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Understanding Sociology of Health among Prostitution Workers in India

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Abstract

The health conditions of female sex workers in India is an area of concern. The paper identifies the health of Female Sex Workers (FSWs) as a social concept, contextualising it through a range of social, political and cultural factors. The stigmatisation of sex work, based on superficial standards of ethics and morality nurtured by preconceived notions has led to poor self-image among sex workers and limited their access to health care. This creates a social hierarchy where women get limited choices and face violence. These countless problems have shown an increase in substance abuse among FSWs which has exacerbated the situation. Further, decriminalisation of sex work is discussed to stop the human rights abuses faced by sex workers and consequently improve their health conditions. The problems encountered by NGOs while implementing targeted intervention projects to improve health outcomes are also examined. A PESTELE analysis is done to understand the situation from all perspectives and finally, recommendations are made to increase sensitisation among other stakeholders with the active collaboration of FSW collective groups regarding the circumstances in which they work, and for further research in examining the role and scope of interventions among other stakeholders in affecting the health outcomes of Female Sex Workers.

Key Words: *Female Sex Workers, stigma, violence, health access, PESTELE*

1.0 Introduction

Prostitution is a term loaded with variable standards of 'morality, social constructs, policy debates, legalities and implications of those involved in this work, especially the 'sex workers'. Prostitution, however, comprises a lot more activities such as soliciting, kerb-crawling, brothel-keeping, etc. which are currently illegal and criminalised under the Indian legislation. Clause 2(f) of the Immoral Trafficking (Prevention) Act (ITA) of India defines sex work as "prostitution which is sexual exploitation or abuse of persons for commercial purposes or consideration of money or in any other kind" (Government of India, 1956, p.1). This definition outrightly categorizes sex work as a form of exploitation and trafficking with no voluntary aspect attached to those practising it. Moreover, it is loaded with ethical notions of morality and portrays sex work in highly negative connotations, and thus

making it difficult to analyse the term from a broader and neutral perspective. Therefore, we have defined sex work in general terms as the practice of exchanging sexual services in exchange for monetary or payments in kind. 'Sex workers' in itself is a broad term comprising not just women, but also cisgender male and transgender people. The 2012 UNDP report titled "Sex Work and the Law in Asia and Pacific" has given a broader definition of the sex workers as adult workers, including male, female and transgenders who have consented to exchange sexual services in return for money and goods. The report also creates a distinction between "sex workers" and the people who are coerced into selling sex involuntarily. This was intended to avoid any unnecessary conflation of sex work and trafficking, or confusion of sex workers with people trafficked for the purpose of sexual exploitation (UNDP et al., 2012). This paper uses the same line of reasoning in giving a definition of sex workers. Since the focus of the paper is specifically on women employed as sex workers, we have used the terminology of Female Sex Workers (FSW) to connote the discussions around female sex workers in India. The authors would like to define Female Sex Workers as adult women who voluntarily engage in sex work, that is the practice of exchanging sexual services in exchange for monetary or payments in kind. We have used the term "adult" in the definition to refer to people considered adults under the Indian law, which currently stands 18 years or above for women.

While arguments persist about the questions of legality and effective policy options, there has been a consensus on both sides that 'health' among FSW is an area of concern and requires effective policy interventions. However, in the same breath, the health discourses are largely unidirectional, with various degrees of stereotypes associated with the health conditions of FSW. Thus, health is far from being a neutral field of study and has various social underpinnings and factors which influence the health outcomes of the situation. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). Health is a social concept, and can hardly be defined without reference to the material and the social environment within which each individual lives (Lewis, 1953).

An attempt has been made to understand the current health situations and outcomes among FSWs through a social lens, that is through "Sociology of Health". "The sociology of health encompasses social epidemiology, disease, mental health, disability and medicalization. The principle insight of sociology is that health and illness cannot be simply regarded as biological or medical phenomena; they are perceived, organized and acted on in a political, economic, cultural and institutional context" (Little, 2014). Social concepts of illness are used to see health through a 'social prism', the role of social factors like stigmatisation, violence, discrimination, psychology in affecting the health access and outcomes for FSWs, the role of these stigmas in perpetuating violence at structural, cultural and experiential levels (Ryan et al., 2019).

