Chapter-2

REVIEW OF LITERATURE

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The history of prostitution extends to all ancient and modern cultures. It has been described as "the world's oldest profession" (Keegan, 1974). One of the first forms of prostitution is sacred prostitution, supposedly practiced among the Sumerians. In ancient sources there are many traces of sacred prostitution, starting perhaps with Babylon, where each woman had to reach once in their lives, the sanctuary of Militta (Aphrodite) and there have sex with a foreigner as a sign of hospitality for a symbolic price (Wikipedia, 2013). In ancient Greek society, prostitution was engaged in by both women and boys. Female prostitutes could be independent and sometimes influential women. Some prostitutes in ancient Greece, such as Lais were as famous for their company as well as their beauty; and some of these women charged extraordinary sums for their services. Prostitution in ancient Rome was legal and widespread. Even Roman men having highest social status were free to visit prostitutes of either sex without incurring moral disapproval. A *tawaif* was a courtesan who catered to the nobility of South Asia, particularly during the era of Mughal Empire. These courtesans would dance, sing, recite poetry and entertain their suitors at *mehfils*. High class or the most popular *tawaifs* could often pick and choose between the best of their suitors (Wikipedia, 2016).

During the middle Ages, prostitution was commonly found in urban contexts. Although all forms of sexual activity outside of marriage were regarded as sinful by the Roman Catholic Church, prostitution was tolerated because it was held to prevent the greater evils of rape, sodomy and masturbation. After the decline of organized prostitution of the Roman Empire, many prostitutes had to live as slaves. However religious campaigns against slavery and the growing marketization of the economy turned the prostitution back into business. In the 7^{th} century, the Islamic Prophet Muhammad declared that prostitution is forbidden on all grounds. In Islam religion, prostitution is considered a sin. Despite this, sexual slavery was very common during the Arab slave trade throughout the middle Ages and early modern period, when women and girls from Africa, Central Asia, and Europe were captured and served as concubines in the harems of the Arab World (Wikipedia, 2013).

In the 19th century, legalized prostitution became a public controversy as France and then the United Kingdom passed the Contagious Diseases Acts and legislations mandating pelvic examinations for suspected prostitutes. These legislations applied not only to the United Kingdom and France, but also to their overseas colonies. While in the 19th century, the British in India began to adopt the policy of social segregation, they still allowed their brothels full of Indian women. In the early 19th and 20th centuries, there was a network of Chinese and Japanese prostitutes being trafficked across Asia, in what was then known as the 'Yellow Slave Traffic'. There was also a network of European prostitutes being trafficked to India, Ceylon, Singapore, China and Japan at around the same time, in what was then known as the 'White Slave Traffic' (Fischer Tine, 2003).

Prostitution as a profession has a long history in India. A whole chapter has been devoted to it in Kautilya's *Arthashastra* written in 300 BC and Vatsayana's *Kama Sutra* written between the first and fourth centuries AD (Nag, 1995). It is an admitted fact that prostitution, as we understand it today, is a product of civilization and a byproduct of the marriage institution (Sinha, & Basu, 1994). India, the seat of ancient civilization is no exception to this rule, and its Epics depict in striking contrasts the various phases of the human society. If the Ramayana and the Mahabharata contain beautiful descriptions of the best type and embodiment of perfect womanhood, if *Sita* and *Sabitri* gave the world the highest ideal of monogamic purity and feminine fidelity, it is also in these epics that we find the immense power of the charms of *Rambha, Urbasi, Menaka,* and a host of other celestial nymphs, who could frustrate the penitential vows of even the most austere sage. Vedic texts give account of a mythic empire builder, *Bharata* and prove that people were acquainted with prostitution through references to 'loose women', female 'vagabonds' and sexually active unmarried girls (Ringdals, 2004). *Devadasi* (hand maiden of god) system of dedicating unmarried young girls to gods in the Hindu temples, which often made them objects of sexual pleasure to temple priests and pilgrims, was an established custom in India by 300 AD (Nag, 1995). There are reasonably good records of prostitution in large Indian cities during the 18th and the first half of the 19th centuries of British rule. Prostitution was not considered as a degrading profession in that period as it was from the second half of 19th century. A Calcutta Corporation Reports (1806) highlighted that there were 2540 women in 593 brothels in 82 streets

of Calcutta and they were tax payers of about 6 per cent of Calcutta's revenue (Ghosh, & Das, 1990).

In India, commercial sex work has existed from ancient periods. Female Sex Workers (FSWs) in India can be categorized in distinct groups with different practices and behavior patterns (Chattopadhyay, & McKaig, 2004). Each of these is associated with specific vulnerabilities and risk towards HIV/AIDS. In brothels, the most common form of prostitution occurs; where FSWs are dependent on brothel keepers and other middlemen for soliciting clients and for their protection. In urban areas, restaurants, bars, clubhouses, and massage parlors, etc. provide the venues for the singing, dancing and massaging girls who practice sex work under the veil of providing entertainment. They often have middlemen with whom they share their income. Street-prostitution, primarily involving survival sex work by soliciting clients on streets, is either through organized but informal networks or through direct solicitation. Call girls are mostly urban adult women who may have other jobs but also undertake sex work to improve their finances. They are probably least dependent upon middlemen and their income from sex work is often higher than other FSWs due to the higher paying capacity of their clients. The ever- expanding internal trade routes provide avenues for wayside prostitutes to operate on highways, truck stops and *dhabas* for serving long distance truck drivers and tourists. A unique category of religious prostitutes described as *Debdasi*, *Jogini* and so on, who are initiated at an early age into sex-work following religious ceremonies and are quite often supported by temples and devotees prevalent in India (Chattopadhyay, & McKaig, 2004). Transvestite and transsexual individuals, known as *Hijaras* serve homo sexual male clients, and their risks, vulnerabilities and problems are similar to those of FSWs (Sahasrabuddhe, & Mehendale, 2008).

The advent of HIV/AIDS has generated few empirical studies along with intervention program in red-light areas of few large cities. The findings of these studies corroborate the common knowledge that prostitutes; in general, lead a poor standard of life in dilapidated and unhygienic environments (Thappa et al., 2007). A major portion of their clients' pay has been shared by pimps, landlords, madams, financiers and policemen. They do not get nutritionally adequate food and they are exploited by local traders who sell them as essential goods by charging high price. Because of the strong prejudice against FSWs they cannot take advantage of the

government health facilities and have to depend mostly on local quacks who charge them exorbitantly for treatments and medicines. A large portion of them suffer intermittently from various kinds of STIs, etc.

The literature review was done after scanning relevant literatures from various sources like books, journals, reports of the government and non-government agencies, etc. through both electronic and manual search methods. Very few published works are available on the topic under the present study. Globally, as well as in India, there is plenty of incidences are occurring on the Female Sex workers, but the academic research studies relevant to the topic under the current study are very few. However, an effort is made by the researcher to review the available literature related to this study. By keeping in view the topic of the study, thematic literature review had been done. The first part of this chapter focuses on the knowledge of FSWs on HIV/AIDS and their risk behaviours. The second part made the literature review on the beneficiaries' perception towards the services provided to them by the Governments and/or NGOs. Lastly, this chapter examines the programs undertaken by Governments and NGOs towards mitigating HIV/ AIDS. Some of the relevant studies reviewed are discussed below:

2.1 Awareness of FSWs on HIV/ AIDS and their Risk Behaviors

Bhatta, Neupane, Thapa, Baker, & Friedman (1993) made a study entitled "*Commercial Sex Workers in Kathmandu Valley: Their Profile and Health Status",* on a total of 373 women currently practicing sex for money. The findings of the study indicate that CSWs are not necessarily illiterate or from poor familial backgrounds. Despite this, the economic factor appears to be the major driving force for the majority of the women who enter the sex trade. Although, the majority of the CSWs are involved in other income generating activities (e.g. carpet industry, garment industry, tea shops or small business), the sex trade accounts for a substantial proportion of their average monthly income. That means sex trade in Kathmandu Valley appears to be a financially lucrative profession. The study found that three out of every four CSWs have a STD-related problem. Although the majority of the CSWs claimed to be aware of STDs and the majority is suffering from certain type of STDs, only a small proportion had ever visited clinic for treatment. This may be due to that many of them may not have good knowledge of the signs and symptoms of STDs, or

could be culturally or socially inhabited from seeking treatment or there is generally a lack of easy access to, and availability of specialized physicians. Other than abstinence, the proper and consistent use of condoms is the only known protection against AIDS and STDs. Over 40 per cent of the CSWs interviewed in this study reported that they rarely or never used condoms with clients. Only 2 per cent claimed they used condoms every time they have sex with clients. Clients' displeasure and lack of satisfaction were cited as the main reasons for not using condoms. This study in Kathmandu Valley reinforces the fact that the commercial sex trade is not only a social problem, but also a health problem, as well as economic problem. As long as men decide to engage in commercial sex for one or another reason, there will be women willing to supply the desired services for the right price. The study concluded that neither the legalization of the trade nor the prosecution of those involved would be the appropriate solution.

Bahve, Lindan, Hudes, Desai, Waqle, Tripathi, & Mandel. (1995) in their study "*Impact of an intervention of HIV, sexually transmitted diseases and condom use among sex workers in Bombay, India"* have studied the level of knowledge and use of condoms among the sex workers in Bombay with a view to develop HIV testing intervention programs targeting sex workers and Madam in the brothels of Bombay. In a controlled interventional trial, with the measurement before and after the intervention 334 sex workers and 20 Madams were recruited from an interventional site, and 207 and 17 respectively from a similar control site in red light areas of Bombay. The study found that the base line level of knowledge regarding HIV and experience with condoms was extremely low among both the sex workers and Madams. But after intervention, the use of condom level has increased and they were willing to refuse clients who would not use them. But at the same time they were concerned about the loss of their business if condom use was insisted upon. FSWs stressed for the strengthening of the interventional programs with regard to condom use to prevent and control the transmission of HIV and STDs.

National Family Health Survey-1 (1995) explains the knowledge of AIDS among the general women of Tripura, India. The report shows that the knowledge of the existence of AIDS is limited in Tripura. Only 13 per cent of the married women of 13-49 years have heard about AIDS. The percentage of misconceptions about different ways of getting AIDS ranges from 35 per cent who think that it can be

contracted from shaking hands with someone with AIDS; 82 per cent have thought that AIDS can be contracted through mosquito, flies, or bed bug bites; 41 per cent of women have thought it is curable and 3 per cent have believed that an AIDS vaccine exists. Only 30 per cent correctly thought that AIDS can be avoided by using condoms during intercourse and 35 per cent have thought that it can be prevented by practicing safe sex. Other modes of avoidance of AIDS such as checking blood prior to transfusion, sterilizing needles and syringes for injections and avoiding pregnancy when infected with AIDS are mentioned by only 13 per cent of women, who have heard about AIDS. This particular survey did not include FSWs.

