CHAPTER - 1

CONCEPT, THEORY AND FRAMEWORK

This chapter deals with conceptual framework of the study. Concept and theory of female sex worker, review of related literature and methodological framework of the study are also discussed in this chapter. Methodological framework includes statement of the problem, research questions, objectives, sampling, tools and techniques of data collection, field work, and delimitation of the study.

1.1 INTRODUCTION

Sex and sexuality is an integral part of human life. It is one of the basic needs of human being which has been surrounded by complex moral and social dilemmas. Sexuality not only keeps generations alive but it also ensures sound physical and mental health. Sex workers in pre-history, history and even in contemporary society are seen to be creation of male domination. Sex workers are produced and reproduced by society for recreation and pleasure of male. They are built for exploiting them physically and mentally. The need and greed of male for female body does not stop until rape and even murder of sex workers. Yet society's attitude towards sex worker across caste, class, religion and region is naive. But sex workers as means of sensual pleasure and physical comfort of the male are not only being perished and ruined, they have now a day's become a threat for entire society. The threat can be observed from the fact that India is the home of more than 3 million people having sero-positivity. The epidemiological interpretation derived from different surveillance data available till date reveals that this threat is

inflowing even in micro society. According to report provided by Assam State Aids Control Society (ASACS), HIV epidemic has entered in Barak valley, a peripheral region of Indian sub-continent. The report also suggests that this epidemic is primarily driven by sex worker and their clients. Clients in turn pass on the transmission of disease to their wives and girl friends, which are the deceased end of transmission chain.

Female sex worker as a part of this social framework grow up with and imbibe with a similar value system. Their positioning into sex work may happen due to a multitude of reasons ranging from being trafficked into the trade at one end, to choosing the trade as a means of livelihood at the other. However this does not change the intrinsic values they have imbibed.

The great majority of HIV infections globally are due to sexual transmission. The links between sex work and HIV/AIDS have been a central concern. It is important to understand the diverse nature of sex work and the attitudes, behavior patterns and contextual factors involved, as the interplay of these dynamics intensifies the risk of HIV transmission.

Silchar town is located in the district of Cachar where a brothel is established since long time. Female sex workers of Silchar town are vulnerable to HIV/AIDS. Physiologically women have a greater vulnerability to HIV/AIDS during sexual intercourse. With the advent of the era of HIV/AIDS, pre existing public health concerns towards female sex workers intensified and they soon emerged as "vectors of the disease"- yet another label amongst many others that they carry.

The concept of sex worker and other related terms are discussed below.

1.2 CONCEPT OF SEX WORKER

A sex worker is a person who works in the sex industry (Oxford English Dictionary). The term "sex worker" was coined in 1978 by sex worker activist Carol Leigh. Its use became popular after publication of the anthology, Sex Work. Written Women in the Sex Industry in 1987, edited by Frederique Delacoste and Priscilla Alexander. The term "sex worker" has spread into much wider use of academicians, NGOs and labor unions, governmental and inter-governmental agencies, such as the World Health Organization[1].

Brothel Based female sex workers are those whose clients contact them in brothels, that is buildings or residential homes where people from outside the sex trade know that sex workers live and work (e.g. Sonagachi in Calcutta, Kamathipura in Bombay). Typically a brothel is a place where a small group of sex workers is managed by a women or agents and usually the sex workers need to pay a part of earning to their agents. **Street Based** female sex workers are those who solicit clients on the street or in public places such as parks, railway stations, bus stands, markets, cinema halls. They entertain their clients in a lodge, car, and truck, hotel room, at the client's home, in a cinema hall or in a public place. **Home Based** female sex workers are those who operate sex work usually from their homes. They contact their clients over phone or through a middleman. Generally, they are not known to be working as sex workers within their neighboring areas. In fact, they could have an entirely different public identity-e.g. housewife. While many sex workers operate "secretly "given the level of harassment, violence and stigmatization they experience from the police and the members of general public ,

1. Carol Leigh, (2004),Unrepentant Whore: The Collected Writings of Scarlot Harlot , p. 69. Retrieved on August 13, 2012 from *http://www.unrepentant whore.com.*

the term "secret" sex workers refers to a specialized category of sex workers. They are only "secret" or "anonymous" in terms of their identity in their immediate context (e.g. family, neighborhoods).**Hotel Based** female sex workers are those who reside in hotel or a lodge and their clients are contacted by the hotel owner, manager or any other employee of the hotel on the basis of sharing the profits. These sex workers do not publicly solicit for clients.[2]

However, the concepts used in the study are operationalised in the following manner.

1.3 OPERATIONAL DEFINITION OF CONCEPTS

HIV/AIDS Consciousness refers to state of being conscious or aware about HIV/AIDS. Awareness means knowledge of virus existence, sensation and thought of female sex workers. Conscious female sex workers know how to prevent sexually transmitted diseases and what medication and measures are to be taken when they are infected by virus.

Female Sex workers – Female sex workers are women who receive money or goods in exchange for sexual services and who consciously define those activities as income generating occupation.

Brothel - An establishment with a number of rooms that acts as a base for sex workers. Sex clients visit the brothel to make contact with the sex workers. The client may use a room at the brothel or may take the sex worker to another place.

[2] NACO (National AIDS Control Organization) October, (2007), *Targeted interventions Under NACP III, Operational Guidelines, Volume - I (Core High Risk group).* Ministry of Health & Family Welfare, Government of India.

The brothel owner takes a good share of the money paid to each sex worker in the house.

Hotel Based sex work – Hotel based sex workers are those who perform sex works in hotels. Hotel based sex workers do not work in hotels rather they directly come to hotel with their clients from within or outsides of the town.

Home-based sex work - Home based sex workers are those who perform sex work in their own house or in rented house. They directly contact with their clients through their network and invite them to their residence when they get a chance of remaining alone at their residence. Sometimes, it is found that single women take rented house in their convenient place to conduct sex work.

Red-light area - Red light area is usually a place where brothels are established. In red light area there may be a single brothel or different brothels. Red light area is generally avoided by people. The clients and venders use to visit red light area.

Street-based sex work - Women who conduct sex work directly on the streets. They actively solicit clients on the street and when they find their client they are picked up from the street to safe place for performing sex work. They tend to work in the day or evenings time.

Clients - Clients are people (usually men) who pay with cash or other resources for sexual services either explicitly or within an agreed package.

1.4 THEORETICAL PERSPECTIVES

There are lot of theories on sex, sex worker, sexuality and consciousness. Some of the major theoretical explanations are briefly explained here.

1.4.1 Bio-medical Theory of Sexual Health

Bio-medical theory of sexual health views sexual health as merely absence of disease or illness. This theory is confined with the intrinsic and extrinsic factors that influence sexual health. Intrinsic factors include the physiological reasons for sexual illness and health where as extrinsic factors stems from germ theory of disease which holds that germs or microbes surrounding us causes many of the sexual diseases which need to be prevented from causing disease. Germ theory of disease is mainly propounded by **Louis Pastur** and **Rovert Koch** and their followers[3].

1.4.2 Holistic Theory of Sexual Health

World Health Organisation (1986) provides a contrasting but comprehensive definition of health. According to WHO, health is a "state of complete physical, mental and social well being not merely absence of disease or infirmity". This paradigm rejects the kind of scientific reductionist characteristic of biomedicine and aims for a more holistic approach (Kelly & Chariton 1995)[4]. World Health Organisation rejects definition of sexual health given by biomedical model which looks sexual health merely as absence of STD/HIV or other sex induced diseases. WHO realises that the biomedical construction of sexual health provides only limited success in changing behaviour and preventing disease[5]. It was increasingly recognised that health status is determined not only by knowledge and the

[3] K. Park, Parks (2007), *Text book of Preventive & Social Medicine,* Banarsidas Bhanot, Jabalpur, pp 12-49.
[4] M. Kelly & B.Chariton (1995), The Modern and Post-Modem in Health Promotion, In: R, Bunton S Nettleton & R Burrows (eds) *The Sociology of Health Promotion: Critical Analyses of Consumption. Lifestyle and Risk*, London, Routledge, p. 78-91
[5] WHO (World Health Organisation) (1986), Ottawa Charter for Health Promotion, Canada, *W.H.O. Reproduced in Health Promotion,* Vol.1, No.1

availability of technical medical services but is inextricably linked to social, political and economic inequality and that this must be addressed if health is to improve long term (Parish 1995)[6].

