single response. Tick appropriate box)]**

Often ☐ Sometimes ☐ Never ☐

6.35. ***The next few questions are about consumption of alcohol or drugs prior to sex***

[(ask prompt and for each tick use appropriate box)] ***During the last 12 months how often have you had sex when:***	Often	Sometimes	Never
You were under the influence of alcohol	☐	☐	☐
You were under the influence of drugs	☐	☐	☐
Your partner/clients were under the influence of alcohol	☐	☐	☐
Your partner/clients were under the influence of drugs	☐	☐	☐
Both were under the influence of alcohol	☐	☐	☐
Both were under the influence of drugs	☐	☐	☐
Under any of the above situations how often have you used a condom	☐	☐	☐

6.36. ***How does your use of alcohol/drugs alter your sexual experience?***

[(For each prompt tick yes or no. If not relevant skip other prompts)]

(Prompt)	**Yes**	**No**
Not relevant as I do not use	☐	☐
Does not alter	☐	☐
Makes sex more enjoyable	☐	☐
Makes sex less painful	☐	☐
Others (specify)	☐	☐

6.37. ***Do you have a guardian (protector) partner?*** [(**Single response. code appropriate category)]**

1= Yes ☐
2= No

6.38 ***If yes, who is your present guardian (protector) partner***? **[(Single response. code appropriate category)]**

1= Male Lover ☐
2= Female lover ☐
3= Sex work partner (friend) ☐
4= Pimp ☐
5= Male drug use partner ☐
6= Female drug use partner ☐

6.39. ***What type of sex did you offered to your client***? **[(Multiple response**. **code appropriate category)]**

1= Vaginal sex ☐
2= Anal sex ☐
3= Oral sex ☐
4= Genital stimulation ☐
5= All of the above ☐

6.40. ***What types of sex do the client seeks***? **[(Multiple response**. **code appropriate category)]**

1= Vaginal sex ☐
2= Anal sex ☐
3= Oral sex ☐
4= Genital stimulation ☐
5= All of the above ☐

7. Violence

7.1. ***Have you ever experienced any violence in your life?***
(single response. Tick appropriate box)

Yes ☐ No ☐ Don't know ☐ No response ☐

If No, DK, NR, skip to 8

7.2. ***Have you experienced verbal violence (name calling, yelling/shouting, threatening)?***
(single response. Tick appropriate box)

Often ☐ Sometimes ☐ Never ☐

7.3. ***Have you experienced physical violence (slapping, beating, kicking, pushing/shoving)?***
(single response. Tick appropriate box)

Often ☐ Sometimes ☐ Never ☐

7.4. ***Have you experienced sexual violence (rape, sexual intercourse without consent/against your will/under threat, sexual assault)?***
[(single response. Tick appropriate box) If Never SKIP to 7.12]

Often ☐ Sometimes ☐ Never ☐

7.5. ***Who did you experience violence from (who was the perpetrator)?***

[(For each prompt record yes or no)]

(Prompt)	**Yes**	**No**
Ex Spouse/Boyfriend/Regular partner	☐	☐
Parents	☐	☐
Siblings (brother, sister)	☐	☐
Extended family members	☐	☐
In laws	☐	☐
Friends	☐	☐
Employer	☐	☐
Community members/Neighbors	☐	☐
Police	☐	☐
Other service providers	☐	☐
Pimp	☐	☐
Local vigilance	☐	☐
Strangers	☐	☐
Clients	☐	☐
Others (Please specify)	☐	☐

7.6. ***Have you ever had sexual violence inflicted on you when the perpetrator was under the influence of drugs/alcohol?***

[(**single response. Tick appropriate box**)]

Often ☐ Sometimes ☐ Never ☐

7.7. ***Have you ever received a physical injury resulting from any kind of violence***?

[(Single response. Tick appropriate box)]

Often ☐ Sometimes ☐ Never ☐

7.8. ***Did you ever seek help?***

[(Single response. Tick appropriate box)]

Often ☐ Sometimes ☐ Never ☐

7.9. ***To Whom did you go for help?***

(Prompt)	**Yes**	**No**
Parents	☐	☐
In laws	☐	☐
Siblings (brother, sister)	☐	☐
Friends	☐	☐
Neighbors	☐	☐
Religious leaders	☐	☐
Police	☐	☐
NGO/CBO	☐	☐
Doctor	☐	☐
Community elders	☐	☐
Others (Please specify	☐	☐

8. HIV/AIDS Awareness

8.1. ***Have you ever heard of HIV/AIDS?***
[(Single response. Tick appropriate box)]

Yes ☐ No ☐ Don't know ☐ No response ☐

8.2. ***How did you get informed about HIV/AIDS?***
[(Single response. code appropriate category)]

☐1= through reading newspapers, magazines, advertisements

☐2= through someone who has given me information on HIV/AIDS

☐3= through both of the above

8.3. ***Do you think your current sexual practice put you at risk of HIV/AIDS?***
[(Single response. Tick appropriate box)]

Yes ☐ No ☐ Don't know ☐ No response ☐

8.4. ***Do you think your partner sexual practice put him at risk of HIV/AIDS?***
[(Single response. Tick appropriate box)]

Yes ☐ No ☐ Don't know ☐ No response ☐

8.5. ***Do you think your clients sexual practice put him at risk of HIV/AIDS?***
[(Single response. Tick appropriate box)]

Yes ☐ No ☐ Don't know ☐ No response ☐

8.6. ***Have you ever been tested for HIV?***

Yes ☐ No ☐ Don't know ☐ No response ☐

8.7. ***What is your status?***

Positive ☐ Negative ☐ Don't know ☐

8.8. ***Do you think you can prevent yourself from HIV/AIDS?***

Yes ☐ No ☐

8.9. ***How many of your clients are positive for HIV?***

Don't know ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 and above ☐

9. Mental State:

I would like to know how your health has been in general over the last few weeks

Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

9.1. ***been able to concentrate on task in hand?***

better than usual	same as usual	less than usual	much less than usual
(0)	(1)	(2)	(3)

9.2. ***lost much sleep over worry?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.3. ***felt that you are playing a useful part in activities?***

more so than usual	same as usual	less so than usual	much less than usual
(0)	(1)	(2)	(3)

9.4. ***felt capable of making decisions about things?***

more so than usual	same as usual	less than usual	much less than usual
(0)	(1)	(2)	(3)

9.5. ***felt constantly under strain?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.6. ***felt you couldn't overcome your difficulties?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.7. ***been able to enjoy your normal day to day activities?***

more so than usual	same as usual	Less so than usual	much less than usual
(0)	(1)	(2)	(3)

9.8. ***been able to face up to your problems?***

more so than usual	same as usual	less than usual	much less than usual
(0)	(1)	(2)	(3)

9.9. ***been feeling unhappy or depressed?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.10. ***been losing confidence in yourself?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.11. ***been thinking of yourself as a worthless person?***

