# Perceived social support, stigma and mental health of female sex workers in Aizawl city

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## ABSTRACT

**Objective:** Sex work is the exchange of sexual services for money or its equivalent. Sex work is related to health issues, mental health problems, and substance misuse. Female sex workers experience stigmatization because of their work and they are poorly studied and socially stigmatized group. The present study aims to conduct a comparative study of younger and older age group of female sex workers and examine the relationship between mental health, stigma, and perceived social support of Younger (Ages 18-34 years) and Older (Ages 35-50 years) female sex workers in Aizawl City, Mizoram. **Method:** Multidimensional Scale of Perceived Social Support, Self-Stigma Scale and Depression Anxiety Stress Scale-21 were used to measure the variables under study. **Results:** The *t*-test revealed a significant relationship between the two groups. Pearson Correlation statistics revealed that among Group 1 participants, there was a significant negative correlation between Self Stigma and Friends Support. Among Groups 2 participants, Self-Stigma was found to have a significant positive relationship with Anxiety, Depression, and Stress. **Conclusion:** Perceived Social Support was found to have a significant negative correlation with Anxiety, Depression, and Stress among the two groups.

*Keywords:* female sex workers, perceived social support, self-stigma, mental health

## INTRODUCTION

Sex work is the exchange of sexual services for money or its equivalent (Overs, 2002). Sex worker activist Carol Leigh coined the term 'sex work' in the 1978s. The term ‘sex worker’ is used to refer to “Woman, male and transgender individuals and young people who have received, frequently or occasionally, money or products in exchange for sexual services. Sex work differs between countries and cultures, and within them. Sex work can vary in the extent to which it is more or less "formal" or structured and in the degree to which it is distinct from other social and sexual relations and forms of sexual economic exchange” (UNAIDS, 2012). Many studies have reported that sex work is related to health issues, mental health problems, and substance misuse (H. Ward and S. Day, 2006). Sex workers are at high risk of getting or transmitting sexually transmitted diseases (STIs) and Human Immunodeficiency Virus (HIV). They face a high level of violence such as physical violence, sexual violence, and emotional and psychological violence than the general female populations which may lead to lifelong disabilities and life-threatening consequences for their health (Bhattacharjya et al.; 2015).

According to Sailo, S. L., (2019) Women Sex Workers in Aizawl, belonged to families where the parents are divorced, remarried, or widowed, and some come from stable families too. Most of

them indulged in injecting drug use, and consume alcohol, and initiation to sex work as 16 years on average. That majority of them studied up to high school and belonged to lower socio-economic background. Sex workers in Mizoram entered into this business at the age of below 18 years, an overwhelming majority of sex workers were initiated into this business by a woman friend; other causes include peer pressure, financial reasons, drug addiction, family instability, etc.

Female sex workers experience stigmatization because of their work (Salazar, C.C., et.al., 2014). Stigma is when a person or society views someone in a negatively ostracizing manner because they have a distinguishing trait or personality characteristic that is, or believed to be, a hindrance, a negative drawback in the stereotype that they are used to (MCS, 2017). Stigma has been referred to as a mark of disgrace or discredits that distinct a person from others. There are three components of Stigma; Social Stigma, Self-Stigma, and Professional Stigma.

Social Stigma: Social Stigma is the disapproval of persons with mental or behavioral disorders which may be perceived as a negative social characteristic that can create barriers in the structural society. Health Professional Stigma: It seems improbable that social workers and other health professionals would bear with them, stigmatized beliefs towards their clients; especially those whom they know are subjected to various barriers to engage in treatment. Self-Stigma or Internalized Stigma: Crocker (1999) demonstrates that stigma not only occurs among others in a community but can also be internalized by the person with the condition or is exposed to that condition. Hence, the continuous influence of social/public stigma impacts an individual to feel remorseful and insufficient regarding their character conditions (Corrigan, 2004).

