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The Role of Faith-Based Organizations and NGOs in Reducing HIV Transmission among Female Sex Workers in Mizoram

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Abstract

Mizoram has one of the highest HIV prevalence rates in India, with female sex workers (FSWs) remaining one of the most vulnerable populations due to social stigma, economic insecurity, limited healthcare access, and marginalization. In this context, both faith-based organizations (FBOs) and non-governmental organizations (NGOs) have emerged as important actors in HIV prevention and support services. This study examines the role of FBOs and NGOs in reducing HIV transmission among female sex workers in Mizoram, with particular focus on Aizawl and Lunglei districts. Using a qualitative research design, the study draws on in-depth interviews with 25 female sex workers, interviews with NGO workers and faith leaders, participant observation, and document analysis.

The findings reveal that NGOs primarily adopt a rights-based and harm-reduction approach by providing HIV testing, counselling, condom distribution, peer education, and linkage to antiretroviral therapy (ART) services. In contrast, faith-based organizations focus more on spiritual healing, behavioural reform, emotional support, rehabilitation, and social reintegration. Despite ideological differences, both sectors contribute significantly to HIV prevention and care among marginalized women. Many participants viewed NGOs as more approachable for immediate healthcare needs, while FBOs were valued for emotional healing, moral support, and community acceptance. The study also identifies emerging collaboration between NGOs and FBOs, particularly in awareness programmes and counselling initiatives.

The paper argues that effective HIV intervention in Mizoram requires a culturally sensitive and collaborative approach that integrates biomedical support with emotional, spiritual, and social care. It recommends stronger partnerships between state agencies, NGOs, and FBOs, increased trauma-informed mental health services, and community-based anti-stigma interventions. The study contributes to broader discussions on religion, public health, gendered stigma, and community-led HIV interventions in Northeast India.

Keywords: HIV/AIDS, female sex workers, Mizoram, faith-based organizations, NGOs, stigma, harm reduction, public health, community support

1. Introduction

Human Immunodeficiency Virus (HIV/AIDS) continues to remain a major public health concern across the world, particularly among marginalized and vulnerable populations. Female sex workers (FSWs) are recognized as one of the key populations at higher risk of HIV infection because of poverty, unsafe sexual practices, gender inequality, violence, social exclusion, and limited access to healthcare services (UNAIDS, 2021). In many developing societies, HIV transmission among FSWs is shaped not only by

individual behaviour but also by broader structural and socio-cultural conditions such as stigma, discrimination, and economic insecurity (Cornish & Ghosh, 2007).

In India, although the national HIV prevalence rate has gradually declined over the years, the epidemic remains highly concentrated in several northeastern states, particularly Mizoram. According to the National AIDS Control Organization (NACO, 2023), Mizoram has one of the highest HIV prevalence rates in India, significantly exceeding the national average. Recent studies further indicate that vulnerable populations such as female sex workers and people who inject drugs continue to experience a disproportionately high burden of HIV infection in the state (Pachuau et al., 2023).

The increasing HIV burden in Mizoram is associated with multiple interconnected factors, including injecting drug use, unsafe sexual behaviour, migration, unemployment, and social stigma (Pachuau et al., 2024). Studies conducted in the region also reveal that HIV-related stigma remains a major obstacle to treatment adherence, counselling, healthcare access, and psychosocial well-being among people living with HIV/AIDS (Lalhruaimawii et al., 2025). Fear of discrimination and social rejection often discourages vulnerable populations from seeking timely medical care and emotional support.

The situation of female sex workers in Mizoram is further complicated by the socio-religious environment of the state. Mizoram is predominantly Christian, and religious beliefs strongly influence social norms, moral expectations, and community life. Churches and faith-based institutions hold significant influence over public opinion and social behaviour. Consequently, issues related to sexuality, HIV/AIDS, addiction, and sex work are often viewed through moral and religious perspectives. In this context, faith-based organizations (FBOs) have emerged as important actors in HIV prevention, counselling, rehabilitation, and social support services.

At the same time, non-governmental organizations (NGOs) continue to play a major role in HIV prevention and care through harm-reduction programmes, HIV testing, condom distribution, peer education, counselling, and linkage to antiretroviral therapy (ART) services (Lorway et al., 2013). NGOs generally adopt rights-based and community-oriented approaches that emphasize healthcare access, dignity, empowerment, and evidence-based interventions. In contrast, many faith-based organizations focus more on moral guidance, behavioural reform, abstinence, spiritual counselling, and rehabilitation.

