CHAPTER - 2

FEMALE SEX WORKERS AND HIV/AIDS IN NORTH EAST INDIA

This chapter provides a general introduction of female sex workers in India with different historical phases. Female sex workers in contemporary India and their health problems in general and North East India with special reference to Cachar district in particular also discussed in this chapter.

2.1 FEMALE SEX WORKERS IN INDIA

2.1.1 The Historical Development of the Sex Trade in India

In ancient India prostitutes have been referred as *devdasis.* Originally, *devadasis* were dancing girls used in temple ceremonies and they entertained members of the ruling class. But around the 6th century A.D, the practice of dedicating girls to Hindu gods became prevalent tradition that was developed by the ruling class to ritualize prostitution. *Devadasi* literally means God's (Dev) female servant (Dasi), young pre-pubertal girls who were 'married off' or 'given away' marriage to God or Local deity. The marriage usually occurred before the girl reached her puberty to make her a prostitute for upper-caste people. Such girls were known as *jogini.* They were forbidden to enter into a real marital life. The system of *devadasi* started only after the fall of Buddhism and writings about them started to appear around 1000 A.D. It is viewed that the *Devadasi`s* were the Buddhist nuns who

were degraded to the level of prostitutes after their temples were taken over by Brahmins during the times of their resurgence after the fall of Buddhism[1].

Reference of prostitution in Kama sutra written by Vatsyayana mentions the presence of devdasi between the second and fourth centuries in ancient India. Reference to dancing girls in Idian temples is also found in Kalidasa's "Meghadhoot". The popularity of devadasis seems to have reached its pinnacle around 10th and 11th century C.E. The rise and fall in the status of devadasis can be seen to be running parallel to the rise and fall of Hindu temples. The devdasi system was mostly prevalent in southern India and it reached its height during the Chola Empire. The prostitution continued from ancient to medieval India and has taken a more gigantic outlook in modern India, the devdasi system still continues[2].

2.1.2 Sex Work in Contemporary India

The scale of the contemporary Indian sex industry is vast. One report estimates that approximately one million women are presently involved in sex work with a daily average of approximately four million clients (NCW 1996). This report estimates that the economic activities associated with the sex trade total at least Rs.200 crore per year. Studies indicate that India's sex industry is by and large a local trade approximately 94% of sex workers are Indian nationals, 2.6% are from

[1] I. Gilada & V.Thakur (1989), Devadasis: a Study of Socio-Cultural Factors and Sexual Exploitation, Paper Presented at: International Abolitionist Federation: Asian Regional Conference on Exploitation of Women and Children, New Delhi, Supported by Govt. of India & UNIFEM, Marglin F (1985), *Wives of the God King: the Rituals of the Devadasis of Puri*, New Delhi, Oxford University Press.

[2] A. Ramesh (1989), The Devadasi Practice, Paper Presented at: International Abolitionist Federation: Asian Regional Conference on Exploitation of Women and Children, New Delhi, Supported by Govt. of India & UNIFEM, U.N.E.S.C.O. (1995), Ritual Slavery: The Sexual Exploitation of the Devadasis, Commission on Human Rights, Working Group Paper on Contemporary Forms of Slavery, Geneva, UNESCO, April.

Nepal, 2.7% from Bangladesh and a tiny fraction from other countries (NCW 1996)[3].

A recent study conducted by CSWB (1992) estimates that 36.5% are from scheduled castes and tribes, 24.2% from other backward classes and 39% from 'other' groups. Many Indian sex workers are women who originally come from poor, underdeveloped rural communities whose economy is in transition following the introduction of capitalist modes of production. They share a common background of poverty and usually lack of education and employment skills or opportunities. Many women are 'single' or female heads of households having been deserted divorced or widowed or must. Another common feature is that, for various reasons, many of these women lack access to traditional forms of social support via family or kinship networks. Some women are kidnapped or misled into the trade, whereas for others it is a conscious decision - one of the only avenues open to them to earn sufficient money to support themselves (and often their immediate or more extended families). In certain areas and among certain social groups, sex work has become (or has always been) a customary occupation. It is known that the women involved in sex work are extremely diverse. However, this diversity is rarely reflected in contemporary research[4] .

Likewise, although the Indian sex trade often evokes images of seedy, mafia controlled red-light areas like those in cities such as Bombay (and also Calcutta), where women live and work in inhuman and exploitative conditions. Majority of

[3] NCW (National Commission for Women) (1996), Societal Violence on Women and Children in Prostitution, New Delhi, Govt. of India.
[4] CSWB (Central Social Welfare Board) (1992), (Unpublished) Report on the Socio-Economic Study of Female Prostitutes and Their Children in Calcutta, New Delhi, Govt. of India.

India's sex workers do business in a less organised, less controlled and more informal manner (for instance in hotels, in scattered brothels, on the street, in massage parlours, along highways, at village markets and fairs, and, sometimes, in the home). From these instances, it is observed sex trade is widely dispersed and diffused. Some sex workers operate relatively independently, but most must negotiate their work through complex and locally varied networks of power brokers who help to procure clients and may manage certain aspects of their work such as providing a room, food or handling relationships with police[5].

The sex trade forms part of India's unorganised economic sector, characterised by casual unprotected income and absence of employment rights. Even in the large red-light areas, the sex trade tends to operate as a collection of many small-scale businesses or is run on an individual basis. Workers in the sex industry tend to be highly mobile, moving between different sex trade establishments and localities[6].