*Mental Health*

Mental health is defined by World Health Organization (2001) as “a condition of whole physical, mental, and social well-being and not merely the absence of disease or infirmity”. Mental health is an essential part of health, closely connected with physical health and behavior, and more than the absence of mental illness.

The present study covered three domains of mental health including depression, anxiety and stress. Depression is a significant contributor to the global burden of disease and affects people in all communities throughout the world. Depression is a serious medical illness that negatively affects how you feel, your way of thinking, and courses of action taken, that showcases itself with devitalized mood, loss of interest or pleasure, lessened quality of life, decreased energy, feelings of guilt and/or low self-worth with fluctuating sense of self-esteem in the negative radar, disturbed sleep including chronic insomnia, increased or thereby lack of appetite, and poor concentration. Anxiety is a mental and physical reaction to perceived threats and situations of unease. In small quantities, anxiety is helpful. It protects and informs us of the sensed impending danger and harm via cognitive corresponding responses, and focuses our attention on problems that made us anxious. But when anxiety is found to be too severe and profound or occurs too frequently, it can become debilitating, stress-inducing, and enervative in all aspects (Therapist Aid, 2017). Stress may be defined as the body's reaction of physical, emotional or psychological strain in correspondence to any change that requires an adjustment or response. The body behaves and reacts to the alterations accordingly and it is a common, normal part of life. Stress can be experienced from the surrounding environment and its influences, the body, and thinking processes.

*Social Support*

Social Support may be regarded as the resources and assistance provided by others, as coping accommodation, or as an exchange of resources (Schwarzer et al, 2003). It is the physical and/or emotional comfort given to us using several different methods by our family, relatives, friends, acquaintances, co-workers, and others as a form of reassurance, validity, or acceptance. It acknowledges the fact that we are a part of a community of people who love and care for us, cherish our presence with value and think pleasantly of us. We all need people we can lean on through the ups and downs, people we can share the merry good times with and can depend on during the bad times; a genuine harmonious rapport. Maintaining a healthy, continuous social support network is hard work, something that requires participation as an ongoing effort over extended periods without major halts (Fairbrother, 2011).

The two perspectives of Social Support are: perceived availability of support (perceived support) and received support (Vangelisti, 2009; Lakey 2010). Perceived support refers to the subjective judgment of the recipient in the expected availability of support that may be provided from one's friends, family, team-mates, teachers, coaches, and loved ones that they will offer (or have) effective aid during times of need. On the other hand, Received Support refers to the support actually received and enacted by the aforementioned friends, family, team-mates, teachers, coaches, and loved ones, when in need of the supportive measures (Bianco and Eklund, 2001; Rees and Freeman, 2010).

Social support has been shown to enhance physical and emotional health. It is an important indicator that acts as a protective factor for individual who encounter negative effect of stress and alleviate depressive symptoms (Aneshensel & Stone, 1982). The significance of social support for sex works was observed by Valera, Sawyer, and Schiraldi (2001) in an investigation into the health needs of a sample of sex workers, and a majority of sex workers who participated in this research reported a need for social support. Baruah & Borooah (2017) reported that among female sex workers high level of perceived social support is related to better quality of life

Female sex workers are poorly studied and socially stigmatized group (Alexandre Teixeira & Alexandra Oliveira, 2017). Sex workers are normal individuals and like everyone else, they deserve access to mental health services (Catharine Smith, 2018). Many of them have to work in the sex industry because they need the money to help their families (Hengartner et. al., 2015). Compared to the normal population, women engaging in sex industry face disproportionate health and social disparities (Benoit C et. al., 2017, Gu J et.al., 2014, Sanders TA et.al., 2004, Rossler W et.al., 2010, Surrat H.L et.al., 2010, Benoit C et.al., 2001, Cohan D et.al., 2006, Shannon K et.al., 2005, Beyer C et.al., 2015).