These differing approaches occasionally create tensions between secular public health interventions and religiously grounded moral frameworks, particularly regarding condom use and perceptions of sex work. However, scholars increasingly argue that collaborative engagement between NGOs and faith-based organizations can strengthen HIV prevention efforts when interventions are culturally sensitive and community-based (Olivier & Wodon, 2012). Community-led and culturally grounded HIV interventions have shown positive outcomes in improving healthcare access, trust, and treatment adherence among vulnerable populations in Northeast India (Sarkar et al., 2023).

Despite the growing scholarship on HIV/AIDS in India, limited research has examined the intersection of religion, public health, and HIV prevention among female sex workers in Mizoram. Existing studies have largely focused on epidemiological trends and behavioural risk factors, while the lived experiences of FSWs navigating between NGO services and faith-based interventions remain underexplored. There is also limited research on how these organizations collaborate, conflict, or coexist within the HIV prevention landscape of Mizoram.

Against this background, the present study examines the role of faith-based organizations and NGOs in reducing HIV transmission among female sex workers in Mizoram, particularly in Aizawl and Lunglei districts. The study explores how these organizations contribute to HIV prevention, emotional healing, counselling, rehabilitation, and social reintegration among marginalized women. It further analyses how female sex workers perceive and negotiate the support provided by secular and faith-based institutions within a deeply religious society.

The paper argues that effective HIV intervention in Mizoram requires a collaborative and culturally sensitive approach that integrates biomedical healthcare with emotional, spiritual, and community-based support systems. Such an approach may contribute to more inclusive, sustainable, and socially acceptable HIV interventions for female sex workers and other marginalized populations in Northeast India.

2. Literature Review

HIV/AIDS-related stigma continues to remain one of the most significant barriers to prevention, treatment, and rehabilitation among vulnerable populations worldwide. Scholars have long argued that stigma is not merely an individual attitude but a social process that reinforces inequality, exclusion, and discrimination. Goffman (1963) described stigma as a deeply discrediting attribute that reduces an individual's social identity and social acceptance. Later, Link and Phelan (2001) expanded this understanding by explaining stigma as a process involving labeling, stereotyping, separation, status loss, and discrimination within systems of power.

In the context of HIV/AIDS, stigma operates at multiple levels, including internalized stigma, enacted stigma, and structural stigma. People living with HIV often experience shame, fear, social rejection, and discrimination in healthcare settings, workplaces, families, and communities (UNAIDS, 2021). Among female sex workers (FSWs), stigma becomes even more severe because they face discrimination not only due to HIV status but also because of their involvement in sex work. This "double stigma" significantly affects mental health, healthcare access, treatment adherence, and overall well-being (Mitra et al., 2022).

Research conducted in India and other South Asian countries suggests that HIV-positive female sex workers frequently encounter violence, social isolation, emotional trauma, and barriers to healthcare services (Kabir et al., 2024). Studies further indicate that structural inequalities such as poverty, gender discrimination, unemployment, and social exclusion increase women's vulnerability to HIV infection and reduce their ability to negotiate safe sexual practices (Cornish & Ghosh, 2007). Female sex workers often experience exploitation and marginalization within both healthcare systems and society at large.

In Northeast India, the HIV epidemic is closely linked to injecting drug use, migration, unsafe sexual behaviour, and socio-economic instability. Mizoram, in particular, has emerged as one of the most severely affected states in India. Recent studies highlight that HIV-related stigma in Mizoram continues to negatively affect healthcare-seeking behaviour, emotional well-being, and treatment adherence among vulnerable populations (Lalhruaimawii et al., 2025). Fear of social rejection and discrimination often prevents women from disclosing their HIV status or seeking timely healthcare support.

Several studies also emphasize the importance of community-based HIV interventions in Northeast India. Community participation, peer support, and culturally grounded programmes have been found to improve trust, awareness, treatment adherence, and emotional resilience among marginalized populations (Sarkar et al., 2023). Peer-led HIV interventions among female sex workers have particularly shown positive outcomes in increasing condom use, HIV testing, and healthcare accessibility (Lorway et al., 2013).