Sentumbwe (1996) made a study on "*Knowledge and Sexual Behavioral Patterns Related to HIV/AIDS Among Commercial Sex workers in Kampala Slum Area"*, which was aimed to determine the knowledge and behavioral patterns related to HIV/AIDS among commercial sex workers living in the Kampala slum areas. The study found that the majority of sex workers had very low educational status and half of them (41.9%) were jobless. Lack of financial support was one of the risk factors which made them vulnerable to sex work. Factual knowledge about HIV/AIDS was high, especially knowledge about HIV/AIDS transmission, the symptoms of AIDS and the asymptomatic nature of infection with the AIDS virus. 59.9 per cent of the respondents felt that they could easily get infected with HIV, since they were not using condoms; were having multiple sexual relations and their partners were not faithful. The remaining others doubted the efficacy of condoms in protecting against the AIDS. Finally, the researcher recommended that as the problem of prostitution is integral to the problem of the spread of STD and HIV/AIDS, there is a need to have sexually transmitted infection programmes to address the special needs of sex workers that drive them into risky behavior even though they are well aware of the potential risks involved.

In-depth interviews were conducted by Pyett, & Warr (1997) in their study *"Vulnerability on the streets: Female sex workers and HIV risk*" with 24 purposively selected female sex workers who were perceived to be vulnerable to risks associated with their lifestyle and occupation. Brothel workers were found to be considerably less exposed to risk than the women working on the streets. Client resistance was the major obstacle to women maintaining safe sex practices. Physical threats and coercion from clients, the absence of legal protection for street sex workers, their extreme

social isolation and lack of community support added to the difficulties experienced by sex workers in their attempts to insist on condoms for all sex services. Youth, homelessness and heavy drug use had contributed to them being at times even more vulnerable because they had less capacity to manage situations of potential violence or STD risk. Whether through sex work or in their private relationships, HIV remains a risk for some of these women. This study highlighted the dangers associated with illegal sex work. While decriminalization of prostitution would reduce some of the dangers to which women were exposed and increase women's capacity to insist on safe sex practices, it is also important for community education programmes to address men's failure to accept responsibility for condom use when taking the services of sex workers.

Westhoff, McDermott, & Holcomb (2000) made a study entitled *"HIV-Related Knowledge and Behavior of Commercial Sex Workers: A Tale of Three Cities"* to measure the HIV-related knowledge and behaviors occurring between the CSWs and their clients in three diverse population centers: Santo Domingo (Dominican Republic), Tijuana (Mexico), and Moscow (Russian Federation). Data were collected from CSWs (n= 78) using a semi structured interview format. The results offer a limited look at the HIV-related risks of commercial sex workers in three diverse settings. The greatest risk for CSWs found in this study was the negotiating power of the clients appears to have over the sex workers. Furthermore, with clients who refuse to pay or who threaten violence for insisting on use of a condom might only exacerbate the risk. Being on the margin of society, the ability of CSWs to negotiate safer working conditions is limited. Moreover, a CSW's financial position can make her vulnerable to customers willing to pay more money for unprotected sex and other high risk practices. It is also found that to sustain sufficient earnings while using a condom requires CSWs to take on more clients as sex with a condom reduced price during the negotiation. More clients mean increasing the competition among the sex workers, as well as risks. The study recommended that HIV-prevention outreach workers be knowledgeable of the risks associated with the CSW population. Peer educators have been shown to be an effective tool in some outreach programs. With training, former CSWs are able to distribute HIV literature and condoms, and to some extent modify the behavior of the target group. A significant HIV-risk reduction among CSWs will come about only when they are empowered by enhanced HIV

knowledge and greater self-efficacy. Outreach programs can assist by: (1) increasing the CSWs' negotiation and communication skills, (2) informing and providing access to barrier methods that will give the sex workers greater control over negotiations, and (3) improving their access to health care services.

Ladipo, Ankomah, Akinyemi, & Anyanti (2002) pointed out in their study *"A Comparative Analysis of Brothel Based Commercial Sex work in Cities and 'Junction Towns' in Nigeria",* that there was no significant difference between the city and junction town sex workers. But in terms of education, significantly more sex workers in the city had at least secondary education than in junction town. Further, the researchers cited that there was no much difference in the knowledge levels of sex workers in the cities and those in junction towns. For both groups of sex workers, less than a quarter knew that a healthy looking person could be infected with HIV, while some cited non use of condoms in risky sex as a predisposing factor to contracting HIV. In both cities and junctions towns, some of the sex workers still 'physically assess' their clients to ensure that they are strong and healthy looking which is perceived to suggest negative HIV status. Regarding the sex and money, the mean number of clients seen per day was significantly higher in the city (4.17) than in the junction town (2.94). However, the amount charged per act of sex in the junction town was almost twice than that charged in the city. Another reason for higher income among FSWs is comparatively lower level of condom use. Substantially, higher economic reward accrues from non-use of condoms in the short run. Sex workers often charge more for clients unwilling to use condoms and significantly higher proportion of those in junction towns compared to cities. The researchers concluded that consistent condom use is much lower in the junction town as the female sex workers have lower risk perceptions of contracting HIV and is a time consuming in a business where time really is money. So, HIV risk reduction programmes must address such needs of sex workers. In addition, programmes with sex workers are less likely to be successful, if their main clientele are not included.

Solomon, & Ganesh (2002) in their article, *"HIV in India: Special Contribution-HIV in India"* mentioned that in ancient times, Indian culture offered the world the renowned treatise on sexuality- the *Kama Sutra.* Sexual imagery found a pride of place in temple sculptures. Elaborate rituals covered marriage, nuptial nights, pregnancy and child birth, recognizing sex and reproduction as part of the social

processes that surrounded them. Such openness about sex and sexuality is now near absent. Talking about sex is taboo, and efforts by policy makers to introduce sex education in schools are half-hearted. There are many social precursors for the rapid spread of HIV in the country including inability to talk openly and learn about sex and sexuality; pressures from family to give birth to an heir and an implicit threat to the marriage when a woman is unable to become a mother, the high prevalence and acceptability of domestic violence against women; the moral double standard imposed on men and women, and the lower status of women in general. The pressure to be a mother is so intense that when a woman has to choose between being HIV-sero-negative but without children and possible conception with possible HIV infection, she often chooses the later.

UNAIDS (2002), in its publication "*Sex work and HIV/AIDS: Technical Update",* reported some factors that increase sex workers' vulnerability to HIV infection. This technical update discussed that stigmatization and marginalization are often linked to sex workers. Social isolation, as a result of stigma and marginalization fosters discrimination that can limit sex workers' access to legal, health and social services; and thus increasing their vulnerability. Secondly, lack of protective legislation and policies makes them vulnerable. Laws and policies to protect sex workers are often non-existent or inadequately enforced. Everywhere sex workers have little hope of successfully bringing charges against someone who rapes them. In contrast, laws, policies and policing methods that perpetuate poor working conditions for sex workers and encouragement of unscrupulous behavior by third parties are common. This combination of circumstances makes both sex workers and their clients more vulnerable to HIV infection. Thirdly, lack of access to health, social and legal services limit sex workers' options to protect themselves from HIV and STIs and get the assistance they or their families may need to address social or legal matter. Inconvenient hours and locations, unwelcoming or judgmental attitudes on the part of health staff and other clients, charging sex workers higher price and overall poor quality of health services are often cited as deterrents. Fourthly, limited information, negotiating skills and power, and access to means of prevention may lead directly to behavior that put sex workers and clients at risk of HIV infection. UNAIDS also documented about other factors which also make them vulnerable to HIV/AIDS like the lifestyle of the sex workers and their increasing mobility.

Khaniya, & Joshi (2004) did a cross-sectional descriptive study entitled *"Sexual Behaviour And Risk Perception Of HIV/AIDS Among Female Sex Workers (FSWs) In Kathmandu City, Nepal"* with the objectives to determine the knowledge and types of sexual behavior that put FSWs at risk of contracting HIV/ AIDS; the reasons for the sex work initiation; the use of condom during sexual activity; and to determine the use of drugs during sexual activity. Different areas of Kathmandu city were selected purposively. The study population consisted of women who were known as waitress in cabin restaurants of Kathmandu as profession and as an extension to the job, worked as female sex workers for the satisfaction of the clients. Sample size was determined by selecting the service areas of PSI. 30 per cent of PSI service areas were selected with 5 respondents from each area making a total of 45. Among 45 FSWs, 55.50 per cent of the respondents fall in the age group 15-20 years and 26.70 per cent fall between the age group 20-25 years. Majority of the respondents (55%) were involved in the sex work for fun/imitation of friends and 44 per cent of the respondents were involved in the sex work because of financial problems. The respondents were practicing only vaginal sex. All of the respondents replied that they were at risk of being infected with HIV if had unsafe sex and have multiple partners. For the majority of the respondents, social workers from different NGOs were the source of information regarding HIV/AIDS. All of the respondents replied that they had used condom last time when they had sex with a client. For majority of the respondents (75%), it is the client who bought the condom and for 24 per cent was themselves. For 60 per cent of the respondents, the reasons for using condom was to prevent both from getting infected with HIV/AIDS and getting pregnant, while for 40 per cent to prevent from getting infected with HIV/AIDS. The pharmacies were the major condom outlets, where more than 78 per cent of the respondents obtained the supply, while the cabin restaurants provided the condom for 11 per cent of the respondents. Majority (89%) of the respondents said that they use alcohol. Among the users, 96 per cent of the respondents replied that they had never forgotten to use condom because they had alcohol and 4 per cent replied that they had not used condom because of the intoxicated condition. The study concludes that young women are involved in the sex work because of fun and the imitation of friends. Awareness about HIV/AIDS among FSWs is high, including awareness about various protective options. Sex workers perceived that they are at a high risk and vulnerable to HIV/AIDS infection and were aware of risk reduction options. They seem to have

good knowledge regarding the reasons for condom use and they were found to be using regularly though it is the client who often bought it. Because of the hesitation, FSWs were reluctant to buy it. Study suggests availability and easy accessibility of condom at the working sites and may reduce the chances of HIV infection among the FSWs.

Hesketh, Zhang, & Qiang (2005) in their study on *"HIV knowledge and risk behavior of female sex workers in Yunnan Province, China: Potential as bridging groups to the general population"* tried to explore factors which may increase the potential for FSWs to act as vectors for HIV transmission. The study was carried out with 84 sex workers in two types of brothel where sex work and injecting drug use are common. The findings of the study show that sex work is carried-out for a short period of time in the late teens and early twenties with low numbers of clients. This means that working lifetime exposure to HIV is low for the majority of these girls and may be a major factor in protecting them from acquiring and transmitting HIV to clients. The risk awareness of HIV among FSWs was good, and also the knowledge of the important modes of transmission (sex and needles) and protective effects of condoms being high. In this context, misinformation about the role of chopsticks, kissing or mosquitoes is probably of minor consequence. The findings also show that the access to condoms was excellent, but the utilization rate was poor especially in the hotels. This is despite good knowledge of the protective effects of condoms, demonstrating the weak association between knowledge and behaviour. The fact that all the 'always' condom-users were from the red light district and clustered in certain establishments and this behavior is because of the influence of brothel owners or perhaps peer pressure and solidarity. Finally, the study reveals that the implications for the potential of FSWs to be a driving force of the HIV epidemic are mixed. Each individual sex worker is exposed for a relatively short time and (for the most part) to relatively few clients, but the corollary is that large numbers of girls are at risk at some point in their life. In the red light districts the risks of HIV transmission appear to be low, but in the hotels low condom use and high STI prevalence create a high potential for HIV transmission.

