

Chapter-5

HIV/AIDS

AWARENESS

AMONG FEMALE

SEX WORKERS IN

TRIPURA

Chapter - 5

HIV/AIDS Awareness among Female Sex Workers in Tripura

The importance of proper understanding of the prostitution as well as of the sex work industry has remarkably increased in sustaining the HIV epidemic particularly in the countries with concentrated HIV epidemic. In many countries, women who engage in sexual activity for cash or kinds, find themselves marginalized from the mainstream of the society. Those women may be termed as prostitutes, call girls, *veshya*, commercial sex workers and now female sex workers (FSWs). Whatever the term may be used, the crude reality is that these women, who are engaged in the provision of sexual services for commercial considerations, put them at special risk of health problems for a variety of reason (Bhatta et al., 1993). Some of the major such reasons are – sexual intercourse with multiple partners, unsafe and other high risk sex practices, inconsistent condom use, alcohol and drug abuse, etc. Hence, all these factors make them vulnerable toward STIs, RTIs and HIV infection.

The vulnerability of a sex worker to HIV needs to be understood across some compositions like whether she is educated, whether she is aware of HIV/AIDS and whether she could follow up her awareness with the capability to enforce the prevention measures (Sahni, & Shankar, 2008). HIV related awareness has equivalent significance in combating HIV/AIDS. One of the effective approaches to mitigate HIV epidemic is to prevent transmission through knowledge improvement and behaviour change, especially among the high risk groups (Enkhbold et al., 2007). Awareness on HIV involves the correct identification of the modes of transmission and the methods needed to prevent further HIV infection (Lwin, 2011). It also includes existing deep rooted myths and misconceptions in the community associated with transmission of STIs, HIV, AIDS, etc. Therefore, it is necessary to convert the knowledge into practice in order to prevent further transmission. It is also fact that only HIV related knowledge is not merely an indicator of required behaviour change, but is also an essential prerequisite in the behaviour change process (Lwin, 2011). The span of knowledge regarding HIV/AIDS also varies among different population. A study in Goa, India shows that although the awareness about sexual risk behavior and level of knowledge about HIV/AIDS was very high, condom use was very low resulting in high risk behavior related to HIV/AIDS and STDs (Lwin, 2011). This

Chapter attempts to know the HIV/AIDS awareness of female sex workers (FSWs) in Tripura. The chapter is divided and discussed separately in two parts. **Part- I** deals with the profile of the female sex workers and **Part- II** is based on the HIV/AIDS awareness of female sex workers under the study.

Part-I: Profile of the Female Sex Workers

5.1 Basic Information about Respondents

5.1.1 Age

In the study of sex workers and HIV/AIDS, age is a major factor. Human being involved in sexual activities through some stages of development. Sexual development starts at the stage of puberty and human being express their sexual behavior in various ways.

Table-5.1: Distribution of the Female Sex Workers by Age Group

<i>Sl. No.</i>	<i>Age Range (years)</i>	<i>No. of Respondents (%)</i>
1.	Below 18 years	01 (01.7%)
2.	18-25 years	11 (18.3%)
3.	26-33 years	24 (40.0%)
4.	34-40 years	22 (36.7%)
5.	Above 40 years	02 (03.3%)
	Total	60 (100%)

Table-5.1 shows the age group of female sex workers (FSWs) under the study. It is found that majority (76.7%) of FSWs is within the age group of 26-40 years and only one FSW is minor, i.e. below 18 years. The table indicates that 18.3 per cent are within 18-25 years, 40 per cent within 26-33 years, 36.7 per cent within 34-40 years and only 2 FSWs are above 40 years.

5.1.2 Education

Education has an important role in shaping human behavior. Education helps people to earn self-esteem, respect from society and finally helps for self-actualization. Due to low levels of education, FSWs are unable to get any gainful employment and compelled to adopt prostitution to earn livelihood for themselves and for their families.

Table-5.2: Educational Qualification of the Female Sex Workers

<i>Sl. No.</i>	<i>Qualification</i>	<i>No. of Respondents (%)</i>
1.	Illiterate	06 (10.0%)
2.	Literate	08 (13.3%)
3.	Up to class V	16 (26.7%)
4.	Up to class VIII	18 (30.0%)
5.	Above VIII but not passed Secondary	11 (18.3%)
6.	Higher Secondary	01 (01.7%)
	Total	60 (100%)

Table-5.2 shows that except one FSW, remaining 59 FSWs (98.3%) have not passed secondary. It is also found that 10 per cent FSWs are illiterate, 13.3 per cent are just literate and 26.7 per cent up to Class-V. The table also indicates that 48.3 per cent FSWs have studied from Class-VI to Class-X.

5.1.3 Religion

Religion is a specific fundamental set of beliefs and practices generally agreed upon by a number of persons or sects. It is also an organized system of beliefs, ceremonies, rituals and rules used to worship a god/goddess or a group of gods/goddesses.

Table-5.3: Distribution of the FSWs by Religion

<i>Sl. No.</i>	<i>Religion</i>	<i>No. of Respondents (%)</i>
1.	Hindu	40 (66.7%)
2.	Muslim	18 (30.0%)
3.	Christian	02 (03.3%)
	Total	60 (100%)

Table-5.3 shows that 2/3rd of FSWs (66.7%) under this study belong to Hinduism. It is also found that 30 per cent FSWs belong to Muslim religion and the remaining 3.3 per cent (2 FSWs) are Christian. In Tripura, it is found that those who have converted their religion into Christian mostly are from ST community.

5.1.4 Caste

Caste is a form of social stratification characterized by endogamy, hereditary transmission of a lifestyle which often includes an occupation, social status in a hierarchy and customary social interaction and exclusion based on cultural notions of purity and pollution. Its paradigmatic ethnographic example is the division of Indian

society into rigid social groups, with roots in India's ancient history and persisting until today. However, the economic significance of the caste system in India has been declining as a result of urbanization and affirmative action programs taken up by the government and non-government organizations (Wikipedia, 2016).

Table-5.4: Caste of the Female Sex Workers

<i>Sl. No.</i>	<i>Caste</i>	<i>No. of Respondents (%)</i>
1.	General Caste	21 (35.0%)
2.	Schedule Caste (SC)	16 (26.7%)
3.	Schedule Tribe (ST)	02 (03.3%)
4.	Other Backward Classes (OBC)	03 (05.0%)
5.	Minority (Muslims)	18 (30.0%)
	Total	60 (100%)

Table-5.4 shows that most of the female sex workers (35%) are from General category followed by 30 per cent minority category. Here minority are from Muslim community only. It is also found that 26.7 per cent FSWs belong to SC, 5.0 per cent OBC and only 3.3 per cent are from ST community.

5.1.5 Living Status of FSWs

The family is the natural and fundamental group unit of society and is entitled to protection by the society and the State (United Nations, 1948). Society's definition of 'family' is rapidly expanding and has come to include single parents, bi-racial couples, blended families, unrelated individuals living cooperatively and homosexual couples, among others. Unfortunately, social response with regards to changes in family structure has been slow to catch up the changing trends along with modern lifestyles.

Table-5.5: Living Status of FSWs

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of the Respondents (%)</i>
1.	Living with family	49 (81.7%)
2.	Living alone	11 (18.3%)
	Total	60 (100%)

Family of the FSWs includes husbands, children, parents and in-laws. Table-5.5 shows that, 81.7 per cent of the sex workers in this study are living with their family and 18.3 per cent of them are staying alone.

5.1.6 Types of Residence

It is already seen (Table-5.5) that out of 60 FSWs under the study, 49 FSWs are living with their family. Table-5.6 shows that more than the half (51.7%) of the FSWs are living in their own houses and 16.6 per cent are staying in parents' houses and 13.3 per cent in rented houses. Out of 11 FSWs who are staying alone, 5 FSWs are living in small huts in slums, 4 are living in footpath and one is living in the rented house. Surprisingly, another FSW doesn't have any residence except living in community toilet. Therefore, it is found that 41 FSWs are having their own houses or parents' house, while remaining 19 FSWs do not have their own houses.

Table-5.6: Types of Residence of the FSWs and their Family Members

<i>Sl. No.</i>	<i>Types of Residence</i>	<i>No. of Respondents (%)</i>
1.	Own house	31 (51.7%)
2.	Parental home	10 (16.6%)
3.	Rented house with family	08 (13.3%)
4.	Huts in slum	05 (08.3%)
5.	Foot path	04 (06.7%)
6.	Rented house (alone)	01 (01.7%)
7.	Community toilet	01 (01.7%)
	Total	60 (100%)

It is not uncommon for sex workers to be homeless or living in places like footpath, slums, or even at community toilet, which are detrimental to their health. They informed that no landlords allow them as tenants also after knowing their profession. 6.7 per cent of the FSWs who are staying at foot path with their beddings, every morning they pack up their beddings and keep those either in the selected shops or under the seat of the park, etc.

5.1.7 Marital Status

According to Sinha, & Basu (1994), "Sexual union of two persons or more (as in polygamy or polyandry), temporary or permanent, having one of its chief objects the procreation and care of the offspring - an union that is sanctioned by the society through the performance of a definite ceremony, is called Marriage". In Indian culture and society, marriage is regarded as compulsory for maintaining family bond and community ties.

Table-5.7: Marital Status of the Female Sex Workers

<i>Sl. No.</i>	<i>Marital Status</i>	<i>No. of Respondents (%)</i>
1.	Unmarried	03 (05.0%)
2.	Married (Living with husband)	28 (46.7%)
3.	Deserted	25 (41.6%)
4.	Widow	04 (06.7%)
	Total	60 (100%)

Table-5.7 shows that out of 60 FSWs under the study, even 46.7 per cent married women living with husbands are working as FSWs. It is also found that remaining 41.6 per cent are deserted, 6.7 per cent are widows and significantly 5 per cent FSWs are even unmarried.