WHO has given rise to a discourse on Primary Health Care (PHC) and hence subsequently suggests for the discipline of health promotion. WHO proposes health is to be promoted (rather than disease prevented) through social, economic and political change, fostered by multi-sectoral collaboration and public participation (WHO 1978, 1984)[7]. To some extent, health promotion challenges the authority of the biomedical discourse but retains an inherent determinism and empiricism that constructs health as a 'state' that is affected by certain identifiable though complex, variables and systems (Bunton & MacDonald 1992)[8].

Tawil (1995) gives much importance upon behavioural change and structural obstacles towards sexual health promotion. According to him, Behaviour change is conceptualised as obstructed by certain obstacles. Intervention is needed to identify obstacles, ameliorate their effects and, therefore, enable behavioural change. The 'enabling' approach within sexual health stems from this discourse. Obstacles are often related to structural inequalities such as poverty, gender and lack of access to and control over resources (information or medical services). With respect to illness and health seeking behavior again a primary focus concerns the removal of obstacles to appropriate treatment seeking and compliance which

[6] R. Parish (1995), Health Promotion: Rhetoric and Reality, In: Bunton R, Nettleton S & Burrows R (eds) *The Sociology of Health Promotion: Critical Analyses of Consumption. Lifestyle and Risk,* London, Routledge, p.13-24

[7] WHO (World Health Organisation) (1978) Alma Ata 1977: *Primary Health Care, 'Health for All'* Series, no.1, Geneva, WHO. WHO (World Health Organisation) (1984) Health Promotion: *A Discussion Document on the Concept and Principles*, Copenhagen, W.H.O.

[8] R. Bunton & G. Macdonald (eds) (1992) *Health Promotion: Disciplines and Diversity,* London, Routledge.

may be both individual (lack of knowledge) or structural (lack of affordable medical facilities in a poor neighborhoods)[9].

Chambers (1983) also emphasises on structural inequality and public participation within health promotion. He has given importance to a discourse of 'empowerment' and overall community development that advocates putting people first (making interventions people-centered, rather than driven by external imperatives), respecting and building upon their existing knowledge and skills, and facilitating their self-development and participation in civic life[10].

1.4.3 Sociological Theory on Sexuality

Foucault (1978), in his book "History of Sexuality**"** highlights issues of sexuality and identity formation. Foucault's original contribution follows from the intellectual fallacy that was propounded through the 1960s by different psychoanalysts led by Freud (1933)[11] who argued that sexuality is a product of some inner human quality that even goes back to our childhood and this is incited to produce the different behaviors that we engage in as adults. Sexuality was reconstructed around the image of the dominant male phallus. Variations in sexuality were deviations from the masculine sexuality and they needed to be redeemed and understood within the masculine perspective. Foucault's contribution to this debate was to deconstruct this popular belief and argued that

[9] 0. Tawil, A.Verster, K.O. Reilly (1995), *Enabling Approaches for HIV/AIDS Prevention: Can We Modify the Environment and Minimize the Risk? AIDS*, Vol. - 9, No.12, p.1299-1306.
[10] R.Chambers (1983), *Rural Development: Putting the Last First,* Harlow, and Longmans.
[11] S. Freud (1933), *Female Sexuality, Standard Edition,* Vol. 21, Hogarth, London.

sexualities are constantly produced, changed and modified and hence the nature of sexual discourse and experience also changes[12].

Foucault's discourse on sexuality is used by feminists to establish relationship between sexuality and the female body. There are two schools of thought in the area of feminist scholarship about the body and sexuality. There are feminists who have argued that women need to affirm and celebrate the capacity of the female body. This is the capacity to recreate as well as nurture human beings. This school of thought looks at the body more as a biological entity that is a historical in its characteristics and its capacities (Gatens 1992)[13]. Hence this school of thought sees people as essentially male or female and does not look at the power that constructs these body dichotomies. Another school of thought is one that refuses body dichotomies of male/female and claims a history for the body. Within this perspective, understanding the body and sexuality also takes into consideration the different ways in which the environment and other typical activities of the body vary historically and create its capacities, desires and actual material form. To give an example of this perspective, the body of a domestic worker or housewife and the body of a female athlete do not have the same capacities. Each has different capacities as well as different desires and demands in order to accomplish its work. In this case the biological similarities cannot account for the specificity of these two bodies even though they are both female. This kind of formulation is important when studying prostitution so that we do not reify sexual difference but also account for the ways in which typical spheres construct and recreate particular

[12] M. Foucault (1978), *The History of Sexuality*, Vol. 1, Harmon worth, Penguin.
[13] M.Gatens (1992), "*Power, Bodies and Difference" in Barrett Michele and Phillips Anne in Destabilizing Theory: Contemporary Feminist Debates*, Stanford University Press, Standford.

kinds of bodies to perform particular kinds of tasks. In this case therefore we do not see the body only as sexual but as sexual within a context. A formulation that historicizes the body is very useful in seeing the different ways in which power constructs bodies which implores us to challenge power and not the bodies per se. It is also important to note that sexuality and the body are integrally connected to conceptions of femininity and masculinity and all these are constitutive of our individuality and sense of identity (Pateman, 1988)[14]. In that case, when sex becomes a commodity, so are bodies and selves. In trying to understand prostitution the easiest escape route has always been to see it as oppression of women by men as if men and women are rigid categories which can be easily identified and their oppression easily mapped out.

1.4.4 Feminist Theory on Sexuality

Pateman C (1988) in her influential work entitled "Sexual Contract" argues that one has to understand prostitution under the whole rubric of the sexual contract. She argues that in some instances the prostitutes take on sex work in order to earn money like in any other job where women chose to be. However, she is quick to add that we should not therefore just equate prostitution to other forms of labor since in other forms of labor the contract is between the men and workers and here it is exclusively a contract between men and women. She goes on to say that prostitution is part of the exercise of male-right to sex, one of the ways in which

[14] C. Pateman (1988), *The Sexual Contract*, Polity Press, Cambridge.

"men have always ensured that they have access to women bodies". She concludes that prostitution is to be differentiated from other forms of labor[15].

Connell R. W (1987)in the influential work "Gender and Power: Society, the Person and Sexual Politics" has also contributed to this discussion by pointing out that sex work is one that takes place in the context of interpersonal balance of power that derives from the unequal access to resources which one partner possesses and the other does not have. He expands the horizon of resources by noting that in this case resources may include; money, physical strength and sexual attractiveness or even the capacity to deploy anger or love. Indeed the debate on sex work still rages on and a view from the practitioners maybe useful at this point.

Zalduondo B & Bernard J (1995) hold that Sex workers, are often among the poorest and most disadvantaged women in a society. According to them, research indicates that sex work represents an economic or social survival strategy in which sexuality is experienced as a resource that is strategically employed. Research has also shown that the universalizing category 'prostitute' masks an enormous diversity among women who do sex work which is reflected in equally diverse sex trade structures and working conditions[16].

Kempadoo K (l998) uses the term sex worker rather than prostitute to establish a perspective that views prostitution: "not as an identity - a social or psychological characteristic of women, but as an income generating activity or form of labour".