Studies carried out on female sex work have focused on Human Immunodeficiency Viruses (HIV) and Sexually Transmitted Infections (STIs) (Nitasha Puri, et, al., 2017), alcohol and drug use, and violence among female sex workers (Chen Zhang et, al., 2014). Few studies have been carried out to explore the mental health, contributing psychological disorder (Hengartner, Michael P, et, al., 2015) and social support (Rima Baruah et, al., 2017) of female sex workers. A few studies that have been conducted reported mental health and psychological issues that depressive symptoms were more prevalent among female sex workers than other female workers (Bassel et al., 2001).

Some studies have found evidence of anxiety, depression, paranoid ideation (El-Bassel et, al., 1997), and symptoms of post-traumatic stress disorder (Farley & Barkan, 1998, Chudakov et, al., 2002). Flower (1998) also noted the prevalence of a multitude of psychiatric disorder such as depression, schizophrenia, and suicidal tendencies in sex workers.

As sex workers represent a marginalized population that faces many occupational hazards (Serena Wong, 2009), they are vulnerable to high rates of violence, sexual coercion, stigma, and Human Immunodeficiency Virus (HIV) (Poliah & Paruk, 2017). They are often stereotyped as filthy, immoral, coldhearted, and unworthy women (Vijayakumar et al, 2015). This stigmatization can lead to a feeling of self-blame and shame, isolated themselves from others, and diminishing accessibility to social and health services (Sallmann, 2010; Rayson & Alba, 2019). And according to labeling theory, deviant labels, criminal labels are associated with stigma, which means that the majority culture has attached specific, negative descriptions or stereotypes to deviant labels (Link & Phellan, 2001).

Most of the prior research has focused on younger female sex workers populations and few studies have been conducted among their older counterparts. Studies with older Female sex workers are important because of socio-biological differences that exist between young and older Female sex workers (Su et al., 2014; Guida et al, 2016). In view of this limitation, the current study aims to fill the gap by including older female sex worker in the study, and conduct a comparative study of younger and older age group of female sex workers. The study will examine the mental health, stigma, and perceived social support of Younger (Ages 18-34 years) and Older (Ages 35-50 years) female sex workers in Aizawl City.

## METHOD

*Participants*

The sample of the present study consists of 100 female sex workers, with their age ranging between 18-50 years living in Aizawl. The sample was divided into two age groups – Group 1 (50 female sex workers; 18-34 years) and Group 2 (50 female sex workers; 35-50 years). The population was drawn through purposive sampling. The data was collected through Non-Governmental Organizations (NGOs).

*Objectives of the study*

1. To investigate the Mental Health (Depression, Anxiety and Stress), Perceived Social Support, and Self-Stigma of female sex workers in Aizawl City.
2. To investigate whether there is any significant difference between the two groups on the variables under study.
3. To examine whether there is any relationship between the Self-Stigma, Perceived Social Support, and Mental Health (Depression, Anxiety and Stress) among the two groups.

*Hypotheses*

1. It is expected that there will be a high level of Self-Stigma in both groups.
2. It is expected that there will be a significant difference between the two groups on Perceived Social Support, Mental health (Depression, Anxiety, and Stress) and Self-stigma among younger and older female sex workers.

3. It the expected that there will be a significant relationship between the Self-Stigma, Perceived Social Support, and Mental Health (Depression, Anxiety and Stress) among younger and older female sex workers.

*Design of the Study*

The present study incorporated Correlational research design where the differences between the two Groups - Group-1 (18-34 years) and Group-2 (35-50 years) was observed on the dependent variable: Perceived Social Support, Sigma and Mental Health. In addition, the study also analyzed t-test to compare the means of Group-1 (18-34 years) and Group-2 (35-50 years).