5.1.8 No. of Family Members

It is already seen (Table-5.5) that out of 60 FSWs under the study, 49 FSWs are living with their family and 11 FSWs are living alone. Table-5.8 shows the number of the family members of the FSWs which includes husbands, children, parents and in-laws.

Table-5.8: No. of Family Members of FSWs

<i>Sl. No.</i>	<i>No. of Family Members</i>	<i>No. of Respondents (%)</i>
1.	1- 2 members	14 (28.6%)
2.	3 - 4 members	25 (51.0%)
3.	5 members and more	10 (20.4%)
	Total	49 (100%)

It is found that out of 49 FSWs, the majority (51%) of the female sex workers have 3-4 family members, 14 FSWs (28.6%) have 1-2 family members, while the remaining 10 FSWs (20.4%) have more than 5 family members. Hence, it can be said that these 20.4 per cent FSWs are over burdened because of the large family size.

5.1.9 Sources and Monthly Income of FSWs

It is quite remarkable to note that none of the 60 FSWs are coming under the below poverty line (BPL) category as per the State Government criteria based on Tendulkar Committee appointed by the Government of India.

Table-5.9: Average Monthly Family Income of FSWs

<i>Sl. No.</i>	<i>Average Monthly Family Income of the FSWs</i>	<i>No. of Respondents (%)</i>
1.	Up to Rs. 3500	08 (16.3%)
2.	Rs. 3501- Rs. 5000	06 (12.2%)
3.	Rs. 5001- Rs. 8000	07 (14.3%)
4.	Rs. 8001 - Rs. 10,000	14 (28.6%)
5.	Rs. 10,001 - Rs. 15,000	10 (20.4%)
6.	Rs. 15,001 - Rs. 20,000	02 (04.1%)
7.	Above Rs. 20,000	02 (04.1%)
	Total	49 (100%)

Table-5.9 shows the average monthly family income of the FSWs. It is found that out of 49 FSWs, 28.5 per cent FSWs' monthly family income is up to Rs. 5000/-; 28.6 per cent FSWs' monthly family income is Rs. 8001/- to Rs. 10,000/-; 20.4 per cent have Rs. 10,001/- to Rs 15,000/-; and remaining 8.2 per cent FSWs' average family income is above Rs. 15, 000/- per month. Again it is to be mentioned here that 11 FSWs who are living alone, their income varies in between Rs. 1000/- to Rs. 5000/-. Out of these 11 FSWs, two FSWs are having an average monthly income of Rs. 1000/- (approximately). In the Table-5.11, the monthly income of the 60 FSWs themselves has been documented.

Table-5.10: Different Sources of FSWs' own Income

<i>Sl. No.</i>	<i>Sources of FSW's Income</i>	<i>No. of Respondents (%)</i>
1.	No other sources of income except sex work	18 (30.0%)
2.	Agri. works and construction works	11 (18.3%)
3.	Maid servant	04 (06.7%)
4.	Rearing of domestic animal	03 (05.0%)
5.	Tuition	05 (08.3%)
6.	Brick kiln labour	04 (06.7%)
7.	Tailoring	03 (05.0%)
8.	ASHA worker	01 (01.7%)
9.	Sweeper	05 (08.3%)
10.	Shop keeper	01 (01.7%)
11.	Selling deshi liquor	02 (03.3%)
12.	Post Office agent	01 (01.7%)
13.	Anganwadi helper	02 (03.3%)
	Total	60 (100%)

Table-5.10 shows the other different sources of FSWs' income other than income from sex work. It is found that out of 60 FSWs under the study, 30 per cent (18

FSWs) don't have any other sources of income except sex work. Amongst other sources, 18.3 per cent are also working as agricultural labor and construction labor; 8.3 per cent each as tutor and sweepers; 6.7 per cent each as maid servant and brick kiln workers. Some of them also work as ASHA worker; *deshi* liquor seller; postal agent; tailor, Anganwadi Helper (under ICDS) and shop-keeper. It is also learnt that despite other sources of income, it is not sufficient to maintain their families; and which forced them to be engaged in sex work to supplement their income.

Table-5.11: Average Monthly Income of the FSWs from Sex Work and other Sources

<i>Sl. No.</i>	<i>Average Monthly Income of the FSWs</i>	<i>No. of Respondents (%)</i>
1.	Below Rs. 1000	02 (03.3%)
2.	Rs. 1001- Rs. 2000	06 (10.0%)
3.	Rs. 2001- Rs. 3000	15 (25.0%)
4.	Rs. 3001 - Rs. 4000	18 (30.0%)
5.	Rs. 4001 - Rs. 5000	09 (15.0%)
6.	Rs. 5001 - Rs. 7000	07 (11.7%)
7.	Above Rs. 7000	03 (05.0%)
	Total	60 (100%)

All the FSWs informed that they don't have any fixed rate for sexual acts per client. For the purpose of the study, the researcher calculated average monthly income of the FSWs on the basis of the data supplied by them. Table-5.11 shows that out of 60 FSWs under the study, majority (83.3%) have income below Rs. 5000/- and rest 16.7 per cent are earning more than Rs. 5000/-. The table also indicates that even 2 FSW's (3.3%) monthly income is below Rs. 1000/- and only 3 (5%) FSWs have more than Rs. 7000/- per month. The average income per month of the majority FSWs (55%) are within Rs. 2001- Rs. 4000 and 11.7 per cent have within Rs. 5001/- to Rs. 7000/- per month. The rate varies from Rs 20/- to Rs 500/- per client. Apparently from the table-5.11, it seems that the monthly income of the sex workers is less. But on further query, they revealed that apart from money, some of the clients provide few of their daily needs like grocery items, bakery item, alcohol, etc. During different festivals, some clients provide gifts like garments, cosmetics, etc.; also take them to dinner or new places outside their locality, etc. In case of night halt or out station, all the expenditures are borne by the clients. In addition, three respondents also shared that their regular customers gave them jewelry (gold) item as a token of love.

5.1.10 Information Regarding FSWs' Husbands

It is already found (see Table-5.7) that 28 FSWs are living with their husbands. One can gauge at a glance from Table-5.12 that the majority (42.9%) of the sex workers' husbands fall in the age group of 35-44 years, while remaining 35.7 per cent FSWs' husbands are in the age of 45 years and above.

Table-5.12: Age of the Female Sex Workers' Husbands

<i>Sl. No.</i>	<i>Age Range (years)</i>	<i>No. of Respondents (%)</i>
1.	Below 25 years	01 (03.6%)
2.	25-34 years	05 (17.8%)
3.	35-44 years	12 (42.9%)
4.	45-50 years	08 (28.6%)
5.	Above 50 years	02 (07.1%)
	Total	28 (100%)

Table-5.13 shows the different occupations of the sex workers' husbands. It is seen from the table that out of 28 FSWs' husbands, none works in government sector and 2 of them doing nothing due to illness. Majority of the sex workers' husbands are engaged in construction works (42.9%). Other different occupations where their husbands work are as driver, farmer, businessman, vegetable vendor, contractor and insurance agent.

Table-5.13: Occupations of the FSWs' Husbands

<i>Sl. No.</i>	<i>Occupation</i>	<i>No. of Respondents (%)</i>
1.	Driver	02 (07.1%)
2.	Construction worker	12 (42.9%)
3.	Farmer	03 (10.7%)
4.	Rickshaw puller	02 (07.1%)
5.	Business man	04 (14.3%)
6.	Vegetable vendor	01 (03.6%)
7.	Contractor	01 (03.6%)
8.	Agent in Insurance Company	01 (03.6%)
9.	Unemployed	02 (07.1%)
	Total	28 (100%)

Table-5.14 shows that out of 28 husbands of FSWs, 2 are unemployed. It is found that out of remaining 26, 28.6 per cent are having monthly income below Rs. 5000/-, 53 per cent are within Rs. 5001/- to Rs. 10,000/-, and remaining 10.6 per cent are having monthly income more than Rs. 10,000/-.

Table-5.14: Average Monthly Income of the FSWs' Husbands

<i>Sl. No.</i>	<i>Average Monthly Income of the FSWs' Husbands</i>	<i>No. of Respondents (%)</i>
1.	Unemployed	02 (07.1%)
2.	Rs. 3001- Rs. 5000	08 (28.6%)
3.	Rs. 5001- Rs. 7000	07 (25.0%)
4.	Rs. 7001 - Rs. 10,000	08 (28.6%)
5.	Rs. 10,001 - Rs. 15,000	02 (07.1%)
6.	Above Rs. 15,000	01 (03.6%)
	Total	28 (100%)

5.1.11 Personal Articles Possessed by FSWs

Table-5.15 shows that 56.7 per cent FSWs under the study are possessing more than one article, while 38.3 per cent are only having mobile phones. Most of the FSWs (95%) said that mobile phone is very part and parcel of their life to maintain their business network for getting clients directly or through pimps, etc. It is found that 31.7 per cent FSWs have both TV set and mobile phone. Remaining 15 FSWs (25%) are having more than two articles such as TV; mobile; gas oven; refrigerator; sofa set and weaving machine. It is quite remarkable that 5 per cent (3 FSWs) possessing no such personal article, which shows another tragedy of sex workers' so called life.

Table-5.15: Different Personal Articles Possessed by FSWs

<i>Sl. No.</i>	<i>Personal Articles</i>	<i>No. of Respondents (%)</i>
1.	Mobile Phone	23 (38.3%)
2.	Television & mobile phone	19 (31.7%)
3.	Television, mobile phone & gas oven	02 (03.3%)
4.	Television, Mobile Phone Gas Oven & Sofa Set	04 (06.7%)
5.	Television, Mobile Phone & Weaving Machine	03 (05.0%)
6.	Television, Refrigerator, Mobile Phone & Sofa	06 (10.0%)
7.	Nothing	03 (05.0%)
	Total	60 (100%)

5.1.12 Perception of FSWs' Family Members about their Sex Work

It is found that out of 60 FSWs, 49 FSWs are living with their family (Table-5.5). Table-5.16 shows that out of 49 FSWs, 37 FSWs' (75.5%) family members are ignorant about their profession. Hence, these 37 FSWs are hiding their profession from their family members and maintaining hidden sex work. As a result, not only

they are struggling at their workplace with related issues, but also they are struggling to maintain the secrecy of their profession in their homes. It is learnt from the 37 FSWs who are successfully hiding their profession from their family members that they tell lie about their extra income or source of income to their respective family members or husbands. Only 12 FSWs informed that their family members are aware about their profession including husbands (see Table-5.19).