[15] Ibid

[16] B. De Zalduondo & J.Bernard J(1995), Meanings and Consequences of Sexual-Economic Exchange: Gender, Poverty and Sexual Risk Behaviour in Urban Haiti, In: Parker R & GagnonJ 280 (eds) *Conceiving Sexuality: Approaches to Sex Research in a Postmodern World*, London Routledge, p.1 57-183

The emphasis upon sex work as a form of labour challenges dominant representations about 'prostitutes' that are found in many societies and that are linked to patriarchal constructions of womanhood and sexuality. His theory set up an image of a good, moral woman who is often a virgin, or strictly monogamous wife, whose sexuality is controlled by men, usually within the institution of the family vis-a-vis image of a sex worker - a woman who transgresses such social norms and, consequently, is often represented as immoral and as a threat to the social order. According to him, many patriarchal societies hold double standard notion about sex workers. Sex workers are simultaneously seen as a necessary evil and at the same time they provide an outlet for men's uncontrollable sexual 'needs'. They are thus required but despised and, in many cases, being publicly labeled a prostitute. Society creates a deeply internalized lifelong stigma to them. Other, more sympathetic representations of prostitution, try to relate and explain women's participation in the profession to dysfunctional social, economic and psychological processes of which they are said to have become victim and from which they need consciousness and rehabilitation.

The ways in which women experience sex work, and the extent to which a sense of identity or self is shaped around their work varies greatly. It is also becoming clear that sex workers do not necessarily accept or conform to dominant representations of themselves as 'victim' or 'deviant', but that their resistances to, or contestations of such representations and associated exploitative social structures have, until recently, been more or less invisible.

Sex work may be a woman's main form of income generation, it may take place simultaneously with other activities or it may be a coping strategy only in times of

acute need. A woman's sex work may be short lived, long term or part of a seasonal labour cycle. Over the course of a life time however, sex work is usually only one of a variety of income generating strategies. Though all classes of women engage in sex work and for different reasons, notes that in modern societies, especially in developing countries, it is primarily (though by no means exclusively) a working class occupation.

Kempadoo writes……

In most cases, sex work is not for individual wealth but for family well being or survival; for working class women to clothe, feed and educate their children; and for young men and women to sustain themselves when the family income is inadequate.....For the majority, participation in sex work entails a life in the margins[17].

1.4.5 Epidemic and Vulnerability Theory

Epidemic or vulnerability theory on sexual health is developed by world Bank. According to this theory, HIV, the virus that causes AIDS, is transmitted through infected blood (by transfusion, injection, pregnancy or childbirth) or semen during unprotected anal or vaginal intercourse. Heterosexual intercourse comprises the main route of HIV transmission in developing countries but other routes of infection such as contaminated blood or blood products, injecting drug use and anal intercourse between men also contribute to its spread. According to **World Bank** (1997), globally over 33 million people are thought to be infected with HIV

[17] K. Kempadoo (1998), Introduction*: Globalizing Sex Workers' Rights,* In: Kempadoo K &Doezema J (eds) *Global Sex Workers: Rights. Resistance and Redefinition*, London,Routledge, p.1-29

and despite of enormous international prevention effort the number is continually rising[18].

World Bank (1997) has also published report on HIV and AIDs. According to this report the virus that causes AIDS, is transmitted through infected blood (by transfusion, injection, Pregnancy or childbirth) or semen during unprotected anal or vaginal intercourse. Heterosexual intercourse comprises the main route of HIV transmission in developing countries but other routes of infection such as contaminated blood or blood products, injecting drug use and anal intercourse between men also contribute to its spread[19].

1.4.6 Socio-Legal Theory on Sex Work

Predominant social attitudes towards sex work are often reinforced through laws and regulations surrounding sex work which have a profound effect upon sex workers' lives and upon their ability to protect themselves against HIV. Three main types of legal system on sex work exist which are classified as prohibition, toleration and regulation (NSWP, 1997 (Network of Sex Worker Projects), Alexander 1987)[20]. Prohibition refers to a situation where sex work is illegal and women must operate outside the law in situations of extreme insecurity. Examples of this kind of system are found in some parts of the USA and Germany. Prohibition gives rise to a criminalized underground sex trade structure where women may be forced to depend upon third parties for protection or management of business. In such a context, women may be unable or unwilling to access

[18] World Bank (1997) *Confronting AIDS: Public Priorities in a Global Epidemic*, World Bank Policy Research Report, Oxford University Press.
[19] Ibid.
[20] NSWP (Network of Sex Worker Projects) (1997) Making Sex Work Safe, London, AHRTAG, Alexander P (1987) Prostitution: a Difficult Issue for Feminists, In: Delacoste F & Alexander P (eds) *Sex Work: Writings by Women in the Sex Industry*, London, Virago Press, P.185-214

statutory health services and may be working in coercive conditions with limited personal autonomy. A similar situation exists under the 'toleration' system where selling sex itself is not illegal (as long as it is not in a public space) but almost all associated activities (such as soliciting) are illegal, making it almost impossible for women to work without committing a crime. Sex work is thus effectively criminalized. India and the UK are examples of this system. In countries such as Turkey, Senegal or Peru where the sex trade is legal, sex workers are required to register with the State and must submit to mandatory health checks and other occupational controls. Many sex workers resist such regulation (or are ineligible for it because they are immigrants) and continue to work outside the officially monitored system, giving rise to a two tier sex market. Women who go underground are similarly reluctant or unable to access health services and may also work in insecure or coercive conditions. Thus, in many countries, the socio-legal context of the sex trade creates criminalized, insecure, sometimes highly controlled or coercive occupational structures that exist in the informal or unorganized economic sector. In these situations, sex workers are deprived of the protection of standard regulations governing working conditions, workers rights and occupational health. Vulnerability to HIV is magnified in various ways by existing laws and regulations. Sex workers may, for example, have to keep on the move to avoid arrest which increases the potential spread of H1V. Harassment by police means that sex workers may be reluctant to carry condoms with them as these are sometimes used as evidence of sex work. Fear of arrest may also result in hurried and covert sexual encounters where negotiation of safer sex may be difficult. In exploitative or coercive working conditions sex workers may have

little control over their own lives and bodies, and violence (or fear of it) from customers or other trade controllers also affects a sex worker's ability to practice safe sex. Sex workers may not be able to access condoms or treatment, and even where it is theoretically possible, they may fear social exposure or stigmatization. Finally, the poverty that underlies many women's involvement in the sex trade makes life insecure and creates 'day to day' livelihood strategies where condom use for an abstract disease whose threat hovers in the future may not make sense (NSWP 1997)[21].

An additional problem is that the unorganized nature of many sex trades and their ambiguous legal status makes it difficult for women to collectively organize for change, though sex workers' rights organizations and movements do exist, though on a relatively small scale in many countries (predominantly the industrialized nations). These groups argue that the stigmatization and legal contexts that characterize sex work deny women basic civil rights and freedoms which are a pre-requisite to health and well being. Many sex workers' groups (now including the Calcutta-based (DMSC)Durbar Mahila Samanwaya Committee) are thus calling for a decriminalization of the sex trade and other legal reforms (Shrage 1994, Kempadoo & Doezema 1998, Scambler & Scambler 1997)[22].

[21] Ibid

[22] L. Shrage (1994) Moral Dilemmas of Feminism: Prostitution. Adultery and Abortion, London, Routledge, K. Kempadoo & J. Doezema J(eds) (1998) *Global Sex Workers: Rights. Resistance and Redefinition*, London, Routledge, G. Scambler & A. Scambler (eds) (1997a*) Rethinking Prostitution: Purchasing Sex in the 1990s,* London, Routledge.

In the present study, the researcher has used the term sex worker rather than prostitute to reflect a perspective that views sex worker: "not as an identity - a social or psychological characteristic of women but as an income generating activity or form of labour". The present work is linked to the theory advocated by Kempadoo K, Zalduondo B & Bernard J, NSWP and World Bank. Kempadoo's theoretical explanations are also followed in the research study.

1.5 FRAMEWORK OF STUDY

1.5.1 Statement of the Problem

Female sex workers are particularly vulnerable to HIV as well as other STI problems and they represent the most significant core group for transmission of sexually transmitted disease to the rest of the population through their clients (NACO 1999)[23]. The critical factors influencing the rate of spread of HIV and STI from sex workers include the number of clients per day and proportion of men in a society who regularly visit sex workers. In nation like India with high levels of both of these factors and where sex is not protected by condoms, HIV epidemic spreads very rapidly. When sex workers become highly infected by HIV, spread of disease to client groups become easier. Regular clients of sex workers who do not use condom in turn make other sex workers infected, and this cycle leads to higher rate of infection among both the groups. Thus sex workers often carry a high STD burden.