Most studies on Indian sex workers and publications from sex workers' rights organisations like the Calcutta DMSC, report that the most pressing concerns of sex workers revolve around their legal and social status, such as the lack of social and legal recognition of their profession; financial and occupational insecurity; social stigma; discriminatory treatment by the criminal justice and health care systems. They are also deprived of basic civil rights such as education for their

[5] C. Sleightholme & I Sinha (1996), *Guilty Without Trial: Women in the Sex Trade in Calcutta,* Calcutta, Stree Publishers.
[6] S. Punekar & K. Rao (1962), *A Study of Prostitutes in Bombay,* Bombay, Allied Publishers Private Ltd.

children (until recently schools would refuse admission to children who could not give a father's name)[7].

2.1.3 Red light areas in India

In India there are few districts which are known as red light districts. Red light districts of India include GB Road in Delhi, Sonagachi in Kolkata, Kamathipura in Mumbai, Budhwar Peth in Pune and Reshampura in Gwalior. According to NCW (1996) there are around 2.8 million prostitutes in the country. Most of the girls are brought from Nepal and Bangladesh. "Young girls are trafficked from Nepal to brothels in Mumbai and Kolkata at an average age of twelve. They are trapped into the vicious cycle of prostitution, debt and slavery. By the time they are in their mid-twenties, they are at the dead end. In modern India different kinds of prostitution is prevailing apart from prostitutes in brothel there are street prostitutes, bar dancers, call girls, religious prostitutes, escort girls, road side brothel, child prostitute, gimmick prostitutes, beat prostitutes. Every hour, four women and girls in India enter in prostitution and three of them against their will[8].

According to Human Rights Watch, there are approximately 1.5 million prostitutes in India. There are more than 100,000 women in prostitution in Bombay, Asia's largest sex industry center. Girls in prostitution in India, Pakistan and the Middle East are tortured, held in virtual imprisonment, sexually abused and raped. Girl prostitutes are primarily located in low-middle income areas and

[7] DMSC (Durbar Mahila Samanwaya Committee) (1996a), Sex Workers Right To Self Determination, In: *Souvenir Journal*, Issued at the First West Bengal Sex Workers Conference, April, DMSC, 8/2 Bhawani Dutta Lane, Calcutta 700-073, DMSC (Durbar Mahila Samanwaya Committee) (1998a), We Demand Workers Rights, *DMSC Journal*, DMSC, 8/2 Bhabani Dutta Lane, Calcutta 700-073.

[8] Kaustubh Nandan Sinha (2008), Prostitution in India,6TH Nov 2008, Retrieved on 5th November 2015 from *http://www.legalserviceindia.com.*

business districts and are known by officials. Brothel keepers regularly recruit young girls. An oft-repeated cause of prostitution is poverty. But poverty is only one of the reasons. The helplessness of women forces them to sell their bodies. Many girls from villages are trapped for the trade in the pretext of love and elope from home only to find themselves sold in the city to pimps who take money from the women as commission. The other causes of prostitution include ill treatment by parents, bad company, family prostitutes, social customs, inability to arrange marriage, lack of sex education, media, prior incest and rape, early marriage and desertion, lack of recreational facilities, ignorance, and acceptance of prostitution. Economic causes include poverty and economic distress. Psychological causes include desire for physical pleasure, greed, and dejection[9].

Screening for HIV infections began in India in 1985 as soon as a test for the HIV antibody was available. India's first known HIV infection was diagnosed in a female sex worker in Chennai in February 1986. HIV had been circulating for some years before in India but after screening during 1986-87 it was found that 3%-4% of sex workers in Vellore and Madurai were infected by HIV and other sexually transmitted disease and 1% infected sex workers in Mumbai. There were already over 20,000 cases in the world before any case was identified in India[10].

Sex workers are among those who are most vulnerable to HIV infection. In low prevalence setting with a concentrated epidemic, such as India, Indonesia, Cambodia and the Russian Federation, the HIV epidemic initially spread rapidly among sex workers with prevalence reaching as high as 65% in some sex workers

[9] Azad India Foundation (2015), Retrieved on 12th November, 2015 from *www.AzadIndia.org*.
[10] Binod K. Sahu (2009), *AIDS and Population Education*, PP 2-3. Sterling publishers private limited.

populations[11]. Several factors are responsible for vulnerability of sex workers to HIV. Many sex workers are migrants and are moving to different places and their disease cannot be diagnosed and they remain out of reach to health services. They face cultural, social, legal and linguistic obstacles to get access to health services and proper information relating to sexually transmitted diseases. Many of them experience violent torture on the streets, brothels, on the place of sex work or in their personal residence which increases their vulnerability to various diseases and other health concerns. Research from India shows that many sex workers, particularly those who work on the streets, reported being beaten, threatened with a weapon, slashed, choked and coerced in to sex. In India, 70% of sex workers in a survey reported that they were beaten by the police and more than 80% had been arrested without evidence[12].

The risk of sexual transmission of HIV infection is well established. In situations where sex workers do not have access to condoms, HIV prevention information and sexual health services are at increased risk of contracting HIV. Violence has a direct and indirect bearing on sex worker's ability to protect them from HIV and to maintain good sexual health. Rape (frequent and gang rape) by individuals engaged in high risk behaviors can directly increase their risk of becoming infected with HIV through vaginal trauma and lacerations. Sex workers are surrounded by a complex web of "gatekeepers" including owners of sex establishments, managers, clients, intimate partners, law enforcement authorities and local power brokers who often have control or exercise power over their daily

[11] UNAIDS and WHO (2004).AIDS epidemic update. Geneva, Switzerland Joint United Nation, Programme on HIV/AIDS and World Health Organization.