Non-governmental organizations (NGOs) have played a critical role in HIV prevention and support services across India. NGOs generally adopt rights-based and harm-reduction approaches that focus on healthcare access, dignity, empowerment, and community mobilization. Their interventions often include HIV testing, condom distribution, counselling, antiretroviral therapy (ART) linkage, nutritional support, peer education, and rehabilitation programmes (Cornish & Ghosh, 2007). NGOs are often viewed as more approachable and less judgmental than formal healthcare institutions, particularly among marginalized women.

At the same time, faith-based organizations (FBOs) have increasingly become important actors in healthcare delivery and HIV intervention globally. Olivier and Wodon (2012) observed that faith-based institutions are among the oldest providers of healthcare and social welfare services in many societies. In highly religious communities, FBOs often influence public attitudes toward morality, sexuality, addiction, and disease. In Mizoram, where Christianity strongly shapes social life and cultural identity, churches and faith-based groups play an influential role in counselling, rehabilitation, emotional support, and social reintegration for people affected by HIV/AIDS.

However, the relationship between NGOs and faith-based organizations in HIV prevention remains complex. NGOs typically support evidence-based public health interventions such as condom promotion and harm reduction, while some faith-based groups prioritize abstinence, moral reform, and spiritual healing. These differing perspectives occasionally create ideological tensions, particularly regarding sex work and sexual health education (Olivier & Wodon, 2012). Nevertheless, recent scholarship increasingly argues that collaboration between secular and religious organizations can strengthen HIV interventions when programmes are culturally sensitive and community-oriented (Sarkar et al., 2023).

Recent HIV research also emphasizes the importance of trauma-informed and intersectional approaches in working with vulnerable women. Trauma-informed care recognizes that many HIV-positive female sex workers experience violence, emotional trauma, social rejection, and long-term psychological distress. Such approaches emphasize dignity, empathy, emotional safety, and empowerment within healthcare systems (Kabir et al., 2024). Intersectionality theory further explains how gender, poverty, HIV status, social stigma, and sex work interact to produce multiple layers of discrimination and vulnerability (Mitra et al., 2022).

Despite the growing literature on HIV/AIDS in India, limited research has specifically explored the role of faith-based organizations and NGOs in HIV prevention among female sex workers in Mizoram. Existing studies have largely focused on epidemiological trends, injecting drug use, and behavioural interventions, while the lived experiences of women navigating both secular and faith-based support systems remain underexplored. There is also limited scholarship examining how FSWs perceive these organizations and how collaboration between NGOs and FBOs shapes HIV prevention outcomes within the socio-cultural context of Mizoram.

The present study addresses this gap by examining the role of faith-based organizations and NGOs in reducing HIV transmission among female sex workers in Mizoram. It further explores how these institutions influence healthcare access, emotional support, rehabilitation, stigma reduction, and community reintegration among marginalized women.

3. Theoretical Framework

This study is guided by three important theoretical perspectives: Stigma Theory, Intersectionality Theory, and the Social Support Theory. These theoretical approaches help explain how female sex workers (FSWs) living with HIV in Mizoram experience discrimination, emotional distress, social exclusion, and survival within a highly religious and socially conservative society.

3.1 Stigma Theory

The concept of stigma was first developed by Goffman (1963), who described stigma as a socially discrediting attribute that reduces a person's social identity and acceptance within society. According to Goffman, individuals who are viewed as socially undesirable often experience rejection, discrimination, shame, and exclusion from mainstream social life.

In the context of HIV/AIDS, stigma operates through negative stereotypes, fear, moral judgment, and social discrimination. Link and Phelan (2001) further explained that stigma involves labeling, stereotyping, separation, status loss, and discrimination within systems of social power. HIV-positive individuals are often blamed, feared, and isolated because HIV is socially associated with immorality, deviance, and risky behaviour.

For female sex workers living with HIV, stigma becomes more complex because they experience multiple forms of discrimination simultaneously. They are stigmatized both because of their HIV-positive status and because of their involvement in sex work. This "double stigma" affects their mental health, self-esteem, healthcare access, and social relationships (Mitra et al., 2022). In Mizoram, where religion and morality strongly shape social attitudes, HIV-positive FSWs often face severe judgment and exclusion from families, churches, healthcare institutions, and local communities.

Stigma Theory is therefore useful in understanding how social attitudes and moral judgments shape the lived experiences of HIV-positive female sex workers in Mizoram.