[23] NACO (National AIDS Control Organisation) (1999a) Report from Workshop on Targeted Interventions, New Delhi, NACO, Ministry of Health and Family Welfare, August 1999.

The problem of sex workers are studied by scholars of numerous disciplines with kin interest. Sex work and life of sex workers becomes subject of study not only for medical scientists and epidemiologists but also it attracts attention of sociologists, social workers, anthropologists, political thinkers and many other scholars hailing from multiple disciplines. Even the issue becomes a matter of hot debate and discussion of international organizations like WHO and World Bank. The debate is now in hot discussion due to rapid spread of HIV/AIDs throughout the globe. Unsafe sex work is one of the major causes of rapid transmission and expansion of HIV/AIDs. Out of the vast arena of study on sexual health, study on female sex workers becomes one of the interesting and focus area for scholars. To understand socio-demographic, sexual risk behavior and to assess the level of consciousness in regards to HIV/AIDS among female sex workers, the present study entitled "HIV/AIDS consciousness among female sex workers in silchar town." is undertaken with the intention to study female sex workers in silchar town and the consciousness among them to halt HIV/AIDS epidemic.

1.5.2 Survey of Related Literature

S.k. Ghosh (1989) in his study '*studies on Indian Women through the Ages'* highlights the problems and risk associated with sex workers. He is of the view that thousands of women in India earn their livelihood by sex work. The sex workers face lot of difficulties to earn their livelihood. They always put their life at risk. The risks includes occurrence numerous diseases.[24]

[24] S. k. Ghosh (1989), *Indian Women through the Ages*, Pub- S.B. Nangia, A.P.H. Publishing corporation, New Delhi.

Rajnarayan et.al (1994) emphasize in their study '*human immunodeficiency virus seroprevalence in high risk group at jaipur'* find that female sex workers constitute one of the major high risk groups in India. They conduct study among 250 female sex workers and find that out of 250 cases 25 female sex workers were infected. Out of 25 infected female sex workers 7 were having human immunodeficiency virus and 10 were VDRL reactive.[25]

Kathleen Barry (1995) studies *"The Prostitution of Sexuality"* and says that Women in prostitution are purchased for their appearance including skin color and characteristics based on ethnic stereotyping. Throughout history, women have been enslaved and prostituted based on race and ethnicity, as well as gender[26].

S.K. Ghosh (1996) in his 'book' *'prostitute women*' highlights that the world of prostitution. According to him, the world of prostitution is made of prostitutes, clients and exploiters of prostitution. For him, the exploiters of prostitutes are procures, pimps, madams, landlords who rent out of their premises, brothel keepers, gangsters of the underworld, law enforcement officials, courts and correctional institutions. He highlights history of prostitution and finds that throughout history prostitutes are exploited and suppressed by the society across the globe. For him, man-made law suppresses the social evils and intentionally punishes the prostitutes who come to this profession due to their poor socio-economic circumstances[27].

[25] Rajnarayan et.al (1994), Human immunodeficiency virus seroprevalence in various high risk groups at jaipur. *Indian J Dermatol Venerol Leprol* 60:262-265.
[26] Kathleen Barry (1995), *"The Prostitution of Sexuality.published"* by New York University press.
[27] S.K. Ghosh (1996), *'prostitute women*'New Delhi, Ashis publishing cooperation.

Frederique Delacoste & Priscilla Alexander (1998) in their work *'Sex Work: Writings by Women in the Sex Industry'* bring together over fifty writings by prostitutes, dancers, feminists and social workers on the subject of work in the sex industry. All are strongly pro-prostitution both morally and ethically. They find that a good majority of the writings detail how the industry as a whole has been very good to the workers-particularly financially. Only a few mentions any abuse or personal emptiness suffered as a result of the profession. Essays range from straightforward autobiographies to somewhat pornographic, but all are blunt and very honest[28].

Melissa Farley (2000) in her 'article' *'Women's Health Issues'* finds that commercial sex industry includes street prostitution, massage brothels, escort services, outcall services, strip clubs, lap dancing, phone sex, adult and child pornography, video and internet pornography and prostitution tourism. Most women who are in prostitution for longer than a few months drift among these various permutations of the commercial sex industry. The study also reveals that all sort of prostitution is harmful for women's health[29].

Reed K. (2001) studies on *"A tale of two cities: brothel based female commercial sex work, spread of HIV and related sexual health care interventions in India, using Bombay and Delhi as examples."* The study reveals different prevalence rates in Bombay (50% among CSWs) and Delhi (less than 5% among CSWs). The study highlights that there is no major differences in sex work activity between the two cities. HIV rate in Delhi is simply delayed because of its more isolated

[28] Delacoste Frederique & Alexander Priscilla (1998), 'Sex Work: Writings by Women in the Sex Industry' Retrieved on 13th January, 2015 from .*http://www.amazon.com.*

[29] Melissa Farley (2003) *Prostitution, Trafficking & Traumatic stress*. Haworth Maltreatment & Trauma Press, USA.

geography. But he is of the view that city will be affected greatly if interventions are not started. A short review of interventions shows that education works to promote condom use and may control HIV infection[30].

Parul R Sheth (2003) in her study *'AIDS a fatal gateway'* emphasizes on the deadly Virus HIV that cause AIDS, its prevention initiative, care and treatment. She puts more emphasis on caring for those who are infected because it is a national or international challenge. She also highlights on protection of young generation from premature illness and death. An attempt has been made in her work to present information on AIDS in a lucid manner, especially regarding the preventive efforts and also for people suffering from AIDS who need the valued know-how and support[31].

Desai, V. K. & J. K. Kosambiya e.t al (2003) study *'Prevalence of sexually transmitted infections and performance of STI syndromes against a etiological diagnosis, in female sex workers of red light area in Surat, India'* The study reveals that 43.2% FSWs in a red-light area in Surat were having HIV infection. Despite of regular use of condom by the female sex workers prevelance of STIs and HIV were high. Syndrome case management was poor for asymptomatic cases. Syndrome diagnosis was of limited use in GUS and VDS among sex workers. The study was based on health camp where 124 female sex workers were diagnosed and treated. They find that madams (mausis) of brothel and peer educators play a vital role in disease awareness programme. They conducted group

[30] K. Reed (2001), "A tale of two cities: brothel based female commercial sex work, spread of HIV and related sexual health care interventions in India, using Bombay and Delhi as examples. "New Delhi. *Journal of Family Planning & Reproductive Health Care* 27(4): 223- 227.

[31] Parul R Sheth (2003), *'AIDS a fatal gateway'*, NISCAIR and New Delhi.

meetings and discussed importance of clinical health checkups, laboratory investigations and prompt treatment among the sex workers[32].

Jai P. Narain (2004) studies on *'AIDS in Asia'* where discussion were made mainly on HIV which causes acquired immunodeficiency syndrome (AIDS). He finds that AIDs is the leading infectious cause of adult deaths in the world. He is of the view that experiences in different countries show that HIV can be prevented with high political commitment, adequate human & financial resources & sustained interventions. It is well recognized that the impact of the HIV/AIDS epidemic in the developed & developing countries differs. Up to 95 percent of new HIV infections now occur in developing countries which are unfortunately also the least equipped to respond effectively. With the availability of new drugs, clinical management of HIV has improved remarkably, enabling AIDS patients in developed countries to survive longer. However, these facilities are still beyond the reach of those in the developing world in Asia and Africa[33].

Thakor H G et. al (2004) study '*Prevalence of sexually transmitted infections in sex workers of Surat city' They* Conduct a study on 118 sex workers in Surat of Gujarath. The study reveal that 67% of female sex workers were below the age group of 30 years, 81.5% were illiterates, 90% of them had more than two sex partners per day, 94.4 % used condom regularly, 96.8% used condom during last sex, 47.5% had one or other STDs, 26.6% had pain in lower abdomen, 18.5% had painful urination and 18.5% had abnormal vaginal discharge[34].