Hjorth (2005) carried out a research work entitled *"Prostitution, HIV/AIDS and human rights: A case study of sex workers in the township of Katutura, Namibia".* The purpose of the study was to provide an analysis of the link between prostitution,

HIV/AIDS and human rights. Several dimensions of the link between human rights and HIV/AIDS have been examined in this thesis particularly in context of when vulnerable groups, such as sex workers, are prevented from accessing relevant treatment. Since sex work is illegal in Namibia, prostitutes have no access to legal instruments with which to better their work situation. Having no opportunity to seek help and support, they are at great risk of becoming exploited and abused. This thesis discussed briefly the implications of the discrimination and stigma faced by the people living with HIV/AIDS (PLWHA). Though everyone has the right to freedom from discrimination which is included even in the Namibian Constitution, but PLWHA in Namibia, in particular those engaged in sex work; do not enjoy this right to the fullest. The informants participating in the study claimed that during visits to a health clinic, they had experienced double discrimination- both as sex workers and as HIV-positive. When discrimination and stigma is very much prevalent in a society, it may form a major obstacle to accessing adequate health care. This is particularly problematic in an HIV/AIDS context, since the rate at which the progression of the disease is entirely dependent upon the level of access to health care by PLWHA. The thesis also discussed poverty aspects of the AIDS epidemic, on an individual as well as at national level. The study suggested that the eradication of poverty would contribute to the improvement of the national AIDS response as treatment and medication could then be made available to a greater part of the PLWHA. Providing medication to PLWHA has proven to be almost a mission impossible for the government of many developing nations.

Myhrman, & Gerdin (2005) in their study *"Awareness and Stigma Related to HIV among Sex Workers in Pune, India"*, stated that none of the respondents had a good socio-economic status. The sex workers have a client turnover of 3 to 4 per day and also have to pay a rather large part of their income plus rent to the brothel owner. There is no safe way for the sex workers to perform their work outside a brothel, so they have to accept the conditions. Regarding information and knowledge about HIV/AIDS, it seems to be highly spread among sex workers. It is mainly health workers and doctors who deliver the information, but friends and media contribute. Teachers and parents have barely any role in spreading information. Schools commonly don't teach about STDs and condoms, because it is seen as promoting promiscuity. Ignorance among youths leads to increase risk behavior. The study also

found that clients pay more for sex without condom, which makes it hard for the sex workers to insist on it. The researchers stated that the sex workers have the problem with addiction to alcohol and drugs and they need to earn enough money to meet the cost of their addiction habits. The study also found that FSWs tend not to use condom with husbands, regular sex partners and with their lovers which is another risk factor to their vulnerability to HIV/AIDS.

Tran, Detels, Long, Van, & Lan (2005) in their study on *"HIV Infection and Risk Characteristic among Female Sex Workers in Hanoi, Vietnam"*, suggest that sharing injecting equipment is the primary cause of the rapid increase of HIV infection among the FSW population in Hanoi. The majority (64%) of drug injecting FSWs in the study shared needles and syringes. The combination of drug use and sex work in this population not only put them at very high risk, but also makes them an important source of infection to others. Young and lower class FSWs with a low level of education and poor knowledge of HIV/AIDS are a very vulnerable group for HIV infection. Once they begin injecting drugs, they lose direction, and are less concerned about their potential risks. The study also found many difficulties in implementing interventions for this particular group of FSWs. Being both sex workers and drug users, they face even greater stigmatization, which isolates them from the rest of the society and even from their non-addicted sex working peers. Low social status, feelings of inferiority and stigmatization make this group depressed and are often less concerned about their potential infection risk; and harder to reach with intervention messages. In this study, the researchers suggested that intervention should promote their self-esteem, reduce stigmatization and reduce their risk behaviors. In addition, power relationship between women and men needs to be changed. Innovative intervention strategies that rely less on the individual power of FSWs, such as interventions for clients of FSWs or interventions including primary sexual partners of FSWs, are also needed.

UNAIDS Inter-Agency Task Team (2005) published their article on *"HIV/AIDS, Gender and Sex Work"* and discussed about the importance of understanding the diverse nature of sex work and the attitudes, behavior patterns and contextual factors involved. The interplay of these dynamics intensifies the risk of HIV transmission. The publication reported that high rates of infection among sex workers may not be due to the fact that they have multiple partners but rather due to a

combination of factors that compound their risk. These factors include poverty, low educational level and consequent levels of knowledge about HIV/AIDS and available preventive measures; limited access to health care services and prevention commodities (such as condoms); gender inequalities; and limited ability to negotiate condom use; social stigma and low social status; drug or substance abuse and compromised sexual interactions; and lack of protective legislation and policies. Sex workers are often outside the protection of the law and particularly vulnerable to coercion and rape. Social stigma and discrimination against sex workers create an environment that perpetuates a culture of violence. Their basic human rights to protection and redress them are commonly disregarded; they are more often penalized and regarded as criminals. They are often targets of harassment, extortion, and deportation from within their own networks of clients, pimps, regular partners and law enforcers. Finally, the publication also recommended some innovative HIV prevention programmes for sex workers.

Dandona, Dandona, Kumar, Gutierrez, McPherson, Samuels, …..ASCI FPP Study Team (2006) made a study entitled "*Demography and sex work characteristics of female sex workers in India",* where 6648 FSWs from 13 districts of Andhra Pradesh were interviewed. Researchers reported that 86 per cent of the FSWs under the study were between 15 to 34 years of age. The home based sex workers also included traditional sex workers, who are in sex work because of the tradition that the elder girl of the family is required to economically support the household through sex work. The data of the study indicated that the turnover of the street based FSWs is higher as compared with non-street based FSWs. The street based FSWs were at a higher risk of HIV infection, because they use condom less often with the clients compared to others. FSWs under the study also reported almost negligible use of condom with their regular partners. Condom used by married FSWs is low because condom is seen as a contraceptive measure. So according to the researchers, within the Indian societal context, promoting condoms with regular partners is not possible without the involvement of men. Moreover, the legal status of sex work in India results in making the already invisible sex workers populations more inaccessible to HIV prevention programs, decreasing the accessibility of health care services for them and increasing the risk of violence. In this matter researchers suggested that effective

collaboration between NACO, law makers and implementers are needed to formulate appropriate policies and programs to achieve the changes in the environment.

Onwuliri, & Jolayemi (2006) in an article on *"Reaching Vulnerable and High Risk Groups in Nigeria"* reported that the low economic status of FSWs heightens their vulnerability as they engage in unprotected sex. At other times, they may be raped or coerced into violent sex; dry sex, with its consequent abrasion and bleeding, increases their risk of contracting STIs and HIV. They are disadvantaged by a lack of self-esteem and adequate negotiation skills, which compromises their ability to manage the situation and to seek legal action, if any. In addition, FSWs face constant sexual harassment and abuse from law enforcement agents such as police officers. They may be forced to have sex without condoms, sometimes at gunpoint, and their money and valuables may be seized. Their impoverishment makes quitting sex work difficult. FSWs have clients from all walks of life, from artisans, to motorcyclists, military personnel, businessmen, civil servants, and politicians. These clients may contract HIV from commercial sex workers, and then transmit the virus to their partners in the general population. FSWs also have "boyfriends" with whom they may feel obliged to have sexual intercourse without condoms. These factors militate against HIV/AIDS control. The illegality of sex work makes legal protection of sex workers impracticable and HIV interventions for them difficult. The daunting challenges contribute to the vulnerability, risk, and rising trend of infection among FSWs. Yet targeting interventions to FSWs remains an effective way to reduce the spread of HIV.

Tran, Detels, & Lan (2006) in their study on *"Condom use and its correlates among female sex workers in Hanoi, Vietnam"*, found that consistent condom use in the past month of data collection was higher with irregular clients, less with regular clients and lowest with 'boyfriends'. Major reasons for not using condoms were partners' objection, condom unavailability, and belief of partner's disease – free status. Partners' objection was the most commonly cited reason by the FSWs. Another reason for non-usage of condom was that FSWs felt they knew their regular clients and believed them free from HIV/AIDS. Condom use was, therefore, in their opinion, not necessary. In this study, no participant mentioned the expense of condoms as a reason for not using condoms with any of their partners. Finally, the researchers suggested that condom promotion should focus on both FSWs and their partners.

Negative attitudes toward FSWs and method of condom promotion need to be changed to reduce stigmatization of FSWs in the society.

EnkhBold, Tugsdelger, Morita, Sakamoto, & Hamajima (2007) in their study on *"HIV/AIDS Related Knowledge and Risk Behaviors among Female sex workers in Two Major Cities of Mongolia"* demonstrated that a comprehensive knowledge on HIV prevention among the FSWs was poor, although the general awareness about HIV and its transmission was quite satisfactory. Relatively better knowledge among the FSWs from Darkhan city of Mongolia could be the result of intensive health education programmes conducted together with 100 per cent Condom Use Programme (CUP). Their study indicated that although condom use with paying clients was relatively high, but it was less with non-paying regular clients, which could potentially increase the risk of HIV transmission. Despite knowledge that condoms can reduce the risk of HIV transmission, the rate of condom use with paying partners remained lower in Darkhan than Ulaanbaatar city. These findings also indicated that only information provision may not be effective to cause behavior changes. Drug and alcohol use are typically associated with increased risky sexual behavior. The study also showed that drug use was very low among the FSWs, but alcohol consumption was quite common. Such a high rate of alcohol consumption among the FSWs could also contribute to STI/HIV transmission. Researchers finally suggested that as the clients of the major respondents of their sample were mobile population groups, like truck drivers and mobile traders, therefore, educational programs aiming at behavior changes of mobile traders and truck drivers could potentially reduce the risk of HIV/STI transmission from and to FSWs.

Oppong, Grimes, Ross, Risser, & Gladstone (2007) in their study *"Social and behavioral determinants of consistent condom use among female commercial sex workers in Ghana"*, investigated the social and behavioral predictors of consistent condom use among female commercial sex workers in Ghana. The study found that the level of condom education was very low. 277 participants out of 450 did not use condoms all the time. HIV knowledge, marital status, and number of days worked were all statistically significant predictors of consistent condom use. The researchers identified five independent predictors of consistent condom use in this population. These variables were age; educational level; religion; cost and number of customer encountered per day. Some of the major obstacles identified in this study to consistent

condom use were refusal by clients, lack of availability of free condoms and the lack of empowerment among FSWs to negotiate safer sex with clients. Finally, the researchers demonstrated that the level of educational attainment is positively associated with consistent condom use. They suggested that, providing higher opportunities for women and better employment will not only reduce their attraction to commercial sex work, but also reduce their vulnerability to HIV/AIDS.

Kassie, Mariam, &Tsui (2008) have discussed about patterns of knowledge and condom use among various population groups in a research article "*Patterns of knowledge and condom use among population groups: Results from the 2005 Ethiopian behavioral surveillance surveys on HIV".* The various population groups in this study were female sex workers, defense personnel, police personnel, pastoralists, truck drivers, intercity bus drivers, road construction workers, teachers, factory workers and people in Ante Natal Care (ANC) catchment areas. The study found that knowledge of the preventive methods, misconceptions and comprehensive knowledge regarding HIV/AIDS was 57 per cent, 75 per cent and 18 per cent respectively. FSWs and the defense force showed some behavioral change in using a condom during the most recent sexual encounter and consistently used a condom with non-regular sexual partners and paying partners, but considerable proportions of FSWs did not use condoms with non-regular partners. Knowledge of preventive methods was fairly high in almost all the target groups. But there exists high levels of misconception about HIV/AIDS among the target groups selected in this study. The misconceptions were greatest due to less access to media. The level of comprehensive knowledge on HIV/AID was very low across all target groups.