This in turn has affected the health outcomes of FSWs and pose challenges in making effective health interventions. This paper explores how the structures of violence and stigmatisation are often the product of legislation, which are based on superficial standards of 'morality and ethics'. Sex work is seen through notions of 'economic insecurity', women helplessness and lack of agency, 'trafficking', engagement in 'immoral acts' (the legislation guiding sex work is titled Immoral Trafficking Act, 1956), thereby undermining the diversity involved in sex work. Also, these incongruous notions leave little scope for open transparent discourses by taking account of the views of the critical stakeholders, namely FSWs. We have used the term 'stakeholders' specifically as the group of people who directly affect the health outcomes among FSWs. This includes, but is not limited to NGO workers, brothel owners, police officials, clients and the FSW. It is clear that these are not water-tight compartments, but are fluid, which keep reinforcing one another.

A Human Rights-based approach in legislation is advocated to provide an adequate ecosystem for sex workers keeping in view their rights. Then, the paper analyzes the role of NGOs in tackling the ongoing "Sociological Epidemic" through interventions at the structural and identity level, through advocacy and their effectiveness in dealing with the health situation. A PESTELE Analysis is done to understand the impact of the Political, Economic, Social, Technological, Environmental, Legal and Ethical aspects on the FSW's health; such an analysis would highlight the overall picture by looking at all the crucial factors. PESTELE

Analysis is often used by organisations to examine the external factors that affect the organisation's performance. By carefully studying the findings of the analysis, the organisation can gain a competitive advantage by making suitable decisions. It is deemed appropriate here as it helps to acknowledge the current situation and suggest suitable policies. This analysis would be followed by recommendations to be adopted to develop a coherent and inclusive solution to the health problems of sex workers.

2.0 Sociology of Health

Sociology of Health tries to understand the social context of health circumstances. "Social constructionism is a conceptual framework that emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural. The emphasis is on how meanings of phenomena do not necessarily inhere in the phenomena themselves but develop through interactions in a social context" (Conrad & Barker, 2010). Put another way, social constructionism examines how individuals and groups contribute to producing perceived social reality and knowledge which is rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition). "In contrast to the medical model, which assumes that diseases are universal and invariant to time or place, social constructionists emphasize how the meaning and experience of illness is shaped by cultural and social systems." "Medical sociologists point to the contingent processes by which certain behaviours and experiences come to be defined as medical conditions, and the way those definitions can function as a type of social control" (Conrad & Barker, 2010).

The writings of Michel Foucault have contributed significantly in the social construction of illness approach. Foucault regarded knowledge as a form of power. Specifically, he argued that "expert knowledge about human 'normality' and 'abnormality', which is not objective or naturally given, is the principal form of power in modern societies." "Foucault stressed how medical discourse constructs knowledge about the body, including disease" (Conrad & Barker, 2010). Thus, this approach analyses how illness is shaped by social and cultural traditions, knowledge discourses and power relations.

All illnesses are not the same. Some illnesses are 'stigmatized' and associated with 'disabilities', while others are not. What is important to understand about these categorisations is that these distinctions are created on social rather than pure biological reasons. These cultural underpinnings impact the way the illness is experienced, depicted, social response and policies created with respect to that illness. HIV AIDS is stigmatised and labelled with FSWs, which alter the way it is socially perceived and acted upon. The point social constructionists thus make is that there is nothing inherent in the condition that makes it stigmatising, it is the social response to that condition, based on the attached values which make it stigmatized.

3.0 Stigmatisation of Sex Work

Stigmatisation in general terms is attaching undesirable social traits and characteristics to a person, institution or practice. Sex work and sex workers are subjected to stigmas associated with impurity, apathy, lack of morality with their work being categorised as immoral. The psychology literature on Self Affirmation (Steele, 2020), advocates that every individual tries to maintain a self-image whose actions are consistent with a person's values and beliefs. Thus, threats to the self-image can produce counter-productive behavioural outcomes. Being marginalised brings with it a considerable stigma, which can distort a person's self-image, resulting in a 'spoiled identity'(Goffman, 1963).