3.2 Intersectionality Theory

The study also draws upon Intersectionality Theory, originally developed by Crenshaw (1989). Intersectionality explains how different forms of social inequality and discrimination intersect and reinforce one another. Gender, class, poverty, HIV status, occupation, religion, and social exclusion do not operate separately but interact to shape people's lived experiences.

Female sex workers living with HIV often experience overlapping vulnerabilities. Many women face poverty, unemployment, domestic violence, substance abuse, and lack of educational opportunities in addition to HIV-related discrimination. These interconnected inequalities increase their vulnerability to exploitation, emotional distress, and poor healthcare access (Kabir et al., 2024).

Intersectionality is particularly relevant in the context of Mizoram because social identity is deeply influenced by religion, gender expectations, and community morality. Women who engage in sex work may be viewed as violating accepted cultural and religious norms, resulting in exclusion and stigmatization. HIV-positive FSWs therefore experience layered forms of marginalization that cannot be understood through a single social category alone.

This theoretical perspective helps explain why HIV-positive female sex workers face unique social and emotional challenges compared to other populations living with HIV/AIDS.

3.3 Social Support Theory

The study further uses Social Support Theory to understand how emotional, social, spiritual, and institutional support helps HIV-positive female sex workers cope with stigma and hardship. Social Support Theory suggests that supportive relationships and community networks can improve psychological well-being, resilience, and coping capacity during stressful life situations (Cohen & Wills, 1985).

Support systems may include family members, friends, peer groups, NGOs, healthcare workers, churches, and community organizations. Emotional support, counselling, practical assistance, and social acceptance help individuals manage stress, trauma, and social isolation more effectively.

In this study, NGOs and faith-based organizations function as important support systems for HIV-positive female sex workers. NGOs provide healthcare assistance, counselling, peer education, and harm-reduction services, while faith-based organizations often offer spiritual guidance, emotional healing, rehabilitation, and social reintegration. Peer networks among women living with HIV also create spaces of trust, solidarity, and shared survival.

Social Support Theory is useful for understanding how community relationships and institutional support contribute to resilience, coping strategies, and survival among marginalized women living with HIV in Mizoram.

4. Research Methodology

4.1 Research Design

This study adopted a qualitative research design to explore the role of faith-based organizations (FBOs) and non-governmental organizations (NGOs) in reducing HIV transmission among female sex workers (FSWs) in Mizoram. A qualitative approach was considered appropriate because the study aimed to understand the lived experiences, perceptions, emotional realities, and coping mechanisms of marginalized women within their socio-cultural context. Qualitative research allows for deeper exploration of sensitive issues such as HIV/AIDS, stigma, sexuality, religion, and social exclusion (Creswell & Poth, 2018).

The study primarily focused on understanding how HIV-positive female sex workers experience support, discrimination, counselling, rehabilitation, and healthcare services provided by NGOs and faith-based institutions. It also examined how these organizations interact within the HIV prevention landscape of Mizoram.

4.2 Study Area

The study was conducted in Aizawl and Lunglei districts of Mizoram. These districts were selected because they have relatively high HIV prevalence rates and active involvement of NGOs, churches, and faith-based organizations in HIV/AIDS intervention programmes. Aizawl, being the capital city, has several HIV intervention centres, rehabilitation programmes, and community-based organizations working with vulnerable populations. Lunglei was selected to provide additional insights from semi-urban settings where healthcare access and support systems differ from urban centres.

4.3 Participants and Sampling

The study included a total of 25 female sex workers, both HIV-positive and at high risk of HIV infection. Participants were selected using purposive sampling and snowball sampling techniques. Purposive sampling was used to identify participants who had direct experience with NGO services, HIV intervention programmes, and faith-based support systems. Snowball sampling helped reach participants from hidden and stigmatized populations through peer referrals.

In addition to female sex workers, the study also included:

- 5 NGO workers involved in HIV intervention programmes,
- 3 faith-based leaders associated with church or rehabilitation activities,
- and 2 healthcare workers involved in HIV counselling and treatment services.

The inclusion of multiple stakeholders helped provide broader understanding and triangulation of findings.

4.4 Data Collection Methods

Data were collected between January and April 2026 using multiple qualitative methods.