Table-5.16: Awareness of FSWs’ Family Members about their Sex Work

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of the Respondents (%)</i>
1.	Family members know about profession	12 (24.5%)
2.	Family members don’t know about profession	37 (75.5%)
	Total	49 (100%)

It is already shown at Table-5.16 that 12 FSWs’ family members including their husbands are aware of their profession. Table-5.17 shows the reactions of these 12 FSWs’ family members towards their profession. Out of these 12 FSWs, 06 FSWs informed that their family members are allowing them to do sex work as they are dependent on their earnings, but 4 FSWs informed that their husbands forced them to do sex work to meet up their cost of alcohol. The remaining 2 FSWs are receiving negative emotions like anger, hatred, etc., from their family members. These 2 FSWs are still continuing this sex work to manage their households by ignoring the negative reactions of their family members. So, it is quite surprising that when sex workers are marginalized in the society due to the social stigma, 10 FSWs’ family members themselves are allowing them to be in this sex workers’ profession.

Table-5.17: Reactions of Family Members about the FSWs’ Profession

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Nothing different, due to dependency	10 (83.3%)
2.	Aggression /hatred by family members	02 (16.7%)
	Total	12 (100%)

5.1.12 Reasons for Taking up of Sex Work as Profession

A vital question arises from the various part of the world that whether sex worker can be called as workers like others engaged in organized and unorganized sector. It is

usually called selling the body of a woman or also known as flesh trade. But according to sex workers' organization like DMSC (Kolkata), sex workers are selling their services.

Table-5.18 shows the various reasons of 60 FSWs under the study for taking up of sex work as profession. It is found that the chief reason of taking up sex work as profession is poverty along with some other additional reasons like to satisfy unmet sexual needs (6 FSWs), to take revenge on husbands (2 FSWs), blackmailing by others (2 FSWs), forced by husbands (4 FSWs), deceived by lovers (3 FSWs), to cope up with loneliness (5 FSWs) and to enjoy more comfortable life (7 FSWs). It is also learnt that some of the respondents (widow, deserted, separated and even married) have taken up this profession to satisfy their unmet sexual needs.

Table-5.18: Reasons for Taking up of Sex Work as Profession

<i>Sl. No.</i>	<i>Reasons</i>	<i>No. of Respondents (%)</i>
1.	Poverty	31 (51.7%)
2.	Poverty & to satisfy unmet sexual needs	06 (10.0%)
3.	Poverty & to take revenge on husbands	02 (03.3%)
4.	Poverty & blackmailing by others	02 (03.3%)
5.	Poverty & forced by husband	04 (06.7%)
6.	Poverty & deceived by lovers	03 (05.0%)
7.	Poverty & to enjoy more comfortable life	07 (11.7%)
8.	Poverty & to cope up with loneliness	05 (08.3%)
	Total	60 (100%)

Another problem is also attached with the difficulty of getting re-married in Indian culture. Two respondents informed that they came into this profession to take revenge against their husbands. They revealed that after few years of their marriage, they came to know that their husbands often visit to prostitutes and they got shocked mentally. According to these two FSWs, if their husbands can visit to prostitutes by ignoring their love and trust, then why not they? So, they enter into this profession to take revenge against their husbands. There are 7 respondents (11.7%) who came into this profession for enjoying more comfortable and luxurious life by extra earnings. Due to highly profitable nature of sex trade and desire to have all materialistic compassion, some women take up this profession. This is what is called 'relative poverty'. These sex workers want to lead luxurious life with costly *sarees*, ornaments, cosmetics, etc. Some of them also want to give better education to their children. There is one

respondent who is a post office agent, had entered into this profession to maintain and increase her agency related business. The maid servants are often objects of the lust of their employers. It is also found that 5 respondents (8.3%) entered into this profession to cope up with their loneliness i.e. unhappy married life. Hence, the table indicates that all FSWs are not in the sex trade just for poverty only. In general, majority of the respondents are illiterate or semi-literate, unable to get any gainful employment and lastly compelled to adopt prostitution to earn livelihood for themselves as well as for their family members.

Table-5.19: Reasons of the Married Women Working as FSWs

<i>Sl. No.</i>	<i>Reasons</i>	<i>No. of Respondents (%)</i>
1.	Poverty	08 (28.6%)
2.	Poverty & to satisfy unmet sexual need	02 (07.1%)
3.	Poverty & to take revenge on husbands	02 (07.1%)
4.	Poverty & Forced by husbands	04 (14.3%)
5.	Poverty & to enjoy more comfortable life	07 (25.0%)
6.	Poverty & to cope up with loneliness	05 (17.9%)
	Total	28 (100%)

It has already been seen (see Table-5.7) that out of 60 FSWs under the study, 28 FSWs are living with their husbands. The reasons for which married women are working as FSWs have been further ascertained and as shown in the Table-5.19. The table indicates that the chief reason of taking up sex work as profession among the married women is poverty along with some other additional reasons like to satisfy unmet sexual needs (2 FSWs), to take revenge on husbands (2 FSWs), forced by husbands (4 FSWs), to cope up with loneliness (5 FSWs) and to enjoy more comfortable life (7 FSWs). The table also indicates that 25 per cent of these 28 FSWs came into this profession due to more income for enjoying more comfortable life, i.e. 'relative poverty'. These sex workers want to lead luxurious and more comfortable life, which their husbands could not provide them. Some of them also want to give better education to their children. Another significant point here is that 17.9 per cent of these 28 FSWs have entered in this profession to cope up with loneliness i.e. for unhappy marital life. Their husbands work at out station and even at home also they are busy with their pending works. Those husbands of FSWs' don't have time for their wives. The table also indicates that out of 28 married FSWs, 24 (85.7%) FSWs

are engaged in this profession without the knowledge of their husbands; while remaining 4 FSWs are forced by their own husbands.

Part-II: HIV/AIDS Awareness among Female Sex Workers

5.2 Awareness of Female Sex Workers on HIV/AIDS

5.2.1 STIs

Today, Sexually Transmitted Infections are a major public health problem in the world. The old terminology of “venereal diseases” (VDs) has been superseded in the past 50 years by “sexually transmitted diseases” (STDs), and more recently by “sexually transmitted infections” (STIs) [Thappa, & Kaimal, 2007]. Most of the STIs are easy to diagnose and its treatment cost is cheap. Sexually transmitted infections are infections whose primary route of infection is through sexual contact including penile-vaginal, penile-anal and penile-oral sex. Bacteria, viruses, parasites and protozoa are its main causal agents. Some STIs may spread via skin-to-skin contact. The organism causing STIs can also be spread through non sexual means such as via blood/blood products and tissue transfer (WHO, 2015). Many STIs can also be transmitted from mother to child during pregnancy and child birth. As many STIs remain unrecognized and undiagnosed, it results in long term morbidity. Some common types of STIs are *Chancroid*, *Chlamydia*, *Gonorrhoea* and *Syphilis*. It is now well recognized that there is a synergy between most STIs and HIV. Many research studies have shown that HIV transmission and acquisition are facilitated by the presence of STIs, probably because of the inflammatory effect of STIs in the genital mucosa. *Chancroid*, *Chlamydia*, *Gonorrhoea* and *Syphilis* increase the risk of HIV transmission by 2 to 9 times. At present, India is experiencing an emergence of STIs due to various factors such as a vulnerable population, changed behaviour and lifestyle. This is also fuelled by lack of awareness amongst FSWs and other HRGs in particular and common people in general along with lack of proper skills and training among the health professionals.

Table-5.20: Awareness of FSWs on STIs

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Aware	48 (80.0%)
2.	Unaware	12 (20.0%)
	Total	60 (100%)

Table-5.20 shows that 80 per cent of the respondents have heard about the Sexually Transmitted Infections and the remaining 20 per cent didn't even hear this.

STIs can affect both men and women irrespective of age or background. Not all STIs are symptomatic, and symptoms may not appear immediately after infection. Infections carries with no symptoms leaves a greater risk of passing disease on to others (Wikipedia, 2016). But when symptoms do develop, often they are mistaken for something else such as urinary tract infection or yeast infection. Vaginal discharge is a common existing symptom in women. *Vulvovaginal candidiasis* is a common infective cause of vaginal discharge. Most women have no symptoms in *Bacterial Vaginosis*. But women with symptoms may have discharge with fishy odour, vaginal itching and pain when urinating. In the case of *Chlamydia*, symptoms for women are abnormal vaginal discharge, burning when urinating and bleeding between periods. If not treated can lead to lower abdominal and back pain, nausea, pain during sex, and fever. The most common presenting symptoms of *Pelvic Inflammatory Disease (PID)* are lower abdominal pain and abnormal vaginal discharge. Other symptoms associated with PID consist of inter menstrual and post-coital bleeding, fever, low backache and rectal discomfort. The symptoms of *Gonorrhoea* are often mild, but symptoms are often appearing mostly within 10 days of becoming infected. The symptoms of *Gonorrhoea* are pain or burning during urinating, yellowish and sometimes bloody vaginal discharge, bleeding between periods, pain during sexual intercourse and heavy bleeding during periods. *Syphilis* makes progress in 4 stages – primary, secondary, latent and late stage. When primary stage remains untreated, it moves to the secondary stage which starts 3 to 6 weeks after the sore appears. The symptoms of primary stage are a single, painless sore appearing within 10 days to 3 months after infection. The sore can be seen in the genital area, mouth or other parts of the body. In the secondary stage of *Syphilis*, symptoms are skin rash with rough, red or reddish-brown spots on hand and feet, fever, sore throat and swollen glands, patchy hair loss, headaches and muscle aches, weight loss and tiredness. In the latent stage of *Syphilis*, symptoms go back but can come back. If not treated, the infection may or may not move to the late stage of *Syphilis*. In this stage, symptoms are related to damage to brain, nerves, eyes, heart, blood vessels, liver, bone and joints. In some cases people may die also. In general, some of the most common presenting symptoms of STIs are urethral discharge in men, vaginal discharge in women, lower

abdomen pain, genital ulceration, warts or rashes in the genital area, itchiness or irritation in the genital area etc. (Adler et al., 2004).