The study conducted among FSWs in Kolkata (Ghosal et al., 2020) finds that owing to strong social prejudices against their profession, they find it difficult to access health care or be able to enrol their children in local schools. They are subjected to biases and seem to internalize such stigma and suffer from a poor self-image. The ethnographic research conducted in Delhi (Ryan et al., 2019) has shown that often the health care workers and NGO workers used derogatory terms and had constructed prejudices and stereotypes among them, exemplifying symbolic stigma. This stigma of sex work is layered with the stigma of HIV. FSWs were also coerced into taking mandatory HIV tests, fostering experiential stigma. This stigma operating at the cultural and systemic level was used to reinforce and justify stigmatising treatment, shifting the blame on FSWs for having poor health.

Internalising the stigma has led to the problem of public health, progress on HIV testing and treatment. This diminished self-image may lead to perceiving a more limited set of responses available in any given situation. Thus, the fatalistic mindset owing to stigma leads in turn to making bad choices in terms of advocacy and mobilization for their rights.

As noted in the Delhi case study, stigmas on identities prevent hesitancy to adhere to a collective identity, which acts as an impediment to public health efforts (Ryan et al., 2019). As per Goffman's conception of stigma as a process, it is not merely an exchange between two people or institution/s, but more broadly a system of beliefs and ideas that motivates action (Stigma and Social Identity, 1963). The experience of stigma at experiential, symbolic and structural levels have pervaded the health system regardless of the position of the stakeholder.

3.1 Stigma: Cause and Effect

Stigma has been defined as being 'built into structures' and its impacts on health may usefully be analyzed through frameworks that take a structural analysis of social systems, including violence and vulnerability.

As discussed earlier, stigma limits the set of choices seen as appropriate for oneself and also leads to a self-fulfilling pessimism about the returns of certain activities. The Kolkata study showed that 62% of their respondents in the baseline survey felt ashamed of their occupation and justified the exploitation and violence by their clients as 'part of their services'. (Ghosal et al., 2020). The Stigmatisation of the FSWs at structural, symbolic and experiential levels has created a social hierarchy based on violence, thereby creating a power structure in which women has to bear the brunt of the violence perpetrated in the hands of pimps, brothel keepers, clients, thereby severely undermining her agency.

The sexual division of labour produces socioeconomic inequities that legitimize violence which in turn increases risk factors for women for poor health practices and enhance health disparities and adverse health outcomes. Conventional social norms and affective attachments reinforce traditional gender stereotypes and acceptable notions of female sexuality, thus limiting a female sex worker's agency toward seeking redress against institutionalized and legitimized violence. For a commercial female sex worker, the social

taboo against female sexuality can effectively marginalize and disempower them on account of their choice of profession and limit their means to seek redress against violence. (Dasgupta, 2020)

4.0 Violence and Sex Workers Health

"Examining violence is crucial to understanding and meeting the health needs of people working in the sex industry, whose health is impacted by stringent social hierarchies constructed along axes of gender, sexuality, economy, geography, and labour. Concepts of structural and symbolic violence to frame sex workers' health elucidates everyday manifestations of social forces and how they influence health" (Ryan et al., 2019). The problem of popular construction of health as an individual choice is noted by A. Basu and Dutta (2008) as:

Since the spread of the HIV pandemic, many studies have examined high-risk sexual behaviour within an individualistic paradigm, framing HIV risk behaviour as the result of either poor information or illogical choices concerning health, and have sought to attribute HIV risk behaviours to individual characteristics of their target audiences. Among commercial sex workers, this can be caused by overlapping individual factors like substance abuse, interpersonal factors like violence exposure and structural level factors like criminalization of sex work and institutionalization of violence as the means of control and regulation of sex work (Dasgupta, 2020).

4.1 Substance Use and Health Outcomes

Female sex workers experience an increased risk of HIV relative to the rest of the population because of unprotected sex and unsafe drug use (Dasgupta, 2020). The reason why many female sex workers use drugs is that they use the substance to escape the problems that they face in this work and also sometimes increased dependence on drugs can lead them to enter sex work. Majorly, they take drugs to increase their confidence and closeness to others and overcome the feeling of sexual distress.

Sex workers thus are abused, oppressed and exploited; fear of violence from regular partners as well as clients can dissuade the sex workers from negotiating safe sex practices.