[12] Sang ram, Point of View and VAMP (2002), Turning a blind eye of veshyas, vamps, wores and women: Challenging preconceived notion of prostitution and sex work.1 (3)

lives. Gatekeepers, for example, may exert control by dictating the amount to be charged by them, how much a sex worker should take from a particular client and even whether the sex worker can or cannot insist on use of condom is determined by gatekeepers. Some gatekeepers exert control through subtle means such as holding a debt, emotional manipulation or through overt means such as threat of a sexual and physical violence and threat of handing them over to legal authorities and forceful use of drug and alcohol[13].

Sex workers also find it difficult to negotiate safer sex with intimate partners or intimate clients in the context of physical and sexual violence perpetrated by some of them. Sex workers often do not have access to health services where Sexually Transmitted Infection (STI) and HIV/AIDS are treated. The reasons for this are varied, but violence or fear of violence and discrimination play a major role on it[14].

According to National AIDS Control Organisation estimated that 2.39 million people live with HIV/AIDS in India in 2008 to 2009. Despite of being home to the world's third-largest population suffering from HIV/AIDS, the AIDS prevalence rate in India is lower than many other countries. In 2007, India's AIDS prevalence rate stood at approximately 0.30% and India's position for HIV prevention is 89th in the world. The spread of HIV in India is primarily restricted to the southern and north-eastern regions of the country and India has also been praised for its extensive anti-AIDS campaign. The National AIDS Control Plan III was set up by India in 2007 and received support from UNAIDS. The main factors which

[13] H. Alexander (2001). The impact of violence on HIV prevention and health promotion. The case of South Africa. *Research for sex Work.*4:20-22.
[14] P. Alexander (2001). Contextual risk versus risk behavior. The impact of the legal, social and economic context of sex work on individual risk taking. *Research for sex Work*.2:3-5.

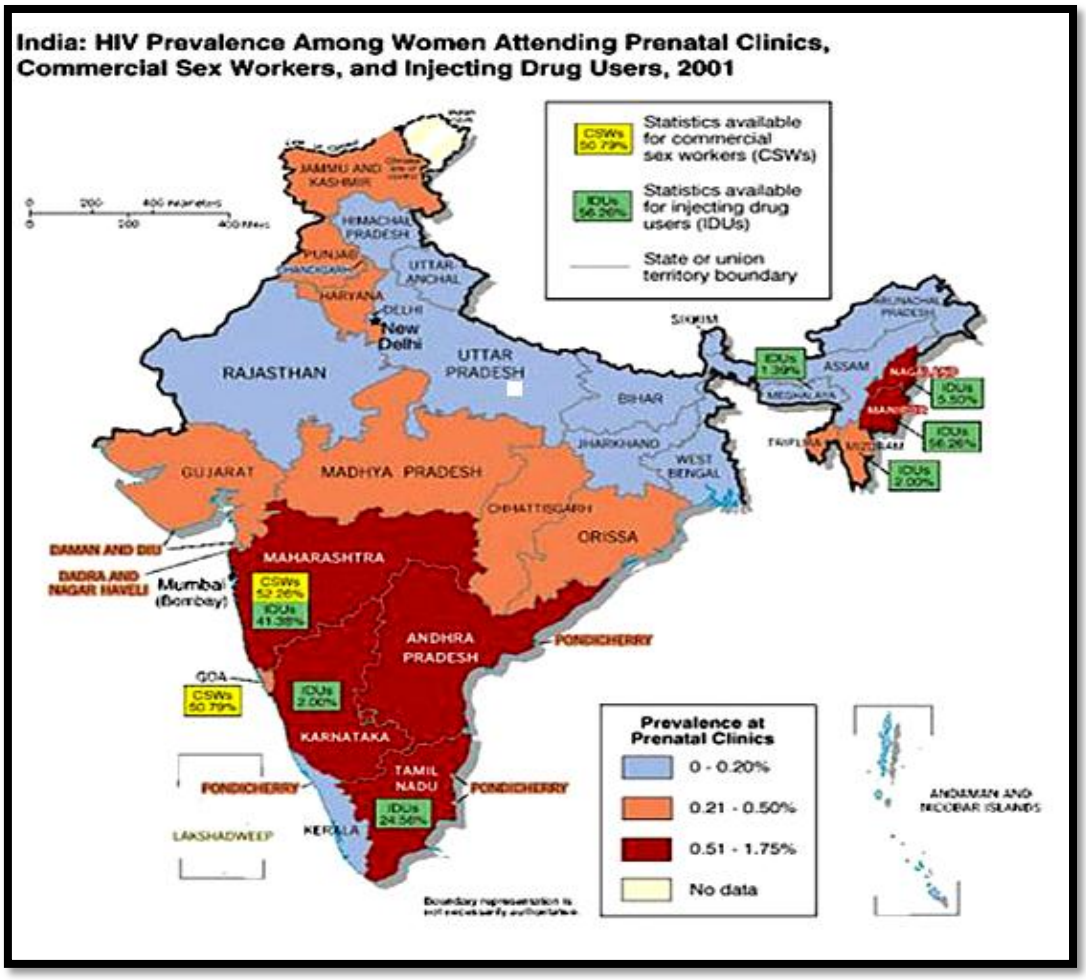
have contributed to India's large HIV-infected population are extensive labor migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity. The Government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS, especially in north-east India and certain urban pockets[15].

A 2006 study published in the British medical journal "The Lancet" reported an approximately 30% decline in HIV infections among young women aged 15 to 24 years attending prenatal clinics in selected southern states of India from 2000 to 2004 where the epidemic is thought to be concentrated. Recent studies suggest that many married women in India, despite of practicing monogamy and having no other risk behaviors, acquire HIV from their husbands. HIV testing of married males can be an effective HIV prevention strategy for general population[16].