Not at all	no more than usual	rather more than usual	much more than usual
(0)	(1)	(2)	(3)

9.12. ***been feeling reasonably happy, all things considered?***

more so than usual	same as usual	less so than usual	much less than usual
(0)	(1)	(2)	(3)

9.13. ***During the last 12 months have you ever felt so unhappy and hopeless that you have felt life is not worth living***?
(Single response. Tick appropriate box)

☐1= Often (more than twice)
☐2= Sometimes (once or twice)
☐3= Never

9.14. ***Has it ever been so bad that you actually attempted to take your own life:***
[(Single response. Tick appropriate box)]

☐1= Often (more than twice)
☐2= Sometimes (once or twice)
☐3= Never

10. Treatment and Hospitalisation

I am now going to ask you some questions about illnesses, any treatment you or your household members (persons you are residing with) have had any treatment for any illness during the last 12 months

10.1

	IIIness	*Yes*	*No*	*Specify*	*who*
1	Terminal Illness				
2	Chronic Illness				
3	Surgery				
4	Hospitalisation for more than 2 months in last 1 year				

11. Awareness of Services

11.1. ***Are you aware of the following services ?***

Services for Women	**Yes**	**No**
Community outreach, particularly peer outreach by female peer educators.	☐	☐
Gender sensitive HIV/AIDS prevention and care material.	☐	☐
Substitution treatment for female drug users.	☐	☐
Access to male condoms.	☐	☐
Access to female condoms.	☐	☐
Access to sterile needles and syringes.	☐	☐
Voluntary HIV testing and counseling.	☐	☐
Diagnosis and treatment of sexually transmitted infections.	☐	☐
Antiretroviral treatment for female drug users.	☐	☐
Services for prevention of mother to child HIV transmission.	☐	☐
Centre where there is treatment services related to drug for women	☐	☐
Services related to vocational training & employment of women	☐	☐
Micro finance programmes for women	☐	☐
Legal support and advocacy services for women	☐	☐
Safe housing/shelter	☐	☐
Mental health services	☐	☐
Nutritional supplementation programmes	☐	☐
Services for children	☐	☐

INTERVIEW SCHEDULE (MIZO)

4.INTERVIEW SCHEDULE (MIZO)

INTERVIEW SCHEDULE FOR RESEARCH

on

Women Sex Workers in Aizawl: A Situational Analysis

under the

Department of Social Work

Mizoram University

Supervised by

Dr. Kalpana Sarathy

Associate Professors

Code No.

CONFIDENTIAL FOR RESEARCH PURPOSE ONLY

WSW Remtihna

(Khawngaih takin i mi kawm tur hnenah hetiang hian sawi ang che)

Chibai, ka hming chu Pu. Samuel Lalzarlawma Sailo a ni a, Department Social Work, Mizoram University a Research Scholar ni mek a hnuaia a thawk mek ka ni. Hmeichhe Sex Worker ten harsatna hrang hrang an tawh mekte zirchian kan tum a ni. Kan tum ber chu chung hmeichhe Aizawla awmte dinhmun hriatchian leh zirchian a ni. He zirna hian hmeichhia heng dinhmuna awm mekte harsatna an tawh mek atanga tanpui dan min kawhhmuh theih mai bakah, tanpuina chi hrang hrang awmze nei zawk a duan chhuah theih dawn a ni.

Heng zawhna te hi dik tak leh zep emah nei lova min chhang turin ka ngen che a ni. I thil sawi reng reng khawiah mah a chhuak leh tawh lo ang tih ka tiam che a ni. He zirna hian mi tumah tel turin a phut lui lo a, mahni duhthlanna liau liau a ni a, i duh phawt chuan zawhna eng pawh hi i chhang lo thei a ni.

Zawh duh te i nei em? I zawhna ka chhang thei lo a nih chuan he zirna a min puitu Dr. Kalpana Sarathy rawn chungin i hriat duhte chu kan hriat tir dawn che nia.

Chhangtu Hmingziak/Kutzungpuia nem (Duhdan a zirin)

Zawttu hmingziak

Date:

WSWs Remtihna

(Khawngaih takin i mi kawm tur hnenah hetiang hian sawi ang che)

Chibai, ka hming chu _____ a ni a _____ Department Social Work, Mizoram University a Research Scholar ni mek Pu. Samuel Lalzarlawma Sailo a hnuaia a thawk mek ka ni. Hmeichhe Sex Worker ten harsatna hrang hrang an tawh mekte zirchian kan tum a ni. Kan tum ber chu chung hmeichhe Aizawla awmte dinhmun hriatchian leh zirchian a ni. He zirna hian hmeichhia heng dinhmuna awm mekte harsatna an tawh mek atanga tanpui dan min kawhhmuh theih mai bakah, tanpuina chi hrang hrang awmze nei zawk a duan chhuah theih dawn a ni.

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Zawh duh te i nei em? I zawhna ka chhang thei lo a nih chuan he zirna buatsaihtu Pu Samuel Lalzarlawma Sailo rawn chungin i hriat duhte chu kan hriat tir dawn che nia.

Chhangtu Hmingziak/Kutzungpuia nem Zawttu hmingziak (Duhdan a zirin)

Date:

Zawhna zawttuin zawhna a zawh hmaa a tih ngei ngei tur:

(bawm chhung milin thai rawh)

Inhmel hriattirna leh inkawmna neihna chhan	
Zawhna chhanna reng reng sawi chhuah emaw puanzar a nih loh tur thu uar taka hrilh hriat	
Tihluihna tel lo mahni duhthu ngeia tel tur a ni tih sawifiah a ni	
Hriattirna fel tak awm hnua inkawm remtihna lak a ni	

NGO code	
City code	

Interview Schedule No:

Inkawm ni: --/--/---- dd/mm/yyyy

1. Inchhungkhur leh mimal thila hriat turte

Khawtlang – Dinhmun kimchang

1.1.1. Chhangtu hmingziak kaihtawi_____

1.1.2. Nihna : ☐ *(a chhanna pakhat chauh tur. a code inhmeh ber ziak rawh)*

1= DIC client hlui 2= Regular client of DIC
3= tun hnai maia DIC ina hmuhchhuah thar

1.1.3. Sakhua : ☐ *(a chhanna pakhat chauh tur. A code inhmeh ber ziak rawh)*

1=Hindu
2=Muslim
3=Christian
4=A dang

1.1.4. Christian nih chuan eng pawla awm nge ☐ *(a chhanna pakhat chauh tur. A code inhmeh ber ziak rawh)*

1= Presbyterian
2= Baptish
3= Roman Catholic
4= Salvation Army
5= UPC
6= A dang

1.1.5. Chenna hmun: ☐ *(a chhanna pakhat chauh tur. a code inhmeh ber ziak rawh)*

1=Khawpui
2=Thingtlang

1.1.6. Pianna ram: _____

1.1.7. Chenna hmun District (awm mekna) :_____

I chenpui te leh i khawsak dan chungchang ka zawt dawn che a. Khawngaih takin tu nen nge in chen (thla ruk kal ta chhung khan) min hrilh thei a ngem. Khawngaihin i chenpui zawng zawngte leh in in laichindan min hrilh thei bawk la.