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[32] V. K. Desai, and J. K. Kosambiya et al (2003) study *'Prevalence of sexually transmitted infections and performance of STI syndromes against a etiological diagnosis, in female sex workers of red light area in Surat, India.* Sexually Transmitted Infections.

[33] Jai. P. Narain (2004) *'AIDS in Asia': The Challenge Continue,* Sage Publication, New Delhi.

[34] HG. Thakor, J K.Kosambiya , DN. Umrigar , VK. Desai (2004) , Prevalence of sexually transmitted

Dobe M et. al (2004) study on **'***Female Sex Workers in kolkata city'* and found that 51.5% of them entered the profession because of poverty, 48.5% entered in to sex work between 11-16 years of age, 69.7% suffered from white discharge, 21.2% had wrong knowledge regarding disease causation, 27.3% took no treatment for disease[35].

S.P. Shah (2004) Studies on *Prostitution Sex Work and Violence* logistically examine. He highlights narratives of danger and moral decline inflect a red-light area in Mumbai. His work tries to counter the stereotypical image of sex work. He also makes full discussion on certain vital and related issues like trafficking, child prostitution and child marriage in his work. Nevertheless, it is thoroughly insightful and appealing in exploring several sociological issues related to sex work in the country today[36].

K.N. Shiwaswamy et.al, (2005) in their study on '*High seroprevalence of herpes simplex virus-1 and herpes simplex virus-2 in sexually transmitted disease clinic attendees'* found that out of 56 female sex workers herpes simplex virus-1 is prevalent among 6 sex workers and herpes simplex virus-2 is present in 1 sex worker. Out of 56 sex workers 45 cases were found having co-infection[37].

Radhika Ramasubban and Bhanwar Rishyasringa (2005) study on 'AIDS *and Civil societ'*. They are of the view that theoretically everyone is at risk of HIV/AIDS. They also argue that HIV/AIDS is in fact posing a challenge to the

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nfections in sex workers of Surat city. *Indian Journal of community Medicine.*29 (3):104-107.

[35] M. Dobe , M Mundle , R N. Mondal (2004), Knowledge about health and health care seeking behavior of commercial sex workers in Kolkata. *Indian Journal of Community Medicine.* 29(4):196-7.

[36] S.P. Shah (2004) Prostitution Sex Work and Violence: Discursive & Political Context for Five Text on Paid Sex, 1987–2001, Retrieved on 4th November 2015 from *online library.wiley.com.*

[37] K.N. Shivaswamy et.al (2005), High seroprevalence of herpes simplex virus-1 and herpes simplex virus-2 in sexually transmitted disease clinic attendees. *Indian J Dermatol Venereol Leprol,* 71:26-30.

Indian society by bringing the minorities who where hitherto inconsequential, invisible, untouchable and unmentionable prostitutes, transvestites (hijras), truck drivers, migrants, people disabled by the incurable affliction of HIV- out of the margins and into the centre. They also put importance upon issues like treatment and care of positive people, Prevention education at the workplace, Sexuality education, Women in prostitution, Men who have sex with men, & Legal approaches to issues raised by HIV/AIDS[38].

Xiang-Sheng chen et.al (2005) conduct study in Yunnan province of china on 505 female sex workers. The study reveals that out of 505 female sex workers syphilis infected sex workers were 9.5% followed by neisseria gonorrhoea 37.8%, herpes simplex virus-2 65.1%, trichomonas vaginalis 43.2%, Chlamydia trachomatis 58.6% and human immunodeficiency virus 10% respectively[39].

Nag Moni (2006) studies on Diversity in Practice of Prostitution and Ways of Life as the first attempt at a comprehensive, social-science examination of sex work in India. Nag provides information indicating limitations and the comparability of data. Ethnographic studies and in-depth interviews locate the quantitative data in the cultural context of India. She also puts importance on intervention of nongovernmental organizations (NGOs) and government agencies that are developing policies and programs that affect the lives of sex workers[40].

Geetanjali Gangoli (2007) studies 'Indian Feminisms Law, Patriarchies and Violence in India'. Her study sets aside some trends within feminist analysis on

[38] Radhika Ramasubban and Bhanwar Rishyasringa (2005) '*AIDS and Civil society*' Rawat Publication.
[39] Xiang-Sheng chen et.al (2005) Sexually Transmitted Infections among Female Sex Workers on 505 FSW in Yunnan province of china19 (12) 853-860. Retrieved on 12th September 2015, from *www.researchgate.net.*
[40] Moni Nag, (2006) *Sex Workers of India: Diversity in Practice of Prostitution and Ways of Life.* New Delhi, India: Allied Publishers Private Limited.

prostitution in India and depicts that the issue of prostitution has been addressed at least in three distinct ways like silence, as hurt and violence and as potential choice, liberation and identity. She is of the view that women's movement in India does not consider sex work or sex workers as an integral aspect of women's movement. She raises questions why the problems faced by a sex worker in red light area with respect to human rights, police harassment, safety, sanitation, literacy, health, drinking water, congested nature of live in place of work is not given due attention by the mainstream group? Her work highlights opinions and responses on issues related to women's movements and their attitudes towards concerns for sex workers[41].

Mukherjee Krittivas (2007) studies Sex workers chronicle life in brothels of Mumbai. His study offers a snapshot of life in India's biggest brothels. His study highlights the murky world of pimps, violent customers, showcasing dreams and talents of sex workers[42].

Talsania N J et al (2007) emphasize in their study on female sex workers of Ahmedabad. The study reveals that mean age of female sex workers was 27.5 years, 64.5% were below 35 yrs, three fourth were living with their husband, 40% had monthly income of less than 1000. Half of them (49.4%) had vaginal

[41] Geetanjali Gangoli (2007) *Indian feminism: Law, Patriarchies and Violence in India*, Ashgate Publication.
[42] Krittivas Mukherjee (2007) *Sex workers chronicle life in Indian brothels, Mumbai*: Mon Jul 30, edt, Mumbai (Reuters).

discharge as the major complaint followed by genital ulcer, burning micturition and lower abdominal pain[43].

Anuja Agarwal (2008) studies 'chaste wives and prostitute sister: an anthropological study of prostitution and patriarchy among the Bedias, a de-notified tribe'. The Bedias exemplify a situation in which prostitution among young unmarried women is the mainstay of the familial economy of an entire social group. The Bedias makes a clear differentiation between sisters and daughters who are engaged in prostitution, on the one hand, and wives and daughters-in-law who lead a chaste life, on the other. The study also deals with the manner in which the institutions and practices of normal society are implicated in producing, reproducing and framing prostitution in this community[44].

Ramesh B M et al (2008) study 10096 FSW's in 23 districts of southern India. The study shows that the median age of the sex workers in south India is 30 years, 45% are of age group ranging from 25 to 35 years, 46.3% of them are currently married, 43.8% are widowed, divorced or separated, 64.1% are illiterate , HIV prevalence was among 14.6% of the sex workers and median client volume was 7 per week[45].

Hong and Li (2008) conduct behavioral study of sex workers in China. They observe that the CSWs in China are young, mobile, have both commercial and

[43] NJ Talsania , D. Rathod , R. Shah , Y. Patel , N. Mathur (2007), STI/HIV prevalence in Sakhi Swasthya Abhiyan, Jyotisangh, Ahmedabad: A clinico-epidemiological study. *Indian J Sexually Transmitted Disease*.28:15-8.

[44] Anuja Agrawal (2008) *Chaste wives and prostitute sister: patriarchy and prostitution among the Bedias of India.* New Delhi: Routledge (Taylor and Francis Group), 251 pp. ISBN 0-415-43077-1, Indiana University Press.

[45] BM Ramesh , S. Moses , R. Washington ,S. Isac , B. Mohapatra B, Mahagaonkar SB et al. (2008) Determinants of HIV prevalence among female sex workers in four South Indian states: Analysis of cross sectional surveys in twenty-three districts. AIDS, S35- S44.

non-commercial sex partners. They have a poor habit of consistent condom use and thus they have high rate of STD infection[46].