*Procedure*

The participants were contacted through Non-Governmental Organizations (NGOs). The primary data for the study was collected in a face-to-face interaction between the participants and the researcher. The participants were informed that anonymity and confidentiality would be maintained. After taking the necessary consent, the psychological tools were administered by the researcher. The researcher took care to see that the respondents provided honest and independent answers to the questions presented. After careful checking of any missing or unattended questions; the data obtained was analyzed by employing appropriate statistical tools.

*Tools*

Multidimensional Scale of Perceived Social Support (Zimmet et, al., 1988): The Multidimensional Scale of Perceived Social Support (MSPSS) (Zimmet, Dahlin, Zimmet, and Farley, 1988) consisted of 12 items rated on a seven-point Likert scale from 1(Very Strongly Disagree) to 7(Very Strongly Agree). It is designed to measure the perception of support from three sources: Family (items 3,4,8,11), Friends (items 6,7,9,12), and Significant Others (items 1,2,5,10).

Self-Stigma Scale (Mak, W.W.S. and Cheung, R.Y. M, 2010): The Self-Stigma Scale (SSS) is developed by Mak and Cheung in 2010. It is a self-report questionnaire, consisted of 9 items rated on a four-point Likert scale from 1(Strongly disagree) to 4(Strongly agree).

Depression Anxiety Stress Scale-21 (DASS-21) (Lovibond & Lovibond, 1995): The Depression, Anxiety, Stress Scale – 21 is the shortened version of the DASS developed by Lovibond and Lovibond (1995) to assess symptoms of depression, anxiety, and stress among adults. The DASS-21 is a 21 items self-report questionnaire, in completing the DASS-21, the individual is required to indicate the presence of symptoms over the previous week.

*Statistical Analysis*

To ascertain the applicability of the psychological tools, the following statistical measures were employed:

Descriptive Statistics (Mean, Standard Deviation, Standard Error, Skewness and Kurtosis) was computed to discern the pattern of the distribution of the measured variables for the scales and subscales of Self Stigma, Significant Others, Family and Friends subscales of Multidimensional Scale of Perceived Social Support (MSPSS), and Anxiety, Depression and Stress the subscales of Depression Anxiety Stress Scale (DASS) among the Two Groups.

Pearson correlation coefficient was computed separately for the behavioral measures: Self-Stigma, Significant Others, Family and Friends the subscales of MSPSS, and Anxiety, Depression, and Stress subscales of DASS.

An independent Sample *t*-test was employed to compare the means of Group 1 and Group 2 on the scales and subscales of the behavioral measures.

## RESULTS AND DISCUSSION

The socio-demographic characteristics were included to highlight the profile of Female sex workers in Aizawl City.

*Age:* In the present study, female sex workers were categorized into two age group – Younger (Ages 18-34 years) and Older (35-50) female sex workers. The results revealed that the mean age for younger female sex worker is 26 years, and the mean age for older female sex workers is 37 years.

*Educational Qualification:* Majority of the participants from Group 1 (44%) and Group 2 (42%) studied till high school, few of them were graduated.

*Marital Status:* In Group 1, the highest proportions of the participants (38%) were single. Among Group 2, the highest proportions of the participants (42%) were married.

*Tobacco Use:* The majority of the Younger (86%) and (98%) Older female sex workers reported using tobacco products.

*Drug Use:* Only 38% from younger female sex workers and 12% from older female sex workers reported a history of drug use.

*Alcohol Use:* The majority of participants from younger female sex workers (60%) and older female sex workers (74%) reported consuming alcohol.

*Medical Hospitalization:* In terms of history of medical hospitalization, younger female sex workers (42%) reported a history of medical hospitalization; in contrast older female sex workers (90%) reported a history of medical hospitalization.

*Security Response Section (SRS)/ Police Arrest:* 78% from Younger female sex workers and 94% from older female sex workers reported a history of Security Response Section (SRS) or Police arrest.

*Confinement/ treatment in Protective Home/Centre:* Among the participants, 46% from Group 1 participants reported a history of confinement in Protective Home or Centre, while 16% participated in the present study while in confinement in a Protective Home/ Centre. Among the Group 2 participants, 68% reported a history of Protective Home or Centre, while 12% of the participants in the present study are currently from protective home/center.