[15] http://nacoonline.org/upload/REPORTS/NACO%20Annual%20Report%202010-11.pdf.
[16] A. Das , GR. Babu , P. Ghosh et al. Epidemiologic correlates of willingness to be tested for HIV and prior testing among married men in India. *Int J STD AIDS.* 2013 Dec; 24(12):957-68.

Map: 2

Map of India shows the HIV Prevalence among Commercial sex workers and their level of attending prenatal clinics.

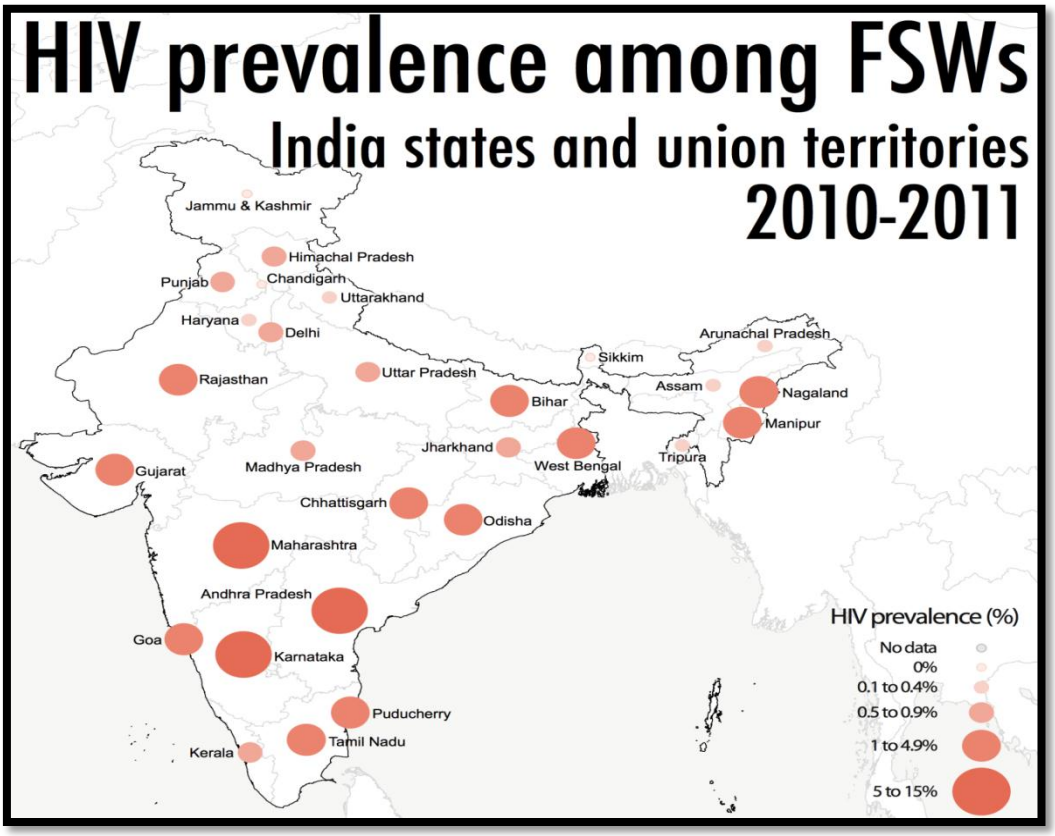


The estimated adult HIV prevalence was 0.32% in 2008 and 0.31% in 2009. The states with high HIV prevalence rates include Manipur (1.40%), Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%).The adult HIV prevalence in India is declining from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. Adult HIV prevalence at national level has declined notably in many states but variations still exist across the states. A decreasing trend is also evident in HIV prevalence among the young population of 15–24 years. The estimated number of new annual

HIV infection has declined by more than 50% over the past decade. According to Executive Director of UNAIDS, India's success comes from using an evidence-informed and human rights-based approach that is backed by sustained political leadership and civil society engagement[17].

Map: 3

Map of India showing the HIV prevalence among Female Sex workers In Indian States and Union Territories, 2010-2011.



Source: Prepared by www.aidsdatahub.org based National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India. (December 2012). HIV Sentinel Surveillance 2010-11: A Technical Brief.

[17]http://www.nacoonline.org/upload/HomePage/NACO%20Press%20Release%20on%20HIV%20Estimates.pdf

According to Government of India data it is clear that in the year 2010-2011 5% to 15% HIV prevelence found among female sex workers in the states of Maharashtra, Andhra Pradesh, and Karnataka, 1% to 4.9% HIV prevelence found among female sex workers in the states of Rajasthan, Bihar, West Begal, Nagaland, Manipur, Gujarat, Chandigarh, Odisha, Goa, PondiCherry, and Tamilnadu. About 0.5% to 0.9% HIV prevelence found among female sex workers in the states of Himachal Pradesh, Punjab, Delhi, Uttar Pradesh, Jharkhand, Madhya Pradesh and Kerala and 1% to 0.4% in Haryana, Uttarakhand, Arunachal Pradesh, Assam and Tripura.

According to Avert, **HIV statistic, 2011,** the state wise statistics for special populations are as follows. Some areas report the presence of the HIV prevalence in antenatal clinics, STD clinics, IDUs, MSMs, FSWs[18].