In-depth Interviews

Semi-structured in-depth interviews were conducted with all participants. Interviews focused on experiences related to HIV prevention, stigma, healthcare access, counselling, emotional support, rehabilitation, condom use, peer education, and interactions with NGOs and faith-based organizations.

Most interviews lasted between 45 and 90 minutes. Interviews were conducted in English or Mizo, depending on participant preference. With informed consent, interviews were audio-recorded and later transcribed verbatim.

Focus Group Discussions (FGDs)

Two focus group discussions were conducted with female sex workers to understand collective experiences, peer support systems, community perceptions, and challenges faced in accessing HIV-related services. FGDs also helped identify shared patterns regarding stigma, discrimination, and support mechanisms.

Participant Observation

The researcher conducted participant observation during NGO awareness programmes, counselling sessions, and community outreach activities. Observation helped provide contextual understanding of interactions between service providers and beneficiaries.

Secondary Sources

Secondary data were collected from:

- National AIDS Control Organization (NACO) reports,
- Mizoram State AIDS Control Society (MSACS) publications,
- NGO documents,
- journal articles,
- policy reports,
- and previous academic studies related to HIV/AIDS and female sex workers.

4.5 Data Analysis

The collected data were analyzed using thematic analysis. Braun and Clarke's (2006) six-step thematic analysis framework was used to identify patterns, recurring themes, and relationships within the data.

NVivo 12 software was used to organize and code qualitative data systematically. Themes were developed both deductively from the theoretical framework and inductively from participant narratives.

4.6 Ethical Considerations

Ethical considerations were given high priority due to the sensitive nature of the study. Ethical approval was obtained from the Institutional Ethics Committee prior to data collection.

Participants were informed about:

- the purpose of the study,
- voluntary participation,
- confidentiality,
- anonymity,
- and their right to withdraw at any stage without consequences.

Written and verbal informed consent was obtained from all participants before interviews were conducted. Pseudonyms were used throughout the study to protect participant identity and privacy.

Special care was taken to avoid emotional distress during interviews. Participants who required psychological support or counselling were referred to appropriate NGOs and healthcare services.

4.7 Limitations of the Study

The study has several limitations. First, due to the sensitive and stigmatized nature of sex work and HIV/AIDS, some participants may have hesitated to share personal experiences openly. Second, the findings are based on qualitative data from selected districts and therefore cannot be generalized to all female sex workers in Mizoram or India. Third, religious and moral sensitivities surrounding sex work may have influenced participant responses during interviews.

Despite these limitations, the study provides valuable insights into the experiences of female sex workers and the role of NGOs and faith-based organizations in HIV prevention and support services in Mizoram.

5. Findings and Analysis

The findings of the study reveal that both faith-based organizations (FBOs) and non-governmental organizations (NGOs) play important but distinct roles in reducing HIV transmission and supporting female sex workers (FSWs) in Mizoram. Thematic analysis of interviews and focus group discussions generated five major themes: stigma and social exclusion, NGO-led HIV prevention and harm reduction, faith-based emotional and spiritual support, peer networks and survival strategies, and challenges in collaboration between NGOs and faith-based institutions.

5.1 Stigma, Discrimination, and Social Exclusion

One of the most dominant themes emerging from the study was the continued experience of stigma and discrimination among female sex workers living with or vulnerable to HIV/AIDS. Participants reported facing rejection not only because of HIV status but also because of their involvement in sex work. Many women described experiencing "double stigma," where they were judged both morally and socially.

Several participants explained that fear of social exposure prevented them from accessing healthcare services openly.

One participant stated:

"People here know each other very quickly. If someone sees us going to an HIV centre, rumours spread immediately. That fear stops many women from getting tested." Rina, age 30

Participants also reported experiencing discrimination within healthcare settings. Some women felt that healthcare workers treated them differently once their occupation or HIV status became known.

Another participant shared:

"Sometimes the nurses talk politely to other patients, but when they know about us, their attitude changes. It makes us feel ashamed." Lalthari, age 27

These findings are consistent with previous research showing that HIV-related stigma negatively affects healthcare access, emotional well-being, and treatment adherence among vulnerable populations (Lalhruaimawii et al., 2025). The findings further support Goffman's (1963) argument that stigma reduces social acceptance and reinforces exclusion.

The socio-religious environment of Mizoram further intensified stigma experiences. Participants explained that strong religious and moral expectations within society often resulted in judgment against women involved in sex work. Many women feared rejection from churches, families, and local communities.