1.2. Inchhungkhur chungchang

1.2.1. ***In chhungkua ah mi engzat nge cheng ho che u*****?** ☐☐

10 aia an tam chuan a upa 10 thlan chhuah tur. Code awm reng reng ah chuan an nihna dik tak mil zelin code hi hman tur a ni

Zawhna chhangtu nena inlaichinna	Kum (kum hman tawh zat chiah)	Sex M=Mipa H=Hmeichhia	Zirna lama kum hman zat	Eizawnna 1=Pawn lama hnathawk 2=Zirlai 3= Pawn lama hnathawk lo.	Nupui pasal chungchang 1= La nei lo 2= Nei 3= Tunah chuan kawppui nei lo (kawppui sun,inthen, awm hrang, kalsan etc) 4=a dang	Hnam hming
(Zawhna chhangtu) Keimah		H				
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

1.2.2 **Zawhna chhangtu nihna diktak zawnah thai rawh** (bawm pakhatah chauh thai rawh)

1= Pasal nei ☐
2= inthen ☐
3= Pasal la nei lo ☐
4= Pasal sun ☐

Zawhna chhangtu chu pasal la nei lo a nih chuan, 1.4 ah kal mai rawh

1.2.3 ***In in neih tirhin kum engzat nge i nih?***

☐☐

1.2.4 ***Engang chenna inah nge tunah i khawsak mek (thla 6 kal atangin)****?* (Bawm pakhatah chauh thai rawh):

1= Pucca House (chhuat, inchung leh bangte cement a zut) ☐

2= Semi-Pucca (In chung lak sawn mai theih, chhuat leh bang cement a zut ve ve emaw a pakhat zawk zawk cement a zut) ☐

3= Kuchha (A chung di chih, leia zut bangte, chhuat mumal taka siam awm lo) ☐

4= Khawlai kawngdunga cheng ☐

5= A dang (sawifiah nise) ☐

1.2.5. ***Thla kalta khan inchhungkua in sum engzat vel nge in hailuh ang khawngaih takin min hrilh thei ang em (calendar thla):***
(Thlatin Hlawh, sumdawnna,lo lam hna, mahni hna insiamchawp,inluahman, penson leh a dangte atanga chhungkaw mimal tinten sum an lakluh zawng zawng te telh vekin)

1.2.6. ***In chhungkaw sum lakluhah i thawhchhuah zaah engzat nge ni ang?***

☐**[(Pakhat chauh chhan tur. A code number hmang hian chhinchhiah tur a ni)]**

1=100%
2= 75% chung lam, 100% aia tlem si
3=50-75%
4=25% atang 50% hnuai lam
5= 25% hnuai lam
6= Awm lo

2. Zawhna chhangtu damdawi hman chungchang

2.1 Zawhna awm zel tur te hian heng ruihhlo te i hman dan chungchang hi a zawt dawn che a ni. Khawngaih takin ngun takin ngaihtuah la chhang ang che:

Heng a hnuaia mite hi vawikhat tal i hmang tawh em: **(Ruihhlo tin te hi a mal mal in an hman leh hman loh zawt ang che. An hmang tawh a nih chuan chunzawm zel ang che.)**	*Hmang tawh em* 1=Aw 2=Aih	Hmang thin tawh chuan kum engzat i nihin nge i hman tan.	*I in chiu tawh em* 1=Aw 2=Aih	*Thla 12 kal ta chhung khan i hmang em?* 1=Aw 2=Aih	*Hman dan (thla 12 kal ta chhungin) Zukin=1 Ei=2 Chase in =3 Hnar emaw ka a hip lut =4 In chiu =5 Hman dan hrang hrang,in chiu telin =6 A dangte =7 (sawifiah nise)*	*Thla kalta a hman zin dan* 1=nitin emaw nitin deuhthawin 2=kar khatah vawikhat tal 3= kar khata vawikhat aia tlem (chhanna pakhat chauh a ni tur a ni)
Tobacco						
Alcohol						
Cannabinoids (ganja, charas, hashish, marijuana)						
Sleeping pills (valium, calmpose, alprax, nitrosun)						
Cough Syrup with codeine						
Buprenorphine						
Proxyvon						
Heroin (Brown Sugar)						
Hallucinogens (LSD, magic mushrooms)						
Solvents (petrol, erasex)						
Cocaine and other stimulants						
Thil dang (sawi chian ni se)						

[Ruihhlo hming tarlan zawng zawng te hi la hmang ngai miah lo a nih chuan 3 naah i kal dawn nia]

(thla 12 chhung khan in chui thin a nih chuan a hnuaia mi te hi chhan nise)

2.2. ***Midang te nen in inchiu ho hnuhnung berah, needle/syringe I hman hmain I tifai em?***

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐ Remchang lo ☐

2.3 ***Aw tih a nih chuan, engtinnge needle/syringe I tihfai?*** (chhanna dik thai rawh***)***

Damdawi Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

Tui pangngai	Aw ☐	Aih ☐	Hre lo ☐	Chhanna awm lo ☐
Tui sa	Aw ☐	Aih ☐	Hre lo ☐	Chhanna awm lo ☐
Zun	Aw ☐	Aih ☐	Hre lo ☐	Chhanna awm lo ☐
A dang (eng?)	Aw ☐	Aih ☐	Hre lo ☐	Chhanna awm lo ☐

2.4. ***Damdawi hmansual vanga enkawl i ni tawh ngai em?*** (Chhanna pakhat chauh thai rawh)

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

2.5. ***Engang enkawlnate nge i lo dawn tawh?*** (Chhanna tinah aw emaw aih tih thai rawh)

(Chhanna)	**Aw**	**Aih**
Inkawmna	☐	☐
Mahni intanpuina pawl	☐	☐
Riah chilha enkawlna	☐	☐
Taksa harsatna leh pan te pawh enkawlna	☐	☐
Hriselna lam inzirtirna	☐	☐
Damdawi hmanga in sim tirna	☐	☐
Damdawi danga thlakthlengna	☐	☐

2.6. ***Khawiah te nge enkawlna I lo dawn tawh?*** (Chhanna tinah a mil tak thai ang che)

(Chhanna)	**Aw**	**Aih**
Tidam thei	☐	☐
Sorkar damdawi lam inenkawlna hmun	☐	☐
Mimal damdawi lam inemkawlna hmun	☐	☐
Pawl dang (NGO)	☐	☐
In lama inenkawlna	☐	☐

3. Kawppui chungchang

3.1 *I kawppui chungchangah zawhna tlemte ka zawt dawn che a. Khawngaihin i theih anga dikin min chhang dawn nia.*

Sl. No.	Inpuanna	Aw	Aih	Kawp pui thin nei lo
1	*Tunah hian kawppui inpawlna ka hmanpui fo thin ka nei*			
2	*Ka pasal/kawppui chuan ruihtheih thil a ti thin*			
3	*Condoms kan hmang ziah thin*			

4. Naupang Chungchang

4.1 ***Fa i nei tawh em?*** **(bawm pakhat chauh thai rawh)**

Aw ☐ **Aih** ☐

4.2. ***I fa te zingah thi an awm tawh em*** **(bawm pakhat chauh thai rawh)**

Aw ☐ **Aih** ☐

[Fa la dam a neih tawh loh chuan, 5-naah kal rawh]

4.3. ***A hnuaia zawhna te hi i fa dam mekte chungchang a ni***.