Table 2.01
State wise statistics for special populations in India

State	Antenatal clinic HIV prevalence 2007 (%)	STD clinic HIV prevalence 2007 (%)	IDU HIV prevalence 2007 (%)	MSM HIV prevalence 2007 (%)	Female sex worker HIV prevalence 2007 (%)
Andhra Pradesh	1 %	17.2 %	3.71 %	17.04 %	9.74 %
Bihar	0.25 %	0.4 %	0.6 %	-	3.41 %
Chhattisgarh	0.25 %	3.33 %	-	-	1.43 %
Goa	0.18 %	5.6 %	-	7.93 %	-
Gujarat	0.25 %	2.4 %	-	8.4 %	6.53 %
Haryana	0.13 %	-	0.8 %	5.39 %	0.91 %
Himachal Pradesh	-	-	-	5.39 %	0.87 %
Jammu & Kashmir	-	0.2 %	-	-	-
Jharkhand	-	0.4 %	-	-	1.09 %
Karnataka	0.5 %	8.4 %	2 %	17.6 %	5.3 %
Kerala	0.38 %	1.6 %	7.85 %	0.96 %	0.87 %
Madhya Pradesh	-	1.72 %	-	-	0.67 %
Maharashtra	0.5 %	11.62 %	24.4 %	11.8 %	17.91 %
Orissa	-	1.6 %	7.33 %	7.37 %	0.8 %
Punjab	-	1.6 %	13.79 %	1.22 %	0.65 %
Rajasthan	0.13 %	2 %	-	-	4.16 %
Tamil Nadu	0.25 %	8 %	16.8 %	6.6 %	4.68 %
Uttar Pradesh	-	0.48 %	1.29 %	0.4 %	0.78 %
Uttaranchal	-	-	-	-	-
West Bengal	-	0.8 %	7.76 %	5.61 %	5.92 %

Source: http://www.avert.org/india-hiv-aids-statistics.htm

[18] *http://www.avert.org/india-hiv-aids-statistics.htm.*

According to Avert, HIV statistic, 2011the Union territories statistics for special populations are as follows. Some areas report the presence of the HIV prevalence in antenatal clinics, STD clinics, IDUs, MSMs, FSWs[19].

Table 2.02

Union territories statistics for special populations

Union Territories	Antenatal clinic HIV prevalence 2007 (%)	STD clinic HIV prevalence 2007 (%)	IDU HIV prevalence 2007 (%)	MSM HIV prevalence 2007 (%)	Female sex worker HIV prevalence 2007 (%)
A & N Islands	0.25	1.33	-	-	-
Chandigarh	0.25	0.42	8.64	3.6	0.4
D & N Haveli	0.5	-	-	-	-
Daman & Diu	0.13	-	-	-	-
Delhi	0.25	5.2	10.1	11.73	3.15
Lakshadweep	-	-	-	-	-
Pondicherry	-	3.22	-	2	1.3

Source: http://www.avert.org/india-hiv-aids-statistics.htm

The above table clarifies the HIV prevalence in Union territories for special population. In Union Territories HIV prevalence among Female sex workers in Delhi 3.5% is most high than Pondicherry 1.3% followed by Chandigarh is 0.4%.

According to Avert, HIV statistic, 2011the North Eastern statistics for special populations are as follows. Some areas report the presence of the HIV prevalence in antenatal clinics, STD clinics, IDUs, MSMs and FSWs[20].

[19] Ibid
[20] Ibid

Table 2.03

North Eastern State statistics for special populations

North Eastern State	Antenatal clinic HIV prevalence 2007 (%)	STD clinic HIV prevalence 2007 (%)	IDU HIV prevalence 2007 (%)	MSM HIV prevalence 2007 (%)	Female sex worker HIV prevalence 2007 (%)
Arunachal Pradesh	-	-	-	-	-
Assam	0	0.5	2.41	2.78	0.44
Manipur	0.75	4.08	17.9	16.4	13.07
Meghalaya	0	2.21	4.17	-	-
Mizoram	0.75	7.13	7.53	-	7.2
Nagaland	0.6	3.42	1.91	-	8.91
Sikkim	0.09	0	0.47	-	-
Tripura	0.25	0.4	-	-	-

Source: http://www.avert.org/india-hiv-aids-statistics.htm

It can be observe from the above table that in north eastern state HIV prevalence among Female sex worker in Manipur 13.07% is most high than Nagaland 8.91% followed by Mizoram 7.2% and Assam next i.e. 0.44%.

So far the researcher has discussed about the origin and development of sex trade in India. Problems of sex workers in their day to day life are also highlighted. It is observed that sex workers face tremendous problem to earn their livelihood from their occupation of sex work. They are not only victim of physical and mental assault but also prone to deadly diseases. Statistical data provided by AIDS Control Society, NACO, Health and Family planning department GOI, highlight the high prevalence of HIV among sex workers.

Sex workers suffer from deadly diseases but their access to health care is very less due to several reasons. Sex trade in North-East India is also highly prevalent and sex workers of North-Eastern states are equally suffering from numerous problems. The researcher discusses the North-Eastern situation in the following parts of this chapter.

2.2 FEMALE SEX WORKERS IN NORTH EAST INDIA

The North Eastern Region, comprising the eight States of Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, is an extensive area, (about 7.8% of India's land mass) with 3.7% of total population of India. It is strategically located, bound by Chinese occupied Tibet and Bhutan to the North and West, Myanmar to the East and Bangladesh to the West and South, connected to mainland India by a narrow corridor in North Bengal. Specifically, the States of Mizoram, Manipur, Nagaland and Arunachal Pradesh share long borders with Myanmar to the East, across hilly, forested, thinly populated terrain. This critical location has had major implications for HIV/AIDS problem in the North Eastern Region. The NE States with the exception of Assam and Tripura are characterized by low population density. The only entry to the NE Region is through Guwahati in Assam. Road transport alone has to meet more than 95% of the transportation needs of the area, all the States being connected to mainland India through Guwahati. The above factors, namely, location of the NER in

relation to Myanmar, terrain, and population characteristics have had major implications for the problem of HIV in this region[21].