Rekha pandey (2008) studies exploration of the changes in ritualized prostitution from the devadasis to jogins in Andhra Pradesh. She cites a few case studies on how these jogins were later converted to sex workers. The study also includes community-based sex work among Nats, a nomadic community[47].

Rohini Sahni, Shanka Kalyan V. and Apte Hemant (2008) study on the prostitution and beyond. It addresses the phenomenon of sex work through its sections on feminist discourse, ethnographic studies, socioeconomic-legal-health framework and cultural reflection. The existing literature on sex work in India being "fragmented`, the study has attempted to "bring about a coherence of issues that are pertinently entwined" and there by "surface the inherent inter-relations that together from the complexity of sex work` in the country. The topics covered, though not exhaustive, are as diverse and representative as possible. In addition to painstaking research, the study also incorporates case studies, live discussions and interviews drawing from the experiences of a wide spectrum of professionals and organizations working with sex workers[48].

Toorjo Ghose, Dallas Swendeman, Sheba George and Debasish Chowdhury (2008) in their article 'Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India' highlight factors responsible for success of

[46] Y. Hong, Y and Li, X (2008), Behavioural studies of Female Sex Workers in China, A Literature Review and Recommendation for Future Research, *AIDS and Behavior,*12 (4) ,623-636.
[47] Rekha Pandey (2008), *Ritualized Prostitution: Devdasis to Jogins- A Few Case Studies.* Sage Publication.
[48] Rohini Sahni, V Kalyan Shankar & Hemant Apte (2008), Prostitution *and Beyond - An Analysis of Sex Work in India,* Sage Publications.

reduction of risk and disease among the sex workers. The factors responsible for reduction of disease are boundaries, consciousness, negotiation framework, state, the success of the peer led interventions that helped to reduce the number of HIV positive cases in the sex workers of Kolkata. According to them, continuous participation is the key to prevent the HIV infections. But the social factors like age, old practices that prevent the acceptance of the women sex workers in the society is still a largely looming question that needs to be answered[49].

Shymal Kumar Das and Indrajit Kundu (2009) conduct study on 'My Body, My Talk': Empowerment and disempowerment Trajectories of Sex Workers in Bangladesh. The study explores sex workers as a group in the empowerment discourse. Many sex workers who participated in social movements under organizational framework combine more than one job such as a formal job at NGO and sex work. The socio-political-juridical enclaves in society encourage the demand for sex work. Authors argue that once the sex workers have attained power in determining their resources, they gain more resources, attain more decision-making power about all aspect of their lives and achieve more social services such as medical facilities, education etc. and thus the unequal situations at every sphere of their life decrease[50].

Asima Jena and N.Purendra Prasad (2009) study 'Risk Culture, Propertied classes and dynamics of a Region: A study of HIV/AIDS in East Godavari District'. They make an attempt to understand the dominant medical, legal and administrative

[49] Toorjo Ghose, Dallas Swendemanb, Sheba George, and Debasish Chowdhury (2008), Mobilizing collective identity to reduce HIV risk among sex workers in Sonagachi, India: The boundaries, consciousness, negotiation framework. *Social Science Medicine.*67 (2): 311–320.

[50] Shymal Kumar Das and Indrajit Kundu (2009), 'My Body, My Talk': Empowerment and disempowerment Trajectories of Sex Workers in Bangladesh, Sociological Bulletin 58 (3), September- December, pp.383-402, *Journal of the Indian Sociological Society.*

approaches that are used to identify and respond to risk zone in HIV/AIDS discourse in India. They argued that these medical, legal and administrative approaches justify or produce medical facts that incorporate the prevalent social biases in categorizing people and targeting certain groups as a 'risk groups'. The problematic issue in the HIV/AIDS discourse is that it only castigates the commercial aspects of sex work and thereby provides legitimacy to other forms of sexuality as non risk zones[51].

Sumaiya Abedin, Mohammad Atikur, Rahman Khan, Taz Uddin and J.A.M Shopquilur Rahman (2009) in their study "Health Hazards Faced by Floating Commercial Sex Workers: A study in Rajshahi City, Bangladesh" highlight that most CSWs resort to commercial sex for their daily survival and they suffer from various physical problems like vaginal pains, blood discharge, vaginal pus discharge, itching and stitch problem[52].

Ronald Weitzer (2009) examines key dimensions of contemporary sex work, particularly prostitution. He is of the view that most research focuses exclusively on street prostitution and female workers with much less attention devoted to indoor prostitution, male and transgender workers, customers and managers. Further more. He is of the view that most of the literature examines prostitution

[51] Asima Jena and N. Purendra Prasad (2009), Risk Culture, Propertied classes, and dynamics of a Region: A study of HIV/AIDS in East Godavari District (Andhra Pradesh), Sociological Bulletin 58 (3) September- December, pp.383-402, *Journal of the Indian Sociological Society.*

[52] Sumaiya Abedin, Mohammad Atikur, Rahman Khan , Taz Uddin and J.A.M Shopquilur Rahman (2009), Health Hazards Faced by Floating Commercial Sex Workers: A study in Rajshani City, Bangladesh. *The Indian Journal of social work,* Vol-70, 104-115.

where it is illegal, neglecting contexts where it is legal and regulated by the government[53].

Raluca Bardugan, Shiva S. Halli and Frances M. Cowan (2009) in their study female sex work typology in India in the context of HIV/AIDS. The study assesses the appropriateness of the existing typologies from a programmatic perspective and identified their strengths and limitations. It indicates that there is conceptual confusion around the typology and none of the existing typologies are exhaustive because none includes all types of sex work documents in India. The typology developed by NACCO is the most comprehensive. The typology is based on the primary place of solicitation and categories Female Sex Workers as Brothel Based, Street Based, Lodge Based, hotel Based, Home Based, Dabha Based and Highway Based Sex Workers. However this typology has its limitations[54].

Raj Kaushik (2010) studies on Sex Workers Face Abuse in India and finds that despite of being centuries-old profession sex workers in the country face persecution at the hands of police, pimps, brothel owners, senior prostitutes & moral police. A majority of the female sex workers are trafficked into the sex trade either by their lovers, relatives, acquaintances or the senior prostitutes who hail from their village or community[55].

[53] Ronald Weitzer (2009), Department of Sociology George Washington University. *Annual Review of Sociology* Vol. 35: 213-234.
[54] Raluca Bardugan , S. Shiva, Halli and M. Cowan Frances (2009) studies on The female sex work typology in India in the context of HIV/AIDS, *Tropical Medicine and International Health* VOL, 14, pp 673-687.
[55] Raj Kaushik (2010) Sex Workers Face Abuse in India. Retrieved on 2nd October 2015 from *http://www.suite101.com.*.

Suganda Ramamoorthi (2010) studies on commercial sex workers in India. The study reveals that timely sex education to sex workers can make them aware of disease attached with their profession[56].

Mandar M Mainkar, Dilip B Pardeshi, Jayesh Dal, Sucheta Deshpande et al (2011) document the impact of Avahan Programme carried out in the different districts of Maharashtra over a period of 4 years. The study reveals that the programme was able to cover 66% of the female sex workers woking in brothel and street. The programme helped to reduce the sexually transmitted diseases (STDs) like Syphilis among the sex workers. The peer contact model of the programme helped to improve the overall health of the female sex workers[57].

Prabha Kotiswaran (2011) studies on Dangerous Sex, Invisible Labor, Sex Work and the Law in India, The Human Rights Watch estimates there are twenty million sex workers in India. The study highlights the view of feminists on sex work. It is found that radical feminists take a political position, advocating abolition of sex work. To them, sex work is nothing more than violence against women. On the other side, materialist feminists are increasingly taking an economic stance, grounded in Marxian theories of reproductive labor. They appeal to economic justice and view sex work as not unlike other forms of reproductive labor, such as housekeeping and child rearing[58].

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[56] Ramamoorthi Suganda (2010) studies on commercial sex workers in India. *Indian development review* vol. 8 No. 12 (January- December): pp19-28

57 Gautam, et al. (2011) Targeted interventions of the Avahan program and their association with Intermediate outcomes among female sex workers in Maharashtra, India. *BMC Public Health*.11 (Supply 6):S2.