Mipa leh Hmeichhia, upat dan indawtin (M=mipa, H=hmeichhia)	Tuna naupang kum	Tuna a zir mek emaw zirna lama a thlen san ber (zir chhung kum telin)	I fate harsatna tawh 1= Hospitala dah ngai khawpa taksa a natna nei 2= Nungchang* 3= Zirna lam 4= rilru lam** 5= zuk leh hmuam lam 6 =zu in 7= Ruihhlo dang **(I fa te harsatna tawh mil zelin thai rawh)**						
			1	2	3	4	5	6	7

*Nungchang tih chuan sikul atanga tlanbo, in atanga tlanbo, dawt sawi, rukruk, midang sual ching, dan kalha chetna te tham deuh te a huam.

** Rilru lamin a huam te chu ngui ngawih ngawihna, rilru dam lo, in la hrang, mahni intihnat ching te.

4.4. ***I faten in lamah kutthlak an tuar thin em****?* **(bawm pakhatah chauh thai rawh)**

Fo ☐ A chang changing ☐ Ngai lo ☐

4.5**.** ***I faten tawngka a tinat an tawk thin em?*** **((bawm pakhatah chauh thai rawh)**

Fo ☐ A chang changing ☐ Ngai lo ☐

4.6. ***I faten inchungah intihnata an hmu thin em?*** **(bawm pakhatah chauh thai rawh)**

Fo ☐ A chang changing ☐ Ngai lo ☐

4.7. ***Namah/i kawppui ina drugs/zu i hman thin hian fate a nghawng i hria em?*** **(bawm pakhatah chauh thai rawh)**

Nghawng nasa ☐ Nghawng ve ☐ Nghawng lo ☐

4.8. ***A hnuaia thil pawimawh tak tak kan han tarlanah hian i fate i ngaihtuah em::***

[**(chhanna tin zawna a bawm mil chiahah thai rawh)**]

Chhanna	**Ngaihtuah nasa**	**Ngaihtuah ve tho**	**Ngaihtuah lo**
Fate enkawl naah			
Thlahthlam			
Sum leh pai			
An hma hun			
Zirna lam			
Him damna lam			
Nungchang			
Hriselna			
Chaw leh ei tur tha			
Damdawi/Zu lakah			
Khawtlanga inhmanna lamah			
Inchhunga hleilenna a taka hmuh leh hriat			

5. Chi thlahna lam hriselna

Hemi huam chhungah hi chuan chi thlahna lam zawhna nangmah leh i kawppui kaihhnawih a ni ang. Khawngaihin zep nei miah lo la. Engemaw hriat thiamloh i nei a nih chuan min zawt hreh lo la sawifiah ka tum dawn nia.

5.1. ***Vawi engzat nge nau i chhiat tawh?*** **(vawikhat mah a nih chuan 00)**

☐☐

5.2. ***Vawi engzat nge nau i tihtlak tawh?*** **(vawikhat mah a nih chuan 00)**

☐☐

5.3. ***Chhangkhatna/Indanna engemaw ber i hmangtawh ngai em?*** **(Bawm pakhat chauh thai rawh)**

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

[Aih, Hre lo, Chhanna awm lo a nih chuan 5.5-ah kal rawh]

5.4. ***Eng indanna nge I hman thin tlangpui*? (Bawm pakhat chauh thai rawh)**

Mipa indanna ☐ Hmeichhe indanna ☐

5.5. ***Indanna hman chungchangah duh thlang theiin i awm em?* (Bawm pakhat chauh thai rawh)**

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

5.6. ***Duhthlang thei ta la enge i thlan ang:* (Bawm pakhat chauh thai rawh)**

Mipa indanna ☐ Hmeichhe indanna ☐ A pahnihnin ☐

Hre lo ☐ Chhanna awm lo ☐

5.7. ***Heng a hnuaia mite hi thla 12 kal ta chhung khan i tawng em?***
[(Chhanna tin atan bawm pakhat chauh thai rawh)]

Chhanna	**Aw**	**Aih**	**Hre lo**
Khawihli/pan/serh bawr vel bawl			
Kawng na			
Inpawl laia na			
Inpawl zawha thi chhuak			
Zun harsat, zun zawnga sa leh na			
Zun in			
Rihna tlahniam thut (mahni bukzat aia 15% a tlahniam)			
Kaw tha lo benvawn			
Thla khat aia tam khawsik leh khuh			
Hmeichhe lam thatlohna dang (sawifiah nise)			

5.8. ***I kawppui in heng a hnuaia harsatna te hi thla 12 kal ta khan a nei em?***
[(Chhanna tin mil zelin bawm pakhatah thai rawh)]

Harsatna	**Aw**	**Aih**	**Hre lo**
Zun zawnga na			
Mipat hmeichhiatna hman phur lo			
Mipat hmeichhiatna hman harsa ti (Entirnan, zang tihkhawng harsat, mipa chi chhuak hma lutuk leh adangte)			
A serha hliam/pilh/pan			
Serh atanga bawlhhlawh eng leh hring lam rimchhe deuh chhuak			

6. Sex Work (Hmeichhiat mipatna kawnga inhmanna leh inzawrhna chungchang)

Zawhna lo awm leh turte hi mipat hmeichhiatna a i in hman dan leh inzawrhna lam hawi zawhna a ni. Hreawm ti lo la zep nei miah lova min chhang turin ka ngen che a ni. I chhanna zawng zawngte chu pakhatmah puanzar a ni lo ang tih hre reng ang che.