Table-5.21: Awareness of Symptoms of STIs among FSWs

<i>Sl. No.</i>	<i>Symptoms</i>	<i>No. of Respondents (%)</i>
1.	White discharge	06 (12.5%)
2.	Genital ulcer with itching & reddening	02 (04.2%)
3.	Pain during sexual intercourse	NF*
4.	Lower abdominal pain & bleeding during Periods	NF*
5.	Painful urination	NF*
6.	Swelling in groin area	NF*
7.	Warts on or around genital	NF*
8.	Changed colour of discharge with bad odour	01 (02.1%)
9.	1+3	01 (02.1%)
10.	1+4	03 (06.2%)
11.	1+ 2	02 (04.2%)
12.	1+2+4	09 (18.7%)
13.	1+4+7	02 (04.2%)
14.	1+2+3+8	04 (08.3%)
15.	1+2+4+8	11 (22.9%)
16.	1+2+4+6	02 (04.2%)
17.	1+2+4+5+7	05 (10.4%)
	Total	48 (100%)

**NF means this particular symptom is not found as single symptom, but coupled with other symptoms*

Table-5.21 highlights the awareness of symptoms of STIs among 48 FSWs (see Table-5.20). FSWs are familiar with the word ‘white discharge’ instead of ‘vaginal discharge’ as a symptom of STIs. Out of 48 FSWs, it is found that 9 respondents know about only one symptom of STIs, while remaining 39 FSWs are aware about multiple symptoms. It is found that out of these 9 FSWs, 6 respondents know about only white discharge as a symptom of STIs, 2 respondents know genital ulcer with itching and reddening around genital organ and only one respondent knows changed colour of discharge with bad odours as the single symptom of STIs. Among the 39 FSWs who are aware about multiple symptoms, 6 FSWs know about 2 symptoms, 11 FSWs know about 3 symptoms, and 17 FSWs know about 4 symptoms and 5 FSWs are aware about 5 symptoms of STIs. The above table also indicates that out of 48 FSWs, majority (46 FSWs) are aware about vaginal discharge as a symptom of STIs. During conversation, it is also learnt that vaginal discharge is due to infection

and quite normal phenomenon to them. Therefore, out of 60 FSWs, though 48 FSWs are aware about the symptoms of STIs, but their knowledge is incomplete and/or superficial. Hence, their poor such knowledge may affect their health seeking behaviour and thereby making them vulnerable to HIV infection.

Table-5.22: Sources of Information about STIs

<i>Sl. No.</i>	<i>Sources</i>	<i>No. of Respondents (%)</i>
1.	Friends	02 (04.2%)
2.	Doctor	02 (04.2%)
3.	NGO staff	32 (66.5%)
4.	Television	02 (04.2%)
5.	News paper& books	02 (04.2%)
6.	Friends & NGO staff	01 (02.1%)
7.	Doctor & NGO staff	05 (10.4%)
8.	NGO staff & television	01 (02.1%)
9.	Friends, NGO staff &television	01 (02.1%)
	Total	48 (100%)

Table-5.22 shows the various sources where from 48 FSWs have heard about STIs. It is seen that out of 48 FSWs, 38 FSWs (79.1%) are informed of STI from various single source and 10 (20.9%) from more than one source. The table also indicates that 83.3per cent FSWs are aware of STIs from the NGO staff members who are implementing TI programmes for FSWs under TSACS. Therefore, in this study, it is found that the awareness level of FSWs on STIs is mainly due to TIPs implemented by the NGOs under TSACS.

5.2.2 Causes of HIV/AIDS

The pathology of HIV infection progresses from the initial infection to AIDS in four phases. These are (1) acute infection, (2) asymptomatic HIV disease, (3) early HIV disease and (4) advanced HIV disease or AIDS. HIV has been found to be present in blood, semen, vaginal fluid and breast milk of infected persons. HIV is also found in cerebro-spinal fluid (which bathes the brain and spinal cord), synovial fluid (which occupies the narrow space between the lungs and the chest wall) and amniotic fluid (which surrounds the foetus) of infected persons. Researchers have also isolated HIV from saliva, tears, stools and urine (in which HIV is present in very small amounts). There is no documentation of HIV transmission through these fluids. However, these fluids are possibly risk factors for transmission of HIV. The primary means of HIV

transmission is heterosexual intercourse with an infected person. Sexually transmitted diseases, such as syphilis, genital herpes, gonorrhoea, and Chlamydia, increase the risk of contracting HIV through sexual contact, probably due to the genital lesions (Encyclopedia Britannica, 2003; Barnett, & Whiteside, 2002; Unnikrishna et al., 1993).

Table-5.23: FSWs' Awareness about the Causes of HIV/AIDS

<i>Sl. No.</i>	<i>Causes of HIV/AIDS</i>	<i>No. of Respondents (%)</i>
1.	Sexually from an infected partner	11 (18.3%)
2.	From transfusion of HIV infected blood or blood products	02 (03.3%)
3.	From infected needles, syringes and other such instruments	02 (03.3%)
4.	From infected parents to baby/infant	02 (03.3%)
5.	1+2+3	05 (80.3%)
6.	1+3+4	03 (05.2%)
7.	1+2+3+4	27 (45.0%)
8.	Taking bath in same pond	01 (01.7%)
9.	Sharing food, cloth and utensils of infected persons	02 (03.3%)
10.	HIV/AIDS is a contagious disease	02 (03.3%)
11.	Mosquito bite	02 (03.3%)
12.	From the cloth used as napkin during menstruation	01 (01.7%)
	Total	60 (100%)

It is found that all the 60 FSWs under the study have heard about HIV and AIDS. Table-5.23 shows the FSWs' awareness about the causes of HIV/AIDS i.e. mode of HIV transmission. It is found that 41.7 per cent respondents are aware about single (25 FSWs) and 58.3 per cent are aware about multiple (35 FSWs) causes of HIV/AIDS. From the table, it is seen that 86.7 (52 FSWs) per cent respondents are aware about scientific causes of HIV/AIDS, while remaining 13.3 per cent (8 FSWs) told about unscientific causes of HIV/AIDS. Out of the 52 FSWs, 27 FSWs are aware about all the scientific causes of HIV/AIDS like HIV can be transmitted through HIV-positive sexual partners; infected blood transfusion; infected needle and syringes; and through infected parents to child. The remaining 25 FSWs told about not all causes, but one or more scientific causes like through sexually from HIV partners (11 FSWs); through transfusion of HIV infected blood or blood products (2 FSWs); through infected needles and syringes (2 FSWs); through parents to child (2 FSWs); through sexually, blood transfusion and needle sharing (5 FSWs); through sexually, needles and parents to child (3 FSWs). But the other 8 FSWs told about the unscientific

causes such as taking bath in same pond (1 FSW); sharing food, cloth and utensils of infected persons (2 FSWs); HIV/AIDS is a contagious disease (2 FSWs); mosquito bite (2 FSWs); and from the cloth used as napkin during menstruation (1 FSW). Therefore, 86.7 per cent (52 FSWs) know at least one or more scientific causes of HIV transmission, while 13.3 per cent (8 FSWs) are totally ignorant. Again, out of 52 FSWs, 25 FSWs are not aware about all scientific causes of HIV/AIDS. Hence, as a whole 33 FSWs are vulnerable to HIV/AIDS.

5.2.3 Symptoms of HIV/AIDS

HIV infection can generally be broken down into four distinct stages – (i) Primary infection, (ii) clinically asymptomatic stage, (iii) symptomatic HIV infection, and (iv) progression from HIV to AIDS. The first stage lasts for a few weeks and is often accompanied by a short flu-like illness. The second stage is free from major symptoms, although there may be swollen glands. Research has shown that HIV is not dormant during asymptomatic stage, but is very active in lymph nodes. The asymptomatic stage varies from 4 weeks to 10 years depending on the immunity system of the concern HIV infected person. The change of second stage to symptomatic HIV infection stage becomes apparent with the development of one or more characteristics of opportunistic infections (OIs). There is an increase in the rate of HIV multiplication in the lymph nodes and spleen. The lymphoid organs – thymus, bone marrow, spleen and lymphnodes gradually deteriorate and the level of virus in the blood increases. Symptoms also include headache, fatigue, muscle pain, joint pain, intermittent fever, recurring diarrhea and weight loss. In the final stage, there is complete deterioration of the interior structure of the lymph nodes, the thymus and bone marrow that started in the third stage. In this final stage, the virus becomes more virulent and they tend to replicate faster and the immune system completely breaks down. There are a number of various severe opportunistic infections (OIs) that can be viral, bacterial, protozoan or fungal in origin. Diarrhoea or loose bowel movements are frequent. Latent infection of the liver by hepatitis B and C virus can be reactivated during this final stage. Both the Central Nervous System and the Peripheral Nervous System are affected. Cancer can occur in the brain during the advanced stage. Psychological problems particularly anxiety and depression are common (Wikipedia, 2016).