**Table 1**

*The Cronbach Alphas of the behavioral measures of Internal Consistency*

| **Scale/Subscales** | **Cronbach's Alpha** |
|---|---|
| Self-Stigma Scale | .83 |
| Multidimensional Scale of Perceived Social Support | .94 |
| Significant Others | .89 |

| | |
|---|---|
| Family | .92 |
| Friends | .88 |
| Depression Anxiety Stress Scale | .91 |
| Anxiety | .77 |
| Depression | .83 |
| Stress | .72 |

The reliability of the scales and subscales were measured to ensure the adequacy of the scales used for the present study. The result shows that the internal consistency of the scales and subscales used in the present study was above .7 which was found to be reliable for the whole sample, indicating the trustworthiness of the scale.

**Table 2**

*Descriptive statistics for the Two Groups*

| | Mean | | SD | | Skewness | | Skewness | | Kurtosis | | Kurtosis | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Group 1 | | Group 2 | | Group 1 | | Group 2 | |
| | G – 1 | G - 2 | G – 1 | G - 2 | Statistics | Std. Error | Statistics | Std. Error | Statistics | Std. Error | Statistics | Std. Error |
| Stigma | 23.44 | 22.74 | 3.535 | 2.522 | -.975 | .337 | .115 | .337 | 4.598 | .662 | -.926 | .662 |
| Significant Others | 18.70 | 17.60 | 2.197 | 3.104 | -.960 | .337 | -1.320 | .337 | .996 | .662 | .434 | .662 |
| Family | 18.20 | 16.40 | 2.969 | 3.110 | -1.127 | .337 | -.326 | .337 | 1.354 | .662 | -1.321 | .662 |
| Friends | 18.36 | 17.98 | 2.694 | 2.818 | -1.830 | .337 | -1.336 | .337 | 3.864 | .662 | .361 | .662 |
| Anxiety | 11.20 | 13.72 | 7.329 | 5.869 | .225 | .337 | -.003 | .337 | -1.004 | .662 | -.678 | .662 |
| Depression | 17.46 | 15.92 | 7.838 | 5.345 | .660 | .337 | .085 | .337 | .183 | .662 | .291 | .662 |
| Stress | 14.24 | 14.40 | 7.190 | 5.206 | .574 | .337 | .234 | .337 | -.445 | .662 | -1.178 | .662 |

The descriptive statistics Table 2 shows the Mean, Standard Deviation (SD), Skewness, Kurtosis, and Standard Error of the scales and subscales of Self-Stigma; Perceived Social Support (Significant Others, Family, and Friend), the subscales of DASS - Depression, Anxiety and Stress

among the two groups. The Mean score and the Standard Deviation for the two groups on Self stigma (Group 1 $\chi$ = 23.44, SD = 3.535; Group 2 $\chi$ = 22.74, SD = 2.522), Significant Others (Group 1 $\chi$ = 18.70, SD = 2.197; Group 2 $\chi$ = 17.60, SD = 3.104), Family (Group 1 $\chi$ = 18.20, SD = 2.696; Group 2 $\chi$ = 16.40, SD = 3.110), Friends (Group 1 $\chi$ = 18.36, SD = 2.694; Group 2 $\chi$ = 17.98, SD = 2.818), Anxiety (Group 1 $\chi$ = 11.20, SD = 7.329; Group 2 $\chi$ = 13.72, SD = 5.869), Depression (Group 1 $\chi$ = 17.46, SD = 7.838; Group 2 $\chi$ = 15.92, SD = 5.345), Stress (Group 1 $\chi$ = 14.24, SD = 7.190; Group 2 $\chi$ = 14.40, SD = 5.206).