6.1. Inpawlna i hman hmasak berin kum engzat nge i nih? (mipa serh lut ngei inpawlna) [**(chhanna pakhat chauh)]**

*Kum*_____

6.2. ***Tu nen nge inpawl hmasa ber chu in hman?***

☐

[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

1= Pasal/kawplai
2= Chhungte
3= Mipa thian
4= Thenawm
5= Dawrtu
6= Hmelhriat loh
7= A dang**.** Sawi fiah la

6.3. ***Inpawlna i hman hmasak ber chu tihluihna nge i duhthlanna*****?**
[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

Remtihna (duhthlanna) ☐ Tih luihna ☐

6.4. ***Inpawlna inzawrh nana i hman hmasak berin kum engzat nge i nih?*** ☐
(chhanna pakhat chauh)

*Kum*_____

6.5. ***Inpawlna inzawrh nana i hman hmasak berin engnge I dawn?***

Sum ☐ ***Sum nilo thil*** ☐ sum a nih loh chuan sawifiah la_____

6.6. ***Inpawlna hmanga inzawrhna ah engtin nge bul I tan ?***
[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

Remtihna (Hrechiangin) ☐ Hre lo in ☐ Tih luihna ☐

6.7. ***Inpawlna hmanga in zuar I chhungte zingah an awm ve em?***
[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

Aw ☐ Aih ☐

6.8. ***Awm chuan tute nge?*** ☐
(chhanna pakhat chauh. A mil chiah bawmah thai rawh)

1=Nu
2=Laizawn nu
3=Chhungte
4=A dang. Sawifiah nise

6.9. ***Tuin nge inzawrh kawhhmuh/hmelhriat tir che?*** ☐

(chhanna pakhat chauh. A mil chiah bawmah thai rawh)

1=Nu	2=Laizawn nu
3=Chhungte	4=Pasal/tuna kawp mek
5=Thian	6=Mipa thian
7=Vengte	8=Hmelhriatloh

6. 10. ***Eng chen nge I in zawrh tawh?***

Kum _____ Thla _____ Kar _____Ni_____

6. 11. ***Eng chen nge I in zawrh tawh?*** ☐

1=1- 2 kum
2=3- 4 kum
3=5 - 6 kum
4=7 kumchung lam

6.12. ***Khawiah nge I in zawrh thin?*** ☐

(chhanna pakhat chauh. A mil chiah bawmah thai rawh)

1=Khawlai	2=Riahbuk
3=zinkawng Kawngkam chawlhna	4=Khawpui chhung Hotel
5=In (a rukin)	6=Other

6.13. ***Khawiah nge nangmah dawrtu che nen in in kawm thin?*** [(**Channa pakhat. A code diktak thai rawh]** ☐

1= Street
2= Lodge
3= Highway Lodge/catering
4= Hotel in city
5= Home
6= A dang

6.14. ***Eng anga zingin nge I inzawrhna I thlakthleng thin?*** [(**Mal chhan. A mil chiah ziak rawh)]**

☐

1= A chang changin
2= fo
3= Zing

6.15. ***I in zawrh hma in eng hna nge I thawh thin*****?** (bawm pakhat aia tam thai theih)

1= Engmah thawk lo	☐
2= In enkawltu	☐
3= Kawng kama thil zuar	☐
4= Thil zuar kual thin	☐
5= Company te a hnathawk	☐
6=Nitin inhlawhfa	☐
7=Thla kipa hlawh nei	☐

8=sumdawng ☐
9=Damdawi zawrh ruk ☐
10=A dang Sawifiah nise ☐

6.16. ***I hna hmasa I kalsan ta em ni?***
[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

Aw ☐ Aih ☐

6.17. ***I chhanna aw a nih chuan engvanga kalsan nge I nih*****?** (bawm pakhat aia tam thai theih)

1= Hna mumal lo leh chiang lo lutuk ☐
2= Hna nghet neih loh vang ☐
3= Chhungte nawr vang ☐
4= Kawppui in nawr vang ☐
5= Hlawh tlem leh mumal lo ☐
6=Thawhna hmuna in thliarna awm vang ☐
7= A dang, sawifiah nise ☐

6.18. ***Thlatin i <u>mimal</u> sum lakluh inzawrhna atangin engzat nge***

☐☐☐☐☐☐☐

6.19. ***Engtin nge I sum lakluh chu I hman thin*****?** (bawm pakhat aia tam thai theih)

1= Damdawi lei nan ☐
2= Mimal hman atan ☐
3= Incheina thawmhnaw leh bungrua ☐
4= In chhung thil tan ☐
5= Damdawi lei nan ☐
6=Thil dang, sawifiah nise ☐

6.20. ***Sum khawl I nei em?***
[**(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]**

Aw ☐ Aih ☐

6.21. ***Engin nge inzuar turin nawr che*****?** (bawm pakhat aia tam thai theih)

1= Retheihna ☐
2= Thiante ☐
3= Pasal thih vang ☐
4= In thenna ☐
5= Ruihhlo ngaih vang ☐
6= Pasal ☐
7= Nuam ti ve hrim hrim ☐
8=Thil dang, sawifiah nise ☐

6.22. ***I in zuarh chhunzawm zel na chhan enge ni*?** (bawm pakhat aia tam thai theih)

1= Sum lam ☐
2= Hna sum hailuhna dang awm lo ☐
3= Chhuah a har ☐
4= Ruihhlo ngaih vang ☐
5= Chhan dang a awm a nih chuan sawifiah nise ☐

6.23. ***Kar khatah ni engzat nge I thawh thin I kal ngun ber kar ah*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= Pathum aia tlem
2= 3-5
3= 5 atanga chunglam

6.24. ***I kal chhuah ni in ni khatah dawrtu che engzat nge I neih*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= Pathum aia tlem
2= 3-5
3= 5 atanga chunglam

6.25. ***Thla khatah dawrtu che engzat nge I neih*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= Panga aia tlem
2= 5 - 10
3= 10 – 15
4= 15 – 20
5 = 20 chunglam

6.26. ***Nangmah dawrtute zingah engzat vel nge dawr ngung bik tu che*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= 5% aia tlem
2= 5 %- 10%
3= 10 %– 15%
4= 15% chunglam

6.27. ***Kum engzat nge an nih thlangpui*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= 12 - 18
2= 18 - 25
3= 25 - 35
4= 35 chunglam

6.28. ***Nangmah dawrtu te nena in inkawp hun chhung eng chen nge*** **?** (**chhanna pakhat chauh. A mil chiah bawmah thai rawh)**

☐

1= Kum khat aia tlem
2= Kum 1 -2
3= Kum 2 - 3
4= Kum 3 – 4
5= Kum 4 chunglam

6.29. ***Tuten nge dawr thin che*** **?** (bawm pakhat aia tam thai theih)

1= Truck driver ☐
2= Mipa rawn pem lut ☐
3= Tleirawl leh nupui la nei lo ☐
4= Zu in thin te ☐
5= Drug ti thin te ☐
6= Hmeichhiat mipatna lama harsatna neite ☐
7= Misual pawl ho ☐
8= Rampawn khual zin ☐
9= Thingtlang pa ☐
10= Nupui nei lai ☐
11= A dang, sawifiah nise ☐