Table-5.24 shows the awareness of FSWs about the symptoms of HIV/AIDS. Out of 60 respondents under the study, 16 respondents (26.7%) know about various single symptom and the remaining 44 respondents (73.3%) shared about multiple symptoms. It is found that out of 44 FSWs who are aware about multiple symptoms, majority i.e. 19 FSWs told about fever, rapid weight loss and diarrhoea as major symptoms of HIV/AIDS. Other major multiple symptoms expressed by the respondents are fever, tiredness and rapid weight loss (11 FSWs); and fever, rapid weight loss and sores of the mouth, anus, or genitals (5 FSWs). Therefore, it is significant to note that only 2 FSWs are aware about all the symptoms of HIV/AIDS.

Table-5.24: Awareness of FSWs about the Symptoms of HIV/AIDS

<i>Sl. No.</i>	<i>Symptoms</i>	<i>No. of Respondents (%)</i>
1.	Fever	04 (06.7%)
2.	Tiredness	01 (01.7%)
3.	Rapid weight loss	03 (05.0%)
4.	Diarrhoea for more than a week	02 (03.3%)
5.	Sores of the mouth, anus, or genitals	04 (06.7%)
6.	Blotches on or under the skin or inside mouth, nose or eyelids	02 (03.3%)
7.	1+2+3	11 (18.3%)
8.	1+3+5	19 (31.7%)
9.	1+3+6	05 (08.3%)
10.	2+3+7	01 (01.7%)
11.	1+2+3+5	02 (03.3%)
12.	White discharge with fishy odour	04 (06.7%)
13.	All the symptoms listed above	02 (03.3%)
	Total	60 (100%)

Table-5.25 shows the sources of information about HIV/AIDS. It is clearly evident from the table that 48 FSWs (80%) have got the information about HIV/AIDS from single source, and the rest 12 (20%) from the multiple sources. Majority (35 FSWs) of the respondents revealed that they received information from the NGO staff of TI programme. Even those who have heard about HIV/AIDS from the multiple sources informed that, they also got the information from the NGO staff and other sources like doctors, neighbours and different media. Hence, NGOs and TSACS are instrumental in generating awareness about HIV/AIDS among the FSWs under the study in Tripura.

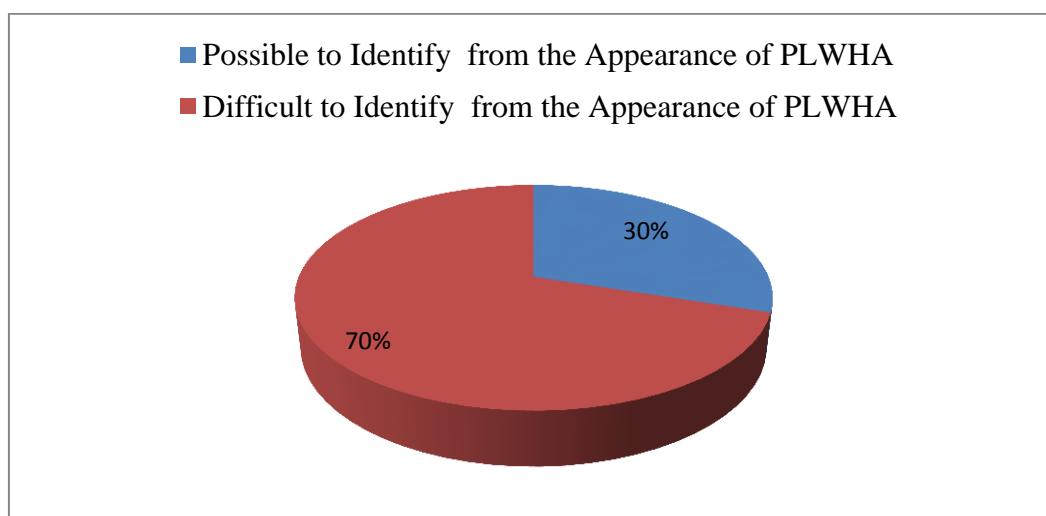
Table-5.25: Sources of Information about HIV/AIDS

<i>Sl. No.</i>	<i>Sources</i>	<i>No. of Respondents (%)</i>
1.	Friends	02 (03.3%)
2.	Doctor	06 (10.0%)
3.	NGO staff	35 (58.3%)
4.	Electronics media (television and radio)	02 (03.3%)
5.	Print media (news paper and books)	02 (03.3%)
6.	Neighbour	01 (01.7%)
7.	Friends & NGO staff	01 (01.7%)
8.	Doctor & NGO staff	04 (06.7%)
9.	NGO staff & electronics media	05 (08.3%)
10.	Doctor, & NGO staff, & electronics media	01 (01.7%)
11.	NGO staff, & electronics media & print media	01 (01.7%)
	Total	60 (100%)

5.2.4 Possibility of Identifying PLWHA from their Physical Appearances

Any person who has acquired the HIV virus may experience slight symptoms at the early stages of HIV infection, but majority of them experience asymptomatic status. The only way for confirmation of HIV status of any person is possible by an HIV antibody test. A person having HIV can look well and healthy in the earlier stages and being unaware, s/he may infect others unknowingly. As HIV presents no external physical symptoms, so it is not possible to know by his/her appearance if he/she has HIV/AIDS. He/she can continue to contribute his/her service to society and can lead a normal life.

Figure-5.1: Possibility of Identifying PLWHA from their Physical Appearances



It is found that out of 60 FSWs under the study; 30 per cent (18 FSWs) told that it is possible to identify PLWHA from their physical appearance, while 70 per cent (42 FSWs) told that it is difficult (see Figure-5.1).

Table-5.26: FSWs’ Opinion about the Possibility of Identifying PLWHA from their Physical Appearances

<i>Sl. No.</i>	<i>Appearance of the Person who have HIV/AIDS</i>	<i>No. of Respondents (%)</i>
1.	Oedema	01 (05.6%)
2.	Looks thin & weak	08 (44.4%)
3.	Looks thin & suffering from fever	04 (22.2%)
4.	Looks thin, weak & having skin disease	05 (27.8%)
	Total	18 (100%)

Table-5.26 shows that 18 FSWs, who opined that PLWHA can be identified from physical appearances, have described different physical symptoms of PLWHA. They told different physical symptoms like looking thin and weak (8 FSWs), skin diseases along with thin and weakness (5 FSWs), and looking thin and have fever (4 FSWs) can be PLWHA. However, only one FSW told that *oedema* may be only body symptom of PLWHA. Hence, all the responses of these 18 FSWs indicate that their knowledge about HIV/AIDS or PLWHA is incomplete and/or superficial.

Table-5.27: FSWs’ Opinion about the Reasons of Difficulty in Identifying PLWHA from their Physical Appearances

<i>Sl. No.</i>	<i>Opinions</i>	<i>No. of Respondents (%)</i>
1.	HIV status can be confirmed by medical test only	27 (64.3%)
2.	Only doctors can understand	09 (21.4%)
3.	Only literate person can understand	02 (04.8%)
4.	Only NGO staff can understand	03 (07.1%)
5.	PLWHA can identify	01 (02.4%)
	Total	42 (100%)

Table-5.27 shows the opinion of 42 FSWs who listed the difficulties in identifying the PLWHA from their physical appearances. It is found that out of 42 FSWs, 27 FSWs (64.3%) opined that without medical test, it is not possible to identify HIV status of the person through physical appearance, while remaining 15 FSWs (35.7%) told PLWHA can be identified even without medical test. These 15 FSWs told that the PLWHA can be identified only by the doctors (9 FSWs), NGO staff (3 FSWs), literate people (2 FSWs), and by the PLWHA themselves (one FSW). Therefore, it is

understood that these 15 (35.7%) respondents, have superficial knowledge on HIV/AIDS or PLWHA. Hence, out of 60 FSWs under the study, 33 FSWs' (55%) knowledge about identifying PLWHA from their physical appearances is incomplete and/ or superficial (see Table-5.26 & 5.27).

Table-5.28: PLWHA Seen / Known by FSWs

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Seen	19 (31.7%)
2.	Not seen	41 (68.3%)
	Total	60 (100%)

It is found from the Table-5.28, majority (68.3%) of the FSWs have never seen or know any PLWHA, while 19 FSWs (31.7%) have seen PLWHA. Out of these 19 FSWs, 2 of them told that they themselves are HIV-positive (see Table-6.17), 7 FSWs told that one of their friends is HIV positive, and one FSW informed that one her clients is PLWHA and remaining 9 FSWs said that they have seen PLWHA in the office of the NGO and TSACS. Out of 2 HIV-positive FSWs, one informed that after knowing the HIV-positive status, she left one of her clients.

5.2.5 Ways to Prevent HIV Infection

Till now there is no medicine to kill the HIV from any HIV infected person. But, so far there are some scientific precautionary measures to prevent HIV infection like remaining faithful to sexual partner; using condom consistently if the HIV and STIs status of the partner is unknown; using sterilized needles/ syringes always, taking screened blood or blood products, etc.

Table-5.29 shows the FSWs' views about the various ways to protect themselves from HIV infection and AIDS. We have already seen (Table-5.23), where FSWs under the study has expressed their views about the causes of HIV/AIDS. But the responses given by them about various ways to protect themselves (Table-5.29) are quite contradictory with the Table-5.23 and Table-5.42. Therefore, the knowledge of FSWs about HIV/AIDS is superficial. Hence, it is understood that out of 60 FSWs, none have full knowledge to protect themselves from HIV infection and AIDS, while 15 FSWs are fully ignorant.