The findings of the present study indicate a moderate level of self-stigma among the female sex workers (Group 1 mean = 23.44; Group 2 = 22.74). This finding is approximately in line with that of a study in China where moderate to high levels of self-stigma were found among female sex workers (Hong et al, 2009). Similarly, the results revealed that majority of the participants from the two groups reported an average level of Perceived Social Support, from Significant Others, Family, and Friends support, in contrast to the present finding, Baruah et al., (2017) conducted a study on female sex workers reported high levels of perceived social support, which leads to better quality of life. Finally, the findings of the present study revealed moderate level of depression and anxiety, and the low level of stress among Younger and Older female sex workers in Aizawl City.

**Table 3.1**

*Pearson Correlation between Self-Stigma, Perceived Social Support (Significant Others, Family and Friends), Anxiety, Depression, and Stress for Group 1*

| | Self Stigma | Significant Others | Family | Friends | Anxiety | Depression | Stress |
|---|---|---|---|---|---|---|---|
| Self-Stigma | - | -.25 | -.20 | **-.35*** | -.03 | .14 | .07 |
| Significant Others | | - | **.88**** | **.59**** | **-.52**** | **-.62**** | **-.53**** |
| Family | | | - | **.58**** | **-.55**** | **-.57**** | **-.48**** |
| Friends | | | | - | **-.63**** | **-.61**** | **-.62**** |
| Anxiety | | | | | - | **.76**** | **.77**** |
| Depression | | | | | | - | **.88**** |
| Stress | . | | | | | | - |

***. Significant at the .01 level*

**. Significant at the .05 level*

From Table 3.1, it was seen that there is a significant negative correlation between Self Stigma and the subscales of Perceived Social Support that is Friends (-.35, $p$<05), which indicating that increasing levels of Friends support was associated with decreasing levels of Self Stigma among Group 1 (Ages 18-34 years) participants. Significant Others, Family, Friends support was found to have a significant negative correlation with Anxiety, Depression, and Stress. The results indicate

that increasing levels of Significant Others, Family and Friends Support was significantly associated with decreasing levels of Anxiety, Depression, and Stress.

**Table 3.2**

*Pearson Correlation between Self-Stigma, Perceived Social Support (Significant Others, Family, and Friends), Anxiety, Depression, and Stress among Group 2*

| | Self Stigma | Significant Others | Family | Friends | Anxiety | Depression | Stress |
|---|---|---|---|---|---|---|---|
| Self-Stigma | - | -.22 | -.00 | -.22 | **.39**** | **.33*** | **.42**** |
| Significant Others | | - | **.68**** | **.84**** | **-.51**** | **-.37**** | **-.45**** |
| Family | | | - | **.71**** | **-.47**** | **-.38**** | **-.47**** |
| Friends | | | | - | **-.51**** | **-.38**** | **-.54**** |
| Anxiety | | | | | - | **.53**** | **.72**** |
| Depression | | | | | | - | **.78**** |
| Stress | . | | | | | | - |

***. Significant at the .01 level*

**. Significant at the .05 level*

From the results (Table 3.2), it was seen that Self Stigma was found to have a significant positive correlation with Anxiety (.39, $p<.01$), Depression (.33, $p<.05$), and Stress (.42, $p<.01$), which indicating that increasing levels of Self Stigma was associated with increasing levels of Anxiety, Depression, and Stress. Significant Others, Family and Friends support was also found to have a significant negative correlation with Anxiety, Depression, and Stress. The results indicate that the increasing levels of Significant Others, Family and Friends support was associated with decreasing level of Anxiety, Depression, and Stress.