Nguyen, Oosterhoff, Hardon, Tran, Coutinho, & Wright (2008) made a study entitled "*A hidden HIV epidemic among women in Vietnam"*. The study was carried out to explore the HIV infection situation among different social groups of women, as well as the behaviors that put them at risk for HIV infection. Research revealed that a high proportion of FSWs sell sex to get money to support their injecting drug habit. They often live with male IDUs; the men acts as pimps to protect FSWs in their work, share their income for sharing drugs with them. Injecting FSWs are, therefore, involved in double risk behavior, unsafe sex as well as unsafe injection. On average, FSW reported having 2-18 clients per week. There was a reported increase in consistent condom use with clients. Despite the increased proportion of consistent

condom use among clients, FSWs were found to have a tendency to use condoms less often with their regular partners, in particular with lovers with whom they share needles/ syringes to inject drugs. More than 30 per cent of FSWs having at least one sexually transmitted infection, reflecting the inconsistent use of condoms among this group.

Oyefara (2008) conducted a study named *"Poverty, Sexual Practices and Vulnerability of Female Sex Workers to HIV/AIDS Pandemic in Lagos Metropolis, Nigeria".* The objectives of this study were to know those factors that made women to join sex industry and effects of these factors on the practice of safe sex by female sex workers in Lagos metropolis within the context of HIV/AIDS pandemic. To achieve these objectives, quantitative and qualitative research methods were adopted. In the quantitative method, 320 female sex workers were sampled in a cross-sectional survey, while 20 in-depth interviews were conducted among the respondents in the qualitative method. Findings of the study showed that female sex workers in the metropolis were young ladies in their early twenties because the mean age of respondents was 23.8 years. Data on family socio-economic background revealed that 74.4 per cent of the respondents were from poor family, while 85.6 per cent of them grew up in one or two-room apartments. 35 per cent of the respondents stated that poverty made them to join sex industry. It is instructive to know that all the respondents had knowledge about the existence of HIV/AIDS and 81.9 per cent of them identified sexual intercourse as major route of HIV transmission. There is significant relationship between poverty, educational level, contraction of STIs, charging of higher price for "flesh to flesh" sexual contact and consistent use of condom by sex workers at $P<0.01$ level. Specifically, only 24.7 per cent of the respondents were using condom regularly in each of the sexual acts. Poverty is a major factor that pushed young women into prostitution and this same factor hindered them from practicing safe sex. Thus, the researcher suggested that programmes that will reduce poverty level should be developed in order to reduce rapid transmission of HIV infection in the country.

Pande (2008) in her paper "*Ritualized Prostitution: Devadasis to Jogins- A few case studies",* examines the institution of ritualized prostitution, namely the *Devadasis*. It also looks at the transformation of this institution on account of the historical forces that have mutated it into a form that has few but striking

resemblances to the original institution. The paper narrated that the semi-arid tropics of the South India are prone to constant droughts and this pushes people to new levels of poverty. This poverty situation leads to prostitution. Large-scale of commercial prostitution developing in industrial cities extends in tentacles in search of easy victims and the tradition provides legitimacy for this profession. The main causes for converting young girls to *Jogins* are recurring death of children in a family, regular occurrence of diseases in the house or village, outbreak of disease in the village or pure lust of landlords. The nexus between caste and forced prostitution is quite strong and the *Devadasi* system is no exception. Like other forms of violence against women, ritualized prostitution, is a system designed to kill whatever vestiges of self-respect the untouchable castes have in order to subjugate them and keep them under privileged.

Sahasrabuddhe, & Mehendale (2008) in their article "*Female Sex Workers and the HIV/AIDS Epidemic in India"* discussed that societal attitudes towards sex work have not been positive or supportive in general in India as is the situation in most parts of the world. Societal neglect, isolation and discrimination lead to poverty and destitution among FSW. Such attitudes and lack of societal support towards issues and developmental activities targeting FSW, often pose barriers in implementation of programs directed at prevention and control of HIV/STI among FSW. The fact that FSW are among women having the highest risk for HIV/STI acquisition should underscore the importance of provision of appropriate prevention and care from the angle of human rights and justice. However, individuals and organizations face difficulties in initiating or sustaining healthcare activities for FSW due to value-laden and moralistic attitudes of individuals in the public or private sector. In addition, the misinterpretation and misrepresentation of human trafficking laws by the police and lack of legal status to the profession of sex trade have made it even more difficult to institute health promotion and disease prevention activities in this high risk population in an organized manner.

Sahni, & Shankar (2008) in their article *"Markets, Histories and Grass-root Evidences: Economics of Sex Work in India",* discussed about the factor that essentially constitutes the economics of sex work today. The comparison between the choice of being a physical laborer in case of a man, and a sex worker in case of a woman needs to be understood in the context of the limited choices available to both

men and women in the unskilled labor markets. In the face of dire poverty, illiteracy and limited choices of employment in the Indian context, addressing livelihoods is a matter of serious concern, particularly in case of women. In their search for sustainable livelihood, women are not only have to suffice with poor, meagre incomes bordering on the poverty line, but also cope with the patriarchal power structures that increase their vulnerability of sexual exploitation at work, or at home. This further limits the economic choices that she may have, or she can avail of at different junctures of her life. Vulnerability is not solely limited to poverty, which explains the existence of highly educated and upper class call girls. Under these circumstances, sex work emerges as a strategy for survival, but also gets recognized as a viable economic option.

Seshu (2008) in her article "*Surfacing Voices from the Underground"* addressed that apart from the stigma already attached to the work of the sex workers in India, society has further marginalized them as core transmitters of HIV infection. It fails to recognize that they are but links in the broad networks of heterosexual transmission of HIV. Women in prostitution and sex work constitute a community that bears and will continue to bear the greatest impact of the HIV epidemic in India, suffering high levels of infection and re-infection. Propagating the myth that women in prostitution and sex work are core transmitters of HIV serves the purpose of 'prostitution bashers', imbued with the moral and judgmental attitude that reinforces the prejudice that AIDS is an 'impure' disease that afflicts immoral and evil persons. The net result is the further targeting of the women, increasing public and police violence against them, decreasing their ability to assert themselves and their negotiating power for safer sex with customers and denying them access to health care services.

Shearer, & Bailey (2008) made a study entitled *"Determinants of risk behaviour of sex workers in Jamaica: A qualitative approach"*, and found that almost all the male and female sex workers of the sample, felt that condoms were their best 'business partner' the sex workers described condom use as being essential to survival. They knew that condoms protected from HIV and other STIs; but they also had a misinformation about HIV/STIs. In case of condom use, the researchers stated that sex workers' intention to use condoms with clients is strong, but condom use with regular clients and main partner is much lower than with other clients. In these cases, this intention is weakened by the subjective norm which comes largely from a desire

for ‘feel – good – sex’ and the related need to satisfy the ‘significant other’. Another barrier is strong resistance to condom use among clients. For a number of reasons especially awareness of HIV and STI, sex workers do turn down offers of more money for unprotected sex. It is very clear that sex workers who are drug addicts will seldom turn down offers of consistent condom use for more money. The study also reported that the FSWs sell condoms, which were distributed freely, to meet up the cost of their drugs.

Veen, Gotz, Leeuwen, Prince, & Laar (2008) in their study “*HIV and sexual risk behavior among commercial sex workers in Netherland”* assessed the potential for HIV transmission among 557 female and male-to-female transgender commercial sex workers in three cities, Amsterdam, Rotterdam and Hague, in the Netherlands. Female CSWs, drug-using female CSWs and transgender sex workers were recruited in street-based and establishment-based sites. The study found that the median age at which CSWs begin with sex work was 26 years. Female commercial sex workers had the highest number of clients per week. 86 per cent of the CSWs had penile-vaginal contacts with their clients, 94 per cent had oral-genital sexual contacts, and 19 per cent reported receptive penile-anal contacts. The penile-anal contact was reported more often by transgender sex workers and drug users than female commercial sex workers. One remarkable finding of the study was that 74 per cent of CSWs were unaware of their HIV infection. In addition, the sex workers might not want to disclose their HIV status, because this may have consequences for their working permits in clubs or brothels. Sex workers with an illegal status might be reluctant to get in touch with officials of health care services and this may also influence both testing behavior and their knowledge regarding HIV status.

Ghimire, & Teijlingen (2009) in their study on *“Barriers to Utilisation of Sexual Health Services by Female Sex Workers in Nepal”* stated that sexual health services are relatively rare in Nepal. Female sex workers (FSWs) do not use health services as often as would be desirable. The study was conducted to identify the barriers of access to sexual health services by FSWs in Nepal. A mixed-method approach consisting of a 425 questionnaire-based survey and 15 in-depth interviews was conducted in 2007. 20 per cent of the FSWs had never visited health facilities. FSWs turned to private clinics, followed by clinics belonging to non-governmental organisations and pharmacies for treatment. A combination of personal and service-

related factors acted as critical barriers in accessing government health services in particular. Lack of confidentiality, discrimination and negative attitudes held by health care providers, poor communication between health service providers and fear of exposure to the public as a sex worker -were the major barriers in seeking sexual health services. The study concluded that barriers should be taken into account while planning for sexual health services. For this, the study suggested that information dissemination and behaviour change interventions for FSWs should focus on strengthening knowledge of STIs. To promote health-seeking behaviour, mobilizing the resources available with the involvement of establishment owners, using peer-referral approaches could greatly increase these women's utilization of health care services. Interventions that focus on FSWs appear to be either focused on awareness rising or full prioritisation of generalized health service delivery. Therefore, a two-pronged approach comprising education and service activities focusing on strengthening the health sector's STI diagnosis and treatment capabilities for both FSWs and their clients should expedite together. FSWs are more willing to communicate with and seek health care provision from physicians/health workers who assure privacy and confidentiality. Integrated health services should be made available within the entire health care system as FSWs seem reluctant to use health service follow-up care provisions due to fear of being labeled as sex workers i.e. social stigma. It is important to link the livelihood of FSWs with their empowerment, including education and improvement of their social status. It is imperative to revisit the income generating programmes implemented by the governmental and non-governmental sectors. Also, it is equally important to collaborate with the private sectors for increasing the input for quality and access to the STI and other health care services for FSWs. Health service provision for FSWs should be viewed in relation to broader socio-political perspectives rather than perceived as a mere problem pertaining to the delivery of sexual health services. Provision of a quality service that ensures the rights of FSWs should be prioritised.