Table-5.29: Views of FSWs about Various Ways to Protect themselves from HIV/AIDS

<i>Sl. No.</i>	<i>Ways to Prevent HIV/AIDS</i>	<i>No. of Respondents (%)</i>
1.	Remaining faithful to sexual partner	03 (05.0%)
2.	Always using condom during sexual act	18 (30.0%)
3.	Taking screened blood or blood products	01 (01.7%)
4.	Avoiding shaking hands, sharing utensils, clothes, toilets, kissing	10 (16.7%)
5.	Blood test every after 6 months	01 (01.7%)
6.	Not to engage in sex with PLWHA	02 (03.3%)
7.	Awareness of clients about HIV/AIDS	02 (03.3%)
8.	1+2+3	11 (18.3%)
9.	1+2+7	07 (11.7%)
10.	2+4+6	05 (08.3%)
	Total	60 (100%)

5.2.6 HIV Test

Integrated Counselling and Testing Centre (ICTC) is an establishment that offers counselling and testing services for HIV infection. Quality HIV counselling and testing is critical for achievement of the aim or objectives of the National AIDS Control Program (NACP). As symptoms of HIV/AIDS appear late, so it is necessary to encourage and motivate regular HIV testing among high risk groups (HRGs) for early detection and timely link them with HIV care and treatment services. This will help in preventing further HIV transmission. Beside this effort, NACP also ensures comprehensive pre-test and post-test counselling at ICTC. Overall, ICTCs are acting like a service hub, facilitates linkages between testing services with broader continuum of care and support services for those who are in need of it.

HIV test can be divided in two categories – indirect or serological tests and direct or virological tests. Tests are done through the identification of HIV antibodies, which accumulate after four weeks to six months after exposure. The most common test for HIV is the enzyme-linked immune sorbent assay (ELISA) test. Other tests are Western blot, Polymerase Chain Reaction (PCR) and Single Use Diagnostic Screening (SUDA). There is no cure or effective vaccine available for HIV infection till date. Efforts are focused primarily on creating awareness, behaviour change communication (BCC) for changing sexual behaviour, promoting use of condoms, discouraging re-use of contaminated needles, etc.

Table-5.30: Opinion of FSWs about the Mandatory HIV Test for FSWs

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Must go for test	54 (90.0%)
2.	No test is needed	06 (10.0%)
	Total	60 (100%)

All the respondents under the study informed that they have heard about ICTC. But most of them (66.7%) recognized ICTC as a place (not by the name of ‘ICTC’), where free blood test is done to detect HIV. The Table-5.30 shows the opinion of the respondents about the mandatory HIV test required for FSWs. It is seen from the Table-5.30 that 90 per cent (54 FSWs) respondents think that every FSW must go for HIV test, while 10 per cent (6 FSWs) told it is not required for them. Out of 6 FSWs, only one FSW informed that it is not required for her as she has not got HIV till now in spite of sex without condom. The remaining 5 FSWs told that “*FSWs, who are using condom consistently, why should they go for HIV test?*”. This shows their in-depth knowledge about the HIV preventive measures.

Table-5.31: Number of FSWs Undergone HIV Test

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Undergone test	51 (85.0%)
2.	Not undergone test	09 (15.0%)
	Total	60 (100%)

The Table-5.31 shows the number of FSWs under the study who has undergone HIV test. It is found that out of 60 FSWs, 51 FSWs (85%) did HIV Test, while 15 per cent did not go for HIV Test.

Table-5.32: Reasons for Undergoing HIV Test

<i>Sl. No.</i>	<i>Reasons</i>	<i>No. of Respondents (%)</i>
1.	Self referred	09 (17.7%)
2.	Referred by NGO staff	40 (78.4%)
3.	Referred by doctor	02 (03.9%)
	Total	51 (100%)

It is seen (Table-5.31) that out of 60 FSWs, 51 FSWs have done HIV Test. The Table-5.32 shows the reason of undergoing their HIV test. It is seen that majority of them done their HIV test as they were referred by the NGO staff (78.4%) and by the

doctors (3.9%). It is quite surprising that only (17.7%) done their HIV Test voluntarily. The finding of the table is contradictory with the Table-5.30.

Table-5.33: Reasons for Not Undergoing HIV Test

<i>Sl. No.</i>	<i>Reasons</i>	<i>No. of Respondents (%)</i>
1.	Out of fear (If found HIV-positive, people will kill)	01 (11.1%)
2.	Using condom in every sexual act	06 (66.7%)
3.	The time required for visiting ICTC will affect earning	01 (11.1%)
4.	Can't access ICTC (mobile in nature)	01 (11.1%)
	Total	09 (100%)

Table-5.33 shows the reasons for not undergoing the HIV Test. It is revealed that out of 9 FSWs, 06 didn't go for HIV test as they are using condom consistently. Out of the remaining 3 FSWs, one of the respondents didn't test HIV out of fear. The reason of her fear is that, if she found positive, people will kill her. This response speaks about the social stigma and ostracism attached with PLWHA. Another FSW informed that, due to mobile nature of occupation, she can't access the services of ICTC for the HIV Test. The remaining one FSW revealed that as the time required for visiting ICTC will affect her earning, so she didn't undergo for HIV test. This is another example of how poverty forced them to engage FSWs in risky behaviour despite their awareness on HIV/AIDS.

Table-5.34: Feelings of the Respondents after HIV Test

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Happy	48 (94.1%)
2.	Not happy	03 (05.9%)
	Total	51 (100%)

Table-5.34 shows the feelings of 51 FSWs, who have undergone HIV Test. It is found that 48 (94.1%) are happy after the test as they were found HIV negative. Two of such FSWs informed that they will use their HIV negative report for getting more clients. Out of the 51 FSWs, 3 FSWs who are unhappy, informed that two of them were found HIV positive after the test, while another FSW was not happy as she has complained about the amount of blood taken by NGO staff. She assumed that the extra blood was taken for the purpose of selling.

5.2.7 Treatment of HIV/AIDS

In the early 1980s, when the HIV/AIDS epidemic began, people with AIDS were not likely to live longer than a few years. There are also people whose bodies naturally suppress the virus without medication (referred to as "elite controllers" by San Francisco AIDS Foundation, 2016). But they are rare cases, and a lack of symptoms should not be interpreted to mean that PLWHA do not need medication if he/she is known to have HIV. Today, there are 31 antiretroviral drugs (ARVs) approved by the Food and Drug Administration to treat HIV infection (National Institute of Health, USA, 2012). Taking HIV treatment requires effort and commitment as drugs must be taken at exact time each day throughout the life. Some people may experience serious side effects or may not respond to certain drug treatment. Care and support can help people to adhere to the treatment and address any problems that they may have with their treatment regimen. Anti Retroviral Drug Treatment is the main type of treatment for PLWHA. The aim of ART is to keep the amount of HIV in the body at a low level. This stops any weakening of the immune system further and allows it to recover from any damage that HIV might have already caused. Anti Retroviral Therapy (ART) in many cases allow the stabilization of the PLWHA's symptoms, in partial recovery of CD4 levels and reduction in *viremia* (the level of virus in the blood) to low or near undetectable levels. Disease specific drugs can also alleviate symptoms of AIDS and even cure specific AIDS defining conditions in some cases. Taking two or more antiretroviral drugs at a time is called 'combination therapy'. Taking a combination of three or more anti-HIV drugs is sometimes referred to as Highly Active Antiretroviral Therapy (HAART). If only one drug was taken, HIV quickly becomes resistant to it; and the drug would stop working. Taking two or more antiretroviral drugs at the same time vastly reduces the possibility of resistance, thereby making the treatment more effective in the long term. For adults and adolescents, World Health Organisation (WHO, 2006) recommend starting on a first line therapy of two nucleoside reverse-transcriptase inhibitors (NRTIs) plus a non-nucleoside reverse transcriptase inhibitor (NNRTI). The favoured recommendation is a fixed-dose combination (just one pill) of – TDF (Tenofovir), 3TC (Lamivudine) or FTC (Emtricitabine) and EFV (Efavirenz). At the beginning of treatment, the combination of drugs that a person is given is called '*first line therapy*'. If after a while HIV becomes resistant to this combination, or if side effects becomes worst, then a change to '*second line therapy*' is usually

recommended. WHO recommendations suggest two NRTIs and a ritonavir-boosted protease inhibitor (PI) for *Second line therapy*.

However, these advances do not constitute a cure, since current treatment regimens cannot eradicate latent HIV from the body (Wikipedia, 2016). Many HIV infected people, sometimes out of superstition visit spiritual leaders of any religion or believer of doctrine taught by *Tantras* and wear *Tabiz* (amulet) to get rid of HIV. Table-5.35 shows about the perception of FSWs about curability of HIV/AIDS.

Table-5.35: Perception of FSWs about the Curability of PLWHA

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Curable	16 (26.7%)
2.	Not curable	42 (70.0%)
3.	Don't know	02 (03.3%)
	Total	60 (100%)

The Table-5.35 shows that 42 FSWs (70%) know that HIV/AIDS is not curable. Further out of 42 FSWs, 20 FSWs added that though HIV/AIDS is not curable, but there is some treatment to stay better and healthy. According to them, there are some treatments for opportunistic infections (OIs) for PLWHA. Out of the remaining 18 FSWs, 16 (26.7%) said that HIV/AIDS is curable disease, while 2 FSWs (3.3%) are not sure and expressed their ignorance. Therefore, the 18 FSWs (30%) are ignorant about disaster effects of HIV/AIDS.

Table-5.36: Sources of Information about the Curability of HIV/AIDS

<i>Sl. No.</i>	<i>Sources</i>	<i>No. of Respondents (%)</i>
1.	Friends	03 (18.7%)
2.	Quack doctor	01 (06.3%)
3.	NGO staff	05 (31.2%)
4.	Self realization	06 (37.5%)
5.	Neighbour	01 (06.3%)
	Total	16 (100%)

It is seen from the Table-5.35, that 16 FSWs think that HIV/AIDS is curable. The Table-5.36 shows that out of 16 FSWs, 5 FSWs (31.2%) got the information from the NGO staff. It indicates that all staff members of TIP implementing NGOs are not properly trained. It is also found that some FSWs still have faith on their friends, neighbours and quack doctors.