"Mental health morbidity caused by violence and rape can compromise the ability of the sex workers to adopt and maintain safe sex practices and to avail local health resources for diagnosis and treatment" (Dasgupta, 2020). An increase in violence is correlated with increased alcohol, drugs and injection use. Usage of drugs itself creates a stigma, thereby creating multiple layers of marginalizations (Dasgupta, 2020).

5.0 Decriminalisation of Sex work, a Human Rights Approach:

Indian legislation criminalizes sex worker's clients, pimps, and brothel owners subjecting them to a fine and imprisonment of 3 to 5 years on the prosecution. Clause 2(f) of the Immoral Trafficking (Prevention) Act (ITA) of India defines sex work as "prostitution which is sexual exploitation or abuse of persons for commercial purposes or consideration of money or in any other kind" (Government of India, 1956, p. 1). Clause 4(a) of the ITA also criminalizes sustenance from a sex worker's earnings, which creates a precarious situation for the offspring and family members of the sex worker (Dasgupta, 2020). While the sex worker is not prosecuted, their clients may be prosecuted if they are found involving soliciting and other activities such as brothel-keeping, kerb-crawling, etc. According to a recent statement by the Bombay High Court, there is no provision under the law that makes prostitution per se a criminal offence or punishes a person because one indulges in prostitution. What is punishable under the Act is the sexual exploitation or abuse of a person for commercial purposes and to earn the bread thereby (PTI, 2020). This ambiguous status of FSW effectively criminalises the work as it is operating in the current scenario. This is so because even if sex workers and sex work is not "criminalised" per se, majority of sex work operates in settings involving brothels, pimps who are by law criminals, rendering the majority of sex work illegal as it is currently constituted. Since the activity itself cannot be insulated from other related transactions it is impossible to engage in consensual sex for money without attracting criminality. This approach, which spotlights on purchasers (clients) and organisers (such as Brothels, pimps, etc.) of commercial sex as criminals pushes the entire system underground. This articulation of sex work as an unlawful and oppressive vocation leaves the sex workers illegal beings themselves with few rights or opportunities and no legal recourse against violence. Thus, rather than protecting FSWs, the legislation takes away FSWs agency

and makes them more vulnerable to violence. The legislation views the activity as 'destroying the moral fabric of the society', something which has to be curbed, to punish those involved in the criminal activities.

The 'ethical notions', which shape the discourses and the direction of legislation, end up portraying sex workers either as those indulged in criminal activities and destroying the 'moral fabric' or a victim (notice the word 'trafficking') of this system. Not surprisingly, the law enforcement through police raids aimed at rescuing sex workers ends up harassing sex workers, extorting money and bribe on the threats of imprisonment. The diversity of viewing sex work as an alternative source of income, providing FSWs with agency and support, is not considered or remains out of the dominant discourse. This sense of 'preservation of the moral fabric' fosters stigma towards the FSWs, who in this discourse are the ones involved in the destruction of moral fabric.

Delegitimization and criminalization of sex work further result in endangering the health and safety of sex workers for they are then forced to ply their trade in subterfuge and become victims of sexual assault and violence (Dasgupta, 2020). In criminalised settings, sex workers face significant abuses of human rights. Forced HIV testing infringes the right to privacy. Another example of human rights abuse is the right to the highest attainable standard of health which is challenged by sexual violence and inaccessibility to health care services (Shankar, 2015). Low levels of respect for the human rights of sex workers results in lower incomes which affect the affordability of health care. The legal structure creates an environment for experiential and systematic stigma based on Symbolic and Structural violence having severe repercussions on the health conditions. On the other hand, a decriminalisation and pro-work model resonates with the view of FSWs which emphasises allowing citizens to have a right to livelihood and that they should be allowed to do work with dignity. The pro-work model challenges the conceptualisation of sex workers as static and powerless who need to be rehabilitated, by providing them with the agency to live and choose their livelihood. This model ensures that FSWs enjoy protection under the labour laws of the country. Under this, owning a brothel is legal and they are mandated to operate under

government regulations. The research has suggested that FSWs are much more willing to disclose the nature of their occupation to their doctors in decriminalised regimes, thus improving their access to information and health initiatives; something which does not happen in criminalised regimes where FSWs face diminished self-image due to stigmatisation. Decriminalisation makes public health intervention easier by placing the sex worker population in reach of services that can provide information on health, safety and treatment. FSWs have a much greater power to negotiate safe sex in an environment of legality since they are protected under legal institutions. This also acts as a deterrent to occupational violence at the workplace. The research also suggests that sex workers are less likely to be vulnerable to HIV and other STDs in decriminalised regimes because stigmatisation, discrimination and fear of prosecution are much reduced or even absent, enabling them to access health care. (Sagade & Forster, 2018).