[58] Prabha Kotiswaran , Jul 1 (2011) *Dangerous Sex, Invisible Labour, Sex Work and the Law in India,* pg 298. Retrieved on 19th August 2012, from http*://www.forewardreviews.com.*

In connection with the nature of the problem stated above and also on the basis of existing survey of literature the following objectives have been formulated for the study:

1.5.3 Objectives:

1. To know the perception of STI and HIV/AIDS among sex workers.
2. To study the hazardous health behavior among sex workers.
3. To study the STI and HIV/AIDS consciousness among Female Sex Workers.
4. To study role of government institutions and non-governmental organizations for prevention of HIV among female sex workers of Silchar town.

1.5.4 Research Questions:

1. Why female sex workers of Silchar town are vulnerable to STI and HIV?
2. How do they face and fight with sexually transmitted infection?
3. What role the Govt., NGOS and media play for their consciousness?

1.5.5 Delimitation of the study

The present study is limited to only female sex workers mainly brothel based female sex workers, street based female sex workers, home based female sex workers and hotel based female sex workers of Silchar town. The study conducted among female sex workers located specifically in the area of brothel situated in the heart of the town, areas of cinema halls, bus stand, bank of the river, and street where street based female sex workers remains available. Moreover in some home

also study was conducted where home based and hotels based female sex workers are available at their respective homes of Silchar town, in the district of Cachar.

1.6 METHODOLOGY

1.6.1 The Study Area

All the female sex workers residing in Silchar town constitute universe of the study. **Silchar** is the headquarters of Cachar Dstrict in the state of Assam in India. It is 343 kilometres south east of Guwahati. It is the second-largest city of the state in terms of population and municipal area. It has an airport which is the second busiest Airport in Assam and 4th busiest airport in North-East after Gauwhati, Agartala and Imphal.

Geographically Silchar is located in the southern part of Assam. Situated on the banks of the Barak River, it is a trade and processing centre for tea, rice and other agricultural products. There is limited industry, principally papermaking and tea-box manufacturing.

Approximately 90% residents of Silchar are Bengalis who speak the Sylheti dialect, the rest being Bihari people, Bishnupriya Manipuri, Dimasa , Kachari (Barman), Manipuri (Meitei), Marwaris, Assamese and some tribal groups like Nagas. Silchar is situated by the banks of the River Barak for which the region is popularly known as Barak Valley. Rice is the staple cereal of this region. Fish is also widely consumed by people. Dry fish and fermented fish are widely consumed by people of this region.

During the British rule, ships were docked at the bank of the river Barak. Gradually, a market developed at the bank and became a major place of economic activity. Over the past few years, the town has seen an influx of people from nearby states and places due to the Silchar increasing prospects and other developments in the field of education, medical facilities etc. making the town quite over-crowded.

Some of the Industrial Complexes are also established at Silchar town to implement modern infrastructure and facilities aiming to develop skills to handle the latest automobiles by providing training to the youths. ONGC based at Silchar located in Srikona known as Cachar forward base with ongoing operations in Tripura, Mizoram and Barak valley. Indian Oil Corporation has resolved to set up a mega storage depot at Silchar. Cachar paper mill is a unit of Hindustan Paper Corporation Limited is located in Panchgram. The distance is 26 km from Silchar. Most of the people from Silchar are working in paper mill.

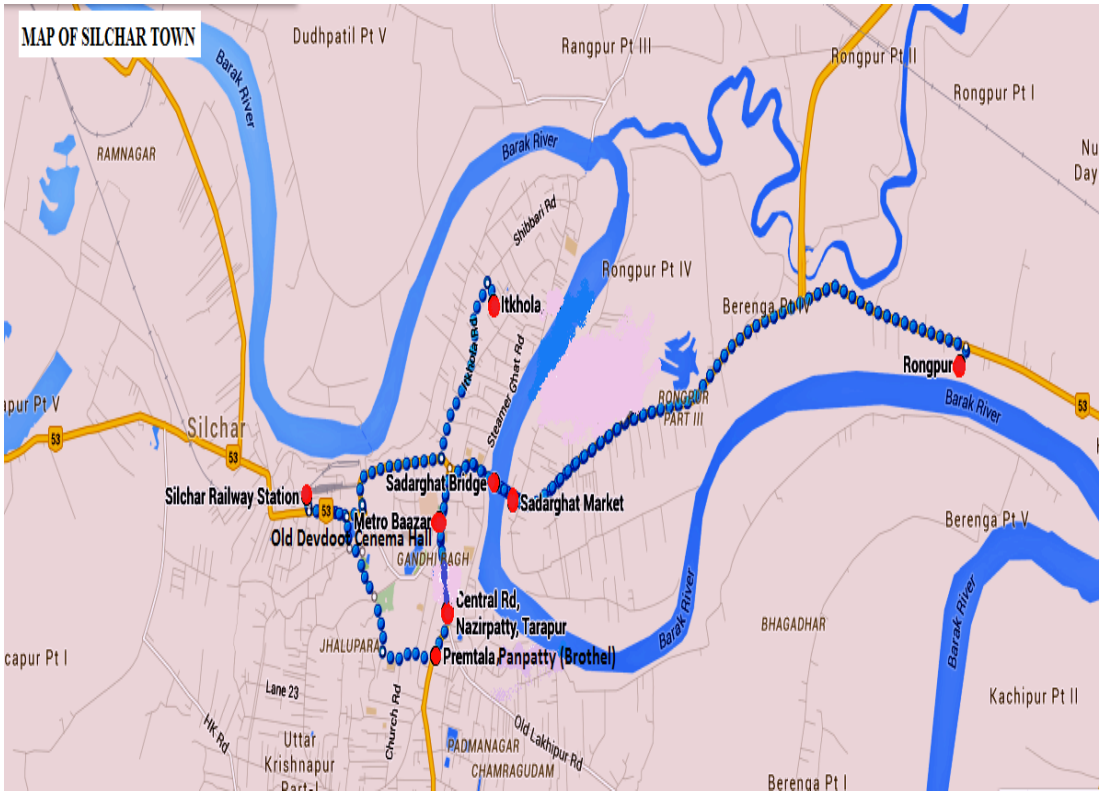
Demographically according to 2011 census report, Silchar has a population of 178,865. Total numbers of males are 89,961 and females are 88,904. The sex ratio of Silchar Town is 988 females per 1000 males, which is above the national ratio of 940 females per 1000 males. Silchar town has an average literacy rate of 91.74%, higher than the national average of 59.5%, with male literacy of 93.97% and female literacy at 89.50%. Major religions followed by the people of Silchar town are Hinduism, Islam, Christianity and Jainism. There are also few Sikhs residing in the town.

Educationally Silchar is endowed with a central university which facilitates education in both the general as well as professional streams. National Institute of

Technology is another institution of higher education from where local students are also getting benefited. There is a medical college and hospital located in the town which serves health needs of the entire region. Apart from these educational institutions there are numerous school and colleges which not only provides education to the students of this region but also increases the influxes of people from other regions.

Silchar has a number of malls and shopping complexes such as Goldighi Mall , Big Bazar, Metro Bazar, Cinema Halls, Vishal Mega-Mart, Entertainment Plaza, Ellora Super Market is a hub of trendy and foreign goods, Nahata -Mart, are located at the heart of the town. Moreover, Silchar has a number of good nursing homes which creates inflow and outflow of different group of people in the town. Silchar is connected by road, railways and air to the rest of the country. The railway station is situated in Tarapur, Silchar which is one of the busiest locality of Silchar town. Regular bus services connect with Silchar Guwahati, Shillong, Aizawl, Agartala and Imphal through NH 37 and NH 53. There is an Inter State Bus and an Inter State Truck Terminus which is another place of public gathering. Silchar has different tourist spots such as Khaspur 20 km away from Silchar town which stands the ruin of a great Dimasa kingdom and capital of Dimas kings of historical time. The main attractions are the Lion Gate, the Sun Gate and age-old king's temple. Bhuban Temple is another spot of tourism which is the most celebrated temple of Lord Shiva in the entire South Assam. Iskcon Temple is another important temple dedicated mainly to Lord Krishna. Gandhibag park is the only Park in Silchar town.