Table-5.37: Sources of Information about Non-Curability of HIV/AIDS

<i>Sl. No.</i>	<i>Sources</i>	<i>No. of Respondents (%)</i>
1.	Doctor	05 (11.9%)
2.	NGO staff	30 (71.4%)
3.	Media (television, radio, newspapers)	04 (09.6%)
4.	Doctor and NGO staff	03 (07.1%)
	Total	42 (100%)

It is seen from the Table-5.35 that 42 FSWs think that HIV/AIDS is not a curable disease. The Table-5.37 shows that out of 42 FSWs, 30 FSWs (71.4%) got this information from the NGO staffs of TI programme, 5 FSWs (11.9%) from the doctors and 3 FSWs (7.1%) from both the doctors as well as from the NGO staff. It is also found that 4 FSWs (9.6%) got the information from different media like TV, newspapers, radio, etc.

Table-5.38: FSWs' Awareness on Availability of Medicine for the Treatment of PLWHA

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Available	36 (60.0%)
2.	Not available	22 (36.7%)
3.	Don't know	02 (03.3%)
	Total	60 (100%)

The Table-5.38 shows the 60 FSWs' awareness about the availability of any medicine for the treatment of PLWHA. The table shows that 36 FSWs (60%) told that medicines are available for the treatments of PLWHA, 22 FSWs are not aware about such medicines and remaining 2 FSWs are fully ignorant. Out of 36 FSWs, 20 FSWs added that those medicines help PLWHA to stay better instead of curing HIV, while 16 FSWs told that those medicines will cure HIV completely from the PLWHA's body. Therefore, except 20 FSWs (33.3%) remaining 40 FSWs (66.7%) are not fully aware about the ART therapy available for PLWHA.

Table-5.39: FSWs' Awareness about the Places for Availability of Medicines for PLWHA

<i>Sl. No.</i>	<i>Places</i>	<i>No. of Respondents (%)</i>
1.	ART Centre	24 (66.7%)
2.	Don't know	12 (33.3%)
	Total	36 (100%)

It is found that none of the 60 FSWs under the study know the exact name of any ART medicine for PLWHA. Table-5.39 shows that out of 36 FSWs who are aware about the availability of ART medicines (see Table-5.38), 24 FSWs (66.7%) know the name of the place/centre where medicines are available for the treatment of HIV/AIDS, while remaining 12 FSWs (33.3%) are not aware about such places/centres. Again it is further learnt that out of 24 FSWs, 15 FSWs know the ART Centre by name, while remaining 9 FSW informed that it is available only in government hospitals. Therefore, out of 60 FSWs under the study, only 15 FSWs (25%) know the ART Centre by name and remaining 45 (75%) are ignorant about such centres and the services offered by these centres.

Provision of free antiretroviral therapy for eligible persons living with HIV/AIDS (PLWHA) was launched on 1st April, 2004 in 8 Government hospitals located in 6 high prevalence States of India (NACO, 2014). Since then, the program has been scaled up significantly both in terms of facilities and number of beneficiaries. First line ART is provided free of cost to all eligible PLWHA through ART Centres. The patients can continue on *first line ART* for a number of years if their adherence is good. But over the years some percentage of PLWHA on *first line ART* develops resistance to these drugs due to mutation in HIV. Then, *second line ART* starts, which is also free of cost. In Tripura, both the *first line ART* and *second line ART* care, support and treatment (CSTs) facilities are available, but not a single case for *second line ART* is found till date. It is to be mentioned here that only one ART Centre is currently functioning in Agartala, in Tripura (see Table-1.10).

Table-5.40: FSWs' Awareness about the Treatment Cost for HIV/AIDS

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Costly	04 (11.1%)
2.	Free of cost	20 (55.6%)
3.	Don't know	12 (33.3%)
	Total	36 (100%)

Table-5.40 shows that out of 36 FSWs those who are aware of medicines available for PLWHA (see Table-5.38), 20 FSWs (55.6%) responded that PLWHA are presently receiving medicines at free of cost from the ART centre, while 4 FSWs (11.1%) said that the treatment is costly. The remaining 12 FSWs (33.3%) don't have any idea about the cost of the said treatment. Therefore, out of 60 FSWs under the study, only 20 FSWs (33.3%) know that ART drugs are available at free of cost from the ART Centre, while the remaining 40 (66.7%) are fully ignorant about such facilities of the government.

5.2.8 Need for HIV/AIDS Awareness

It is already seen (Table-5.34) that out of 60 FSWs under the study, 2 FSWs are already found HIV-positive. Table-5.41 shows the remaining 58 FSWs' opinion regarding their possibility of getting infected with HIV in future.

5.41: FSWs' Opinion Regarding their Possibility of Getting HIV in Future

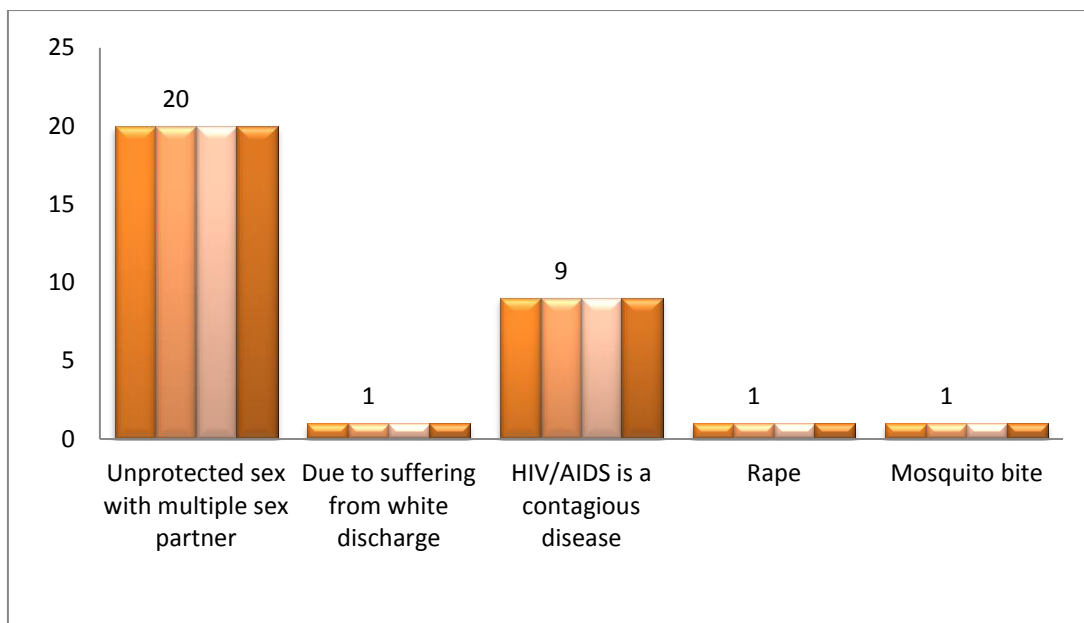
<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	May get HIV	32 (55.2%)
2.	May not get HIV	26 (44.8%)
	Total	58 (100%)

It is found that out of 58 FSWs, 32 FSWs (55.2%) told that they may get HIV/AIDS in future, while 26 FSWs (44.8%) told that they will not get HIV in future. Hence, only 32 FSWs (53.3%) are having the fear of getting HIV infection in future. But this finding is quite contradictory with Table-5.23, where 52 FSWs informed that they are aware about the scientific causes of HIV/AIDS.

It is already found that 32 FSWs expressed about their possibility of getting HIV/AIDS in future (see Table-5.41). The Figure-5.2 shows that out of 32 FSWs, 20 FSWs (62.6%) think that they may get HIV/AIDS as they are not always engaged in sexual intercourse with condom and providing service to multiple clients, while remaining respondents cited the unscientific reasons like contagious diseases, mosquito bites and white vaginal discharge. These 20 FSWs also informed that it is not possible for them to know the HIV status of their clients. Hence, these 20 FSWs under the present study are aware but are not capable to use their knowledge into

practice. But, the other 9 FSWs think that they may get HIV/AIDS as it is a contagious disease.

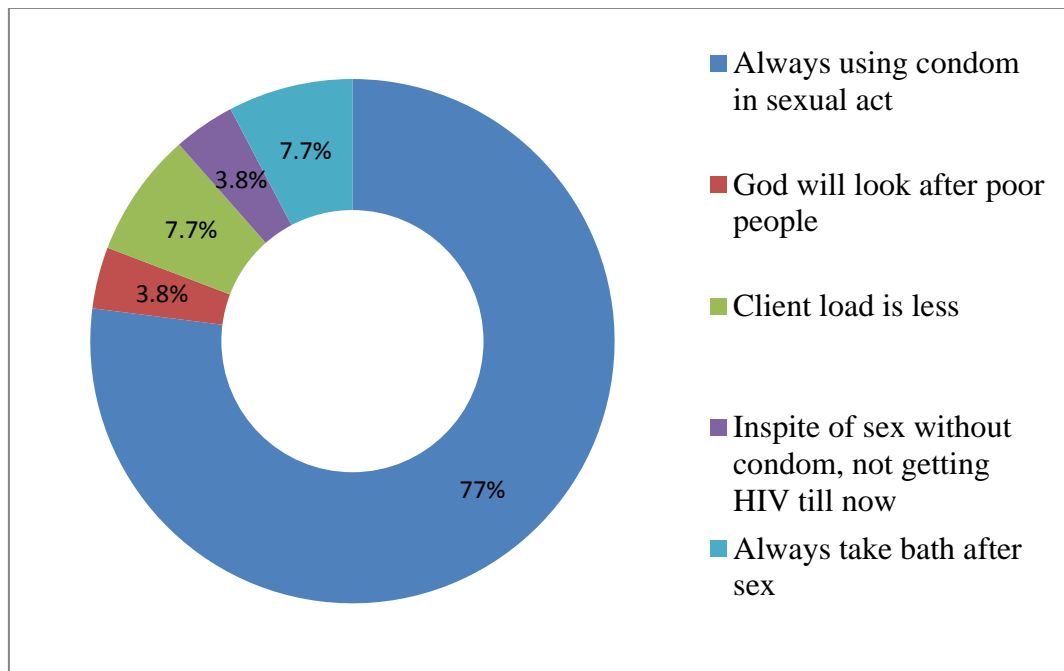
Figure-5.2: Reasons of Getting HIV/AIDS in Future



They further informed that they may get HIV/AIDS through cough and cold, flu, sneezing, kissing hugging, sharing food and utensils. One FSW each told that they may get HIV/AIDS through white discharge and mosquito bite respectively. Only one FSW said that they may get HIV/AIDS through rape as it is forced unsafe sex by an unknown person who may be HIV-positive. This figure indicates that out of 32 FSWs, 21 FSWs (65.7%) told about the scientific reasons of getting HIV infection in future, while remaining 11 FSWs (34.3%) expressed unrealistic reasons about the possibility of getting HIV infection in future. Therefore, altogether out of 58 FSWs (as 2 FSWs are HIV-positive), only 21 FSWs (36.2%) are aware about the possibility of getting HIV infection in future, while the remaining 37 FSWs (63.8%) are fully ignorant about such risks involved in their profession.