This change is seen in countries such as the Netherlands and New Zealand, both of which have adopted a pro-work model. In Netherlands, the physical work conditions of sex workers have improved with complaince of standards set up for the Industry. While it is not easy to make a smooth transition from one model to another; consistent efforts in tackling stigmatisation can lead to acceptance of the working model. “For example, in the early 1990s, Dutch attitudes did not support decriminalisation. After decriminalisation, and a major public awareness campaign, in a 1997 survey, 73 per cent of Dutch citizens favoured the decriminalisation of brothels, 74 per cent said that prostitution was an ‘acceptable job’, and by 1999 a similar poll found 78 per cent considered sex work ‘is a job like any other job” (Sagade & Forster, 2018). Similarly, the Prostitution Reform Act, 2003 in Newzealand has completely decriminalised prostitution for sex workers above the age of 18 years in favour of a pro-work model. Here also, FSWs have the same labour rights as workers in other occupations, with proper legal and government institutions (primarily Occupational Safety and Health- OSH). Brothels are legal under the law and are mandated to provide occupational safety in accordance with other occupational safety standards levels (*NZPC > The New Zealand Model*, 2021). A pro-work model provides sex workers with the agency to work, the right to a dignified socio-economic life guaranteed by economic opportunities and due legal

protection and combating stigmatisation by creating a sense of equality and self-respect in the society.

6.0 Self Mobilisations and Targeted NGO Interventions Outcomes

The challenges and problems addressing timely health interventions to improve health outcomes among FSWs through NGOs and the ways these could be overcome are important to discuss. FSWs find health access difficult due to structural stigmatisation, wherein the NGO workers have themselves developed biases against the FSWs, leading to their marginalisation and lack of trust. The ethnographic study in Delhi showed a lack of facilities available in the 'social environment' of FSWs, discrepancies in timings, and health access (Ryan et al., 2019). A cross-sectional qualitative study (Ratta & Meshram, 2020) conducted on 6 NGOs which are working for female sex workers shows that in implementing the Targeted Interventions (TIs), problems were encountered because the project managers found out that there was a shortage of people for the position of outreach workers. Rapid turnover was also reported for the post of peer educators. This brings out that NGOs do face challenges in gathering people for this cause.

On the other hand, stigma related to Sexually Transmitted Illness (STI) clinics among FSWs and hence induced inclination to go to private practitioners was found to be the major barrier in preventing them from utilizing the health services provided by Targeted Interventions. When the peer educators among FSWs were asked about condom use they replied that although free condoms were supplied as a part of TIs, it was very difficult to convince the clients to use them. Regular clients desired to not use the condom during intercourse which prevents TIs from being successful.

Targeted efficient interventions can considerably improve health outcomes among FSWs. The study analysing the phenomenon of Self Image stigma among FSWs conducted a training program with the association of Durbar Mahila Samanwaya Committee (DMSC) involving 8 sessions running across 8 weeks through which an attempt was made to improve sex workers self-image through training programmes. The training programmes encouraged them to re-examine their self-image in multiple ways; beyond those defined under the paradigm of

stigma. Through the series of sessions and the study, it was found that women have positive effects on their self-image and also they look forward to improving their conditions, thus willing to shed their fatalistic mindset of self-blame and passivity. This serves as a ground for identity-based mobilization as sex workers (which earlier refrained them from collectivising in public), which provides them with a front in opposing stigmatisation and violence (Ghosal et al., 2020). Workers concur to the conclusion that violence has declined since the last decade from the time DMSC has started operating in its fully functional role. The rate of condom usage in Sonagachi, Kolkata was 98% in 2019 (NACO), which indicated that structural barriers to safe sex practices like violence were overcome to a great extent.