2.2.1Background of HIV Transmission in the North Eastern Region

When the first case of HIV was reported in India in the beginning of April 1986, specifically from Bombay and adjoining areas, there was a sense of complacency in the North Eastern States, that being geographically isolated as they are from mainland India, and with small isolated tribal communities, they would be safe from HIV. Still, in line with national policy, HIV surveillance was initiated first at Guwahati Medical College and thereafter at Regional Medical College, Imphal, and other places in 1986. Beginning with the first case of HIV detected in Manipur in September 1986, there has been a steep rise in number of cases detected and prevalence of HIV among specific risk groups in certain States of the Region. The investigation on spread of HIV in the region and number of HIV cases led to the discovery of drug abuse as the chief cause of the HIV problem in the Region[22].

2.2.2 Beginning of HIV Transmission in the NE Region

Initially needle sharing was practiced out of feelings of peer group sharing, and ignorance of HIV and disease risk. Since 1990, needle sharing became a compulsion, due to crackdown by police on drug addicts, on the strength of the "Prevention of Narcotic and Psychotropic Drug Abuse Act of 1985". As a result, in some States of the Region including Manipur, it became illegal to possess a needle and syringe, liable to land the possessor in prison, and illegal to sell a needle and syringe without doctor's prescription. Therefore, in spite of widespread

[21] ISHA, Study Report, 2003.
[22] Ibid 14

awareness among youth, of HIV risk due to needle sharing (almost 85%), many, who would not like to do so, continued to share needles; in place of syringes, ink fillers were being fitted to the needles, which withdraw some blood into the ink filler after the drug is injected into the vein. These factors expose the entire group of addicts to HIV, even if one in the group is positive.

HIV was introduced into the region since some of the addicts are drug traffickers, frequently visiting Myanmar and having regular contacts with addicts and sex workers. Once the HIV epidemic among sex workers was discovered in Thailand in late 1980s, they were screened. Those found HIV positive of Burmese origin were deported back to Myanmar and drug traffickers from Manipur visiting them took the virus back with them to Manipur. Thus with combination of high risk behaviors, youth in Manipur were severely affected and earliest to be affected by the HIV problem. Other States have had apparently a slower progression of drug abuse and HIV, but nevertheless face a major potential HIV epidemic, due to drug abuse catching up among the youth of these States also, (as drug traffickers facing trouble in Manipur and Nagaland States turn their business to other States, finding a large youth population, good number with Westernized values, traditionally liberal attitudes to sex and free lifestyle, widespread unemployment, low skills development for productive employment entrepreneurship and in some tribal cultures, cultural sanction for addictions[23] .

Commercial sex workers (CSWs) were present in significant numbers in all the NE States. Commercial Sex Workers tended to concentrate along main inter-State roads and highways, largely to meet the needs of truck drivers travelling through

[23] Ibid 14

the States. Non-commercial, free sex among youth or sex offered, in exchange for trivial gifts of cigarettes or alcoholic drinks, to Defense personnel and others, was reported to be a major feature in all the States. The major risk groups were as follows: a)Truck drivers in all States, b) immigrant labourers (Arunachal Pradesh and Meghalaya), c) mining labourers (Meghalaya), d) rickshaw pullers (Tripura), e) commercial blood donors (Assam, Manipur and Tripura where commercial blood donation either openly or covertly continued) and f) blood transfusion recipients (particularly in Assam which has large number of private hospitals and nursing homes giving unscreened blood, Tripura, Meghalaya and Manipur where significant number of transfusions were being done at the State HQ, district HQ towns, and Community Health Centre's. The report of high prevalence or suspicion of prevalence of STD among Commercial Sex Workers and/or general population in all States is a matter of concern, since co-existence of STD multiplies HIV transmission risk by 30-50 times[24].

According to State Aids Control Society officials at least 89 cases of full-blown AIDS infections have been detected in Mizoram, out of which 49 patients have died. Describing the incidence of aids in the state as alarming, the officials said that the number of deaths due to AIDS in the state preceded only Manipur and Nagaland. The SACS records said that out of the total 16,983 blood samples tested so far till August 2004, at least 909 people have been found to be infected with HIV. Mizoram-Myanmar border Champhai district has the highest number of HIV positive pregnant women while Aizawl district has the highest number of people infected with the dreaded disease through sex. The Mizoram Government has

[24] Source: NACO

estimated that 779 young Mizo lives have been lost in the last 10 years because of drug abuse which has assumed alarming proportions in the hill State. According to Mizoram Health and Family Welfare Minister F Malsawma a section of illegal migrants from neighboring Myanmar, which is closer to the infamous 'Golden Triangle', had been engaged in smuggling and peddling of contraband drug in the hill State. The comparative finding of 2003-2005 indicates the sharp rose of HIV/AIDS in the Region. It is a fact that trafficking and sexual exploitation is alarming in North East. As per the information given by the government of Assam,-75.65% of 696 sero-positive cases found in Assam is infected through unwanted sexual practices. Study indicated that there are 23,087 HIV positive cases in North East. Around 80% of them belong to the state Manipur alone. About 19,033 out of 1,20,213 drug abusers tested positive in Manipur followed by a distant 1,903 out of 31,391 in Nagaland. In Mizoram there are 1,019 positive cases out of which 18,792 are drug abusers. Assam has 750 positive cases out of 47,307 are drug abusers. Tripura has 278 positive cases out of 17,664. Meghalaya has 70 positive cases out of 17,664 drug abusers. In Sikkim 41 cases are found positive out of 7,800 drug abusers. It is suspected that the figures may be higher looking into the grim situation and as per the fast increased of the cases reported[25].