Lutnick, & Cohan (2009) conducted a study entitled *"Criminalization, legalization or decriminalization of sex work: What female sex workers say in San Francisco, USA".* The aim of the study was to examine sex workers' experiences with and perspectives on the criminal nature of sex work in San Francisco. Sex work is a criminal offence in San Francisco, USA, and sex work advocates have so far

unsuccessfully campaigned for decriminalizing it. Some groups argue that the decriminalization movement does not represent the voices of marginalized sex workers. Using qualitative and quantitative data from the Sex Worker Environmental Assessment Team Study, the researchers investigated the perspectives and experiences of a range of female sex workers regarding the legal status of sex work and the impact of criminal law on their work experiences. 40 women were enrolled in the qualitative phase in 2004 and 247 women in the quantitative phase in 2006-07. Overall, the women in this study seemed to prefer a hybrid of legalization and decriminalization. The majority voiced a preference for removing statutes that criminalize sex work in order to facilitate a social and political environment where they had legal rights and could seek help when they were victims of violence. They did not want to be arrested for their sex work, yet they also did not want to be regulated by government or pay taxes, sentiments that hold true for many people. The researchers suggested that, advocacy groups need to explore the compromises that the sex workers are willing to make to ensure safe working conditions and the same legal protections afforded to other workers, and with those who are most marginalized for better understanding their immediate needs and how these can be met through decriminalization of sex work.

UNAIDS (2009) had developed a guidance note on "*HIV and Sex work"* to provide the UNAIDS Co-sponsors and Secretariat with a coordinated human-rights-based approach to promoting universal access to HIV prevention, treatment, care and support in the context of adult sex work. According to this guide note, sex work varies between and within countries and communities. Sex work may vary in the degree to which it is more or less "formal" or organized, and in the degree to which it is distinct from other social and sexual relationships and types of sexual-economic exchange. Where sex work is organized, controllers and managers generally act as clearly-defined, power-holding intermediaries between the sex worker and client, and often between both and local authorities. Self-employed sex workers usually find their clients through independent means, increasingly through mobile telephones and the internet, and may be recruited or excluded from settings where an organized system is in place. Individuals may sell sex as a full-time occupation, part-time, or occasionally to meet specific economic needs (such as education costs, or in a family financial crisis). Others are trafficked or coerced into selling sex. Many people who exchange

sex for money or goods do not self- identify as sex workers, and do not seek nor have access to HIV prevention, treatment, care and support advice or services for sex workers, including in humanitarian and post conflict settings. Some sex work settings have served as excellent venues for HIV-prevention programmes, many others neither promote safer sex nor protect sex workers from violence perpetrated by clients, law enforcement officers, gangs, establishment owners or controllers. In addition, debt-bondage, low pay and inadequate living conditions may further compromise the health and safety of sex workers. Where sex workers are able to assert control over their working environments and insist on safer sex, evidence indicates that HIV risk and vulnerability can be sharply reduced.

Panchanadeswaran, Johnson, Sivaram, Srikrishnan, Zelaya, Solomon,…..Celentano (2010) through their study "*A Descriptive Profile of Abused Female Sex Workers in India"* captured the FSWs' differential experiences of abuse in intimate relationships versus violence that emanated from their work sphere in a purposive convenience sample of abused street based FSWs in Chennai, India. It appeared that, for abused FSWs, the risk of HIV infection emanates from both their intimate partners and clients. The findings of the study echoed the dangerous environments in which street-based FSWs operate. Women who were inexperienced in the sex-trade had significantly higher odds of being forced to have sex and perform unwanted sexual acts as demanded by clients who exerted more power in the context of illegal sex work in India. These problems were exacerbated in the context of alcohol-use by clients, intimate partners and sometimes FSWs themselves. The study concluded that considering the vulnerability of FSWs to violence from clients due to condom initiation, it would be important to examine the efficacy of programs that emphasize the condom promotion efforts initiated by sex workers themselves.

Wang, Chen, Sharp, Brown, Smith, Ding,…..Wang (2010), in a research article on "*Mobility, risk behavior and HIV/STI rates among female sex workers in Kaiyuan City, Yunnan Province, China"* examined FSWs' mobility and its role in facilitating the transmission of HIV/STI. The study found that mobility patterns among FSWs in southern China were associated with the type of entertainment establishments in which they worked. FSWs in low risk venues were actually more mobile than those from other establishments. FSWs in higher risk venues were less likely to change residence, less likely to use condoms with clients and earned less per client. But they

had more months engaging in sexual service, more working locations and more clients each month and have many characteristics in common with HIV positive and drug using sex workers. Thus, although FSWs in general are quite mobile, the highest risk FSWs in the study was less mobile than those at lower risk. The underlying motivation for mobility may be related to income as the main reasons for changing residence and working locations were 'business not good', 'to earn more money', 'to protect their identity' and 'for fear of bringing shame to their family'. The FSWs in higher risk venues were less mobile because their lower income means they have less resource to move. In addition, those with drug addiction may find it difficult to move to an unfamiliar town where they do not have connection to the local illicit drug market. The study further more documented high rates of HIV/STIs in FSW in higher risk venues which when combined with the high rates of mobility, implies that HIV may spread to low risk areas through mobile FSWs.

UNFPA (2010) published an article on *"HIV and Sex Work: Preventing HIV Risk and Vulnerability".* This article uttered that HIV disproportionately affects sex workers; yet less than 1 per cent of global prevention funding for HIV is spent on sex workers. The legal, social, cultural and economic factors that increase the HIV risk and vulnerability of sex workers are major challenges in national AIDS responses and need to be comprehensively addressed. Sex workers include female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not self-identify as sex workers. Many sex workers choose freely to sell sex. Others enter into sex work as a result of conditions, which while deplorable, do not involve direct coercion and/or deceit by another. Examples include poverty; gender inequality; harmful cultural practices, such as early child marriage; low levels of education; humanitarian emergencies; and post-conflict situations. Regardless of the reasons for entry, sex work is work and, as such, sex workers should have the same rights to safe working environments like all other workers engaged in organized and unorganized sectors. UNFPA suggested some human rights-based approach to promote universal access to HIV prevention, treatment, care and support in the context of adult sex work. This approach includes: (i) addressing the need to immediately scale up access to prevention, treatment, care and support for sex workers and their clients; (ii) addressing the need to build supportive environments, strengthen partnerships and expand choices for sex workers

through economic empowerment; and (iii) addressing the underlying drivers of HIV risk and vulnerability that contributes to people selling sex. Regarding enabling environment for sex workers, the article narrated that sex work must be addressed as an integral part of national responses to HIV. The delivery of effective programmes often encounters barriers and resistance which reflect significant cultural, religious, and social dynamics. It is important that sex workers are involved in the development, implementation, monitoring and evaluation of these programmes to ensure they are sustainable, human rights based, and evidence-informed i.e. participatory approach. Sex workers around the world identify stigma, discrimination and violence as three of the greatest challenges they face. Health care providers, law enforcement officers, the judiciary, clients, managers of sex work establishments and the community have a shared responsibility in ensuring that sex workers have access to the services they need, free from harassment, victimization and incarceration. The legality or illegality of sex work is a matter for individual national governments. Irrespective of the legal status of sex work, all sex workers have common human rights to dignity, right to liberty and security of person, and agency over their own bodies.

Seshu (2011) in her article on "*Why do Women in India Become Sex Worker"* reported that poverty and limited education push females in labor markets at an early age, but the sheer desire for a better income and a better life pushes them into sex work. In her study only about 20 per cent of the women surveyed were forced, sold cheated or otherwise pushed into sex work according to the study. Nearly 80 per cent of the 3000 females surveyed in 14 States across India entered sex work by themselves. The higher incomes and livelihoods they could access weighed significantly in that decision. The harsh fact is that for many women working conditions are cruel or incomes are disastrously low in other labor markets, the report categorically revealed.

Cunha (2011) in her article entitled "*Demand for Legitimising of Prostitution in the West: A Critique"* debated on legalization of prostitution. According to her to view prostitution as a legitimate form of women's work is to accept and reinforce the already prevalent patriarchal notion that sex and women's bodies are commodities over which a male acquires a right for a consideration. Prostitutes are thus the shared property of several males. This sexist idea is at the core of sexual violence and oppression in a male dominated society gets reinforced in prostitution and only serves

to reduce and maintain women at the lowest and most debasing level in such a society. The author also narrated that legitimizing prostitution as a valid form of women's work refrains from putting pressure on the government for providing occupational skills and education for women, increasing their absolute and relative numbers in employment and paying them living wages commensurate with their skills. Licensing prostitution as a legitimate form of work is discriminatory and humiliating as most other forms of male and female labor do not require a license.

George, Sabarwal, & Martin (2011) in their study on *"Violence in contract work among female sex workers in Andhra Pradesh, India"* put forward that violence in sex work in India is associated with FSWs' age, early initiation in sex work, clients' alcohol use and FSWs' movement for work outside their 'home' areas. The findings from this study demonstrate a high prevalence of sex work–related physical and sexual violence among FSWs aged 18–25 years residing in Andhra Pradesh, India. One in every 2 FSWs reported experiencing physical violence, and 3 in 4 reported experiencing sexual violence while engaged in sex work within the past 6 months. Such violence was significantly associated with the type of sex work. FSWs engaged in contract work were 2–3 times more likely to experience physical and sexual violence than their counterparts engaged in the sex trade within their district and not controlled by a third party.

Hemalatha, Harikumar, Venkaiah, Srinivasan, & Brahmam (2011) conducted a study *"Prevalence of and knowledge, attitude and practices towards HIV and sexually transmitted infections (STIs) among female sex workers (FSW) in Andhra Pradesh"* with a total number of 5580 FSWs. They found that marital status, migration typology (brothel or street based), age or educational status had no influence on consistent condom use (CCU). However, high client volume (5-9 and more than 10 per week) had significantly higher risk of not practicing CCU. Similarly, not carrying condom was significantly associated with increased risk of not practicing CCU. Amongst FSWs who were forced for sex, CCU was lesser when compared to those who were not forced. Similarly the rate of CCU is less among ignorant FSWs than that of the informed FSWs. According to the researchers, one of the principle reasons for lower condom use amongst non-commercial partners could be that it may signal distrust. The study recommended that educational messages should aim at enabling individuals to correctly assess their own risks of HIV

infection. It is also important to encourage the condom use in all types of sexual relationships, including regular and non- commercial sex partners. As most FSWs in their study had first sexual debut at a very young age, so attempts are needed to educate young girls in their early teens about HIV prevention programmes and those that empower women. Hence, the demand of introducing 'sex education' in schools and colleges is quite justified.

Mujtaba (2011) in his study *"A Case Study through IR & D Method for Intervention and Control of HIV/AIDS in Chennai, India"*, classifies the female sex workers into four categories according to their method of work. These four categories are – family-based, street-based, brothel-based and mobile sex workers. He found the number of working days is variable across the different categories of sex workers. Brothel-based sex workers have a more demanding regimen since they work on all around the month. As a result, they deal with the maximum number of clients. Given that they have the maximum degree of physical contact, those who work in brothels belong to the medically high risk group. On the other hand, for those in the street based, mobile and residential categories, and sex work is less demanding relatively. On an average, in a month, they work for roughly 22, 16 and 9 days respectively. Regarding HIV/AIDS awareness, the level of awareness about sexually transmitted diseases (STD) is reasonably high, perhaps as a consequence of the numerous HIV prevention programmes of the government and non-government organizations (NGOs). More than two-thirds of the interviewees are aware of being in a HIV high risk group. About 68 per cent of the sex workers reported regular condom use. The remaining 22 per cent do not practice safe sex due to various reasons, while quite a few do not use condoms because of misconceptions. Some feel that they cannot contract HIV or other STDs because they are clean and healthy and have regular medical checkups. Others feel secure because they cater to regular clients whom they believe to be healthy. Some FSWs believe that washing and cleaning sex organs with soda immediately after every physical contact ensure safety. Similarly, they have misconception about oral sex that HIV infection never occurs through oral sex.