5.2 NGO-Led HIV Prevention and Harm Reduction

NGOs emerged as one of the primary sources of HIV prevention and healthcare support for female sex workers. Participants frequently described NGOs as safer, more approachable, and less judgmental than formal institutions.

NGO interventions mainly focused on:

- HIV awareness programmes,
- condom distribution,
- HIV testing and counselling,
- peer education,
- linkage to ART services,
- rehabilitation support,
- and emotional counselling.

Many women reported that NGOs helped them gain knowledge about HIV prevention and treatment.

One participant explained:

"Before meeting NGO workers, I did not understand how HIV treatment worked. They explained everything slowly and without judging me." Rosy, age 25

Peer educators attached to NGOs played an especially important role in building trust within the community. Participants felt more comfortable discussing sensitive issues with peer counsellors who had similar life experiences.

The findings indicate that NGO-led interventions promote harm reduction and healthcare accessibility through community-based approaches. These findings align with earlier studies showing that peer-led HIV programmes improve condom use, HIV testing uptake, and treatment adherence among female sex workers (Lorway et al., 2013).

Several NGO workers also emphasized the importance of trust-building and non-discriminatory services.

One NGO worker stated:

"If we approach women with moral judgment, they will never come to us. We first try to build trust and listen to their problems." NGO counsellor, Aizawl

The study therefore suggests that rights-based and community-oriented approaches remain crucial for HIV prevention among marginalized women.

5.3 Role of Faith-Based Organizations in Emotional and Spiritual Support

Faith-based organizations were found to play a different but equally significant role in the lives of HIV-positive female sex workers. While NGOs focused more on biomedical and harm-reduction interventions, FBOs primarily emphasized emotional healing, spiritual guidance, behavioural reform, and social reintegration.

Participants described churches and faith-based rehabilitation centres as spaces that offered hope, forgiveness, emotional support, and community acceptance.

One participant shared:

"When I was completely broken, the church people prayed for me and encouraged me to start life again. That emotional support helped me survive." Zamzami, age 34

Some women explained that spirituality and prayer helped them cope with depression, guilt, and hopelessness after HIV diagnosis.

Faith leaders interviewed during the study emphasized compassion, rehabilitation, and moral support rather than punishment or exclusion.

One church leader explained:

"The church should not reject people living with HIV. They need care, counselling, and acceptance from society." Faith leader, Lunglei

However, the findings also revealed certain limitations within faith-based interventions. Some participants reported discomfort with approaches that focused heavily on moral reform or abstinence while avoiding discussions about condom use and sexual health.

These findings reflect broader tensions identified in previous literature between public health-based HIV interventions and religiously grounded moral frameworks (Olivier & Wodon, 2012).

Despite these tensions, many participants valued faith-based organizations because they addressed emotional suffering and social reintegration in ways that NGOs alone could not fully provide.

5.4 Peer Networks and Survival Strategies

Peer support networks emerged as one of the strongest coping and survival mechanisms among participants. Women often depended on friends, peer educators, and informal support groups for emotional encouragement, healthcare information, financial assistance, and companionship.

Participants explained that speaking with others who shared similar experiences reduced feelings of loneliness and shame.

One participant stated:

"Only another woman like us can fully understand what we go through every day." Jenny, age 29

Peer groups also helped participants:

- access HIV testing services,
- continue ART treatment,
- avoid risky sexual practices,
- and manage emotional stress.

Several women who initially entered programmes as beneficiaries later became peer educators themselves. This created cycles of empowerment and leadership within the community.

The findings support Social Support Theory, which argues that supportive social relationships improve resilience and psychological well-being during stressful situations (Cohen & Wills, 1985).

5.5 Challenges in Collaboration Between NGOs and Faith-Based Organizations

Although both NGOs and faith-based organizations contributed positively to HIV prevention and support, the study identified several challenges in collaboration between the two sectors.

NGO workers reported that some faith-based groups were hesitant to openly support condom promotion and harm-reduction programmes because of moral concerns. At the same time, some faith leaders expressed concern that public health approaches focused too heavily on prevention without addressing behavioural and spiritual transformation.

One NGO worker commented:

"We focus on prevention and saving lives, but sometimes religious groups think condom education encourages immoral behaviour." NGO outreach worker

Despite these differences, some organizations had started collaborating through:

- awareness campaigns,
- counselling services,
- rehabilitation programmes,
- and youth education initiatives.