The border area is looked upon as a site of pervasive threats. If it is not the threat of security, migration or terrorism then there is AIDS, a seemingly insurmountable threat to collective health. And the site of that threat remains the border, whether it is with Bangladesh or with Myanmar. One newspaper report from eastern India encapsulates this threat well. In it is stated: "AIDS, the most feared of modern day

[25] North East, India Harm Reduction Network Report.

diseases, is stealthily spreading from villages along the Indo-Bangladesh border to other parts of the country. Its progress has so far been unhindered. West Bengal has the longest border-sharing zone with Bangladesh and there is a constant flow of infiltrators from Bangladesh to West Bengal[26].

Attached to this threat of migration is the threat of AIDS. One workshop on

AIDS received special coverage because it was a workshop designed for migrant workers. The participants were "35 migrant workers, most of them hailed from Bihar and Bangladesh[27].

The attendance of the workers was meant to seem almost as an admission of guilt. The porous borders of this region are also blamed instead of only the migrants for the growing number of AIDS cases in Northeast India[28].

Female sex workers are one of easiest target is clear from a number of media reports. There is a plethora of reports that clearly blames female sex workers for the spread of HIV/AIDS in Northeast India. Flesh trade is fast spreading its net in Arunachal Pradesh. So are HIV positive cases. The impact of this double trend has made people of the state to sit up. The mission to check sex trade – which is more prevalent in Itanagar – was triggered by the detection of HIV virus in 38 blood samples out of 22,000 during a survey "With flesh trade expanding its base the situation can only become worse"[29].

[26] AIDS: The enemy at the frontier," *The Statesman*, 15 October , 2006.
[27] Advocacy program on HIV/AIDS for migrant workers," *Nagaland Post*, 28 March 2004.
[28] Rebels threaten death to drug addicts, peddlers," *The Shillong Times*, 2 July 2004
[29] Arunachal wakes up to flesh trade & HIV risks," *Hindustan Times*, 13 May 2005

2.2.3 North East Vulnerable to HIV/AIDS

Many North East students go outside of the cities like Delhi, Pune, Mumbai, Bangalore and Kolkata, Chennai and Pondicherry for their higher studies. As per the daily newspaper research conducted amongst the North East students of the above-mentioned metros 607 boys and girls are infected with the HIV. Besides this, as far the information of Govt. of Assam from Guwahati city alone there are 215 infected cases out of which 125 are boys and 90 girls, Dibrugargh, boys 25 and girls 60, Jorhat 42, boys 38 and girls 4, Goalpara 9 , Tezpur 27 ,21 boys and girls 6, Golaghat, 38 boys 16 and girls 22, Barpeta 8, boys 7 and girls 1, Nogaon 54, boys 36 and girls 18 , Dhubri 22, boys 16 and girls 6, Nalbari 3 girls, Mangaldai 1 girls, Dipu 9, boy 1 and girls 8. All are from the wealthy families. They were tested positive however their confidentiality is maintained. This news was one of the shocking news in entire Assam and whole North East as particular. Due to the unending conflict in the region many uninformed boys and girls move out for further study and are vulnerable to HIV and other SIT[30]

Trafficking of women for prostitution has not been documented in North East region, although there are cases of women who are also deceived and find themselves forced into prostitution. There is a significant movement of cross border within the region for prostitution. The cases reported of trafficking have been arising day by day from North East. More work needs to ascertained that extend of coercion in trafficking for the sex industry, as there is also clearly migration for sex work that may not been trafficking. Some report have indicated that South East Asian women especially Indian/North East women trafficked to

[30] Survey paper of ENGKONG, BTC, Assam.

African countries under the guise of working as performers, but then are forced into prostitution[31].

The scholar has highlighted the prevalence of sex trade and spread of HIV virus among sex workers through drug users. Drug use among the youths particularly in the bordering states of North-East India accelerates the spread of deadly diseases of HIV and AIDs. Sex workers of this region are one of the major target groups who are vulnerable for poverty, illiteracy and unemployment. Trafficking of girls and women through border area is another problem surmounted in this region. The above factors along with the factor of terrestrial isolation of the region make the region a hub for spread of HIV and AIDs. Silchar town of Cachar district is an important centre for trade and commerce and it is used by many states of the region as a corridor towards the main land. The scholar highlights the prevalence of HIV and AIDs in Cachar district of Assam in the last part of this chapter.

2.3 FEMALE SEX WORKERS IN CACHAR DISTRICT

Cachar District has its population of around 14.7 lacks and the district is a transport hub for many of the North-eastern states. The prevalence of HIV in the district appears to be low and stable among general population as indicated by low HIV positivity among pregnant women as well as in blood donors. There is no direct source of estimating positivity among bridge and high risk population in the district. However positivity among high risk and vulnerable group provide indication of low to moderate level of HIV prevalence with increasing trend. The

[31] Africa regional report on trafficking in women, forced prostitution and slavery like practice.

epidemic is primarily driven through heterosexual route. The district has geophysical, economic and social factors making it vulnerable to HIV epidemic. The district is susceptible perennial drought and lack of non farm sector activities, absence of employment opportunities, high incidence of poverty and subsequently economic compulsions promote migration of workers to the nearby states. More than 14000 female sex workers and 300 injecting drug users have been mapped in the district. High risk behavior in terms of number of clients and duration of involvement in the sex work seems to indicate towards the driver of the epidemic in this region. The district is implementing of comprehensive HIV/AIDS programme. There are three centre's for HIV counseling and testing service. Two blood banks are operational to provide safe blood to patients. Package of service are available to FSWs through two target intervention (TIs) and one target intervention programme reaching out to the injecting drug users. Care, support and treatment and service to people living with HIV/AIDs are being provided through one ART centre, one community care centre and one district level network. Almost one sixth of estimated pregnancies are covered in PPTCT programme during 2010, still prophylaxis administration for prevention of parents to child transmission is low[32].