Sharma (2011) in her article *"HIV prevention among commercial sex workers"* narrated that the levels of risk that the CSWs face, in terms of HIV infection, can be vastly different, depending on the country that they live in, where they work (e.g. a brothel or on the street) and whether they have access to condoms amongst other

factors. According to the author, though major efforts have been put into the education of the sex workers for HIV prevention, HIV is still widely prevalent among CSWs. The use of condoms has not been at par with efforts. The researcher addressed the reason behind that with the help of Maslow's theory of the 'Hierarchy of Needs', which is a psychological model that largely explains, why humans behave the way they do. This model takes the shape of a pyramid, with the most fundamental needs of a human being at the bottom of the pyramid, and the need of self-actualization at the top. Human being needs to the safety levels of needs after fulfilling his basic needs (food, clothes and shelter) only. So the thought of getting AIDS and dying from it is quite farfetched for the sex workers, especially when their daily lives are full of other life threatening situation. As a result sex workers are quietly going to agree to the demands of the client, even though she knows that doing so will put her and her unborn baby at risk for HIV and AIDS. So to achieve the maximum effects of the intervention programs, the author suggested that before addressing the health problems of the sex workers their basic needs are to be addressed. This could be done by making them financially self- sufficient with implementing vocational program which would be one of the most effective interventions.

Joshua, Gupte, Adhikary, Paranjape, Manikar, Brahman,...Ramesh (2012) conducted a study on *"Index based mapping of high risk behaviours for HIV among female sex workers in India".* The study population consisted of 10461 female sex workers (FSWs) from 29 sites spread over 24 districts from five HIV high prevalent States namely Nagaland (Dimapur, the only district studied in North-East region), Andhra Pradesh, Maharashtra, Karnataka and Tamil Nadu. The present exercise revealed that the proxy determinants are the condom practices (never used a condom, wanted to use a condom but did not use and experience of condom breakage) and current STI symptoms that need a doctor. Moreover, the State- wise analysis of the study was that in Dimapur the FSWs were highly hidden, and needs the greatest attention or intervention. In terms of the prevalence rate, this district was identified as a medium care district (below median value), whereas when several other high risk related variables were considered, it needs greatest attention. Dimapur has already been labeled as a commercial hub of Nagaland and owing to its unique location in the foothills and population comprising people from different regions of the India, fuel the different manifestations of STIs and HIV infection. All the districts surveyed in

Andhra Pradesh stood above the average score and in the second priority for intervention. According to Andhra Pradesh AIDS Control Society, HIV/AIDS in Warangal district had already reached at alarming proportions due to trading sex centers and floating population. Warangal is well known for highest HIV positivity among antenatal clinic (ANC) attendees and STD clinic attendees. In Maharashtra, most of the districts surveyed need greater care and among those Yavatmal and Mumbai (brothel based area) districts deserve greater priority. As such the district Yavatmal had the HIV prevalence of 37.3 per cent and the high-risk related variables were on the higher side. The above fact about Mumbai was emphasized by NACO by stating that "Mumbai sits at the epicenter of the HIV/AIDS epidemic - the city is home for the largest brothel-based commercial sex work in India". In Karnataka, the district Belgaum attained the top priority and needed greater attention. The State's first case of HIV was identified in this district and it has highly-concentrated areas of high risk groups, and has been marked 'red' on the HIV/AIDS map of the country. In Tamil Nadu, Dharmapuri and Salem districts needed more care compared to Madurai, Chennai and Coimbatore. These two districts are already identified as areas with high intensity of HIV/AIDS. Similar hierarchy was found among the HIV high prevalent states even in the general population, which has been reflected by the National Family Health Survey (NFHS-3, 2005-06) data. At the end, the study suggested that enlightening the FSWs about the importance of their well-being, making right decisions, safe sexual practices and immediate attention in treating the current STI may bring down the HIV transmission to a greater extent. The score together with the mapping exercise will be helpful for the policy makers and programme officials to identify regions that require additional interventions and to devise more efficient strategies for the reduction of HIV/STI infection in India.

Mahapatra, Sagguruti, Halli, & Jain (2012) conducted a study entitled "*HIV Risk Behaviors among Female Sex Workers Using Cell Phone for Client Solicitation in India".* This study is based on data from a cross-sectional survey conducted among FSWs in 22 districts, across four states where there is high migration in Southern and Western India. With a sample of 5498 FSWs, the study measured HIV risk behaviors using the indicators of inconsistent condom use; experience of STI related symptoms, alcohol consumption by FSWs prior to sex and difficulty in condom use negotiation. The key independent variable in this study was use of cell phone for client

solicitation. The findings indicated that FSWs using cell phone for solicitation, as compared to those not using cell phones, were more likely to report inconsistent condom use, experience STI-related symptoms, consume alcohol prior to sex and face difficulty in condom use negotiation independent of their traditional places of solicitation. Furthermore, among FSWs using cell phone, lodge-based FSWs were more likely to engage in high HIV risk behaviors than FSWs practicing sex work in brothels, streets or homes. The current research shows that such behaviors are more likely to occur among FSWs using cell phones for solicitation than others, leading into higher inconsistent condom use with both regular and occasional clients. FSWs using cell phones for solicitation may be entertaining clients with whom they have established rapport and trust. In such circumstances, FSWs may not be able to insist on condom use because of their familiarity with the client, or more money being earned or their inability to negotiate condom use. Although FSWs who use cell phones are better educated, younger and more dependent on income from sex work than others, but their exposure to HIV prevention programs is limited. Further, with the increasing use of cell phone, FSWs may not visit traditional venues like streets, brothels to solicit clients. Such dynamics can pose several challenges to program planners, while designing outreach strategies for FSWs. The results of the study suggest that outreach programs for FSWs need to be strengthened with special attention to those FSWs who use cell phones. An effective way of providing communication messages to FSWs who use cell phone may be through text messaging, which could emphasize to improve knowledge about HIV/AIDS, information on HIV risk reduction, sexual negotiation skills, proper condom use, and development of partner norms supportive of consistent condom use.

Mbonye, Nnalusiba, King, Vandepitte, & Seeley (2012), made a study on "*A qualitative study of coping strategies of women involved in sex work in Kampala, Uganda"* to explore the challenges face by the sex workers and the strategies they employ to manage those challenges in their working lives. This qualitative study was nested within an epidemiological cohort of 1027 women at high risk of STI including HIV in Kampala, Uganda. In this study the women reported experiencing physical and sexual violence from clients especially when they moved away from their familiar working territory. To avoid such violence they blacklist violent clients and keeping in places well known to them where they could easily get help. However, the need for

money sometimes led them to go against their own risk avoidance strategies. The study also reported that in case of managing stigma attached to sex work, the sex workers tried to disguise their occupation and use manufactured identity. They separate their social identities from sex work identities using different names while at work, had a different work dress code from that at home or in community due to social stigma. The findings have also shown that alcohol is an important part of many sex workers' lives. They use alcohol to reduce the emotional stress associated with having sex with many strangers as well as helping manage night cold. Hence, under the influence of intoxicants, they are vulnerable to unsafe sex and STI/HIV infection.

UNAIDS (2012) reported that all countries of Asia and the Pacific region criminalize sex work or certain activities associated with sex work, except New Zealand and New South Wales (Australia). In some countries, a punitive approach to sex work is entrenched by national constitutions (Bangladesh, Cambodia and Pakistan). Criminalization increases vulnerability to HIV by fuelling stigma and discrimination, limiting access to HIV and sexual health services, condoms and harm reduction services, and adversely affecting the self-esteem of sex workers and their ability to make informed choices about their health. Police abuses of sex workers, including harassment, extortion, unauthorized detention and assaults, are reported from countries across the Asia Pacific region. In some countries, peer educators and outreach workers have been harassed or arrested by police (India, Nepal and the Philippines). Violence against sex workers perpetrated by police or military personnel contributes to HIV vulnerability and is reported in numerous countries. Incidents involving sexual assaults by police or military have been reported from Bangladesh, Cambodia, China, Fiji, India, Kiribati, Myanmar, Nepal, Papua New Guinea and Sri Lanka. Sex workers are often targeted for harassment and violence because they are considered immoral and deserving punishment. Criminalization legitimizes violence and discrimination against sex workers, particularly from law enforcement authorities and health care providers and from society in general. Criminalization makes sex workers reluctant to report abuses and authorities are also reluctant to offer protection or support to sex workers even if they report such abuses.

Scorgie, Vasey, Harper, Richter, Nare, Maseko, & Chersich (2013), made a qualitative study on *"Human rights abuses and collective resilience among sex workers in four African countries: A qualitative study"* to explore the impact of

violence and related human rights abuses on the lives of sex workers, and how they have responded to these conditions, as individuals and within small collectives. The analysis of the study are based on data from 55 in-depth interviews and 12 focus group discussions (FGD) with female, male and transgender sex workers in Kenya, South Africa, Uganda and Zimbabwe. Data were collected by sex workers working as outreach workers, are trained to conduct qualitative research among their peers. In describing their experiences of unlawful arrests and detention, violence, extortion, vilification and exclusions; participants present a picture of profound exploitation and repeated human rights violations. This situation has had an extreme impact on the physical, mental and social wellbeing of this population. Overall, the article details the multiple effects of criminalization of sex work on the everyday lives of sex workers and on their social interactions and relationships. Underlying their stories, however, are narratives of resilience and resistance. Sex workers in this study have developed their own individual survival strategies and informal forms of support and very occasionally opt to seek recourse through normal channels. They generally recognize the benefits of unified actions in assisting them to counter risks in their environment and mobilize against human rights violations, but the fluctuant and stigmatized nature of their profession often undermines collective action. The study concluded that criminal laws urgently need reform. Supporting sex work self-organization i.e. CBO is key interim strategy for safeguarding sex workers' human rights and improving health outcomes in these communities. If developed at sufficient scale and intensity, sex work organizations could play a critical role in reducing the present harms caused by criminalization and stigma as well as their vulnerability to HIV/AIDS.

Ezema, & Ukwuaba (2014) in their study on "*Reaching Vulnerable and High Risk Groups in Nigeria Through Open and Distance Learning System*" stated that vulnerability describes those features of a society, social or economic institution, or process that affect the likelihood which increases morbidity and mortality associated with disease. These are beyond the natural factors associated with susceptibility; poverty, fragmented social issues, and gender inequality which exacerbate vulnerability. These deep rooted factors however, weaken people's ability to cope with the impact of vulnerability and those with high-risk groups in any society, especially developing country like Nigeria. The study has shown that the low

economic status of female sex workers (FSWs) heightens their vulnerability, as they often engage in unprotected sex. At other times, they may be raped or coerced into violent sex, dry sex with its consequent abrasion and bleeding, thereby increasing their risk of contracting HIV. They are disadvantaged by a lack of self-esteem and adequate negotiation skills, which compromises their ability to manage the situation and seek legal action. In addition, FSWs face constant sexual harassment and abuse from law enforcement agents such as police officers. They may be forced to have sex without condoms, sometimes at gun point, and their money and valuable may be seized.