The unionisation of FSWs provided them with a platform for the vocalisation of their demands, who earlier found it hard to oppose the structural foundations of violence and stigma. This also allowed policy level advocacy, thereby challenging the narratives operating at the macro level, pressing onto government and police officials. This was followed by stakeholders negotiation, where FSWs were negotiating for their rights on an equal footing. Maintaining a process of collective decision-making with external agents such as brothel owners, clients, law enforcement agencies, political leaders were recognised to be necessary (Dasgupta, 2020). Community mobilization through peer outreach under the Sonagachi project addressed health issues such as imparting STI information, distributing free condoms and disseminating safe sex awareness (Jana et al., 2013).

The Peer Outreach program addressed structural barriers to FSWs health and centred its philosophy around three ‘Rs’— *Respect, Recognition, and Reliance.* Achievement of the three ‘Rs’ entails generating respect for the sex workers and their profession, gaining legal recognition and labour rights and creating a reliance on their understanding and ability.

This allowed them to act as a self-empowering group challenging the stigma developed by Non-Government Organisations, health providers, etc. and were thus considered ‘outsiders'' by the FSWs (Dasgupta, 2020). In Andhra Pradesh, female sex worker-led community advocacy groups have been successful in increasing access to social entitlements (such as ration cards for food subsidies) and sensitising police and improving police behaviour towards sex workers (Punyam et al., 2012).

7.0 PESTELE Analysis

7.1 Political

Political narratives about FSWs have determined the way policy objectives have unfolded in impacting the health outcomes of FSWs. Political narratives have viewed sex work as a 'social problem' and thus requires efforts in curbing the activities of sex workers to control the problem. Often, this has been accomplished through state machinery such as law enforcement agencies, who try to maintain control over these activities. Political narratives reinforce the prejudices and biases operating at the social level.

Political actions also have an impact on how health interventions are conducted. NGOs are known to face hindrances and lack of cooperation from police and government health providers, having negative health impacts on FSWs. The involvement of collectives of FSWs such as DMSC provides a political platform for FSWs to exert their rights and also manage to involve political stakeholders such as local politicians, police officers, government health providers in meaningful discussion for empowering social conditions for the FSWs.

7.2 Ethical

Ethics or code of ethics defines what things should be acceptable and cooperated in society and what should not be; it sets the parameters of society. Ethics shape societal and political thinking, and in turn, gets affected by social and political processes. The dominant discourses about prostitution in India are imbued with ethics; that is what amounts to be right and what not is right. The notions of purity-impurity and morality-immorality show their association with prostitution work in India. Since sex work does not fit into the defined parameters, ethics serve as a tool for labelling them with antonyms of the desired elements.
The ethical expectations, however, are manifestations of the majority and leave those at minority potential to marginalisation. FSWs opinions do not fit into the dominant viewpoint, and thus their viewpoint of seeing sex work as a vocation and means to an end, are not accepted and open to be stigmatised. A broader definition of ethics giving due recognition to the viewpoints of prostitution workers can instil the structure of justice.

7.3 Social

The paper has discussed in detail why it is important to look at the problem of HIV and health issues pertaining to FSWs (section 2.0) in a social context. The theory of social construction of illness emphasizes how interactions at social and cultural levels affect health outcomes. The biases and prejudices prevalent in society in respect to FSWs get converted into stigmas, through the process of social interactions. These social interactions based on stigma, in turn, shape the identity of the FSWs, which in turn forms the basis of the structure of violence in society. Interaction of these processes affects the health outcomes of the workers at physical, emotional and identity level. Social constructs are complex, deep and slow to change and evolve. This makes it difficult to challenge and change them through one lone end. All institutions in a state are rooted in the society and receive their legitimacy through societal norms and customs. This process thus constitutes a whole system of beliefs and outcomes in which every social actor perpetuates and fosters the structure the society has so developed.

7.4 Technological

The role of technology has been enhanced in the sex industry. Despite the workers facing socio-cultural vulnerabilities, the mobile phone teledensity among urban FSWs is high. While on one hand mobile phones have helped in enclosing identity, on the same breadth it has allowed FSWs collective groups to expand and increase their outreach in terms of dissemination of information related to the health of FSWs, etc. It has also allowed FSWs to break through the physical and structural constraints posed while working under brothels and pimps by directly connecting with the clients, thereby eliminating middlemen.