From the Figure-5.3, it is observed that out of 26 respondents, 20 FSWs (77%) informed that they are using condom consistently in every sexual act, so they may not get HIV infection. But, remaining 6 FSWs (23%) told about the unscientific reasons like God will look after poor people, client load is less, even without using condom still did not get HIV and always take bath after sex. This finding of the present study indicates the existence of high level of misconception about HIV/AIDS among FSWs.

Figure-5.3: Reasons of Not Getting HIV/AIDS in Future



Hence, these 6 FSWs (23%) in the present study are vulnerable and there is a possibility of getting HIV infection in future. Therefore, out of 58 FSWs, only 20 FSWs are using condom consistently in every sexual act i.e. practicing safer sex always.

Table-5.42 shows the opinion of the respondents about the existing public views regarding the causes of HIV/AIDS. 60 FSWs under this study expressed their agreements and disagreements with such public views about the causes of getting HIV/AIDS. The very purpose of asking the respondents' views on these questions were to cross-check or test their actual knowledge and awareness level on HIV/AIDS. The responses given by the respondents regarding the popular public views about the causes of HIV/AIDS are quite contradictory with the responses given by them (see Table-5.23). Therefore, the actual knowledge and awareness of FSWs under the study about the causes of HIV/AIDS is superficial. Hence, they are naturally vulnerable to get STIs, HIV/AIDS and other such diseases.

Table-5.42: FSWs' Opinions on the Public Views about the Causes HIV/AIDS

Sl. No.	Public Views	Responses of FSWs			Total (%)
		Agree (%)	Disagree (%)	Not Sure (%)	
1.	HIV/AIDS from Mosquito bites	15 (25.0%)	04 (06.7%)	04 (06.7%)	60 (100%)
2.	Having sex without condom	60 (100%)	NA	NA	60 (100%)
3.	Sharing food with PLWHA	23(38.3%)	36 (60.0%)	01 (01.7%)	60 (100%)
4.	Shaking hand with PLWHA	24 (40.0%)	33 (55.0%)	03 (05.0%)	60 (100%)
5.	Through contaminated needle/syringe	55 (91.6%)	01(01.7%)	04 (06.7%)	60 (100%)
6.	Having sex with multiple partners	60 (100%)	NA	NA	60 (100%)
7.	From infected mother to unborn child	51 (85.0%)	03 (05.0%)	06 (10.0%)	60 (100%)
8.	Sharing same utensils with PLWHA	22 (36.7%)	30 (50.0%)	08 (13.3%)	60 (100%)
9.	Using same bathroom/ toilet seat	18 (30.0%)	35 (58.3%)	07 (11.7%)	60 (100%)
10.	FSWs are responsible for spreading of HIV/AIDS	23 (38.3%)	23 (38.3%)	14 (23.3%)	60 (100%)
11.	Through breast feeding from infected mother	43 (71.7%)	12 (20.0%)	05 (08.3%)	60 (100%)
12.	Kissing/hugging with PLWHA	23 (38.3%)	34 (56.7%)	03 (05.0%)	60 (100%)

All the 60 FSWs under the study believe that awareness on HIV/AIDS is a must and required for each and every FSW. Table-5.43 shows the FSWs' opinion about the necessity of awareness on HIV/AIDS among sex workers. FSWs are considered as one of the HRGs due to their nature of work as well as some vulnerable factors that make their life at risk and vulnerable towards HIV/AIDS. The major reasons expressed by them regarding the need of awareness on HIV/AIDS for FSWs are – (i) having multiple sexual partners (31.7%); (ii) no medicine to cure HIV/AIDS (25%); (iii) low level of education among sex workers (20%); (iv) inconsistency in condom use due to lack of negotiation skill (5%); and (v) ignorance about HIV status of their clients (5%). It is also found that only 8 FSWs (13.3%) expressed about the multiple reasons for the necessity of HIV/AIDS awareness among sex workers, while remaining 52 FSWs (86.7%) expressed single reason only.

Table-5.43: FSWs' Opinion about the Need of HIV/AIDS Awareness among Themselves

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	FSWs' Education level is low	12 (20.0%)
2.	FSWs have multiple sexual partners	19 (31.7%)
3.	FSWs don't know the HIV status of their clients	03 (05.0%)
4.	Inconsistency in condom use due to lack of negotiation skill	03 (05.0%)
5.	As there is no medicine to cure HIV/AIDS	15 (25.0%)
6.	2+4+5	08 (13.3%)
	Total	60 (100%)

Therefore, FSWs themselves are not fully aware why they need to know about HIV/AIDS, which indicates their vulnerability towards HIV/AIDS and spread the same to others. It is already seen that at the national level, mode of HIV/AIDS transmission through heterosexual route is 88.2% (NACO, 2012).

Table-5.44: Necessity of Public Awareness on HIV/AIDS

<i>Sl. No.</i>	<i>Responses</i>	<i>No. of Respondents (%)</i>
1.	Awareness needed	59 (98.3%)
2.	Awareness not needed	01 (01.7%)
	Total	60 (100%)

Table-5.44 shows that 59 FSWs (98.3%) revealed that it is necessary for everyone to be aware of HIV/AIDS. Only 01 respondent replied that it is not required for everyone to be aware of HIV/AIDS as all are not sex workers. To her, it is required for FSWs only as they are vulnerable and high risk group. She too believes that HIV is a sex workers' disease.

Table-5.45: Reasons for the Necessity of Public Awareness on HIV/AIDS

<i>Sl. No.</i>	<i>Reasons</i>	<i>No. of Respondents (%)</i>
1.	To lead HIV free life	36 (61.0%)
2.	As there is no medicine which can cure HIV/AIDS	07 (11.9%)
3.	People will practice safe sex	16 (27.1%)
	Total	59 (100%)

It is seen from the Table-5.44 that 59 FSWs (98.3%) opined for the necessity of public awareness. Table-5.45 shows the reason given by FSWs for the necessity of public awareness about HIV/AIDS. All the informants (59 FSWs) have shown single reason for awareness on HIV/AIDS for public. They have given various reasons like –

to lead HIV free life (61%) people; will practice safe sex (27.1%); and lack of medicine (11.9%). According to them, through public awareness only their clients also will be aware about HIV/AIDS and will help to all concerned. To them, if all become aware about HIV/AIDS, then there will be no problem in practicing safe sex.

From the above discussion (Part-I & Part-II), it is a confirmed fact that information and knowledge related to HIV/AIDS is essential for all to combat this HIV/AIDS pandemic. Awareness is an important prerequisite for prevention programmes to overcome the prevailing misconceptions and bring necessary change in the behaviour pattern of FSWs in particular and other HRGs in general. The promotion of safer sexual behaviour is at the core of HIV/AIDS programmes, particularly with young people. Youth are also more amenable to behavioral change than that of adults, and especially with the high risk group. This chapter throws a considerable light on HIV/AIDS awareness among female sex workers (FSWs) in Tripura. In the context of awareness of STIs, though majority FSWs is aware about its symptoms, but their knowledge is incomplete and/or superficial. With regards to HIV/AIDS, majority FSWs know at least one or more scientific causes of HIV transmission, while some FSWs are totally ignorant and they are also having misconceptions regarding the transmission of HIV and very few FSWs are aware about all the symptoms of HIV/AIDS. Majority of them don't have full knowledge to protect themselves from HIV infection, while some are totally ignorant. In this respect, all the findings indicate that the comprehensive knowledge of FSWs under the study on HIV/AIDS is not up to that level which is required for FSWs to remain HIV/AIDS free. Therefore, their poor such knowledge may hinder their health seeking behaviour and thereby making them vulnerable to HIV infection. One possible explanation of this poor knowledge is linked with their poor educational level, as majority of the FSWs under the study has read up to class VIII. Another possible explanation of these findings can be viewed in the context of the FSWs' socio-cultural aspect where talking about sex, sexuality and related issues continues to be a cultural taboo. Again, other explanation of their poor knowledge can be related with incorrect information. Incorrect information and lack of proper sufficient information may lead to the development of misconceptions. Moreover, all the findings of the study indicate that all the staff members of TIP implementing NGOs are not properly trained. Despite of awareness campaign throughout the years, some

FSWs still have faith on their friends, neighbours and quack doctors. At the same time, it is also a fact that NGOs engaged in TIPs can be instrumental in generating awareness about HIV/AIDS among the FSWs in Tripura only if the NGOs' staff members are having proper knowledge and effective training. Hence, it necessitates re-thinking for the planners and policy makers to wisely adopt appropriate strategies considering the field realities. Appropriate policies and programmes are needed to eliminate misconception and/or superficial knowledge about HIV/AIDS for FSWs especially for those places like Tripura, where sex workers are scattered and hidden in nature due to absence of brothel and lack of Sex Workers' Association like other States.