Hence all the above studies in this section highlighted that sex workers are marginalized and stigmatized because of their work and the fact that prostitution is still criminalized. Many sex workers are further marginalized because of their poverty. Poverty, urbanization, ignorance and gender inequality are all significant factors that shed light on the complexity of halting the HIV/AIDS epidemic in India. Poverty leads many women into the sex industry either by force or a lack of other employment options. Unable to find other means of employment, this somewhat lucrative business can support basic economic needs of these women. Discrimination experienced by sex workers has been increased by the HIV epidemic, which has exposed sex workers to further discriminatory attitudes and become victims of double stigma- being FSW and HIV carrier. Sex workers are widely and popularly assumed to be HIV positive, and have been characterized as "vectors" or "reservoirs" of HIV infection. These assumptions ignore the fact that many sex workers use condoms and refuse the client for unsafe sex and thereby potentially exposing them to physical and sexual violence. Sex workers are often more concerned with safe sex than their clients, whose responsibility in HIV transmission is rarely, if ever, considered. The stigmatization faced by sex workers drive them away from social and health services, because of the fear of being judged, humiliated or discriminated against. Service providers refuse to provide sex workers with assistance, advice or medical treatment. The illegal status of sex workers' activity prevents them from prosecuting abusive clients and pimps. The law can also hinder the efforts of sex workers at protecting themselves from HIV infection. They are also harassed by the police, if they seek their help. Moreover, the vulnerability of a sex worker to HIV is not dependent on the sex worker's education, awareness of HIV/AIDS, use of condoms etc. Therefore, it is

necessary to convert their knowledge into practice in order to prevent further transmission of HIV/AIDS. Few studies of present literature review show that although the awareness about sexual risk behavior and level of knowledge about HIV/AIDS was very high, condom use was very low and FSWs are engaged in high risk behaviour. Again, other studies show that the knowledge of STIs, HIV and AIDS among FSWs is superficial, and they failed to minimize their vulnerability to STIs, HIV and AIDS.

2.2 Response to HIV/AIDS

To show the efforts of Government of Botswana, Mogomotsi (2004) in his paper *"Efforts Towards HIV/AIDS Prevention – The Case of Botswana"* stated that the government of Botswana has engaged in a strong advocacy approach led by the State President to mobilize the resources both locally and internationally. HIV/AIDS has been declared as a national crisis. This has resulted tremendous support. The private sector, the civil society in partnership with government strengthened prevention, care and support, impact mitigation, stigma and discrimination elimination programmes. The National AIDS Coordinating Agency (NACA) has also been established to serve as the Secretariat to the NAC. NACA is mandated to coordinate HIV/AIDS activities at the national level. All the Districts have established District Multi-Sectoral AIDS Committees (DMSAC), which has the responsibility of coordinating HIV/AIDS activities at the district level. Sub-DMSACs have also been initiated in some of the sub-districts. Village Multi-Sectoral AIDS Committees are also being established at village level although this process is still slow. HIV/AIDS prevention and Care and Support programmes such as Prevention of Mother-to-Child Transmission (PMTCT), Community Home Based Care (CHBC), Voluntary Counseling and Testing Centres (VCTC), Anti-retroviral Therapy (ART) and the Orphan and Vulnerable Children (OVC) are being implemented in many districts across the country.

Shivdas (2008) in her case study on *"In the Interest of Business and Health: Women Sex Workers' Efforts to Protect themselves from HIV"* examines the efforts of SANGRAM (Sampada Grameen Mahila Sanstha) and VAMP (Vesya Anyay Muqabla Parishad) to build awareness about female sex workers' right among sex workers in their everyday lives. The observation of the study emphasizes that any HIV/AIDS

intervention for female sex workers that is initiated in collaboration with the sex worker community (i.e. CBOs) is more likely to succeed, as FSWs have more knowledge than anyone else about what works and what does not. Facilitating the realization of rights will give the marginalized FSWs a voice and space to realize their potential as 'Change Agents' in transforming the unequal social situations.

Tambe (2008) in his article *"Different Issues/Different Voices: Organization of Women in Prostitution in India"* has remarked that in India one of the most celebrated organizations of women in prostitution which has undertaken STD/HIV intervention programme is Durbar Mahila Samanwaya Committee (DMSC) in Kolkata. The other significant organization is SANGRAM for HIV prevention that eventually led to the formation of Vesya AIDS Muqabla Parishad (VAMP). Along with HIV intervention program, these organizations have launched several other programmes like formation of co-operative society or a cultural wing, educational program for women and their children, health awareness program, and notably, a self-regulatory board (Sukai, 2010). It is initiation of these organizations that the first national congress of sex workers' conference was held in Kolkata in 1997. An Asian Meet was organized in Kohlapur in 1999 and the sex workers' Carnival—Millenium Milan Mela was initiated in 2001 to urge for rights to oppose wrongs done to FSWs, thus heralding the autonomous activism of the women in prostitution for their right as human beings.

Kumar, Mehendale, Panda, Venkatesh, Lakshmi, Kaur,…..Pawer (2011) conducted a study entitled *"Impact of targeted interventions on heterosexual transmission of HIV in India"* to evaluate the impact of Targeted Intervention Programmes (TIPs) on HIV prevalence in high HIV prevalence Southern States (Tamil Nadu, Karnataka, Andhra Pradesh and Maharashtra). The findings of the study indicates that there is an increase in consistent condom use among FSWs and MSM, decline in the prevalence of syphilis and HIV among FSWs and young antenatal women. The said study also reported that in India, focused interventions started well before 1995 in the Metropolitan cities like Chennai, Mumbai and Kolkata, the epicenters of HIV epidemic at that time. Since then, targeted interventions (TIs) have been standardized and consistently scaled up. A gradual increase in TIs, especially among FSWs has been seen in Southern States of India. Support for these targeted interventions is derived from the 'standard core group theory' based on sexual networks in African and Western societies. Predictions from mathematical models

also suggest that a package of interventions focusing on condom use in commercial sex work and treatment of STIs would be sufficient to curtail and ultimately virtually eliminate the HIV epidemic in India.

Ndimbwa, Emanuel, & Mushi (2013) conducted a study in two NGOs at Tanzania, namely Wamata and Pasada. In their study entitled *"The Role Played by NGOs in Preventing the Spread of HIV/ AIDS and Supporting People Living with HIV/AIDS in Tanzania: A Case of Dar Es Salaam Region"* narrated that NGOs are important agents for limiting the impacts of HIV/AIDS which help in provision of free services lead to sustain livelihoods for people living with HIV/AIDS. The extent to which NGOs have contributed in preventing the spread of HIV/AIDS in Tanzania is quite encouraging. Many PLWHA who are registered in these organizations testified that if it were not these NGOs, they would have died long time ago. Clients confessed that these NGOs have given them new hope of life. Their health status has been improved, prolonged life and some of them have returned to productive activities. However, the challenges of HIV/AIDS are many and cannot be addressed alone by technical and formal institutions. The situation needed a more social approach by which NGOs by creating solidarities and identities among people affected by HIV/AIDS have managed to overcome social stigma, discrimination, spread and cure of the disease.

Kavinya (2014) in his article *"Analysis on Malawi government initiatives in the fight against the HIV/AIDS pandemic"* reported that the Malawian government has put up a great effort in response to the AIDS epidemic in recent years. The government and international donors have both made notable strides to increase access to treatment and to improve prevention initiatives. The government efforts to fight this pandemic are heavily dependent on international donors and in recent years it has strived to increase its funding in the national budget on HIV/ and AIDS programmes. But some factors such as the scale of the epidemic and inadequate human and financial resources have been hindering the desired progress. Recently, the President of Malawi launched the First UNIAIDS-Lancet Summit in Lilongwe and she challenged the Commission to fight for an HIV free generation in a few years to come. She said that with total commitment and determination of the UNIAIDS and Lancet, she is optimistic that the post-2015 agenda of AIDS and global health would be achievable.

Pathfinder International (2014) in its publication *"Combination Prevention of HIV: A Technical Guide to Working with Key Affected Populations"* highlighted that common approach to preventing HIV among FSWs is to direct huge amounts of effort at 'social rehabilitation' usually through 'alternative skills training'. This approach has often been justified by equating all sex work with 'trafficking of women and children', which appeals to moralize of and condemnation of sex work. This approach has significant pitfalls as it does not recognize the women who voluntarily choose sex work. Likewise, the social rehabilitation offered is most often not a workable or desirable alternative for FSWs. The idea that sex workers need to be rehabilitated stems from a perception of sex work as 'immoral'. The struggle of sex workers around the world should be centered on gaining respect for their rights, not on gaining sympathy or pity for them. Sex workers do not want to be condemned as 'sinful' or 'vectors of disease', but want instead to live safe, satisfying lives with a supportive community around them. Pathfinder supports preventative activities related to sexual and reproductive health and FSWs' rights, but does not involve itself in any income generation activity, except when a lack of a buffer (a second, supplementary source of income) reduces sex workers' capacity to refuse to have sex without a condom or enter unsafe situations. Pathfinder understands sex work as a profession and it does not suggest any nurse, doctor, clerk to change their jobs based on risks—all jobs have same risks like sex workers on the job, health providers can also be occupationally infected by HIV.

Ranebennur, Gaikwad, Ramesh, & Bhende (2014) in their study on "*Addressing vulnerabilities of female sex workers in an HIV prevention intervention in Mumbai and Thane: Experiences from the Aastha project*" stated that FSWs reporting higher vulnerability and who are exposed to project services for a longer period of time in *Aastha* (NGO) are more likely to report a higher uptake of services and a higher degree of overall empowerment than those who are less vulnerable. This study illustrates the fact that project strategies of increasing awareness about services and risk over a period of time can lead to improved results. Creating mechanisms to address cases of harassment, violence, and other contingencies, and organizing FSWs in support groups has been pivotal in creating an enabling environment and challenging existing structures and power dynamics through empowered actions like - disclosing their profession, effectively dealing with violence from stakeholders, and

participating in friendly social interactions with peers outside of work contexts. The researchers suggested that the vulnerable factors should be thoroughly and strategically addressed in program design and periodically reviewed to take into account changes in economic, social, and legal scenarios. Moreover, it is important to look at a holistic interaction of different socio-cultural vulnerabilities, such as lack of education, poor economic status, financial debts, presence of dependents such as children, lack of other livelihood options, mobility due to sex work, and duration in sex work, as well as changes in the social and legal environment, which contribute towards an environment of increased violence and lack of individual agency and control, rather than just one or two factors. Though addressing structural barriers is a complicated and long-term process, it plays a critical role in reducing HIV risk amongst high-risk groups like FSWs.