Cachar district lies on the southern side of Assam. While its eastern borders are shared with state of Manipur, the western border is shared with Karimganj and Hailakandi district of Assam and Bangladesh. Northern border of the district is attached with Dima Hasao District of Assam and Meghalaya state. Southern border is attached with Mizoram state. There are three blocks in the district. Total

[32] ASACS, Dec 2013, Epidemiological profiling of HIV/AIDS situation at district/sub-district level using data triangulation, Assam.

population of the district is 1,46,9,696 with sex ratio of 945 females per 1000 males. The literacy rate among total population is 67.82% with 75.7% among males and 59.41% among female. Urban population is 201387, will rural population is 1, 243, 534.The economy of the district is mainly dependent on agriculture and related industries and being the transit point for many other state in north east. These entire factors are responsible to increase high risk of infection in the district. The epidemic vulnerabilities include social and political unrest leading to migration, high development of defense personnel's, highway with heavy traffic of long distance truckers and several halting points for them at various locations within the district and key train stations connecting the state of Mizoram, Manipur and Tripura Socio demographic analysis of HRGs shows that female sex workers are more than 25 years age and currently married. Thus risk of heterosexual transmission to the spouse of female sex workers or to vertical transmission to their children cannot be excluded. Typology wise most of the female sex workers in Cachar district (75.1% or 884) are street based sex workers, 19.2% or 266 are home based sex workers while 5.7% or 67 are brothel based. Home based sex workers are known to pose challenge in providing quality service and coverage. Risk behavior analysis shows that more than three fourth of the sex workers are working for more than 2 years and more than 80% of the sex workers have 5 or more clients per week showing high vulnerability of sex workers in the district[33].

[33] Ibid 22

Table 2.4 shows the routes of HIV transmission, and percentage of transmission routes in the district of Cachar.

Table 2 .04

Routes of HIV Transmission

Routes of HIV Transmission	Percentage
Heterosexual	88.31%
Homosexual	2.59%
Blood transfusion	1.20%
Needle Syringe	0.00%
Parents to child	2.50%
Unknown	2.50%

Source: ASACS, Assam Factsheet 2014 district, HIV/AIDS Epidemiological profiles[34]

Data highlights that heterosexual route is the main source of HIV transmission in the district about 88.31% followed by Homosexual 2.59, Blood transfusion 1.20%, Needle Syringe 0.00%, Parents to child 2.50%, unknown 2.50%.

Table 2 .05

Target Population size in the district of Cachar.

High Risk Group Size in Cachar district.			
Target group	Female Sex Workers	Men Sex with Men	Injecting Drug User
Size estimated (Mapping data, 2009)	450	487	-
Covered by TI Programme (2013)	1400	120	300

Source: ASACS, Assam Factsheet 2014 district, HIV/AIDS Epidemiological profiles[35].

[34] ASACS, Assam Factsheet 2014 district, HIV/AIDS Epidemiological profiles.
[35] Ibid

In the year 2009 around 450 numbers of female sex workers were presents in the district but it is clear from the data that numbers of female sex workers were increased in year 2013 and around 1400 female sex workers are presents in the district.

An alarming rise to the HIV infected patients in Barak Valley of South Assam and spurts in prostitution in Silchar town have set the alarm bells ringing. Several NGOs engaged in AIDS awareness campaigns in the region mentioned the spread of the disease in Cachar district was highly alarming because it was never been an HIV prone area. However the district recorded more than a thousand HIV positive cases in the past couple of years[36].

Blood sample collection during January to end of March from Silchar town has resulted in detection of six HIV positive cases. Among them, two are truck drivers, two female sex workers and two commercial sex workers (CSW) who belong to red-light area. This was stated by Nivedita Nari Sangstha (NNS), an NGO working in this area.NNS is working on HIV AIDS Intervention Programme on FSW and truckers. In the year 2005 they collected 200 blood samples from 110 FSW, 88 truckers and two from CSW were taken. Among them, six persons were found HIV positive.NNS was established 1996. It has been registered under Societies Registration Act 1860 in the year 1997 and functioning in a rented house at Sonai Road. Since its inception, NNS has been disseminating information among downtrodden women in the field of social welfare, health, development along with

[36] Flesh trade sets of Barak AIDS alarm," *Times of India*, 1 October 2005.

the action projects and assisting the allied agencies in the concerned field infection rate among women rising alarmingly in Manipur[37].

2.4 SUMMARY

Sex trade in India is having its legacy of ancient time. Gradually it was patronized by a section of people who for their self recreation used to compel women particularly belonging to weaker sections of society to fulfill their lustful desire. Female sex workers serving to fulfill sexual need of male are now in threat for their survival. They are not only starving for food and shelter but for a disease free life. Not only their life is threatened by deadly virus like HIV but they have turned into a medium of HIV transmission which is a threat for all human being since the transmission is increasing in geometric progression in the world. India is also at the vertex of risk. Not only is the urban main land India in serious problem but each and every corner including the remotest part of North-East India is now touched by HIV and AIDs. The Cachar district which has become second district in Assam for spread of AIDs. Silchar town vulnerable to the problem is not an exception as has been revealed.

[37] *Assam Tribune*, 4 December 2005.