Map: 1
Map of Silchar Town



Source: *http://www.google.co.inmaps/@24.8281717,92.7836395,13z*

Map of Silchar town is given above to indicate different locations where Female Sex Workers are available. Female sex workers are found in streets of Sadar Ghat, Central Road, Bank of the river Barak, Itkhola, Railway Station and Rongpur area. The location of Brothel in heart of Silchar town is also highlighted in the map.

Silchar, Red Light Area

Silchar red-light area has evidence of sex trade from colonial period. Sex trade was started approximately hundred years before in this area and at present it is full pledged red light area with a brothel. Before the establishment of brothel the area was a big market known as Fatak Bazar market. The businessmen as well as merchant used to come from different parts of India and aboard by inland water transport. Foreigners used to visit the market because it was a big tea market of

India. With the intention of recreation of the travelers, merchants, military and policemen at that time sex work was started with 2-3 rooms comprising of 10-15 sex workers. The area of sex trade was adjacent to Sadar Thana but due to public pressure and intervention of local administration the sex trade was shifted to Panpatty area. In this Panpatti area the present brothel of Silchar town is established.

A view of brothel of Silchar town dumped with garbage.

1.7 THE UNIVERSE: The female sex workers in Silchar town constitute the universe of the study. It is very difficult to mention the exact number of female sex workers available in Silchar town at present. According to Desabandhu Club, an NGO based at Silchar town, there are total 1000 sex workers residing in Silchar town including brothel based sex workers. However no other authentic source is available to get exact population of sex workers in Silchar town. Female sex workers of Silchar town in the present study are classified as brothel based sex workers, street based sex workers, home based sex workers and hotel based sex

workers. But exact population of sex workers in each category is not found till now. So it becomes very difficult to know exact size of the population. As per survey conducted before field work in the brothel of Silchar town it observed that total number sex workers residing in brothel is around 500.

1.7.1 Sampling: Out of this 500 population of female sex workers in brothel, total 200 female sex workers are purposively selected for the study. Another 50 sex workers outside the brothel have been selected by accidental sampling method. Out of these 50 sex workers 40 sex workers are street based female sex workers who are mainly available in streets of *Sadar Ghat area, Central Road, Bank of the river Barak, Itkhola, Railway Station and Rongpur area.* Another 7 are home based female sex workers and 3are hotel based female sex workers are selected by accidental sampling method.

1.7.2 Tools and techniques of data collection

The study is descriptive and explorative in nature. Both quantitative and qualitative data are collected for the study. Because of the nature of the problem and difficulties involved in the collection of data the researcher has used quantitative and qualitative data.

Primary data are collected pertaining to the numbers and types of sex workers, their life style, sexual behavior, sexual health and consciousness of HIV/AIDs & STI. In order to gather primary data, observation, interview and case study methods are used as tools for data collection. The primary data is collected from the brothel based, home based, street based and hotel based female sex workers. Moreover, primary data is also collected from key informants like doctors,

counselors, project managers and other official of Aids Control Society, officials of NGOs and peer educators. Case studies of selected female sex workers have been conducted to make the study more intensive.

Secondary data is collected from books, journals, web sites and published & unpublished research studies, official records of NGOs working with sex workers, records of social welfare department of Cachar district (Assam) and records of Assam State AIDs Control Society.

1.7.3 Field Work

For the sake of clarity, the researcher has categorized the fieldwork into 3 phases.

1st Phase: First phase of field work was conducted during June to August, 2010. In this phase feasibility of the study was checked by observing the study area. In this phase of field work I tried to find out the locations where sex workers of Silchar towns can be easily met and to make a rapport with the sex workers whom I intended to meet. But it is very difficult to get direct access to sex workers on the part of an outsider. My access in sex worker's habitation and making familiarity with them became possible for *Deshabandhu Club*, a reputed NGO based at Cachar district of Assam, which works for sex workers of this region. I visited them regularly and kept abreast of contact to respondents for field work and tried to build trust and to ensure confidentiality. Initially they refused to co-operate me since they were fearful to make familiarity with me. Despite of regular visit to them for a period of six months I failed to become trustworthy to them. I felt that it would be impossible on my part to continue my study. Then I took a short term in

house training from *Deshabandhu Club* to make smooth interpersonal communication with female sex working community. Moreover, I got familiar with some of peer educators who were engaged in HIV prevention project work of *Deshabandu club*. But after facing lot of constraint at the initial phase of fieldwork, my inter-personal communication was clicking the mind of Sex workers because I was trained how to communicate and day by day I became familiar and trustworthy to them.

2nd Phase: Second Phase continued from Dec 2010 to Dec 2011. During this phase I was fully prepared for collecting data from the field because I could overcome the problems faced in the earlier phase. In second phase I collected data from female sex workers based at brothel and street of Silchar town. Though I constructed semi-structured interview schedule to conduct interview of respondents but I found the necessity of data collection through participant observation and case study method. My continuous visit to brothel, meeting them in different socio-cultural occasions, interaction with children of the brothel helped me to conduct participant observation smoothly. I also interacted with different people in brothel like regular client, boyfriends or husbands, non-sex working women; ex-sex workers and peer educators. I interacted in such a way inside the brothel that my respondents feel me as a member of their own family.

But it is difficult to conduct participant observation of the street based female sex workers. So I collected data from them through interview schedule and case study method. Along with data collection I also observed many aspects of living conditions of female sex workers in the brothel.

In brothel it was difficult to collect data through one to one contact because whenever I used to visit the brothel a group of sex workers came to meet me together. Then I also collected data through group discussion. Despite of disclosing my purpose of visit to them respondents were not fully aware of the fact. During field work on a number of occasions I heard them telling each other about me that I am an NGO staff or I want to know about their life or I am doing studies on AIDS. Some of the respondents often asked for practical help and advice from me for their involvement in different occupations such as making handicraft products, tailoring or any other work to become self employed because they are always fearful about their old age. Many of the respondents disclosed health problem of self and their kids and sought some advice from me to overcome these problems. I interviewed different sex workers on a number of sittings because most of the time female sex workers of brothel remain busy with their clients and personal works. I visited brothel in the morning because at afternoon or night they remain busy with clients. It is to be mentioned that it was very difficult on my part to control emotions and sentiments of female sex workers. In order to collect data free from bias I tried to maintain a respectable distance. But objective data collection is really a very difficult task.

3rd Phase: Third phase continued for one year from June, 2012 to May, 2013. During this period I collected data mainly from home based and hotel based female sex workers. It is really a difficult task to identify and to communicate to these groups of female sex workers. Because these group of sex workers do not want to disclose their identity easily and they were hidden in nature. I had to suffer a lot to identify them and to make faithful relation with them. In this task I was

mainly helped by some peer educators who know the network of home based and hotel based female sex workers. Initially peer educators were also not agreeing to introduce myself with home based and hotel based female sex workers but my long term interaction and friendship with them helped me to reach to my destination. Finally I got 7 (seven) home based and 3 (three) hotel based sex workers due to strong intervention of my peer educator friends.

I have made contact with total 250 sex workers, including brothel based, street based and home based and hotel based female sex workers. In the month of May 2013, I completed my entire field work.

1.7.4 Data Analysis: The data collected from field through interview Schedule, case study and observation method have been fully analysed scientifically. Statistical techniques are used for analyzing the data since quantitative components of the study are available. Considering the nature of primary data tabulation, graph, charts and pie diagram are used for data analysis. Numerical calculations are also done to analyse the tabulated data. SPSS and other statistical tools are not used to analyse the tabulated data. All the findings of the study are described in a systematic way and no correlation have been drawn.

1.8 SUMMARY

In this chapter, the researcher has described the complex assemblage of factors that affect sex workers' potential vulnerability to H1V. She has also analysed how HIV has illuminated central problems in the understanding of health of female sex workers and vulnerability towards the HIV and STI.