Arogya AIDS Support Group (2016) in its document on *"Government AIDS initiatives"* reported that AIDS is a life threatening disease in India, which is a major cause of concern for the government. As the cure for AIDS is not known as yet, it is important that people acquire as much preventive information about AIDS as possible. The government's major AIDS control initiative is the National AIDS Control Programme (NACP) and the premiere AIDS agency is the National AIDS Control Organization or NACO. This organization aims to create an India where every person living with HIV is treated with dignity and has access to quality health care services. Every State has a State AIDS Control Society (SACS) run by the respective State governments. These State societies are a part of NACO. Besides government bodies at the Centre and the State level, a large number of NGOs are involved in spreading information regarding the spread of HIV/AIDS, its prevention and available treatment facilities. Many international NGOs and organizations run by the United Nations are also involved in HIV/AIDS programmes of India. Some of these international NGOs are: Action Aid, AVERT, AIDS Care Education and Training (ACET), Family Health International (FHI), International Red Cross and the PANOS, ILO, UNAIDS, Bill and Melina Gates Foundation, Clinton Foundation, etc.

From this section of literature review, it is understood that the TI approach is the mainstay for prevention of HIV among all the high risk groups (HRGs) like FSWs, MSM, and IDUs as well as among bridge population and general population. It also appears from the review that for ease of program management at the macro level,

a ‘uniform-template’ style has been adopted, but by doing this, some of the finer nuances related to unique needs of at-risk population have not received the desired level of attention. Those engaged in sex work have no direct welfare support for proper rehabilitation from the government. FSWs are systematically denied basic entitlements such as ration cards, admission of their children to educational institutions; and their children most often face discrimination in access to schools, colleges and hostels. Hence, policy makers and other concerned must pay due attention if this epidemic is to be curbed and eliminated from India as well as from the world.

2.3 Beneficiaries’ Perception

Rodriguez, Tripathi, Bohren, Paul, Singh, Chhabra,….Bennett (2005) have conducted a series of longitudinal studies of targeted intervention programmes (TIs) entitled *“From me to HIV: A case study of the community experience of donor transition of health programs”*. The study has explored in detail the transition experience from the perspective of the involved stakeholders, including the beneficiary community. The focus of the study is also to understand how the transition of *Avahan* (AIDS programme) financing and management responsibility to government was experienced by the beneficiary community. The findings from this study have highlighted three areas of the beneficiary community experience of transition. Communication with key populations (FSWs, MSM, IDUs, TGs, and the clients of FSWs) and peer educators (PEs) was inadequate in the first tranche of transition, but improved over the time. But, employment issues characterized by stagnating salaries, loss of travel funds and changes to education requirements, etc. persisted as a challenge throughout the transition. A key theme emerging from the findings of the study is that key populations (KPs) perceive the TIs as shifting from being about the KPs and their needs to being about HIV/AIDS only. Respondents described a sense that the TIs’ previous holistic approach, including general health services, empowerment activities and social engagement, had been lost in favor of an emphasis on HIV/AIDS-related clinical services, particularly HIV testing and condom distribution. This theme resonated across the various States, TIs, and transition rounds. Even in settings where most KPs praised an overall improvement in clinical services, they expressed regret at the discontinuation of or reduced support for

community events and non-clinical services that had been appreciated in the past– such as hair salon services at drop-in centers and cultural celebrations coded as feminine for TGs (e.g., baby showers). The cessation of benefits like refreshments at TIs also contributed to a sense that building social cohesion or showing respect to KPs was de-prioritized in favor of a target-driven monitoring of clinical service uptake. These incentives had functioned as a form of politeness or respect not usually extended to marginalized populations in mainstream venues by the society. Similarly, the loss of support for travel costs or compensation for lost work time affected adversely the KPs for participating in TI programs of NACO/SACS.

Sukai (2010) in his book entitled *"AIDS, NGOs and Globalisation"*, discussed about the Globalization and NGO response to HIV/AIDS. He conducted his study in the State of West Bengal. In his study, out of the total sixty NGOs engaged in HIV/AIDS care in West Bengal, a sample of maximum six NGOs were selected for in-depth case study by using purposive sampling technique. These six NGOs were working with six different types of target groups – FSWs, IDUs, MSM, PLWHA, Truckers and Migrated Labour. From the beneficiaries' point of view, the study found that the beneficiaries' perceptions towards the working of the six selected NGOs are mixed. Out of eleven groups of beneficiaries, eight groups have expressed positive perception and few members of remaining three groups have shown dissatisfaction. By and large beneficiaries have better perception towards the working of the respective NGOs. The HIV/AIDS programs of the respective NGOs are satisfactory to all the beneficiaries. These NGOs have helped them in improving their health status and awareness level on various HIV/AIDS related issues. The programs include more preventive services and less curative services. Majority of the beneficiaries use these NGOs as a stepping-stone for better referral health services and to avoid the indifferent attitude and apathy of the health personnel in government run hospitals/clinics. Finally, the study concluded that in West Bengal, NGOs are found as suitable means to provide HIV/AIDS prevention, care and support services; but can't contribute much in providing treatment services for PLWHA. There is a need of more integration and co-ordination of services of all stakeholders in providing better HIV/AIDS care services. It is also important to note that NGOs in HIV/AIDS care prefer to work in socio-economically developed areas in West Bengal and can't continue to work for a long time due to their external resource dependency i.e.

sustainability of NGOs' programmes is less in future. Major findings of this study will be worth for the government and other stakeholders in formulating appropriate policy in designing, implementing and monitoring HIV/AIDS programs.

Therefore, it is found that the literatures of the above section that the beneficiaries' perceptions towards the respective TIP implementing NGOs are positive. NGOs are found as one of the suitable means to deliver services for HIV/AIDS prevention, care and support. By and large beneficiaries have better perception and satisfied with the services provided by the respective NGOs. NGOs have helped the beneficiaries in improving their beneficiaries' health status and making them aware in related issues. But, their dependency on external funding makes the programme less sustainable. It is also to be mentioned here that there is a plausible of literature with regards to beneficiaries' perception.

As a whole, from the discussion of all three sections (i.e. 2.1; 2.2; & 2.3) of above literatures, it is clear that the problems and vulnerability of FSWs throughout the world is both complex and diverse. Definitions of female sex workers and self-identification of them as sex workers vary along with number of their clients, length of time spent in sex work and reasons for being in sex work. Further, there are inter-regional and intra-regional differences. The above literature review reveals that female sex workers are as vulnerable as other high risk groups (HRGs) to HIV infection and AIDS throughout the globe. Many studies have been conducted both by the government agencies, non-government agencies and various academic researchers in different parts of India as well as in other countries covering various aspects of female sex workers' risky sexual behaviour to evaluate the vulnerability of the female sex workers towards HIV/AIDS. The literature review considers that female sex workers are highly vulnerable to HIV/AIDS especially through heterosexual intercourse. This increased vulnerability is attributable to the facts that are beyond their control such as sexual violence and exploitation, early sexual initiation and inability to negotiate for safe sex. Their vulnerability is further heightened by individual level factors such as lack of education, low socio economic conditions and HIV related knowledge. Condom use and the spread of HIV and other sexual transmitted infections have also been studied extensively. Several studies have supported the use of condoms as a way of practicing safe sex and declining the transmission of contagious disease such as STIs, RTIs and HIV/AIDS. Studies on the

influence of HIV knowledge on safer sex practice have reported mixed results. Some studies found association between individual perception of HIV risk and safer sex practices. This implies that safer sex is complex and determined by several factors and varies in different settings. Several factors acted as barriers for FSWs to implement their safer sex knowledge into practice. It may reflect a lack of ability of FSWs to assess the risks involved and apply knowledge during a sexual encounter. Sexual decision making is mostly done by their customers, which involves the weighing up of a number of risks. It is again nothing but a reflection of patriarchy and subordination of women in a male dominated society. It may also imply that safer sex knowledge and the dynamics of sexual behavior are two different phenomena, neither of which necessarily influences the other when sexual encounter being contemplated. In various studies, it is found that the majority of the FSWs are forced for unsafe sex in exchange of additional money with clients who refused to use condoms. Besides it, poverty limits their negotiating ability to resist unsafe sex along with the fear of losing clients and the economic benefit. In such an environment that offers fewer occupational choices for FSWs, poverty is likely to influence risky sexual behaviors and heighten their exposure to HIV infection. Therefore, despite FSWs' awareness on HIV/AIDS, several factors like poverty, gender inequality, lack of empowerment, safer sex negotiation skill and low social status of FSWs diminish their ability to act on positive intentions to use condoms with clients, which is the only available way for them to prevent HIV/AIDS.

From the above literature it is also clear that physical, sexual and verbal violence are common experiences for many female sex workers. The causes of such violence are the criminalization of the prostitution and indifferent attitude of the police and other law enforcing personnel, pimps, clients and the society in general. Majority of the studies indicated that violence is a prominent feature in the lives of FSWs in almost all sex work settings all over the world. Those studies on violence also show that the countries having criminalization policy of sex work have higher levels of violence. As a result of such violence, FSWs' physical and mental health got affected adversely.

From the above review, some basics questions are to be answered. Do the FSWs face same problems in all parts of India and other countries of the world? Do the brothel-based and mobile FSWs face same problems? Do the FSWs have same

awareness and knowledge level on HIV/AIDS in developed and developing countries or in rural and urban areas? Do the clients of FSWs have same awareness and knowledge on HIV/AIDS? Are the vulnerability factors of all FSWs same everywhere? Do they adopt similar coping strategies to cope up with their day to day personal and professional life? Are all FSWs empowered and having same socio-economic status across the India and globe? Do not the religion, cultures, rituals, etc. have any influence on the FSWs' coping strategies? Is the stigma level same in all parts of the India and other countries? Is all the governments' approach, policies and programmes towards sex work and FSWs same? Do all governments have uniform laws to criminalize and punish FSWs only? Why they do not have same mechanism for punishing not their clients? There are laws to deal with domestic violence in different countries. Are there any such laws or mechanism to deal with sexual violence faced by FSWs? If not, why? Do the FSWs face same indifferent attitude from the health service providers in all regions and countries? Are all such HIV/AIDS programmes are adequate enough and have provisions to meet the general and other health needs of FSWs? Do such HIV/AIDS programmes provide enough scope for beneficiaries' (FSWs) participation in planning process? Are all NGO staff members capable enough to deal with FSWs' problems?

In the planning process, uniform approaches to change risky behavior of all female sex workers without considering the knowledge level of FSWs and the local unique needs of the particular region did not make the programme fully successful and gave desired results. Besides, each FSW or each region has its own unique culture and way of life. Hence, the uniqueness of every region needs to be considered. Attempts are to be made to analyze problems of FSWs in each region and at the micro level, their feelings, needs, problems, their coping strategies *vis-a-vis* governmental approaches/policies to address such issues. It is also needless to say that such problems demand immediate attention of the social scientists and concerned policy makers. But not a single study has been found in India and other countries on the specific coping strategies of the FSWs in encountering their day to day problems. It is also found that the studies on general health problem of FSWs are limited. From the above literature review, it is also found that not a single study has been conducted on FSWs or on HIV/AIDS in Tripura.

Therefore, it is quite justified to undertake a study on the proposed topic. The current study attempted to assess the socio-economic status of FSWs in Tripura, their HIV related knowledge, risk behaviours and various contributing factors of such risky behaviours. The study also tried to know their coping strategies with regard to their various problems *vis-a-vis* impact of targeted intervention programme (TIP) of Tripura State AIDS Control Society (TSACS). An attempt has also been made to identify the areas where psychological and social work intervention may be useful to address the problem of FSWs effectively. It is also believed that the findings of study may be useful to all stakeholders who are interested in the betterment of the female sex workers in the country in general and in Tripura in particular.