6.30. ***Tuten nge I hnehah rawn tir thin*** **?** (bawm pakhat aia tam thai theih)

1= Min dawrtu dangte ☐
2= Ka hriat sa ☐
3= Ka agent ☐
4= Chhungkhat te atangin ☐
5= Ka thian inzuar ve te atangin ☐
6= Min rawn pan ve tawp ☐
7= A dang, sawifiah nise ☐

6.31. ***Dawrtu che eng Sakhua nge an nih*** : ☐ *(a chhanna pakhat chauh tur. A code inhmeh ber ziak rawh)*

1=Hindu
2=Muslim
3=Christian
4=A dang

6.32. ***Dawrtu che nupui pasal chungchanga an dinhmun tam ber enge*****?** (bawm pakhat chauh thai theih)

1= Nupui nei lo ☐
2= Nupui nei ☐
3= Hnathawk rawn pem nupui nei parawl ☐
4= A dang ☐

6.33. ***Nangmah Dawrtu ten Condom an hmang ngai em?*** : ☐ *(a chhanna pakhat chauh tur. A code inhmeh ber ziak rawh)*
1=Ngai lo
2=Hmang ziah
3=A chang changin

6.34. ***Drugs neih nan inpawlna i hmang tawh em?***
[(chhanna pakhat chauh. A mil chiah bawmah thai rawh)]

Fo ☐ A chang changin ☐ Ngai lo ☐

6.35. ***Zawhna awm leh turte hi inpawlna hman hmaa drugs leh zu hman leh hman loh chungchang a ni***
[(Chhana awmsa hi zawt la tichuan a zawn theuha bawm milah thai rawh)]
Thla 12 kalta chhung khan eng anga zing nge inpawlna in hman:

	Fo	**A chang chang in**	**Ngai lo**
Zu i ruih lain	☐	☐	☐
Drugs i ruih lain	☐	☐	☐
I kawppuiin zu a ruih laii	☐	☐	☐
I kawppuiin drugs a ruih laiin	☐	☐	☐
In pahniha zu in ruih lain	☐	☐	☐
In pahniha drugs in ruih lain	☐	☐	☐
A chunga sawi dinhmun engah pawh khian eng anga zing nge condoms in hmang	☐	☐	☐

6.36. ***Zu/Drug i hman thinna hian engtinnge mipat hmeichhiatna i hman thindan a khawih danglam? -***
[(Chhanna pek sa tinah aw emaw aih thai rawh. A huam ve lo a nih chuan chhana dangah kal nise)]

(Chhana)	**Aw**	**Aih**
Ka hman loh avangin min huam ve lo	☐	☐
Khawih danglam lem lo	☐	☐
Inpawlna hman a tinuam	☐	☐
Inpawlna laia na a tinep	☐	☐
A dang (sawifiah nise)	☐	☐

6.37. ***Venghimtu kawppui I nei em?*** [**(a chhanna pakhat chauh tur. A code dik ziak rawh]**

1= Aw ☐
2= Aih

6.38. ***I chhanna aw anih chuan tunge tunah I neih mek***? **(bawm pakhat chauh thai theih)**

1= mipa ngaihzawng ☐
2= Hmeichhe ngaihzawng ☐
3= Inzawrh pui thian ☐
4= Pimp ☐
5= Mipa drug tih pui ☐
6= Hmeichhe drug tih pui ☐

6.39 ***Engang inpawlna nge nangmah dawrtu che I pek***? **(bawm pakhat aia tam thai theih)**

1= Vaginal sex ☐
2= Anal sex ☐
3= Oral sex ☐
4= Genital stimulation (serh khawiha inhrikthlak) ☐
5= A chunga mi zawng ☐

6.40. ***Engang inpawlna nge nangmawh dawrtu ten an beisei thin***? **(bawm pakhat aia tam thai theih)**

1= Vaginal sex ☐
2= Anal ☐
3= Oral sex ☐
4= Genital stimulation(serh khawiha inhrikthlak) ☐
5= A chunga mi zawng ☐

7. Hleilenna

7.1. ***I nunah hleilenna i tawk tawh ngai em?***
(chhanna pakhat chauh. A bawm mil chiahin thai ang che)

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐
Aih, hrelo, chhang lo a nih chuan 8 naah kal ang che

7.2. **Aw a nih chuan, khawngaihin hleilenna tawh ngun dan han sawi teh**

Fo ☐ A chang changin ☐ Ngai lo ☐

7.3. ***Tawngkaa hleilenna i tawk thin em (Auh nawmnah, an khum/au khum vak vak, in vau)?***
((chhanna pakhat chauh. A bawm mil chiahin thai ang che))

Fo ☐ A chang changin ☐ Ngai lo ☐

7.4. ***Taksa chungah hleilenna i tawk ngai em (ben, velh, pet, Nam/nawr)?***
((chhanna pakhat chauh. A bawm mil chiahin thai ang che))

Fo ☐ A chang changin ☐ Ngai lo ☐

7.5. **Inpawlna hmanga hleilenna i tawk ngai em** ***(pawngsual / i phalna/ duh lova inpawlna hmanpui/vaubeh vang, hmeichhiat/mipat kawnga in nghaisakna)?***
[(Chhanna pakhat chauh. A bawm mil chiahin thai ang che)

Fo ☐ A chang changin ☐ Ngai lo☐

7.6. ***Tu hnen atangin nge hleilenna i tawh thin (tunge a thlentu)?***
[(Chhanna pakhat chauh. A bawm mil chiahin thai ang che)]

(Chhana)	**Aw**	**Aih**
Kawppui tawh thin /bial pa/kawplai mek	☐	☐
Nu leh pate	☐	☐
Unaute (nuta, laizawn)	☐	☐
Chhungkhat hnai tak	☐	☐
Lawiluhna chhungte	☐	☐
Thiante	☐	☐
Hnathawhna a ruaitu	☐	☐
Veng mite/Thenawmte	☐	☐
Police	☐	☐
Midang mi tanpuina pe thinte	☐	☐
Pimp (hmeichhe inzawrhnaa kharchhawngtute)	☐	☐
A Dang (sawfiah nise)	☐	☐

7.7. ***Mi tuin emawDrugs leh zu rui chungin inpawlna hmangin i chungah hleilenna lek a tawh ngai em?***
[(**Chhanna pakhat chauh. A bawm mil chiahin thai ang che**)]

Fo ☐ A chang changin ☐ Ngai lo☐

7.8. ***Hleilenna avangin i Taksa hliam leh na i dawng tawh ngai em***?
[(Chhanna pakhat chauh. A bawm mil chiahin thai ang che)]

Fo ☐ A chang changin ☐ Ngai lo☐

7.9. ***Tanpuitu i zawng ngai em?***
[(Chhanna pakhat chauh. A bawm mil chiahin thai ang che)]