7.5 Environmental

This paper has taken environment to refer to the ‘social environment’ in which FSWs live and work. The social environment has put various structural and physical constraints leading to scenarios of violence, health access issues, etc. The Red Light Areas where FSWs are forced to work provide inadequate access to health care facilities as per the requirements of FSWs. Stigmatisation and biases prevalent among the health providers hold FSWs

responsible for their hygiene, implicating social setup/environment had no role to play in the overall health of the workers.

The physical environment plays a major role. Female sex workers who use drugs may be displaced by their manager to street settings where they can be forced into unprotected sex and hence increase the risk of HIV. When sex work is conducted in public places it makes it difficult to negotiate condom use, increasing HIV. FSWs also face an increased risk of suffering violence when they operate as "flying sex workers", working in street settings such as deserted hotels and highways.

7.6 Legal

Legal laws determine the direction of political conditions with respect to the situations. In that perspective, legislation related to sex work, The Immoral Trafficking (Prevention) Act, 1956 reinforces the political values concerning sex work in India. This Act criminalises sex work in almost all of its manifestations, considering it immoral and attempts to curb this practice. The legislation solidifies the stigma of seeing people involved in it as being criminals. Also, it makes the redressal in case of violence very difficult, making FSWs highly vulnerable. A human rights-based law based on decriminalisation would uphold the value of being human and provide the right to dignity to labour.

7.7 Economic

FSWs are able to earn substantial income to support their family and even schooling by working in the Sex Industry. Contrary to the general supposed opinion, FSWs find their work an attractive source of income and so often intend to work in this profession, rather than looking for alternative sources. This income also provides them with some agency.

The pandemic however exposed the vulnerabilities associated with sex work. Even after the withdrawal of lockdown, clients are hesitant to engage in intimate activities, severely affecting FSWs economic conditions. This has been manifested in terms of difficulty in procuring adequate amounts of ration, accessing general and specific treatment. Largely being an 'underground industry', it has hardly received any special state stimulus to support FSWs and their families.

8.0 Recommendations

While it is important to actively mobilise for a self-identity of sex work based on dignity and respect among FSWs; it is fundamental to challenge this very belief of sex work being impure, which serves as the nurturing ground for the creation of stigma. This belief system is predominantly incorporated by the stakeholders who work in the premises of Red Light areas, such as healthcare providers, NGOs and police officers who seldom get any special training, knowledge or understanding development about the requirements and challenges of FSWs. 'Working as Usual' fails to take into account the intrinsic biases the stakeholders have incorporated from this societal belief system of impurity, thereby failing to achieve their objectives.

Involving FSWs collective organizations is crucial in sensitising stakeholders. Sensitisation should be the part of the training, working and interaction with FSWs, adopted through a ground-level initiating and implementing the model. This process can erode the foundations of stigma and violence which hitherto existed due to their active or passive support.

Sensitisation attacks the foundations of stigma and the uncritical acceptance of the belief system and allows one to have a multi-dimensional perspective of the problem. This can be a starting point for ending structural and experiential violence through steps like:

- Stop on the discriminatory usage of mandatory HIV testing;
- Engagement of FSWs in collaboration and research;
- Increasing sensitivity to mental health issues due to experiential stigma;
- Active adoption of safe work practices for FSWs; this includes mandatory use of condoms by the clients, right of FSWs to "say no" to a client and a right to a "safe working environment" ensuring protection from violence by clients and brothel owners.
- Legislations respecting basic labour and human rights, paving the ground for destigmatisation.

This paper thus acts as a starting point for future research in understanding the social factors, policy options, and the impact of interventions on other stakeholders involved in the prostitution sector, and how it further determines the health outcomes of FSWs in India.

9.0 Conclusion

This paper tried to analyse health status and challenges among sex workers in India through a social constructionist approach. Building on secondary literature review, it attempted to build a comprehensive understanding of the social factors such as stigmatisation, violence, legal framework, etc. which affect the health outcomes of Female Sex Workers (FSWs) in the prostitution sector. Based on the social constructionist approach, an attempt was made to broaden the scope of health discourse to include issues of experiential stigma, violence in health access and workplaces and issues of diminishing self-identity. It was found that effective health interventions through NGOs and self-mobilisation among FSWs proved vital and beneficial in dealing with health issues and provided them with abilities to secure their rights in the socio-political realm.

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