Participants generally believed that collaboration between NGOs and churches could improve HIV prevention if both sides focused on compassion, healthcare access, and reducing stigma rather than ideological differences.

The findings therefore suggest that culturally sensitive partnerships between secular and faith-based institutions may strengthen HIV prevention efforts in Mizoram.

Analytical Interpretation

The findings demonstrate that HIV prevention among female sex workers in Mizoram cannot be understood only as a biomedical issue. HIV vulnerability is deeply connected to social stigma, religion, gender inequality, emotional trauma, and community exclusion.

NGOs primarily address the medical and public health dimensions of HIV through harm reduction and healthcare access, while faith-based organizations provide emotional healing, spiritual guidance, and community reintegration. Both sectors therefore contribute differently but significantly to the survival and well-being of marginalized women.

The study further reveals that effective HIV intervention requires integrated approaches that combine:

- biomedical healthcare,
- emotional and mental health support,
- peer-led community participation,
- trauma-informed care,
- and culturally sensitive engagement with religious institutions.

These findings reinforce recent scholarship emphasizing the importance of community-based and intersectional HIV interventions among vulnerable populations (Kabir et al., 2024; Sarkar et al., 2023).

6. Discussion

The findings of this study demonstrate that HIV prevention among female sex workers (FSWs) in Mizoram is shaped not only by biomedical factors but also by social stigma, religious morality, emotional trauma, gender inequality, and community relationships. The study highlights the important yet distinct roles played by non-governmental organizations (NGOs) and faith-based organizations (FBOs) in addressing the HIV epidemic among marginalized women.

One of the central findings of the study is the continued presence of HIV-related stigma and discrimination within society. Female sex workers living with HIV experience multiple layers of stigma because of their HIV-positive status, occupation, gender, and social position. This finding strongly supports Goffman's (1963) theory of stigma, which explains how socially discredited identities lead to exclusion and discrimination. Participants in the study frequently described feelings of shame, fear, secrecy, and social isolation due to community judgment and moral condemnation.

The findings also align with Link and Phelan's (2001) argument that stigma operates through broader systems of power and social inequality. In Mizoram, religious morality and conservative social norms significantly influence public attitudes toward sexuality, HIV/AIDS, and sex work. Many participants feared being rejected by families, churches, healthcare workers, and local communities if their HIV status or occupation became publicly known. Similar findings have been reported in recent studies on HIV-related stigma in Mizoram, which show that fear of discrimination negatively affects healthcare-seeking behaviour and emotional well-being among people living with HIV (Lalhruaimawii et al., 2025).

The study further demonstrates that NGOs play a critical role in reducing HIV transmission through harm-reduction and rights-based approaches. NGO interventions such as condom distribution, HIV counselling, peer education, ART linkage, and awareness programmes were viewed positively by most participants. Women described NGOs as more approachable, supportive, and non-judgmental than formal healthcare institutions.

These findings support earlier research emphasizing the importance of community-based HIV interventions among vulnerable populations in Northeast India (Lorway et al., 2013). NGOs were particularly effective in building trust and encouraging women to seek HIV testing and treatment services. The involvement of peer educators also strengthened communication and healthcare accessibility because participants felt more comfortable interacting with individuals who shared similar experiences.

At the same time, the findings reveal that faith-based organizations contribute significantly to emotional healing, counselling, rehabilitation, and social reintegration. In the socio-cultural context of Mizoram, where Christianity strongly shapes community life, many participants viewed spiritual support as an important source of hope, resilience, and emotional survival. Prayer, religious counselling, and church-based rehabilitation programmes helped several women cope with depression, guilt, loneliness, and fear after HIV diagnosis.

These findings suggest that HIV interventions in highly religious societies cannot rely solely on biomedical approaches. Emotional and spiritual dimensions of care are equally important for marginalized populations facing social rejection and psychological distress. The study therefore supports recent scholarship advocating trauma-informed and holistic approaches to HIV intervention (Kabir et al., 2024).

However, the study also identified tensions between NGO-led public health approaches and faith-based moral frameworks. NGOs generally emphasized condom use, sexual health education, and harm reduction, whereas some faith-based organizations focused more on abstinence, behavioural reform, and spiritual transformation. Similar tensions have been discussed in previous studies examining the relationship between religion and public health interventions (Olivier & Wodon, 2012).