Fo ☐ A chang changin ☐ Ngai lo☐

7.10. ***Tanpuina dawng turin tu hnenah nge i kal thin??***

(Chhana)	**Aw**	**Aih**
Nu Leh pa	☐	☐
Pasala chhungte	☐	☐
Unaute (Nuta, laizawn)	☐	☐
Thiante	☐	☐
Thenawmte	☐	☐
Kohhran/ sakhaw hruaitute	☐	☐
Police	☐	☐
Tlawmngai pawl awmte	☐	☐

Doctor ☐ ☐
Khawtlang hruaitute ☐ ☐
A dang (Sawifiah nise) ☐ ☐

8. HIV/AIDS Hriatna lam

8.1. ***HIV/AIDS i hre tawh ngai em?***
[(Chhanna pakhat chauh. A bawm mil chiahin thai ang che)]

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

8.2. ***HIV/AIDS engtinnge i lo hriat?***
[(Chhanna pakhat chauh. A Code milin ziak ang che)]

☐1= Newspapers, magazines leh advertisements lo chhiarna atangin

☐2= HIV/AIDS chanchin min hriattirtu atangin

☐3= A chunga mi pahnih hmang khian

8.3. ***HIV/AIDS hi i tan vei a hlauhawmin i hria em?***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

8.4. ***HIV/AIDS hi i kawppui tan vei a hlauhawmin i hria em?***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

8.5. ***HIV/AIDS hi nangmah dawrtu te tan a hlauhawmin I hria em?***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

8.6. ***HIV I in test tawh em?***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Aw ☐ Aih ☐ Hre lo ☐ Chhanna awm lo ☐

8.7. ***HIV I in test tawh chuan enge I dinhmun?***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Positive ☐ Negative ☐ Hre lo ☐

8.8. ***HIV/AIDS lakah i inveng thei a ngem:***
[(Chhanna pakhat chauh. A Chhana milin thai ang che)]

Aw ☐ Aih ☐

8.9. ***Dawrtu te zingah engzat nge positive?***

Hre lo ☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 chunglam ☐

9. Rilru Dinhmun:

Kar engemaw zah kalta chhunga I hriselna ka hre duh a ni.

A hnuaia zawhna te leh a chhanna ni thei awm 4 te hi ngun takin chhiar la. i chhanna atana inhmeh bera i rin i kualkhung dawn nia.Zawhna zawng zawng i chhan avangin ka lawm e.

Tun hnai maiah hian:

9.1 ***I thil tihah i rilru i pe thei em?***

Pe tha thei zawk pangngai pe tha thei lo zawk pe tha thei lo zawk fe

(0) (1) (2) (3)

9.2. ***Rilru hah avangin i muhil thei lo em?***

Thei lo hran lo muhil thei zawk muhil thei lo muhil thei lo fe tawh

(0) (1) (2) (3)

9.3. ***Tangkai in in hria em?***

Hre zawk pangngai Tangkai nep Tangkai tawh lo hle

(0) (1) (2) (3)

9.4. ***Thutlukna siam theiin i in ring em?***

In ring zawk pangngai a hma aiin inring lo deuh inring lo viau tawh

(0) (1) (2) (3)

9.5. ***Chau ngawih ngawihin i in hre thin em?***

Hre lo chau lo zawk aw, in hria hah tak ka ni

(0) (1) (2) (3)

9.6. ***I harsatnate i sukiang thei loin i in hria em?***

Hre lo pangngai a hma aiin sukiang thei lo sukiang thei lo fe zawk

(0) (1) (2) (3)

9.7. ***I nitin khawsak phungah i hlim zel thei em?***

A hma aiin ka hlim zawk Pangngai hlim lo zawk hlim lo zawk fe

(0) (1) (2) (3)

9.8. ***Harsatna i tawn i hmachhawn thei em?***

Thei zawk Pangngai thei lo zawk thei lo zawk fe

(0) (1) (2) (3)

9.9. ***Rilru hlim lo leh nguai in i awm em?***

Teuh lo mai Pangngai a hma aiin awm zawk Awm tam zawk fe

(0) (1) (2) (3)

9.10. ***Mahni inrintawkna i hlauh em?***

Teuh lo mai	Pangngai	tunhma aiin hlauh	hlauh nasa khawp mai
(0)	(1)	(2)	(3)

9.11. ***Tangkaina nei lo mihring angin i inngai em?***

Teuh lo mai	Pangngai	tunhma aiin inngai	Inngai zawk fe
(0)	(1)	(2)	(3)

9.12. ***Thil zawng zawng ngaihtuahin i hlim em?***

Tun hma aiin hlim zawk	Pangngai	hlim lo zawk	hlim lo zawk fe
(0)	(1)	(2)	(3)

9.13. ***Thla 12 kal ta chhung khan i nun beidawn avang leh i hlim loh em avawngin nun hian awmzia neiin i hre lo thin em?***
(Chhanna pakhat chauh.bawm mil chiahah thai rawh)

☐1= thin (vawihnih aia tam)
☐2= a changin (vawi khat emaw vawi hnih)
☐3= hre ngai lo

9.14. ***I nunna titawp duh khawpin i hreawm thin em:***
(Chhanna pakhat chauh.bawm mil chiahah thai rawh)

☐1= thin (vawihnih aia tam)
☐2= a changin (vawi khat emaw vawi hnih)
☐3= hre ngai lo

10. Inenkawlna leh Hospitala awm chungchang

Tunah chuan in inchhunga chhengte natna leh inenkawlna thla 12 chhunga in lak dan chungchang ka zawt dawn che a ni.

10.1

	Natna chungchang	*Aw*	*Aih*	*Sawifiah nise*	*tunge*
1	Natna hlauhawm				
2	Natna benvawn				
3	In zai				
4	Kum kalta chhung khan thla 2 aia tam Hospital ah awm				

11. Tanpuina Hmanrua Hriat Dan

11.1. ***Heng tanpuina hmanrua te hi I hria em?***

Hmeichhe tanpuina pe thei tu/ hmanrua	**Aw**	**Aih**
Vantlang hnaihchilha zirtirna petu, a bik takin hmeichhe rualpui zirtirtu an awm em.	☐	☐
Hmeichhe mil zawng HIV/AIDS invenna leh tanpui lam hmanrua.	☐	☐
Hmeichhe drugs ti thinte a thlakthlengna damdawi tela enkawlna.	☐	☐
Mipa condoms lak theih maia awm	☐	☐
Hmeichhe condoms lak theih mai a awm	☐	☐
Hriau leh syringes thianghlim lak theih mai a awm.	☐	☐
Mahni duhthu ngeia HIV nih leh nih loh enna leh counseling na hmun.	☐	☐
Inpawlna hmanga inkai theih natna inentirna leh enkawlna	☐	☐
Antiretroviral damdawi hmanga hmeichhia drugs ti thinte enkawlna	☐	☐
Nuin a fa HIV a kai lohna tura invenna hmalakna.	☐	☐
Hmeichhe Ruihhlo ngaite enkawlna hmun bika awm em	☐	☐
Hmeichhe tan ei zawn tling thei tur thiamthil in zirtirna hmun.	☐	☐
Hmeichhia ten bul in tanna tura sum tlem te a an puk theihna (Mico Finance)	☐	☐
Dan hmanga hmeichhiate humhimna leh an harsatna a dinpuitu.	☐	☐
Chenna/khawsakna him	☐	☐
Rilru hriselna lam puitu	☐	☐
Ei leh in tur tha pe theitu	☐	☐
Naupang tanpuina pethei tu	☐	☐