The present also revealed significant positive relationship between perceived social support and mental health (depression, anxiety and stress) among younger and older female sex workers. Perceived social support plays an important role in mental health among female sex workers regardless of age (Nemoto et al., 2011; Maryam & Sahar, 2010; Rossler et al., 2010; Sherbourne et al., 1992). Among younger female sex workers friend support is negatively associated with self-stigma. Sullivan (1953) stated that friends could negate the effects of negative experiences. One research study found that the presence of friends during negative events caused a reduction in stress levels (Santo and Bukowski, 2011). Among older female sex workers, significant positive relationship was observed between self-stigma and mental health (depression, anxiety and stress). Previous study also found a consistent result, for instance, Rael, (2015) Female sex workers reported a high level of perceived stigma, and this perceived stigma predicted the depression.

Similarly, Carlson et al., (2017) noted that due to internalizing stigma, female sex workers reported of having depressive symptoms.

**Table 4**
*Levene's test for the effect of two groups on the scales and subscales of behavioral measures*

| **Levene's Test for Equality of Variances** | | | | **t-test for Equality of Means** | | |
|---|---|---|---|---|---|---|
| | | **F** | **Sig.** | **T** | **Df** | **Sig.** |
| **Self-Stigma** | Equal variances assumed | 1.01 | .317 | 1.14 | 98 | .257 |
| **Significant Others** | Equal variances not assumed | 4.72 | .032 | 2.05 | 88.250 | .044 |
| **Family** | Equal variances assumed | 1.08 | .301 | 2.96 | 98 | .004 |
| **Friends** | Equal variances assumed | .38 | .540 | .69 | 98 | .492 |
| **Anxiety** | Equal variances assumed | 3.50 | .064 | -1.90 | 98 | .061 |
| **Depression** | Equal variances not assumed | 7.92 | .006 | 1.15 | 86.466 | .254 |
| **Stress** | Equal variances assumed | 2.42 | .123 | -0.1 | 98 | .899 |

The analysis of the t-test for two groups (Group 1 vs Group 2) on the scales and subscales of Self-Stigma, Significant Others, Family and Friends subscales of MSPSS and Anxiety, Depression, and Stress Subscales of DASS were done by using Independent Sample t-test.

The results table 4 revealed that Group 1 (Ages 18-34 years) showed higher levels of Perceived Social Support from Significant Others and Family support as compared to Group 2 (Ages 35-50 years) participants. In contrast with the present findings, Mao et al., 2018 found that despite the age differences, female sex workers reported high levels of Perceived social support from their family. Besides family support, female sex workers received a support from significant others such as a boyfriend, co-workers, and friends.

## CONCLUSION

The present study found a moderate level of Self-Stigma, Perceived Social Support and Mental Health from depression and anxiety, and low level of stress among the female sex workers in Aizawl. Significant differences were observed on Significant Others and Family support between Group 1 (Ages 18-34 years) and Group 2 (Ages 35-50 years) participants, indicating that Group 1 participants show higher Significant Others and Family support as compared to Group 2 participants. Perceived social support is positively associated with mental health among female sex workers, increase in friend support significantly associated with decrease in self-stigma among

younger female sex workers and significant negative relationship was observed on self-stigma and mental among older female sex workers.

The findings of this study may be indicative that Mizo Female sex workers in Aizawl have different experience. Each individual accesses and applies different coping skills and mechanisms to manage feelings of stigma, which vary greatly from individual to individual as does the level of effectiveness of these skills in managing feelings and experiences of stigma. Additionally, each individual will find his or her own meaning and voice in experiences of stigma. The study does not provide answers as to why some people believe that poor mental health and stigma is valid whereas others do not. This study demonstrated that sex work as a profession significantly predict the mental health and stigma in the population under study. The present finding such as moderate level of mental health among female sex workers may be due to less experienced of violence, stigma and received social support. The majority of the participants in the present study reported a history of involved with Protective Home or Centre, which could be the contributing factors that change the degree of mental health in the present study.

This study indicates that there is a major need and also the importance of reducing negative stereotyping in popular media, and sensitizing people and the community at large. Several important factors associated with being a female sex worker were identified in this study and the findings can be used for further in-depth research studies, for policy makers to plan more effectively targeted intervention strategies.

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