Despite these differences, the findings indicate growing possibilities for collaboration between secular and faith-based institutions in Mizoram. Several participants and stakeholders emphasized that both sectors ultimately aim to reduce suffering and improve community well-being. Collaborative programmes involving HIV awareness campaigns, counselling services, rehabilitation activities, and anti-stigma initiatives may therefore strengthen HIV prevention outcomes.

Another important finding of the study is the significance of peer support and community solidarity. Women who participated in peer networks often showed greater emotional resilience, treatment adherence, and healthcare engagement. These findings support Social Support Theory, which argues that emotional and social support systems help individuals cope more effectively with stress and adversity (Cohen & Wills, 1985).

The study also reflects the relevance of Intersectionality Theory in understanding HIV vulnerability among female sex workers. Participants experienced overlapping forms of marginalization related to gender, poverty, HIV status, occupation, and social stigma. These interconnected inequalities shaped their access to healthcare, emotional well-being, and social acceptance. The findings therefore reinforce previous research showing that HIV vulnerability among women is deeply connected to broader systems of gendered and structural inequality (Mitra et al., 2022).

Overall, the study demonstrates that effective HIV prevention in Mizoram requires integrated and culturally grounded approaches. HIV/AIDS should not be understood only as a medical condition but also as a social, emotional, cultural, and structural issue. Interventions that combine healthcare services with counselling, trauma-informed care, peer support, community participation, and culturally sensitive engagement with religious institutions are more likely to produce sustainable outcomes among marginalized women.

The findings contribute to broader academic discussions on religion and public health, gendered stigma, community-based healthcare, and HIV intervention in Northeast India. The study also highlights the importance of developing locally grounded HIV policies that recognize the socio-cultural realities of vulnerable populations rather than relying only on generalized national approaches.

7. Conclusion and Recommendations

This study examined the role of faith-based organizations (FBOs) and non-governmental organizations (NGOs) in reducing HIV transmission among female sex workers (FSWs) in Mizoram. The findings reveal that HIV/AIDS among female sex workers cannot be understood only as a biomedical or behavioural issue. Rather, it is deeply connected to broader social realities such as stigma, gender inequality, poverty, emotional trauma, religious morality, and community exclusion.

The study found that female sex workers in Mizoram continue to experience severe stigma and discrimination because of both their HIV status and involvement in sex work. Fear of social rejection, moral judgment, and public exposure often discourages women from seeking healthcare services, HIV testing, counselling, and emotional support. These findings demonstrate that stigma remains one of the greatest barriers to effective HIV prevention and treatment in the region (Lalhruaimawii et al., 2025).

The findings further show that NGOs play a significant role in promoting HIV prevention through harm-reduction and rights-based approaches. Services such as condom distribution, HIV testing, counselling, peer education, healthcare referrals, and ART linkage programmes were found to improve healthcare accessibility and awareness among female sex workers. NGOs were widely perceived as more approachable and less judgmental than many formal institutions. Peer educators associated with NGOs also played an important role in building trust, encouraging treatment adherence, and reducing emotional isolation among women.

At the same time, faith-based organizations emerged as important providers of emotional healing, spiritual guidance, rehabilitation, and social reintegration. In the highly religious socio-cultural context of Mizoram, many participants viewed spiritual support as essential for coping with depression, guilt, fear, and hopelessness after HIV diagnosis. Churches and faith-based rehabilitation centres often provided emotional comfort, acceptance, and opportunities for rebuilding social identity.

However, the study also identified tensions between secular public health approaches and religious moral frameworks, especially regarding condom promotion, sexuality, and harm reduction. Despite these differences, the findings indicate that collaboration between NGOs and faith-based organizations is both possible and necessary for strengthening HIV prevention efforts in Mizoram.

The study therefore argues that effective HIV intervention requires integrated, culturally sensitive, and trauma-informed approaches that combine biomedical healthcare with emotional, spiritual, and community-based support systems. HIV/AIDS interventions should move beyond treatment-focused models and address the broader social and psychological realities faced by marginalized women.

The research contributes to existing scholarship by highlighting the intersection of religion, public health, gendered stigma, and community-based HIV interventions in Northeast India. It also provides important insights into how local socio-cultural realities shape HIV prevention and support systems in Mizoram.

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