INTERVIEW GUIDE FOR FGD

Interview Guide for Focus Group Discussion

Women Sex Workers in Aizawl: A Situational Analysis

under the

Department of Social Work

Mizoram University

Supervised by

Dr. Kalpana Sarathy

Associate Professor

Women Sex Worker Consent

Introduction

Greetings. My name is Samuel Lalzarlawma Sailo and I am a Research Scholar from Department of Social Work, Mizoram University. I am carrying out a study among women sex workers in Aizawl. I would like to inquire about the perceptions of women sex workers on how the society, service providers and Church perceived them and request you in participating in a group discussion of the issues.

Purpose of the study

This study is being conducted in order to understand the nature of sex work in Mizoram and various problems faced. A particular focus will be on trying to understand the impact of Sex Work on health, children and social support. This study would help us to understand some of the specific problems that women in such situations face, so that appropriate services can be planned.

Procedure for Focus Group Discussions

You will be asked to participate in a discussion with 9-10 other participants who are also sex workers. A moderator will manage the discussion and raise the topics to be discussed within the group. The discussion will last approximately 45-60 minutes, notes will be written during the discussion by the moderators. The discussion is being conducted at an impartial location where all participants are comfortable speaking. I would like to ask for your consent to be part of this focus group discussion.

Benefits and Risks

Benefits: By participating in this study, you shall be contributing your valuable experience in the study of women sex workers in Aizawl.. Once the assessment is complete more knowledge will be gained through feedback received from the participants and will be used for the study.

Risks: Please keep in mind that while participating in this focus group discussion you will be interacting and disclosing yourself to other participants in the focus group discussion. You will also be discussing sensitive issues. Your opinions and points of discussions will be kept completely confidential, and will only be used for research. However, your participation is completely voluntary and I urge you to participate only if you are completely comfortable in sharing your experience.

Compensation

You will receive no monetary compensation for participation in the focus group discussion. Refreshments shall be provided during the discussion.

I request you to participate frankly and as truthfully as possible. I can assure you that anything you say will be confidential. Your participation in this study is entirely voluntary and you can refuse to answer any question that you do not wish to answer**.**

Is there anything you would like to ask me? If I am unable to answer your question, I will clarify the same with the supervisor of this study and provide you the information.

Confidentiality

Everything that you report during the discussion will be kept strictly confidential and your name will not be recorded on in the notes. NGO staff will not be present at the discussion nor have access to notes. This is done to keep your identity confidential.

Member's Statement

I have read the consent document regarding my participation in the study / the consent document regarding my participation in the study has been read out to me. I have been given a chance to ask questions and my questions have been answered to my satisfaction.

I understand that all records will be kept private and that I can leave the study at any time. I have also understood that my decision not to be in this study or to leave the study will not affect the services I will receive.

I agree to be in this study as a volunteer.

Name of the FGD member_____ (Optional)

Signature/thumbprint of respondent Signature of Research Scholar

(Optional)

Date:_____

Focus Group Discussion Format

Name of Place :

Moderator :

Facilitator :

Observer :

Topic : Perceptions of Sex Worker on how the Health Care Providers, General Community and Church perceived them.

Date :

Time :

The Research Scholar obtained consent from the respondents listed below

No. of participants:-

SI. No.	Name	Code ID	Age	Category	Marital status	Educational attainment	Address
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

Issues Discussed:

1. Perceptions of Sex Worker on how the Health Care Providers perceived them.

   _____

2. Perceptions of Sex Worker on how the General Community perceived them.

   _____

3. Perceptions of Sex Worker on how the Church perceived them

   _____

***Signature of Moderator*_____**

***Signature of Facilitator*_____**

***Signature of Observer*_____**

(FGD Interview Guide adapted from Ethical Guideline for Biomedical Research and Human Participations, Indian Council of Medical Research(ICMR) and NACO Template on Informed Consent)

INTERVIEW GUIDE FOR KII

Interview Guidelines for Key Informant Interview

Women Sex Workers in Aizawl: A Situational Analysis

under the

Department of Social Work

Mizoram University

Supervised by

Dr. Kalpana Sarathy

Associate Professor

Greetings. My name is Samuel Lalzarlawma Sailo and I am a Research Scholar from Department of Social Work, Mizoram University. I am carrying out a study among women sex workers in Aizawl in order to understand the nature of sex work in Mizoram and various problems faced. A particular focus will be on trying to understand the impact of Sex Work on health, their children and social supports. This study would help us to understand some of the specific problems that women in such situations faced, so that appropriate services can be planned in such situations in the future.

I request you to participate frankly and as truthfully as possible. I can assure you that anything you say will be used for the purpose of this study. Your participation in this study is entirely voluntary and you can refuse to answer any question that you do not wish to answer**.**

Is there anything you would like to ask me? If I am unable to answer your question, I will clarify the same with the supervisor of this study and provide you the information.

Signature of KI Signature of interviewer

Date:

Checklist to be completed by interviewer before starting the interview:

(Tick the appropriate boxes)

Introduction and purpose of interview mentioned	
Confidentiality of information emphasized	
Explained that participation is voluntary	
Obtained informed consent	

PART 'A'

Name :

Sex :

Age :

Marital Status :

Department :

Designation :

Date :

Place of KII :

Interview by :

PART 'B'

KI Interview Schedule

1. What is the magnitude of the problem related to sex work in Aizawl?
2. What is the nature and pattern of sex work in Aizawl? Has it changed in recent years.
3. What in your opinion are the key issues and needs of women sex workers in Aizawl?

4. What are the needs or key issues in the execution of Law concerning sex work in Aizawl?

5. As a community leader what are the challenges that you faced to address this problem?

6. What are the challenges faced by your community/ department/organization in dealing with sex work in Aizawl

7. What are the challenges faces by law enforcers as far as sex work in Aizawl is concerned?

8. What are the kinds of support and services that are available for women sex workers in your community/department/ organization?

Do you have any suggestions to address these issues? (KII guidelines adapted from National Guidelines on Ethics for Research on HIV/AIDS, NACO)